Clinical and Care Governance Committee

Thursday, 28 March 2024

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, 28 March 2024** at **14:00** to consider the business noted below.

AGENDA

MORAY INTEGRATION JOINT BOARD

SEDERUNT

Mr Derick Murray (Chair)

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

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

Clerk Name:	Caroline O'Connor
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MINUTE OF MEETING OF THE CLINICAL AND CARE GOVERNANCE COMMITTEE

Thursday, 30 November 2023

To be held remotely in various locations

PRESENT

Mr Ivan Augustus, Councillor Peter Bloomfield, Mr Simon Bokor-Ingram, Mr Sean Coady, Mr Graham Hilditch, Councillor Scott Lawrence, Mr Derick Murray, Ms Deborah O'Shea, Ms Fiona Robertson, Ms Elizabeth Robinson, Ms Tracy Stephen

APOLOGIES

Professor Duff Bruce, Dr Robert Lockhart, Dr Malcolm Simmons, Mr Kevin Todd

IN ATTENDANCE

Interim Integrated Service Manager, Mental Health and Substance Misuse Service; Social Work Service Manager; Occupational Therapy Team Manager; Locality Manager and Caroline O'Connor, Committee Services Officer.

1. Chair

The meeting was chaired by Mr Derick Murray.

2. Declaration of Member's Interests

There were no declarations of Member's interests in respect of any item on the agenda.

3. Minutes of meeting of 31 August 2023

The meeting of the meeting of 31 August 2023 was submitted and approved, subject to an amendment by Mr Murray in reference to para 8 of the minute relating to the Progress Update in Relation to Upaid Carers Strategy 2023-27. He noted it had been agreed discussions were to take place place between officers rather than with the Chair and suggested the wording of the third paragraph be amended to read:

"The Chair agreed that the frequency of reporting should be discussed by the Chief Officer, Self Directed Support Officer and Mr Augustus following the meeting."

This was unanimously agreed by the meeting.

4. Action Log - 31 August 2023

The Action Log of the meeting of 31 August 2023 was discussed and updated accordingly.

5. Strategic Risk Register

The meeting had before it a report by the Chief Officer providing an overview of the current strategic risks, along with a summary of actions which are in place to mitigate those risks, updated in September 2023.

The Chief Officer sought agreement from the Committee to amend Recommendation (ii) to agree the reporting schedule to this Committee will align with the Audit, Performance and Risk Committee reporting schedule. This was unanimously agreed.

Mr Augustus, Carers Representative queried whether the Unpaid Carers Strategy should be included in the controls section of Appendix 1 in relation to the Strategic Plan "Partners in Care". In response, the Chief Officer agreed specific mention could be made if Mr Augustus deemed it appropriate. It was agreed by both to discuss offline.

Following consideration the Committee unanimously agreed to note:-

i. the updated Strategic Risk Register included in Appendix 1;

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

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

6. Health and Social Care Moray Clinical and Care Governance Group Update

The meeting had before it a report by the Chief Nurse, Moray informing the Committee of progress in refreshing the Clinical and Care Governance Framework in Health and Social Care Moray.

Following consideration the Committee unanimously agreed to note:-

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

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

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

7. Complaints Report for Quarter 2 2023-2024

The meeting had before it a report by the Clinical and Care Governance Group Co-Chairs informing the Committee of complaints reported and closed during Quarter 2 (1 July 2023 - 30 September 2023).

Mr Augustus, Carers Representative, in terms of securing improvement across the services and noting the figures for the quarter were relatively low, sought clarification on whether learning outcomes were being transferred across the service or to the individual complainants concerned.

In response the Chief Nurse advised improvement work was ongoing with complaints and learning outcomes being considered at fortnightly clinical risk management meetings.

Following consideration the Committee unanimously noted the totals, lessons learned, response times and action take for complaints completed within the last quarter.

8. Inspection of Fostering, Adoption and Adult Placement June-July 2023

The meeting had before it a report by the Head of Service and Chief Social Work Officer updating the Committee following a full inspection of of Placement Services (fostering, adoption and adult placement) by the Care Inspectorate in June/July 2023.

Following consideration the Committee unanimously agreed to note the outcome of the full inspection of Placement Services (fostering, adoption and adult placement) by the Care Inspectorate in June/July 2023.

9. Drug Related Deaths in Moray

The meeting had before it a report by the Interim Integrated Service Manager for Mental Health updating the Committee about drug-related deaths in Moray.

Mr Hilditch queried why the death statistics for this year had decreased given that mental health issues are on the increase.

In response the Service Manager advised her understanding was the reduction was due to a combination of factors relating to post covid, support from the third sector, people being more open to interventions and lastly noting the Suicide Prevention Group were working on an Action Plan.

Ms Robinson recommended caution in terms of the reduction being seen as a long terms downward cycle and, given the long term consequences of drug and alcohol use leading to chaotic lifestyles, recognise it remains a significant issue.

Following consideration the Committee unanimously agreed to note:-

i. the drug related death figures for Moray;

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

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

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

10. Health and Social Care Moray Clinical and Care Governance Group Escalation Report

The meeting had before it a report by the Chief Nurse informing the Committee of progress and exceptions reported to the Clinical and Care Governance Group since the last report to Committee in August 2023.

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

11. Community Occupational Therapy Service

The meeting had before it a report informing the Committee that the waiting time for Occupational Therapy (OT) allocation is at a high level with people waiting far over the timescales for allocation and provide details on some of the ways the teams are working to reduce waiting times to a more acceptable level.

Following consideration the Committee unanimously agreed to note the Community OT team continue to work on reducing waiting times for allocation by improving and refining the service provided.

12. Recommended Allowances for Kinship and Foster Carers

The meeting had before it a report by the Head of Service and Chief Social Work Officer informing the Committee of the recommended allowances for kinship and foster carers.

The Service Manager advised there was an updated figure in paragraph 4.10 of the report of £261,570.21 for Moray's allocation from the Scottish Government based on correspondence received since the report was submitted.

The Chief Officer queried whether it was for the Council to approve the allowances given the financial governance sits with the Council.

In response the Head of Service and Chief Social Work Officer confirmed it should go through the Council as the service is in the shadow year and the budget responsibility remains with the Council. She noted the implications were less significant for 2023/24 as the Scottish Government was providing funding and noted the longer term implications would be the responsibility of the Moray Integration Joint Board.

Councillor Lawrence queried whether the intention was to report to the Council for 2023/24 with the costs covered by the Scottish Government funding and would then be reported to the MIJB for future years.

In response the Head of Service and Chief Social Work Officer advised it was not known whether the Scottish Government funding would continue beyond 2023/24. She confirmed it should go through the Council's governance process for 2023/24 and a paper would then be brought back to MIJB once the position was clarified.

Following consideration the Committee unanimously agreed to endorse the adoption of the proposals regarding the recommended allowances for kinship and foster carers and recommend to the Council the adoption of the proposals for 2023/24.

13. Items for Escalation to MIJB

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

MEETING OF MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE

THURSDAY 30 NOVEMBER 2023

ACTION LOG

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY	**UPDATE MARCH 2024**
1.	Strategic Risk Register	Unpaid Carers to be woven into the risk register at a strategic level. Discussion to take place between Chief Officer and Unpaid Carer Officer on whether specific mention of Unpaid Carers Strategy should be included in controls section.	March 2024	Corporate Manager	Work commenced on refreshing the Risk Register. Agreed any emerging risks will be presented as soon as possible.
2.	Progress Update in Relation to Unpaid Carers Strategy 2023-27	Chief Officer, Self Directed Support Officer and Unpaid Carer Officer to discuss and agree the frequency of the progress reports to Committee.	November	Chief Officer	Agreed next update will be presented to Cttee March 2024 – deferred to May 2024
3.	Recommended Allowances for Kinship and Foster Carers	To be reported to Moray Council for approval and further report to be prepared for MIJB once position is clarified.	Jan 2024	Chief Social Work Officer	Report deferred to May 2024. Updated allowances were backdated to 1 April 2023 and paid to carers

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 28 MARCH 2024**

SUBJECT: **FINANCIAL STRATEGIC RISK REGISTER – MARCH 2024**

BY: **CHIEF OFFICER**

1. REASON FOR REPORT

1.1 To provide an overview of the increase to the strategic financial risks, along with a summary of actions which are in place to mitigate those risks, updated March 2024.

2. RECOMMENDATION

2.1 It is recommended that Committee agree to:

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

ii) consider and endorse the draft format of the new Strategic Risk Register

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) Financial Strategic Risk Register is attached to this report at **Appendix 1** and sets out the increasing 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.

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

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

3.5 As agreed at Audit, Performance and Risk Committee on 26 October 2023 (para 8 of minute refers), amendment was approved to report on the Strategic Risk Register from quarterly to biannually unless any significant change required to be informed to committee. As agreed, the Financial Strategic Risks are presented to committee today.

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 A report was presented to MIJB with a budget update for 2024/25 on 25 January 2024. The MIJB requested comprehensive details to be included in a report for further consideration.

4.3 The financial position poses a significant complexity and challenge to service planning.

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. However, Impact Assessments will be core to any financial decision making.

(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 and Operational Management Teams.

6. CONCLUSION

6.1 This report and appendices contain 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 draft version of the Strategic Risk Register.

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

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 and providing capacity to deliver on planned strategic aims.
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 Assessment Table – Multiply likelihood score by impact score to determine the risk rating (score).

Risk Heading	Lead Officer	Current Risk Rating	Target Risk Rating	Last Reviewed	Position Change
Financial Sustainability	Chief Finance Officer	20	9	23/1/24	↓

Key	
↑	Risk improvement
↔	No change to risk
↓	Risk deterioration

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.
Consequence: MIJB is unable to deliver its strategic priorities, statutory services and identified projects.

Rationale for Risk Appetite	The Board recognises the financial constraints all partners are working within. MIJB has a low risk appetite to financial failure and recognises the significance of achieving a balanced budget. The Board also acknowledges the statutory requirements to provide services within the allocated budget. The cost of current service delivery is higher than available budgeted resources. Those risks will only be considered: • 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
Rational for Risk Rating	If the MIJB's strategic plan and medium term financial plan are not prepared on a sustainable basis, there is a risk that the recurring cost base could exceed future funding allocations resulting in an underlying deficit. This will adversely affect both current and future service provision and will impact on the MIJB's ability to deliver its strategic priorities and vision. Given the current level of uncertainty associated with civil unrest across the globe, cost of living crisis, tight financial settlements for local government and health and the impact of increasing demand, the magnitude of the potential costs involved represent a continuing significant financial risk. Additional consequentials have ceased and any recurring costs will have to be met from existing baseline budgets. National Care Service legislation also introduces a new area of financial uncertainty

Untreated Likelihood	Untreated Impact	Untreated Score	**Mitigations / Current controls in place**	Current Likelihood	Current Impact	Current Score
5	5	25	1. Budgets delegated and managed by Service Managers with Head of Service oversight. 2. Vacancy controls via the Resource Management Group 3. The interim arrangement for Chief Financial Officer will cease on 31 March 2024 with the appointment being permanent from 1 April 2024. 4. CFO and SMT working to continuously identify additional savings. 5. A reviewed Financial Framework was presented to MIJB on 30 March 2023, and a further update will be presented in March 2024.	4	5	20

			6. Financial information is reported regularly to MIJB, Senior Management Team and Operational Management Team. 7. The CO and CFO continue to regularly engage in finance discussions with key personnel of both NHS Grampian and Moray Council. 8. The CO and CFO will continue to engage with partner organisations in respect of the financial position throughout the year. Cross partnership performance meetings are with partner CEOs, Finance Directors and Chair/Vice Chair of MIJB.			

Assurances:	MIJB and Audit, Performance and Risk oversight and scrutiny of budget Reporting through MIJB, NHS Grampian and Moray Council
Gaps in Assurance:	None identified

Further Controls Required	Further Controls Owner	Target Date
Regular financial workshops with Service Leads to identify further savings	Chief Financial Officer	2/2/24 - Completed
Financial development session with MIJB members	Chief Officer	7/3/24 - Completed
Reporting from Resource Management Group to SMT for oversight of agreed spend	Chief Officer	4/3/24 - Completed
Financial workshops with OMT looking at savings options	Head of Service	2/2/24 - Completed

Review Date	Review Notes / Decisions
8/3/24	A Recovery plan was submitted to MIJB in January 2024, a development session took place to discuss options in 7/3/24 with the recovery plan going back to MIJB in March 2024.

Likelihood – What is the likelihood of the risk occurring? Assess using the criteria below.

Rare	Unlikely	Possible	Likely	Almost Certain
(1)	**(2)**	**(3)**	**(4)**	**(5)**

Don't believe this event would happen Will only happen in exceptional circumstances	Not expected to happen but definite potential exists Unlikely to occur	May occur occasionally Has happened before on occasions Reasonable chance of occurring	Strong possibility that this could occur Likely to occur	This is expected to occur frequently/ in most circumstances more likely to occur than not

Impact – What could happen if the risk occurred? Assess for each category and use the highest score identified.

The impact scale is from an organisational level perspective. It reflects the key areas that if impacted could prevent the organisation achieving its priorities and objectives. The scale is a guide and cannot cover every type of impact therefore judgement is required.

Category	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Patient or Service user Experience	Reduced quality patient experience/clinical outcome not directly related to delivery of clinical care	Unsatisfactory patient experience/clinical outcome directly related to care provision – readily resolvable	Unsatisfactory patient experience/ clinical outcome, short term effects – expect recovery less than 1wk	Unsatisfactory patient experience /clinical outcome, long term effects - expect recovery over more than 1week	Unsatisfactory patient experience/clinical outcome, continued ongoing long term effects
Objectives/ Project	Barely noticeable reduction in scope/quality/ schedule	Minor reduction in scope/quality/schedule	Reduction in scope/quality/project objectives or schedule	Significant project overrun	Inability to meet project/corporate objectives, reputation of organisation seriously damaged
Injury /illness (physical and psychological) to patient/service user/visitor/staff/carer	Adverse event leading to minor injury not requiring first aid	Minor injury or illness, first aid treatment required	Agency reportable, e.g. Police (violent and aggressive acts) Significant injury requiring medical treatment and/or counselling	Major injuries/long term incapacity /disability (e.g. loss of limb), requiring, medical treatment and/or counselling	Incident leading to death(s) or major permanent incapacity
Complaints/Claims	Locally resolved verbal complaint	Justified written complaint peripheral to clinical care	Justified complaint involving lack of appropriate care	Claim above excess level. Multiple justified complaints	Multiple claims or single major claim Complex Justified complaint

Service/ Business Interruption	Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service	Short term disruption to service with minor impact on patient care/service provision	Some disruption in service with unacceptable impact on patient care Temporary loss of ability to provide Service.	Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked	Permanent loss of core service/ facility Disruption to facility leading to significant "knock on" effect -- to function
Staffing and Competence	Short term low staffing level temporarily reduces service quality (less than 1 day) Short term low staffing level (>1 day), where there is no disruption to patient care	Ongoing low staffing level reduces service quality Minor error due to lack of/ ineffective training/ implementation of training	Late delivery of key objective/service /care due to lack of staff Moderate error due to lack of/ ineffective training / implementation of training Ongoing problems with staffing levels	Uncertain delivery of key objective/service/care due to lack of staff Major error due to lack of/ ineffective training / implementation of training	Non-delivery of key objective/ service/care due to lack of staff. Loss of key staff Critical error due to lack of/ ineffective training/ implementation of training
Financial (including Damage/Loss/Theft/ Fraud	Negligible organisational/ personal financial loss up to £1k	Minor organisational/ personal financial loss of £1-10K	Significant organisational/personal financial loss of £10-100k	Major organisational/personal financial loss of £100k-1m)	Severe organisational financial loss of more than £1m
Inspection/ Audit	Small number of recommendations which focus on minor quality improvement issues	Recommendations made which can be addressed by low level of management action	Challenging recommendations that can be addressed with appropriate action plan Improvement Notice	Enforcement/prohibition action Low Rating Critical report	Prosecution Zero rating Severely critical report

Adverse Publicity/ Reputation	Rumours, no media coverage Little effect on staff morale	Local media coverage – short term. Some public embarrassment Minor effect on staff morale/public attitudes	Local media – long term adverse publicity Significant effect on staff morale/public perception of the organisation	National media adverse publicity less than 3 days Public confidence in the organisation undermined Use of services affected	National/International media/ adverse publicity, more than 3 days MSP/MP/SEHD concern (Questions in Parliament) Court Enforcement/Public Enquiry/FAI

Likelihood	**Consequences/Impact**				
	Negligible	**Minor**	**Moderate**	**Major**	**Extreme**
Almost Certain	Medium	High	High	V High	V High
Likely	Medium	Medium	High	High	V High
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

Review Timescales – When a risk rating has been assigned the criteria below should be used to assess the review timescales.

Very High or High	Requires monthly monitoring and updates.
Medium	Requires quarterly monitoring and updates.
Low	Requires 6 monthly monitoring and updates.

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 28 MARCH 2024**

SUBJECT: **PRIMARY CARE PRESCRIBING BUDGET FOR 2024-25**

BY: **LEAD PHARMACIST, HEALTH AND SOCIAL CARE MORAY**

1. REASON FOR REPORT

1.1 To inform the Committee of the predicted prescribing budget resource requirements for 2024-2025, alongside key drivers of growth and mitigations regarding costs.

2. RECOMMENDATION

2.1 It is recommended that the Committee consider and note:

(i) the recommendations made in this paper regarding volume, costs, risks and the net predicted need for a budget resource of £23,799m, as part of the overall Health and Social Care Partnership budget setting process for 2024-25;

(ii) the estimated budget requirements; and

(iii) mitigations regarding cost efficiencies.

3. BACKGROUND

3.1 Current forecasting indicates that Moray will end the 2023-24 year with a prescribing deficit of -£3,703,000 which will be further affected by identified factors and estimates for these factors. Historic limited budget uplifts have resulted in significant historic overspends.

3.2 **Appendix 1** highlights a trend of increasing void between actual budget and actual spend.

3.3 There has been unprecedented growth in items and costs across all boards in Scotland (**Appendix 2**). This has been further impacted also by the increase in acute prescription requests by patients. There are wide ranging factors affecting performance.

3.4 Resource assessment for prescribing has been undertaken for 2024-25. This was done using the approach adopted in previous years, which estimates growth in volume and spend in the coming year, and also offsets these with generic savings and approved efficiency plans. The key themes and data

presented here are taken from the more comprehensive 'Health and Social Care Prescribing Budget Supporting Information and Data for 2024/2025', which has been scrutinised and approved by the multidisciplinary / cross sector Grampian Area Drug and Therapeutics Committee (GADTC) and NHS Grampian Primary Care Prescribing Group.

3.5 A breakdown of the components of the Moray requested budget for 2024-25 is provided in **Appendix 3**.

3.6 A growing and ageing population demographic has had an effect on prescribing volumes and subsequent costs:

(i) NRS figures for mid-2021 showed an increase of 700 people (+0.72%), and 2023 figures now show that 22% of Moray population are now over age 65 which carries much higher cost per patient (**Appendix 4**). Mitigation is to offer Primary and Secondary prevention and adopt Realistic Medicine approaches to care.

3.7 Volume growth for 2023-24 is still highly variable due to multiple factors, including changes in volumes and treatments, and post-Covid variation in operating levels across Primary and Secondary care. Pre-Covid Grampian annual growth of prescription items was steady at 1% but 2022/23 growth exceeded this at 4.4% items with 6.6 % costs. In 2023/24 we have unprecedented growth in items and costs. Many drivers of growth are out with our HSCP control.

3.8 Following Grampian's increasing trend over time, the number of items and cost trends per financial quarter show an increase, as does the cost per item (detailed in **Appendix 5**).

3.9 The need for sustainable and environmentally friendly prescribing is a consideration.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

The following are the main financial risks:

4.1 Scottish Drug Tariff Pricing and Medicine Shortages: Volatility within pricing of several widely used medications means that prices are likely to remain high in 2024-25.

4.2 There is a risk in that the future prices for generic medicines, and associated reimbursement levels set within the Scottish Drug tariff, remain high and difficult to predict. The Scottish Government has committed to rebalancing Community Pharmacy contractor payments by reducing the emphasis on margin share and moving these payments to within the guaranteed global sum.

4.3 Generic shortages arise from increase in demand, lack of active ingredient, quality control and manufacturing delay, etc. These result in more costly prescribing e.g. more expensive sometimes unlicensed medication choices, as well as impacting pharmacy admin and clinician time required.

4.4 The global supply chain of medication remaining fragile continues to be a significant sourcing problem for Community Pharmacy within a wide range of medicines for a variety of conditions. Such shortages can lead to unpredictability in the cost per item during the year.

4.5 The growth in consumption of medicines had been stabilising. Anecdotally this has been linked to the end of Quality and Outcomes Framework (QOF) pressure to prescribe preventative medication, strengthened approaches to medication review and associated reductions in polypharmacy. The variations in volume since 2020 are partially related to COVID-19 and changes in patient behaviours, as well as changes in capacity within Primary Care. Repeat prescribing increase has continued, and acute prescribing and outpatient/medication requests are variable corresponding to service provision and patient flow.

4.6 In terms of Primary Care rebates, the system that provides the NHS in Scotland with post-use discounts on spend on specific medicines has remained generally stable, but there remains a risk that these rebates may change or are removed. N.B. these discounts accrue to the individual Health and Social Care Partnerships (HSCPs) based on spend.

4.7 Sustained and increased pressures within GP practices and expectation of workload by Pharmacotherapy teams to deliver Pharmacotherapy Memorandum of Understanding (MOU) work has reduced time availability for medicines management cost efficiency work by Pharmacists and GPs.

4.8 National/international research, change to evidence based guidance or change to government policy. Many new medicines and new indications/licensing change for existing medications, from new protocols, are likely to have a significant clinical and subsequent financial impact e.g. HRT/Testosterone treatment in women and Attention Deficit Hyperactivity Disorder (ADHD) treatment in adults. **Appendix 6** highlights examples of medicines predicted to cause impact of an additional £4.3m in Grampian. The list is not exhaustive and difficult to predict.

4.9 Changes in delivery of local services and patient pathways, some following COVID, have the potential to affect medicine use e.g. transfer of prescribing from secondary care to primary care has a financial impact.

4.10 Extended hospital procedure waiting lists also requires extended prescribing time while patients are on the waiting list.

4.11 In addition, **Appendix 7** lists medicines with unknown financial impact in the near future.

5. SUMMARY OF RISK MITIGATION

Patent Expiry

5.1 On expiry of a drug patent, increasing competition can drive down market prices where there are alternative manufacturers. On patent expiry there is also opportunity to review the preparation prescribed and change to generic or more cost effective drug.

Prescribing Cost Efficiencies and Cost Avoidance

5.2 There is an urgent need and opportunity to deliver several cost efficiencies. An actionable tracker (in line with Grampian Primary Care Prescribing Group) holds some drug therapeutic switches, and other appropriate cost efficiency work for the pharmacy team to complete. Moray Pharmacotherapy staff annotate work when completed. This work has been challenging in terms of workforce capacity and workload pressures. We aim to deliver measurable efficiencies but would require protected “invest to save” in this area. Grampian Medicines Management support us in this area also. Appendix 8 details a summary of some work which could be delivered.

Spend to Save Initiative

5.3 Opportunities remain to achieve considerable cost savings by increased dedicated focused work if we allocated capacity. As well as therapeutic switches prescribing of items of low clinical value could be looked at .This does require some Clinician input as well as Pharmacy Technician input. Recent targeted cost efficiency drug therapeutic switches work was carried out by a Moray Pharmacy Technician on 20 medications, and this realised measurable savings of £21,606 per annum on therapeutic switches from 35 hours of Technician time with additional Pharmacist support.

5.4 A Grampian primary care prescribing efficiencies agreement has been put in place with the aim of medication review interventions which will involve drug therapeutic switches and generic switches. There will be 3 levels of work stream and GPs have been identified as suitable to sign up to do level 3 aspects. The plan may be that pharmacy technicians will be identified to enable level 1 and 2 work.

Scriptswitch

5.5 This is a communication tool providing electronic advice messages to the prescriber. We continually review these messages to ensure that Scriptswitch underpins and delivers many cost saving initiatives. This can be in the form of a targeted therapeutic drug switch, reducing waste by dose optimising, as well as safety alerts. In 3 months Moray generates approximately £48,215 savings via Scriptswitch, as well as influencing prescribing for future.

Generic Savings Work

5.6 On our actionable tracker, we include work from the Practice Generic Savings Quarterly Report, and all teams are given details on medications not prescribed generically and the costs involved, although admittedly this is less than previous impact. The teams are requested to review and annotate changes made.

Extraordinary Prescribing Report

5.7 Moray Pharmacotherapy Team Management check reports and request copies of prescriptions in order to identify where pricing and reimbursement overpayments may require to be claimed. This can be from specials medications or normal prescribing. Time capacity more recently prevents much of this work, however in 2022, we claimed back £23,545 via pricing recovery.

Tighter Control of Specials Items

5.8 Automatic authorisation of specials items of £100 or less has now been removed to allow more scrutiny of the specials prescribing and payments.

Medicine Care and Review – Serial Prescribing

5.9 Use of this serial prescription service, and now also in care homes, has the potential to reduce wastage as prescriptions are issued at correct intervals, which prevents any unnecessary stock piling.

The Grampian Formulary

5.10 A Grampian Formulary tool is installed in all Moray GP Practices to steer the appropriate cost-effective prescribing choices. There remains opportunity to identify and amend non formulary prescribing.

6. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Partners in Care 2022-2032"
As set out within Moray's Integration Scheme.

(b) Policy and Legal
There are no policy or legal implications arising from this report.

(c) Financial implications
Primary Care prescribing remains a material financial risk area and this paper identifies the anticipated requirements for additional investment. This is described in Appendix 3.

(d) Risk Implications and Mitigation
There is a risk of financial failure; the risk is that demand for medicines outstrips the budget and the MIJB cannot deliver priorities, statutory work, and therefore project an overspend. Risk will be mitigated by actions set out in this report to manage the budget, but the key financial risks are highlighted above.

(e) Staffing Implications
There is a risk of Pharmacotherapy time capacity implications arising from this report.

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

(g) Equalities/Socio Economic Impact
There are no equalities/socio economic implications arising from this report.

(h) Climate Change and Biodiversity Impacts
There are positive benefits to environment included in some therapeutic switches where inhalers are changed to lower Global Warming Potential impact devices.

(i) Directions
None arising directly from this report.

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

- Chief Financial Officer, Moray Integration Joint Board
- GP Clinical Leads, Health and Social Care Moray
- Clinical and Care Governance Group

7. CONCLUSION

7.1 Committee are asked to consider the recommendations made in this paper with regard to volume, costs, risks and the net predicted need for budget resource of £23,799m, as part of the overall HSCP budget setting process for 2024-25 and taking into account new and existing cost pressures and historic overspends.

7.2 Also consider mitigations to address some rising costs.

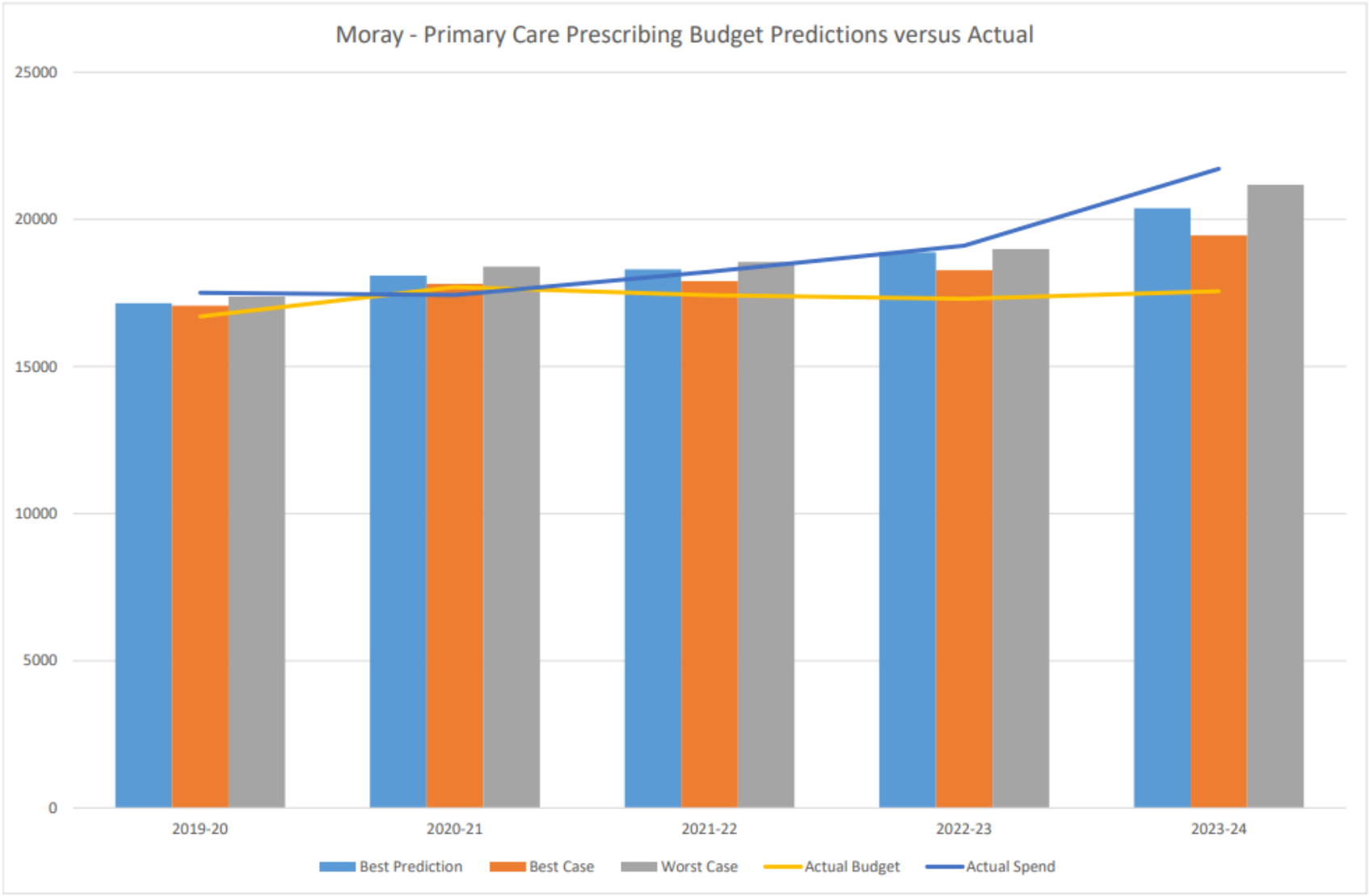
Author of Report: Christine Thomson, Moray HSCP Lead Pharmacist

Background Papers: with author

References:

- Health and Social Care Prescribing Budget Supporting Information and Data for 2024-2025
- NHS Grampian Pharmacy & Medicines Directorate, Grampian Area Drug &Therapeutics Committee & Finance Directorate.
- BNF Sep 2023
- Pharmaceutical Journal
- NHS Inform
- SP3A The Impact of COVID on GP Prescribing
- Scottish Drug Tariff
- www.cps.scot/nhs-services/remuneration/drug-tariff/adjusted-prices
- NRS council profiles accessed at https://www.nrscotland.gov.uk

Moray Budget Predictions, Budget Allocation and Actual Spend



NHS Grampian vs Other Health Boards

Figure 1 – Items Trends, NHS Scotland Mainland Health Boards

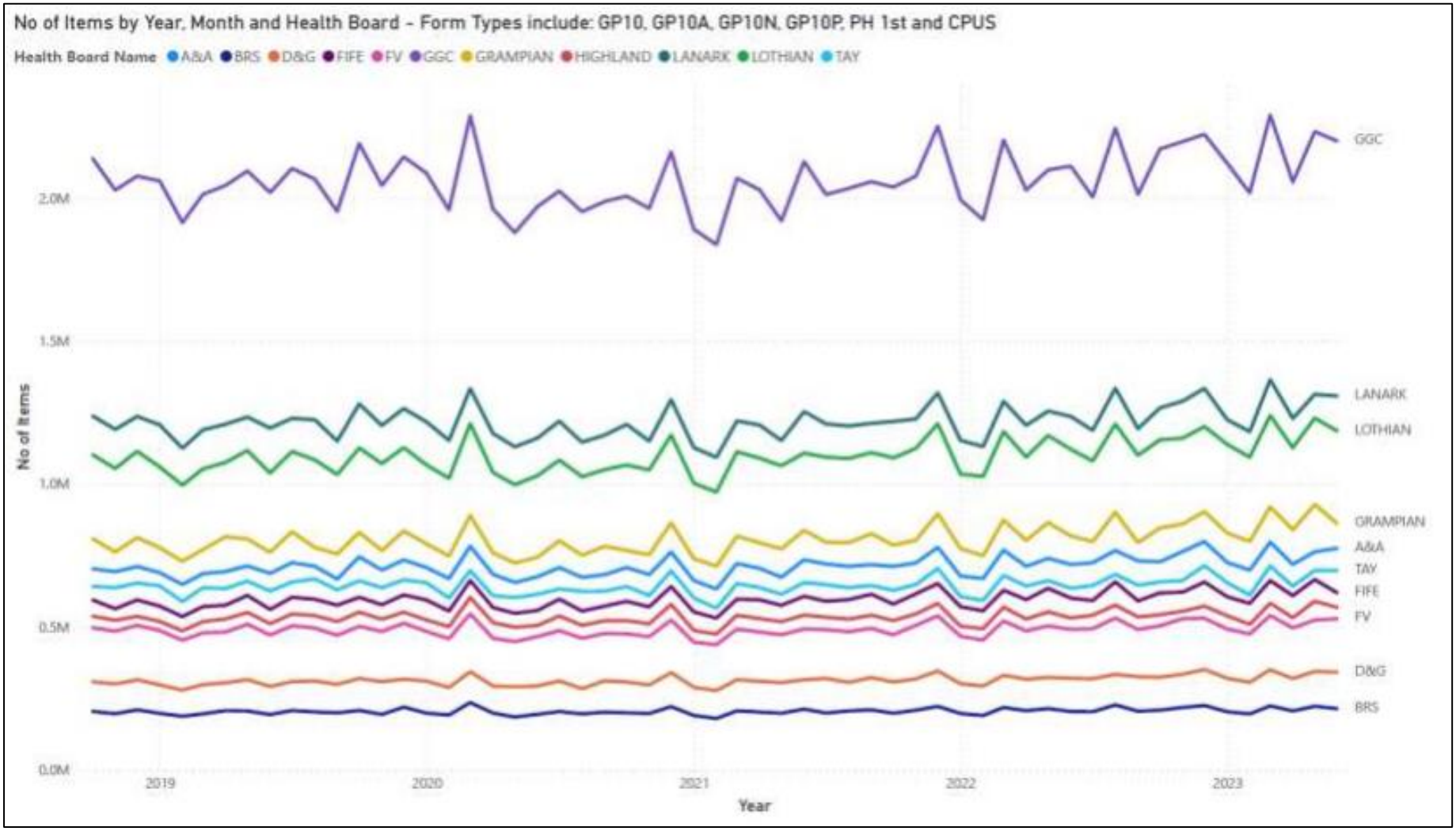
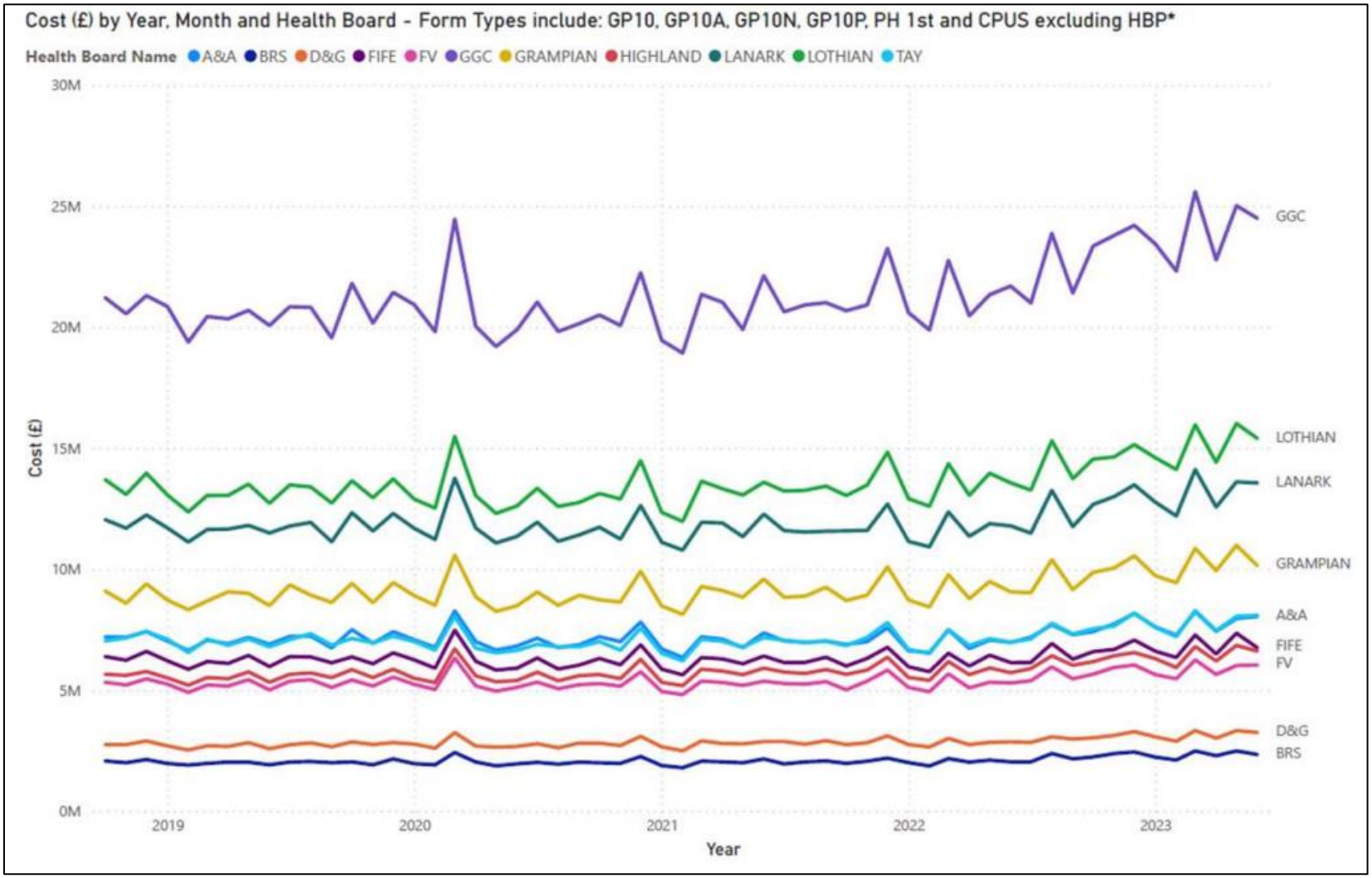


Figure 2 – Cost Trends, NHS Scotland Mainland Health Boards



Moray Health and Social Care Partnership: Summary and Budget Estimates

Tables A and B: Estimates for Prescribing

Table A: Growth, Expenditure and Savings – Primary Care Prescribing

Factor	Low estimate		Medium estimate		High estimate	
	£000's		£000's		£000's	
	Level of		Level of		Level of	
Remove under accrual impact from 2023/24	-100		-100		-100	
Demographic impact	143		143		143	
Volume estimate movement	467		803		1052	
Price impact from 2023-24	73		73		73	
Price impact further movement	0		325		542	
ScriptSwitch allocation and communications	44		44		44	
Discount income	-9		-13		-15	
New Medicines affecting Primary care	8		8		8	
Existing Medicines affecting Primary Care	801		801		801	
Scottish Tariff discount % reduction	116		116		116	
Further Prescribing Efficiencies	-160		-160		-160	
Total Movements	1384		2041		2505	

Table B: Overall Moray HSCP Suggested Primary Care Prescribing Budget Requirement 2024/25

Factor	Low Estimate		Medium Estimate		High estimate	
	£000's		£000's		£000's	
Full year Budget 2023-24	18054		18054		18054	
Predicted Year End Outturn 2023-24	21757		21757		21757	
Total Movements	1384		2041		2505	
Suggested Total budget 2024/25	23141		23799		24262	
% increase on 2023-24 budget	28.2		31.8		34.4	
% increase on predicted 2023-24 expenditure	6.4		9.4		11.5	

Table C: Moray HSCP Suggested Primary Care Core HSCP Service Requirements 2024/25

Full year budget 2023/24 (£000's)	Estimated Out-turn 2023/24 (£000's)	Suggested Budget 2024/25 (£000's)	Uplift on 2023/24 Budget %	Uplift on 2023/24 Budget %
279	240	321	14.7	34.0

Table D: Hosted Services Impact by IJB

Hosted Sector	2024/25 Total uplift £000's	Moray IJB impact 2024/25 £000's	Moray IJB % shares
City Sexual Health	43	8	18
City Intermediate Care	84	3	4
Moray GMED	48	8	18
Shire HMP Grampian	To be confirmed following Hep C review		
Shire Police Custody	0	0	18
Total	175*	19*	

*HMP Grampian uplift and impact still to be added

Population Calculations

Rationale for Financial Updates Associated for Population Changes

Increases in spend across each HSCP relating to population growth and demographic changes was calculated using the following steps:

1. Population projection figures were obtained from National Records of Scotland (NRS). These projections were based on 2018 data.
2. Costs for financial year 2022/2023, split by 4-year age bands (0-4, 5-9, 10-14, 15, 19……85-90, 90+), were obtained from Prescribing Information System (PIS) for each HSCP.
3. Using the cost per age band, and 2022 population numbers per age band (obtained from 2022 census data - https://www.scotlandscensus.gov.uk/documents/scotland-s-census-2022-rounded-population-estimates-data/) cost per age band was calculated for each age band in each HSCP.
4. The calculated cost per patient, per age band was then used alongside predicted population numbers to calculate the potential financial impact of changes in both absolute population numbers and demographics.

