**REPORT TO:** **CLINICAL AND CARE GOVERNANCE COMMITTEE ON 28 FEBRUARY 2019**

**SUBJECT:** **COMPLAINTS AND ADVERSE EVENTS – QUARTER 3**

**BY:** **CHIEF OFFICER**

## 1. REASON FOR REPORT

1.1 To inform the Clinical and Care Governance Committee of Health and Social Care Moray complaints and incidents reported in quarter 3 (October - December 2018).

## 2. RECOMMENDATION

**2.1 It is recommended that this Committee consider and note:**

**i) quarter 3 (October - December 2018) complaints and adverse events summary; and**

**ii) further work is underway to develop the processes and systems for collation and analysis of information to provide assurance across all services.**

## 3. BACKGROUND

3.1 This report combines the complaints information from both H&SCM and Moray Council systems for Quarter 3 for October – December 2018. The appended data is the beginning of collation of trend data and will be further enhanced and analysed as reporting continues.

3.2 Adverse events provided in this report only relate to those recorded on DATIX by H&SCM staff for which there are reports collated. Systems in place for Council staff do not facilitate easy collation and analysis of these types of events, this requires further development. A system is required to be developed to allow the collation and reporting of all relevant adverse events within the local authority pertinent to Health and Social Care Moray in one report.

## 4. KEY MATTERS RELEVANT TO RECOMMENDATION

### 4.1 Complaints

4.1.1 Overall, a total of 25 complaints were received/closed for H&SCM during Quarter 3 of 2018. **7** from the Council and **18** from H&SCM. These are outlined below.
A total of **25** complaints were processed and completed by H&SCM during Quarter 3. Further detail is included in **APPENDIX 1** to this report.
A total of **7** complaints were received and **6** were closed by the Council Outcomes from completed investigations are shown in the table below.

**Council**

| Directorate | Department | Service | Upheld | Partially Upheld | Not Upheld | Grand Total |
|---|---|---|---|---|---|---|
| Education and Social Care n= 6 | Community Care | Access Team | 0 | 0 | 1 | 0 |
| | | Community Care Finance | 0 | 1 | 1 | 2 |
| | | Head of Service | 0 | 1 | 1 | 2 |
| | | Occupational Therapy | 0 | 0 | 1 | 1 |
| | | MC Specialist Units | 0 | 1 | 0 | 1 |
| **Total** | | | **0** | **3** | **4** | **6** |

**H&SCM**

| Recording system | Service | Upheld | Partially Upheld | Not Upheld | Not Coded * | Total |
|---|---|---|---|---|---|---|
| H&SCM DATIX n= 18 | GMED | 3 | 1 | 3 | 3 | 10 |
| | Mental Health – Adult Health | 0 | 0 | 2 | 0 | 2 |
| | Mental Health – Learning Disabilities | 0 | 0 | 0 | 0 | 0 |
| | Mental Health – specialisms | 0 | 0 | 0 | 0 | 0 |
| | Community Hospital Nursing | 0 | 0 | 1 | 2 | 3 |
| | Allied Health Professionals | 0 | 0 | 0 | 2 | 2 |
| | Public Dental Services | 0 | 0 | 0 | 1 | 1 |
| **Total** | | **3** | **1** | **6** | **8** | **18** |

| Type of Complaint | NHS Complaints * | Council Complaints |
|---|---|---|
| Complaint against service | 5 | 0 |
| Clinical Care and treatment | 8 | 0 |
| Complaint against staff | 2 | 2 |
| Waiting times | 1 | 0 |
| | | |
| Process/Procedure | 3 | 1 |
| Other | | |
| Totals | 19 | 3 |

*One complaint was relevant to more than one type
2 of the complaints received to DATIX were from MP/MSP

4.2 **Adverse Events**

4.2.1 Incidents are recorded by NHS staff on the DATIX system. Each incident is reviewed by the appropriate line manager and investigated where required, with the relevant level of investigation applied. Analysis of this quarter's data shows that the majority of incidents were resolved following a local review by the line manager. **4** incidents were investigated with a Level 1 review (full review team), and **2** with a Level 2 review (local management review team). The remaining incidents had a Level 3 review (local review by line manager)

During Quarter 3 there were a total of **396** incidents recorded on DATIX. The highest prevalence were:-

121 incidents related to Slips Trips and Falls
107 incidents related to Abuse/ Disruptive Behaviour
38 incidents categorised as "Other"

4.2.2 **Slips, Trips and Falls**

The majority of these incidences occurred within the community hospital setting, with a relatively even spread across all locations, and can be attributed to known associated contributory factors, co-morbidities and mobility difficulties. Further analysis of the data is required to review trends, and a plan is being developed to review these incidents with Senior Charge Nurses and Service Managers on a more frequent basis.

4.2.3 **Abuse/ Disruptive Behaviour**

The majority of Abuse/Disruptive behaviour occurred within a Mental Health Setting. 13 patients had multiple episodes of abusive/disruptive behaviour reported, ranging from 1 to 28. This is concurrent with illness and behaviours relevant to this speciality. Those with a high number of reports will be further investigated.
Further analysis of the data is required to review trends.

4.2.4 **Other**

Having reviewed the incidents 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.
This will be included in the regular review of incidents as mentioned above.

4.2.5 **Severity Rating**

Of the 396 incidents reported there were 310 rated as negligible; 79 as minor; 3 as Moderate; and 2 as Extreme.

There were 2 incidents rated Extreme (death or major permanent incapacity, permanent loss of service, severe financial loss) which are currently being reviewed and investigated following appropriate investigative methodology.

## 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.

**(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**

An Equality Impact Assessment is not required because there are no changes to policy or practice arising from 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 Health and Social Care Moray complaints handling, performance and adverse events during Quarter 3 (October - December 2018) and outlines the intention to develop the contextual information across all services for future reports.**

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Background Papers: held by author
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