REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 28 OCTOBER 2021**

SUBJECT: **HEALTH AND SOCIAL CARE MORAY (HSCM) CLINICAL AND CARE GOVERNANCE GROUP ESCALATION REPORT FOR QUARTER 2 (JULY TO SEPTEMBER 2021)**

BY: **CHIEF NURSE, HEALTH AND SOCIAL CARE MORAY**

1. REASON FOR REPORT

1.1. To inform the Clinical and Care Governance Committee of progress and exceptions reported to the Clinical and Care Governance Group during quarter 2 of 2020/21 (1 July up to 30 September 2021).

2. RECOMMENDATION

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

3. BACKGROUND

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

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

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

3.4. The agenda for the Clinical and Care Governance Group has been updated and now follows a 2 monthly pattern with alternating agendas to allow for appropriate scrutiny of agenda items and reports. A reporting schedule for Quality Assurance Reports from Clinical Service Groups/departments is in place. This report contains information from these reports and further information relating to complaints and incidents/adverse events reported via

Datix; and areas of concern/risk and good practice shared during the reporting period. Exception reporting is utilised as required. Since April 2020, the 3 minute brief template has been used for services to share their updates; this has been met with positive feedback.

3.5. The Clinical and Care Governance Group have met 3 times during this reporting period.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

Audit, Guidelines, Reviews and Reports

4.1 Relevant Audits, Guidelines Reviews and Reports are tabled and discussed. These include local and national information that is relevant to HSCM, for example, recommendations from Health Improvement Scotland (HIS) reports from other areas which require to be discussed and assurance given that services in Moray are aware of these and have process in place to meet/ mitigate these recommendations. Overview from quarter 2 2021/22 is listed below:

- CRM Minutes
- Forres & Lossiemouth Locality 3 Minute Brief
- GMED 3 Minute Brief
- Pharmacotherapy 3 Minute Brief
- Policy & Procedure Following a Death in Care Services (social work and social care staff)
- Healthcare Improvement Scotland (HIS), Covid-19 focused Inspections, Combined Care of Older People/Safety & Cleanliness
  - Dumfries & Galloway Royal Infirmary, NHS Dumfries & Galloway -
  - Victoria Hospital, NHS Fife
  - Western Isles Hospital, NHS Western Isles
  - Borders General Hospital, NHS Borders
- Improving the outcomes for people with dementia in hospitals, including acute, community and specialist dementia unit settings (HIS)
- Practice Governance Board Minutes
- Prevention & Management of Violence and Aggression (PMVA)
- Moray Integrated Mental Health 3 Minute Brief
- Children and Families Health Services 3 Minute Brief
- Speyside and Keith Locality 3 Minute Brief
- Learning Disability 3 Minute Brief
- HSCM Feedback and Complaints
- Summary of External Inspection to NHS Scotland Boards
- Adverse Events
- Risk Register
- Mental Welfare Commission:
  - Woodland View Hospital, NHS A&A
  - Stobhill Hospital, NHS GG&C
  - Beckford Lodge, Iona & Gigha Wards, NHS Lanarkshire
  - Vale of Leven Hospital, Fruin & Katrine Wards, NHS GG&C
  - Cleland Hospital, Parkside North & South Wards, NHS Lanarkshire
  - Leverndale Hospital, Ward 2, NHS GG&C
  - Midpark Hospital, Balcary & Ettrick Wards, NHS D&G
- Medication Management Policy & Procedures

Areas of achievement / Good Practice

4.2 Forres District Nursing team has a close working relationship with Forres Treatment and Care Hub, the Practice Nursing Team and the Forres Neighbourhood Care Team (FNCT). This avoids duplication of provision, allows caseload cover where required and helps reduce footfall within the patient's home and the Forres Health and Care Centre. The Varis Court Augmented Care Units (ACU) and FNCT have been part of a Service Review and resultant Organisation Change. Next actions are to fully implement the Varis ACU/FNCT Organisational Change process, and to continue to develop the role of the Forres Treatment and Care Hub.

4.3 GMED has regular Quality and Performance meetings where adverse events, complaints and staff performance are discussed. The role of a Supernumerary Clinical Supervisor (CS) has been embedded within the service.
Links with the GP Sub and Performance Committee have been established with representation from GMED.
Clinical Educational Sessions are held on a monthly basis. Topics/ subjects for Continuous Medical Education are identified via adverse events and review of feedback/ complaints as well as topics identified by staff.