Table 1 – Moray Estimated Costs based on Population Predictions using Cost per Patient per Age Band

HSCP	AGE BAND	GIC YR 2022.3	£ per Patient	2023	2024	2025	2026	2027	2028	2029	2030
Moray	Age 0-4	282,207	67.19	276,429	276,160	274,816	273,808	272,330	271,053	269,575	267,895
Moray	Age 5-9	342,779	69.95	320,113	311,299	304,863	296,189	292,901	291,502	291,222	289,753
Moray	Age 10-14	413,845	76.64	405,875	395,299	384,953	375,297	368,399	355,064	345,408	338,357
Moray	Age 15-19	337,207	67.44	359,665	365,330	369,444	371,872	363,374	353,730	344,693	336,263
Moray	Age 20-24	300,900	68.39	320,117	311,637	307,875	307,944	312,799	321,621	326,340	329,691
Moray	Age 25-29	405,693	82.79	453,466	448,664	439,805	426,226	415,463	409,585	399,401	394,930
Moray	Age 30-34	517,680	94.12	521,539	528,033	532,269	540,740	532,363	524,268	518,433	508,267
Moray	Age 35-39	642,548	118.99	684,790	687,527	677,770	669,916	674,557	678,127	685,266	690,145
Moray	Age 40-44	737,413	139.13	801,971	803,223	812,545	827,850	829,241	835,502	838,842	828,267
Moray	Age 45-49	948,874	166.47	928,898	921,240	927,400	924,070	954,534	977,840	979,837	990,658
Moray	Age 50-54	1,428,717	201.23	1,375,392	1,324,481	1,275,784	1,211,794	1,146,596	1,097,496	1,088,642	1,097,295
Moray	Age 55-59	1,643,870	222.14	1,616,768	1,613,436	1,591,888	1,581,670	1,554,790	1,511,250	1,455,714	1,401,733
Moray	Age 60-64	1,779,014	261.62	1,822,182	1,864,041	1,891,249	1,916,103	1,923,952	1,913,225	1,909,563	1,885,755
Moray	Age 65-69	1,854,579	309.10	1,921,963	1,951,018	2,005,728	2,030,146	2,078,674	2,123,184	2,172,949	2,206,950
Moray	Age 70-74	2,059,021	374.37	2,066,134	2,077,739	2,069,129	2,111,806	2,169,085	2,220,373	2,257,810	2,322,950
Moray	Age 75-79	2,034,841	462.46	2,201,790	2,236,937	2,300,295	2,349,779	2,266,997	2,257,748	2,274,397	2,268,847
Moray	Age 80-84	1,455,573	501.92	1,545,417	1,606,149	1,655,338	1,705,028	1,859,118	1,940,429	1,977,069	2,033,285
Moray	Age 85-89	951,098	559.47	1,066,349	1,089,287	1,091,525	1,118,939	1,143,555	1,187,753	1,239,225	1,281,744
Moray	Age 90+	471,878	524.31	561,534	581,982	609,771	630,219	652,764	676,882	700,476	724,070
				19,250,390	**19,393,482**	**19,522,445**	**19,669,395**	**19,811,493**	**19,946,634**	**20,074,860**	**20,196,854**

Items and Cost Performance Trends

Figure 1 – Number of Items Prescribed in General Practice (GP10, GP10N, GP10P (practice pharmacist) and GP10A)

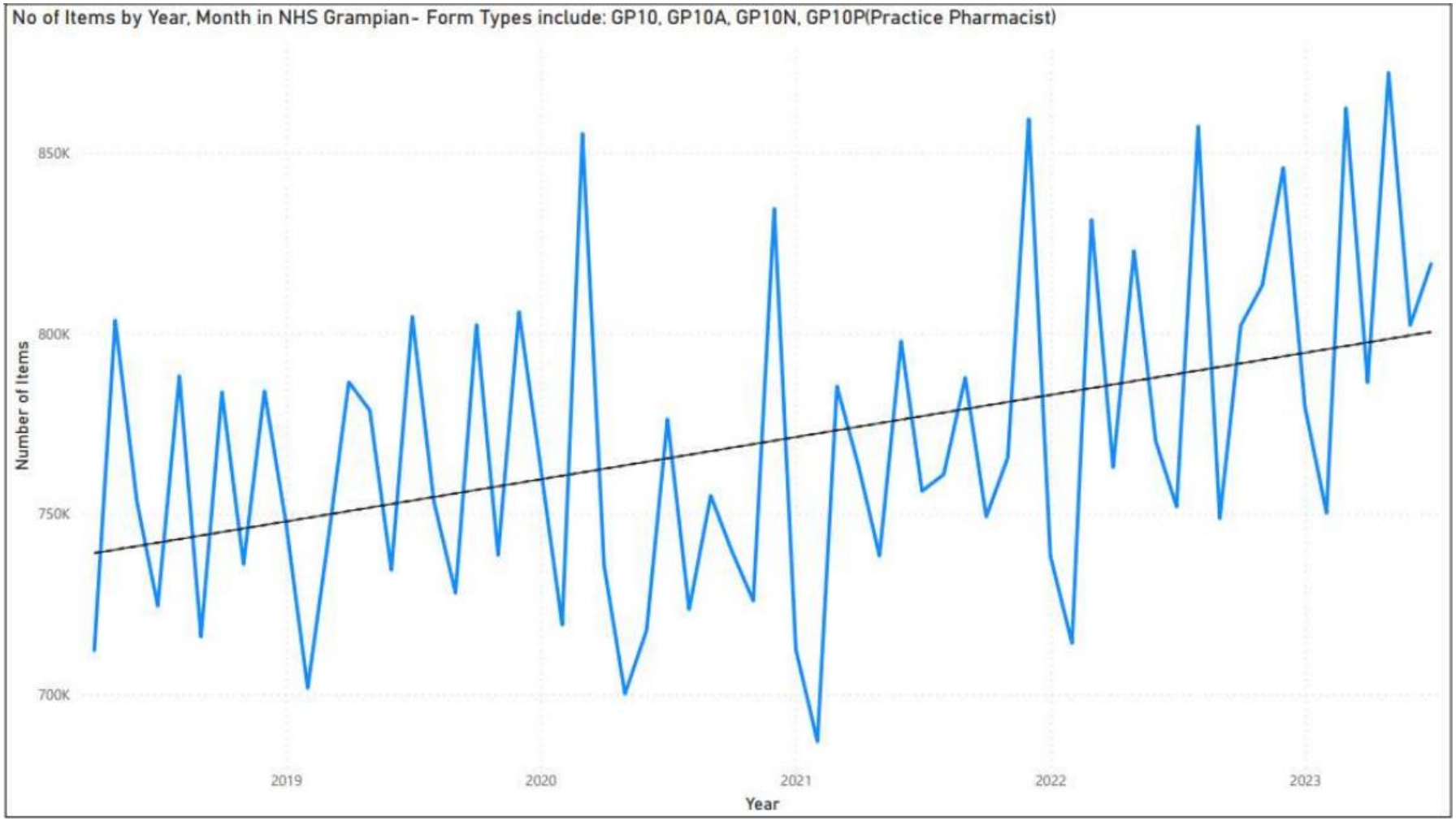
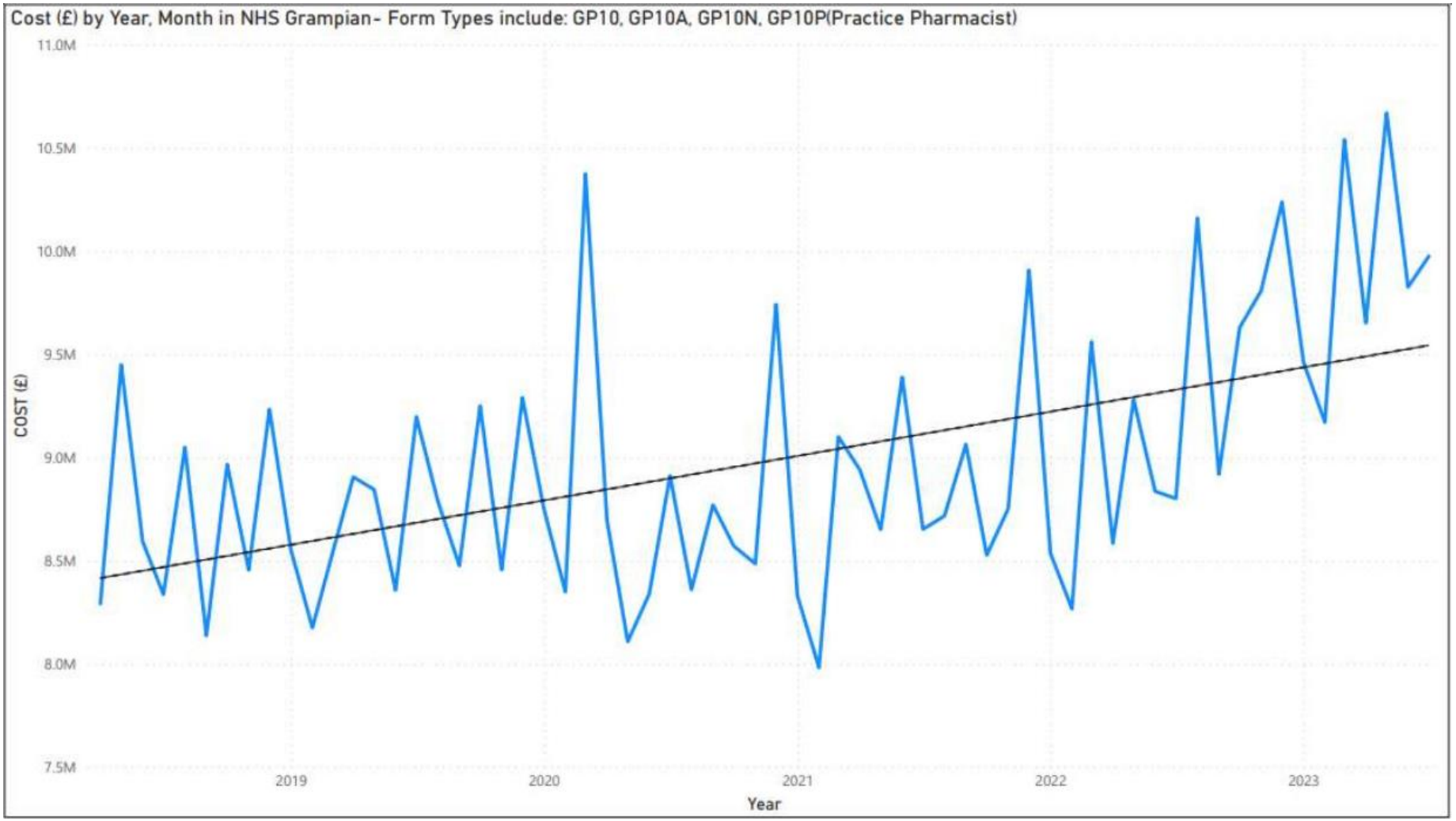


Figure 2 – Cost of Items Prescribed in General Practice (GP10, GP10N, GP10P (practice pharmacist) and GP10A)



Primary Care Growth of Medicines Predictions (existing and new medicines)

Primary Care Growth Existing Medicines (all from types excluding HBP and GP14)							
Medicine/Medicine Group	**Prediction**	**2023/2024 cost (12M estimate)**	**2024/2025 cost (12M estimate)**	**Uplift/saving**	**Impact**	**Drivers**	**How calculations have been undertaken**
Direct acting anticoagulant (DOAC)	Continued growth in prescribed items and associated costs.	£ 5,021,171	£ 4,104,921	-£ 916,249	Moderate	Overall DOAC usage continues to grow; the addition of apixaban (2.5mg and 5mg to SDT) has resulted in a significant reduction in pricing. Calculations are based on the assumption that the price of apixaban in December 2023 will hold and that growth will continue at a rate similar to growth over the last 12 months (Q2 22/23 - Q1 23/24)	Quantity used to calculate uplifts (average of % uplift from last 4 quarters of data, Q2 22/23 - Q1 23/24). Apix 2.5mg 4%, apix 5mg 7% and all others flat. % increase applied to Q1 23/24 quantity and then extrapolated from there.
Sodium Glucose Co-Transporter 2 (SGLT2) Inhibitors	Continued growth in prescribed items and associated costs.	£ 2,715,171	£ 3,975,282	£ 1,260,111	High	SGLT2 and GLP1 are relatively novel agents used in the management of T2 diabetes. It is anticipated that prescribing will continue to grow and that these medicines will be used earlier in the management of diabetes. As such, growth is to be expect in 2024/2025 and coming financial years. Calculations are based on the assumption that prices will remain stable and that growth will continue at a rate similar to growth over the last 12 months (Q2 22/23 - Q1 23/24).	Average % increase in GIC from last 4 quarters (Q2 22/23 - Q1 23/24) used to make 23/24 and 24/245 estimates. Taken actual GIC for Q1 23/25 and then applied 10% increase per quarter
Glucagon like peptide (GLP1) receptor agonists	Continued growth in prescribed items and associated costs.	£ 736,808	£ 1,068,371	£ 331,563	Moderate		Average % increase in GIC from last 4 quarters (Q2 22/23 - Q1 23/24) used to make 23/24 and 24/245 estimates. Taken actual GIC for Q1 23/25 and then applied 9% increase per quarter

Medicine/Medicine Group	Prediction	2023/2024 cost (12M estimate)	2024/2025 cost (12M estimate)	Uplift/saving	Impact	Drivers	How calculations have been undertaken
Antidepressant Medications	Continued growth in prescribed items and associated costs.	£ 3,570,304	£ 4,679,940	£ 1,109,636	High	Mental health prescribing increased during COVID, and this trend has continued post-COVID, attributed mainly to the financial and cost of living crisis. Growth is challenging to predict and as such, anti-depressant prescribing should be considered an ongoing risk to Primary Care prescribing. Calculations are based on the assumption that prices will remain stable and that growth will continue at a rate similar to growth over the last 12 months (Q2 22/23 - Q1 23/24).	Average % increase in GIC from last 4 quarters (Q2 22/23 - Q1 23/24) used to make 23/24 and 24/245 estimates. Taken actual GIC for Q1 23/25 and then applied 7% increase per quarter
ADHD medicines	Continued growth in prescribed items and associated costs.	£ 1,649,805	£ 1,930,038	£ 280,233	Moderate	ADHD prescribing has increased in recent years due to increased awareness of the condition, increased diagnoses, and transfer of prescribing from private sector diagnosis and prescribing. This is particularly prevalent within the adult population. Calculations are based on the assumption that prices will remain stable and that growth will continue at a rate similar to growth over the last 12 months (Q2 22/23 - Q1 23/24). Medication shortages within this area have the potential to further impact on increasing spend (not included in calculations).	Average % increase in GIC from last 4 quarters (Q2 22/23 - Q1 23/24) used to make 23/24 and 24/245 estimates. Taken actual GIC for Q1 23/25 and then applied 4% increase per quarter

Medicine/Medicine Group	Prediction	2023/2024 cost (12M estimate)	2024/2025 cost (12M estimate)	Uplift/saving	Impact	Drivers	How calculations have been undertaken
Continuous Glucose Monitors (CGM)	Continued growth in prescribed items and associated costs.	£ 2,588,089	£ 3,653,299	£ 1,065,210	High	Use of CGMs in patients with Type 1 and Type 2 diabetes is expected to deliver continual growth with the MCN predicting an additional 700 patients to be using the devices in the next 18-24months. The introduction of a second CGM (Dexcom ONE) which is a two part system has allowed for greater patient choice, and an alternative for patients who are unable to use Freestyle Libre (annual costs £910 for FreeStyle Libre vs £923 for Dexcom ONE). Care should be taken when interpreting item predictions for CGMs, as FreeStyle Libre is a one-part CGM system, while Dexcom ONE is a two-part system (skewing item data) - ongoing patient count and cost will be a more reliable measure of growth in this area.	From MCN: We expect another additional 300 people with type 1 diabetes over the next 18-24 months and another 400 people with Type 2 diabetes to take up continuous glucose monitoring over the same period. Average % increase in GIC from last 4 quarters (Q2 22/23 - Q1 23/24) used to make 23/24 and 24/245 estimates. Taken actual GIC for Q1 23/25 and then applied 9% increase per quarter. Comparator calculation undertaken using MCN prediction of 700 patients, with average cost of £916.50/annum, at a rate of 1/8th of predicted growth per quarter....£20k more in prediction than if use average growth.

Medicine/Medicine Group	Prediction	2023/2024 cost (12M estimate)	2024/2025 cost (12M estimate)	Uplift/saving	Impact	Drivers	How calculations have been undertaken
Hormone Replacement Therapies (HRT)	Continued growth in prescribed items and associated costs.	£ 1,479,235	£ 2,012,483	£ 533,248	High	Prescribing medications to support with menopause management has increased in recent years due to increased awareness of the condition (government policy and media attention as well as increased diagnoses and transfer of prescribing from private sector diagnosis and prescribing). Calculations are based on the assumption that prices will remain stable and that growth will continue at a rate similar to growth over the last 12 months (Q2 22/23 - Q1 23/24). Medication shortages within this area have the potential to further impact on increasing spend (not included in calculations).	Average % increase in GIC from last 4 quarters (Q2 22/23 - Q1 23/24) used to make 23/24 and 24/245 estimates. Taken actual GIC for Q1 23/25 and then applied 8% increase per quarter
Testosterone in women	Continued growth in prescribed items and associated costs.	£ 16,910	£ 18,304	£ 1,394	Low	Testosterone prescribing in post-menopausal women with low libido has received notable media attention, which has resulted in increased requests for primary care prescribing. This coupled with increased awareness related to menopause management and increase private diagnoses/prescribing has seen an increase in Primary Care expenditure for this indication. While the spend in this particular area is small, it is included as it forms part of the wider HRT risk. Calculations are based on the assumption that prices will remain stable and that growth will continue at a rate similar to growth over the last 12 months (Q2 22/23 - Q1 23/24). Medication shortages within this area have the potential to further impact on increasing spend (not included in calculations).	Average % increase in GIC from last 4 quarters (Q2 22/23 - Q1 23/24) used to make 23/24 and 24/245 estimates. Taken actual GIC for Q1 23/25 and then applied 2% increase per quarter

Primary Care and Hosted Service Growth Existing Medicines							
Medicine/Medicine Group	**Prediction**	**2023/2024 cost (12M estimate)**	**2024/2025 cost (12M estimate)**	**Uplift/saving**	**Impact**	**Drivers**	**How calculations have been undertaken**
Buvidal*	Continued growth in prescribed items and associated costs.	£ 922,879	£ 1,386,665	£ 618,379	High	Scottish Government focus. Within NHS Grampian, work is underway to resolve logistical challenges in prescribing and administration through work with primary care and community pharmacy. It is anticipated that this will drive patient numbers and subsequent cost	2023/2024 estimate based on 5M spend. 2024/2025 estimate based on specialist service predictions. Uplift based on variance between 23/24 and 24/25 total spend prediction.

*It should be noted that Buvidal spend is split across a variety of services, including GP10 and hosted service prescribing. While out with the scope of this paper it is imperative that monies are allocated within the correct service line.

Primary Care Growth New Medicines					
Medicine/Medicine Group	**Prediction**	**Uplift**	**Impact**	**Drivers**	**How calculations have been undertaken**
Daridorexant (Quviviq)	New medicine indicated for insomnia (SMC Forward Look 19)	£ 15,405	Moderate	Product launched. Impact from April 2024. Potential for growth following Y1. To be used in Primary Care setting.	Information taken from SMC Forward Look 19
Fezolinetant (Veozah)	New medicine indicated for vasomotor symptoms associated with menopause (SMC Forward Look 19)	£ 6,682	Moderate	Impacted predicted Oct 2024. Potential for growth following Y1. To be initiated in secondary care.	
Ruxolitinib topical (Opzelura)	New indication and formulation indicated for vitiligo (SMC Forward Look 19)	£ 26,240	Moderate	Impacted predicted Oct 2024. Potential for growth following Y1. To be initiated in secondary care.	

Medicines with Potential to Impact on Primary Care with no Financial Prediction

Medication	Rationale for inclusion
Sativex® - treatment for symptom improvement in adults with moderate to severe spasticity due to multiple sclerosis.	Sativex® is now included on formulary for Primary Care prescribing following trial of therapy. At present, there is no increase in patients being observed in Primary Care data.
Methenamine hippurate – prophylaxis of urinary tract infections (UTI)	This medication is more costly that other UTI medications used for prophylaxis however has the significant advantage of not contributing to antibiotic resistance. Costs would be offset against other medications previously used, however would be overall more costly in terms of prescribing cost. 419 patients have been prescribed methenamine hippurate (July 23 – Dec 23)
Dienogest - endometriosis	An alternative medication for use in endometriosis. Costs would be offset against other medications previously used; impacts would be dependent on previous treatments. 14 patients have been prescribed dienogest (July 23 – Dec 23)
Anastrazole, tamoxifen and raloxifene – breast cancer chemoprevention	New indication for chemoprevention of breast cancer will increase usage of these medications. Benefit of chemoprevention in reduction in breast cancer cases.
Fidaxamycin and Vancomycin – treatment of clostridium difficile	Changes to first-line agents for the treatment of clostridium difficile from metronidazole. Both agents are more expensive than metronidazole, so will have overall cost impact. Benefits in way of more efficacious treatment.
Rimegepant (oral calcitonin gene-related peptide (CGRP) receptor antagonist) - treatment of acute migraine and prevention of migraine.	New medications for treatment of acute migraine and prevention of migraine. Costs more than current agents in pathway, cost of use will be offset against cost of previous treatments.

Potential Medicines Management Work Streams to Deliver Prescribing Efficiencies

Activities Requiring Pharmacy Technician Level Input to Deliver

Type	Value Type	Details of efficiency	Level of difficulty	Level of prescriber input	Work needed	Rationale
SWITCH	COST	Liothyronine tabs - caps	G	Tech	N	More cost effective formulation. Confirmed with endocrine consultants.
SWITCH	COST	Melatonin 3mg caps - tabs	A	Tech	N	Licensed product available. In line with MHRA. Assume 50% switch rate
SWITCH	COST	Melatonin 2mg MR cap/Circadian - melatonin 2mg MR tab	A	Tech	N	
SWITCH	COST	Concerta - Xaggitin (ScriptSwitch figures noted for 27mg and 54mg only)	G	Tech	N	More cost effective brand. Prescribing by brand ensures Px safety.
SWITCH	COST	Fostair - Luforbec	A	Tech/Check	Y	Equivalent produce MCN choice
SWITCH	COST	Lumigan - Bimatoprost 100micrograms/ml eye drops	G	Tech	N	Generic Rx, allows cost effective dispensing
SWITCH	COST	Longtec - Oxypro NHS Grampian preferred brand	G	Tech	N	More cost effective brand. Prescribing by brand ensures Px safety.
SWITCH	COST	Vagifem - Vagirux NHS Grampian preferred brand	G	Tech	N	More cost effective formulation. Confirmed OK with menopause consultants.
SWITCH	SAFETY	Branded buprenorphine patches (Transtec figures only)	G	Tech	Y	Predominatley safety however can make this cost effective switch also
DE-PRESCRIBE	COST	Dermacool (Pay&Report)	A	Tech	Y	Est annual spend based on Q3 23 data £28k. Need formulary position. Currently sits on pay and report
DE-PRESCRIBE	COST	Flexitol heel balm (Pay&Report)	A	Tech	Y	
DE-PRESCRIBE	COST	Topical NSAID Rx - esp diclofenac 2.32%	A	Tech	Y	Currently spend ~£133k/annum on 2.32% diclofenac gel.

Activities Requiring Pharmacy Technician Level Input and Pharmacist/Clinician Support to Deliver

Type	Value Type	Details of efficiency	Level of difficulty	Level of prescriber input	Work needed	Rationale
SWITCH	COST	Venlafaxine 225mg CAP to 150mg+75mg	A	Tech/Check	Y	More cost effective combination. Increased tablet burden. Some Px may be challenging - need clinician check
SWITCH	COST	Venlafaxine 300mg to 2x150mg	A	Tech/Check	Y	More cost effective combination. Increased tablet burden. Some Px may be challenging - need clinician check
SWITCH	PATIENT CARE	Resp MCN - open vs closed triple Costs based on estimated patient numbers	A	Clinician	Y	Await update from MCN via FD. Clinician input required for switches.
SWITCH	COST	Venlafaxine 225mg TAB to 150mg+75mg	A	Tech/Check	Y	More cost effective combination. Increased tablet burden. Some Px may be challenging - need clinician check
SWITCH	COST	Doxazosin MR - doxazosin IR	A	Clinician	Y	Equivalent and more cost effective. BP monitoring required. Assumed equivalent dose switch for calc ue 4mg for 4mg. Monitoring post change recommended - will impact capacity to achieve
SWITCH	COST	Aveeno (non-formulary)	A	Tech/Check	Y	switch Aveeno cream to formulary choice Epimax Oatmeal Cream
DE-PRESCRIBE	LITTLE EVIDENCE	Bath additives (Hydromol excluded as on formulary)	A	Tech/Check	Y	
SWITCH	COST	Metformin MR	A	Tech/Check	Y	500mg & 1g MR

Activities Requiring Clinical Input to Deliver

Type	Value Type	Details of efficiency	Level of difficulty	Level of prescriber input	Work needed	Rationale
SWITCH	COST	Keppra - levetirecetam (**EPILEPTIC**)	R	Clinician	Y	Generic Rx, allows cost effective dispensing. Cat 3 anti-epileptic so can switch however specialist advises additional engagement and monitoring would be required. Some Px will be seizure free for so long they won't be under the care of specialist service anymore.
INVEST TO SAVE	PATIENT CARE (COST)	Melatonin non-formulary / non tariff	A	Tech/Check	Y	Melatonin spend is >£1million/annum (this number does not include dummy Rx so will be underestimate). Number of considerations to reduce cost and also deprescribe. Ensure SDT solid oral dosage forms used Liquid vs adaflex which can be dissolved in water Review/holidays/stop or continue - guidance
INVEST TO SAVE	COST	Quetiapine MR to IR Assumes switch to same quantity of IR bd	A	Clinician	Y	Previously highlighted but PC not to undertake switch without specialist input. 2/22-1/23 568 Px receiving Rx for MR quetipaine. Savings variable depending on combination and regime used to make up IR. Cost associated with clinician time, need to review. Potentially challenging group of patients

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 28 MARCH 2024**

SUBJECT: **COMPLAINTS REPORT FOR QUARTER 3, 2023/2024**

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

1. REASON FOR REPORT

1.1 To inform the Committee of complaints reported and closed during Quarter 3 (1 October 2023 – 31 December 2023).

2. RECOMMENDATION

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

3. BACKGROUND

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

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

3.3 NHS and Local Authority (LA) Complaint Handling Procedure/Policy requires all staff to deal with feedback and complaints in a person/client-centred way. The procedure has been developed working closely with the Scottish Public Services Ombudsman (SPSO). There is a standard approach to handling complaints across the NHS and 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 continue to be included in quarterly complaints performance reports and annual complaints reports.

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

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

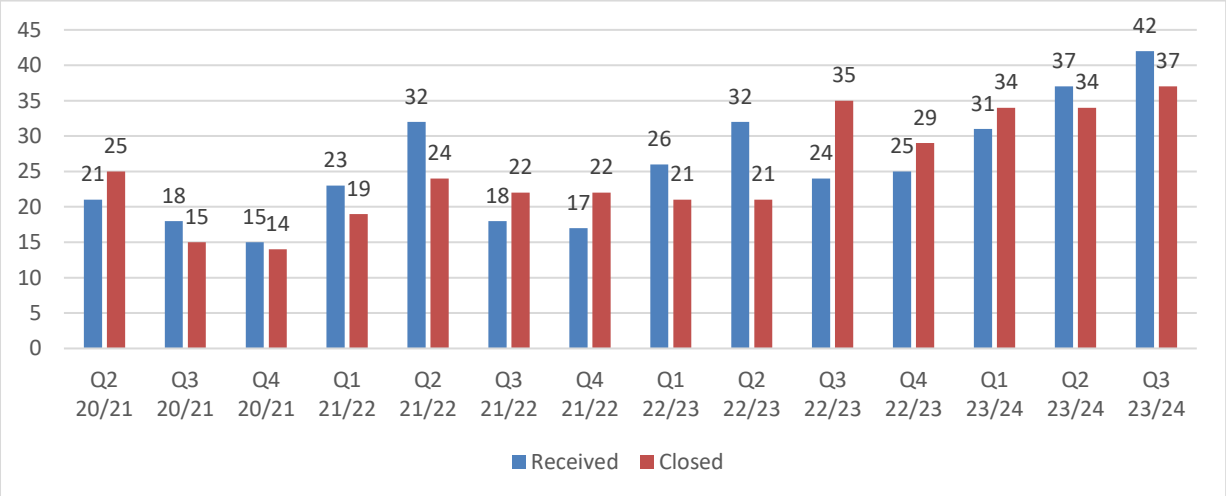
4.5 Figures reported do not include complaints raised regarding the vaccination appointments or processes as these are being dealt with through a dedicated team covering the Grampian area. Any complaints or comments regarding the Fiona Elcock Vaccination Centre in Elgin are included in reported figures.

4.6 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. All complaints and enquiries received regarding these services and recorded on Lagan are captured in **Appendix 1** and the figures below.

4.7 Overall, a total of 42 complaints were received during Quarter 3.

	Total Rec'd Q3 22/23	Total Closed Q3 22/23	Total Rec'd Q4 22/23	Total Closed Q4 22/23	Total Rec'd Q1 23/24	Total Closed Q1 23/24	Total Rec'd Q2 23/24	Total Closed Q2 23/24	**Total Rec'd Q3 23/24**	**Total Closed Q3 23/24**
LA	4	6	9	8	17	21	16	9	**26**	**20**
NHS	20	30	16	21	14	13	21	25	**16**	**17**
	24	**35**	**25**	**29**	**31**	**34**	**37**	**34**	**42**	**37**

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



4.9 There were 15 MP/MSP enquiries received regarding council services, under HSCM (including Children and Families and Justice), and recorded on the Council system, Lagan. These were allocated as follows:

Service	Number of Enquiries
Care at Home	4
Mental Health	1
Occupational Therapy	1
Access Team	1
Children and Families Area Teams	3
Moray East	3
Moray West	2

4.10 Four of these enquiries were closed as they were out of jurisdiction. 1 case was cancelled and 1 closed as it was a duplicate. The remaining 9 cases were resolved.

4.11 General enquiries regarding health services 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. Any patient specific enquiries/concerns are logged on Datix and captured in figures presented today. Work is progressing to create a mechanism to capture all enquiries received. This will give oversight for the senior management team and enable improved reporting to this Committee.

4.12 Any complaints or concerns received from MPs/MSPs on behalf of constituents regarding health service provision, under HSCM, are recorded on Datix and captured in the data provided.

4.13 Three concerns were received during Quarter 3 and recorded on Datix.

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
- Caroline O'Connor, Committee Services Officer, Moray Council
- Clinical and Care Governance Group

6. CONCLUSION

6.1 This report provides a summary of HSCM complaints received and closed during Quarter 3 (1 October – 31 December 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 3 (01/10/23 – 31/12/2023)

Learning from complaints

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

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

Table 1

Complaints Information Extracted from Datix – **17** complaints were **closed** during Quarter 3, 2023/24.

Actions Taken/Outcome of complaints **closed** during Quarter 3, 2023/24:

	Fully upheld: Complaint is accepted	Partially upheld: Complaint is partly accepted	Not upheld: Complaint is not accepted	Consent not received: Consent form not received from patient	Total
Access - Improvements made to service access	2	0	0	0	2
Action plan(s) created and instigated	1	0	0	0	1
Communication - Improvements in communication staff-staff or staff-patient	1	5	0	0	6
Conduct issues addressed	1	0	0	0	1
Education/training of staff	2	1	0	0	3
No action required	0	0	7	1	8
Share lessons with staff/patient/public	1	1	0	0	2
Waiting - Review of waiting times	0	1	0	0	1
Total	8	8	7	1	24

**this figure does not represent number of complaints closed as complaints may have more than one action*

Table 2

Complaints Information Extracted from Lagan: **20** complaints were **closed** during Quarter 3, 2023/24

Directorate	Department	Service	Upheld	Partially Upheld	Not Upheld	Resolution	Grand Total
Health and Social Care Moray	Children and Families and Criminal Justice	Access Team	0	1	0	1	**2**
		Children and Families Area Teams	2	3	1	0	**6**
		Fostering and Adoption and Supported Lodgings	3	1	0	0	**4**
		Throughcare	1	0	0	0	**1**
	Health and Social Care Moray	Access Team	0	1	1	0	**2**
		Care at Home	0	0	2	0	**2**
		Community Care Finance	0	0	1	0	**1**
		Mental Health	0	1	0	0	**1**
		Occupational Therapy	0	1	0	0	**1**

Table 3

Complaints Information Extracted from Datix: **17** complaints were **closed** during Quarter 3, 2023/24

	Fully upheld: Complaint is accepted	Partially upheld: Complaint is partly accepted	Not upheld: Complaint is not accepted	Consent not received: Consent form not received from patient	Total
Allied Health Professionals	0	0	1	0	1
Community Hospital Nursing	1	0	0	0	1
Community Nursing	1	1	0	0	2
GMED	0	2	2	1	5
Mental Health - Adult Mental Health	2	2	4	0	8
Total	4	5	7	1	17

Graph 1

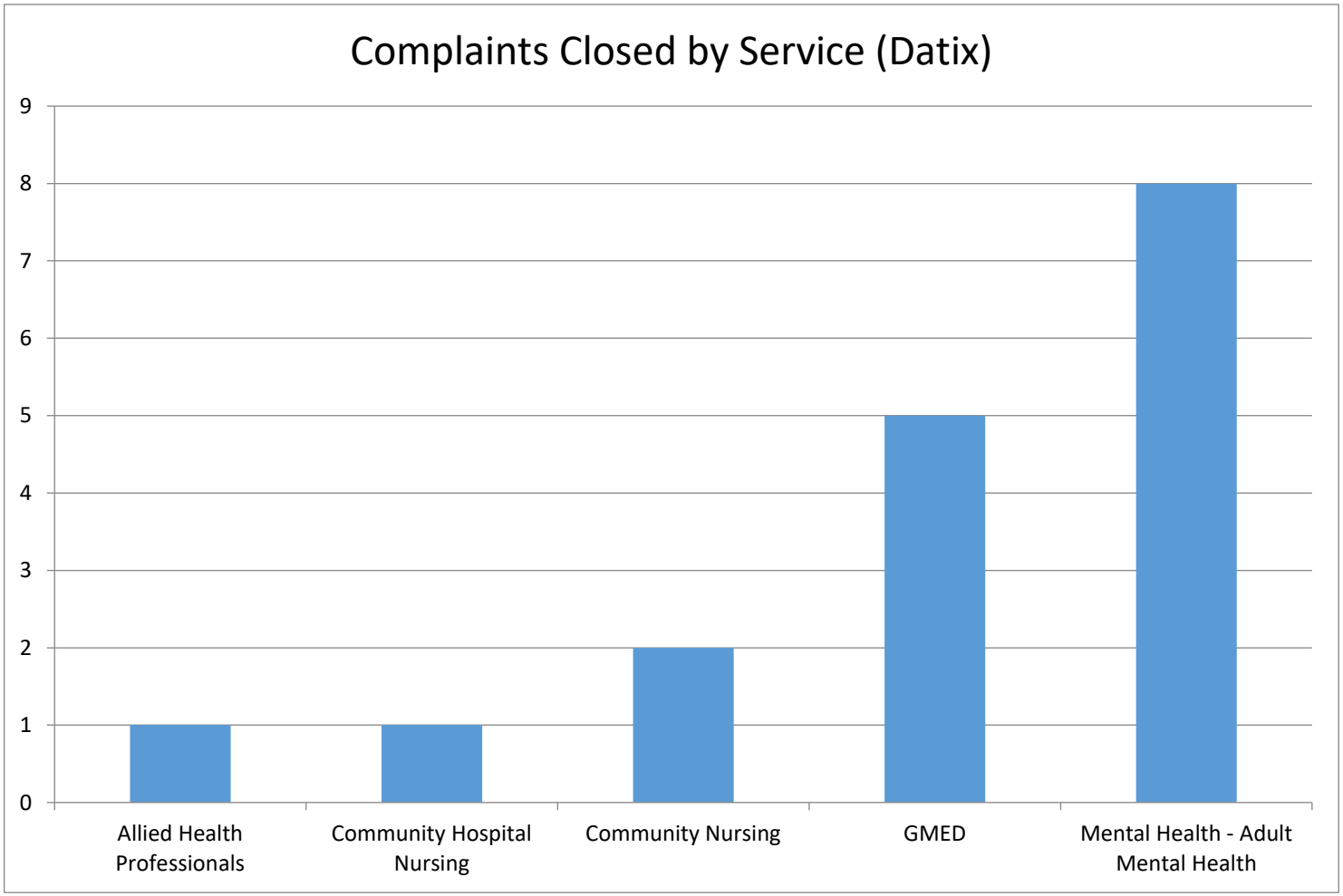

Complaints Closed by Service (Datix)
9
8
7
6
5
4
3
2
1
0
Allied Health Professionals
Community Hospital Nursing
Community Nursing
GMED
Mental Health - Adult Mental Health

Table 4

Complaints Information Extracted from Datix – Action Taken by Service (complaints **closed** during Quarter 3, 2023/24)

	Allied Health Professionals	Community Hospital Nursing	Community Nursing	GMED	Mental Health - Adult Mental Health	Total
Access - Improvements made to service access	0	0	0	0	2	2
Action plan(s) created and instigated	0	1	0	0	0	1
Communication - Improvements in communication staff-staff or staff-patient	0	1	1	2	2	6
Conduct issues addressed	0	0	1	0	0	1
Education/training of staff	0	1	1	0	1	3
No action required	1	0	0	3	4	8
Share lessons with staff/patient/public	0	1	0	0	1	2
Waiting - Review of waiting times	0	0	0	1	0	1
Total	1	4	3	6	10	24

**this figure does not represent number of complaints closed as complaints may have more than one action*

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

Table 5

Actions and Lessons Learned (Datix)

Education/ training	Staff made aware of the importance of seeking consent for any physical help being offered to patients.
	Relaunch of Self Discharge Against Advice policy to all staff.
Communication	Learning taken regarding how staff approach difficult conversations and how patients may perceive these.
	Processes between primary and secondary care services to be reviewed.
Share Lessons	Reflection around restrictions for informal patients.

Table 6

Learning Outcomes (Lagan)

Redress	Ensure more care is taken with confidential information.
	Staff member to receive additional support / supervision for workload management / reflection.
	Communication process to be developed to help build stronger relationship between staff member and client.
Revision	Staff member to receive further training in relation to Initial Referral Discussion procedures.
	Training opportunities to be discussed with staff.
	A review of processes within the team have been carried out, particularly around timescales and sharing of information within timescales.
Reinforcement	OT team to complete necessary paperwork to initiate a process.

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

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

Table 7 – Total number of complaints **received** in Quarter 3, 2023/24

System recorded	Early Resolution / Frontline	Investigation	Not Marked	**Total**
NHS - Datix	**0** marked early resolution ***	**16** marked investigation	**0**	**16**
Moray Council - Lagan	**4** marked frontline	**15** marked investigative	**7** not yet marked	**26**
Total	**4**	**31**	**7**	**42**

*** 13 out of 16 complaints received by NHS were suitable for early resolution (ER) but current stage is not ER

Table 8 – Allocation of complaints **received** in Quarter 3, 2023/24

NHS Service - Datix	
GMED	7
Community Hospital Nursing	1
Adult Mental Health	6
Vaccination Transformation Programme	1
Primary Care	1
Total	**16**

Table 9 – Allocation of complaints **received** in Quarter 3, 2023/24

MC Service - Lagan		
Children and Families and Criminal Justice	Fostering and Adoption and Supported Lodgings	7
	Children and Families Area Teams	6
	Access Team	2
Health and Social Care Moray	Care at Home	4
	Access Team	3
	Occupational Therapy	1
	Community Care Finance	1
	Mental Health	2
Total		**26**

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 **17 Complaints closed** on the NHS system Datix during Quarter 3, 2023/24 – breakdown as follows:

Early Resolution – 0

Investigation – 16

SPSO – 1

There were **20 Complaints closed** on the MC system Lagan during Quarter 3, 2023/24 – breakdown as follows:

Frontline – 4

Investigation – 11

Escalated Investigative – 5

Table 10 – number and percentage of complaints at each stage closed within timescales **(based on complaints closed during Quarter 3, 2023/24)**

	Frontline/Early Resolution within timescale	Investigation within timescale
NHS - Datix	N/A	1 out of 16 (6%)
Moray Council - Lagan	0 out of 4 (0%)	0 out of 11 (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 11 – *average time in working days to respond at stage 1, stage 2 and after escalation* **(based on complaints closed during Quarter 3, 2023/24)**

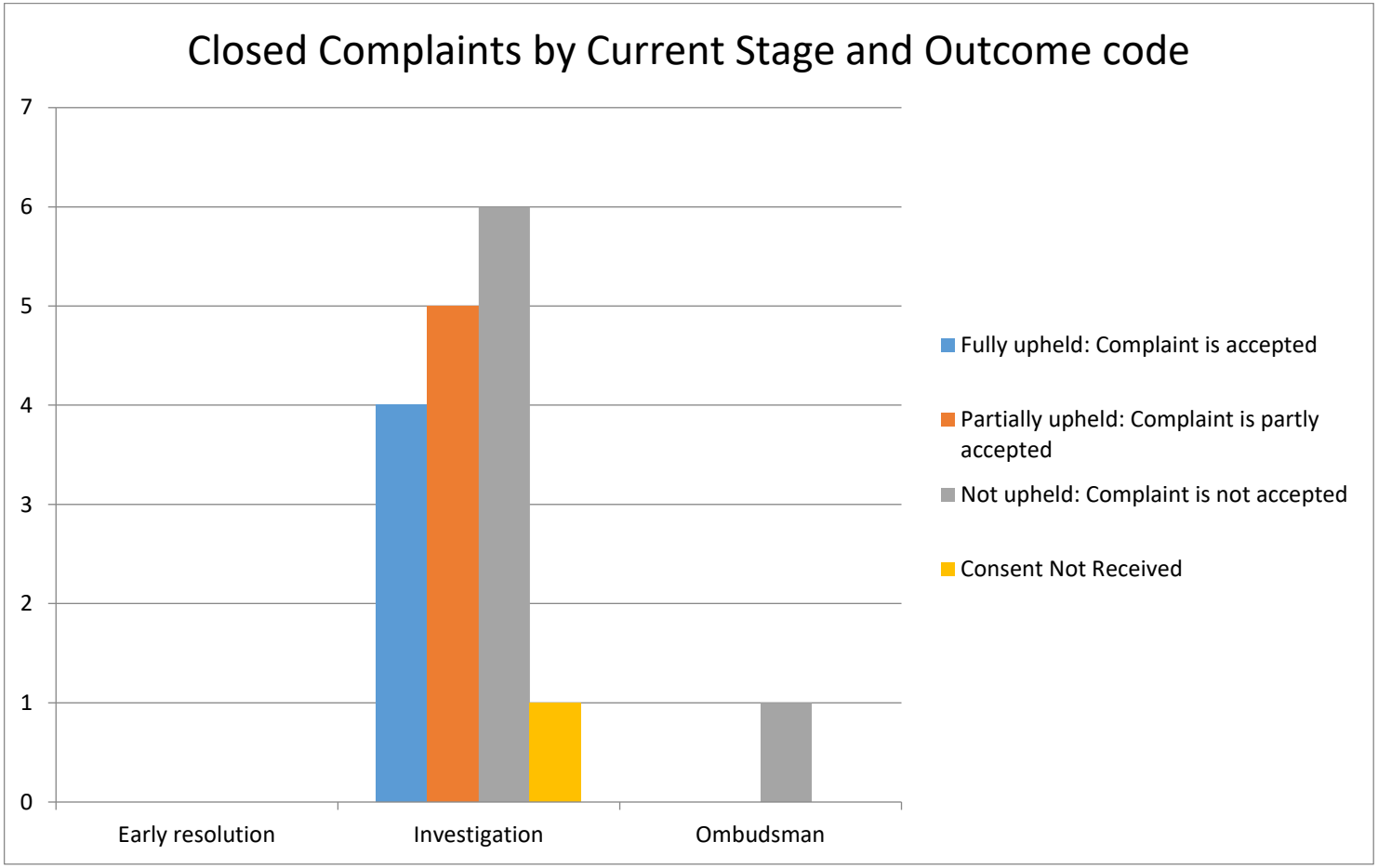
	Frontline	Investigative
NHS - Datix	N/A	43 days
Moray Council - Lagan	19 days	40 days

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

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

Graph 2 below shows the number of complaints fully upheld, partially upheld and not upheld as recorded in Datix during Quarter 3, 2023/24.

