MORAY INTEGRATION JOINT BOARD

CLINICAL AND CARE GOVERNANCE COMMITTEE

Thursday, 29 August 2019

Inkwell Main, Elgin Youth Café

NOTICE IS HEREBY GIVEN that a Meeting of the **Moray Integration Joint Board Clinical and Care Governance Committee** is to be held in **Inkwell Main, Elgin Youth Café**, **Francis Place, Elgin, IV30 1LQ** on **Thursday, 29 August 2019** at **13:00** to consider the business noted below.

AGENDA

MORAY INTEGRATION JOINT BOARD

CLINICAL AND CARE GOVERNANCE COMMITTEE

MEMBERSHIP

VOTING MEMBERS

Mr Sandy Riddell (Chair)	Non-Executive Board Member, NHS Grampian
Councillor Tim Eagle	Moray Council

NON-VOTING MEMBERS

Mr Ivan Augustus	Carer Representative
Mr Tony Donaghey	UNISON, Moray Council
Ms Pam Gowans	Chief Officer, Moray Integration Joint Board
Mrs Linda Harper	Lead Nurse, Moray Integration Joint Board
Ms Jane Mackie	Chief Social Work Officer, Moray Council
Dr Malcolm Metcalfe	Secondary Care Advisor, Moray Integration Joint Board
Dr Graham Taylor	Registered Medical Practitioner, Primary Medical Services
Mrs Val Thatcher	Public Partnership Forum Representative

ADVISORS

Mr Sean Coady	Head of Primary Care, Specialist Health Improvement and NHS Community Children's Services, Health and Social Care Moray
Dr Ann Hodges	Consultant Psychiatrist
Ms Pauline Merchant	Clinical Governance Coordinator, Moray Health and Social Care Partnership
Ms Jeanette Netherwood	Corporate Manager, Health and Social Care, Moray
Mrs Liz Tait	Professional Lead for Clinical Governance and Interim Head of Quality Governance and Risk Unit

Clerk Name: Caroline Howie
Clerk Telephone: 01343 563302
Clerk Email: caroline.howie@moray.gov.uk

MINUTE OF MEETING OF THE MORAY INTEGRATION JOINT BOARD

CLINICAL AND CARE GOVERNANCE COMMITTEE

Thursday, 30 May 2019

Alexander Graham Bell Centre, Moray College, Moray Street, Elgin, IV30 1JJ

PRESENT

Mr Ivan Augustus, Mr Sean Coady (NHS), Ms Pam Gowans, Mrs Linda Harper, Ms Jane Mackie, Dr Malcolm Metcalfe, Jeanette Netherwood, Mr Sandy Riddell, Dr Graham Taylor, Mrs Val Thatcher

APOLOGIES

No apologies for absence were received.

IN ATTENDANCE

Ms Eilidh MacKechnie, Corporate Communications Officer, Health & Social Care Moray and Mrs Caroline Howie, Committee Services Officer as Clerk to the meeting.

1 Chair of Meeting

The meeting was chaired by Mr Sandy Riddell.

2 Welcome

Mr Riddell welcomed Ms Eilidh MacKechnie, Corporate Communications Officer, Health & Social Care Moray, to her first meeting as an observer.

3 Declaration of Member's Interests

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

4 Minute of Meeting dated 28 February 2019

The Minute of the meeting of the Moray Integration Joint Board Clinical and Care Governance Committee dated 31 August 2018 was submitted and approved.

5 Action Log of Meeting dated 28 February 2019

The Action Log of the Moray Integration Joint Board Clinical and Care Governance Committee dated 28 February 2019 was discussed and it was noted that all items due, other than the following, had been completed.

Item 2 - Health Care Standards - Implementation - the Chair sought clarification on who would be providing the verbal report on progress of completion of the self-reflection tool from Scottish Government. On being advised there was no one available to provide the update he requested an email be issued to update all members.

Mrs Harper entered the meeting during discussion of this item.

6 Social Work Governance Arrangements

A report by the Chief Social Work Officer (CSWO) presented Committee with information in relation to professional social work governance.

Lengthy discussion took place on how communication takes place between different professions and what accessibility there is for the CSWO to ensure any concerns raised are addressed in a timely manner. It was stated there are different systems in use that can make the sharing of information challenging.

The CSWO outlined proposals to hold briefing meetings with Board and Council members to highlight any issues and matters for attention.

The Corporate Manager advised an operational group had been established between Aberdeen City Integration Joint Board (IJB), Aberdeenshire IJB and Moray IJB to look at solutions to challenges around access to information.

Thereafter the Committee agreed to note the content of the report.

Dr Taylor and Mr Coady entered the meeting during discussion of this item.

7 Complaints and Adverse Events - Quarter 4

Under reference to paragraph 7 of the Minute of the meeting dated 28 February 2019 a report by the Chief Officer informed the Committee of Health and Social Care Moray (HSCM), complaints and incidents reported in Quarter 4 (January - March 2019).

During discussion it was stated that the report was helpful to Committee and provided assurance that complaints and adverse events were being reviewed as required. It was further stated that the inclusion of information on how any lessons learned were being disseminated following investigations would be beneficial in future reports.

The Committee were in agreement that good practice should also be captured and staff should be encouraged to report compliments as well as complaints received. To this end Committee requested that a newsletter be developed to communicate quality and learning to focus on good outcomes to be incorporated in the communications strategy.