4.4 The implementation of the Policy and Procedure following a Death in Care Services (social work and social care staff) will close a significant gap in policy areas. It will also significantly reduce the risk to HSCM identified on the Services Risk Register. The implementation of the policy will provide clear guidance to social care teams and staff where there is an expected or unexpected death in care services.

4.5 One of HSCM's Community Hospital Senior Charge Nurses (SCN) was awarded his long service award having completed over 45 years in the NHS.

4.6 Improved processes, multi-agency work, planning and documentation has resulted in safe, timely and effective discharges for patients at Turner Hospital. With the support of the League of Friends, they are able to provide every patient who requires it with a 'going home food bag' which includes essential items including milk, tea etc.

4.7 The Speyside locality, where possible, are working to establish good local networks and potential support from community groups and the third sector. One aim is to establish a list that can be shared amongst teams regarding the various other services, groups and opportunities available to access by patients/service users. An example of this is meeting with the Speyside Community Council with representatives from Social Work, Care at Home and the District Nursing Team to chat about what we are doing and how local communities could support e.g. carer vacancies.

4.8 The Learning Disability (LD) Team Clinical Psychologist and Occupational Therapist attended a virtual poster presentation at two events; The NHS Scotland Event 2021 and the International Association for the Scientific Study of Intellectual and Developmental Disabilities Conference (IASSIDD) in Amsterdam. Both presentations were positively received; feedback and networking opportunities are being followed up. The poster, entitled Building

the Right Homes for Adults with Learning Disability and Autism, sets out the process of developing environmental needs specifications for 3 specific LD groupings – people with significant challenging behaviour; people with little challenging behaviour and people who need support with gatekeeping and keeping themselves safe.

Clinical Risk Management (CRM)

4.9 The Clinical Risk Management (CRM) group meet every 2 weeks to discuss issues highlighted on the HSCM Datix dashboard. This includes Level 1 and Level 2 investigations, Complaints, Duty of Candour and Risks.

4.10 The group is attended by members of the senior management team, clinical leads, chief nurse and relevant service managers / consultants. An action log is produced following each meeting and is administered and monitored. Individual services can be invited to attend to offer further scrutiny and assurance.

Complaints and Feedback

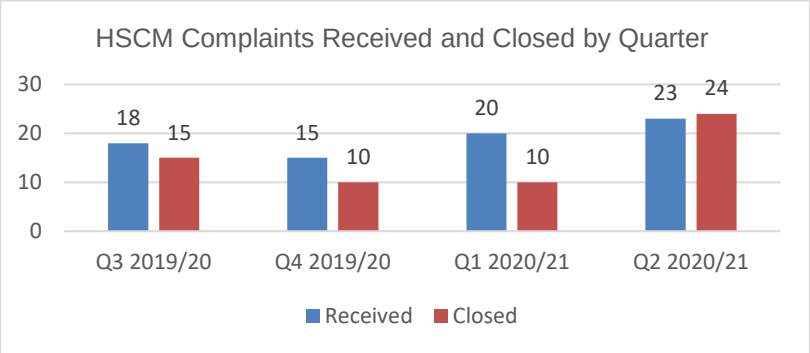
4.11 Within HSCM, complaints received by NHS Grampian and Moray Council are recorded on 2 separate systems, in accordance with the appropriate policy and procedure of these organisations.

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

4.13 Overall, a total of **33** complaints were received during quarter 2.

	Total Received in last quarter	**Total Closed in last quarter**
Local Authority	9	7
NHS	23	17
	32	**24**

4.14 Complaints received and closed by Quarter



4.15 Timescales for completion of complaints

Timescale	Total Closed
Within 20 days	14
21-30 days	3
31-50 days	2
>51 days	4
	23

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

4.17 These figures do not include complaints raised regarding the vaccination appointments or processes as these are being dealt with through a dedicated team covering the Grampian area.

4.18 **Actions and Lessons Learnt from complaints**
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.