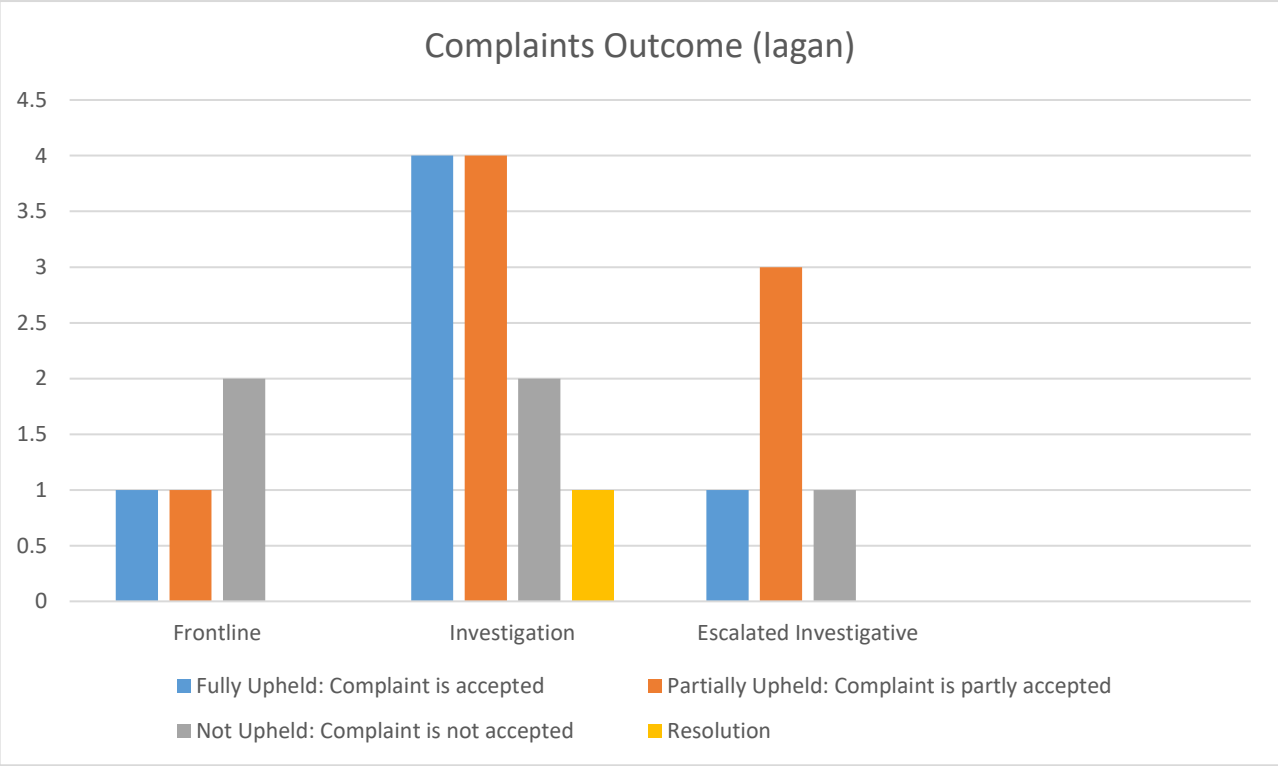
17 complaints were closed during Quarter 3: 1 was closed due to no consent – from the remaining 16 closed complaints 25% were upheld, 31% were partially upheld and 44% were not upheld



Complaints Information Extracted from Lagan:

20 complaints were **closed** during Quarter 3, 2023/24: **approx. 30% were fully upheld, 40% partially upheld, 25% were not upheld and 5% were resolved.**

Graph 3 below shows the amount of complaints upheld, partially upheld and not upheld as recorded in Lagan from the **20 closed** complaints during Quarter 3, 2023/24.



REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE (CCG) COMMITTEE ON 28 MARCH 2024**

SUBJECT: **JOINT INSPECTION OF SERVICES FOR CHILDREN AND YOUNG PEOPLE AT RISK OF HARM IN MORAY**

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

1. REASON FOR REPORT

1.1 To provide the Committee with an overview of the findings from the joint inspection of Childrens Services by the Care Inspectorate report that was published on 23 January 2024, as at **Appendix 1.**

2. RECOMMENDATION

2.1 It is recommended that the Committee note:

i) the overview of the findings from the joint inspection of Children's Services by the Care Inspectorate; and

ii) the Childrens Services partnership have developed an improvement plan in respect of the findings.

3. BACKGROUND

3.1 Conducted at the request of Scottish Ministers, joint inspections consider the effectiveness of services for children and young people at risk of harm. Children at risk of harm means children up to the age of 18 years who need urgent support due to being at risk of harm from abuse/neglect and those who pose a significant risk to themselves and/or others in the community.

3.2 The inspection team is led by the Care Inspectorate's strategic scrutiny children's team and their scrutiny partners: Education Scotland; Healthcare Improvement Scotland (HIS) and His Majesty's Inspectorate of Constabulary in Scotland (HMICS). The inspection team looks at the impact the community planning partnerships are having on the lives of children and young people at risk of harm and their families.

3.3 Moray received notification of inspection on 10 July 2023. The inspection was conducted in 3 phases, beginning from the point of notification and ending with the final partnership discussion meeting held on 29 November 2023.

3.4 A consistent approach is taken to inspections by using the quality framework for children and young people in need of care and protection. Inspectors collect and review evidence against all 22 quality indicators in the framework to examine four inspection statements:

1. Children and young people are safer because risks have been identified early and responded to effectively.
2. Children and young people's lives improve with high quality planning and support, ensuring they experience sustained loving and nurturing relationships to keep them safe from further harm.
3. Children and young people and families are meaningfully and appropriately involved in decisions about their lives. They influence service planning, delivery and improvement.
4. Collaborative strategic leadership, planning and operational management ensure high standards of service delivery

3.5 Inspectors use a six-point scale to provide a formal evaluation of just one quality indicator, 2.1 impact on children and young people. This indicator focuses solely on the experience and feelings of children and young people at risk of harm. It relates to the differences services are making to their lives and future life chances. It includes measuring the impact of services aimed at optimising the wellbeing of children and young people against the wellbeing indicators.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 Inspectors evaluated the impact of services on the lives of children and young people as **adequate**. This meant that strengths just outweighed weaknesses. Although many strengths were identified as having a positive impact, the likelihood of achieving positive experiences and outcomes was reduced significantly because of key performance areas which needed to improve.

4.2 Inspectors found strengths in areas where our partnership working and joint improvement efforts were well established. Due to the fact that many of the areas for improvement identified were already reflected in our partnership plans, inspectors are confident that the partnership in Moray has the capacity to make changes in the areas that require improvement.

4.3 **Identified Strengths**

- Children and young people were safer as a result of our approach to identification and initial response to risk. The quality of local Interagency Referral Discussion partnership working has been highlighted as a good practice example which is a significant achievement.
- The introduction of a solution orientated approach to child protection planning meetings was beginning to improve the participation and quality of meetings for children, young people and their families.
- Staff were confident in their knowledge, skills and ability to recognise, report and respond to child abuse and neglect and harm from parental behaviour or circumstances.
- When children and young people received support from universal and specialist services this made a positive difference to their lives. Where available, specialist services were helping children and young people recover from abuse and neglect.

- Most children and young people reported that they felt safe where they live all or most of the time. When children and young people were identified as being at risk of neglect or abuse, the support provided had helped the majority of children and young people to become safer.
- When children and young people had supportive and trusting relationships with staff, this was making a positive difference to their lives.

4.4 **Areas for improvement**

- Young people at risk of harm from themselves or to others, or from risk in the community did not always receive the help they needed to make a positive difference in their lives.
- Not all children and young people felt that their worker spent time with them or gave them the help they needed. This was linked to a lack of consistency of staff members and some families experienced frequent changes in staff.
- The quality of chronologies, assessments and plans was variable.
- Children and young people at risk of harm had not consistently benefited from independent advocacy, and had limited opportunities to influence service planning and delivery.
- The child protection committee had not yet fully developed the mechanisms necessary to understand and communicate the difference that services were making to the lives of children and young people at risk of harm.
- The partnership's agenda for improvement and change was not yet underpinned by a cohesive approach to service review and self-evaluation.

4.5 The Care Inspectorate have requested a joint action plan that clearly details how the partnership will make improvements in the key areas identified by inspectors. This is to be submitted by 5 March 2024. A partnership discussion session with inspectors was held on 7 February 2024 which supported the development of key areas within the improvement plan.

4.6 A timeline for developing the improvement plan has been established to include consultation with key stakeholders and governance groups across the partnership. In keeping with the approach taken by most authority areas, the timeline outlines approval stages via the Child Protection Committee and Public Protection Chief Officers Group prior to final submission.

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"

This report notes that an improvement plan is currently being developed in respect of the inspection findings that will align with key priority areas across the Childrens Services partnership.

(b) Policy and Legal

None arising as a direct result of this report.

(c) Financial implications

None arising as a direct result of this report.

(d) Risk Implications and Mitigation

None arising as a direct result of this report

(e) Staffing Implications
There are no proposed changes to the staffing or reporting relationships.

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

(g) Equalities/Socio Economic Impact
None arising as a direct result of this report

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

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

(j) Consultations
MIJB Senior Management Team

6. CONCLUSION

6.1 The joint inspection of Moray's Childrens services has concluded and the findings were published by the Care Inspectorate on 23 January 2024.

6.2 A partnership communication plan has been developed to ensure co-ordinated dissemination of key messages internally and externally, including a proactive media release on publication date.

6.3 The partnership had six weeks, from publication, to develop an improvement plan in response to the inspection, for submission to inspectors by 5 March 2024.

Author of Report: Tracy Stephen, Chief Social Work Officer/Head of Service

Background Papers: Report of a joint inspection of services for children and young people at risk of harm in Moray (**APPENDIX 1**)

Report of a joint inspection of services for children and young people at risk of harm in Moray community planning partnership

Prepared by the Care Inspectorate in partnership with Education Scotland, Healthcare Improvement Scotland and His Majesty's Inspectorate of Constabulary in Scotland

23 January 2024

Contents

Introduction

Our remit

At the request of Scottish Ministers, the Care Inspectorate is leading joint inspections of services for children and young people at risk of harm.

The remit of these joint inspections is to consider the effectiveness of services for children and young people up to the age of 18 at risk of harm. The inspections look at the differences community planning partnerships are making to the lives of children and young people at risk of harm and their families.

Joint inspections aim to provide assurance on the extent to which services, working together, can demonstrate the following.

1. Children and young people are safer because risks have been identified early and responded to effectively.

2. Children and young people's lives improve with high-quality planning and support, ensuring they experience sustained loving and nurturing relationships to keep them safe from further harm.

3. Children and young people and families are meaningfully and appropriately involved in decisions about their lives. They influence service planning, delivery and improvement.

4. Collaborative strategic leadership, planning and operational management ensure high standards of service delivery.

The terms that we use in this report

- When we say **children at risk of harm**, we mean children up to the age of 18 years who need urgent support due to being at risk of harm from abuse and/or neglect. We include in this term children who need urgent support due to being a significant risk to themselves or others or are at significant risk in the community.

- When we say **young people**, we mean children aged 13-17 to distinguish between this age group and younger children.

- When we say **parents** and **carers**, we mean those with parental responsibilities and rights and those who have day-to-day care of the child (including kinship carers and foster carers).

- When we say **partners**, we mean leaders of services who contribute to community planning. This includes representatives.

- When we say **staff**, we mean any combination of people employed to work with children, young people and families in Moray.

Appendix 2 contains definitions of some other key terms that we use

Key facts

Total population: 96,410 people on 30 June 2021

This was an increase of 0.7% from 2020. Over the same period, the population of Scotland increased by 0.3%.

NRS Scotland

In 2021 16.5 % of the population were under the age of 16, similar to the national average of 16.6%.

NRS Scotland

In 2021/22, Moray had a rate of 3.1 for the number of children on the child protection register (per 1,000 of the 0 –15yr population), higher than the Scottish average of 2.2.

The rate of child protection investigations (per 1,000 of the 0 –15yr population) was 22.5, this was higher than the Scottish average of 12.2.

Childrens social work statistics 2021/22

4 (3.17%) of Moray's data zones are in the 20% most deprived in Scotland. In Moray 2,582 children (16.1%) age 0-16 were living in relative low income families in 2021.

SIMD

UK Govt children in low income families

Moray had 91 incidents per 10,000 population, of domestic violence recorded by Police Scotland in 2021/22. This was lower than the national average of 118.

Domestic abuse recorded by Police Scotland 2021/22

Our approach

Inspection teams include inspectors from the Care Inspectorate, Healthcare Improvement Scotland, His Majesty's Inspectorate of Constabulary in Scotland and Education Scotland. Teams also include young inspection volunteers, who are young people with direct experience of care or child protection services. Young inspection volunteers receive training and support and contribute to joint inspections using their knowledge and experience to help us evaluate the quality and impact of partners' work.

We take a consistent approach to inspections by using the quality framework for children and young people in need of care and protection. Inspectors collect and review evidence against all 22 quality indicators in the framework to examine the four inspection statements. We use a six-point scale (see appendix 1) to provide a formal evaluation of quality indicator 2.1: impact on children and young people.

How we conducted this inspection

The joint inspection of services for children at risk of harm in the Moray community planning partnership area took place between 10 July and 29 November 2023. It covered the range of partners in the area that have a role in meeting the needs of children and young people at risk of harm and their families.

- We listened to the views and experiences of 113 children and young people and 94 parents and carers. This included face-to-face meetings, telephone or video calls and survey responses.
- We reviewed practice by reading a sample of records held by a range of services for 60 children and young people at risk of harm.
- We reviewed a wide range of documents and a position statement provided by the partnership.
- We carried out a staff survey and received 404 responses from staff working in a range of services.
- We met with members of staff, including senior leaders and those who work directly with children, young people and families.
- We met with five elected members.

We are very grateful to everyone who talked to us as part of this inspection.

As the findings in this joint inspection are based on a sample of children and young people, we cannot assure the quality of service received by every single child and young person in Moray who may be at risk of harm.

Background

In 2016, we carried out a joint inspection of services for children and young people in the Moray community planning partnership area. At that time, we were not confident that joint planning of children's services was resulting in improved wellbeing for children and young people. We identified six priorities for improvement and reported again in December 2017 and March 2019 on the progress the partnership had made.

While this joint inspection had a different scope with the focus on children and young people at risk of harm, brief comment is made in this report where findings relate to improvement since our last joint inspection.

Key messages

- The partnership's approach to identification and initial response to risk was helping to keep children and young people safe.
- The majority of children and young people were benefitting from caring and trusting relationships with key staff, but not all felt that staff spent the time with them that they needed.
- Where available, specialist services were helping children and young people recover from abuse and neglect.
- Young people at risk of harm from themselves or to others, or from risk in the community did not always receive the help they needed to make a positive difference in their lives.
- Children and young people and parents and carers were contributing to decisions about their lives, though not all had access yet to independent advocacy.
- Children and young people at risk of harm were not yet routinely influencing service planning and delivery.
- The child protection committee had not yet fully developed the mechanisms necessary to understand and communicate the difference that services were making to the lives of children and young people at risk of harm.

Statement 1: Children and young people are safer because risks have been identified early and responded to effectively

Key messages

- Early help and preventative approaches were making a difference to the wellbeing and safety of some children and their families.
- Children and young people were safer due to the partnership's effective initial response to protective concerns.
- The introduction of a solution orientated approach to child protection planning meetings was beginning to improve the participation and quality of meetings for children, young people and their families.
- Staff were confident in their knowledge, skills and ability to recognise, report and respond to child abuse and neglect and harm from parental behaviour or circumstances.
- Responses to young people at risk of harm was variable. A multi-agency co-ordinated approach to risk was not yet in place for young people at risk of harm from themselves, to others or from risk in the community.

Preventative approaches

The percentage of children living in relative low income families in Moray has increased over the last few years. The relatively remote and rural landscape presents particular challenges in relation to poverty and the ability to access services locally. Partners had introduced a number of helpful initiatives to maximise income and reduce the impact of poverty on whole family wellbeing. Examples included the use of a 'money worries' toolkit by staff, implementation of guidance on the cost of the school day and free or subsidised leisure and school holiday provision for some children and young people. Efforts had also been made to increase the uptake of free bus travel for all children and young people.

A range of targeted prevention activity was taking place across Moray in response to anti-social behaviour, violence reduction, substance abuse, online safety and risk from children and young people going missing from home. Strong collaborative working arrangements were helping to prevent risks escalating and improve the wellbeing and safety of children and young people at risk of abuse and neglect. While the partnership had more to do to evaluate approaches, the majority of staff who completed our survey were confident that effective intervention was in place to prevent or reduce incidences of accumulating signs of abuse and neglect.

The partnership had established a locality network approach, led by third sector partners, which brought together staff working in local areas to help identify concerns

and plan a local response. We heard examples of how this work had helped address issues at an early stage and prevent the need for more targeted interventions. Initiatives included the development of the Aberlour YP Zone, which provided support to young people to reduce harm from drug and alcohol use and a fire safety project in Forres to reduce the incidence and harm from fire raising. An external evaluation had confirmed that locality networks were helping to identify emerging needs and were able to quickly and effectively deliver support.

The partnership had improved its approach to learning reviews in line with the 2021 national guidance for child protection committees undertaking learning reviews. Learning from recent reviews helped partners identify and respond to the need to strengthen practice in relation to unborn and very young children. A new pathway for multi-agency support in pregnancy provided a clearer process with appropriate timescales. A revised training programme had also strengthened practitioner guidance on safe sleeping. The practice reflection improvement short module (PRISM) methodology was helping to engage frontline staff in the implementation of improvement actions. While too early to measure impact, the changes in practice were promoting early, multi-agency and needs-led intervention to ensure timely and proportionate care was received by vulnerable women, children and their families.

Staff confidence

Almost all staff were confident in their knowledge, skills and ability to recognise, report and respond to child abuse and neglect and harm from parental behaviour or circumstances. Almost all staff agreed that learning and development opportunities were increasing their confidence and skills in working with children and young people at risk of harm. A training needs analysis was helpfully undertaken by the child protection committee as part of the partnership's approach to learning and development.

The partnership had sought to strengthen practice in relation to domestic abuse and neglect, two of the most common concerns linked to child protection registration in Moray. Working alongside Women's Aid, multi-agency staff training was supporting the introduction of the Safe and Together approach to addressing domestic abuse. The implementation of the Graded Care Profile 2 was intended to support staff to better identify and respond to neglect. While the roll out of these programmes had been comprehensive, it was too early to tell the impact of this work.

Partners were in the early stages of developing a trauma informed workforce. Resource had been agreed to provide a development worker post, though this had not yet been recruited to. The partnership had identified this as an area for further development.

Initial response and follow up to concerns

Children and young people were safer as a result of the effective initial response and follow up to concerns. Most children and young people who completed our survey felt safe where they lived all or most of the time. The majority of parents who

responded to our survey told us that workers responded quickly when concerns were first identified.

Collaborative multi-agency approaches had helped staff identify and respond to concerns. We evaluated the quality of the initial response to concerns as good or better in most of the records we read. Staff from all agencies were helpfully communicating with each other and sharing relevant information to help determine the need for an initial referral discussion (IRD). All concerns were shared with police and social work without delay. However, in a few instances, cumulative concerns were not identified early enough.

Practice example: the quality of the partnership's local working on initial referral discussions (IRDs)

Social work, police, health and education (including early years) were all routinely contributing to IRD information sharing and decision making as equal partners. While the introduction of virtual meetings had made the process more timely, partners reported that it was the commitment across all agencies that had improved the quality of the meetings. To achieve this, education partners had strengthened their support arrangements to improve staff confidence in participating in child protection planning processes. They had also put in place a rota of senior officers, including the chief education officer, to provide education support for IRDs during school holidays. The contribution of health had been extended so that consultant paediatricians were contributing directly to discussions when necessary. Feedback from staff indicated that the enhanced participation had improved the quality of information sharing, reduced delays in decision making, and it was helping to avoid unnecessary medical examinations for children and young people. Health staff reported that this was also helping to manage pressures on acute health services.

Moray is part of the pan-Grampian IRD model. Partners had successfully sustained and built on the improvements to their IRD process that we last reported on in 2019. We evaluated the follow up of concerns as good or better in most of the records we read. Staff were successfully working together using the IRD process to respond to and make decisions about protection concerns. In line with the 2021 national guidance for child protection, IRD practice included all children from pre-birth to 18 years in relation to both familial and non-familial harm. In almost all cases, IRDs were carried out within expected timescales and clear decisions were made about next steps. Where necessary, safety planning and IRDs were started outside normal office hours. This was supported by police and social work staff until a full multi-agency IRD could take place on the next working day.

The partnership had appropriate arrangements in place for chairing, recording and sharing the outcome of the meetings. Guidance was supporting staff to ensure that risk and harm were fully explored. The need for medical examinations, legal measures and joint investigative interviews was routinely considered.

A multi-agency IRD quality assurance process was supporting ongoing improvement. Regular audit practice had highlighted as an issue the consideration of non-familial harm, and action was taken to strengthen this. An escalation process was introduced to support joint working and decision making. Partners recognised that their quality assurance approach could be further developed to provide multi-agency review of decision making when concerns did not progress to IRD.

Investigations

Police, health, social work and staff of the Grampian-wide Scottish child interview model (SCIM) pilot were co-located within the joint child protection unit. This helped provide a co-ordinated child protection response for children and young people. An interview suite with a separate entryway was part of the facility, with appropriate space for families to spend time together during breaks from interviews.

The SCIM was used for almost all investigations and was helping to improve the quality of the investigative process for children and young people at risk of harm. The multi-disciplinary team comprised of four posts shared across police and the children's social work service. As the SCIM is a pan-Grampian approach, some additional capacity was provided from other SCIM teams when necessary.

SCIM staff attended IRDs where a joint interview was likely to be required. Staff told us that this helped with planning of investigations and reduced delays. In almost all the records we read, investigations were carried out within expected timescales. We found that the views of children and young people and parents and carers had been considered and immediate and interim safety planning had taken place.

The SCIM approach was subject to multi-agency quality assurance that had more recently been extended to include feedback from children, young people and their families. Families who had completed SCIM questionnaires had been positive about their experiences.

When medical investigations were necessary, consultant paediatricians based at Dr Gray's hospital in Elgin supported triage and assessment. Staff reported that this was helping to reduce the need for children and young people to travel to the children's hospital in Aberdeen.

Information collated as part of the preparation for a SCIM investigation was routinely shared with lead professionals, alongside the outcome of any investigation. Staff reported that this supported ongoing intervention.

Initial child protection planning meetings

Initial child protection planning meetings were effectively supporting planning for children and young people at risk of harm. In our record reading sample, we evaluated most as good or very good for the overall quality. One record was evaluated as excellent. Strengths included timeliness of meetings and clarity of decision-making.

A solution-orientated approach to child protection planning meetings was introduced across the child protection planning process in January 2023 for all children and young people from pre-birth to 18 years. The aim was to reduce stigma, enhance family participation, avoid revisiting traumatic incidents and build on family strengths. Initial feedback was sought from families and staff about their experiences of meetings to inform future quality assurance and improvement. Although the partnership had more to do to demonstrate what difference the changes were making to outcomes for children and young people, early indications were positive in relation to supporting participation and decision making.

Young people at risk of harm from themselves or to others, or from risk in the community

When young people posed risks to themselves, or to others or were at risk in the community, the response was too variable. While initial referral discussions (IRDs) helpfully provided initial co-ordination and support, follow-on child protection planning processes were not routinely supporting older young people. Care and risk management (CARM) processes or equivalent pathways for vulnerable young people had not yet been introduced to support planning. The inconsistency in approach impacted on quality. In the records we read, there was an overall reduction in the quality of the response where concerns stemmed from behaviour or community, with initial meetings less likely to take place for this group of young people.

Work had been undertaken to raise awareness and train staff in relation to identifying exploitation and signs of harm in young people. We heard from some staff that there had been improved recognition of risks affecting young people. However, partners understood the need for further work to ensure that there was a multi-agency co-ordinated response to young people at risk from themselves, or to others or from risk in the community.

Statement 2: Children and young people's lives improve with high-quality planning and support, ensuring they experience sustained loving and nurturing relationships to keep them safe from further harm

Key messages:

- Multi-agency assessment, planning and review was being undertaken routinely for children and young people at risk of harm. While the majority of reviews contributed effectively to the lives of children and young people, the quality of chronologies, assessments and plans was variable.
- Children and young peoples' experience of nurturing relationships with key staff was mixed. Some children and young people benefited from compassionate and caring relationships but not all felt that their worker spent time with them or gave them the help they needed.
- Where available, specialist services were helping children and young people recover from abuse and neglect and mitigate risk.
- Planning and support for young people at risk of harm from themselves, to others, or at risk in the community, was less effective than support for children and young people at risk of abuse and neglect.

Assessment and planning to reduce risk

Chronologies, assessments of risk and need, and child's plans were being completed routinely for children and young people at risk of harm. Effective joint working across agencies, within a GIRFEC approach, helped to support a shared understanding of risk and collaborative decision making. When necessary, contributions from adults' services working with parents enhanced the quality of the child's planning process. A refreshed approach to solution-focused planning supported staff and families to identify, and work towards, goals together. The majority of reviews were taking place within timescales and were of good or better quality. Some families told us that strengths in planning arrangements had helped to keep their child safer.

In the records we read, the quality of chronologies, assessments and plans was variable. While there were chronologies of good or better quality, we evaluated the majority as adequate and a few as weak. Although we evaluated the majority of assessment and plans to be good or better, there was significant variation with some evaluated as weak and in one instance, unsatisfactory. We heard from staff that too many assessment tools had made it challenging to make improvements.

Partners recognised that they had more to do to improve the consistency of the quality of assessment and planning. Senior leaders told us about the roll out of a

revised single assessment framework within children's social work. The Scottish Children's Reporter's Administration was helpfully providing feedback about the quality of assessments it received. While some single-agency audit activity had taken place, the partnership had not yet developed a comprehensive multi-agency approach to quality assurance to support improvement.

Nurturing relationships with key professionals

The majority of children and young people told us they had a trusted adult they could talk to about things important to them and that staff listened to their opinions.

Children, young people and families' experience of nurturing relationships with key professionals was mixed. When children and young people experienced caring and supportive relationships with staff, this was helping them to overcome their difficulties. Some families we spoke to told us about compassionate and caring staff who had taken the time to build relationships with children and young people and parents and carers. However, not all children and young people benefited from supportive and nurturing relationships with key professionals.

Some staff we spoke to told us that capacity had impacted on their ability to provide support. Just under half of the children and young people who completed our survey reported their worker spent time with them and gave them the help they needed only some, or none of the time. We heard from a few families who felt let down by professionals when they didn't follow through on agreed actions. Some children and young people experienced changes in key professionals, making it difficult to sustain relationships.

Support for children and young people

The majority of staff felt that the GIRFEC approach was having a positive impact on the lives of children and young people. Support within universal services was helping to meet the needs of children, young people and their families. Nurturing provision and pupil support bases within schools provided a safe space. These addressed social and emotional needs through positive relationships in a supportive environment. Early years provision helped to mitigate difficulties, supporting early childhood development and providing a protective environment. Exchange counselling services provided opportunities for 10–17-year-olds to talk and optimise mental health. The Pinefield service provided support for young people from the age of 14 years who could not be sustained in mainstream education, including those who were at risk of harm from themselves or to others. The service helped young people in their transition into post school opportunities by supporting social skills and work experience.

Where available, specialist services were helping children and young people recover from abuse and neglect. Examples of family-focused support included the Children 1st Families Together project, which provided practical and emotional support to children and their parents/carers who were experiencing difficult times. Aberlour children's charity was providing preventative community supports, including individual support for families. Quarriers' Arrows service worked alongside families

who were impacted by adult problematic drug and alcohol use. Children and young people were benefitting from group and individual time with a trusted adult through these family-focused services.

Some young people were benefitting from supports in the community. Aberlour's Youth Point service provided extra help for young people who struggled with their emotions, behaviour and wellbeing. This included young people who were at risk of exclusion from school or who experienced a chaotic home life. Youth workers and mentors provided support in a safe environment away from home and school. The service also worked with parents and carers to improve relationships within the home. Young people were helped to develop a variety of employability skills in advance of leaving education. The service had supported care experienced young people through the Family Firm initiative.

An Action for Children Functional Family Therapy service had recently been introduced to support relationships and help keep families together. Rape Crisis was providing individual recovery support for young people, which had helped to improve safety and wellbeing. School nurses were providing Let's Introduce Anxiety Management (LIAM) to help children and young people better manage feelings of anxiety. Children and young people requiring specialist mental health support benefited from quicker access to child and adolescent mental health services (CAMHS). Since May 2022, overall waiting times had reduced and most children and young people received specialist mental health treatment through CAMHS within 18 weeks of referral.

Availability and impact of support

The majority of staff who responded to our survey agreed that children and young people who had experienced abuse and neglect were being supported to recover. However, we heard from some staff that pressures on capacity had impacted on their ability to provide timely and consistent support. Some children and young people did not have access to the right services when they needed them to stop difficulties getting worse. Staff felt wellbeing concerns around neglect were exacerbated while families were waiting on support. Staff and families were not always clear about what services were available.

We found a mixed picture in relation to the effectiveness of intervention. While the work to reduce risks from abuse and neglect and from parents and carers circumstances was evaluated as good or better in the majority of records we read, not all children and young people experienced improved outcomes. In a third of the records we read, the effectiveness of work carried out to reduce risks of abuse and neglect and risks arising from parents and carers circumstances was evaluated as adequate. Some were evaluated as weak and a few were unsatisfactory. Just under half of the parents and carers who completed our survey disagreed or were not sure that their children were safer because of the help and support they received from workers. A small number of parents and carers we spoke to told us that intervention had not made life better for their family.

The outcomes for young people at risk of harm from themselves or to others, or from risk in the community, was most variable. The effectiveness of the work carried out to reduce risks from the child harming themselves or others and to reduce risks to the child arising from circumstances within the community was found to be adequate or less in the majority of records we read. The partnership was aware that it had more to do to ensure support was effective for all young people at risk of harm and had identified this as an area for development.

While the partnership monitored some key processes, performance was not yet sufficiently analysed to support consistently high standards of service delivery and improved outcomes.

Statement 3: Children, young people and families are meaningfully and appropriately involved in decisions about their lives. They influence service planning, delivery, and improvement

Key messages:

- The views of children and young people and parents and carers were considered during decision making and most contributed to meetings about their lives.
- Children and young people at risk of harm and their families were not always aware of or supported to access independent advocacy. The partnership had recently introduced a rights-based approach to advocacy to address this.
- Children and young people at risk of harm had limited opportunities to influence service planning and delivery.
- The partnership's approach to ensuring that the voice of children, young people and families regularly contributed to strategic planning and improvement was at an early stage of development. There was not yet a clear strategy in place to prioritise, co-ordinate and evaluate activity.

The involvement of children, young people and their families in decisions about their lives

Most children and young people who completed our survey told us that their worker listened to them. Their rights had been explained to them and they had someone who could help them express their views. In almost all records we read, the views of children and young people and in most instances the views of parents and carers were considered during investigations. Most children and young people and their parents and carers had contributed to meetings about their lives.

In the records we read, the impact of involvement for children and young people was variable. While one record was excellent for the effectiveness of how well the child was listened to, heard and included, we evaluated just under half of the records as adequate or lower. Parents and carers were more effectively involved than children and young people. Half of the parents and carers who completed our survey agreed that communication had been good and just over half felt that their views had been taken seriously. Some of the families we spoke to felt that their views had not been listened to and that they had not been included. In some instances, staff vacancies had affected the capacity to meaningfully involve children, young people and their families.

The partnership had already identified that they needed to improve how they listened to and included children and young people and their families. UNCRC rights-respecting schools activity had taken place across the partnership area. We heard

examples of reviewing officers and panel members who had met with children, young people and their families before and after meetings. Staff also told us about how they were taking advantage of training and developing their skills to help younger children to share their views.

Access to independent advocacy

Where children, young people, parents and carers had access to independent advocacy this had helped to ensure that their voice was heard. However, some families had experienced delays in accessing independent advocacy and not all were aware of the availability of this support. The way in which independent advocacy provision had developed in the area meant that there had been several different providers for children and young people. Accessibility was dependent on which process the service had been commissioned for. The commissioning terms were different in each contract and none had provided the impact data that the partnership required.

Partners had recognised the need to improve their advocacy provision and better understand the difference this support made to the lives of children and young people. They had very recently replaced all previous arrangements with one independent advocacy service for all children and young people. Delivered by Quarriers, the new service focused on rights-based advocacy, supporting children and young people to be their own best advocate. The commission for the service had been informed by the views of care experienced young people and had a greater emphasis on evidencing outcomes. Although it was too early to determine impact, there were indications of a strengthened approach to rights and participation.

Influencing service planning, delivery and improvement

Children and young people at risk of harm had limited opportunities to contribute to service planning and delivery. Information about children and young people's experience of services was not routinely sought, analysed and used to inform service planning. A new child-friendly complaints process had recently been launched in the children's social work service but it was too soon to evaluate what impact this had on service delivery.

As part of its strategic GIRFEC arrangements, the partnership had in place a children's rights, participation and engagement group. Partners had established a Promise team, comprising a project lead and engagement lead. The team co-ordinated service-based Promise champions who had been established across the partnership. They had re-established a champions board for care experienced young people aged 16 years and older, and the Little Fix group for care experienced young people aged under 16 years. As part of this work, young people were supported to contribute to the commission for the new Quarriers rights-based advocacy service. These strategic arrangements were helping partners develop opportunities for children and young people's voices to influence service planning and delivery.

There were a few examples of how children, young people and parents and carers' voices had influenced strategic planning and improvement more widely. Partners had engaged with groups of children and young people, including care experienced and those with additional support needs, as part of a joint strategic needs assessment that informed the partnership's new children's services plan. Through locality network arrangements, surveys were used to seek the views of children and young people, which contributed to the development of the Aberlour YP Zone to reduce harm from drug and alcohol use. In partnership with Who Cares? Scotland, the Scottish Children's Reporter's Administration and Children's Hearings Scotland, the children's social work service worked with some care experienced and a few children and young people at risk of harm to redesign hearing rooms and develop the Better Meetings participation guidance. Partners had commissioned Children 1st to seek the views of parents whose children had been removed from their care, with a view to influencing service improvement.

In the majority of examples, it was too early to determine what difference participation had made to the lives of children and young people. Partners recognised that they were at an early stage of developing their approach, particularly in relation to the participation of children and young people at risk of harm. They were planning to strengthen the links between the child protection committee and the work of the children's rights, participation and engagement group. However, there was not yet a clear strategy in place to prioritise, co-ordinate, and evaluate participation activity.

Statement 4: Collaborative strategic leadership, planning and operational management ensure high standards of service delivery

Key messages

- Senior leaders had a shared vision which had been clearly communicated and understood by staff.
- Collaborative strategic leadership had helped maintain the improvements made in 2019 to strengthen governance arrangements between chief officers and the child protection committee.
- The child protection committee had not yet fully developed the mechanisms necessary to understand and communicate the difference that services were making to the lives of children and young people at risk of harm.
- The partnership's agenda for improvement and change was not yet underpinned by a cohesive approach to service review and self-evaluation.

Strategic vision

Moray partnership had a shared vision for all children to "grow up loved, safe, respected and equal because our services and workforce put people first and support families with the right help at the right time". This was joined by a vision developed by a group of Moray young people that they "live in communities where our voice is heard, and we are built up to be all we can be". Partners had streamlined strategic children's planning and produced one overarching children's services plan aligned to the partnership's two vision statements. The plan represented all key areas of activity including child protection and poverty and was helpfully structured around the five foundations of the Promise.

Across services, leaders were visible and had communicated a clear vision to staff. All partners demonstrated commitment to the support and protection of children and young people at risk of harm. The majority of staff who completed our survey felt that leaders knew the quality of work they were able to deliver at the front line and communicated regularly with staff at all levels.

Strategic governance and oversight of child protection

The partnership had in place comprehensive arrangements for strategic governance and accountability. In our 2019 progress review, we identified that governance arrangements between chief officers and the child protection committee had been strengthened considerably. In our inspection, we found that progress had been maintained, supported by collaborative strategic leadership.

Elected members felt informed about the effectiveness of services for children and young people at risk of harm. They received performance information at appropriate intervals and had opportunity to scrutinise reports and presentations. To strengthen oversight, joint reporting to the council's education, children's and leisure services committee and integration joint board (IJB) was established following the transfer of children's social work services to the IJB in April 2023.

The chief officers group maintained a strategic overview of all public protection activity in Moray. This helpfully provided strong links between child and adult protection strategic priorities, for example violence against women and adult support and protection. Written terms of reference and clear reporting arrangements supported chief officers to provide appropriate levels of support and challenge to the chair of the child protection committee, who reported directly to the chief officers group. Chief officers had built in opportunities for development sessions within their regular meetings schedule to better understand key issues. Use of a risk register was helping ensure that chief officers maintained a line of sight to current and emerging risk. An example of response to strategic risk was the agreement from the chief officers group to share new resource from the Moray alcohol and drugs partnership to strengthen the child protection committee's approach to data analysis.

Written terms of reference and clear subgroup reporting structures underpinned the work of the child protection committee. Appropriate committee membership was in place, including third sector representation. A new joint independent chair, with a strong background in care and protection, had been appointed to chair both the child protection committee and the adult support and protection committee. We heard from partners how the new chair was providing helpful support and challenge during meetings. Although there were a number of subgroups, leaders had been careful to align child protection with the wider children's services planning. A core shared membership and collaborative subgroup arrangements reduced duplication and provided strong links between the child protection committee and GIRFEC leadership group.

Members of the child protection committee were appropriately informed of the key protection priorities linked to the overall visions within the children's services plan. Most staff who had completed our survey expressed a confidence in local child protection arrangements. However, a training needs analysis undertaken by the partnership had identified that not all staff understood the role and the contribution of the child protection committee. To address this, the chair had begun a programme of engagement with the multi-agency workforce, starting with social work staff, though this had not yet been rolled out across the partnership. More recently, direct reporting between the community-based locality networks and the GIRFEC leadership group was beginning to help bridge the strategic and operational landscapes.

Leadership of strategy and direction

A gap analysis and the establishment of a child protection committee subgroup for implementation of the national guidance for child protection had supported partners to align local training, policy and procedure with the national guidance published by

Scottish Government in 2021. Good progress had been made in relation to strengthened approaches to initial referral discussion and child protection planning meetings, and the introduction of the Scottish child interview model (SCIM). The strategic approach to the quality of assessment and planning had not progressed as well. The refresh of GIRFEC guidance remained a work in progress, though a few schools were piloting a revised child planning format. The partnership had identified their approach to assessment and planning as an area for development. This was appropriately reflected in the risk register maintained by senior leaders.

Leadership of people and partnerships

Across agencies, staff told us that they valued the support provided by their peers and through line management arrangements. The partnership had in place shared policies and procedures which were helping staff in their work with children and young people and their families. Specific trauma support was available for staff undertaking SCIM work. Across all services, staff members knew what was expected of them and felt supported to be professionally curious with the aim of keeping children and young people safe. Almost all staff who completed our survey felt they received appropriate support and challenge.

Staff who responded to our survey agreed that learning and development opportunities were increasing their confidence and skills in working with children and young people at risk of harm. The majority felt that participation in multi-agency training and development had strengthened their contribution to joint working. In a few instances, communication of intended learning outcomes was not effective. A few staff we spoke with were not clear how some training opportunities improved their support of children and young people at risk of harm.

While staff were making a positive contribution to the lives of some children and young people at risk of harm, senior leaders recognised they had more to do to ensure that there was sufficient support and capacity to consistently achieve high standards of practice.

Data and quality assurance

Partners were developing their approach to multi-agency quality assurance. While the new children's services plan was informed by a joint strategic needs assessment, partners had not yet fully developed the measures necessary under the plan to help them understand what difference they were making to the lives of children and young people at risk of harm.

There were some helpful examples of single-agency activity. A new policy, development and commissioning team established in the children's social work service was strengthening the role of reviewing officers in contributing to quality assurance. However, with the exception of initial referral discussion and SCIM, partners were not routinely undertaking quality assurance on a multi-agency basis to inform service improvement. Wider quality assurance arrangements implemented following previous inspection activity had not been sustained.

The national minimum data set had been adopted by the child protection committee and a data subgroup had been established to support analysis. We heard from child protection committee members how these arrangements had improved the collation, quality and presentation of data. Minutes and reports confirmed that regular scrutiny of data was taking place at child protection committee meetings. The existing data subgroup of the child protection committee was reconfigured to bring together data and audit activity and better develop a multi-agency approach. There were limited examples of the views of staff, children, young people, parents and carers contributing to quality assurance.

While there was better interrogation of data, senior leaders recognised that more needed to be done to develop a greater understanding and articulation of the experiences of children and young people. As noted above, chief officers had agreed the sharing of new resource from the Moray alcohol and drugs partnership to support this work.

Management of resources and workforce planning

The partnership had experienced significant budgetary pressures and challenges in recruiting and retaining staff. While services were working hard to meet needs, demand at times exceeded capacity and impacted negatively on staff's ability to sustain relationships and provide support to children and young people at risk of harm. There was a lack of certainty among staff about the partnership's capacity to meet the needs of children and young people at risk of harm. Of the staff who completed our survey, only half were confident that leaders had ensured the necessary capacity to meet the needs of children and young people at risk of harm. There was some recognition among partners of the reliance at times on the creativity and dedication of the workforce to address gaps. Concerns about capacity were not limited to frontline arrangements. On a few occasions, we heard from staff who had been left feeling frustrated because the time taken for senior managers' decision making about resources had contributed to delays in planning for children and young people.

Senior leaders were working together to try and address service pressures. Chief officers had agreed additional resource for a key social work post and had adopted a pan-Grampian approach to determine where further collaboration could reduce internal pressures. Individual services and agencies had undertaken a number of different initiatives to try and support recruitment and retention and maximise capacity. The council and the integration joint board had medium-term financial plans in place, though were cognisant of the increasingly difficult budgetary position and the continued national challenges of recruitment and retention. Elected members had established cross-party working to support effective decision making. In the face of further pressures, they recognised the need for discussion with partner agencies to consider the wider impact of current and future financial decision making.

Leadership of improvement and change

While some improvements had been achieved and maintained in response to findings of our previous inspection, some momentum had been lost. Partners considered that this was due in part to meeting the additional demands of the Covid-19 pandemic. They recognised that they had more work to do to consistently improve the experiences and outcomes for children and young people at risk of harm.

In seeking to re-establish its agenda to improve the safety of children and young people, the partnership had set out priorities for change within a relatively ambitious children's services plan. While this had resulted in a number of improvement activities taking place in a short space of time, leaders were aware of the need to maintain stability in the system.

Partners recognised the need for strengthening relational practice, though the pressures on the capacity of services was making this more difficult to achieve. They had invested in a number of new relational service initiatives and approaches, many of these in partnership with third sector providers. Examples included Functional Family Therapy, Children 1st Families Together service and the Safe and Together model. New commissioning arrangements were helpfully placing a greater emphasis on outcomes. In addition to external investment, changes had also been made to strategic governance and core areas of service delivery. This was particularly evident in relation to the children's social work service which had experienced both a change in strategic governance and a new senior management team.

With the exception of a few key areas, the majority of improvement activity was very recent and it was not yet clear what impact the changes had on the lives of children and young people. As many initiatives were new, the partnership was yet to understand what difference their investment had made. Evaluation and improvement was not always visible or understood by staff. Not all staff who completed our survey were confident that changes had led to improved outcomes for children and young people. While senior leaders recognised that they needed to do more, management of improvement and change was not yet underpinned by a cohesive approach to service review and self-evaluation.

Evaluation of the impact on children and young people - quality indicator 2.1

For these inspections, we are providing one evaluation. This is for quality indicator 2.1 as it applies to children at risk of harm. This quality indicator, with reference to children at risk of harm, considers the extent to which children and young people:

- feel valued, loved, fulfilled and secure
- feel listened to, understood and respected
- experience sincere human contact and enduring relationships
- get the best start in life.

Evaluation of quality indicator 2.1: Adequate

We evaluated the impact of services on the lives of children and young people as **adequate**. This meant that strengths just outweighed weaknesses. We found strengths that were having a positive impact. Nonetheless, the likelihood of achieving positive experiences and outcomes was reduced significantly because there were key areas of performance that needed to improve.

Important strengths that had positive impacts on children and young people

- Most children and young people told us that they felt safe where they live all or most of the time. When children and young people were identified as being at risk of neglect or abuse, the support provided had helped the majority of children and young people to become safer.

- When children and young people had supportive and trusting relationships with staff, this was making a positive difference to their lives.

- When children and young people received support from universal and specialist services, this made a positive difference to their lives. Examples of this included support in nurturing bases and pupil support bases in schools, provision of counselling services and support from resources such as Children 1st, Quarriers, Aberlour, and Rape Crisis.

Aspects of practice that were working well for some children and young people but not others

- While we heard individual reports of particular staff members and services making a positive difference in the lives of children and young people, some families told us they struggled to access the right support. We also heard a few examples, particularly from parents, of services negatively impacting children and young people.

- While most children, young people and parents and carers benefited from positive relationships with staff, some parents and children told us they had not benefited from positive relationships with staff. This was linked to a lack

of consistency of staff members and some families experienced frequent changes in staff.

- There was mixed evidence from our record reading, children and young people's surveys and during engagement about how effectively children and young people had been listened to, heard and included.

Areas for improvement

- When young people were at risk of harm from themselves or to others, or from risk in the community, they did not consistently receive the right help and support they needed to improve their lives.

- Children and young people at risk of harm were not routinely and meaningfully influencing service planning and improvement.

- Children and young people at risk of harm had not consistently benefited from independent advocacy.

Conclusion

The Care Inspectorate and its scrutiny partners are confident that the partnership in Moray does have the capacity to make changes in the areas that require improvement.

This is based on the following.

- Although consistency across protection work needed to improve, the partnership had in place an effective initial response to risk for children and young people at risk of harm.

- Many of the practice areas identified in this inspection as requiring improvement were already reflected in partnership planning. While some momentum had previously been lost, partners had recommenced implementing the changes necessary to improve outcomes for children and young people.

- Although more needed to be done to understand impact, there was evidence of effective joint working across the partnership having led to improvement in key processes including inter-agency referral discussions and child protection planning meetings.

- Leaders, including elected members, recognised the need for change, had in place appropriate risk management arrangements and, in their collaborative working and investment in new approaches and services, had demonstrated commitment to driving forward their improvement agenda.

What happens next?

The Care Inspectorate will request a joint action plan that clearly details how the partnership will make improvements in the key areas identified by inspectors. We will continue to offer support for improvement and monitor progress through our linking arrangements.

Appendix 1: The quality indicator framework and the six-point evaluation scale

Our inspections used the following scale for evaluations made by inspectors, which is outlined in the quality framework for children and young people in need of care and protection. Published in August 2019, it outlines our quality framework and contains the following scale for evaluations:

- **6 Excellent** - Outstanding or sector leading
- **5 Very Good** - Major strengths
- **4 Good** - Important strengths, with some areas for improvement
- **3 Adequate** - Strengths just outweigh weaknesses
- **2 Weak** - Important weaknesses – priority action required
- **1 Unsatisfactory** - Major weaknesses – urgent remedial action required

An evaluation of **excellent** describes performance which is sector leading and supports experiences and outcomes for people which are of outstandingly high quality. There is a demonstrable track record of innovative, effective practice and/or very high-quality performance across a wide range of its activities and from which others could learn. We can be confident that excellent performance is sustainable and that it will be maintained.

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

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

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

An evaluation of **weak** will apply to performance in which strengths can be identified but these are outweighed or compromised by significant weaknesses. The

weaknesses, either individually or when added together, substantially affect peoples' experiences or outcomes. Without improvement as a matter of priority, the welfare or safety of people may be compromised, or their critical needs not met. Weak performance requires action in the form of structured and planned improvement by the provider or partnership with a mechanism to demonstrate clearly that sustainable improvements have been made.

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

Appendix 2: Key terms

Note: more key terms that we use are available in The Guide to our inspections.

Alcohol and drugs partnership is a locally-based, inter-agency strategic partnership responsible for commissioning and developing local strategies for tackling problem alcohol and drug use and promoting recovery.

Care and risk management (CARM) are processes that are applied when a child between the ages of 12 and 17 has been involved in behaviours that could cause serious harm to others. This includes sexual or violent behaviour that may cause serious harm. CARM processes are also applicable when an escalation of behaviours suggests that an incident of a seriously harmful nature may be imminent.

Champions boards allow young people to have direct influence within their local area and hold their corporate parents to account. They also ensure that services are tailored and responsive to the needs of care experienced young people and are sensitive to the kinds of vulnerabilities they may have as a result of their experiences before, during and after care. Young peoples' views, opinions and aspirations are at the forefront in this forum and are paramount to its success. Champions boards build the capacity of young people to influence change, empower them by showing confidence in their abilities and potential, and give them the platform to flourish and grow.

Child and adolescent mental health services (CAMHS) are multi-disciplinary teams that provide assessment and treatment/interventions in the context of emotional, developmental, environmental and social factors for children and young people experiencing mental health problems. They also provide training, consultation, advice and support to professionals working with children, young people and their families.

Chief officers group is the collective expression for the local police commander and the chief executives of the local authority and NHS board in each local area. Chief officers are individually and collectively responsible for the leadership, direction and scrutiny of their respective child protection services and their child protection committees.

Children's services plan is for services that work with children and young people. It sets out the priorities for achieving the vision for all children and young people and what services need to do together to achieve them.

Child protection committee is a locally-based, inter-agency strategic partnership responsible for child protection policy and practice across the public, private and third sectors. Working on behalf of chief officers, its role is to provide individual and collective leadership and direction for the management of child protection services in its area.

Contextual safeguarding is an approach that recognises that as young people grow and develop, they are influenced by a whole range of environments and people outside of their family.

Family Firm is a concept recognised by the Scottish Government to promote skills and employment opportunities for care experienced young people.

Functional Family Therapy is a short-term, specialist family support programme for children and young people aged 11-18 years and their families where there is a risk of family breakdown.

Getting it Right for Every Child (GIRFEC) is a national policy designed to make sure that all children and young people get the help that they need when they need it.

Graded Care Profile 2 helps professionals measure the quality of care provided by a parent or carer in meeting their child's needs, particularly where there are concerns about neglect. Using the GCP2 assessment tool, professionals score aspects of family life on a scale of one to five. This assessment helps them identify areas where the level of care children receive could be significantly improved.

Independent advocacy is when the person providing advocacy is not involved in providing the services to the individual, or in any decision-making processes regarding their care.

Integration joint board (IJB) plans and commissions integrated health and social care services in their areas. Integration joint boards are local government bodies, as defined by Section 106 of the Local Government (Scotland) Act 1973. They are responsible for overseeing the local health and social care partnership and managing social care and health services in their area.

Inter-agency referral discussion (IRD) is the start of the formal process of information sharing, assessment, analysis and decision making following reported concern about abuse or neglect of a child or young person under the age of 18 years, in relation to familial and non-familial concerns. This may include discussion of concern relating to brothers and sisters, or other children within the same context, and can refer to an unborn baby that may be exposed to current or future risk. They may also be known as initial referral discussions, or initial referral tripartite discussions.

Joint strategic needs assessment is the means by which local leaders work together to understand and agree the needs of all local people, in order to deliver a strategy which sets priorities for collective action.

Learning review brings together agencies, individuals and families in a collective endeavour to learn from what has happened in order to improve and develop systems and practice in the future and thus better protect children and young people. The process is underpinned by the rights of children and young people as set out in the United Nations Convention on the Rights of the Child (UNCRC). Until the updated national guidance for child protection was published in 2021, the term 'significant case review' was more commonly used.

Let's Introduce Anxiety Management (LIAM) is intended to develop cognitive behaviour therapy informed skills and approaches to treat children and young people with mild to moderate anxiety symptoms.

National minimum dataset for child protection committees in Scotland is a set of agreed measurements, criteria or categories required to create a robust understanding of information about a service. The data populated through these

measures provide a baseline and then a progress measurement for the planning and development of services delivered.

Practice reflection improvement short module (PRISM) is an open learning event where the local child protection committee's evaluation of local practice is shared and discussed with a multi-agency group of practitioners. Small group reflection is then supported and ways to improve local practice is considered.

Safe and Together is a suite of tools and interventions designed to help staff improve their awareness and understanding of domestic abuse. It is based on three key principles: keeping children safe and together with their non-abusive parent ensuring safety, healing from trauma, stability and nurture; partnering with the non-abusive parent as a default position ensuring efficient, effective and child-centred practice; and intervening with the perpetrator to reduce the risk and harm to the child through engagement, accountability and criminal justice.

Scottish child interview model (SCIM) is a new approach to joint investigative interviewing that is trauma-informed. It maintains the focus on the needs of the child in the interview, minimises the risk of further traumatisation and aims to achieve best evidence through improved planning and interview techniques.

Scottish Children's Reporter Administration is an executive non-departmental public body of the Scottish Government with responsibility for protecting children at risk.

Trauma-informed workforce is able to recognise when someone may be affected by trauma. It collaborates and adjusts how it works to take this into account and responds in a way that supports recovery, does no harm and recognises and supports people's resilience.

The Promise Scotland was established to take forward the work of the Independent Care Review. In 2021, it published its plan for 2021-2024, outlining key outcomes that aim to ensure that Scotland's children and young people grow up loved, safe and respected, so they can realise their full potential.

United Nations Convention on the Rights of the Child (UNCRC) is a widely-ratified international statement of children's rights.

Universal services are those services used by the whole population of children and young people, mainly in health and education, including schools and nurseries, GPs and health visiting.

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REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 28 MARCH 2024**

SUBJECT: **HEALTHCARE IMPROVEMENT SCOTLAND (HIS) UNANNOUNCED SAFE DELIVERY OF CARE INSPECTION OF DR GRAY'S HOSPITAL, NHS GRAMPIAN, OCTOBER 2023**

BY: **CHIEF NURSE, MORAY**

1. REASON FOR REPORT

1.1 To inform the Committee of the Unannounced Safe Delivery of Care Inspection by Healthcare Improvement Scotland (HIS) on 9 – 11 October 2023.

2. RECOMMENDATION

2.1 It is recommended that the Committee consider and note the outcome of the inspection of Dr Gray's Hospital and NHS Grampian by Healthcare Improvement Scotland (HIS). Learning from this inspection has been shared and implemented across Health and Social Care Moray.

3. BACKGROUND

3.1 In November 2021 the Cabinet Secretary for Health and Social Care approved Healthcare Improvement Scotland inspections of acute hospitals across NHS Scotland to focus on the safe delivery of care. Taking account of the changing risk considerations and sustained service pressures the methodology was adapted to minimise the impact of inspections on staff delivering care to patients. The inspection teams carry out as much of their inspection activities as possible through observation of care and virtual discussion sessions with senior hospital managers. They keep discussions with clinical staff to a minimum and reduce the time spent looking at care records.

3.2 From April 2023 the inspection methodology and reporting structure were updated to fully align to the Healthcare Improvement Scotland Quality Assurance Framework (**Appendix 1**).

3.3 The inspection considers the factors that contribute to the safe delivery of care, including:

- observe the delivery of care within the clinical areas in line with current standards and best practice.

- attend hospital safety huddles.
- engage with staff where possible, being mindful not to impact on the delivery of care.
- engage with hospital management to understand current pressures and assess the compliance with the NHS board policies and procedures, best practice statements or national standards.
- report on the standards achieved during the inspection and ensure the NHS board produces an action plan to address the areas for improvement identified.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 The HIS Unannounced Safe Delivery of Care Inspection, 9 – 11 October 2023, at Dr Gray's Hospital, NHS Grampian, resulted in 2 areas of good practice, 1 recommendation and 20 requirements.

4.2 A parallel inspection during this time was also undertaken at Aberdeen Royal Infirmary (ARI) to provide wider assurance of systems and processes across NHS Grampian.

4.3 As a result of concerns identified during the inspection, HIS inspectors wrote to the NHS Grampian Board on two occasions in relation to the management of controlled drugs within the Emergency Department (ED) at Dr Gray's Hospital, along with the oversight and management of incident reporting systems (Datix) and processes.

4.4 NHS Grampian provided HIS with a detailed response and evidence regarding improvement work and actions put in place to ensure outstanding incident reports are reviewed and lessons learned are shared to improve patient safety.

4.5 In relation to the wider incident reporting system, HIS were provided with information regarding the implementation of a rapid improvement approach, with adverse event reports incorporated into the hospital safety huddles. Protected time has been allocated to staff with large numbers of outstanding incidents to support completion, feedback and learning.

4.6 HIS were provided with a detailed review and improvement action plan to support the systems and processes for the safe management and incident reporting for controlled drugs. NHS Grampian provided a review of outstanding incidents and were able to account for any controlled drug discrepancies.

4.7 Further actions to be undertaken by NHS Grampian in response to the concerns raised include a review of all controlled drug record books and unannounced controlled drug compliance checks.

4.8 Healthcare Improvement Scotland (HIS) Inspectors provided initial verbal feedback to NHS Grampian Executive Team, Senior Leadership Teams and Portfolio Leads on 11 October 2023, with an opportunity to ask questions.

4.9 The HIS Unannounced Safe Delivery of Care 'Draft' Inspection Report was received by NHS Grampian on 8 January 2024, for factual accuracy.

4.10 The HIS Unannounced Safe Delivery of Care 'Embargoed' Inspection Report was received by NHS Grampian on 26 January 2024, with the Full Report published on 1 February 2024 (**Appendix 2**) along with the Improvement Action Plan (**Appendix 3**).

4.11 NHS Grampian and Dr Gray's Hospital Senior Leadership team are working through the action plan to support improvements and safe delivery of care. Learning from the Improvement Action Plan has been shared and implemented throughout Health and Social Care Moray.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Partners in Care 2022 – 2032"
This report is in accordance with 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
From April 2023 the inspection methodology and reporting structure were updated to fully align to the Healthcare Improvement Scotland Quality Assurance Framework (**Appendix 1**).

(c) Financial implications
There are no financial implications.

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

(e) Staffing Implications
There are no staffing implications.

(f) Property
There are no property implications.

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

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

(i) Directions
None arising directly from this report.

(j) Consultations
HSCM Clinical and Care Governance Group have been consulted.

6. CONCLUSION

6.1 The Clinical and Care Governance Committee are asked to note the HIS Unannounced Safe Delivery of Care Inspection of Dr Gray's Hospital, NHS Grampian and the associated Action Plan.

Author of Report:	Debbie Barron
Background Papers:	Appendices 1, 2 and 3
Ref:	

Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report

Acute Hospital Safe Delivery of Care Inspection

Dr Gray's Hospital
NHS Grampian

9 – 11 October 2023

Healthcare Improvement Scotland is committed to equality. We have assessed the inspection function for likely impact on equality protected characteristics as defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation (Equality Act 2010). You can request a copy of the equality impact assessment report from the Healthcare Improvement Scotland Equality and Diversity Officer by emailing his.contactpublicinvolvement@nhs.scot

First published February 2024

www.healthcareimprovementscotland.org

About our inspection

Background

In November 2021 the Cabinet Secretary for Health and Social Care approved Healthcare Improvement Scotland inspections of acute hospitals across NHS Scotland to focus on the safe delivery of care. Taking account of the changing risk considerations and sustained service pressures the methodology was adapted to minimise the impact of our inspections on staff delivering care to patients. Our inspection teams are carrying out as much of their inspection activities as possible through observation of care and virtual discussion sessions with senior hospital managers. We will keep discussion with clinical staff to a minimum and reduce the time spent looking at care records.

From April 2023 our inspection methodology and reporting structure were updated to fully align to the Healthcare Improvement Scotland Quality Assurance Framework. Further information about the methodology for acute hospital safe delivery of care inspections can be found on our website.

Our focus

Our inspections consider the factors that contribute to the safe delivery of care. To achieve this, we:

- observe the delivery of care within the clinical areas in line with current standards and best practice.
- attend hospital safety huddles.
- engage with staff where possible, being mindful not to impact on the delivery of care.
- engage with management to understand current pressures and assess the compliance with the NHS board policies and procedures, best practice statements or national standards, and
- report on the standards achieved during our inspection and ensure the NHS board produces an action plan to address the areas for improvement identified.

About the hospital we inspected

Dr Gray's Hospital serves Elgin and the surrounding region. It contains 153 inpatient beds and 42 Day Case beds and has a full range of healthcare specialties.

About this inspection

We carried out an unannounced inspection to Dr Gray's Hospital, NHS Grampian on Monday 9 to Wednesday 11 October 2023 using our safe delivery of care inspection methodology. In parallel to this inspection, we also carried out a safe delivery of care inspection at Aberdeen Royal Infirmary to provide wider assurance of systems and processes across NHS Grampian.

As a result of concerns identified during our inspection at Dr Gray's Hospital, we have written to NHS Grampian on two occasions. Further information about these concerns can be found in this report.

During our inspection of Dr Gray's Hospital, we inspected the following areas:

- acute medical assessment unit
- emergency department
- high dependency unit
- stroke ward
- ward 5
- ward 7

We also visited the paediatric short stay assessment unit.

During our inspection, we:

- inspected the ward and hospital environment.
- observed staff practice and interactions with patients, such as during patient mealtimes.
- spoke with patients, visitors and ward staff, and
- accessed patients' health records, monitoring reports, policies, and procedures.

As part of our inspection, we also asked NHS Grampian to provide evidence of its policies and procedures relevant to this inspection. The purpose of this is to limit the time the inspection team is onsite, reduce the burden on ward staff and to inform the virtual discussion session.

On Tuesday 14 November 2023, we held a virtual discussion session with key members of NHS Grampian staff to discuss the evidence provided and the findings of the inspection.

The findings detailed within this report relate to our observations within the areas of Dr Gray's Hospital we inspected at the time of this inspection.

We would like to thank NHS Grampian and in particular all staff at Dr Gray's Hospital for their assistance during our inspection.

A summary of our findings

Our summary findings from the inspection, areas of good practice and any recommendations and requirements identified are highlighted as follows. Detailed findings from the inspection are included in the section 'What we found during this inspection'. We observed staff providing compassionate and responsive care with most patients being complimentary about the care provided.

However, as a result of serious concerns identified during our inspection, we wrote to NHS Grampian on two occasions. We raised concerns about the management of controlled drugs within the emergency department. We also raised concerns regarding the oversight and management of the incident reporting systems and processes impacting on patient safety, dignity and respect at Dr Gray's Hospital.

During our inspection we observed evidence of failures to review, action and close incidents reports relating to patient safety, privacy and dignity, and staff concerns around workload and culture, particularly in the emergency department. We are not assured of senior management oversight of possible and reported risk to patients and staff, especially in the emergency department. Staff described a culture where they were encouraged to raise concerns. However, they did not feel that these were always listened to by senior managers.

We have concerns about the availability of staff training in paediatric immediate life support and systems and processes for patient triage in the emergency department.

Increased capacity and pressures within the emergency department has had an impact on patient privacy and dignity.

Other areas for improvement have been identified at Dr Gray's Hospital. These include the safe storage of medication and of cleaning products and the completion of patient documentation.

What action we expect the NHS board to take after our inspection

This inspection resulted in two areas of good practice, one recommendation and 20 requirements.

A requirement in the inspection report means the hospital or service has not met the required standards and the inspection team are concerned about the impact this has on patients using the hospital or service. We expect all requirements to be addressed and the necessary improvements implemented.

A recommendation relates to best practice which Healthcare Improvement Scotland believe the NHS board should follow to improve standards of care.

We will seek assurance in regard to the serious concerns raised relating to the management and oversight of the incident reporting systems and management of

controlled drugs within the emergency department at future inspections and through NHS Grampian's improvement action plan.

We expect NHS Grampian to address the requirements. The NHS board must prioritise the requirements to meet national standards. An improvement action plan has been developed by the NHS board and is available on the Healthcare Improvement Scotland website: www.healthcareimprovementscotland.org

Areas of good practice

The unannounced inspection to Dr Gray's Hospital resulted in two areas of good practice.

Domain 4.1	
1	All areas inspected were calm and well organised (see page 23).

Domain 6	
2	We observed positive and caring interactions between staff and patients (see page 29).

Recommendation

The unannounced inspection to Dr Gray's Hospital resulted in one recommendation.

Domain 4.1	
1	NHS Grampian should ensure that patients are assisted with hand hygiene at mealtimes (see page 23).

Requirements

The unannounced inspection to Dr Gray's Hospital resulted in 20 requirements.

Domain 1	
1	NHS Grampian must ensure that nursing staff are provided with necessary training to safely carry out their roles and comply with the NMC Code, Professional standards of practice and behaviour for nurses, midwives and nursing associates (see page 15). This will support compliance with: The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (2018).
2	NHS Grampian must ensure effective and appropriate governance approval and oversight of policies and procedures are in place (see page 15). This will support compliance with: Quality Assurance System: Quality Assurance Framework (2022) criterion 2.5 and 2.6.
3	NHS Grampian must ensure that systems and processes are in place to ensure both adult and paediatric patients are triaged in a timely manner (see page 15). This will support compliance with: Quality Assurance System: Quality Assurance Framework (2022) Criteria 6.1.
4	NHS Grampian must ensure all staff are aware of fire evacuation procedures (see page 15). This will support compliance with: NHS Scotland 'Firecode' Scottish Health Technical Memorandum SHTM 83 (2017) Part 2; The Fire (Scotland) Act (2005) Part 3, and Fire Safety (Scotland) Regulations (2006).

Domain 2	
5	NHS Grampian must ensure that there are suitable systems, processes, resources and support and oversight in place to ensure students experience safe and effective coordination of learning within practice learning environments (see page 18). This will support compliance with: NMC Standards for student supervision and assessment (2023).
6	NHS Grampian must ensure that all staff comply with controlled drug management in line with NHS Grampian policy and procedures for the safe management of controlled drugs in hospitals and clinics (see page 18).

	This will support compliance with: Royal Pharmaceutical Society and Royal College of Nursing Professional Guidance on the Administration of Medicines in Healthcare Settings (2019) and relevant codes of practice of regulated healthcare professions.
7	NHS Grampian must improve feedback to staff on incidents raised through the incident reporting system and ensure learning from incidents is used to improve safety and outcomes for patients and staff (see page 18). This will support compliance with: Quality Assurance System: Quality Assurance Framework (2022) Criteria 3.1 and Learning from adverse events through reporting and review: A national framework for Scotland (2019).
8	NHS Grampian must ensure effective senior management oversight and support, to reduce the risks for staff and patients receiving care (see page 18). This will support compliance with: Health and Social Care Standards (2017) Criteria 4.23, Quality Assurance System: Quality Assurance Framework (2022) criterion 2.3, 2.6 and 5.5 and relevant codes of practice of regulated healthcare professions.

Domain 4.1	
9	NHS Grampian must ensure effective senior management oversight and support, to ensure the fundamentals of care are provided and reduce the risks for staff and patients at times of extreme pressure within the emergency department (see page 23). This will support compliance with: Health and Social Care Standards (2017) Criteria 4.23; Quality Assurance System: Quality Assurance Framework (2022) criterion 6.2 and 6.3, and relevant codes of practice of regulated healthcare professions.
10	NHS Grampian must ensure that all patient documentation is accurately and consistently completed. This includes Adults with Incapacity section 47 documents (see page 23). This will support compliance with: Quality Assurance System: Quality Assurance Framework (2022) Criteria 4.1, relevant codes of practice of regulated healthcare professions and Adults with Incapacity (Scotland) Act (2000).
11	NHS Grampian must ensure safe storage and administration of medicines at all times (see page 23).

	This will support compliance with: Royal Pharmaceutical Society and Royal College of Nursing Professional Guidance on the Administration of Medicines in Healthcare Settings (2019) and relevant codes of practice of regulated healthcare professions.
12	NHS Grampian must ensure the safe disposal of sharps (see page 23). This will support compliance with: National Infection Prevention and Control Manual (2023).
13	NHS Grampian must ensure used linen is managed appropriately (see page 23). This will support compliance with: National Infection Prevention and Control Manual (2023).
14	NHS Grampian must ensure the care environment is maintained to allow for effective cleaning (see page 23). This will support compliance with: National Infection Prevention and Control Manual (2023).
15	NHS Grampian must ensure all hazardous cleaning products are securely stored (see page 23). This will support compliance with: Control of Substances Hazardous to Health (COSHH) Regulations (2002).
16	NHS Grampian must ensure consistent recording of flushing of infrequently used water outlets to improve compliance and provide assurance in line with current national guidance (see page 23). This will support compliance with: National Infection Prevention and Control Manual (2023).
17	NHS Grampian must ensure that patient care equipment is kept clean and ready for use (see page 24). This will support compliance with: National Infection Prevention and Control Manual (2023) Standard 6.

Domain 4.3	
18	NHS Grampian must ensure that it consistently reports and records staffing risks, as well as robustly recording mitigations and recurring risks in line with established governance processes (see page 27). This will support compliance with: Health and Care (Staffing) (Scotland) Act (2019) and Quality Assurance System: Quality Assurance Framework (2022) criteria 1.3 and 2.2.

Domain 6	
19	NHS Grampian must ensure when patients are cared for in mixed sex bays, this is regularly risk assessed and suitable mitigations are put in place to maintain patient dignity, respect and choice (see page 29). This will support compliance with: Health and Social Care Standards (2017) criteria 1.20 and Quality Assurance System: Quality Assurance Framework (2022) Criteria 6.1.
20	NHS Grampian must ensure that patient privacy and dignity is maintained at all times and all patients have access to a call bell (see page 29). This will support compliance with: Health and Social Care Standards (2017) criteria 4.11, 5.2, 5.3 and 5.4; Healthcare Improvement Scotland Care of Older People in Hospital Standards (2015) Standard 2; Quality Assurance System: Quality Assurance Framework (2022) Criteria 6.2; Health and Social Care Standards (2017) Criterion 1.23 and relevant codes of practice of regulated healthcare professions.

What we found during this inspection

Domain 1 – Clear vision and purpose

- Quality indicator 1.5 – Key performance indicators

During this inspection we did not observe any significant delays in ambulance turnaround times. Ambulance crews we spoke with described emergency department staff as being responsive. However, we have concerns about the availability of staff training in paediatric immediate life support and systems and processes for patient triage. We are not assured of the processes in place to

maintain patient safety or staff health and wellbeing within the emergency department.

At the time of this inspection NHS Grampian and Dr Gray's Hospital, like much of NHS Scotland, was experiencing significant pressures including increased hospital capacity and reduced staff availability.

The national target for accident and emergency waiting times means that 95% of patients should wait no longer than four hours from arrival at the emergency department or other admission units before admission, discharge or transfer for other emergency treatment.

Across NHS Scotland for the week ending 15 October 2023, 65.9% of patients were seen within the four hour target with 67% patients seen within the four hour target at Dr Gray's Hospital. Further information on emergency department attendances can be found at NHS Performs - weekly update of emergency department activity and waiting times.

Scottish Government emergency signposting guidance seeks to ensure patients receive care in the most appropriate setting while helping to improve waiting times and delays in emergency departments and acute admission units. Evidence provided by NHS Grampian includes the Aberdeen Royal Infirmary and Dr Gray's Hospital signposting/redirection guidance. This includes the flow navigation centre and 'Call Before You Convey' service. This service enables the ambulance service to contact the flow navigation centre to discuss alternative available pathways for patients, such as out of hours primary care appointments. Evidence provided by NHS Grampian documents that since introduction in October 2022 the flow navigation centre and 'Call Before You Convey' service has received over 7,000 calls from the Scottish ambulance service. Of these calls just over 30% required admission to the emergency department. Further information can be found at emergency department signposting/redirection guidance.

We asked NHS Grampian to provide evidence of any incidents reported by staff from the emergency department through its incident reporting system for the past 12 months. From this information we could see there had been several occasions where patients had remained in ambulances outside the hospital for up to six hours waiting for available space within the department. Despite these delays we did not see any incidents reported where patients became critically unwell while waiting in ambulances. On this inspection we did not observe any significant delays in ambulance turnaround times. Ambulance crews we spoke with described emergency department staff as being responsive if they require to escalate concerns, or if a patient's condition deteriorates whilst waiting in the ambulance. Inspectors were also told that there is available provision of food and fluids for patients who are waiting in ambulances.

Patients referred by general practitioners to Dr Gray's Hospital are received by the emergency department in the first instance. Staff told inspectors that this leads to further pressure and reduced patient flow within the department.

Triage is an essential part of emergency care. On a patient's arrival to the emergency department, the person responsible for triage assesses the patient's needs and assigns the priority of treatment required. There is no standardised triage system in Scotland. However, the Royal College of Emergency Medicine advises that triage should occur within 15 minutes of presentation. More information can be found at initial assessment of emergency department patients - Royal College of Emergency Medicine. Evidence provided by NHS Grampian includes an incident report detailing that patients were not prioritised according to clinical need at Dr Gray's Hospital due to increased pressure and reduced staff availability to provide triage.

The Royal College of Emergency Medicine indicates that staff undertaking triage should be experienced in working in emergency care. Evidence provided by NHS Grampian includes the adult triage and assessment pathway for the emergency department at Dr Gray's Hospital. Further narrative documents that 79% of registered nurses in the department are trained in triage with the remaining staff having only worked in the department for the past six months.

Incident reports provided by NHS Grampian included an incident where a patient had become critically unwell after waiting approximately 80 minutes to be triaged. As part of evidence requested, we asked NHS Grampian for further information on this incident. From this information we could see that a serious adverse event review is being undertaken and that progress is monitored at the fortnightly Dr Gray's Hospital clinical risk management meetings. However, the incident had not been reviewed or closed within the timelines specified in NHS Grampian's management of and learning from adverse events policy. Narrative provided by hospital managers regarding this incident documents that this delay was due to challenges in identifying appropriate staff to undertake the review as these included colleagues from the wider health care system such as primary care. This will be discussed further in domain 2 of this report.

Dr Gray's Hospital provides inpatient paediatric services and paediatric patients are assessed and treated within the emergency department. Most nursing staff within the emergency department are trained to provide adult care. We were told by staff that several registered nurses had completed the paediatric immediate life support course. This course is developed by the Resuscitation Council UK for health professionals who may have to manage and treat paediatric patients in an emergency. We observed that compliance with staff completion of this course was low, with 44% of the registered nursing staff in the emergency department and 64% on the paediatric ward having completed the training. Staff we spoke with told us there is no current paediatric immediate life support training provision at Dr Gray's Hospital. We raised this with senior managers who advised us that the NHS

Grampian resuscitation team have approached an external company to provide training with the intention that all registered nurses in both the emergency department and paediatric ward receive training by February 2024. A requirement has been given to support improvement in this area.

Evidence provided by NHS Grampian includes the clinical pathway to be followed if a paediatric patient requires to be transferred to the high dependency unit at Royal Aberdeen Children's Hospital. This pathway is overdue its review date of October 2020. During our corresponding inspection at Aberdeen Royal Infirmary, we also observed several guidelines and risk assessments which are in draft form or overdue their review date. We discussed this with NHS Grampian senior managers at the virtual discussion for Aberdeen Royal Infirmary, further information on this can be seen in our inspection report for Aberdeen Royal Infirmary. A requirement has been given in both inspection reports to support improvement in this area.

We were provided with Dr Gray's Hospital emergency department paediatric medical admission flow pathway. This documents the process to be followed when paediatric patients present in the emergency department with a medical condition. This specifies that the emergency department consultant observes the patient in the waiting room. If the patient is stable and a bed is available, the patient will then be transferred to the paediatric department to be seen by the paediatric medical team. If there is no bed available, the patient is triaged by the emergency department and the duty paediatric doctor reviews the patient in the emergency department. Patients that are unstable are reviewed and treated in the emergency department prior to transfer to the paediatric ward. This pathway indicates that between 09.00 – 17.00 Monday – Friday the initial point of contact for paediatric medical presentations would be the duty paediatric consultant. Trauma and minor injuries in paediatric patients are seen and treated in the emergency department.

However, staff we spoke with in the emergency department told us paediatric patients are often triaged by the paediatric ward nursing staff. This is not in line with the emergency department paediatric medical admission flow pathway. Evidence provided by NHS Grampian included several incident reports raised by staff where paediatric patients had been assessed as stable to be transferred to the paediatric ward but required immediate treatment on arrival as their condition was not stable.

As part of this inspection, we requested evidence regarding triage pathways and systems for the emergency department. Returned evidence included the adult triage assessment which documents observations such as blood pressure and pulse, presenting complaint and triage priority category. However, we were not provided with a specific paediatric triage system for the emergency department, other than the medical admission flow pathway previously discussed. Evidence provided by hospital managers states that the agreed pathway for paediatric patients attending the emergency department will be reviewed to include criteria led assessments by the end of January 2024.

We are not assured that both the adult and paediatric triage pathways and processes in place within the emergency department are sufficient to promote the safe delivery of care. A requirement has been given to support improvement in this area.

The clinical decisions unit is a separate area within the emergency department which is a bay with space for four beds and a small seating area for two chairs. The unit is used to provide extra capacity when there is reduced flow and overcrowding in the emergency department. At the time of this inspection the clinical decisions unit had four patients in bed spaces. We observed that all patients had access to call bells, privacy screens and electrical points. Evidence provided by NHS Grampian included a clinical decisions unit risk assessment which documents that the unit should only be used following consultation between the emergency department consultant/duty manager and emergency department nurse in charge. The risk assessment identifies that the environment is challenged with limited access to bathroom facilities. Inspectors observed that there is one shower and one toilet available for the patients being cared for in the clinical decisions unit. It is also documented that only patients who are mobile and require minimal assistance with personal care are transferred to the unit.

NHS Grampian provided the health and safety risk assessment for the unit which includes control measures to provide nurse staffing cover. This includes requesting additional staff via senior nurses and senior managers. However, inspectors were told that additional staff were often not available resulting in the emergency department staff covering the unit which increased their workload. Staffing will be discussed further in domain 4.3.

We reviewed the incident reports relating to the emergency department. While these include several reports documenting that the clinical decision unit had more than four beds in use, the incidents did not appear to highlight a significant negative impact on patient safety.

Evidence provided by NHS Grampian includes several incident reports of overcrowding in the emergency department with up to five patients being cared for in the corridor at one time. Inspectors were told by staff in both the emergency department and the acute medical admissions unit that a fire evacuation plan is in place. Staff in the acute medical admissions unit told inspectors they would feel confident if they needed to complete a ward evacuation.

We were told by staff that there had been a ‘walkthrough’ by the fire safety officer in the emergency department. Evidence provided by NHS Grampian includes the local fire plan and emergency fire procedures for Dr Gray’s Hospital. This documents that if patients are being cared for in the corridors these beds should be moved first to facilitate evacuation of the remaining area. Returned evidence also includes the fire risk assessments for the emergency department. This includes actions taken, risk responsibility and time frames. However, several staff we spoke to were not aware

of the process for evacuation in the case of fire if patients were being cared for in the corridors. A requirement has been given to support improvement in this area.

Requirements

Domain 1	
1	NHS Grampian must ensure that nursing staff are provided with necessary training to safely carry out their roles and comply with the NMC Code, Professional standards of practice and behaviour for nurses, midwives and nursing associates.
2	NHS Grampian must ensure effective and appropriate governance approval and oversight of policies and procedures are in place.
3	NHS Grampian must ensure that systems and processes are in place to ensure both adult and paediatric patients are triaged in a timely manner.
4	NHS Grampian must ensure all staff are aware of fire evacuation procedures.

Domain 2 – Leadership and culture

- Quality indicator 2.1 – Shared values

While we observed that wards and departments were calm, organised and well led at local level. We are not assured of senior management oversight of possible and reported risk to patients and staff, especially in the emergency department. Staff described a culture where although they felt encouraged and able to raise concerns, these were not listened to by senior managers.

Staff we spoke with described a supportive culture provided by senior charge nurses at local level, including being encouraged to raise concerns. However, we were told that they did not feel concerns were listened to at a more senior level. Staff described a lack of clear structure, communication and collaboration from senior managers, describing that they often felt overwhelmed with workload and increased pressures.

As part of this inspection, we attended the Dr Gray's Hospital safety huddles. While staffing numbers were discussed at the huddle there was no discussion of patient acuity and dependency, or mitigation of risk. Staff told inspectors that while patient acuity and dependency constantly changed, this was not considered by senior managers, and staff therefore felt discouraged to raise concerns at hospital safety huddles. The hospital staffing safety huddle will be discussed further in domain 4.3.

In one ward inspected we observed that the only two registered nurses on duty were both supplementary staff, one was a bank nurse who was familiar with the ward and

the other an agency nurse. Two student nurses were also working in the ward with support available from the advanced nurse practitioner for the ward. We raised concerns with hospital managers at the time of inspection regarding student support in this ward due to high numbers of supplementary staff and lack of availability of practice supervisors. Following this we received evidence that NHS Grampian had written to Robert Gordon University advising of the situation and inspection feedback. NHS Grampian confirmed that ward rotas have now been reviewed to ensure that a substantive member of staff is on each shift. This letter also highlighted that student placement numbers had already been reduced at Dr Gray's Hospital to improve the student learning experience. A requirement has been given to support improvement in this area.

NHS Grampian's policy for the management of learning from adverse events includes the associated timescales required for incident reviews. These timescales are aligned with the learning from adverse events national framework. This framework indicates that all adverse incidents should be reviewed, immediate actions taken, and lessons learned shared. The level of the review will be determined by the category of the event and is based on the impact of harm, with the most serious requiring a significant adverse events review. Further information on the national framework can be found at Learning from adverse events through reporting and review - a national framework for Scotland.

During this inspection staff we spoke with in the emergency department raised concerns relating to incident management and a large number of outstanding adverse events that had been reported but not reviewed. Staff told inspectors that due to increased pressures and patient acuity and dependency, the senior charge nurses did not have time to review incidents as they were required to provide clinical care. We asked NHS Grampian to provide us with incidents reported by staff from the emergency department for the past 12 months and across the hospital for the 6 months prior to the inspection.

These were provided and we were able to see that in the emergency department 186 incidents were overdue their timescales for completion of review, including 42 which date back to 2022. Of the 186 overdue incidents 41 were still awaiting initial review. We observed a significant amount of the incidents related to overcrowding in the emergency department impacting on patient safety, privacy and dignity and staff ability to provide safe delivery of patient care. Several incidents described staff feeling overwhelmed, unable to provide care and not feeling supported by senior managers, including the site and capacity team, with staff unable to take their breaks overnight. One incident described a night shift where a band 5 registered nurse was in charge of the emergency department and was also required to assume responsibility for the site and capacity aspect of the site nurse practitioner role for the hospital. We raised these concerns with senior hospital managers who advised that the number of band 6 senior staff nurses have been increased, including within the emergency department, and a dedicated nurse staffing safety huddle has been

implemented. Evidence provided by NHS Grampian documents that they were unable to provide feedback from the incident review to the staff member as the incident had been submitted anonymously.

There were also several incident reports relating to the management of controlled drugs within the emergency department at Dr Gray's Hospital dating from December 2022 to October 2023. These included discrepancies in the management and recording of controlled drugs, with several drugs unaccounted for and stock found at reception which had not been signed in on arrival from the pharmacy department.

Learning from adverse events is essential to continually maintain and improve the safe delivery of patient care. During this inspection, and through the review of evidence and discussions with staff and senior managers, we were not assured that senior hospital managers had clear oversight of potential and actual risk to patients and staff. We were also unassured that there are effective support processes in place for staff when they are unable to review incidents due to workforce pressures. As discussed earlier in this report, Healthcare Improvement Scotland wrote to NHS Grampian on two separate occasions to highlight a number of concerns from the findings of this inspection. One in relation to the management and oversight of controlled drugs and the second in relation to oversight and governance of the incident reporting system within Dr Gray's hospital and staff concerns about senior management support. We requested assurance that these concerns were being addressed and an update on improvement actions.

NHS Grampian provided us with a detailed response and evidence regarding improvement work and actions put in place to ensure outstanding incident reports are reviewed, and lessons learned are shared to improve patient safety. This includes a detailed review and improvement action plan to support the systems and processes for the safe management of, and incident reporting for controlled drugs. NHS Grampian provided a review of these incidents and were able to account for any controlled drug discrepancies. Further actions to be undertaken by NHS Grampian in response to the concerns raised include a review of all controlled drug record books, and unannounced controlled drug compliance checks. Whilst we are assured that NHS Grampian has reviewed these incidents and provided a detailed action plan a requirement has been given to ensure ongoing oversight.

In response to the concerns relating to the wider incident reporting system and senior management support for staff, we were provided with information regarding the implementation of a rapid improvement approach by the senior management team. To support the rapid improvement approach, adverse event reports have been incorporated into the hospital safety huddle. Protected time has now been allocated to staff who had a large number of outstanding incidents. This approach has seen the number of incidents across the hospital awaiting initial review reduce from 348 to 78. This was a prompt and positive response by NHS Grampian.

We were also provided with information about the NHS Grampian wide cultural roadshows. These roadshows are designed to create awareness and foster the development of a positive values-based culture across NHS Grampian. Information provided also included the 'we care – because you care' resource pack. This pack includes staff health and wellbeing resources, including a team wellbeing check-in tool and advice on where staff can access support such as the chaplaincy service and listening service.

Whilst NHS Grampian response has shown an improvement in outstanding incident reviews and shows increased senior management oversight, two requirements have been given to ensure improvement is maintained.

Requirements

Domain 2	
5	NHS Grampian must ensure that there are suitable systems, processes, resources and support and oversight in place to ensure students experience safe and effective coordination of learning within practice learning environments.
6	NHS Grampian must ensure that all staff comply with controlled drug management in line with NHS Grampian policy and procedures for the safe management of controlled drugs in hospitals and clinics.
7	NHS Grampian must improve feedback to staff on incidents raised through the incident reporting system and ensure learning from incidents is used to improve safety and outcomes for patients and staff.
8	NHS Grampian must ensure effective senior management oversight and support, to reduce the risks for staff and patients receiving care.

Domain 4.1 – Pathways, procedures and policies

- Quality indicator 4.1 – Pathways, procedures and policies

All areas inspected were calm and well organised with staff working hard to support the safe delivery of care. However, concerns were raised by staff in the emergency department regarding the ability to provide safe and effective care in times of increased pressure.

Inspectors observed all areas visited were calm and well led, with staff describing a supportive culture at senior charge nurse level. We observed that patients appeared well cared for and had access to call bells which were answered in a timely manner. Inspectors observed that staff interactions with patients were positive, with patients being treated with dignity and respect. The majority of patients and visitors we spoke with were complimentary about the care they had received. Patients told us that they could see staff were busy and were working hard. Visitors spoke highly of the care provided.

We observed that additional beds were in use throughout the hospital. These beds included reopened beds in ward areas that had been closed during the COVID-19 pandemic to ensure physical distancing. Evidence provided included NHS Grampian health and safety risk assessments for these beds, including control measures such as keeping areas clutter free to reduce the risk of trips and falls. Inspectors observed that these additional beds were placed in designated bed spaces in patient bays and therefore not obstructing corridors or fire exit routes. All additional beds had available privacy screens, call bells and electrical sockets. Inspectors observed one patient being cared for on a chair in the corridor of the emergency department whilst awaiting the result of a diagnostic scan. The patient did not have an available call bell but was accompanied by a visitor.

Within the emergency department we observed that patients appeared well cared for with staff providing responsive and compassionate care. However, within the incident reports provided we observed a significant number of incidents submitted by emergency department staff describing severe overcrowding in the department. These described incidents where staff had been unable to meet patients' fundamental care needs due to increased pressures and staff workload. We can see from these incident reports that on occasion the department was operating at 200% capacity. NHS Grampian risk assessment for the utilisation of corridor beds within the emergency department states that there should be a maximum of two additional patients being cared for in the corridor space. However, several incident reports document that up to five patients were being cared for on trolleys in the corridor at one time, with others sitting in chairs. In this instance staff describe that patients did not have access to adequate bathroom facilities, privacy and dignity was compromised and there was reduced provision of food and fluids. Privacy and dignity will be discussed further in domain 6. A requirement has been given to support improvement in this area.

We were able to observe two mealtimes in ward areas during this inspection. We observed that meals were given out in a timely manner and patients were given appropriate assistance, with red meal trays being used to identify which patients required assistance. Inspectors did not observe a mealtime in the emergency department. However, staff told us that the clinical decisions unit has regular mealtimes with the provision of hot food. Food and fluids were available in the emergency department. However, as previously discussed, provision of food and fluids has been compromised when the department is under pressure. Inspectors observed patients were not always assisted with hand hygiene prior to mealtimes. Hand hygiene will be discussed later in this report.

Intentional rounding is when staff review the care of individual patients at regular intervals, this is often recorded on a care rounding document. NHS Grampian no longer uses a specific care rounding document. We asked senior managers how fundamentals of care, such as analgesia and pressure area relief are recorded and monitored in the place of care and comfort rounding documentation. We were advised that care is recorded on the electronic system. Evidence returned highlights that fundamentals of care are documented within the electronic inpatient clinical record. Data from the electronic record is submitted to the Care Assurance and Improvement Resource as part of delivering *Excellence in Care*. This is a national resource available to all NHS boards which enables users to view and understand their data over time. This data is then presented to NHS Grampian's board's quality council every 6 weeks to enable focus on areas of improvement. Evidence provided by NHS Grampian documents that wards and departments focus on areas that have been highlighted as requiring improvement on the care assurance tool. These are then reviewed during the following months' care assurance report. More information on the Care Assurance and Improvement Resource and *Excellence in Care* can be found at The Care Assurance and Improvement Resource (CAIR).

We observed good completion of patient documentation in an area which had patients with complex pressure ulcer care needs. All the patients had thorough documentation in place. This included wound management records which were completed and reviewed appropriately. However, in several other areas we observed incomplete patient care documentation. This included bed rail assessments, falls care plans, fluid balance charts, pressure ulcer prevention and do not attempt cardiopulmonary resuscitation documentation.

An Adults with Incapacity Certificate is a legal document which assists the patient, their family and staff to make decisions about the patient's care when the patient is unable to do so independently. Inspectors observed several Adults with Incapacity documents, the majority of which were incomplete and did not include dates and signatures. During our corresponding inspection at Aberdeen Royal Infirmary, we also observed incomplete Adults with Incapacity Section 47 documentation. A requirement has been given in both inspection reports to support improvement in this area.

Inspectors observed that several drug cupboards were unlocked in the emergency department and acute medical admissions unit. This included the cupboards and drug fridge in the resuscitation bay in the emergency department. Due to the layout of the department this area could be accessed by patients, visitors, or staff without easily being seen. We raised this with the emergency department staff at the time of inspection. Staff advised that this was due to needing new locks for the cupboards which had been reported but there had been a delay in the maintenance work being completed. We escalated this to hospital managers at the time and the work was completed immediately. During our corresponding inspection at Aberdeen Royal Infirmary, we also observed medication was not always stored securely. A requirement has been given in both inspection reports to support improvement in this area.

Standard infection control precautions should be used by all staff at all times to minimise the risk of cross infection. These include patient placement, hand hygiene, the use of personal protective equipment (such as aprons and gloves), management of patient care equipment and the care environment, safe management of blood and fluid spillages, linen and waste management and prevention and exposure management (such as sharps injuries).

Practising good hand hygiene helps reduce the risk of the spread of infection. Inspectors observed that the majority of staff were compliant with hand hygiene including the use of alcohol-based hand gel. However, we observed that patients were not always assisted to complete hand hygiene prior to mealtimes. A recommendation has been given to support improvement in this area.

Other standard infection control precautions such as linen, waste and sharps management minimise the risk of cross infection and must be consistently practiced by all staff. Inspectors observed poor compliance with sharps management, this included sharps boxes not being labelled as per guidelines and sharps boxes that were over full. During our corresponding inspection at Aberdeen Royal Infirmary, we also observed poor compliance with sharps management. A requirement has been given in both inspection reports to support improvement in this area.

Inspectors observed that used linen was not managed in line with guidance. The used linen trolley was not always taken to the point of care, and we observed staff carrying used linen in their arms. We also observed soiled linen being left on the floor until staff brought in the used linen trolley. This can increase the risk of contamination and cross infection and is not in line with the National Infection Prevention and Control Manual. A requirement has been given to support improvement in this area.

While the majority of areas appeared clean, there was some wear and tear to the environment including the use of tape to repair flooring. Within the emergency department we observed damaged paintwork, water-stained ceiling tiles and damaged doors. Staff described delays in estates and maintenance work being

completed. We were told at the virtual discussion with hospital managers that the overall process for maintenance repairs and requests is under review. During our corresponding inspection at Aberdeen Royal Infirmary, we also observed flooring repaired with tape. A requirement has been given in both inspection reports to support improvement in this area.

During the inspection, staff within the children's ward made inspectors aware of a previous infection control incident relating to the healthcare-built environment. We spoke with hospital senior managers about this who were able to provide appropriate evidence of actions taken in line with appropriate guidance.

We observed that cleaning products were not always stored securely and could therefore be accessed by patients or members of the public. This is not in line with the Control of Substances Hazardous to Health (COSHH) Regulations. During our corresponding inspection at Aberdeen Royal Infirmary, we also observed that cleaning products were not stored securely. A requirement has been given in both inspection reports to support improvement in this area.

Inspectors observed that the layout of the emergency department made it difficult for staff to observe all areas easily. The resuscitation area, nurse/doctor area with central cardiac monitor console and clinical decisions unit are separate areas. Evidence returned included the space quality and function review of Dr Gray's Hospital, including for the emergency department. This describes that the area is too small for its current activity with the layout making observation of all areas difficult. The report recommends reconfiguration of the department, including the removal of central rooms to improve visibility as a future action. Evidence provided included two incident reports completed by staff in the past 12 months which described poor visibility of patients as a possible risk factor for falls.

Health and safety risk assessments provided by NHS Grampian for the use of corridor beds and the clinical decisions unit document that a member of staff should be allocated to each area if in use. During our inspection we observed that a member of staff was allocated to the clinical decisions unit. The risk assessment for the clinical decisions unit specifies to ensure that patients are mobile if they are cared for in the area.

NHS boards are required to have water safety systems in place for the control and management of risks posed by waterborne organisms that may cause disease. Inspectors observed that checklists to record daily flushing of toilets were not completed consistently. NHS Grampian has since shared an action plan to ensure compliance with water flushing. A requirement has been given to ensure oversight in this area.

Care equipment can be easily contaminated and a source of transferring infection if equipment has not been effectively cleaned. We observed that while the majority of patient care equipment was clean. the blood gas machine and two patient trolley

mattresses were contaminated with blood. A requirement has been given to support improvement in this area.

Area of good practice

Domain 4.1	
1	All areas inspected were calm and well organised.

Recommendation

Domain 4.1	
1	NHS Grampian should ensure that patients are assisted with hand hygiene at mealtimes.

Requirements

Domain 4.1	
9	NHS Grampian must ensure effective senior management oversight and support, to ensure the fundamentals of care are provided and reduce the risks for staff and patients at times of extreme pressure within the emergency department.
10	NHS Grampian must ensure that all patient documentation is accurately and consistently completed. This includes Adults with Incapacity section 47 documents.
11	NHS Grampian must ensure safe storage and administration of medicines at all times.
12	NHS Grampian must ensure the safe disposal of sharps.
13	NHS Grampian must ensure used linen is managed appropriately.
14	NHS Grampian must ensure the care environment is maintained to allow for effective cleaning.
15	NHS Grampian must ensure all hazardous cleaning products are securely stored.
16	NHS Grampian must ensure consistent recording of flushing of infrequently used water outlets to improve compliance and provide assurance in line with current national guidance.

17	NHS Grampian must ensure that patient care equipment is kept clean and ready for use.

Domain 4.3 – Workforce planning

- Quality indicator 4.3 – Workforce planning

The recruitment challenges experienced by NHS Grampian are similar to the workforce staffing pressures currently faced throughout NHS Scotland, although there is recognition of the unique challenges of recruiting staff to hospitals in remote and rural settings.

Workforce data submitted by Dr Gray's Hospital demonstrated the current vacancy level within the overall nursing workforce was 6.8%. This is a reduction from 11.2% since January 2023. However, there is a 21.5% vacancy within the registered nursing workforce, we consider a high vacancy level to be above 10%. Workforce challenges within the emergency department at Dr Gray's Hospital was considered an area of significant concern, with staff reporting concerns about staffing levels, skill mix and how these can impact on the delivery of safe and effective care and staff wellbeing. This has also been highlighted in section 4.1 in the report.

Dr Gray's Hospital has a morning multi-disciplinary site and nursing staffing huddle and additional huddles at different points throughout the day. At the nursing staffing huddles, we observed staffing decisions were based on the agreed funded staff for the area. However, did not consider the dependency or acuity of the patients, skill mix or professional judgement of actual staffing levels and skill mix required daily to support the delivery of safe and effective care. While staffing risks are recorded on the staffing and site huddle template, no mitigations and the outcome of these decisions were recorded. Following the inspection senior managers have shared a nursing staffing template which they have recently developed as an interim measure to record any mitigations that have been put in place. This document is accessible to staff. Many staff informed inspectors that nursing staffing decisions and plans are made without consultation or discussion with teams, which has led to staff describing a lack of engagement and transparency.

In preparation for the Health and Care (Staffing) (Scotland) Act, Aberdeen Royal Infirmary have successfully implemented a real time staffing system and process for nurses, this includes the use of a national electronic system. This system provides an overview of nurse staffing levels and skill mix, alongside the acuity and dependency of the patients. Within this system, there is an escalation process for staff should they professionally judge that they require additional staff or a different skill mix, to support the delivery of safe and effective care. This can support an open and transparent culture in the recording, reporting and management of staffing risks. We were told by hospital managers that this system will be introduced at Dr Gray's

Hospital in January 2024. We did not observe real time staffing decisions, systems and processes for other clinical disciplines during this inspection. This will be a requirement of the legislation once enacted in April 2024.

NHS Grampian describe a coordinated recruitment approach for new graduate nurses and international recruitment, which resulted in NHS Grampian being able to successfully recruit registered nurses. We have been informed that 27 of these nurses have been allocated to Dr Gray's Hospital. These registered nurses are then allocated to the clinical areas of greatest need, for example areas experiencing high levels of vacancies or workforce challenges. All newly recruited staff are supported by the practice education teams who deliver an education programme which NHS Grampian hope will improve the experience of staff.

NHS Grampian describes recruitment and retention can be associated with geographical challenges of a remote and rural setting. To improve recruitment, NHS Grampian has adopted innovative ways to attract and plan for future nursing workforce. This includes work experience and opportunities for young people within the area. This is detailed in the NHS Grampian plan for the future strategy (2022-2028).

Due to a high level of vacancies, absences and clinical areas experiencing increased clinical and service demands this has necessitated a reliance on supplementary staff, particularly registered nurses, which includes bank and agency staff.

Supplementary staffing includes substantive staff working additional hours, staff from the NHS board's staff bank or staff from an external agency.

Staff have reported that the inappropriate placement of supplementary staffing has been detrimental to skill mix, reporting lack of experienced or unfamiliar staff in charge of wards. Staff told inspectors that this makes it difficult to ensure safe and effective care is delivered, this included fundamentals of care and the completion of essential record keeping. This was raised with senior managers who described the processes in place regarding the use of supplementary staff which includes forward planning by senior charge nurses to fill staffing gaps, the ability to request a specific skill set for staff and an induction process for agency staff.

We were told staffing level tools were completed within ward areas in May 2023, and a reporting template was trialled for use which incorporated the common staffing method. The information and data collected using the tool and staffs' professional judgement should be triangulated using the common staffing method to inform decisions about staffing. Senior managers told us they plan to repeat the staffing level tool in December 2023, incorporating any learning from the previous tool run process.

A review of nursing staffing in the emergency department was carried out in May 2023 using the national professional judgement tool. In addition to the professional judgement tool, there is a mandated specialty specific staffing tool for the multi-

disciplinary team within an emergency department. The data collected using this tool calculates the recommended workforce for nursing and medical staff using both the tool and staff professional judgement to ensure safe staffing. Senior managers decided to focus on the professional judgement tool for nurses only as they wished to create the correct conditions for a staffing level tool run in the future.

The outcome of the professional judgement tool application highlighted that taking into consideration the increasing demands of the department, the whole-time equivalent nursing workforce would need a substantial uplift to meet the department needs and provide safe and effective care. It was noted from the workforce data that there has been additional recruitment into the emergency department and senior leaders told inspectors that they have increased staffing levels using supplementary staff to support the department until a longer-term solution has been agreed. We were told a re-run of the professional judgement tool would be carried out in the emergency department by the end of December 2023, before moving onto the specialty specific staffing tool. Preparatory work is ongoing for this. To ensure a comprehensive review, it is essential to use the emergency department and emergency medicine staffing level tool and professional judgement tool, including all multi-disciplinary team, and apply the common staffing method to ensure a robust review is undertaken.

As part of the review of the staffing in the emergency department we requested vacancy information for both nursing and medical staff. It was noted that there are enduring long-term vacancies within medical staff. At consultant level there are 71% vacancies in the department. This has necessitated the use of locum and overtime to cover the staffing gaps. We were assured by the senior leadership team that the locum staff are long-term and experienced, and they have substantive staff that they share with Aberdeen Royal Infirmary. As part of their recruitment for emergency consultants they have developed a video which will be used in an advertisement campaign to highlight the benefits of working in the area.

Senior managers advised that the weekly clinical risk management group has oversight of all incidents and staffing concerns and reports quarterly to the Clinical Care Governance Committee. Although we were told of the governance processes and reporting structures in place, it is unclear how the process of review, action planning and recording of improvements is consistently completed and reported to ensure a quality improvement approach.

Senior managers we spoke with recognised improvements are required and highlighted actions they are planning to take which includes a new resource which will formally capture and report risk. A requirement has been given to support improvement in this area.

Requirement

Domain 4.3
18 NHS Grampian must ensure that it consistently reports and records staffing risks, as well as robustly recording mitigations and recurring risks in line with established governance processes.

Domain 6 – Dignity and respect

- Quality indicator 6.2 – Dignity and respect

All interactions between staff and patients were positive and inspectors observed staff treating patients with respect and dignity. However, we have concerns relating to patients' dignity within the emergency department during times of increased capacity.

The majority of patients we spoke with were complimentary about the care provided with patients being treated with dignity and respect. However, staff in the emergency department told inspectors that patient privacy and dignity was compromised when the department was operating above capacity. Staff described at times they had been required to provide patient personal care in the corridor with just privacy screens to maintain dignity. Within evidence provided we observed several incident reports documenting a lack of privacy and dignity for patients being cared for in corridor areas. This includes staff describing a lack of adequate and private bathroom facilities for patients resulting in patients receiving personal care such as using bed pans whilst in the corridor. Incident reports also documented patients sleeping on mattresses on the floor of the emergency department due to increased capacity.

We raised the lack of privacy and dignity for patients being cared for in the corridors of the emergency department with senior managers. We were provided with evidence of NHS Grampian's health and safety risk assessment for caring for patients in the corridor in the emergency department. This documents that privacy screens are available. However, these can be claustrophobic and reduce visibility of patients by staff. It therefore advises that the appropriateness of the use of privacy screens should be assessed by the member of staff allocated to patients in corridor beds. The risk assessment further documents that all corridor patients will have a dedicated member of staff responsible for providing support with accessing bathroom facilities. Inspectors were told by staff that there are two available call bells for patients who are in corridor beds. However, as described within the incident reports staff have highlighted on several occasions when more than two patients have been cared for within the corridor areas. Inspectors also observed that call bells were not available for patients who would be sitting in the chairs in the clinical decisions unit.

Mixed sex bays can have an impact on the privacy, dignity, and personal choice of patients. Staff told inspectors that the clinical decisions unit can have male and female patients at the same time The clinical decisions unit surge bed risk assessment from May 2023 includes an existing control measure of limiting mixed sex placement to 24 hours. However, there are no further mitigations documented to mitigate the impact of patients being cared for in mixed sex bays. A requirement has been given to support improvement in this area.

Inspectors observed one closed circuit television camera within the emergency department corridor. Staff told us that this camera is for security purposes. The use of a camera could have further impact on patient privacy and dignity if being cared for in a corridor bed. We raised this with senior managers who provided evidence that the camera does not record sound. Images are recorded and streamed to a screen in the portering team leader office and access is strictly limited. The closed circuit television at Dr Gray's Hospital is controlled by the portering team lead as per policy and in line with general data protection regulations. Recordings are deleted after 31 days. A requirement has been given to support improvement in this area.

NHS Grampian's closed circuit television policy was due to be reviewed in 2021. Evidence provided by NHS Grampian states that the policy is currently under review. During our corresponding inspection at Aberdeen Royal Infirmary, we also observed a number of policies which required review or ratification as they were in draft form. A requirement has been given in both inspection reports to support improvement in this area.

During the inspection we identified one ward where the door for entry and exit to the ward had been locked electronically and required swipe card access to enter or exit the ward. This prevented any patients or visitors from leaving without the assistance of staff. We observed that clear signage was in place on the locked ward during inspection advising staff and visitors that the doors are locked and to speak to a member of staff if they wish to exit or enter the ward.

NHS Grampian provided its draft policy on the use of locked doors in adult inpatient hospital settings. We can see in evidence returned that this policy is undergoing review and ratification. The policy includes the proformas to be completed when ward doors are locked either on a permanent or ad hoc basis (such as nighttime locking of doors for patient and staff safety).

Inspectors observed portering staff providing security assistance to staff to maintain the safety of a patient who was attempting to leave the hospital but had been assessed as not having the capacity to do so. Staff told us that portering staff access patient notes prior to providing assistance in security incidents to see if appropriate documentation is in place. We raised this as a concern with senior managers at the time of inspection, who have now confirmed that while portering staff receive information governance training they no longer review patients notes. This has been

widely communicated to the portering team and relevant information is now provided to the portering staff directly by the nursing staff.

Area of good practice

Domain 6	
2	We observed positive and caring interactions between staff and patients.

Requirements

Domain 6	
19	NHS Grampian must ensure when patients are cared for in mixed sex bays, this is regularly risk assessed and suitable mitigations are put in place to maintain patient dignity, respect and choice.
20	NHS Grampian must ensure that patient privacy and dignity is maintained at all times and all patients have access to a call bell.

Appendix 1 – List of national guidance

The following national standards, guidance and best practice were current at the time of publication. This list is not exhaustive.

- Allied Health Professions (AHP) Standards (Health and Care Professionals Council Standards of Conduct, Performance and Ethics, September 2023)
- Care of Older People in Hospital Standards (Healthcare Improvement Scotland, June 2015)
- Food Fluid and Nutritional Care Standards (Healthcare Improvement Scotland, November 2014)
- Generic Medical Record Keeping Standards (Royal College of Physicians, November 2009)
- Health and Care (Staffing) (Scotland) Act (Acts of the Scottish Parliament, 2019)
- Health and Social Care Standards (Scottish Government, June 2017)
- Infection prevention and control standards (Healthcare Improvement Scotland, 2022)
- National Infection Prevention and Control Manual (NHS National Services Scotland, August 2023)
- Operating Framework (Healthcare Improvement Scotland and Scottish Government, November 2022)
- Prevention and Management of Pressure Ulcers - Standards (Healthcare Improvement Scotland, October 2020)
- Professional Guidance on the Administration of Medicines in Healthcare Settings (Royal Pharmaceutical Society and Royal College of Nursing, January 2019)
- The Quality Assurance System (Healthcare Improvement Scotland, September 2022)
- Staff governance COVID-19 guidance for staff and managers (NHS Scotland, August 2023)
- The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (Nursing & Midwifery Council, October 2018)

You can read and download this document from our website.
We are happy to consider requests for other languages or formats.
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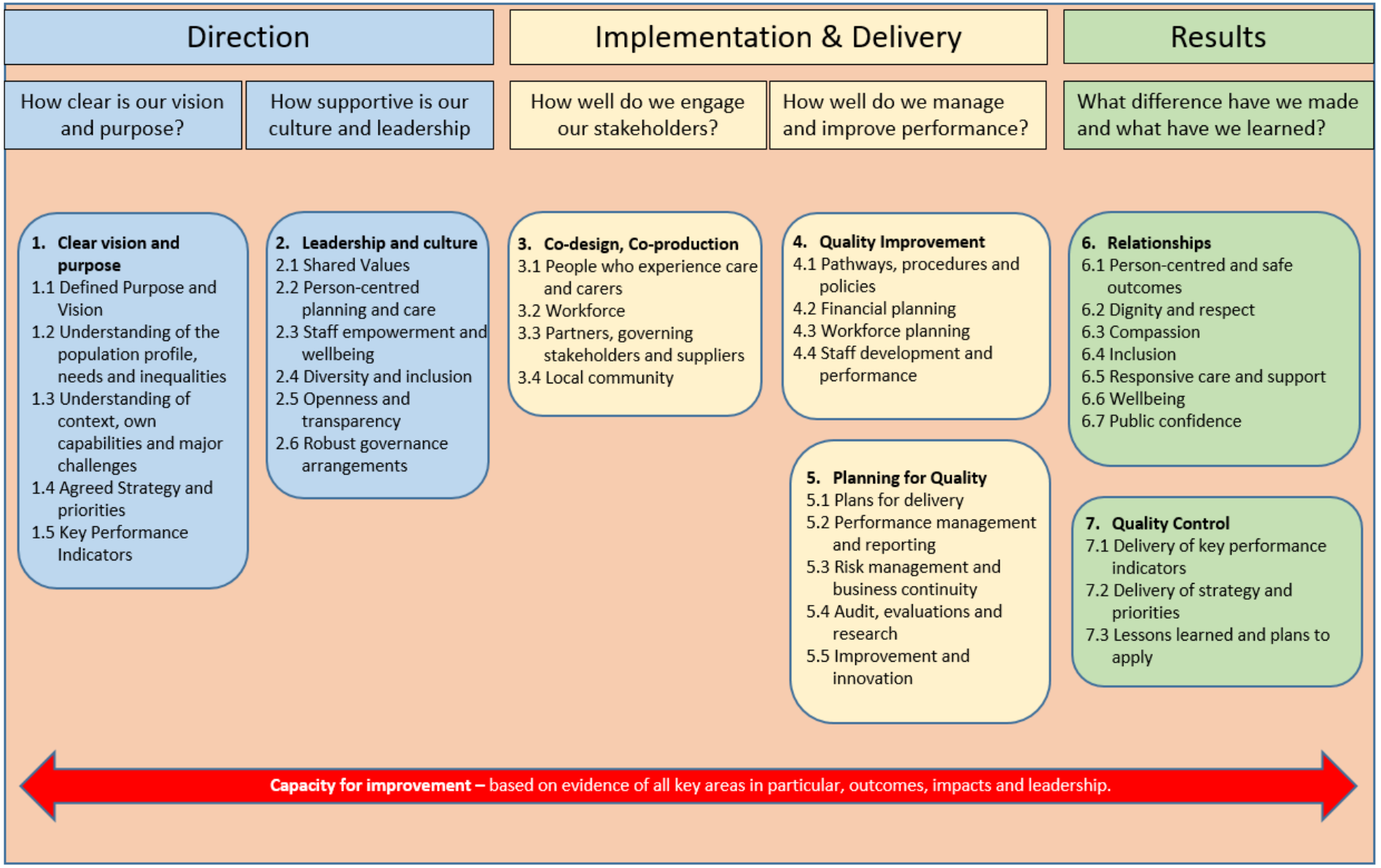
Quality Assurance Framework

Our Quality Assurance Framework allows an assessment of capacity for improvement based on evidence from all domains or specifically selected domains for some programmes of work. The framework will help inform a proportionate discussion about any follow-up activity or support that may be required. It reinforces the HIS Quality Management System by highlighting what good care looks like; and emphasising the importance of leadership and culture; vision and purpose; and the importance of co-design and relationships. The Framework is not a checklist. It is a reference guide to support and inform reflection, evaluation and decision making about how best to improve outcomes for users of services. It has seven areas of focus, known as domains. Each domain has criteria with associated quality indicators.

“The service” could be an organisation, a HSCP or a single service, ward or department within either, such as dermatology services, cardiology wards or outpatient department.


Direction
Implementation & Delivery
Results
How clear is our vision and purpose?
How supportive is our culture and leadership
How well do we engage our stakeholders?
How well do we manage and improve performance?
What difference have we made and what have we learned?
1. Clear vision and purpose
1.1 Defined Purpose and Vision
1.2 Understanding of the population profile, needs and inequalities
1.3 Understanding of context, own capabilities and major challenges
1.4 Agreed Strategy and priorities
1.5 Key Performance Indicators
2. Leadership and culture
2.1 Shared Values
2.2 Person-centred planning and care
2.3 Staff empowerment and wellbeing
2.4 Diversity and inclusion
2.5 Openness and transparency
2.6 Robust governance arrangements
3. Co-design, Co-production
3.1 People who experience care and carers
3.2 Workforce
3.3 Partners, governing stakeholders and suppliers
3.4 Local community
4. Quality Improvement
4.1 Pathways, procedures and policies
4.2 Financial planning
4.3 Workforce planning
4.4 Staff development and performance
5. Planning for Quality
5.1 Plans for delivery
5.2 Performance management and reporting
5.3 Risk management and business continuity
5.4 Audit, evaluations and research
5.5 Improvement and innovation
6. Relationships
6.1 Person-centred and safe outcomes
6.2 Dignity and respect
6.3 Compassion
6.4 Inclusion
6.5 Responsive care and support
6.6 Wellbeing
6.7 Public confidence
7. Quality Control
7.1 Delivery of key performance indicators
7.2 Delivery of strategy and priorities
7.3 Lessons learned and plans to apply
Capacity for improvement – based on evidence of all key areas in particular, outcomes, impacts and leadership.

Domain 1 - Clear vision and purpose Direction: How clear is our vision and purpose?	
Criteria	**Quality Indicators (statements of what good care looks like)**
1.1 Defined purpose and vision	a) The service has clear vision, strategy, and aims, which are person-focused easily understood by staff, people who experience care, carers and stakeholders. b) The service involves its stakeholders in defining, shaping and communicating its purpose and vision. The strategy clearly defines how priorities and deliverables contribute to the vision. c) The service regularly reviews the connection between the strategy, vision, workforce and outcomes for people, particularly when scoping new pieces of work.
1.2 Understanding of the population profile, needs and inequalities	a) The service involves people experiencing care, carers, the public, staff and local agencies in strategic planning, to identify the needs of the population and plan delivery of equitable, safe, quality care. b) The needs and assets of the person experiencing care and carers perspectives are understood in terms of securing safe and effective care; the necessary workforce to deliver safe and effective care and continuous improvement. c) The service works to identify and address health inequalities. d) Audit, governance, and planning structures all incorporate health promotion, prevention, and health inequalities. e) Services are developed and promoted effectively to support understanding and engagement with the people who use or might need the services.
1.3 Understanding of context, own capabilities and major challenges	a) The service assesses demand for services and undertakes regular and robust workforce planning in line with relevant legislation to ensure appropriate staffing levels and skills mix match service requirements and ensure safety. b) The service ensures that at all times suitably qualified and competent individuals, from a range of professional disciplines as necessary, are working in such numbers as are appropriate for: • the health, wellbeing and safety of patients, service users and staff • the provision of safe and high-quality healthcare c) The service utilises data to inform and respond to service and workforce changes. d) Real time staffing, including the identification, mitigation and escalation of risk to the health, well-being and safety of staff and patients is in place. e) The service takes a proactive approach to contingency planning, including anticipating workforce requirements, to mitigate service or care disruption and help safeguard future delivery. f) There is regular review of care system resources to support delivery of services. g) The service is aware of and demonstrates flexibility to respond to broader social, political, economic and contextual factors, such as pandemic.

	h) The service has capacity to avoid unacceptable delays to the assessment, treatment, discharge or transfer of people who experience care. i) The service (and leadership at all levels) understands the level of demand on individual services and the elements that constrain the patient journey. j) The service provides assurance that the provision of safe and high-quality healthcare is being maintained during service mobilisation whilst services remain under workforce pressures.
1.4 Agreed strategy and priorities	a) The service reviews strategic plans regularly and they are adapted in response to external or internal drivers. b) Board members actively influence and drive policy and strategy to encourage continuous improvement. c) There is good connection and communication between strategic planning, service redesign (including workforce) and clinical or operational services. d) The vision and strategy support joined-up arrangements with Integration Joint Boards, Health and Social Care Partnerships and Community Planning Partnerships. e) The service has a clear Quality Strategy which aligns with the organisational vision and articulates the key priorities for improvement.
1.5 Key performance indicators	a) The service understands the factors feeding from quality control; and which determine effectiveness of clinical and care governance b) The service sets clear priorities and goals for delivery and improvement c) The service implements statutory requirements d) The service takes into account national guidance, standards, codes of practice, relevant international guidance and guidance from any relevant professional bodies, in its service delivery. e) The service develops a meaningful mix of process indicators/performance targets, clinical audits and related outcome measures, for example, common staffing method, Excellence in Care (EIC), Essentials of Care and Scottish Patient Safety Programme (SPSP).

Domain 2 - Leadership and culture Direction: How supportive is our culture and leadership?	
Criteria	**Quality indicators (statements of what good care looks like)**
2.1 Shared values	a) The service has a clearly defined set of values, which staff adopt. b) The service has evidence of a shared commitment to high quality services. c) Those who experience care, carers and stakeholders easily understand the values. d) There is clear evidence that staff live the values. e) Staff describe the culture and morale in positive terms. f) Staff would recommend the service as a good place to work. g) Leaders promote staff autonomy and accountability appropriately. h) Staff feel they are treated with dignity and respect at all times. i) Leadership is well respected by stakeholders, staff and communities. j) Staff understand the principles of safe care, including relevant child or vulnerable adult protection guidance, and apply local or national safety policies and procedures. k) The service promotes a "no blame culture" enabling staff to feel psychologically safe to escalate staffing concerns
2.2 Person-centred planning and care	a) The service recognises people experiencing care or their legal guardians as experts in their own experience, needs and wishes, and are fully involved in planning, assessment and decision making about their care. b) Care, supported and/or provided by several staff or organisations, is well planned and co-ordinated so that the person experiences continuity and consistency. c) The service takes forward national improvement programmes such as Scottish Patient Safety Programme activities, and Excellence in Care. d) The service always considers the needs of people who experience care, and their carers, when developing innovative improvement ideas. e) Services are centred on helping to maintain or improve the quality of life of people and equity of outcomes for people who use those services. f) Development of services is In line with the vision/purpose and the current and future needs of existing and potential people experiencing care, to deliver efficiently **the right care, at the right time, by the right person, in the right setting.** g) The service is working toward being in line with the Health and Care (Staffing) (Scotland) Act 2019 whereby there is a statutory basis for the provision of appropriate staffing in health and care service settings. This is to enable safe and high quality care and improved outcomes for service users and ensuring that the right people with the right skills are in the

	right place at the right time, creating better outcomes for patients and service users, and supporting the wellbeing of staff. h) Staff who are sufficiently trained, competent and skilled meet the needs of people experiencing care. i) The processes and culture of the service supports individuals, families and communities to become equal partners in all aspects of care.
2.3 Staff empowerment and wellbeing	a) The organisation/service has a strategic plan for developing staff capabilities and skills to improve clinical care and services, such as development or leadership programmes. b) Staff describe the service as one in which they experience compassionate and inclusive leadership approaches that lead to empowered, trusted and valued staff members. c) Staff feel that the service supports and develops them: • shows commitment to a culture of learning • promotes continual professional development • staff demonstrate positive attitudes towards learning and improving. d) The service Leaders encourage staff to be responsibly proactive and innovative. e) Leadership for improvement is nurtured at every level of the organisation. f) Clinical and professional leaders at all levels are encouraged and supported to actively lead and deliver improvement work. g) Staff respond effectively to complaints and adverse events, have the knowledge and skills needed and are empowered to do so. h) The service's culture is open and fair and recognises that, in the vast majority of cases, it is the systems, procedures, conditions, environment and constraints that people face that lead to safety problems. i) Effective staff rostering is in line with rostering policy and maintains guiding principles of staff governance to ensure safe working practice and safe and effective high-quality patient care and staff well-being. j) Staff have support, feel confident to challenge bullying, harassment or discrimination and do so when necessary, as leaders manage bullying and harassment issues effectively k) The service supports staff to take breaks, particularly on shifts when there are less staff. This is supported by readily available restrooms and catering facilities. l) The service considers the safety of staff at the end of shifts; and provides accessible and quiet rest facilities that support staff to sleep on-site when required. m) Staff are supported to undertake leadership activities and demonstrate positive leadership behaviour, which motivates and inspires confidence in others. n) The service monitors staff physical and mental health and supports and promotes positive wellbeing.

	o) Staff feel supported in their role, by their immediate team and wider leadership and know where to go for support on a clinical or operational issue and have easy access to that support. p) Staff have good awareness of the organisation/service's whistle blowing policy and feel confident and supported to raise concerns. q) Staff feel empowered with a sense of worth, self-confidence and responsibility to act to manage issues locally where appropriate such as resolving complaints or managing near misses. r) The service encourages people experiencing care and families or carers to respect those involved in the delivery of care. s) The delegated level of authority supports managers to make decisions locally and there are clear lines of escalation for issues to be raised. t) Staff feel that senior managers, leaders and Board members are visible and accessible.

2.4 Diversity and inclusion	a) Staff ask people-experiencing care about their individual needs, lifestyle preferences and aspirations, and support them to achieve these where possible. b) Support is available for those with particular needs or cognitive impairment such as vulnerable young adults or children, people with dementia or learning disabilities or profound multiple learning disabilities. c) Personalised care plans are in place and up to date for all people especially for those with complex care needs such as multiple morbidities or profound multiple learning disabilities. d) The service promotes a human rights-based approach to care, and people receiving care are made aware of their rights and responsibilities, and how to raise concerns (including children and young people). Human rights-based approach is about ensuring people's human rights are at the centre of policies and practice based on the PANEL principles (Participation, Accountability, Non-Discrimination and Equality, Empowerment and Legality). e) The quality of care provided does not vary or discriminate because of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation, socio-economic status, or any other status. f) People experiencing care, are assessed for health improvement and inequalities as part of their care pathway. g) The service works with stakeholders to contribute to and draw inspiration from the National Health and Social Care Standards, National Performance Framework, Human Rights Approach and United Nations Sustainable Development Goals. h) The service ensures that everyone has the ability to be actively involved in their care and takes steps to remove any potential barriers to participation, including reaching out to seldom-heard groups known to be more likely to experience health inequalities. i) There is support for people who experience care to communicate in a way that is right for them. This could include large print, audio, Braille, different languages, induction loops, Talking Mats, Talking Points, translation or interpreting services. j) The care environment considers individual needs and preferences where possible (particularly for those with a disability, cognitive impairment and dementia). k) People who are socially or culturally excluded experience positive attitudes and behaviour from the service and its staff.
2.5 Openness and transparency	a) People experiencing care receive a timely response to their requests or complaints and the service seeks their feedback on the handling of complaints or concerns. b) The service implements improvement plans and notifies people of changes made in response to feedback. c) Staff receive information of the outcome, lessons learned or actions taken forward after they have raised an issue or reported an adverse event.

	d) Actions are taken in response to staff surveys, feedback and discussions (including formal action plans) and staff are made aware of improvements made because of feedback. e) Staff and volunteers feel involved and supported to improve continuously the care, information and support they provide. f) Leaders regularly consult their teams for ideas and suggestions and involve staff in shaping and influencing decisions as well as implementing them. g) Staff follow the organisation/service's Duty of Candour procedures. For example, people experiencing care receive an apology if things go wrong and the service takes responsibility for its actions. h) Leadership encourages both 'top-down' (formal, planned) and 'bottom-up' (informal, emergent) approaches to quality improvement. i) Leadership is open and honest about pressures and challenges they face, which helps staff and stakeholders understand and have confidence in the decisions taken. j) The service works with everyone involved in delivering care services to gain their commitment and support shared ownership of the challenges and solutions. k) The service works with key stakeholders to create an atmosphere of openness, trust, confidence and commitment. l) Leaders encourage and listen to staff 'voices' and act upon their feedback. m) Mechanisms are in place for people experiencing care to request access to their personal information.
2.6 Robust governance arrangements	a) The organisation develops and assesses its corporate governance structure in accordance with the 'Blueprint for Good Governance' approach or other relevant guidance. b) An assurance framework and appropriate governance committees are in place to provide assurance that the focus of the service is safe, and effective and that a safe number of suitably qualified and competent individuals are working i to support delivery of this. c) Board members have assurance that effective governance systems are in place and working well by understanding their responsibilities, providing constructive challenge and working alongside executive director colleagues. d) The Board has assurance that healthcare and practice, clinical and care governance is subject to rigorous scrutiny, including review by relevant delegated governance committees (including but not exclusively: staff, clinical, risk, information, audit and performance). e) There is an integrated approach to governance that draws from all relevant sources of information and data. f) The Board routinely receives information on adverse events, complaints, claims, inspections, audits, review findings and feedback from staff and people experiencing care to help gain assurance of appropriate action and shared learning. g) The Board is informed of serious issues, or potential concerns and receives sufficient high quality information to enable effective decisions, assess risks and hold directors to account for the service's performance (including results of trainee surveys and variation to care outcomes such as suicide or maternal deaths).

	h) The service has mechanisms in place to recognise vulnerable people and to ensure public protection. i) The service has an effective knowledge management strategy that supports evidence-based and transparent decision-making. j) Information governance systems and processes are in place and implemented. k) Systems provide an audit trail such as an electronic reporting or document management system. l) Policies and procedures support staff to manage and learn from adverse events consistently and appropriately. m) Clearly documented and robust controls are in place to ensure ongoing information accuracy, validity and comprehensiveness. n) Version control is evident on policies and key documents. o) The organisation/service has a Caldecott Guardian who is easily accessible to staff p) The service develops a meaningful mix of process indicators/performance targets and related outcome measures. q) The organisation/service designs and implements a performance management system to support delivery of outcomes and transformation priorities. r) A quality assurance system is in place to ensure that the care environment and equipment are safe. s) The service has mechanisms in place to support people when things go wrong, such as Duty of Candour. t) Workforce reviews are undertaken, and the common staffing methodology applied, where applicable, to ensure that data is triangulated when planning services.

Domain 3 - Co-design, Co-production Implementation and delivery: How well do we engage our stakeholders?	
Criteria	**Quality indicators (statements of what good care looks like)**
3.1 People who experience care and carers	a) The organisation uses a range of approaches to 'bring people experiencing care into the boardroom'. b) People experiencing care, families or carers have a variety of accessible mechanisms to provide feedback on their experience of care and have support to do so. c) The service involves the public in policy and service design and development. d) The service encourages and empowers communities of interest, third sector organisations and minority groups to be involved in co-producing local health and care services. e) The service optimises the flow of people experiencing care, through sufficient staffing and a joined-up approach, to minimise the number of transfers to provide a smooth journey for those receiving care. f) In transitions and handovers of care, the needs and preferences of people experiencing care, including access to services such as pharmacy, social work and allied health professional staff, are considered. g) The quality of communication and flow of information supports continuity of care. h) The service has capacity to anticipate and resolve IT issues to ensure continuity of care. i) For people experiencing care transferring between care areas or services, the reason for transfer is clinically appropriate and clearly documented. j) The service anticipates and appropriately plans transitions of care, particularly for people with complex needs. k) The service takes a proactive and effective approach to identify and respond to people experiencing care whose condition is deteriorating. l) The service has systems in place to reduce the burden and harm on people experiencing care from over-investigation and over-treatment. m) The notes for people experiencing care are legible, understandable, accurate, up to date, signed and compliant with any relevant professional requirements.
3.2 Workforce	a) The Board review Staff feedback including feedback from trainees through National Education for Scotland or General Medical Council surveys. b) Leaders involve staff in shaping and influencing decisions as well as implementing them. c) The service has a clinical engagement strategy and leaders take into account clinical opinion when making decisions. d) There is effective communication between management, clinicians, people who experience care and partner organisations.

	e) The service works with everyone involved in delivering care services to gain their commitment and support shared ownership of the challenges and solutions. f) Real time escalations, decision making and allocation of resources is clear and transparent to staff. g) All trainees or relevant staff have direct access to an on-call senior member of staff at all times, clearly documented and communicated contact details are in place. h) At the start and end of each shift, and before the consultant leaves the site, there is routine contact between the on-call consultant and the on-call senior resident trainee. i) There is evidence of effective multidisciplinary team working and robust communication across the team such as handovers, team meetings, team newsletters or team cascade discussions. j) In clinical areas where there are validated workforce tools, reviews of the outputs of these tools are carried out applying the common staffing method, and feedback is provided for teams.
3.3 Partners, governing stakeholders and suppliers	a) The service works with stakeholders and partners in developing and delivering person-focused services. b) The service recognises the importance of its relationship with key stakeholders and partners, and pro-actively gathers feedback from them to maintain or enhance working relationships c) The service engages with partner organisations to build collaborative leadership capacity and enable innovation and appropriate risk-taking across boundaries. d) The service is able to demonstrate how collaborative working with other agencies, including the third sector, is leading to improved outcomes in a person-centred way. e) The service works with community and interest groups to support sustainable care. f) The service works internally and with partner agencies to co-ordinate and optimise clinical treatment, health improvement pathways and journeys or transitions of care.
3.4 Local community	a) The service focuses the design of its services around anticipating need and it plans service delivery and workforce in proportion to this in collaboration with Integration Joint Boards, Community Planning Partnership and relevant stakeholders. b) The service actively seeks the perceptions of governing stakeholders, partners, suppliers and the wider population regarding their experiences and expectations, and reviews how it is meeting those expectations.

Domain 4 - Quality Improvement Implementation and delivery: How well do we manage and improve performance?	
Criteria	**Quality indicators (statements of what good care looks like)**
4.1 Pathways, Procedures and policies	a) The service has clear expectations for care excellence, including care bundles or pathways, and uses local and national audits and initiatives to monitor reliability. b) People receive care and support based on relevant evidence, guidance and best practice. c) The service has processes in place to enable staff to evaluate improvement projects. d) Robust processes are in place to ensure suitably trained staff review adverse events thoroughly, to identify all contributing factors and root causes, and any recommendations and improvements implemented. e) There is a review process for action plan progress and completion, including the effectiveness of any changes implemented. f) The service has an established horizon-scanning capability to review UK or international reports, which have relevant learning for care or safety. g) Effective policies are in place and implemented to protect people from abuse, neglect or harm (in particular children, young people, the vulnerable and the elderly). h) The procedure for making a complaint is clear and well publicised. The procedure is accessible to people experiencing care and families or carers, and includes information on the Scottish Public Services Ombudsman for those unhappy with the response they receive. i) Staff are aware of the process for raising or escalating concerns and feel confident to report things that go wrong, including near misses, and to communicate safety issues with their colleagues. j) Staff receive feedback from complaints and adverse events in a timely manner. k) Care and support are provided in a planned and safe way with clear and robust processes for managing and escalating issues or unexpected events. l) Assessments of the individual's health and wellbeing are carried out at admission to identify the care required, and anticipate any issues that might develop such as dietetic, occupational therapy or social care requirements, to inform the care plan m) Re-assessments to ensure that the ongoing care is appropriate and effective are undertaken and documented. n) Procedures support staff to obtain appropriate informed consent and carry out discharge and/or transfer of people experiencing care. o) There are effective handovers with clear communication between staff and services.

4.2 Financial planning	a) The service evaluates its financial performance and uses financial resources to best effect in the interests of those who receive or deliver care. b) The service reviews the cost effectiveness of its activities and focuses on how it might use resources more effectively (while supporting safe, quality care). c) The service works to identify and reduce unwarranted variation in practice to achieve optimal outcomes. d) The service works to identify waste of resources such as equipment, supplies, energy, and uses evidence or research results to drive waste reduction.
4.3 Workforce planning	a) People experiencing care receive safe, high quality care, support and improved outcomes, due to the provision of appropriate staffing in health and care service settings. This is achieved by ensuring that the right people with the right skills are in the right place at the right time creating better outcomes for patients and service users, and supporting the wellbeing of staff. b) The service regularly monitors and undertakes assessment of staff workforce to provide assurance that the right people with the right skills are in the right place, at the right time and determine where staffing has impacted on the quality of care. c) Proactive monitoring of rosters/workforce to minimise the risk of resource and skill gaps occurring, review staff skills through formal appraisals, measure performance, benchmark reporting and identify areas of improvement. d) The management and leadership structure, roles and responsibilities are clear to staff and there is no ambiguity between leadership roles or activities. e) The service has an open and honest culture where clinical/professional staff are engaged in relevant processes and informed about decisions relating to staffing requirements. f) The service is working to enable further improvements in workforce planning by strengthening and enhancing arrangements already in place to support transparency in staffing and employment practice across Scotland. This is achieved through the use of, and outputs from, the common staffing method and associated decision making processes. g) The service promotes engagement, participation and involvement of staff. h) Staff undertaking leadership activities continuously aim to improve their leadership capability, including engagement with staff, through critical reflection and feedback from a range of sources. i) The service has appropriate and safe recruitment processes, for instance all candidate registrations and references (including agency, bank and locum) are checked, disclosure and Protecting Vulnerable Groups membership is in place. j) Staff, including agency, bank staff, locums, temporary staff and volunteers, receive appropriate induction.
4.4 Staff development and performance	a) The service provides a programme of mandatory training for staff to support safe, quality care with regular updates, such as health and safety and infection prevention and control. b) The service has effective training and support for all staff, including Board members.

	c) Time is available for staff to attend required training. d) The service has a range of training methods to give staff the opportunity to be active learners, to reflect and learn from their own and others' experiences. e) Training records are up to date and training needs analyses, carried out where appropriate. f) Staff feel they have access to good support and training opportunities. g) Motivational leadership activity is evident across all levels and parts of the service. h) The service has an organisation commitment and resourced plan for developing QI capability that ensures that everyone has the relevant skills and capacity to contribute commensurate with their role. i) Staff undertaking leadership activities have access to development programmes to support them in their role. j) There is sign off and monitoring of Job plans/performance development reviews annually. k) Staff with supervisory roles have sufficient training and time in their job plan to provide adequate support to trainees and staff. l) Where supervision is not directly present, trainees have appropriate training and can demonstrate competency to operate with distant supervision. m) The service has a system for addressing under performance and recognising good performance at individual, team and service level. n) The service supports staff to be competent and skilled, and able to reflect on their practice and follow their professional and organisational codes. o) The service ensures that all frontline staff are aware of legislative requirements and their application, for example for people with a cognitive impairment or adults with incapacity. p) Staff have a clear understanding of their roles and responsibilities, have a positive approach to their duty of care and demonstrate accountability for their actions and behaviour. q) Leaders and staff do not tolerate poor or unacceptable levels of care.

Domain 5 - Planning for Quality Implementation and delivery: How well do we manage and improve performance?	
Criteria	**Quality indicators (statements of what good care looks like)**
5.1 Plans for delivery	a) Standard operating procedures and referral pathways are in place that ensure, appropriately skilled staff, are available and easily contactable at all times, to perform all required emergency procedures. b) Quality planning principles focus on understanding the needs and assets from the perspective of those using and delivering the services. c) Systems are in place that ensure planning activities incorporate factors identified through what is learned and through robust quality control and quality assurance at each level of the system. d) The service designs physical systems and technological infrastructures that support improvement and knowledge management. e) The service uses digital information and technology to support service delivery such as remote e-health or telehealth monitoring, and digital personal health records. f) Relevant staff are involved in regional or national discussions such as planning groups or Managed Clinical Networks.
5.2 Performance management and reporting	a) The service participates in relevant third-party accreditation schemes. b) The service has mechanisms to collect and integrate data. c) Measurement and reporting systems are designed to support and enable continuous learning and improvement. d) There are sufficient staff with capabilities in data collection, analysis, measurement, presentation and use of data for improvement. e) Systems are in place that enable access to meaningful data from Board to service level to understand and monitor quality. f) To anticipate potential risks to safety, such as staff or equipment shortages, reviews of data and proactive action is taken on potential threats. g) The service maintains a questioning approach even when data suggest things are going well. h) Lessons learned from adverse events (including near misses), feedback from people experiencing care, inspections, internal audits, and claims are clearly recorded. i) Regular discussions take place of feedback, complaints, and adverse events (including lessons learned) at service or department level. j) Mechanisms are in place to inform staff of findings and outcomes from the data they have collected. k) Board members routinely participate in walk-rounds or discussions with staff and stakeholders to enable them to understand the level of care and treatment provided to people experiencing care and the issues facing staff.

5.3 Risk management and business continuity	a) To support and promote the health, safety and wellbeing of people experiencing care, visitors and staff the service has clear strategies or plans for safety. b) The care environment, including buildings, grounds and estate services, is designed, maintained, and reviewed in line with relevant regulations. c) The care equipment is installed, used, maintained and replaced in line with regulation and guidance d) The service does not wait for things to go wrong before trying to improve safety. e) There is a proactive approach to risk management. f) Effective risk management systems are in place to record clinical, legislative, finance and other risks focused on the safety of staff and people who experience care. g) Operational and organisational risks are formally identified, reviewed, and subsequently controlled, with evidence of action to mitigate the risks. h) Decisions about the management of adverse events are risk-based, informed and transparent to allow appropriate level of scrutiny.
5.4 Audit, evaluations and research	a) The service has a robust process for implementing national standards, indicators and guidelines, and undertakes self-assessment and audit where required. b) Evidence-based practice is implemented in line with national guidance, for example, infection prevention and control, prevention of pressures ulcers c) Current and evidence-based advice on the use of medicines is readily available to relevant staff when making clinical decisions about medicines use. d) Current and evidence based advice on clinical procedures is readily available to relevant staff. e) There are mechanisms embedded in teams/services to detect variation from agreed standards/desired quality in relation to the delivery of safe, effective care and improved outcomes.
5.5 Improvement and innovation	a) The Board and leadership maintain a state of intelligent wariness even in the absence of poor outcomes. b) Leaders encourage and listen to staff 'voices' and act upon their feedback. c) The Board and senior leadership undertake leadership activities in improvement and commit time and/or money for delivering quality improvement initiatives. d) Quality improvement is a core part of main Board meetings, both as a standing agenda item and as an integrated element of all major discussions and decisions. e) The quality strategy enables the embedding of knowledge/skills and permission at team level to fix/ improve problems within team control. f) Individuals, teams and services working on similar challenges are enabled to learn together. g) The service has a consistent approach to delivering quality improvement using appropriate methods to address the relevant improvement priority.

	h) Teams/the service routinely take time out to consider their capacity for change, reflect and document upon their objectives, strategies, processes, environments and any barriers to change and adjust change plans accordingly. i) Staff and volunteers feel involved and supported, to improve the care, information and support they provide. j) Staff are informed of the outcome, lessons learned or actions being taken forward after they have raised an issue or reported an adverse event. k) Staff are supported and feel empowered to challenge poor or unsafe practice so that care is safe and effective. l) The service takes a proactive approach to engaging with people who currently, or potentially might, experience care to identify issues and learning points and to shape improvements. m) Staff are able to identify improvements made in response to a complaint or adverse event. n) Leadership responds well to new challenges or obstacles and addresses problems directly. o) Leadership provides support to identify opportunities for innovation and improvement.

Domain 6 – Relationships Results: What difference have we made?	
Criteria	**Quality indicators (statements of what good care looks like)**
6.1 Person centred and safe outcomes	a) People feel safe while in the care of the service (including feeling safe with staff, people who experience care, families or carers). b) The service actively engages people who experience care, members of the public, staff and other key stakeholders using feedback and data to identify trends to inform quality improvement initiatives and improve care. c) People experiencing care report that their care is consistent and stable. d) There is clear signage to guide people receiving care and families or carers around the care environment, including dementia-friendly signage. e) People experiencing care and support are fully informed about what information about them is shared with others.
6.2 Dignity and respect	a) People experiencing care feel that staff speak and listen in a way that is courteous, dignified and respectful, with their care and support being the focus of staff's attention. b) People experiencing care feel that staff respect their privacy, keep private information confidential and offer opportunities for confidential discussions.
6.3 Compassion	a) People experiencing care, are supported and cared for with kindness and compassion. b) Staff work with legal guardians, families, carers and volunteers to support person-centred care. c) Staff demonstrate compassionate and encouraging care and are sensitive to the individual needs of people experiencing care.
6.4 Inclusion	a) People experiencing care and families or carers know who is in charge of their care. b) People experiencing care receive clear and timely communication and have their condition and treatment explained to them. c) There is support for people experiencing care, families or carers, to make informed choices and decisions about risks. d) People experiencing care are kept informed of their clinical or care progress and discharge plans.
6.5 Responsive care and support	a) Staff work to understand concerns or issues raised by people experiencing care, families or carers and what outcome they wanted to see and reassure them that raising concerns will not negatively influence their care delivery. b) Staff follow the organisation/service's Duty of Candour procedures. For example, people experiencing care receive an apology if things go wrong and the service takes responsibility for its actions. c) The service and its staff demonstrate positive attitudes and behaviour towards those who may be socially or culturally excluded.

	d) Those providing care and support are informed about the person's relevant life, health and care history, and the impact of this.
6.6 Wellbeing	a) Staff are able to access support for people's spiritual needs. b) The service provides health promotion information, education and sign posting to encourage and help people who experience care towards independence and self-care to achieve their full potential. c) The service works with stakeholders to encourage people experiencing care (including those with disabilities, frailty or long-term conditions) to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. d) Where relevant, the service and staff encourage people experiencing care to take positive risks which enhance their wellbeing or quality of life (positive risk refers to recognising the potential benefits in taking risks in day-to-day life and making balanced decisions around taking calculated and reasoned risks).
6.7 Public confidence	a) Members of the public have good awareness about how to report concerns about the quality of care, safety or people's wellbeing. b) The public has confidence in the effectiveness of services. c) Performance information and quality improvement outcomes are made public (and accessible) and include objective coverage of both good and bad performance. d) The service shares learning out with the service with relevant stakeholders and partner organisations.

Domain 7 - Quality Control Results: What have we learned?	
Criteria	**Quality indicators (statements of what good care looks like)**
7.1 Delivery of key performance indicators	a) Systems are in place that enable access to meaningful data from Board to service level to understand and monitor quality. b) Systems and culture enables the embedding of knowledge/ skills and permission at team level to fix/ improve problems within team control. c) Processes and culture ensure an appropriate response to issues that individuals/ teams can't fix such as, escalation, additional support/resource. d) Teams at a local level have access to meaningful data on cost, workforce and performance and use this to: • monitor reliable delivery of high quality care, • identify where improvement focus is required, and • assess the impact of new changes e) Procedures are in place to monitor performance regularly against key indicators. f) There is evidence that re-audits to assess levels of improvement are undertaken. g) Reviews of data and evidence drive improvement. h) There is evidence of action following debriefs, adverse events, safety walk rounds, inspections, audits, complaints or performance data. i) The service complies with nationally agreed standards and indicators of care to ensure that people are safe and well cared for, and their needs met. j) Board members challenge performance data to support assurance that it is reflective of what is happening operationally. The following list provides examples of potential key performance indicators. This list is not exhaustive and there may be further or specific measures or outcomes relevant to particular programmes, themes, sectors or legislation. • Clostridium difficile infection, staphylococcus aureus bacteraemia, surgical site infection and catheter associated urinary tract infection. • Falls, pressure ulcers, cardiac arrests and sepsis. • Violence, restraint and seclusion in mental health. • Medicines harm.

	• Maternity, neonatal and paediatric harm. • Stillbirth and neonatal. • Hospital Standardised Mortality Ratio. • Mortality or longer survival. • Unscheduled care episodes. • Reported outcomes from people experiencing care. • Local health inequalities. • Access to GP or out-of-hours services. • Patient waiting lists or time from referral to treatment. • Sufficient skilled staff to deliver safe care. • Turnover. • Vacancies. • Sickness absence. • Positive feedback from people experiencing care, families, carers, stakeholders, staff, partners and the wider population. • Staff are positive about the organisation and care provided both internally and externally. • Real time staffing escalations/mitigations • Complaints
7.2 Delivery of strategy and priorities	a) The service monitors and links both key performance results and outcomes for people and keeps the strategic plan up to date and appropriate. b) Individual objectives aligned to the key priorities for improvement are reviewed regularly. c) The service can demonstrate fulfilment of key stakeholder expectations. d) The service can evidence improved performance and positive transformation. e) The service identifies predictive measures aligned with its strategy, resources and stakeholder expectations.
7.3 Lessons learned and plans to apply	a) The service can demonstrate how it identifies transformation and change needs that reflect the strategy and aims, and relevant external challenges and opportunities. b) The service can demonstrate how people to come together to share and learn, to build and action new knowledge and speed up improved outcomes. c) The service demonstrates preparedness to help ensure safe care today and in the future.

	d) The service makes judgements on quality improvement based on evaluation of quality indicators, tests of change, feedback and good practice. e) Lessons learned from people's care experience, adverse events, improvement and redesign initiatives and staff feedback informs quality improvement activity. f) The service uses a variety of mechanisms to ensure shared learning throughout the service from adverse events, complaints and safety alerts, including actions and improvements. g) The service identifies good practice (within the service or from external sources) or key themes and shares and replicates across the service where relevant and appropriate. h) Leadership is aware of sustainability issues and any gaps in service provision and work to address these.

Improvement Action Plan

Healthcare Improvement Scotland:

Unannounced acute hospital safe delivery of care inspection

Dr Gray's Hospital, NHS Grampian

09-11 October 2023

Improvement Action Plan Declaration

It is the responsibility of the NHS board Chief Executive and NHS board Chair to ensure the improvement action plan is accurate and complete and that the actions are measurable, timely and will deliver sustained improvement. Actions should be implemented across the NHS board, and not just at the hospital inspected. By signing this document, the NHS board Chief Executive and NHS board Chair are agreeing to the points above. A representative from Patient/Public Involvement within the NHS should be involved in developing the improvement action plan.

NHS board Chair

Signature: 

Full Name: ALISON EVISON

Date: 18 January 2024

NHS board Chief Executive

Signature: 

Full Name: ADAM COLDWELLS

Date: 18 January 2024

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
1.	**Domain 1 – Clear vision and purpose** **NHS Grampian must ensure that nursing staff are provided with necessary training to safely carry out their roles and comply with the NMC Code, Professional standards of practice and behaviour for nurses, midwives and nursing associates.** **This will support compliance with: The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (2018).**				
1.1	Nursing staff from the Emergency Department (ED) and Paediatric Short Stay Assessment Unit (PSSAU) to have completed Paediatric Immediate Life Support (PILS) training.	30 June 2024	Senior Charge Nurses and Resuscitation Team with support from Chief Nurse.		
1.2	Nursing staff from the Emergency Department to have completed Immediate Life Support (ILS) training.	30 June 2024	Chief Nurse facilitated with Senior Charge Nurses and Resuscitation Team		
2.	**Domain 1 – Clear vision and purpose** **NHS Grampian must ensure effective and appropriate governance approval and oversight of policies and procedures are in place.** **This will support compliance with: Quality Assurance System: Quality Assurance Framework (2022) criterion 2.5 and 2.6.**				
2.1	Review policies for Dr Gray's Hospital, ensuring all are compliant with timescales. All governance meetings (clinical and non-clinical) to include: • policy review to be agenda item • conduct an audit after 3 months to ensure compliance • ensure NHS Grampian's closed circuit TV policy, locked door policy and health and	30 June 2024	Associate Director Quality Improvement and Assurance/ Portfolio Senior Leadership Teams/ Deputy General Manager for Facilities and Estates		

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
	safety risk assessment for adults being cared for in non-standard patient areas are complete				
3.	**Domain 1 – Clear vision and purpose** **NHS Grampian must ensure that systems and processes are in place to ensure both adult and paediatric patients are triaged in a timely manner.** **This will support compliance with: Quality Assurance System: Quality Assurance Framework (2022) Criteria 6.1.**				
3.1	Emergency Department Adult & Paediatric Medical Admission Flow to be reviewed and updated to ensure it is criteria led by 31 January 2024. Compliance with pathway and inclusion of Paediatric Early Warning Score (PEWS) assessment and safe and effective triage. An audit to be conducted after 3 months to understand effectiveness and compliance.	30 April 2024	Hospital Clinical Director and Clinical Leads supported by Unit Operational Managers		
4.	**Domain 1 – Clear vision and purpose** **NHS Grampian must ensure all staff are aware of fire evacuation procedures.** **This will support compliance with: NHS Scotland 'Firecode' Scottish Health Technical Memorandum SHTM 83 (2017) Part 2; The Fire (Scotland) Act (2005) Part 3, and Fire Safety (Scotland) Regulations (2006).**				
4.1	Communication shared to ensure staff are aware of fire evacuation processes. All Dr Gray's Hospital (DGH) Fire Plans to be reviewed including in areas with increased capacity by 31 January 2024 and a review after 3 months on the staff awareness of fire evacuation procedures.	30 April 2024	Hospital Senior Leadership Team (SLT) supported by Deputy Nominated Fire Officer and Health & Safety Group	Review of fire plans for all areas in progress.	

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
	A Fire Risk Assessment will be completed for all areas including those with additional patients and fire plans to be updated.				
4.2	Fire evacuation tabletop exercises to take place with the Deputy Nominated Fire Officer in all areas by 30 September 2024, with feedback from attendees and a review after 3 months on the staff awareness of fire evacuation procedures.	31 December 2024	Hospital Senior Leadership Team supported by Deputy Nominated Fire Officer		
4.3	In line with NHS Grampian compliance levels for statutory and mandatory training, 70% compliance to be achieved for fire safety training by 29 February 2024, and review after 3 months for training compliance.	31 May 2024	Hospital Senior Leadership Team supported by Operational Managers		
5.	**Domain 2 – Leadership and culture** **NHS Grampian must ensure that there are suitable systems, processes, resources and support and oversight in place to ensure students experience safe and effective coordination of learning within practice learning environments.** **This will support compliance with: NMC Standards for student supervision and assessment (2023).**				
5.1	Review of the Practice Learning Environments, allocation of nursing students, educational audits, and student placement experience to ensure all areas meet the Quality Standards for Practice Education (NES 2021)	31 May 2024	NHS Grampian Lead Nurse for Practice Education and Development supported by the Lead Practice Educator for Dr Gray's Hospital		
5.2	All clinical areas to have substantive nursing staff member on each shift to ensure student support, and assurance obtained daily via staffing huddles.	12 October 2023	Chief Nurse with support from Nurse Managers	Action completed and monitored daily at staffing huddles	12 October 2023

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
			and Senior Charge Nurses		
6.	**Domain 2 – Leadership and culture** **NHS Grampian must ensure that all staff comply with controlled drug management in line with NHS Grampian policy and procedures for the safe management of controlled drugs in hospitals and clinics.** **This will support compliance with: Royal Pharmaceutical Society and Royal College of Nursing Professional Guidance on the Administration of Medicines in Healthcare Settings (2019) and relevant codes of practice of regulated healthcare professions.**				
6.1	A Controlled Drugs management improvement action plan has been developed, approved and implemented following initial feedback and letter of concern provided by Healthcare Improvement Scotland.	01 March 2024	Director of Pharmacy With support from Chief Nurse, Dr Gray's Hospital Lead Pharmacist & Controlled Drugs Pharmacy Team	Improvement Action Plan shared with Healthcare Improvement Scotland and in progress	
7.	**Domain 2 – Leadership and culture** **NHS Grampian must improve feedback to staff on incidents raised through the incident reporting system and ensure learning from incidents is used to improve safety and outcomes for patients and staff.** **This will support compliance with: Quality Assurance System: Quality Assurance Framework (2022) Criteria 3.1 and Learning from adverse events through reporting and review: A national framework for Scotland (2019).**				
7.1	Monitor, review and progress against overdue actions on Datix through Portfolio governance structures and clinical risk meetings, and audit effectiveness of measures after 3 months and as per action plan timelines.	31 March 2024	Head of Performance and Governance	Improvement Action Plan shared with Healthcare Improvement Scotland following letter of concern. Progress being monitored as per action plan.	

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
7.2	Support areas with significant numbers of improvement actions requiring completion	31 January 2024	Hospital Senior Leadership Team		
7.3	Monitor and review captured in action 7.1. Improvement action plans have been developed aligned with requirement 8.1.	31 January 2024	Hospital Senior Leadership Team		
7.4	Escalation of concerns where areas cannot complete timely review of Datix events to Grampian Clinical Risk Meeting (CRM) by 14 February 2024, and a review after 3 months on the effectiveness of provided support measures and compliance position of Datix events.	31 May 2024	Hospital Senior Leadership Team		
8.	**Domain 2 – Leadership and culture** **NHS Grampian must ensure effective senior management oversight and support, to reduce the risks for staff and patients receiving care.** **This will support compliance with: Health and Social Care Standards (2017) Criteria 4.23, Quality Assurance System: Quality Assurance Framework (2022) criterion 2.3, 2.6 and 5.5 and relevant codes of practice of regulated healthcare professions.**				
8.1	Improvement Action Plan shared with Health Improvement Scotland following letter of concern; Refreshed Clinical Risk Management, Assurance and Accountability processes in place. Training and education and protected time for staff in place. Including Staff Health & Wellbeing measures. Progress being monitored as per Requirement 7.	31 March 2024	Hospital Senior Leadership Team		

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
9.	**Domain 4.1 - Pathways, procedures and policies** **NHS Grampian must ensure effective senior management oversight and support, to ensure the fundamentals of care are provided and reduce the risks for staff and patients at times of extreme pressure within the emergency department.** **This will support compliance with: Health and Social Care Standards (2017) Criteria 4.23; Quality Assurance System: Quality Assurance Framework (2022) criterion 6.2 and 6.3, and relevant codes of practice of regulated healthcare professions.**				
9.1	Current Dr Gray's Hospital Site Escalation Plan, associated Standard Operating Procedures (SOP) and risk assessments for the use of non-standard patient areas and Clinical Decisions Unit to be reviewed, updated and shared with Department/Service Leads including Senior Charge Nurses and Operational Support Teams 22 December 2023 and review end of January 2024 for the effectiveness and compliance.	30 April 2024	Hospital Senior Leadership Team with support from Operational Teams	Escalation Plan updated and shared 22 December 2023.	
9.2	Emergency Department daily shift report template to be developed by 31 January 2024 to capture patient quality of care and staff safety concerns associated with department pressures. A review of this report template to be undertaken after 2 months.	31 March 2024	Hospital Senior Leadership Team facilitated with Unscheduled Care Management Team		
10.	**Domain 4.1 - Pathways, procedures and policies** **NHS Grampian must ensure that all patient documentation is accurately and consistently completed. This includes Adults with Incapacity section 47 documents.** **This will support compliance with: Quality Assurance System: Quality Assurance Framework (2022) Criteria 4.1, relevant codes of practice of regulated healthcare professions and Adults with Incapacity (Scotland) Act (2000).**				
10.1	Monthly Audit to review effective completion of patient documentation and record keeping including Adults with Incapacity (AWI) legislation and completion of documentation. Will be	31 March 2024	Hospital Senior Leadership Team with support from Nurse Managers, Medical		

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
	incorporated into suite of Quality Assurance activity.		Leadership and Allied Health Professional Lead		
10.2	Ensure training and education sessions are arranged for staff specifically on Adults with Incapacity (AWI) legislation and completion of documentation.	31 May 2024	Hospital Clinical Director support by Frailty Clinicians		
11.	**Domain 4.1 - Pathways, procedures and policies** **NHS Grampian must ensure safe storage and administration of medicines at all times.** **This will support compliance with: Royal Pharmaceutical Society and Royal College of Nursing Professional Guidance on the Administration of Medicines in Healthcare Settings (2019) and relevant codes of practice of regulated healthcare professions.**				
11.1	Introduction of regular audits across all Dr Gray's Hospital inpatient areas, led by nurse managers & Medication Safety Advisor, on safe storage and administration of medicines.	31 January 2024	Chief Nurses/ Pharmacy facilitated by Nurse Managers/ Medication Safety Advisor		
12.	**Domain 4.1 - Pathways, procedures and policies** **NHS Grampian must ensure the safe disposal of sharps.** **This will support compliance with: National Infection Prevention and Control Manual (2023).**				
12.1	Audit of sharp boxes to be undertaken to ensure boxes are labelled as per guidelines and temporary closures are used appropriately.	30 June 2024	Senior Charge Nurses/Nurse Managers	Weekly walk rounds commenced and Safe and Clean Care Audit to take place	
13.	**Domain 4.1 - Pathways, procedures and policies** **NHS Grampian must ensure used linen is managed appropriately.**				

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
	This will support compliance with: National Infection Prevention and Control Manual (2023).				
13.1	Operational Team weekly assurance walk rounds and 6-monthly Safe and Clean Care Audits to take place to ensure compliance with Linen Policy.	30 June 2024	Senior Charge Nurses facilitated with the Nurse Managers and Operational Teams.	Weekly walk rounds commenced and Safe and Clean Care Audit to take place	
14.	**Domain 4.1 - Pathways, procedures and policies** **NHS Grampian must ensure the care environment is maintained to allow for effective cleaning.** **This will support compliance with: National Infection Prevention and Control Manual (2023).**				
14.1	Facilities to develop action plan and schedule of works for identified remedial works including flooring by 29 February 2024 and monitor on quarterly basis for progress.	31 May 2024	Deputy General Manager, Facilities supported by Facilities Heads of Service	Action plan currently in development. Schedule of meetings set up with Heads of Services to monitor and progress.	
15.	**Domain 4.1 - Pathways, procedures and policies** **NHS Grampian must ensure all hazardous cleaning products are securely stored.** **This will support compliance with: Control of Substances Hazardous to Health (COSHH) Regulations (2002).**				
15.1	Wards and departments to be reminded at daily safety briefs and assurance walk rounds of the need to keep all hazardous substances for cleaning within lockable cupboards. A review of the effectiveness of these measures in action 15.1 and 15.2 to be undertaken after 3 months.	31 May 2024	Hospital Senior Leadership Team facilitated by Operational Teams, Senior Charge Nurses & Head of		

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
			Domestic and Support Services		
15.2	Audit compliance with storage of hazardous substances e.g. Actichlor, in line with COSHH requirements.	31 May 2024	Hospital Senior Leadership Team facilitated by Operational Teams, Senior Charge Nurses & Head of Domestic and Support Services		
15.3	Robust escalation process for issues of non-compliance.	31 May 2024	Hospital Senior Leadership Team supported by Senior Charge Nurses, Nurse Managers & local Facilities and Estates team		
16.	**Domain 4.1 - Pathways, procedures and policies** **NHS Grampian must ensure consistent recording of flushing of infrequently used water outlets to improve compliance and provide assurance in line with current national guidance.** **This will support compliance with: National Infection Prevention and Control Manual (2023).**				
16.1	To ensure all staff are aware that water flushing to be completed twice weekly for clinical and non-clinical areas, apart from the High Dependency Unit which should be completed daily, ensuring that the evidence of this is recorded.	30 June 2024	Hospital Senior Leadership Team with support from Infection Prevention Control	Water Flushing Improvement Action Plan developed and in progress monitored by Healthcare Associated	

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
	Non-compliance is escalated via Nurse Managers and Operational Management team.		Nurse, Nurse Managers & Senior Charge Nurses	Infections (HAI) Group. Safe and Clean Care Audit will also provide oversight.	
17.	**Domain 4.1 - Pathways, procedures and policies** **NHS Grampian must ensure that patient care equipment is kept clean and ready for use.** **This will support compliance with: National Infection Prevention and Control Manual (2023) Standard 6.**				
17.1	Operational Team weekly assurance walk rounds and 6 monthly Safe and Clean Care Audits to take place to ensure equipment is clean and ready to use.	30 June 2024	Chief Nurse facilitated with the Senior Charge Nurses, Nurse Managers and Operational Teams.	Weekly walk rounds commenced and Safe and Clean Care Audit to take place	
18.	**Domain 4.3 - Workforce planning** **NHS Grampian must ensure that it consistently reports and records staffing risks, as well as robustly recording mitigations and recurring risks in line with established governance processes.** **This will support compliance with: Health and Care (Staffing) (Scotland) Act (2019) and Quality Assurance System: Quality Assurance Framework (2022) criteria 1.3 and 2.2.**				
18.1	Twice daily nurse staffing huddles to ensure safe staffing levels and any risks are escalated and mitigated.	31 October 2023	Chief Nurse facilitated with the Nurse Managers	Action completed and monitored daily	31 October 2023
18.2	Use of Healthroster across Dr Gray's Hospital to support effective rostering of nursing staff and managing short and moderate term rostering risks	31 January 2024	Chief Nurse facilitated with the Nurse Managers	Weekly scheduled data sets relating to rostering gaps and performance set up for Chief Nurse and Nurse Managers to	11 January 2024

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
				support improved roster governance	
18.3	Implement SafeCare system and associate processes for the assessment, mitigation, escalation of reporting of real-time staffing risks.	31 January 2024	Chief Nurse/ Clinical lead for eRostering	Engagement meetings complete and training programme commenced. On track for completion by 31st January 2024	
18.4	Develop data metrics to identify recurrent risk based on Healthroster and SafeCare data	30 June 2024	Clinical Lead eRostering		
18.5	Risk register entry detailing nursing workforce risks across the hospital site, reported to Nurse Director and Workforce Council.	31 January 2024	Chief Nurse	Risk captured on the Dr Gray's Risk Register.	Updated in January 2024
18.6	Adverse events submitted detailing nurse staffing risks to be reviewed in line with the NHS Grampian Policy for the Management and Learning from Adverse Events reported to Workforce Council and Staff Governance Group.	31 January 2024	Chief Nurse facilitated with the Nurse Managers		
19.	**Domain 6.1 - Person-centred and safe outcomes** **NHS Grampian must ensure when patients are cared for in mixed sex bays, this is regularly risk assessed and suitable mitigations are put in place to maintain patient dignity, respect and choice.** **This will support compliance with: Health and Social Care Standards (2017) criteria 1.20 and Quality Assurance System: Quality Assurance Framework (2022) Criteria 6.1.**				
19.1	Develop a Standard Operating Procedure for accommodating mixed sex bays including access to toilets	31 May 2024	Nurse Director and Corporate Chief Nurse		
19.2	Risk assessments for non – standard patient areas were circulated to nurse managers for onward sharing 22 December 2023 (circulated as per 9.1), and risk assessments to be reviewed quarterly.	31 March 2024	Chief Nurse facilitated by Nurse Manager and Senior Charge Nurses		

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
20.	**Domain 6.2 - Dignity and respect** **NHS Grampian must ensure that patient privacy and dignity is maintained at all times and all patients have access to a call bell.** **This will support compliance with: Health and Social Care Standards (2017) criteria 4.11, 5.2, 5.3 and 5.4; Healthcare Improvement Scotland Care of Older People in Hospital Standards (2015) Standard 2; Quality Assurance System: Quality Assurance Framework (2022) Criteria 6.2; Health and Social Care Standards (2017) Criterion 1.23 and relevant codes of practice of regulated healthcare professions.**				
20.1	Ensure sufficient call bells are available for use by all patients, when appropriate in all areas of the Emergency Department	29 February 2024	Nurse Manager facilitated by Chief Nurse		
20.2	Ensure sufficient temporary privacy screens are available at times of increased capacity	29 February 2024	Nurse Manager facilitated by Chief Nurse		
	Recommendation				
1.	**Domain 4.1 - Pathways, procedures and policies** **NHS Grampian should ensure that patients are assisted with hand hygiene at mealtimes.**				
1.1	Mealtime co-ordinator to be identified at the beginning of each shift each to ensure patients are prepared appropriately for mealtimes	29 February 2024	Chief Nurses facilitated by Nurse Managers and Senior Charge Nurses		
1.2	Learning from Healthcare Improvement Scotland inspection regarding preparation for mealtimes (including hand hygiene) shared with all sectors of NHS Grampian via Grampian Strategic Hydration and Nutritional Care Group	14 March 2024	Grampian Strategic Hydration and Nutritional Care Group		

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 28 MARCH 2024**

SUBJECT: **RESIDENTIAL CHILD CARE SERVICE (CALA) INSPECTION REPORT**

BY: **SERVICE MANAGER, PROVIDER SERVICES**

1. REASON FOR REPORT

1.1 To update the Committee on the outcome of the recent Inspection of the Care Home Service by the Care Inspectorate.

2. RECOMMENDATION

2.1 It is recommended that Committee consider and note the outcome of the inspection of the Care Home (Children and Young People) Service by the Care Inspectorate.

3. BACKGROUND

3.1 The purpose of this report is to ensure the Moray Integration Joint Board (MIJB) fulfils its ongoing responsibility to ensure effective monitoring and reporting on the delivery of services and on the programme of work as set out in its Strategic Plan.

3.2 In December 2023, the Care Inspectorate carried out an unannounced inspection of the Moray Council's Care Home at the Residential Child Care Service located at CALA. A copy of the full inspection report is included in **Appendix 1**.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 A summary of the Care Inspectorate's grading for the area assessed is noted in Table 1.

There were no new areas identified for improvement for the service in this report. It should be noted that all areas for improvement from previous inspection reports have been met, demonstrating that the service is actively reviewing and improving practices through listening to those receiving a service (including their families), and those providing it.

Table 1

Area	Rating
How well do we support children and young people's rights and wellbeing?	5 – Very Good

How well do we support children and young people's rights and wellbeing

4.2 The Care Inspectorate found significant strengths in the care provided and how these supported positive outcomes for young people.

4.3 Young people reported they experienced relational and nurturing care which promoted their emotional and physical safety. Risk assessments and care plans provided meaningful responses to risk, and had a clear foundation in the strong relationships staff have with the young people. Training and trauma informed practice resulted in very limited use of restrictive practices.

4.4 Young people living in the house were safe and felt confident about staffs' abilities to keep them safe.

4.5 Young people experienced warm, trusting, nurturing and respectful relationships with those caring for them, and staff clearly had the right value base required to provide compassionate care.

4.6 Significant importance was placed on ongoing relationships with young people who had moved on from the service.

4.7 Feedback from parents was extremely positive about staff respecting their role, views and working together for the benefit of their child or young person.

4.8 Young peoples' voices were present in most aspects of their care and were provided with ample opportunities to actively engage in discussions and decisions about things that were important.

4.9 There are no requirements or recommendations for areas for improvement noted by the Care Inspectorate.

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"
Performance management reporting is a legislative requirement under Section 42 of the Public Bodies (Joint Working) (Scotland) Act 2014. In addition to publishing an Annual Performance Report, the Moray Integration Scheme requires that the MIJB will "monitor the performance of the delivery of integrated services using the Strategic Plan on an ongoing basis" (para 5.2.2 of the Moray Integration Scheme refers).

(b) Policy and Legal
None directly associated with this report.

(c) Financial implications
None directly associated with this report.

(d) Risk Implications and Mitigation
There are no risk issues arising directly from this report.

(e) Staffing Implications
None directly associated with this report.

(f) Property
None directly associated with this report.

(g) Equalities/Socio Economic Impact
An Equality Impact Assessment is not required for the Care Inspectorate Inspection report because there will be no impact, as a result of the report, on people with protected characteristics.

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

(i) Directions
There are no directions arising from this report.

(j) Consultations
The following have been consulted in the development of this report:

Senior Management Team, Operational Management Team HSCM, Finance and Human Resources.

6. CONCLUSION

6.1 This report provides the Committee with a summary of the recent inspection of the Moray Council Care Home (Children and Young People) base at CALA, which provides Residential Child Care, by the Care Inspectorate. There are no areas identified for improvement for the service in this report. Good progress has been shown and this report outlines the hard work and dedication of our teams resulting in a positive inspection.

Author of Report: Donna McDonald, Residential Child Care Service Registered Manager

Background Papers: Available on request
Ref:

Cala
Care Home Service

10 - 12 Cumming Circle
Elgin
IV30 6JX

Telephone: 01343 550 990

Type of inspection:
Unannounced

Completed on:
7 December 2023

Service provided by:
The Moray Council

Service provider number:
SP2003001892

Service no:
CS2014333593

About the service

The service is purpose-built and provides residential accommodation for six children and young people. The service is provided from two separate houses, with young people benefitting from a smaller household of three young people living in each house. The houses share the aims and objectives, manager and senior staff but otherwise operate quite separately to each other. Both of the houses provide a homely, nurturing environment for the young people living there.

The aims and objectives of the service are to:

- Provide and maintain a nurturing, therapeutic and stable environment for young people where they will feel safe, included, and develop a sense of belonging. The focus for providing this is found in the nurturing, caring, and meaningful relationships which are fundamental to the ethos at Cala.
- Create and maintain relationships within a family atmosphere.
- Provide consistent, respectful care and support.
- Develop a person centred therapeutic approach.
- Promote a culture in which young people are supported to overcome previous traumas, and to develop positive, secure, and appropriate attachments.
- Provide support for young people to reach their own potential and progress further into independence.

About the inspection

This was an unannounced inspection which took place on 28 and 29 November, and 6 December 2023. The inspection was carried out by one inspector from the Care Inspectorate.

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

In making our evaluations of the service we:
- spoke informally with all of the young people using the service, and with three formally
- spoke with three parents
- spoke with staff and management
- observed practice and daily life
- reviewed documents
- spoke with visiting professionals.

We also received very positive pre-inspection questionnaires from 10 staff, 10 external professionals and five young people.

Key messages

- Young people experienced warm, trusting, nurturing, and respectful relationships with those caring for them.
- There was a clear culture of relationship-based practice which reduced the likelihood of incidents. Training, trauma informed practice, and knowledge of behaviour support strategies supported early intervention, and very limited use of restrictive practices.
- Education was given a high priority with most young people doing really well. Staff advocated strongly on behalf of young people to ensure their right to education was upheld.
- Feedback from parents was extremely positive about staff respecting their role and views, and working together to the benefit of their child.

From this inspection we evaluated this service as:

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

How well do we support children and young people's rights and wellbeing?	5 - Very Good

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

How well do we support children and young people's rights and wellbeing?

5 - Very Good

We found significant strengths in the care provided and how these supported positive outcomes for young people, therefore, we evaluated this key question as very good.

Young people experienced relational nurturing care, which promoted their emotional and physical safety. Risk assessment and safety plans provided meaningful and realistic responses to risk, that had a clear foundation in the strong relationships that staff had with young people. Training, trauma informed practice, and knowledge of behaviour support strategies supported early intervention, with very limited use of restrictive practices. A high level of reflective practice promoted insight and effective strategies of support.

Young people were safe in the house. They said that staff would challenge bullying, and would definitely keep them safe. Staff were aware of the dynamic of the group, and where there might be tensions. Staff received child protection training as part of ongoing core training. They were clear what to do if they had a concern.

Young people experienced warm, trusting, nurturing, and respectful relationships with those caring for them. This was evident in observation, discussion, and very positive questionnaire responses from both young people and staff. Staff clearly had the right value base required to provide compassionate care. Significant importance was placed on ongoing relationships with young people who had moved on from the service, and to people who were important to the young people. Feedback from parents was extremely positive about staff respecting their role and views, and working together to the benefit of their child.

The houses were very homely, both in décor and atmosphere. Young people had been involved in decisions about the house, and their views were sought and listened to. In response to young people's requests, and the views of the team generally, they were hoping to install a bath, and actively pursuing better Wi-Fi. Young people's photos were displayed and contributed to the homely environment and a sense of belonging.

Young people had a number of people outwith the service who could advocate for their rights. Not all wanted this, but all had the opportunity. In discussion, most young people felt that people were interested in their views and that change had, or would, come about from them sharing their views. A 'young person friendly' complaints procedure allowed them to understand how to raise any concerns. This should be updated to include Care Inspectorate's 'text to complain' service available to young people.

Young people had access to a range of activities, and were encouraged to develop new interests which helped promote self-esteem and confidence. Staff were seen to be hugely encouraging to the young people's interests, and sensitive to ensuring they got the best from their experiences.

Young people's voices were present in most aspects of their care and support. They had written their own care plans and every section of their adult care plan identified their views, though the format could be developed to better identify whether these are directly expressed views, or an adult perception of their views. In the house there were formal opportunities such as young people's meetings, individual time with keyworkers, and general discussion across the day. All of these provided ample opportunities for young people to actively engage in discussion and decisions about things that were important.

All young people were registered with appropriate healthcare services. Where they had specific healthcare needs they were supported to access relevant services to ensure their positive mental and physical wellbeing. Medication was appropriately stored, recorded, and administered, with young people involved in their own medication reviews.

Some young people were involved with the throughcare worker preparing for the next steps in their lives. Support plans indicated that young people who were keen to move on, continued to get a high level of support with tasks they would soon be responsible for themselves. This reflected the nurturing care provided at the service, but perhaps needed further consideration to ensure young people were as equipped as possible for caring for themselves in their own property.

Young people's goals and ambitions were recognised and supported. Their education was given a high priority with most young people doing really well. It was very positive to hear staff advocating strongly on behalf of young people to ensure their right to education was upheld.

Wherever possible, mealtimes were used to come together to chat about the day. Significant emphasis was placed on healthy, home cooked meals, with young people influencing the menu with meals of their preference. The kitchen was a warm welcoming area where lots of discussion and activity took place, and which contributed further to the homely environment young people enjoyed.

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

Areas for improvement

Previous area for improvement 1

The care plans that were in place were detailed and contained relevant information to inform staff as to the care and support to be provided to young people. However, there were too many documents in place and we believe this would ultimately cause confusion for staff and young people. Therefore, the service need to continue with their review of the care plans to ensure there is clear evidence that the care plan incorporates the views, wishes, and aspirations of young people. Young people must be at the heart of the care plan.

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS) which state that:

'I am fully involved in developing and reviewing my personal plan, which is always available to me' (HSCS 2.17).

This area for improvement was made on 27 September 2019.

Action taken since then

Young people wrote their own care plans which expressed their views and wishes. These were also incorporated into the wider care plan.

This area for improvement has been met.

Complaints

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

Detailed evaluations

How well do we support children and young people's rights and wellbeing?	5 - Very Good
7.1 Children and young people are safe, feel loved and get the most out of life	5 - Very Good

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REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 28 MARCH 2024**

SUBJECT: **CARE AT HOME INSPECTION REPORT**

BY: **SERVICE MANAGER, PROVIDER SERVICES**

1. REASON FOR REPORT

1.1 To update the Committee on the outcome of the recent inspection of the Care at Home Service by the Care Inspectorate.

2. RECOMMENDATION

2.1 It is recommended that the Committee consider and note the outcome of the Inspection of the Care at Home Service by the Care Inspectorate.

3. BACKGROUND

3.1 The purpose of this report is to ensure the Moray Integration Joint Board (MIJB) fulfils its ongoing responsibility to ensure effective monitoring and reporting on the delivery of services and on the programme of work as set out in its Strategic Plan.

3.2 In November 2023, Care Inspectors carried out a full unannounced inspection of the Moray Council Care at Home Service. A copy of the full inspection report is included in **Appendix 1**.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 A summary of the Care Inspectorate's grading for each area of the service is noted in Table 1.

There were no new areas identified for improvement for the service in this report. It should also be noted that all areas for improvement from previous inspection reports have been met, demonstrating that the service is actively reviewing and improving practices through listening to those receiving a service, and those providing it.

Table 1

Area	Rating
How well do we support people's wellbeing?	5 – Very Good
How good is our leadership?	5 – Very Good
How good is our staff team?	5 – Very Good
How well is our care and support planned?	5 – Very Good

How well do we support people's wellbeing

4.2 The Care Inspectorate found significant strengths in all areas being inspected.

4.3 During the inspection, 52 people told the Care Inspectorate they were very happy or happy with the care they were receiving from Care at Home Service.

4.4 The service was found to be well prepared for appropriate actions in the event of adverse weather or other emergency situations.

4.5 It was found that administration of medication is supported in a flexible way, allowing service users the opportunity to maintain choice and control over how they are supported with their medication.

How good is our leadership

4.6 The service was found to have an experienced and dedicated leadership team, with staff stating they found the management structure supportive, whilst being able to provide help and guidance where required.

4.7 The service was commended for having several projects ongoing, looking at innovative solutions to the difficulties facing the care sector and improving peoples' outcomes.

How good is our staff team

4.8 The service was praised for role and function with a clear pathway for training and development. The Care Inspectorate commented on the high standard of training being delivered, especially around medication management and the bespoke training provided for individual packages of care.

4.9 It was noted during the inspection that supervisions were being used effectively to support staff development and identify their learning needs.

How well is our care and support planned

4.10 The care plans were recognised as being written in a person-centred manner, which allowed the service to try and fulfil the persons wishes and preferences whilst balancing these out with any potential risks.

4.11 There was clear evidence of regular reviews, evaluations and changes being made to care plans, to ensure they stayed relevant to the person's needs.

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"

Performance management reporting is a legislative requirement under Section 42 of the Public Bodies (Joint Working) (Scotland) Act 2014. In addition to publishing an Annual Performance Report, the Moray

Integration Scheme requires that the MIJB will "monitor the performance of the delivery of integrated services using the Strategic Plan on an ongoing basis" (para 5.2.2 of the Moray Integration Scheme refers).

(b) Policy and Legal
None directly associated with this report.

(c) Financial implications
None directly associated with this report.

(d) Risk Implications and Mitigation
There are no risk issues arising directly from this report. The long-term impact of the COVID-19 on the Health and Social Care system are still unknown and any service evaluation will remain flexible to enable the service to be prepared and react to any future developments.

(e) Staffing Implications
None directly associated with this report.

(f) Property
None directly associated with this report.

(g) Equalities/Socio Economic Impact
An Equality Impact Assessment is not required for the Care Inspectorate Inspection report because there will be no impact, as a result of the report, on people with protected characteristics.

(h) Climate Change and Biodiversity Impacts
No climate change or biodiversity implications have been determined for this policy/activity. It should be noted that extreme weather events, such as the recent storms, are expected to occur more frequently and with greater ferocity in future years. In the longer-term there are likely to be issues with the reduction in availability and increases in costs of fossil fuels that will pose challenges for the delivery of care services to people living in rural areas.

(i) Directions
There are no directions arising from this report.

(j) Consultations
The following have been consulted in the development of this report:

Senior Management Team, Operational Management Team HSCM, Finance and Human Resources.

6. CONCLUSION

6.1 This report provides the Committee with a summary of the recent inspection of the Moray Council Care at Home Service by the Care Inspectorate. Good progress was shown in addressing previous areas for improvement and this report outlines the hard work and dedication of our teams resulting in a positive inspection

Author of Report: Joan Hall Team Manager, Care at Home
Aylsa Kennedy, Performance Officer

Background Papers: Available on request
Ref:

Home Care Service - Care at Home Support Service

Home Care -Care at Home
Council Headquarters
High Street
Elgin
IV30 1BX

Telephone: 01343 563 928

Type of inspection:
Unannounced

Completed on:
21 November 2023

Service provided by:
The Moray Council

Service provider number:
SP2003001892

Service no:
CS2004085958

About the service

Home Care Service - Care at Home is provided by Moray Council. It covers the whole of Moray and the office is based in Elgin.

The service aims to support and enable people to live independently within their own homes, for as long as they are able and it is safe to do so.

About the inspection

This was an unannounced inspection which took place on 9, 10, 13, 14 and 15 November 2023. The inspection was carried out by three inspectors from the Care Inspectorate.

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

In making our evaluations of the service we:

- spoke with 21 people using the service and 34 of their family/friends/representatives
- spoke with 116 staff and management
- observed practice and daily life
- reviewed documents.

Key messages

- Most people were very happy or happy with their standard of care. They told us their carers mostly turned up on time and had enough time to meet their needs.
- People told us they were treated with respect and dignity.
- People had confidence in their care staff because they were knowledgeable, competent and skilled.
- The service had a very good dedicated and experienced management team who worked hard to improve the quality of care.

From this inspection we evaluated this service as:

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

How well do we support people's wellbeing?	5 - Very Good
How good is our leadership?	5 - Very Good
How good is our staff team?	5 - Very Good
How well is our care and support planned?	5 - Very Good

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

How well do we support people's wellbeing? 5 - Very Good

We found significant strengths in the care provided and how these supported positive outcomes for people, therefore we evaluated this key question as very good.

We found the service had significant strengths. Fifty-two people told us they were very happy or happy with their standard of care. Most people felt staff turned up on time and had enough time to meet their needs. They felt the staff were respectful and attentive and knew how to provide their care according to their preferences. People expressed having confidence in the service. People told us:

- 'We are very lucky as a family for the care our (relative) receives from all the carers that come into (our relative's) home - each and every one of them are very special individuals, very attentive and very hard working and we don't know what we would do without them - they are all one in a million.'

- 'The care my (relative) receives is 5*. The care team are very special people with hearts of gold.'

- One service user described the staff as, 'guardian angels.'

- 'Excellent standard of care received.'

- 'The support my (relative) receives from the team is invaluable as it enables (them) to continue living in (their) own home. The home carers are professional, patient, sensitive to (my relative's) needs and are extremely kind.'

- 'Nae complaints. They're all good.'

- 'They (carers) are all very nice, they can't do enough for you.'

Occasionally, people described challenges with their care and we found the service was very good at working with people to find solutions, where this was possible. For example, changing the times of care, how the care was delivered and/or increasing staff knowledge and training. However, sometimes the solution was not within the power of the service to give. Additionally, sometimes the service found upon investigation that they had made a mistake. On the rare occasion this happened, they apologised and put proactive measures in place to prevent it happening again. This was very good practice and gave people confidence that they could raise issues and complain and action would be taken. We did pass on anonymised feedback to the service for the small number of issues people raised when speaking with us and the manager agreed to follow these up.

The service had good contingency measures they could action quickly during inclement weather or infectious outbreaks. This meant the service was able to meet people's needs and keep people safe during challenging times. One service user told us during a recent storm when the roads to their house were closed, the carers still managed to reach them on foot and they were very relieved and pleased to see them.

Medication was well-managed, administered according to the prescribers' guidelines and people's preferences. Staff were good at quality assuring their own work by noticing any discrepancies on the medication administration record (MAR), for example, a missed signature and then taking the necessary actions to ensure people were given their medication as prescribed. This helped to keep people safe as any

potential missed doses of medication were recognised early on and medical advice sought as to the next steps. It also promoted people's health and wellbeing.

We found the service was flexible and creative in the way it supported people to take their medication in the way that was right for them. It carefully balanced people's rights versus the risks, which gave people more control and choice over how they were supported with their medication.

Staff were very good at recognising and reporting potential adult support and protection (ASP) matters, which helped to keep people safe. We could see that the service ensured all of these referrals were followed-up and concluded according to ASP guidelines. It is important, however, that the service remembers to inform the Care Inspectorate of all ASP matters. The service agreed to do this from now on. As there was no impact on people's experiences or outcomes we decided not to raise it as an area for improvement.

How good is our leadership? 5 - Very Good

We found significant strengths in aspects of the care provided and how these supported positive outcomes for people, therefore we evaluated this key question as very good.

The service had an experienced and dedicated leadership team who fully understood the care at home model and the challenges facing the sector. Their value base drove their decision making and ensured all areas for improvement kept the needs and wellbeing of people at the centre. This resulted in very good outcomes for people. For example, they managed to reintroduce a comprehensive induction programme for new staff, which equipped staff with the knowledge and expertise they required to provide very good quality care. People told us that sometimes they had different carers, but this did not bother them because every carer who attended to their needs had the knowledge and professionalism to know how to care for them well. This is particularly important because of the recruitment challenges currently facing the care sector.

They had well-established governance arrangements in place for the day-to-day functions of the service and these had improved expected standards of performance in a reliable and sustainable way. These fed into their improvement plan and the leaders were well aware of their strengths and areas that required further development. This allowed them to focus their resources on priority areas. There were several projects undergoing consideration which could provide innovative and creative solutions to the difficulties facing the care sector and improve people's outcomes. We look forward to following these up at the next inspection.

On the whole feedback from staff regarding their management team was very positive. Eighty-eight staff described a supportive management structure, with line managers listening to their views, supporting their training and development and providing help and guidance when required. However, 20 staff raised issues about a lack of communication and support from their direct line manager. These views (which were anonymous) were fed back to the senior management team who agreed to investigate.

How good is our staff team? 5 - Very Good

We found significant strengths in aspects of the care provided and how these supported positive outcomes for people, therefore we evaluated this key question as very good.

Each job role had a clear structure for learning and training pathway attached to it. This ensured staff had the knowledge and skills to do their job well. The service was very good at evaluating and assessing staff's

knowledge and competency and taking action to address any shortfalls. From the staff surveys it was clear to see that the newer staff who had the more thorough two-week induction felt better prepared and more confident than some of their colleagues who had a shorter induction. The management team were aware of this and were in the process of identifying what additional training was now required for those staff, so that any gaps in knowledge would be addressed. This will support the staff to provide good quality care.

There was clear focus on staff values and the Scottish Social Services Council (SSSC) Code of conduct. This promoted more person-centred care and professional practice, with 53 service users and relatives who responded to us feeling that they were treated with respect and dignity by a professional workforce.

Supervisions were being used effectively to support staff development and their learning needs. Where it was identified that staff needed additional training and support this was provided and followed up by reviewing staff practice via the quality assurance system, for example, spot checks and observations of practice. This ensured that learning was put into practice, which promoted good outcomes for people.

When required we could see that additional person specific training was put in place which helped staff understand people's unique needs and how best to meet them. This was done as part of a multi-disciplinary team and was regularly evaluated with additional oversight and clear reporting procedures so that staff could seek more guidance if required. This resulted in good outcomes for people. For example, reducing someone's stress and distress or managing someone's medical condition well, thereby enabling them to remain in their own home.

How well is our care and support planned? 5 - Very Good

We found significant strengths in aspects of the care provided and how these supported positive outcomes for people, therefore we evaluated this key question as very good.

The service had recently redeveloped the care plan format and this seemed to be working well. Each care plan had a short person-centred section at the beginning which helped the reader get to know and understand the person before detailing their needs and preferences. The care plan had many sections and it was being used smartly and proportionately, so that only the sections that applied to the person were completed. We could see the care plans were written in a person-centred manner which ensured people's wishes and preferences were paramount. We saw some very good work whereby the service had supported people to uphold their rights by balancing people's wishes versus the potential risks.

The plans were regularly reviewed, evaluated and updated, which meant they stayed relevant to people's current needs.

Staff told us they could easily access the care plans and that they used them to direct how they supported people. This ensured people's care was consistent and delivered the same way regardless of which carer was available.

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

Areas for improvement

Previous area for improvement 1

The provider should review the service agreement for people who use the care at home service and explain what further assessments may take place should their needs change. This should include informing people and their representative this may result in a change of service provision and reasons provided for this. When there are changes to the service provision, the service agreement should be updated.

This is in order to comply with: Health and Social Care Standard 4.11: I experience high quality care and support based on relevant evidence, guidance and best practice.

This area for improvement was made on 13 October 2022.

Action taken since then

The provider had reviewed the support plan, risk assessment and review documentation which included the service agreement. We found that when there were changes to service provision the support plan had been updated to reflect this.

This area for improvement has been met.

Previous area for improvement 2

The provider should ensure that when the care at home service is not being provided for any reason as per the service agreement and plan of care, a risk assessment is undertaken. This should include consideration of the person's health, well being and associated risks of the service not being provided. It should also take account of a person's carer's needs. The risk assessment should be evident to escalate a person's situation to the lead agency for further action and ensure there is a follow up process in place.

This is in order to comply with: Health and Social Care Standard 4.11: I experience high quality care and support based on relevant evidence, guidance and best practice.

This area for improvement was made on 13 October 2022.

Action taken since then

From the sample of care plans we analysed we found the provider had undertaken risk assessments which included what should happen in the event that care could not be provided. Likewise, it also considered the risk to the supported person. There was a process in place to escalate unmet needs to the lead agency, usually the care manager.

This area for improvement has been met.

Previous area for improvement 3

To ensure people experience stability in their care and support from people who know their needs, choices and wishes, even if there are changes in the service or organisation, the service should:

- Progress their plans to change the way rotas are allocated.

- Move to smaller teams.

- Progress the personal outcomes based approach as soon as possible to improve stability and consistency in people's care and support.

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS) which state that:

'People know who provides their care and support on a day to day basis and what they are expected to do' (HSCS 3.11); and

'It is important that people can build a trusting relationship with the person supporting and caring for them in a way that they both feel comfortable with' (HSCS 3.8).

This area for improvement was made on 2 July 2020.

Action taken since then

The service had made progress towards meeting this area for improvement (AFI) and therefore we have assessed it as met. Albeit, since the AFI was made there have been significant challenges in the care sector making some of the improvements difficult due to the shortage of care staff. There has been progress made towards a personal outcomes approach and people's outcomes were being measured. The service was undergoing further improvement work which included using a specific outcomes measuring tool. We look forward to seeing this in practice. However, the move to smaller teams was not possible due to staff shortages.

This area for improvement has been met.

Previous area for improvement 4

In order to ensure people's physical, emotional, social and psychological needs are being met and staff know what they are expected to do, for example in people's skin or pressure area care, the provider should:

- Review the title and layout of their 'service delivery plan' to ensure the plan sets out how people's care needs will be met.

- Review the process and regularly audit people's care plans to ensure care planning informs all aspects of current and support experienced by people.

- Include feedback about the results to staff to support continuous improvement.

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS) which state that:

'Any treatment of intervention that I experience is safe and effective' (HSCS 1.24); and

'My personal plan is right for me because it sets out how my needs will be met as well as my wishes and choices' (HSCS 1.15).

This area for improvement was made on 2 July 2020.

Action taken since then

Care plans had been fully redeveloped and now included how people's care needs were to be met. People's care plans were audited and found, on the whole, to be of a very good standard.

This area for improvement has been met.

Previous area for improvement 5

To ensure people can be confident that their medication was administered safely and their wellbeing promoted, the service should:

- Introduce body maps for recording the use of topical medications.

- Following administration of people's 'as and when' medications, evaluation of the effect should be undertaken and recorded.

- Increase the numbers of audits of completed Medicine Administration Record (MAR) in light of the multiple MAR sheets in use.

- Complete the review of the Health and Social Care Moray Medication Management Guidelines within the timescale advised by the service.

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS) which state that:

'I experience high quality care and support based on relevant evidence, guidance and best practice' (HSCS 4.3).

This area for improvement was made on 2 July 2020.

Action taken since then

Medication practice had been reviewed and included topical body maps, as well as a clear process for administering, 'as and when required' medication.

This area for improvement has been met.

Previous area for improvement 6

The service should seek guidance and support from local health professionals about the potential to record all pressure-relieving device pump settings in people's care plans. This will enable the care workers to check the setting as part of people's care and support and therefore reduce the risk of an incorrect setting which can put a person at risk of pressure damage.

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS) which state that:

'Any treatment of intervention that I experience is safe and effective' (HSCS 1.24).

This area for improvement was made on 12 February 2020.

Action taken since then

People's care plans included all pressure relieving device settings and care staff were aware that they needed to check the pump settings during their visits.

This area for improvement has been met.

Complaints

Please see Care Inspectorate website (www.careinspectorate.com) for details of complaints about the service which have been upheld.

Detailed evaluations

How well do we support people's wellbeing?	5 - Very Good
1.1 People experience compassion, dignity and respect	5 - Very Good
1.2 People get the most out of life	5 - Very Good
1.3 People's health and wellbeing benefits from their care and support	5 - Very Good

How good is our leadership?	5 - Very Good
2.2 Quality assurance and improvement is led well	5 - Very Good

How good is our staff team?	5 - Very Good
3.2 Staff have the right knowledge, competence and development to care for and support people	5 - Very Good

How well is our care and support planned?	5 - Very Good
5.1 Assessment and personal planning reflects people's outcomes and wishes	5 - Very Good

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REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 28 MARCH 2024**

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

BY: **CHIEF NURSE, MORAY**

1. REASON FOR REPORT

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

2. RECOMMENDATION

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

3. BACKGROUND

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

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

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

3.4 A refresh of the Terms of Reference for the HSCM CCG Group was undertaken in 2023 and reported to this Committee on 30 November 2023 (para 6 of the minute refers).

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

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

3.7 The CCG Group met three times during this reporting period.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

Audit, Guidelines, Reviews and Reports

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

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

Areas of achievement / Good Practice

Out of Hours Community Nursing (covering Aberdeenshire and Moray)

4.2 This service is continuing to work well, with positive feedback from staff Tupe'd over to NHS Grampian. It was agreed between the operational/nursing leads and the Chief Nurses for Moray and Shire that GMED would take over the line management and day to day running of the service from 5 February 2024. This is a welcome development by the GMED team.

GMED

4.3 Advanced Nurse Practitioner Education Sessions are being opened up to all clinical staff – these sessions take the form of case based discussions and evaluation suggests that embedding these sessions into what GMED can offer to less experienced members of the clinical team would be a valuable development.

4.4 The team conducted a test of change to pause re-triaging calls from NHS 24, this produced mixed results but the decision has been made to not continue this process. Home visits will still be re-triaged if needed and a hybrid model may be adopted during periods of high demand and poor staffing. This is to enable the team to be responsive and dynamic to situations as they arise.

4.5 Regular huddles have commenced with GMED staff from all locations meeting via MS teams. This is good for improving communication, building relationships and identifying any areas that may require support.

4.6 A review of the Controlled Drug (CD) policy and daily checking of CD's has enabled efficient investigation of Adverse Events when they arise.

Vaccinations

4.7 Uptake rates for COVID-19 and Influenza Vaccinations as at 14 March 2024.

COVID-19			
Cohort	Population	Vaccinated	% Uptake
Age 65 to 74	11,281	8,686	77.0%
Aged 75+	10,051	8,431	83.9%
All social care workers	2,101	305	14.5%
At risk age 5 to 11	506	37	7.3%
At risk age 6 months to 4 years	103	14	13.6%
At risk age 12 to 64	11,771	4,219	35.8%
Frontline health care workers	1,088	329	30.2%
Older people care home residents	456	410	89.9%
Weakened immune system	1,998	1,185	59.3%
Total	39,335	23,612	60.0%

Influenza			
Cohort	Population	Vaccinated	% Uptake
Age 50 to 64	14,050	6,057	43.1%
Age 65 to 74	11,281	8,700	77.1%
Aged 75+	10,051	8,444	84.0%
All health care workers	958	237	24.7%
All social care workers	1,407	185	13.1%
At risk age 18 to 64	13,301	5,885	44.2%
Older people care home residents	456	415	91.0%
Weakened immune system	1,966	1,256	63.9%
Total	53,448	31,175	58.3%

4.8 It has been well publicised the impact of coronavirus, but the impact of flu is often underestimated. Even healthy people can become seriously ill from flu, as it can lead to complications that may result in hospitalisation or even death. During 2023, hospital admissions to Dr Gray's Hospital for influenza and pneumonia accounted for the highest number of 'potentially preventable admissions' - i.e., emergency admissions resulting from medical problems that may be avoidable with, for example, higher levels of vaccine uptake. This year's flu vaccine gives the best possible protection against the flu viruses likely to be circulating this season.

4.9 NHS Inform provides information on who is eligible and how to access vaccines. The Winter vaccine programme lasts until 31 March 2024.

Autism Diagnostic Assessment Pathway Team (ADAPT)

4.10 An update is awaited from NHS Grampian on the move to a Grampian Neurodevelopmental Pathway. The ADAPT, while depleted, continue to work through the referral list and provide diagnostic service to children. The Committee will be kept appraised of the situation as developments become available.

Clinical Risk Management (CRM)

4.11 The CRM group continues to 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.

4.12 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 and shared following adverse events and complaints.

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

Complaints and Feedback

4.14 HSCM complaints information for Quarter 3, 2023/24 is included in a separate report on today's agenda.

4.15 The HSCM CCG Group have noted a number of complaints recorded on Datix during Quarter 3 could have been resolved at early resolution stage but the current stage is investigation. Early resolution is where complaints are straightforward, require little or no investigation and are resolved at the point of contact at the earliest opportunity, usually within 5 working days. Achieving early resolution, where appropriate, helps reduce the number of stage 2 complaints and is really helpful for patients and families, preventing anxiety and upset if they can be given a quick response rather than waiting for a complaint investigation outcome. This will be discussed further at the CRM meeting to understand why it is not always possible for suitable complaints to be resolved at stage 1 and support teams with this approach.

Adverse Events (AE)

4.16 Information about AE reported on Datix during Quarter 3, 2023/24 is available at **APPENDIX 1**.

Findings and Lessons Learned from incidents and reviews

4.17 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.

4.18 There are currently 4 Level 1 reviews in progress (at the time of reporting).

4.19 Key learnings during this reporting period, have been discussed at team meetings and the CRM, and on 1 occasion escalated to the Vaccination Governance Group for Grampian wide Learning.

HSCM Risk Register

4.20 Each Clinical Service Group/Department highlights risks associated with their service, which are then discussed at CRM. The risk register is routinely reviewed with leads with guidance and support provided regarding updates. Work is ongoing to review and improve this process and this will be discussed at OMT every month.

4.21 New risks identified on Datix are discussed at CRM. There is an ongoing review of the operational risk registers. At the time of reporting, there are 37 risks on the risk register, 2 of which have been added since November 2023. These are monitored and reviewed as appropriate, by the service managers.

Duty of Candour

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

Items for escalation to the Clinical and Care Governance Committee

General Practice

4.23 Following the presentation of a 3 minute brief to HSCM CCG Group in December 2023, by the Moray Primary Care Clinical Leads, which detailed findings from visits to GP Practices across Moray, the Group requested the pressures found in general practice be escalated to Committee. There is a separate report on today's agenda.

Moray Integrated Drug and Alcohol Service (MIDAS)

4.24 Due to the lack of suitable clinical space in the building that this team operates from, there remains ongoing issues which impact the service's ability to meet Medically Assisted Treatment (MAT) standards 4, 6, 9 and 10. These standards relate to harm reduction and psychological and mental health care. As part of the financial recovery plan HSCM, with NHS Grampian, is considering its full estate and the requirements of the services and their priorities.

5. SUMMARY OF IMPLICATIONS

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

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

(b) Policy and Legal

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

(c) Financial implications

None directly associated with this report.

(d) Risk Implications and Mitigation

There are systems and processes in place across service areas to support clinical governance, providing assurance to the HSCM Senior Leadership Team and to the CCG 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 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
- Caroline O'Connor, Committee Services Officer, Moray Council
- Fiona Robertson, Interim Chief Nurse Moray
- Service Managers, Drug & Alcohol, GMED

6. CONCLUSION

6.1 The HSCM CCG 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 this Committee that there are effective systems in place to reassure, challenge and share learning.

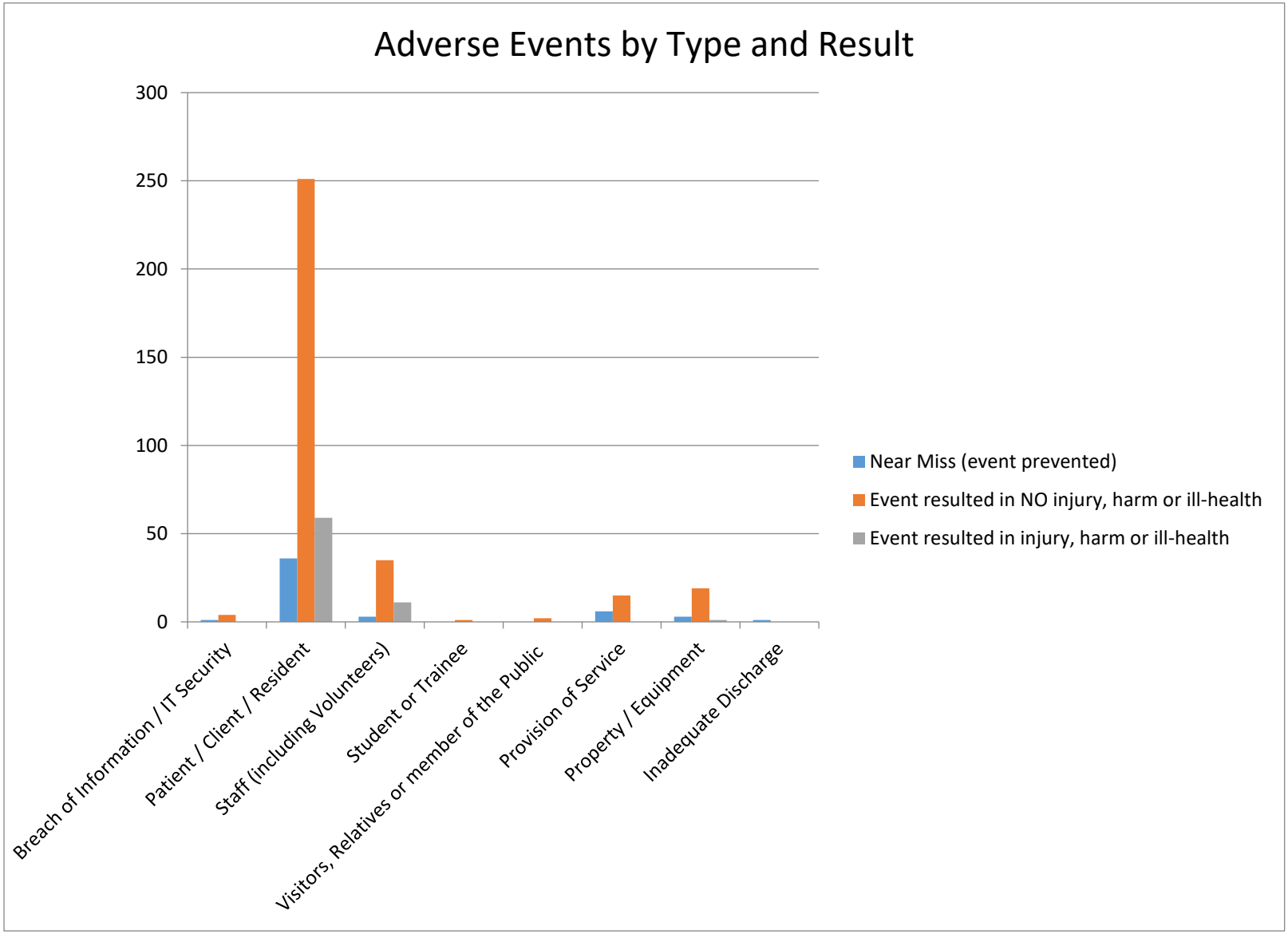
Author of Report: Isla Whyte, Interim Support Manager, HSCM Background Papers: with author

Ref:

Adverse Events by Category and Level of Review Reported on Datix (Quarter 3, 2023/24)

	Level 3 - local review by line manager in discussion with staff	Level 2 - local management team review	Level 1 - significant adverse event analysis and review	Total
Abusive, violent, disruptive or self-harming behaviour	184	2	0	186
Access, Appointment, Admission, Transfer, Discharge (Including Absconders)	15	0	0	15
Accident (Including Falls, Exposure to Blood/Body Fluids, Asbestos, Heat, Radiation, Needlesticks or other hazards)	97	2	1	100
Clinical Assessment (Investigations, Images and Lab Tests)	5	1	0	6
Consent, Confidentiality or Communication	10	1	0	11
Fire	7	0	0	7
Implementation of care or ongoing monitoring/review (inc. pressure ulcers)	5	1	0	6
Infrastructure or resources (Staffing, Facilities, Environment, Lifts)	11	0	0	11
Medical device/equipment	3	0	0	3
Medication	40	0	0	40
Other - please specify in description	34	2	0	36
Patient Information (Records, Documents, Test Results, Scans)	4	0	0	4
Security (no longer contains fire)	6	0	0	6
Treatment, Procedure (Incl. Operations or Blood Transfusions etc.)	2	0	0	2
Total	423	9	1	433

Adverse Events by Type and Result Reported on Datix (Quarter 3, 2023/24)



Adverse Events by Service and Level of Review Reported on Datix (Quarter 3, 2023/24)

	Level 3 - local review by line manager in discussion with staff	Level 2 - local management team review	Level 1 - significant adverse event analysis and review	Total
Allied Health Professionals	14	0	0	14
Community Hospital Nursing	77	1	0	78
Community Nursing	16	1	1	18
Community Pharmacy	3	0	0	3
Community Therapy Services	1	0	0	1
General Practice	3	0	0	3
GMED	19	0	0	19
Mental Health - Adult Mental Health	115	2	0	117
Mental Health - Learning Disabilities	2	0	0	2
Mental Health - Old Age Psychiatry	132	0	0	132
Mental Health - Specialisms	8	2	0	10
Out of Hours (Excluding GMED)	0	1	0	1
Primary Care	5	1	0	6
Public Dental Service	9	0	0	9
Vaccination Transformation Programme	20	1	0	21
Total	424	9	1	434

Adverse Events by Type and Severity Reported on Datix (Quarter 3, 2023/24)

	NEGLIGIBLE: Negligible/no injury or illness, negligible/no disruption to service, negligible/no financial loss	MINOR: Minor injury or illness, short term disruption to service, minor financial loss	MODERATE: Significant injury, externally reportable e.g. RIDDOR, some disruption to service, significant financial loss	Total
Breach of Information / IT Security	5	0	0	5
Patient / Client / Resident	296	43	7	346
Staff (including Volunteers)	40	8	1	49
Student or Trainee	1	0	0	1
Visitors, Relatives or member of the Public	2	0	0	2
Provision of Service	21	0	0	21
Property / Equipment	22	1	0	23
Inadequate Discharge	1	0	0	1
Total	388	52	8	448

All adverse events by result by Quarter on Datix

	2021/22 Quarter 2	2021/22 Quarter 3	2021/22 Quarter 4	2022.23 Quarter 1	2022/23 Quarter 2	2022/23 Quarter 3	2022/23 Quarter 4	2023/24 Quarter 1	2023/24 Quarter 2	**2023/24 Quarter 3**
Occurrence with NO injury, harm or ill-health	239	271	189	218	214	283	200	210	270	327
Occurrence resulting in injury, harm or ill-health	61	87	79	89	98	78	60	73	76	71
Near Miss (occurrence prevented)	37	25	31	29	40	38	20	22	26	50
Property damage or loss	0	0	0	0	0	0	0	0	0	0
Death	0	1	0	0	0	0	0	0	0	0
Total	**337**	**383**	**299**	**336**	**352**	**349**	**280**	**305**	**372**	**448**

Adverse Events by Severity Reported by Quarter on Datix

	2021/22 Quarter 2	2021/22 Quarter 3	2021/22 Quarter 4	2022/23 Quarter 1	2022/23 Quarter 2	2022/23 Quarter 3	2022/23 Quarter 4	2023/24 Quarter 1	2023/24 Quarter 2	**2023/24 Quarter 3**
Negligible	281	308	231	259	264	283	226	240	305	388
Minor	48	72	64	70	78	60	48	58	61	52
Moderate	8	2	2	4	8	5	6	5	6	8
Major	0	0	2	1	2	0	0	1	0	0
Extreme	0	1	0	2	0	1	0	1	0	0
Total	**337**	**383**	**299**	**336**	**352**	**349**	**280**	**305**	**372**	**448**

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 28 MARCH 2024**

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

BY: **CONSULTANT PRACTITIONER, ADULT SUPPORT AND PROTECTION LEAD 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 July 2023.

1.2 To provide further update to the Committee on the Care Inspectorate's Phase 2 of Adult Support and Protection Inspection Activity across Scotland.

2. RECOMMENDATION

2.1 It is recommended the 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;

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

iv) that further updates 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 (**Appendix 1**) 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 multi-agency plan 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.

3.4 The Care Inspectorate have commenced Phase 2 of the Adult Support and Protection Activity. This Activity will include follow up Inspection of the Partnerships inspected in 2018/2019 and further assurance and follow up of the Partnerships in which weaknesses outweighed strengths – this includes Moray.

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 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 and take positive steps to Inspection readiness.

4.4 The Improvement and Planning sub group of the Moray Adult Protection Committee meet every 10 weeks. This group is multi-agency and has been formed to discuss progression and allocation of tasks and will have full oversight of the improvement plan ensuring all stakeholders are involved and consulted on progress and actions. The plan will then be presented to the Adult Protection Committee at each meet.

4.5 In the coming months, the Improvement and Planning sub group will now look to fully revise and update the Multi-Agency Improvement Plan for the year 2024-2026 following consultation activities across the Partnership. The revised Multi-Agency Improvement Plan will be presented in draft to June 2024 Adult Protection Committee.

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.

4.8 The correspondence from the Care Inspectorate has been discussed at Moray Adult Protection Committee. It is unlikely that a full Joint Inspection will be undertaken from the information available and will most likely by an assurance activity linked to areas of weakness from the last Inspection.

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 and to ensure inspection readiness.

(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 Committee that there are effective processes in place to monitor and progress actions in the plan.

Author of Report: Vicki Low, Consultant Practitioner, Adult Support and Protection Lead Officer – HSCM
Background Papers: with author
Ref:

Moray ASP Improvement Action Plan 2022-24

Report Type: Actions Report
Generated on: 25 January 2024

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- 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.
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- Strategic leaders should strengthen governance of adult support and protection practice. There should be robust measures in place to identify concerns early and promptly implement remedial action.
- Strategic leaders should continue to develop multi-agency self-evaluation activities. Frontline staff should be fully involved in the design, implementation and consequent improvement work.

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

1. Lived Experience (PRIORITY)

Code	Action Title	Agency	Due Date	Latest Status Update	Status Progress	Status Icon	Assigned To
ASP SIP Cat1.1	Review commissioned advocacy service to ensure formal advocacy services are as accessible as possible for people involved in ASP process	**AGENCY**: Local Authority **CARE INSPECTORATE PRIORITIES**: 4, 5, 6	31-Mar-2024	New contract not awarded. Existing Contract extended for one year. Presently, Advocacy Services - existing Circles contract extended for one year. ASP are part of the group taking new advocacy contract forward.	80%		
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. Plan and questionnaires have both been updated following feedback and consultation. (7.11.23)	100%		Advocacy Representative; Elaine MacDonald
ASP SIP Cat1.3	Review of the ASP Case Conference process to ensure involvement of the adult. This will include engagement with individuals, as well as front line practitioners.	**AGENCY:** Local Authority **CARE INSPECTORATE PRIORITIES**: 4, 6	31-Oct-2023	Feedback from Social Work Teams progressing in relation to involvement of the Adult. Feedback from partners requested. Continued engagement with individuals subject to process. Moray will also be contributing to Kate Fennels PHD research in relation to Participation in Case Conferences. November 2023 - Review completed. New format in place for ASPCCs and will be rolled out for reviews from January 2024. New documentation has been developed to ensure the adult's views	100%		Elaine MacDonald ; Sammy Robertson

				are formally represented and feedback about their experience is collated at the beginning and end of the ASP process.			

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	29-Feb-2024	Due to absence this has not progressed. Due date moved to be more realistic.	50%		Vicki Low
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	29-Feb-2024	January 2024 - Still to be actioned. Due date changed to reflect this.	0%		Elaine MacDonald ; 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, 2, 3, 4, 5, 6	31-Jul-2022	Next IRD audit to take place Summer 2023 Case Conference Audit activity to take place on a multi-agency basis – date to be arranged	100%		
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-Jan-2024	Update – Multi-Agency audit undertaken. Report to be written and recommendations cascaded. Recommendations to be written into improvement plan as required.	80%		Vicki Low; Elaine MacDonald ; Kenny O'Brien; Sammy Robertson
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	100%		Vicki Low; Elaine MacDonald ; Sammy Robertson

				Multi-Agency Case Conference Assurance Audit Tool written – Initial audit took place 03.11.23 and regular sessions to be set up for 2024.			
ASP SIP Cat2.9	Council Officer feedback document requested to be completed following investigation to provide feedback of experience and to inform further training and development, as well as improvement activity. feedback to be reviewed August 2023	**Multi-Agency Care Inspectorate Priorities:** 1, 2, 3, 4, 5, 6	July 2024	January 2024 – Insufficient responses from Council Officers to provide proper analysis of information. Extending period of information gathering until end June 2024.	80%		Elaine MacDonald

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	This action has now been completed – every client documents now has link to Adult Protection Drive Files – access to all Adult Social Work and Out of hours	100%		Samantha Wiseman
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
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;
ASP SIP Cat3.5	Procedure in place for use of events/activities in relation to Adult Support and Protection activity on CF	**AGENCY:** Local Authority **CARE INSPECTORATE PRIORITY**: 1, 2, 3, 4, 5,	31-Dec-2022	Audit required of CF system on a monthly basis – to take place March 2023.	100%		Vicki Low;

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	Update- due to work absence this has been unable to progress. National Data Submissions have been submitted as well as quarterly reporting, however, work still to do on multi-agency data group. New end date to be established	30%		Vicki Low

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	Regular catch ups with Team Managers/AP's for RASPCCs – feedback indicates that this appears to be collaborative in approach and enables RASPCCs to have adequate oversight within teams. However, it is noted that Team Managers are not undertaking all Review Case Conferences, with the Consultant Practitioner Team continuing to undertaking a large portion, as well as continued admin support. This is no longer sustainable. Workshop to take place in October 2023 to support practice and skills in chairing of ASPCC. Admin Guide to be written to support transition Chairs Guide to be written to support transition 3MB written to OMT to request support	60%		Vicki Low
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,	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

		6					
ASP SIP Cat4.4	Core Group of front line practitioners formed to devise, design and implement Large Scale Investigation recording and investigation documentation on Carefirst. Attention required in relation to risk management and protection planning	**AGENCY:** Local Authority CARE INSPECTORATE PRIORITIES: 1, 3, 6	30-Nov-2022	Subgroups to commence August 2022. Due to LSI activity this activity has been completed by LSI lead Officers and will be reviewed alongside x8 council officers following current LSI to inform any changes to document Feedback meeting with practitioners took place and further small changes agreed as well as practitioner guidance produced and to use document moving forward with further review following each LSI activity undertaken **Assigned to:** Vicki Low	100%		Vicki Low; Sammy Robertson
ASP SIP Cat4.5	Full Review of the Decision Specific Capacity Tool to be undertaken on a multi-agency basis – with input from NHSG and Lead Agency council employed staff.	**AGENCY:** NHS Grampian CARE INSPECTORATE 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 now rolled out in Moray area. 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. MIVA report to be shared at APC 17.11.23	100%		Vicki Low; Elaine MacDonald
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	**Agency:** Multi-Agency CARE INSPECTORATE PRIORITIES: 1, 2,	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	100%		

	revised COPs and Local Guidance.	3, 4, 5, 6		March 2023, likely to go through governance groups April/May 2023			
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	First draft finalised. Preparing for initial consultation with Psychiatry; Psychology and GP governing bodies –then to take through governance for sign off.	80%		
ASP SIP Cat4.10	Review of Moray's Operational Guidance to be undertaken	**AGENCY:** Lead Agency	31-Dec-2023	Awaiting completion of Grampian procedure review prior to commencement - End date to be reviewed to allow for this	0%		Elaine MacDonald ; Sammy Robertson
ASP SIP Cat4.11	Adult Support and Protection Information Pack to be available for all individuals subject to intervention	**AGENCY:** Lead Agency	31-Dec-2023	ASP information pack now available and being used by practitioners. Practitioner feedback /material review to be undertaken. Discussion to take place with Kenny O'Brien regarding use of ASP video materials.	80%		Elaine MacDonald ; Sammy Robertson
ASP SIP Cat4.12	Implement ASP Flags/ Key Clinical Alerts on NHS Systems so that when an adult is formally classified as an 'adult at risk' under the terms of ASP legislation - NHS staff can see this.	**AGENCY:** NHS Grampian	31-Jul-2023	Fully in place up in Moray - with appropriate communication between NHSG and lead agency	100%		

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	ASP training now available on Eventbrite – to continue to monitor.	100%		Elaine MacDonald
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.	100%		Vicki Low;
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-2024	Updates provided at each APC National work continues within the National ASP Implementation Subgroup. This will feed into the work locally.	10%		Vicki Low
ASP SIP Cat5.5	Clear and up to date records of all Adult Support and Protection training undertaken - Module, 1, 2, 3 and 4 - including when Council Officer refresher training is required	**AGENCY:** Local Authority CARE INSPECTORATE PRIORITIES: 1, 5, 6	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-Agency basis by November 2023.	10%		Vicki Low
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-Dec-2023	Update due to work absence this has been delayed – end date to be amended.	50%		Vicki Low
ASP SIP Cat5.7	Develop Practitioner Guidance on Self-neglect and Hoarding	**AGENCY:** Local Authority CARE INSPECTORATE PRIORITIES: 1, 2, 3, 4,	31-Jul-2024	January 2024 - Suzy is currently developing this and we can provide an update at the next APC	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-2025	Trauma Informed post job description written and with HR – post requires grading panel. Post will sit with Service Manager – Lizette Van Zyl	50%		Vicki Low
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,	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	40%		

		3, 4, 5		highlight areas of improvements. Themes to be incorporated into Training Feedback to APC see action 5.16 **Assigned to**: Suzy Gentle			
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, 3, 4, 5	31-Aug-2024	Training framework signed off and in place. ASP Level 2 now mandatory for NHSG patient facing staff with a 3 year repeat built in. Courses being run. **Assigned to**: Kenny O'Brien	100%		
ASP SIP Cat5.11	For NHSG staff recording of ASP input and activity - revise ASP Level 2 Training to include specific section on Health records and ASP, good practice examples to be included.	**AGENCY:** NHS Grampian CARE INSPECTORATE 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	100%		

				Assigned to: Vicki Low and Elaine MacDonald for Social Work			
ASP SIP Cat5.16	Grampian Approach to Risk Assessment Training	**Multi-Agency Care Inspectorate Priorities 1, 2, 3,**	30-Jun-2023	The arrangements for this are shared between the three local authorities; Moray is allocated 2024.	100%		
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 feedback information to allow for further learning and development	**MULTI-AGENCY Care Inspectorate Priorities TBC**	30-Jun-2023	Completed.	100%		
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. Consideration in Moray as to whether a multi-agency ASP Decisions App would be of benefit.	**MULTI-AGENCY CARE INSPECTORATE PRIORITIES TBC**	31-Dec-2023	Due to sick leave this has been unable to progress.	5%		
ASP SIP Cat5.19	Awareness raising in Moray with local banks and financial institutions regarding the use of the S10 mandate. This will be carried out as a multi-agency.	**Multi-Agency**	31-Jan-2024	January 2024 – awaiting date for next FH Sub Group meeting.	0%		Elaine MacDonald ; Sammy Robertson
ASP SIP Cat5.20	IRD continuity sessions to be undertaken with Lead Agency Chairs. This will include development of a Chairs Checklist to support continuity as well as further discussion around ASP Thresholds	**Agency:** Lead Agency	31-Aug-2023	Completed.	100%		Elaine MacDonald ; Sammy Robertson

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 (renamed Multi-Agency Training) in Adult support and protection	**MULTI AGENCY** CARE INSPECTORATE PRIORITIES: 1,2, 3, 4, 5	31-Dec-2023	Training designed and rolled out – Involvement in Adult Support and Protection– this is multi-agency training for practitioners who may be involved in ASP Investigation and beyond. Training Report to be delivered. Report to be presented at APC 17.11.23	100%		
ASP SIP Cat6.3	ASP Live Event	**MULTI AGENCY** CARE INSPECTORATE PRIORITIES: 5, 6	31-Jan-2024	Theme – Grampian Procedures. November 2023 - Due date changed – awaiting updating of 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 INSPECTORATE PRIORITIES: 1, 2, 3, 4, 5, 6	30-Nov-2022	Council Officer Forums in place. Formally recorded and training materials to be available within SharePoint for CO viewing - TO be reviewed Nov-22 by consultation with CO's Council Officer Forum due in December **Assigned to**: Elaine MacDonald, Suzy Gentle	100%		
ASP SIP Cat7.2	Regular Team Manager 'catch up' meetings to take place to discuss adult support and protection practice within teams	**AGENCY:** Local Authority CARE INSPECTORATE 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;
ASP SIP Cat7.3	To provide ongoing mentoring and support for Social Work Council Officers undertaking ASP activity	**Agency:** Local Authority CARE INSPECTORATE	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	100%		

		PRIORITIES: 1, 2, 3, 4,		tasking documents in place. **Assigned to**: Elaine MacDonald			
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%		

Copy of 7. Quality Assurance and Audit

Code	Action Title	Agency	Due Date	Latest Status Update	Status Progress	Status Icon	Assigned To
ASP SIP Cat7.4	Copy of Multi-Agency IRD Summary Quality Assurance Audit to take place - review all IRDs from commencement	**MULTI AGENCY**	31-Jul-2022		100%		

Review across all patient facing areas that professional supervision is offered/available

Code	Action Title	Agency	Due Date	Latest Status Update	Status Progress	Status Icon	Assigned To
ASP SIP Cat7.4a	ASP is a clearly defined identified area for regular discussion (ensure this is capture on any NHSG police/procedure/guidance)		30-Sep-2022		100%		
ASP SIP Cat7.4b	Ensure specific ASP clinical/professional supervision is offered to staff who are actively working with adult protection cases	CARE INSPECTORATE 5, 6	30-Sep-2022		100%		

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 28 MARCH 2024**

SUBJECT: **LEARNING DISABILITY SERVICE DYNAMIC SUPPORT REGISTER**

BY: **INTEGRATED SERVICE MANAGER (INTERIM), COMMUNITY LEARNING DISABILITY SERVICE**

1. REASON FOR REPORT

1.1 To inform Committee of the requirements of the Scottish Government directive relating to the Coming Home Report, and of the actions and progress made by the Learning Disability Service in response to the directive. Assurance is also given that planning and development continues which will address future anticipated needs associated to the directive.

2. RECOMMENDATION

2.1 It is recommended that the Committee;

i) note the requirements of the Scottish Government in relation to the Coming Home Report and Dynamic Support Register and the actions taken by the Learning Disability Service to respond to the Scottish Government Directive as set out in paragraphs 4.1–4.6; and

ii) continue to support the housing projects that are to be utilised by adults with a Learning Disability which is integral to meeting the requirements of the register and which was previously agreed at the Moray Integration Joint Board (MIJB) on 30 March 2023 (para 12 of the minute refers).

3. BACKGROUND

3.1 The Scottish Government published the 'Coming Home Implementation Report' on 21 February 2022: https://www.gov.scot/publications/coming-home-implementation-report-working-group-complex-care-delayed-discharge. This report set out a new framework for adults with Learning Disabilities and complex support needs who are placed in unsuitable out of area placements, or who are inappropriately admitted to hospital, due to breakdown of their community-based support.

3.2 This framework aims to ensure that there is greater visibility for adults with a Learning Disability (LD), and expects that there will be development of specialist multi-disciplinary teams focused on tailoring the complex services required in the community. Furthermore, this should act as a driver for our local commissioning strategy and appropriate housing development.

3.3 On 15 May 2023, a memorandum of understanding was signed by both Maree Todd, Minister for Social Care and Paul Kelly, COSLA Health and Social Care Spokesperson, agreeing that all integration authorities will use a Dynamic Support Register to collate information about adults with a Learning Disability in hospital or inappropriately placed. This will act as a tool to improve local case management and to inform planning and provision. Each integration authority will report monitoring data from their Dynamic Support Registers using national reporting mechanisms.

3.4 The Dynamic Support Register has been provided by the Scottish Government as a standard template with the criteria for the red, amber and green categories clearly defined.

3.5 The Moray Integrated Learning Disability Team have collectively agreed which adults, in accordance with the criteria, should be entered on to the Dynamic Support Register, and a lead worker for each person has been identified. Each adult on the register has a detailed action plan outlining their support needs, and identifies the multi-disciplinary team around them supporting the plan. It also indicates what is being done to find appropriate accommodation or bring individuals ‘home’ to Moray.

3.6 Action plans are reviewed 2 or 4 weekly depending upon red or amber category, and the Practice Consultant in Complex and Challenging Behaviour supports this process where appropriate. Governance of the plans takes place at the Learning Disability Resource Allocation Meetings, with wider discussions, planning and agreement taking place at the Learning Disability Transformation Board, which is attended by the Chief Social Work Officer / Head of Service and representatives of all linked services including Provider Services. Updates on the register are regularly provided to our housing colleagues.

3.7 A local Integrated Complex Care Pathway setting out processes relating to the Dynamic Support register is currently under development and this will offer clear guidance, reinforcing the work that is already being done. A Complex Care Pathway for Moray will seek to achieve commitment from all professional health leads that allocation priority will be given to those people identified on the Dynamic Support Register as complex and high risk, where appropriate.

3.8 The need for suitable housing for people with a Learning Disability in Moray has been embedded in strategy and planning for many years. In 2013, The Moray Council adopted the then Moray Learning Disability Partnership Board, Commissioning and Delivery Plan 2013-2023 following approval by the Moray Council Health and Social Care Services Committee on 9 October 2013 (para 6 of the minute refers). This plan was updated and agreed by the MIJB on 28 January 2021 (para 8 of the minute refers) and again on 30 March 2023 (para 12 of the minute refers).

3.9 The development of housing for adults with a LD remains a continuous process, with recent housing projects completed including the Highland Way development in Buckie which opened in August 2021 and the Greenfield Circle development in Elgin which opened in March 2022.

3.10 A project currently in planning stages is the Woodview 2 Development which would be adjacent to the Woodview Housing Scheme and would offer a further 8 - 10 bungalow style houses. This is in Partnership with Grampian Housing who will be going to Tender for a building contractor within the next few weeks. It is estimated that the build would be completed and ready for people to move in approximately one year from the build start date.

3.11 The Woodview and Woodview 2 development are the most appropriate to accommodate those people on our Dynamic Support Register who have a Learning Disability and Autism and who exhibit significant levels of challenging behaviour. This new facility will prioritise those adults from out with Moray and from within Moray, where current housing arrangements are unsuitable.

3.12 The Moray Council Housing Service continues to source and negotiate the planning of further housing developments. The next focus on housing will be for adults who may be on the register but do not exhibit such extreme challenging behaviour.

3.13 Where there is no new and appropriate housing available, Adults on the Dynamic Support register can be supported to make an application for entry onto the Moray Council Housing Register and with independent housing associations. This wouldn't be the preferred route of rehousing as mainstream housing will generally not be designed with the required environmental specifications in line with individuals assessed needs. Standalone properties also cannot benefit from efficiencies that would otherwise be possible in core and cluster developments.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 Moray supports over 450 people with a Learning Disability. There are many reasons why people with a LD could find themselves in hospital, in inappropriate care settings or at risk of breakdown of care. The service has identified 21 people who live with parents where those parents are past retirement age. These parents are unable to maintain their role indefinitely and inevitably, care can break down should their health decline or they are no longer able to provide the care. The service maintains a register of people in this situation so it is possible to anticipate who will need future care and accommodation to try and avoid emergency scenarios. Other reasons can include an increase in frequency and severity of challenging behaviour or through not having the correct support in place.

4.2 The first data submission from the Dynamic Support Register to the Scottish Government has been made and the first publication released, available here, where page 8 makes reference to Moray: https://publichealthscotland.scot/media/23866/2023-11-28-insight_learningdisabilities_complex-needs-full-report.pdf

4.3 To give context to the report, whilst Moray ranks relatively highly on the graph which is an unfavourable place to be, the reality is that the number of people on the register in the red category remains low in number (less than 10). There are some individuals that the team are seeking accommodation and care for as a matter of urgency. For all on the register, the team are already undertaking review and planning for identified individuals' return to Moray, and for many this is in partnership with the provider services. Some of these people are identified for the Woodview 2 accommodation.

4.4 Those people who are in the amber category are mostly supported by one particular care provider who is under enhanced monitoring with Social Work and Commissioning working together to improve the quality of care.

4.5 There are 12 people in the green category who are appropriately placed out of area who do not wish to return to Moray.

4.6 In planning for the future, the Learning Disability Service and the 'Disability Pod' under Childrens Services are working closely together to aid planning for transitions and to avoid making out of area placements for children, where there would be a responsibility to return them to Moray once they are 18 if placed out of area as a child.

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 Dynamic Support register is a functional tool for the recording of high risk and complex individuals. The systems around the Learning Disability Service into which it feeds such as the Transformation Board, the Complex Care Pathway and the Housing Projects are consistent with the MIJB vision and values as set out in the strategic plan.

(b) Policy and Legal

The Scottish Government, 'Coming Home Implementation Report, 21 February 2022. This report sets out measures to prevent delayed discharge of people with a learning disability, to repatriate those living out with their home authority, to avoid unnecessary hospital admissions and requires each partnership area to create and maintain a dynamic register of those people who are most at risk. Data from the register is required to be reported back to the Scottish Government.

There can be legal implications relating to supporting adults to move out of hospital or into new accommodation. This is dependent on the adults' capacity as they will be required to sign a tenancy agreement. Should the adult not have capacity to do this, there is a legal process to apply for Guardianship which may be held privately or by the local authority. Intervention orders must also be sought should a guardianship already be in place.

(c) Financial implications

The dynamic support register focuses on the individuals who generally have high levels of need and are particularly complex. These individuals can require 24 hour 1-1 or 2-1 support within their home and local community, which may also have to be delivered by specialist services. There will be increased expenditure for this type of care provision and costs will be variable depending upon the exact hours of support required and the individual service providers' hourly rate.

If care breaks down as a result of ageing parents who are no longer able to support their adult children, there will be increased expenditure to the package of support they are already receiving. This will be due to having to provide the care and support that the parents would once provide.

Out of area placements are usually high cost, therefore it is anticipated that Health and Social Care Moray (HSCM) will see a reduction in costs to the support of those adults returning to Moray.

In order to ensure that these higher cost services can be funded within the current financial climate, transformational change within the service is planned, looking at alternative options for service delivery.

(d) Risk Implications and Mitigation

Addressing the needs of those on the dynamic support register relies upon:

- The responsiveness and capacity of the multi – disciplinary team to work together
- Houses in which to accommodate people
- Sourcing the right care provision.

There are risks with all of the above. The team has faced challenges with recruitment over the past 18 months, particularly within Psychiatry, Psychology and Social Work. The mitigation is that the dynamic support register is seen as a 'priority' and those individuals on the register should be allocated promptly to the relevant professionals and in line with a complex care pathway.

Whilst the learning disability housing projects have been underway for some time, housing specific to adults with a learning disability, where the team have nomination rights are few, and there is not enough housing to accommodate all on the register, and are at risk of care breaking down. The Woodview 2 build has been delayed and other projects are still under negotiation. There is a risk that hospital discharges will be delayed and HSCM cannot support people to return to Moray in the foreseeable future. The only mitigation here would be the continued use of out of area placements, however this does not align with the Scottish Government instruction, and would not be in the best interest for supported individuals.

There is a national recruitment crisis in care provision which Moray has been impacted by. Neither in-house Provider Services nor independent organisations have care hours readily available and whole staff teams need to be recruited to support individuals with a learning disability. This

is a lengthy process which can take 6 months or more. This may be acceptable where time is needed to undertake long term planning, or where the individual requires a slow transition however, the mitigating option when requiring care more quickly would be to fund a placement outside of Moray. There are rare occasions where a large care package may end and HSCM can take advantage of a staff team that's already available. Should this happen the care should be redirected to those identified on the dynamic support register given their recognised priority and will be in keeping with the Scottish Government directive.

(e) Staffing Implications

There are no staffing implications associated directly with the upkeep and management of the dynamic support register.

Individual staff teams will need to be recruited to support some of the individuals on the dynamic support register in accordance with their assessed needs.

(f) Property

There are no property implications. Housing will be owned by the Moray Council Housing or by a housing association. Individuals moving into those properties will be tenants.

(g) Equalities/Socio Economic Impact

No impact. No change in Policy. Entry onto the dynamic support register is determined by a set criteria and will be applicable to all adults with a learning disability.

(h) Climate Change and Biodiversity Impacts

There are no impacts directly related to the keeping of the Dynamic Support Register. Climate change and biodiversity impacts are considered and managed by the housing developers and builders as part of their own requirements.

(i) Directions

There are no directions associated with this report.

(j) Consultations

Simon Bokor-Ingram, Chief Officer
Tracy Stephen, Head of Service
John Campbell, Service Manager
Fiona Geddes, Housing Strategy Development Manager
Anna MacLeod, Learning Disability Team Manager (Social Work)
Karen Lennox, Learning Disability Team Manager (Health)
Rob Outram, Practice Consultant for complex and challenging needs.
Isla Whyte, Interim Support Manager

6. CONCLUSION

6.1 The Dynamic Support Register is a practical tool to record and manage adults who are highly complex. Whilst the multidisciplinary LD team are able to identify those who should be on the register, assess needs and provide Health and Social Work support, there is an inextricable link

between the team, In–House Provider Services and Moray Council Housing Services and it is imperative that services continue to work together to meet the needs of those individuals to achieve the desired outcomes set out by the Scottish Government.

6.2 The Housing model offered by the projects noted above offers the most sustainable and best value option for long term support.

6.3 HSCM Provider Services Staff Team based at Woodview is managed by the Practice Consultant in Complex and Challenging Needs, and this team have in the past been successful in recruiting and maintaining appropriate staffing with skills specific to supporting those with complex and challenging behaviour. This provision, both at Woodview and via outreach, achieves the most successful outcomes for those on the dynamic support register.

Author of Report: Marie Burnell, Service Manager
Background Papers: There are no background papers.
Ref:

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 28 MARCH 2024**

SUBJECT: **PRESSURES ON GENERAL PRACTICE**

BY: **CLINICAL LEAD FOR PRIMARY CARE IN MORAY**

1. REASON FOR REPORT

1.1 To inform the Committee of the ongoing pressures affecting General Practices in Moray and posing a threat to their sustainability.

2. RECOMMENDATION

2.1 It is recommended that the Committee:

i) consider and note the pressures affecting Moray Practices; and

ii) support the operational delivery of the NHS Grampian General Practice Vision project.

3. BACKGROUND

3.1 A report was submitted to the Moray Integration Joint Board on 25 May 2023 (para 11 of the minutes refers) informing the Board of sustainability issues affecting General Practices across Moray.

3.2 The Chair of the Moray Integration Joint Board wrote to Cabinet Secretary for NHS Recovery, Health & social Care on 13 June 2023 highlighting the issues disproportionally affecting Moray. The Cabinet Secretary replied on 13 July 2023.

3.3 On 9 June 2023, the Grampian GP Leadership Team presented these challenges to the NHS Grampian Chief Executive Team, receiving a supportive commitment to collaboratively address and develop a more sustainable vision for General Practice. After petitioning of Scottish Government this developed into the Grampian General Practice Vision Programme.

3.4 This series of work consisted of 4 workshops with wide ranging representation and stakeholder engagement. The output from this process was developed into a Vision Statement (A sustainable General Practice across Grampian

which enables people in their communities to stay well through the prevention and treatment of ill health) & a series of Specific, Measurable, Attainable, Realistic, Time-Bound (SMART) objectives. This was the subject of a report to the Moray Integration Board at their meeting on the morning of 28 March 2024.

3.5 Throughout the development and progression of this Program, the sustainability challenges faced by Moray's General Practices have persisted. These ongoing issues encompass heightened clinical demands for GP services, persistent challenges in recruiting General Practice staff, a diminishing share of the overall health budget allocated to General Practice, limitations in space for expanding multi-disciplinary teams, and a notable decline in staff morale. Practices find themselves grappling with the task of adequately supporting patients awaiting procedures or diagnostic tests, and there is a growing apprehension that the accumulating strain may lead to Practices relinquishing their contracts.

3.6 These issues were discussed at the Health and Social Care Moray (HSCM) Clinical and Care Governance Group at their meeting on 7 December 2023 (see **Appendix 1**) and it was agreed that the report should be escalated to this Committee.

3.7 On the 19 February 2024 the General Medical Services contract holder for the Aberlour Practice ended the contract with Moray Health and Social Care Partnership. The partnership are currently running the Practice to ensure continued access to primary care services for the community

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 General Practice, responsible for 90% of all patient health contacts and seeing approximately 10% of the population each week, plays a pivotal role. If there were a widespread breakdown of General Practice locally, the broader health service would be unable to sustain its current function. Additionally, the costs linked to Health and Social Care Partnership run Practices far exceed those of Partnership ones.

4.2 The count of GP Practices in Moray has decreased by 25% since 2007, placing added strain on the remaining practices and their staff. This situation poses challenges for communities and poses a threat to future delivery of coordinated General Practice.

4.3 A pivotal component of Moray Integration Board's Strategic Plan for Health and Social Care in Moray & NHS Grampian's Plan for the Future involves transitioning to a proactive healthcare system that keeps individuals well within the proximity of their homes. Achieving this vision relies heavily on the effective operation and support of General Practice.

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"
Functional General Practice serves as a linchpin in the broader Moray health system, with any challenges within it reverberating across all sectors and hindering the achievement of strategic

delivery goals. Furthermore, the Moray Portfolio holds operational responsibility for Primary Care in Grampian. Consequently, sustainability issues affecting the wider Grampian region will inevitably impact the operational efficiency of the Moray Portfolio.

(b) Policy and Legal
None.

(c) Financial implications
Additional backfill and support costs for Practices needing help, and the risk of increased costs if we have Health and Social Care run Practices. In the current financial environment these increase costs could hamper attempts to save money overall.

(d) Risk Implications and Mitigation
The precarious state of Moray's General Practices poses a substantial threat to the Moray Population, giving rise to issues such as unequal access to General Practice, deterioration in population health, suboptimal patient outcomes, and heightened strain on Secondary Care services. Additionally, there is a risk of a notable surge in complaints and adverse media coverage. Furthermore, the potential departure of GP staff poses an additional challenge, intensifying the pressure on Practices and exacerbating recruitment difficulties. These risks can be effectively mitigated by acknowledging and supporting the indispensable role that General Practice plays in our broader health system. The operational implementation of the NHS Grampian GP Vision project presents an opportune moment to bolster a more sustainable General Practice, aligning with the strategic intent of NHS Grampian.

(e) Staffing Implications
Recruitment opportunities exist, but a well-supported General Practice is vital to attracting GPs and Practice staff to the area.

(f) Property
None from this report.

(g) Equalities/Socio Economic Impact
Lowest Scottish Index of Multiple Deprivation (SIMD) quintile areas have decreased access to General Practice across Scotland, and sustainability issues in General Practice would exacerbate this.

(h) Climate Change and Biodiversity Impacts
None.

(i) Directions
None.

(j) Consultations
The Deputy Chief Officer, Health and Social Care Moray; GP Clinical Leads, Primary Care Development Manager and HSCM Clinical and Care Governance Group.

6. CONCLUSION

6.1 General Practice in both Grampian and Moray is experiencing an unprecedented period of sustainability pressure that is impacting on operational delivery.

6.2 The impact of this instability in General Practice continues to be felt across the entire Moray Health and Social Care system.

6.3 The NHS Grampian GP Vision Project offers an opportunity to support sustainable future delivery of General Practice.

Author of Report: Dr Robert Lockhart, GP Clinical Lead, Moray.
Background Papers: 3 Minute Brief, General Practice for 7 December 2023 meeting of the Moray Clinical and Care Governance Group
Ref:

APPENDIX 1

3 MINUTE BRIEF – GENERAL PRACTICE

What?

In recent months both clinical leads for Primary Care in Moray have visited our GP practices. At these visits it was clear that every practice in Moray is under significant strain, with common themes emerging that are detailed below. Two practices (Aberlour and Fochabers) have required significant support from Health & Social Care to continue operational delivery, with this support ongoing at Aberlour.

1) General Practices throughout Moray are facing challenges in providing safe and effective primary care to patients. A diverse array of external pressures are exerting considerable strain on these practices, pushing many to the brink of sustainability. While similar feasibility issues are evident across the north of Scotland, the impact is particularly acute in Moray due to a combination of factors outlined in the attached documents, including an IJB paper, a letter to the Cabinet Secretary for NHS Recovery, Health and Social Care, and the subsequent reply.
2) The demand for services in General Practice has surged significantly. While media and political attention have primarily focused on A&E wait times and growing secondary care waiting lists, there has been a notable shift of responsibilities toward General Practice. Analysis of GPAS data, In Hours Dashboard figures, and independent consulting trend assessments reveal a substantial increase. The total number of consultations per patient per year for all staff has risen from 11 to 25 over the past two decades, and for GPs, this has increased from 5 to 8 (refer to the attached Consultation Patterns BMJ paper). Notably, these trends have accelerated since the paper's publication, as indicated by the attached General Practice Data pdf and GPAS report. For instance, at Maryhill, the total number of quarterly clinical GP appointments, including emergency duty appointments and scheduled GP clinics, has risen significantly from 10,827 in October to December 2019 to 20,999 for the quarter spanning July to September 2023. This surge is further supported by GPAS data, revealing 80,000 to 90,000 GP appointments occurring on a weekly basis across Grampian. These figures underscore the intensifying demand placed on General Practice services, highlighting the need for a comprehensive and sustainable approach to meet the evolving healthcare landscape.
3) The 2018 national GMS contract has failed in its stated intent to take work away from GPs. Locally its implementation has been dogged by recruitment difficulties and clawing back of funding, while the establishment of teams within practices has faced significant operational challenges (particularly relating to CTAC services, but extending to other streams also). Spending on PCIP staff is high (representing 32.81% of total general practice staff spend – 2023 Association of Independent Specialist Medical Accountants figures). Data from Maryhill shows that cost per consultation is disproportionally high for PCIP staff compared to those who are practice employed (General Practice Data pdf.)
4) Investment in core general practice (designated as General Medical Service PMS in attached Health Budget Trends pdf) has fallen from 6.21% of total health budget spend in 2016/17 to 5.15% in current year. Historically this figure sat at 10 to 12% throughout the eighties and nineties. Investment has also fallen 15% behind inflation and 25% behind total health budget uplift over the last seven years.

5) Worsening secondary care waiting lists (see attached NHS Grampian Waiting Times pdf, which shows many specialities with waits of over one year, and over 3 years 3 months for routine urology) are adding pressure to General Practice. Patients who are waiting for tests, consultations or interventions visit their GP practice more often and experience worsening health and socioeconomic outcomes. Waits for orthopaedic, vascular and cardiology interventions can be particularly difficult for patients, leading to significant increase general practice consultations (General Practice Data pdf.) There is also a concerning trend towards a higher proportion of cancers being metastatic at diagnosis, with the associated reduction in curative treatment options and an increase in mortality.
6) General Practice premises need significant investment. Across Moray practices are struggling to house their expanded multidisciplinary teams and patient care is suffering. There is also concern that projected population growth from planned housing developments will exacerbate this issue.
7) Morale is at an all-time low. The 2023 GP Wellbeing survey in Scotland showed that 85% of GPs say they sometimes, or regularly, struggle to cope and work is having a negative impact on their physical and mental wellbeing – with 31% saying they are unable to achieve a good work-life balance and it is getting significantly worse over recent times. A quarter of GPs are planning to leave their practice in the next two years, while three quarters say the last year has made them more likely to leave the profession entirely (BMA Scotland GP Wellbeing pdf.)

So What?

1) The challenges affecting Moray's General Practices have far-reaching implications for both the wider healthcare system and our communities. The surge in demand, coupled with inadequate investment and operational issues, jeopardises the delivery of quality primary care.
2) The shortcomings of the national GMS contract and the declining morale among GPs & their staff are compounding factors that will intensify the shortage of healthcare professionals, directly affecting the quality of patient care. As GPs experience diminishing job satisfaction and an increasing likelihood of leaving their practices or the profession altogether, the impending workforce shortages pose a significant risk. This potential exodus could diminish the healthcare system's ability to provide essential primary care services, adding an additional layer of strain to the broader healthcare infrastructure.
3) The relative underinvestment in core general practice, coupled with increasing costs, will cause worsening financial difficulties for practices. This could limit the resources available for essential health services and worsen patient outcomes.
4) Insufficient investment in GP premises has led to outdated and inadequate infrastructure, impacting the ability of GP practices to offer modern and efficient healthcare services. This will compromise patient comfort, accessibility, and the overall quality of care provided. This will impact on capacity to accommodate growing populations, reduce workforce content and worsen patient experiences.
5) The shifting of workload from secondary care to General Practice, combined with deteriorating waiting lists, has escalated the burden on GP medical services. This heightened pressure may result in delays in administering treatments, thereby adversely affecting patient outcomes.

6) As General Practices struggle to meet demand, there will likely be a higher influx of patients seeking care at emergency services, exacerbating existing pressures on A&E departments.
7) Communities may face challenges in accessing timely and adequate healthcare services, leading to potential health disparities and worsening health outcomes for residents.
8) The struggle to deliver safe and effective primary care may compromise the quality of healthcare services available to communities. This could lead to increased health risks, reduced overall community well-being and worsening health inequality
9) Communities with limited access to well-functioning General Practices may experience disparities in health outcomes, as some residents may face barriers in receiving timely and adequate medical attention.
10) Poor community health, exacerbated by healthcare challenges, may have broader economic implications. Increased healthcare needs and delayed interventions could lead to increased absenteeism and reduced productivity in the workforce.

Now What?

1) Addressing these implications requires a comprehensive approach, involving strategic investments, policy adjustments, and collaborative efforts between healthcare providers, policymakers, and communities to ensure the resilience and effectiveness of the healthcare system at both the local and regional levels. This necessitates prioritising general practice and community-driven patient care as the focal points in health strategic planning. It is crucial to actively engage general practice in shaping future health plans, thereby enabling the delivery of high-quality, community-based, and patient-centred care. This approach aims to reintegrate proactive and preventative healthcare into the core of our healthcare system, a key feature of the wider NHS Grampian health strategy.
2) The 2023 Moray Joint Strategic Needs Assessment allows us an opportunity to utilise health data and consider how best to allocate resources to best look after our communities.
3) The GP Vision work affords us an opportunity to collaborate with stakeholders and patients to develop a sustainable model to deliver general practice with local flexibilities that best meet the needs of our patients. It is also a chance to reassess the national GMS contract, addressing its shortcomings and modifying its provisions to better align with the needs of local General Practices and the evolving healthcare landscape.
4) The Moray Growth Deal offers an exciting opportunity to invest in health information technology and digital solutions to streamline processes, enhance patient care, and improve overall operational efficiency. Harnessing personalised data stores, seamlessly integrating technological apps to coordinate services, incorporating health monitoring devices, and placing a strong emphasis on preventative health measures promise an exciting future for our Moray patients.

By combining strategic investments, policy adjustments, and collaborative efforts, stakeholders can work together to build a more resilient and responsive healthcare system. This holistic approach addresses the identified challenges and ensures that GP services are not only accessible but also of high quality, meeting the needs of communities both now and in the future.

APPENDIX 1

Benefits

Investing in the sustainability of General Practice yields numerous rewards that extend beyond individual practices to positively impact patients, communities, and the overall healthcare system. Some key benefits include:

1) Investments in General Practice premises leads to improved infrastructure and expanded facilities, increasing the capacity to accommodate more patients and reducing wait times for appointments. This also allows for the improvement of working conditions, creating a positive and supportive environment that enhances the job satisfaction and well-being of healthcare professionals.
2) Quality general practice supports preventive care and early intervention, contributing to the timely detection and management of health issues, ultimately improving patient health outcomes. Focussing on preventive care can reduce the economic burden associated with treating advanced or chronic conditions. This allows General Practices to actively engage in health promotion and education initiatives within the community, contributing to overall public health awareness and well-being.
3) Easing pressure on GPs facilitates continuity & the maintenance of long-term relationships between patients and their doctors, improving patient outcomes and reducing wider impact on the healthcare system.
4) Focusing on technological solutions enhances the efficiency of administrative tasks, medical record-keeping, and communication, leading to more streamlined and effective healthcare services. Patient experiences are improved.
5) Well supported General Practices contribute to a positive patient experience, fostering trust in the healthcare system and promoting higher levels of patient satisfaction. Surgeries become a cornerstone of community health, encouraging active participation and collaboration between healthcare providers and the community.

Creating a sustainable General Practice is essential for building a resilient and patient-centred healthcare system, promoting overall community health, and achieving long-term cost savings through preventive measures and early intervention. Not doing so risks more practices ceasing to deliver healthcare, negatively impacting the wider health system and leading to worse health outcomes for patients & increasing health inequality.

Authors: Dr Robert Lockhart, Dr Malcolm Simmons – Moray Clinical Leads
Date: 19th November 2023
Attached documents –

- Consultation_patterns_BMJ
- IJB Report - General Practice Sustainability
- 2023-11-17 Grampian LMC GPAS Sitrep
- BMA Scotland GP Wellbeing
- General Practice Data
- Health Budgets Trends
- Letter to Cabinet Secretary Final
- NHS Grampian Waiting Times
- Response-202300363844 Michael Matheson