Thereafter the Committee agreed to note:

i. the complaints and adverse events summary for Quarter 4 (January - March 2019) shown in appendix 1 of the report;

ii. further investigation and development will be undertaken to align reporting mechanisms and timescales, where practicable;

iii. a mechanism will be developed to collate Audit, Quality Assurance and Quality Improvement Activity in HSCM, to provide assurance and confidence that appropriate and relevant audit, evaluation and monitoring activities are taking place;

iv. development of a newsletter about quality and learning to focus on good outcomes to be incorporated in the communications strategy; and

v. future reports will include exception reporting from the HSCM Clinical Governance Group.

8 Care Home Large Scale Investigation 2018

Under reference to paragraph 5 of the Minute of the meeting dated 31 May 2018 a confidential report by the Chief Social Work Officer informed the Committee of the actions taken as a result of the Large Scale Investigation which was undertaken at a Care Home in Elgin.

DATIX (the system used for capturing information) was discussed and it was stated that the system was sometimes underutilised as it was possible to automate the production of regular reports, therefore reducing workload involved in producing these each time they were required. It was further stated this may be due to lack of knowledge in using the system.

Committee requested this be investigated and a report in relation to Care Homes be provided to a future meeting.

Thereafter the Committee agreed to:

i. note the contents of the report and the actions taken as a result of the Large Scale Investigation; and

ii. seek a further report on the use of DATIX in relation to Care Homes.

MEETING OF MORAY INTEGRATION JOINT BOARD

CLINICAL AND CARE GOVERNANCE COMMITTEE

THURSDAY 30 MAY 2019

ACTION LOG

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY
1.	Action Log dated 28 February 2019	Item 2 – Health and Social Care Standards – Implementation – email briefing to Committee members to update on the current status and progress of implementation of the standards.	29 August 2019	Liz Tait/ Sean Coady
2.	Complaints and Adverse Events – Quarter 4	Future exception reports to provide assurance of the learning and how information is disseminated and action taken on areas of good practice.	Ongoing	Liz Tait
3.	Care Home Large Scale Investigation 2018	Report to be provided on the progress with use of DATIX recording for care homes, outlining any actions taken as a result.	28 November 2019	Jane Mackie

REPORT TO: **CLINICAL AND CARE GOVERNANCE COMMITTEE ON 29 AUGUST 2019**

SUBJECT: **CLINICAL CARE GROUP – UPDATE AND EXCEPTION REPORT – QUARTER 1**

BY: **CHIEF OFFICER**

1. REASON FOR REPORT

1.1 To inform the Clinical and Care Governance Committee of Health and Social Care Moray (HSCM), of progress and exceptions reported in Quarter 1 (April to June 2019).

2. RECOMMENDATION

2.1 It is recommended that the Clinical and Care Governance Committee consider and note for Quarter 1 (April to June 2019):

i) the complaints and adverse events summary shown in Appendix 1;

ii) an update on Audit, Quality Assurance and Quality Improvement Activity in HSCM shown in Appendix 2; and

iii) exception reporting from HSCM Clinical Governance Group.

3. BACKGROUND

3.1 The 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 draft minute refers).

3.3 This report contains information relating to complaints and incidents reported via Datix and information collated in Council systems. Graphs and tables with collated data are shown within **Appendix 1**.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 Complaints Quarter 1 2019/20

The information gathered for complaints and adverse events are in accordance with respective NHS Grampian and Moray Council policies and systems. Due to the fact there are two systems and approaches it does not facilitate easy collation and analysis of these types of events. Discussions will be taking place between partner agencies to agree and fully understand process and performance measures and to facilitate accurate consolidation, alignment and comparison of data, to provide assurance to this committee.

4.1.1 Overall, a total of **12** complaints were recorded within Datix, and **5** recorded within the complaints system of the Local Authority. Of those recorded on Datix, **1** was resolved through Early Resolution (within 5 days), **6** were resolved within 20 days and **2** were resolved in 25 and 31 days respectively, with a median of 16.5 days. **3** complaints remain active.
On review of those taking longer than 20 days, it is apparent that this was due to the complexity of the complaint, with multi-disciplinary and more than one service being involved in the investigation. On 2 occasions the complaint had been assigned to the incorrect manager which incurred a delay in responding. Complainants had been notified of the extended time required for the investigation.

Of those recorded on the Local Authority system, **1** was resolved through Early Resolution (within 5 days) and **4** were resolved within 20 days.

HSCM Outcome of Complaints

Recording system	Service	Upheld	Partially Upheld	Not Upheld	Not Coded *	**Total**
DATIX n=12	GMED	0	3	1	0	**4**
	Mental Health – Adult Health	1	0	1	0	**2**
	Allied Health Professionals	1	0	1	1	**3**
	Community Nursing	0	0	1	2	**3**
Local Authority =5	Drug and Alcohol	0	0	1	0	**1**
	Community Care - Head of Service	1	2	0	0	**3**
	Moray East	0	1	0	0	**1**
Total		**3**	**6**	**5**	**3**	**17**

4.2 **Adverse Events/Incidents**

Incidents recorded on Datix - During Quarter 1 there were a total of **424** incidents recorded on Datix. Incidents are recorded by NHS Grampian and some HSCM staff on the Datix system. Each incident is reviewed by the appropriate line manager, with the relevant level of investigation applied. Analysis of quarter 1 data shows that the majority of incidents (400) were resolved following a local review by the line manager. **1** incident is currently being investigated with a Level 1 review (full review team), and **8** with a Level 2 review (local management review team). **One** incident met the threshold for Duty of Candour in the last quarter, and appropriate action was taken. Learning from this review has resulted in:

- The introduction and implementation of an Interactions Protocol.
- Improved communication channels between the 2 services.
- Warnings being added to patient records who have been prescribed a specific drug.