- Communication improvements were highlighted as an action in 7 complaints. Staff are being reminded of the importance of sharing information in a timely, appropriate and sensitive manner and acknowledging and responding to correspondence or information received.
- Improvements to access was identified as an action in 6 complaints. This included the reduced face to face contact made during COVID 19 restrictions. It was also highlighted that advising people and their families/carers of changes to care packages should be improved.
- Training was identified in 1 case. This had led to staff being redirected to and undertaking relevant training and updates. Information was shared with the whole staff group with guidance being shared on how to access training programmes. This was especially pertinent to staff who are moving between health board areas.
- On one occasion staff conduct issues were raised and addressed. Identified staff were required to undertake additional training and carry out reflective practice. Additional supervision was implemented to support development.

Complaints Handling Procedures

4.19 Since 2012 the Scottish Public Services Ombudsman's (SPSO) Complaints Standards Authority has worked closely with a range of partners and stakeholders to develop and implement Model Complaints Handling Procedures (MCHPs) for each public service sector. In 2018-19 the SPSO conducted a review of MCHP to establish effectiveness and usability. Following consultation the MCHPs were revised, updated and published under section 16B(5) of the Scottish Public Services Ombudsman Act 2002 on 31 January 2020 to give public sector organisations time to implement any changes by April 2021**.**

4.20 Complaints can arrive from many different avenues, including email, mail and verbally, from service users, members of the public and MSP's, and often to different Officers within HSCM.

4.21 It is evident that there are multiple sources of complaints into HSCM. To learn from complaints and to improve services, it is important that all complaints are logged centrally. Complaints are being received directly to service managers/ team leaders/ the Chief Officer, as well as through the generic complaints and feedback systems. Not all complaints are logged centrally which prevents HSCM being able to identify trends, learning and to be aware of the true number being received. The Model Complaints Handling Procedures outline clear processes and timescales.

4.22 To support teams and managers, a complaints workshop was delivered on 16 September 2021, which gave the opportunity to: -

- Increase knowledge and understanding of complaints handling procedures
- Identify opportunities to streamline processes and establish a consistent approach to managing complaints in HSCM
- Develop reporting and shared learning processes.

4.23 This workshop was well attended and participants were involved in active discussion. A number of challenges were identified along with suggestions for solutions. This includes multi agency/service complaints. An action plan and information document is being produced which will support constructive feedback to staff to support effective and efficient response to complaints within HSCM.

4.24 For complaints relating to the actions and processes of the Integration Joint Board itself, IJBs are asked to adopt the MCHP for the Scottish Government, Scottish Parliament and Associated Public Authorities.

Adverse Events

Adverse Events by Category and Level of Review* Reported on Datix (Quarter 2, 2021/22)

	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	61	0	0	61
Access, Appointment, Admission, Transfer, Discharge (Including Absconders)	19	1	1	21
Accident (Including Falls, Exposure to Blood/Body Fluids, Asbestos, Radiation, Needlesticks or other hazards)	95	0	0	95
Clinical Assessment (Investigations, Images and Lab Tests)	2	0	0	2
Consent, Confidentiality or Communication	7	0	0	7
Diagnosis, failed or delayed	0	1	0	1
Fire	8	0	0	8
Implementation of care or ongoing monitoring/review (inc. pressure ulcers)	5	2	0	7
Infrastructure or resources (Staffing, Facilities, Environment, Lifts)	12	2	0	14
Medical device/equipment	1	0	0	1
Medication	37	1	0	38
Other - please specify in description	36	0	0	36
Patient Information (Records, Documents, Test Results, Scans)	5	0	0	5
Security (no longer contains fire)	4	0	0	4
Treatment, Procedure (Incl. Operations or Blood Transfusions etc.)	1	0	0	1
Total	293	7	1	301

4.25 Adverse Events by Harm Reported on Datix (Quarter 2, 2021/22)

All Adverse Events Q2 21/11 n = 337	2020/21 Quarter 2	2020/21 Quarter 3	2020/21 Quarter 4	**2021/22 Quarter 1**	**2021/22 Quarter 2**
Occurrence with no injury, harm or ill-health	204	170	222	**193**	**239**
Occurrence resulting in injury, harm or ill-health	77	73	72	**80**	**61**
Near Miss (occurrence prevented)	26	35	34	**34**	**37**
Property damage or loss	5	2	0	**0**	**0**
0Death	0	0	0	**0**	**0**
Total	312	280	328	**307**	**337**