The highest prevalence of incidents were**:-**

Incidents related to Slips Trips and Falls -**135**
Incidents related to Abuse/ Disruptive Behaviour -**108**
Incidents categorised as "Other" - **25**

Incidents and Accidents recorded by Moray Council

During Quarter 1 a total of 60 incidents were recorded.
The highest prevalence were:-

Slip, trip or fall on same level - **16**
Hitting a fixed/ stationary object - **7**
Other - **11**

4.2.1 **Slips, Trips and Falls**

Incidents recorded on Datix
Further analysis of the data shows that half of these incidents (65) are attributed to the same 9 patients with 4 or more falls. These are located within Community Hospitals and Adult Mental Health setting. The Senior Charge Nurses for these areas have provided further analysis. All of these patients had a falls Risk Assessment completed, and had been re-assessed using the Falls Multifactorial Assessment. Corrective and supportive measures are in place for falls including increased observations, the use of slipper socks, falls monitor and falls sensor mats. In the majority of these cases, the high incidence of falls is attributed to co-morbidities, current health conditions and non-compliance.
This has shown that there are significant systems in place to mitigate these risks however these cannot be 100% effective due to the complex conditions affecting these patients. Contributory factors included cognitive impairment and clinical condition. The timing of these incidents, staffing and the layout of

the facilities was also considered during this review, but these were not found to be contributory factors.

Incidents recorded by Moray Council processes
Of the 16 slip/trip/fall incidents, **4** resulted in a major injury, **4** a minor wound, **3** strain/sprain, **1** categorised as other.

4.2.3 **Abuse/ Disruptive Behaviour (Datix)**
The majority of Abuse/Disruptive behaviour occurred within a Mental Health Setting and Community Hospitals. Four patients had multiple episodes (4 or more) of abusive/disruptive behaviour reported, accounting for 47 (43%) of the incidents reported. This is concurrent with illness and behaviours relevant to this speciality and areas.

4.2.4 **Other**
Having reviewed the incidents on Datix that were coded as "Other", it appears that the majority of these could be allocated a specific category rather than 'other'. Review indicates that these incidents included Abuse/ Disruptive Behaviour; Access/Appointments/Discharge; Infrastructure Resource and Medical Equipment.
These continue to be reviewed at the local Clinical Risk Management Group, and relevant managers and approvers contacted to update.

4.2.5 **Severity Rating**
Of the **424** incidents reported on Datix there were **322** rated as negligible; **98** as minor; **3** as Moderate; and **1** as Extreme. Those rated as Extreme are currently being reviewed and investigated following appropriate investigative methodology.

4.3 **Learning from recent reviews**
Four level 2 investigations (Local Management Team Review) have recently been completed. Lessons learned and improvements to practice have been identified from these reviews. Due to the nature of the incidents, it is not pertinent to be too specific, as this may allow individuals to be identified. Learning has included:

- Staff have been reminded of Information Governance security measures and have reviewed the information governance and IT security training.
- Following reviews of care delivery out with hospital, measures are now in place to ensure that staff have the relevant competencies in place and that these are measured and monitored.
- Treatment escalation plans are in place and are communicated and shared with relevant practitioners.

Several immediate changes have been implemented successfully but emphasis will be on maintaining the programme of learning so as to be able to demonstrate effective long term change and improvement.

4.4 **Audit, Quality Assurance and Quality Improvement Activity in HSCM**

4.4.1 The information contained in **Appendix 2** highlights the activities underway within HSCM. These are currently in progress and will be updated when completed. As work progresses it will be populated to provide a comprehensive register and inventory which will support quality assurance. It may also be used to facilitate planning to support upcoming initiatives, and to support internal and external inspection of services, including demonstrating how the H&SC Standards are making a real difference in personal experience and outcomes for those in receipt of services in Moray.

4.5 **HSCM Clinical Governance Group**

4.5.1 The HSCM Clinical Governance Group continues to meet monthly. It has been noted that there is a reduction in the number of services being represented at these meetings and also the submission of requested assurance reports has reduced. This has been escalated and the Chair and Vice-Chair will be contacting relevant services to ensure representation at future meetings.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019

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

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:

- Chief Officer, MIJB
- Caroline Howie, Committee Services Officer
- Chief Financial Officer, MIJB

6 CONCLUSION

6.1 This report provides a summary and analysis of HSCM complaints handling performance and adverse events during Quarter 1 (April to June 2019) and the monitoring in place.

Authors of Report: Pauline Merchant, Clinical Governance Coordinator
Background Papers: held by author
Ref:

Complaints Summary - Quarter 4

Complaints recorded on Datix Q1 2019/20

Recording system	Service	Upheld	Partially Upheld	Not Upheld	Not Coded*	Total
NHS	GMED	0	3	1	0	4
	Mental Health – Adult Health	1	0	1	0	2
	Allied Health Professionals	1	0	1	1	3
	Community Nursing	0	0	1	2	3
	Total	**2**	**3**	**4**	**3**	**12**

Upheld

Quarter	Type of complaint	Number received	Outcome
Q1 19/20	Minor and unsatisfactory patient experience.	1	• Early resolution – misunderstanding/ miscommunication of information.
Q1 19/20	Moderate – Unsatisfactory patient experience	2	• Apology regarding the delay in accessing treatment, now resolved. • Apology regarding delay in access to equipment, now resolved.

Partially Upheld

Quarter	Type of complaint	Number received	Outcome
Q1 19/20	Minor and unsatisfactory patient experience.	3	• Apology given for delay in access to appointment x2 • Apology re misunderstanding and improvements made to communication.

Complaints recorded on Moray Council System

	Total
Complaints Received	5
Complaints Closed	2

Directorate	Department	Service	Upheld	Partially Upheld	Not Upheld	Not Coded	Grand Total
Education and Social Care	Community Care	Drug and Alcohol	0	0	1	0	**1**
		Head of Service	1	2	0	0	**3**
		Moray East	0	1	0	0	**1**
TOTALS			**1**	**3**	**1**	**0**	**5**

Upheld

Quarter	Type of complaint	Number received	Outcome
Q1 19/20	Process/ Procedure	**1**	Agree that there should be a system to appeal – working with policy officer

Partially Upheld

Quarter	Type of complaint	Number received	Outcome
Q1 19/20	Process/ Procedure	**3**	• Care package offered then withdrawn. • Further discussions required • Apology and explanation given

DATIX – ADVERSE EVENTS – NHS Q1, Q2, Q3, and Q4

This is the beginnings of trend data, and further data will be reviewed and analysis carried out to provide robust trend data for the committee.

Q1 - 365 incidents in total Q2 - 416 incidents in total Q3 - 396 incidents in total
Q4 – 390 incidents in total Q1 – 424 incidents in total

Overall severity Grading

	Q1 n=365	**Q2** n=416	**Q3** n=396	**Q4 n= 390**	**Q1 n = 424**
Negligible	283	319	310	292	320
Minor	70	80	79	118	98
Moderate	11	17	3	4	3
Extreme	1	1	2	3	1

Of these 50 were categorised as a near miss, 257 caused no injury/harm, 106 caused injury/harm (94 minor, 3 moderate, 9 negligible)

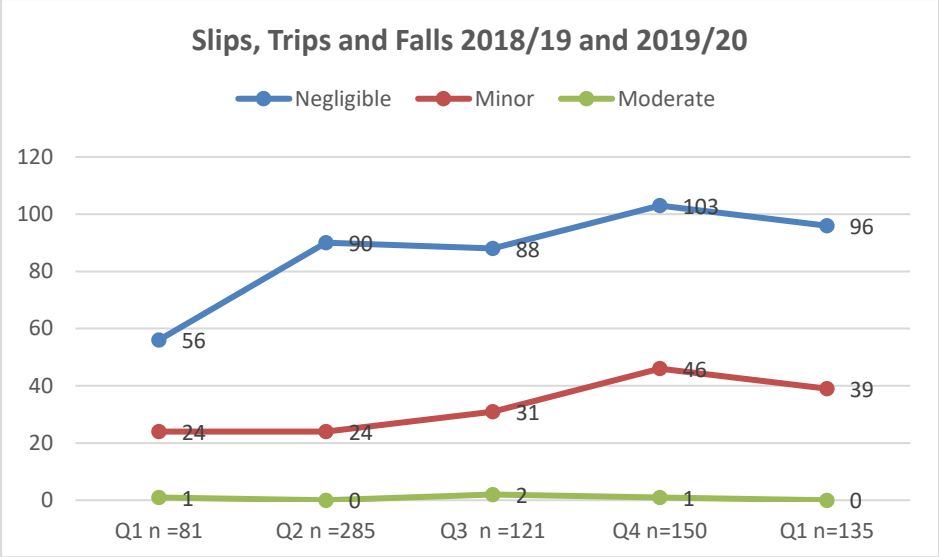
Top 3 Highest Prevalence

		Q1 n=183	**Q2** n= 285	**Q3** n=260	**Q4 n = 281**	**Q1**
	Type	**Number of Incidents**	**Number of Incidents**	**Number of Incidents**	**Number of Incidents**	**Number of Incidents**
A	Slips, Trips and Falls	81	124	121	150	135
B	Abuse/ Disruptive Behaviours	77	124	107	101	108
C	Other	25	37	38	30	29

A) Slips Trips and Falls analysis

By Severity

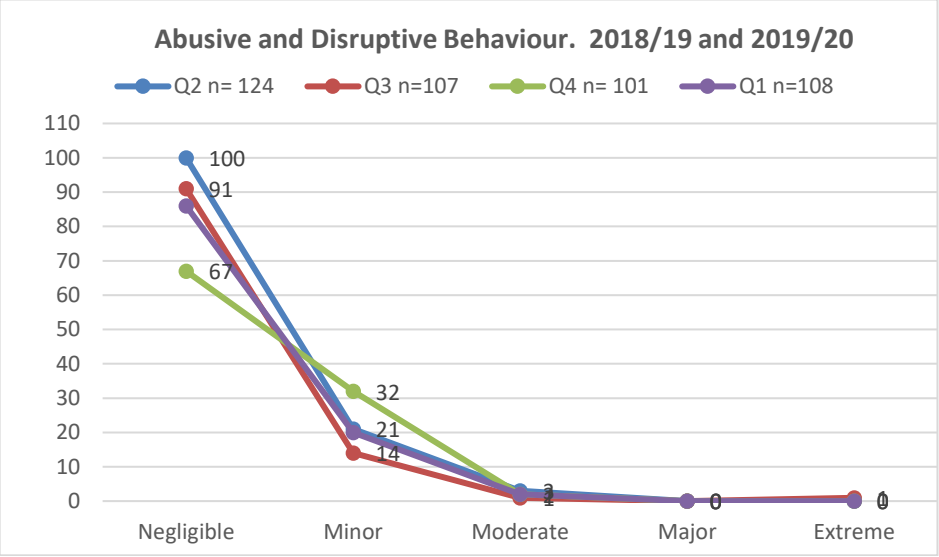
	Q1 n=81	**Q2** n=124	**Q3** n=121	**Q4 n=150**	**Q1 n=135**
Negligible	56	99	88	103	95
Minor	24	25	31	46	39
Moderate	1	0	2	1	0



B) Abuse/ Disruptive Behaviour analysis

By Severity

	Q1 n= 77	**Q2** n= 124	**Q3** n=107	**Q4** **n= 101**	**Q1**
Negligible	60	100	91	67	
Minor	15	21	14	32	
Moderate	1	3	1	2	
Major	0	0	0	0	
Extreme	0	0	1	0	



B) Abuse/ Disruptive Behaviour analysis continued.

Sub Category	Q1 n=77	Q2 n=124	Q3 n=107	Q4 n=101	Q1 n=109
Patient Abuse - Other	11	19	9	17	12
Patient by Staff	1	0	0	0	1
Patient to Patient	5	7	7	11	7
Patient to Staff	48	83	70	52	62
Patient Self harm in Primary Care	2	2	2	2	3
Patient Self harm in 24 hour care	9	12	19	18	20
Staff Abuse – Other	1	1	0	0	0
Staff to Staff	1	1	0	1	4
	86	**126**	**107**	**101**	**109**

C) Access/Appointments/Discharge

By Severity

	Q1	Q2	Q3	Q4	Q1
Negligible	24	9	21	29	27
Minor	1	1	0	2	4
	26	**10**	**21**	**31**	**31**

Type	Q1	Q2	Q3	Q4	Q1
Appointment	1	0	3	1	3
Discharge	3	1	0	0	8
Absconded	18	7	15	26	15
Transfer	3	0	3	0	1
Delay in Admission	-	1	0	0	4
	25	**9**	**21**	**27**	**31**

Other

By Severity n = 30 (no data for Q1 at present)

	Q2	Q3	Q4	Q1
Negligible	31	31	22	27
Minor	5	6	7	4
Moderate	1	0	0	0
Extreme	1	1	1	0

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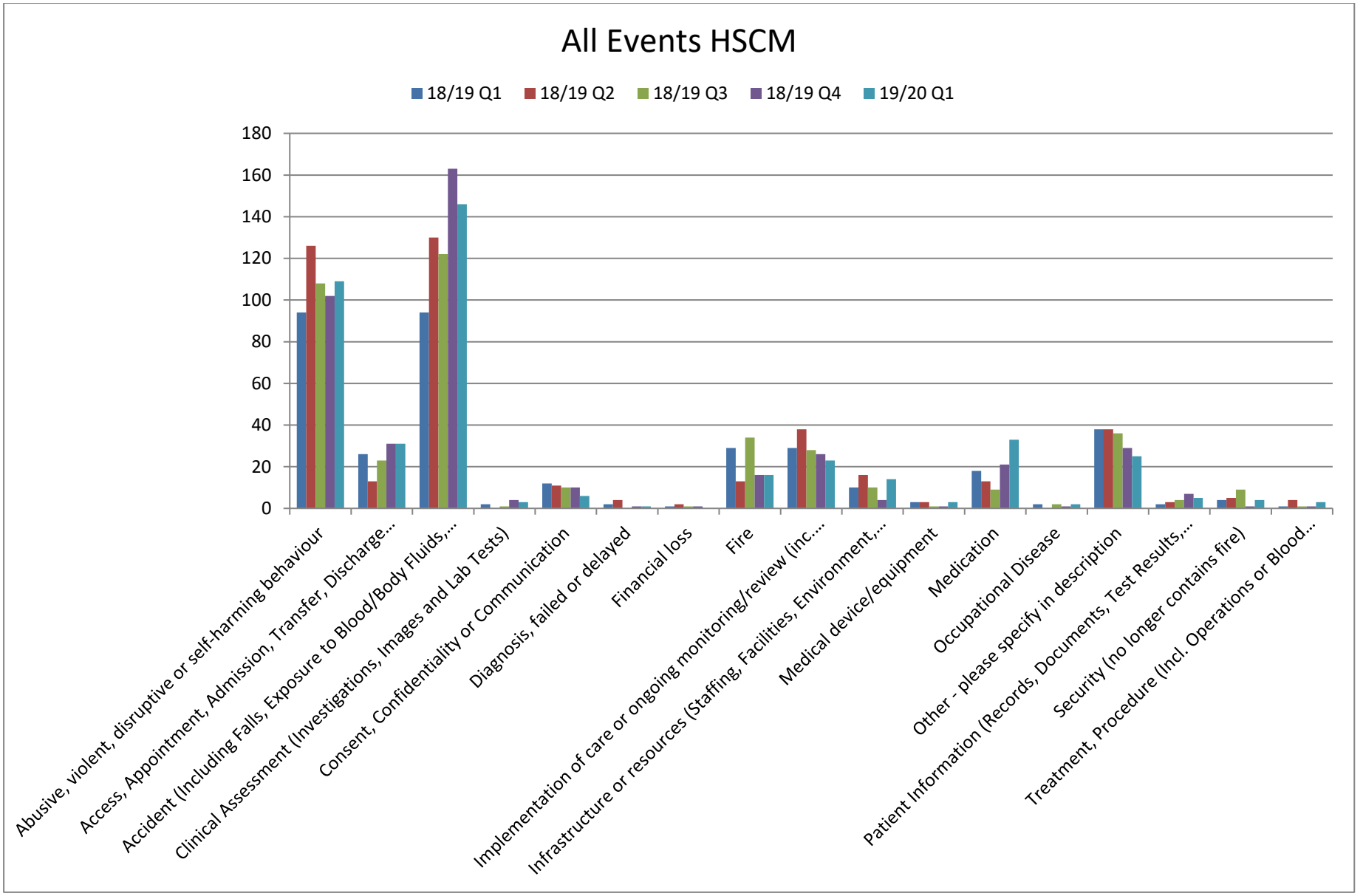
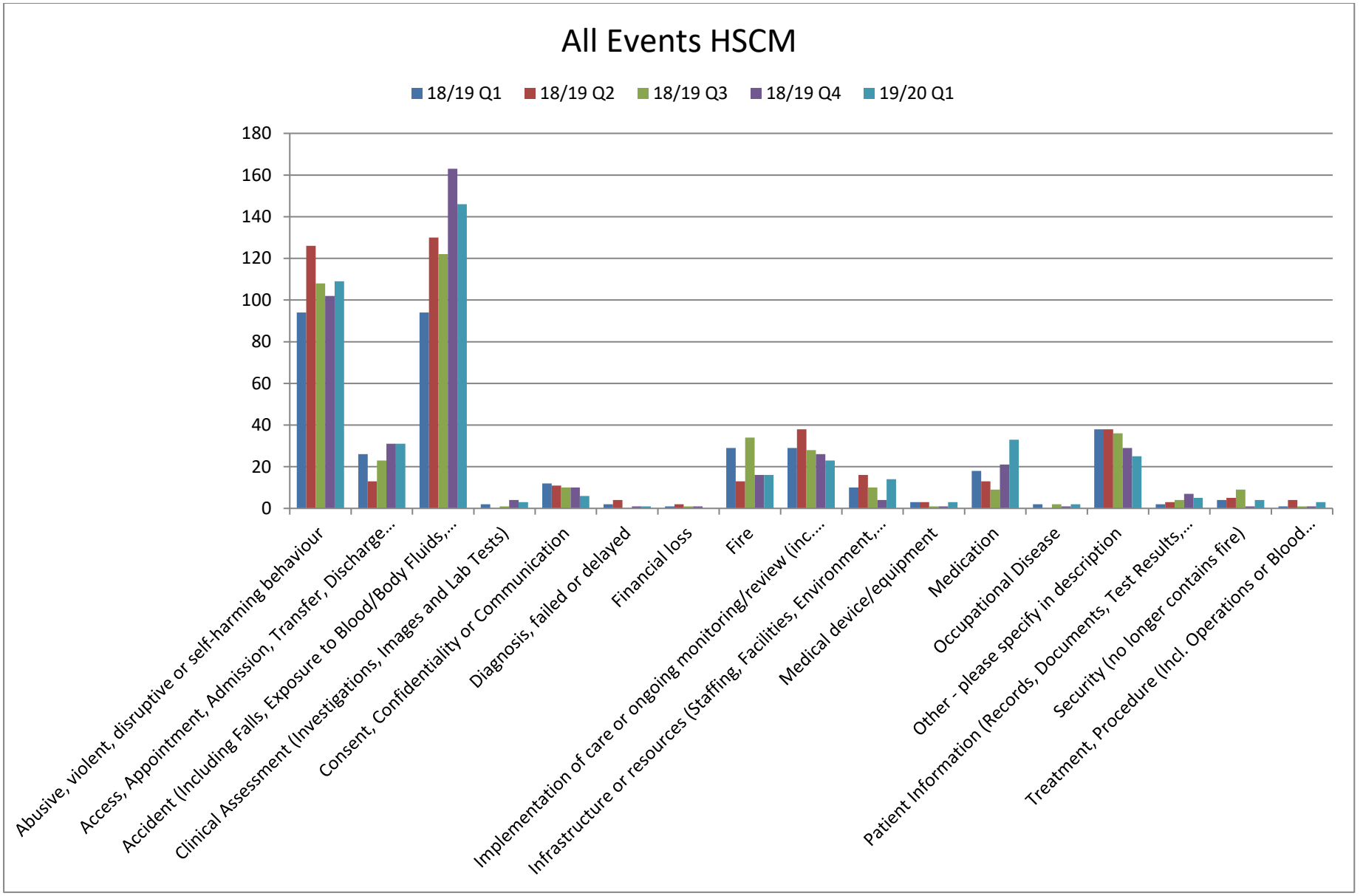

All Events HSCM
18/19 Q1
18/19 Q2
18/19 Q3
18/19 Q4
19/20 Q1
180
160
140
120
100
80
60
40
20
0
Abusive, violent, disruptive or self-harming behaviour
Access, Appointment, Admission, Transfer, Discharge...
Accident (Including Falls, Exposure to Blood/Body Fluids,...
Clinical Assessment (Investigations, Images and Lab Tests)
Consent, Confidentiality or Communication
Diagnosis, failed or delayed
Financial loss
Fire
Implementation of care or ongoing monitoring/review (inc....
Infrastructure or resources (Staffing, Facilities, Environment,...
Medical device/equipment
Medication
Occupational Disease
Other - please specify in description
Patient Information (Records, Documents, Test Results,...
Security (no longer contains fire)
Treatment, Procedure (Incl. Operations or Blood...


All Events HSCM
18/19 Q1
18/19 Q2
18/19 Q3
18/19 Q4
19/20 Q1
180
160
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120
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40
20
0
Abusive, violent, disruptive or self-harming behaviour
Access, Appointment, Admission, Transfer, Discharge...
Accident (Including Falls, Exposure to Blood/Body Fluids,...
Clinical Assessment (Investigations, Images and Lab Tests)
Consent, Confidentiality or Communication
Diagnosis, failed or delayed
Financial loss
Fire
Implementation of care or ongoing monitoring/review (inc....
Infrastructure or resources (Staffing, Facilities, Environment,...
Medical device/equipment
Medication
Occupational Disease
Other - please specify in description
Patient Information (Records, Documents, Test Results,...
Security (no longer contains fire)
Treatment, Procedure (Incl. Operations or Blood...

HSCM Audit and Quality Improvement Actions

Title	Overview	Start Date	End Date	Action Plan	Update	Owner	Documents
Mental health Assessment completion and communication	As part of the QI cohort	Jan-19				Julie MacKay	TBU
Improving Observations Practice	As part of the QI cohort	Jan-19				Corrinen Lackey	TBU
Integrated Occupational Therapy and Physiotherapy intervention with Acute Care of the elderly	As part of the QI cohort	Jan-19				Julie Campbell - physio DGH Karen Erskine - Occupational Therapist DGH	TBU
Falls prevented in Seafield Hospital, Buckie	As part of the QI cohort	Jan-19				Jim Brown Matthew Wilson Debbie Wood Fiona Russell Audrey Work	TBU
Support Nicotine Dependant Patients	As part of the QI cohort	Jan-19				Katherine Mackie - Smoking Cessation Advisor	TBU
Prescribing in breast Feeding - Education for Junior Doctors	As part of the QI cohort	Jan-19				Galye Anderson - Clinical Pharmacist, DGH	TBU

Title	Overview	Start Date	End Date	Action Plan	Update	Owner	Documents
Visual cues and MDT working to reduce falls	As part of the QI cohort	Jan-19				Angela Boyle - Physiotherapist DGH	TBU
Recude incidences of escalation in Stephen Hospital	As part of the QI cohort	Jan-19				Keith MacKay Angela Hay Sarah Stewart David Ridgers	TBU
Development of new Child Health Record	Development of a new paper record, to facilitate more effective record keeping and reduce duplication. Also to help inform the new electronic record development.	Apr-18	Jul-19		Currently piloting document. For review in May 2019.	Pauline Merchant	TBU

Title	Overview	Start Date	End Date	Action Plan	Update	Owner	Documents
Audit of consent and communication	NHS Grampian wide audit. 90% of dentists over a 6 month period. Previous audit have resulted the production and introduction of patient information leaflets.	Apr-19	Oct-19	Awaited on completion of audit		Rosemary Reeve	
Audit of Soft Tissues to ensure they are recorded appropriately.	Following a Level 1 review, three dentists and the clinical lead are currently undertaking an audit of soft tissue cases.	Apr-19	Oct-19	Awaited on completion of audit		Rosemary Reeve	
Clinical Record Keeping Audit	Following a Level 1 review, all dentists will undertake a clinical record keeping audit, approx. 15 hours over 12 months	Apr-19	Apr-20	Awaited on completion of audit		Rosemary Reeve	
Health and Safety Audits	within Community Hospitals	Jan-18	Ongoing			Alison Smart	

REPORT TO: **CLINICAL AND CARE GOVERNANCE COMMITTEE ON 29 AUGUST 2019**

SUBJECT: **DUTY OF CANDOUR ANNUAL REPORT**

BY: **HEAD OF CLINICAL AND CARE GOVERNANCE**

1. REASON FOR REPORT

1.1. To present the Clinical and Care Governance Committee with information in relation to how Health and Social Care Moray (HSCM) implemented the duty of candour legislation from the 1 April 2018 to 31 March 2019.

2. RECOMMENDATION

2.1. It is recommended that the Committee considers and notes the content of the report and the information contained in APPENDIX 1.

3. BACKGROUND

3.1. The Duty of Candour Act came into being on 1 April 2018. As a provider of health and social care services in Scotland there is a legal organisational duty of candour. This means that when unintended or unexpected events happen that result in death or harm as defined in The Duty of Candour Act, those involved and affected understand what has happened, receive an organisational apology and that we learn, as an organisation, how to improve for the future. Part of this duty is that the service provides an annual report about how the Duty of Candour (DOC) is implemented within the services.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. The annual DOC report for 2018/19 is attached in **APPENDIX 1.**

4.2. The report highlights 4 reportable DOC incidents within HSCM health services during the previous financial year.

4.3. This report has informed NHS Grampian's overarching report which will be uploaded to their webpage.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019

As defined within the Moray Integration Scheme values and meeting the strategic aims contained within the Moray Integration Joint Board (MIJB) Strategic Plan 2016-19.

(b) Policy and Legal

Clinical and Care Governance requirements are set out within the MIJB 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

MIJB, Moray Council and NHS Grampian could find themselves exposed to significant risks if good governance and reporting structures are not in place. Reputational damage is mitigated by being open and honest with service users when an incident has occurred. To support staff in understanding their responsibilities around the Act a number of training sessions have been held and information distributed across HSCM.

(e) Staffing Implications

None directly associated with this report.

(f) Property

None directly associated with this report.

(g) Equalities/Socio Economic Impact

An equalities impact assessment is not required for inclusion within this report as there is no change in policy.

(h) Consultations

Consultation on this report has taken place with the following staff who are in agreement with the content in relation to their area of responsibility:-
MIJB, Chief Officer;
HSCM Systems Leadership Team
NHS Grampian Duty of Candour Lead

6. CONCLUSION

6.1. The Committee are asked to note this report and take cognisance of the progress made across health services managed by HSCM to implement the Act during this first year.

Author of Report: Liz Tait, Head of Clinical and Care Governance
Background Papers: with author
Ref:

APPENDIX 1

Duty of Candour Update Report May 2019

Author: **Pauline Merchant,**
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HSCM

Lead : **Liz Tait**
Head of Clinical and Care Governance
Moray Alliance

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

An important part of this duty is that we provide an annual report about how the duty of candour is implemented in our services. This short report shows how Health and Social Care Moray has operated the duty of candour during the time between 1April 2018 and 31 March 2019.

About Health and Social Care Moray

HSCM is an integrated health and social care partnership working under the direction of the Moray Integration Joint Board (MIJB). Moray has a population of approximately 93, 000 (ISD General Practice Populations data) and stretches across approximately 860 square miles of predominantly rural landscape.

Health & Social Care Moray is responsible for adult social care, adult primary health care and unscheduled adult hospital care, along with some hosted services including GMED, Primary Care Contracts and Children and Families.

Four community hospitals exist in Moray in the towns of Buckie, Aberlour, Dufftown and Keith providing 71 (= 10 MH) inpatient beds in total delivering a range of acute and intermediate care services for local areas. Community health and social care services are built around the community hospitals with community based teams co-located where possible.14 GP services are arranged in practice clusters around the natural communities.

This report comprises events from Community Hospitals, hosted services and community nursing services. Independent contractors complete and report on their own investigations.

1. Duty of Candour Process

HSCM identify Duty of Candour incidents through DATIX - our adverse event management process. We identify through the significant adverse event review process if there were factors that may have caused or contributed to the event, which helps to identify duty of candour incidents.

At present, consideration as to whether the Duty should be triggered is requested for all adverse events where a patient is the person affected, the event resulted in harm and the event was reported on or after 1st April 2018. In all instances where the criteria are met it is mandatory to record whether the event triggers the Duty, the person who made the decision and the rationale for the decision. If it is decided that the Duty is not triggered, there are no further changes to the information required to be recorded on Datix. Where it is decided that the Duty has been triggered, additional sections and questions will appear on the form.
Once it has been decided that the Duty has been triggered, the next step is to identify the ‘relevant person’ i.e. the person that NHS Grampian will be communicating with regarding the event and the application of the Duty.

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

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

It is, however, recommended that where the Duty has been triggered a **minimum** of a Level 2 review is carried out by local management team review, including a service manager with multidisciplinary team input. A level 1 review where a significant adverse event analysis and review is required. This can be viewed in our local policy -Policy for the Management of and Learning from Adverse Events and Feedback.

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

We know that adverse events can be distressing for staff as well as people who receive care. We have support available for all staff through our line management structure as well as through our occupational health service.

Over the time period for this report we carried out, or are in the process of, 4 significance adverse event reviews. These events include a wider range of outcomes than those defined in the duty of candour legislation as we also include adverse events that did not result in significant harm but had the potential to cause significant harm.

2. Learning

All staff receive training on adverse event management and implementation of the duty of candour as part of their induction, so that they understand when it applies and how trigger the duty. Additional training is also available for those members of staff who frequently review adverse events, and for those who are regularly key points of contact with people who have been affected by an adverse event.

Adverse events are reviewed weekly at our local Clinical Risk Management group, and exceptions are escalated through the HSCM Clinical Governance Group. This also provides a platform for sharing learning and identifying challenges

As the process is relatively new, all incidents that have caused harm are reviewed to see if the Duty has been or should be triggered. There have been a limited number of incidents which have been up or down graded following review. Reporting staff are always informed if there has been a change to the allocation of the duty of candour.

Overall, it would appear that the processes in place are being followed appropriately, with staff being open to appropriate discussion and decisions. Learning from these

events is being shared through governance structures. Ensuring learning is shared across all staff groups in a meaningful way is to be developed.

3. Improvements

Following review of duty of candour events, improvements to services has included;

- Adoption of NICE guidance NG12
- Recording of lesions –position, size, shape, colour and digital photograph.
- Introduction of regular record keeping audits.
- Identification and delivery of specific training for targeted/ specialist groups of staff

Overall there is more conversation and discussion taking place between staff, with greater awareness evident regarding duty of candour.

4. Challenges

This is the first year of the duty of candour being in operation and it has been a year of learning and refining our existing adverse event management processes to include the duty of candour outcomes.

The main challenge around duty of candour has been ensuring that all relevant incidents/events trigger the duty. Having mandatory fields within the reporting system has assisted in raising awareness of the need to consider duty of candour. To help us to support the correct allocation of the duty, all incidents that have caused harm have been reviewed for accuracy. As awareness and confidence grows, it is envisaged that the need to review all incidents will decrease.

Sharing learning between sectors and services is not yet established. We need to continue to engage with independent contractors to build relationships and systems to facilitate sharing of learning from adverse and duty of candour events.

5. Numbers

Between 1 April 2018 and 31 March 2019, there were 4 incidents where the duty of candour applied. These are unintended or unexpected incident's that result in death or harm as defined in the Act, and do not relate directly to the natural course of someone's illness or underlying condition.

HSCM identified these incidents through DATIX - our adverse event management process. Over the time period for this report we carried out, or are in the process of, 4 significance adverse event reviews. These events include a wider range of outcomes than those defined in the duty of candour legislation as we also include adverse events that did not result in significant harm but had the potential to cause significant harm.

In each case, we reviewed what happened and what went wrong to try and learn for the future. Currently, one of the reviews have been completed, with the remaining 3 ongoing.

The appropriate level of review has been applied, with two Level 2 reviews and two Level 1 reviews allocated. The correct procedure was followed in 2 out of the 4 occasions (50%). This means we informed the people affected, apologised to them, and offered to meet with them. The remaining 2 occasions are still under investigation and it is currently unclear if we followed the duty of candour procedure.

This is the first year of the duty of candour being in operation and it has been a year of learning and refining our existing adverse event management processes to include the duty of candour outcomes.

If you would like more information about this report, please contact us:

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