Occurrence resulting in injury, harm or ill-health **Q2 21/22 n = 61**		**Negligible**	**Minor**	**Moderate**	**Major**	**TOTAL**
Staff	n = 15	4	9	0	0	**15**
Patient	n = 37	1	29	7	0	**37**
Student or Trainee	n = 1	0	1	0	0	**1**
Visitor/ Member of Public	n = 2	0	2	0	0	**2**
Equipment	n = 1	0	1	0	0	**1**
Provision of Service	n = 6	0	5	1	0	**5**
		5	**47**	**8**	**0**	**61**

Occurrence resulting in No injury, harm or ill-health **Q1 21/22 n = 239**		**Negligible**	**TOTAL**
Staff	n = 9	21	**21**
Patient	n = 144	178	178
Equipment	n = 6	15	**15**
Provision of Service	n = 1	15	**15**
Discharge	N = 3	3	**3**
Information Governance	n = 5	5	5
Visitor/ Member of Public	n = 2	2	**2**
			239

4.26 Adverse Events by Severity Reported on Datix (Quarter 2, 2021/22)

N = 337		2020/21 Quarter 3	**2020/21 Quarter 4**	**2021/22 Quarter 1**	**2021/22 Quarter 2**
Negligible	No injury or illness, negligible/no disruption to service / no financial loss	215	262	234	**281**
Minor	Minor injury or illness, short term disruption to service, minor financial loss	60	58	66	**48**
Moderate	Significant injury, externally reportable e.g. RIDDOR, some disruption to service, significant financial loss	4	7	6	**8**
Major	Major Injury, sustained loss of services, major financial loss	1	1	1	**0**
Total		280	328	307	**337**

Findings and Lessons Learned from incidents, complaints and reviews

4.27 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.

4.28 There are currently **4** Level 1 reviews in progress (at the time of reporting).

4.29 There were no Level 1 reviews completed in the last quarter.

HSCM Risk Register

4.30 New risks identified on Datix are discussed at each Clinical and Care Governance Group and CRM. There have been no new risks identified as "High" during this reporting period.

4.31 Each Clinical Service Group/Department will highlight risks associated with their service, which are discussed during a reporting session to the HSCM Clinical and Care Governance Group. The risk register has been reviewed with leads given guidance and support to update. There are 4 "Very High" risks currently on the register. These are being closely monitored by the CRM and senior leadership team.

Duty of Candour

4.32 Four events were considered for Duty of Candour (DoC) during Quarter 2. Of these, 2 have been investigated and did not meet the DoC threshold. The 2 remaining events are currently being investigated and are currently being considered for DoC.

Items for escalation to the Clinical and Care Governance Committee

4.33 Adult Support and Protection (ASP) – multi-disciplinary joint inspection of adult protection activity in Grampian is expected in 2021/22. Preparatory work is ongoing. The NHS Grampian Adult Public Protection Training Framework has been approved for use within the organisation by the Grampian Area Partnership Forum (GAPF). This document sets out the training offered to NHSG staff in relation to adult public protection and the expected levels of training that should be undertaken. It is designed to be used by both frontline staff, teams and also management.

4.34 Adult Support and Protection in Moray – the Adult Support and Protection Improvement Plan is currently being updated, with working groups being established to progress actions. The initial Referral Discussion (IRD) process within in Moray is progressing. A single point of contact for Health has been appointed and will take up post on 18 October 2021. Interviews for an Adult Support and Protection Practitioner have also taken place, and the successful candidate will take up post at the end of November.

4.35 A multi-agency group has convened to reinforce a coordinated approach to ASP and self-evaluation within Moray.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Moray Partners in Care 2019 – 2029"

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

(b) Policy and Legal

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

(c) Financial implications

None directly associated with this report.

(d) Risk Implications and Mitigation

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

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

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

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

(e) Staffing Implications

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

(f) Property

None directly arising from this report.

(g) Equalities/Socio Economic Impact

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

(h) Consultations

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

- Jane Mackie, Head of Service / Joint Clinical and Care Governance Group Chair
- Jeanette Netherwood, Corporate Manager
- Tracey Sutherland, Committee Services Officer, Moray Council

6. CONCLUSION

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

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Background Papers: with author (data extracted 07.10.21)
Ref: