ITEM No …5………..

REPORT TO:	**HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** **20 APRIL 2022**
REPORT ON:	**CLINICAL CARE AND PROFFESSIONAL GOVERNANCE**
REPORT BY:	**CHIEF OFFICER**
REPORT NO:	**DIJB27-2022**

1.0 PURPOSE OF REPORT

1.1 To provide the Integration Joint Board with information relating to Clinical, Care and Professional Governance for the periods 01.10.2021 to 30.11.2021. and 01/12/2021 to 31/01/2022. Clinical, care and professional governance matters are reported through the Performance and Audit Committee on a 2-monthly basis, following submission to NHS Tayside's Care Governance Committee. As a result of the schedule of meetings for the Performance and Audit Committee, the programme of reports for the period 01/10/21 – 31/01/2022 are presented as exceptional reports to the IJB to ensure there are no unnecessary lags in providing assurance.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Notes the content of this report and the attached appendices.

2.2 Instructs the Chief Officer to provide an annual Clinical, Care and Professional governance report for the financial year April 2021 – March 2022 to the June IJB meeting.

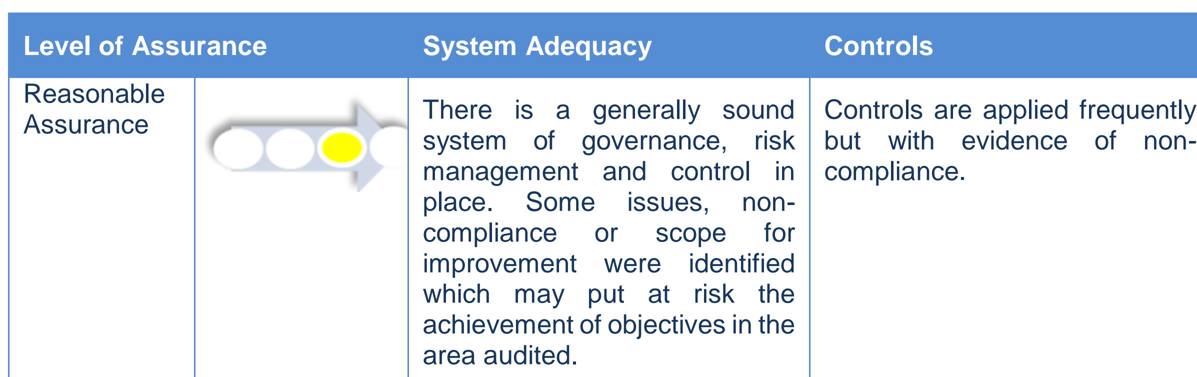
2.3 Notes that the level of assurance provided for this period is Reasonable assurance (as defined in section 4.6).

3.0 FINANCIAL IMPLICATIONS

There are no additional financial implications arising from this report.

4.0 MAIN TEXT

4.1 This report is being brought to the meeting to provide assurance on the clinical and care governance activities and arrangements across the Partnership as outlined in the Getting It Right For Everyone Framework in accordance with the Partnership integration scheme. Clinical Governance is a statutory requirement to report on, at Board level, from Scottish Government as per NHS MEL (1998) 75.



Level of Assurance		System Adequacy	Controls
Reasonable Assurance		There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.	Controls are applied frequently but with evidence of non-compliance.

4.2 The role of the Dundee HSCP Governance forum is to provide assurance to the Dundee Integration Joint Board, NHS Tayside Board (through the Care Governance Committee) and Dundee City Council, that there are effective and embedded systems for Clinical, Care & Professional Governance in all services within Dundee Health and Social Care Partnership.

4.3 The GIRFE Framework has been agreed by all three HSCPs and the refresh of the document was endorsed at Care Governance Committee and noted by NHS Tayside Board on 31 October 2019. To ensure consistency of approach between Local Authorities, Tayside NHS Board and the IJBs for the three HSCPs, quality assurance is assessed against an agreed, prioritised common data set for each of the governance domains as detailed below. A GIRFE Steering Group has been established and continues to meet, with representatives from each of the three Partnerships and part of its remit is to support additional common assurance measures and this template.

4.4 The six domains continue to evolve over time and must be adaptable and responsive to the changes in legislation and external support and monitoring. The domains reflect the principles set out in the Health and Social Care Standards, My support, My life; Scottish Government, 2018 and the Quality of Care Approach, HIS and Care Inspectorate, September 2018. The domains are:

Information Governance
Professional Regulation and Workforce Development
Patient / Service User / Carer and Staff Safety
Patient / Service User / Carer and Staff Experience
Quality and Effectiveness of Care
Promotion of Equality and Social Justice

4.5 This report is assuring the IJB that clinical governance and risk management processes are in place, that reliable, safe and effective, and person-centred care is delivered in all health and care settings, and learning is identified and shared thereby reducing harm to people.

4.6 The IJB is being asked to provide their view on the level of assurance the attached reports provides and therefore the level of assurance regards clinical and care governance within the Partnership. The timescale for the data within this report is from 01/11/2021 to 31/01/2022 and is provided through two reports as submitted to the Care Governance Committee. Appendix 1 presents the information for the period 01.10.2021 to 30.11.2021. and Appendix 2 presents the information for period 01/12/2021 to 31/01/2022.The level of assurance provided for the period is assessed as Reasonable.

4.7 In addition to the bi-monthly reporting, the DH&SCP CC&PG group provides an annual report summarising the actions, risks and governance arrangements for each financial year. It is proposed that the annual report for the financial year be submitted to the IJB for the June 2022 meeting.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues.

6.0 RISK ASSESSMENT

Risk 1 Description	That clinical, care and professional governance standards are not met,
Risk Category	Operational, Governance
Inherent Risk Level	Likelihood (3) x Impact (4) = Risk Scoring (12)
Mitigating Actions (including timescales and resources)	An established framework and process for the monitoring and responding to Clinical, Care and Professional Governance risk is embedded within the Dundee Health and Social Care Partnership.
Residual Risk Level	Likelihood (3) x Impact (3) = Risk Scoring (9)
Planned Risk Level	Likelihood (3) x Impact (3) = Risk Scoring (9)
Approval recommendation	That the risk should be accepted.

7.0 CONSULTATIONS

The Chief Finance Officer and the Clerk were consulted in the preparation of this report.

8.0 DIRECTIONS

The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working) (Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

Direction Required to Dundee City Council, NHS Tayside or Both	Direction to:	
	1. No Direction Required	X
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

9.0 BACKGROUND PAPERS

None.

Vicky Irons
Chief Officer
Dundee HSCP

DATE: 04 October 2021

Appendix **1**

Title: Dundee HSCP Clinical and Care Governance Assurance Report for Period 01.10.2021 to 30.11.2021

Responsible Officer: Dr David Shaw, Clinical Director
Diane McCulloch, Head of Health and Social Care

Report Author: Matthew Kendall, Allied Health Professions Lead

1 Assessment

A Clinical and Care Risk Management

a.1 There are no new current risks added to Datix since the last report.

Out of the 24 current risks, 17 have actions required to ensure that they remain up to date, which shows a deteriorating position. Risk owners have all been contacted and offered support in updating their risks.

Title of Risk	Priority Level	Inherent Risk Score (without controls)	Current Risk Score (with current controls in place)
Increasing demand in excess of resources, DDARS	1	15	25
Insufficient numbers of DDARS staff with prescribing competencies	1	25	25
Current funding insufficient to undertake the service redesign, DDARS	1	20	20
COVID-19 impact: maintaining DDARS	1	12	15
Clinical treatment of patients – Mental Health Service (946)	2	15	15

<u>DDARS</u>

a.2 Four of the top five risks continue to sit with the Dundee Drug and Alcohol Recovery Service. There have been further service pressures due to staff turnover that affect all the key risks identified. The current pandemic response has also limited the HSCP progress with risk management due to a significant number of staff in isolation.

Two of these risks continue to show a current risk score in excess of the inherent risk score. This is primarily due to ongoing challenges relating to recruitment and retention into the DDARS service.

The service continues to experience staffing pressures across both social work and nursing staff as a result of vacancies and sickness absences. DDARS continues to experience nursing vacancies and increasing recruitment difficulties.

Since the addition of the third consultant, the service is progressing initial assessments and is beginning to see a reduction in referral waiting lists (155 people currently waiting: 90 for alcohol assessment, 57 for drugs assessment and 8 for both drugs and alcohol, with the longest current wait being 139 days). Key worker unallocated remains a concern.

The restructuring of the service now supports patients from two GP practices to be managed and supported by their own GP while still registered to the service.

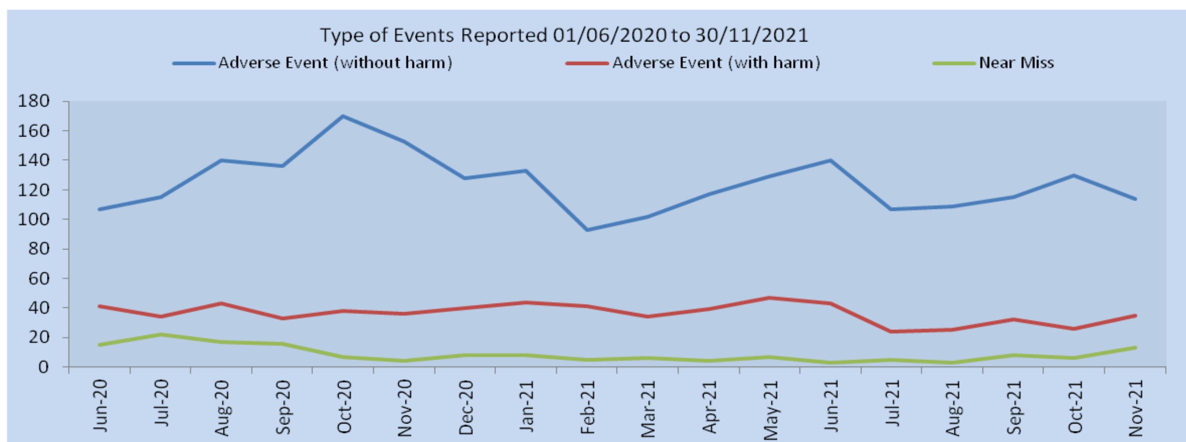
The service is scoping out potential alternative accommodation, although remains an area of concern.

Mental Health

a.3 The Community Mental Health Team are medically staffed entirely by Locum Consultants but have a stability to this in people remaining longer-term in post than previously. There is currently one locum on paternity leave and the CMHT has a significant number of people awaiting first assessment. To begin to better mitigate the short-term risks and address the national shortage of psychiatrists in the longer term, the service have appointed two Advanced Nurse Practitioners and a specialist mental health pharmacist who is further supported by a pharmacy technician. The service have a further two ANPs in training and intend to graduate them into this role on qualification.

b. Adverse Event Management

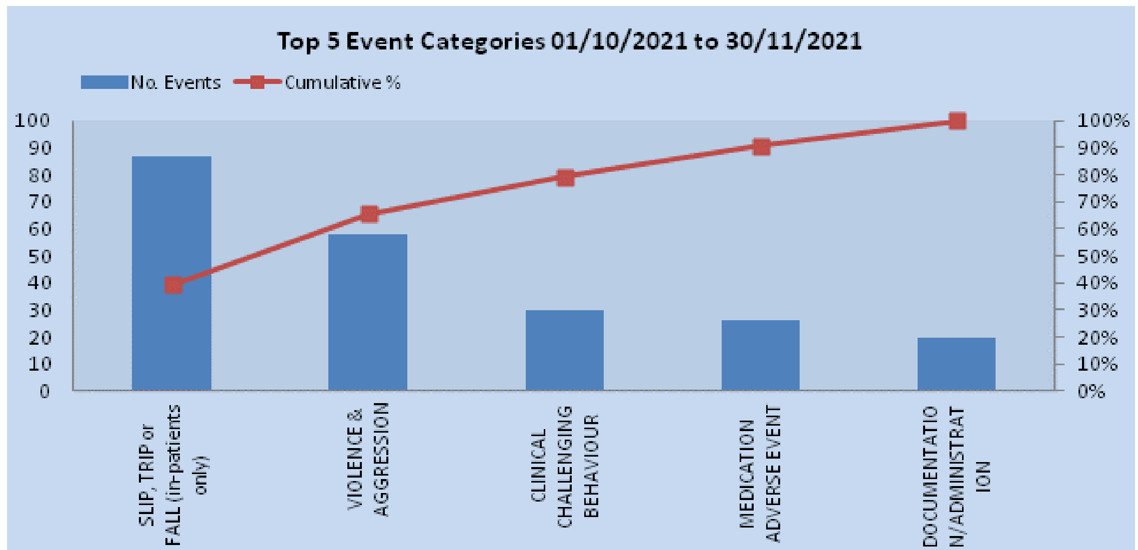
b.1 There were 324 adverse events reported within the time period 01/10/2021 to 30/11/2021. The following graph shows the type of adverse events reported though Datix by month over the past 18 months.



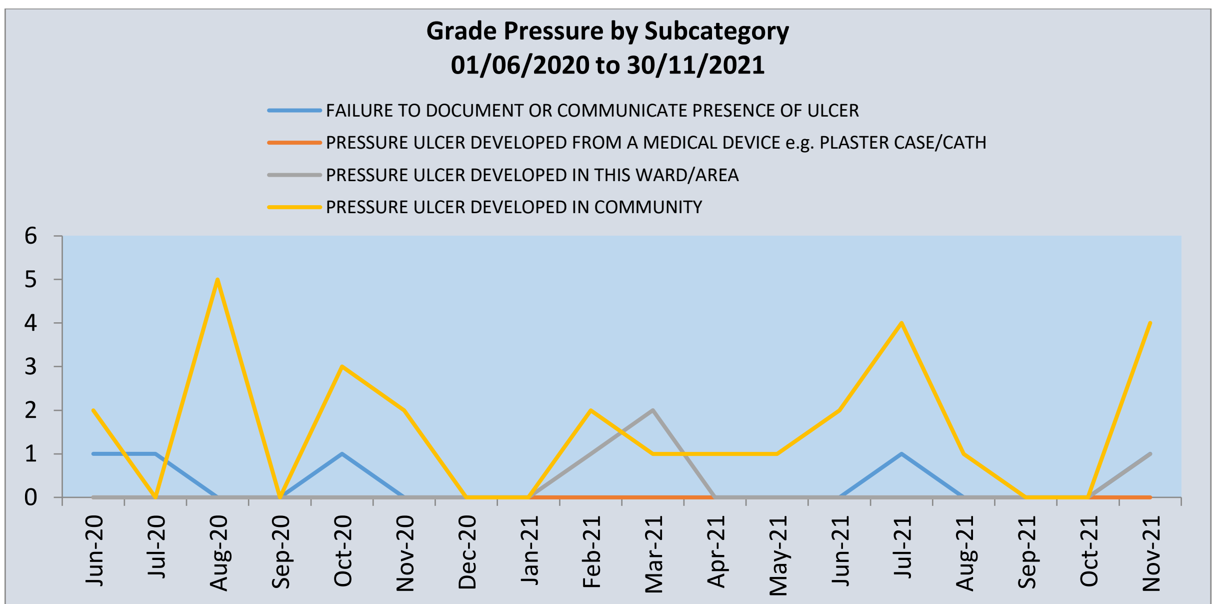
There are no significant concerns relating to this data for escalation. Teams continue with quality improvement work in relation to falls and violence and aggression (V&A) / clinically challenging behavior(CCB), with a specific focus on accurate reporting for V&A and CCB.

b.2 While medication adverse events remain in the top 5 reported incidents they remain widely reported across teams with no themes or patterns identified. The weekly governance huddle follow up on these events to ensure reflective practice is taking place and the opportunity for improvement is sought across teams.

The following graph shows the top 5 categories reported between 01.10.2021 and 30.11.2021. The top 5 categories are: slip, trip or fall (inpatients only), violence and aggression, clinically challenging behaviour, medication adverse event and documentation/administration. These categories account for 221 of the 324 events (68%) reported within the time period.



b.3 There have been seven pressure ulcer events reported within the time period. The number of pressure ulcers reported over the past 18 months is shown in the following graph, by subcategory.



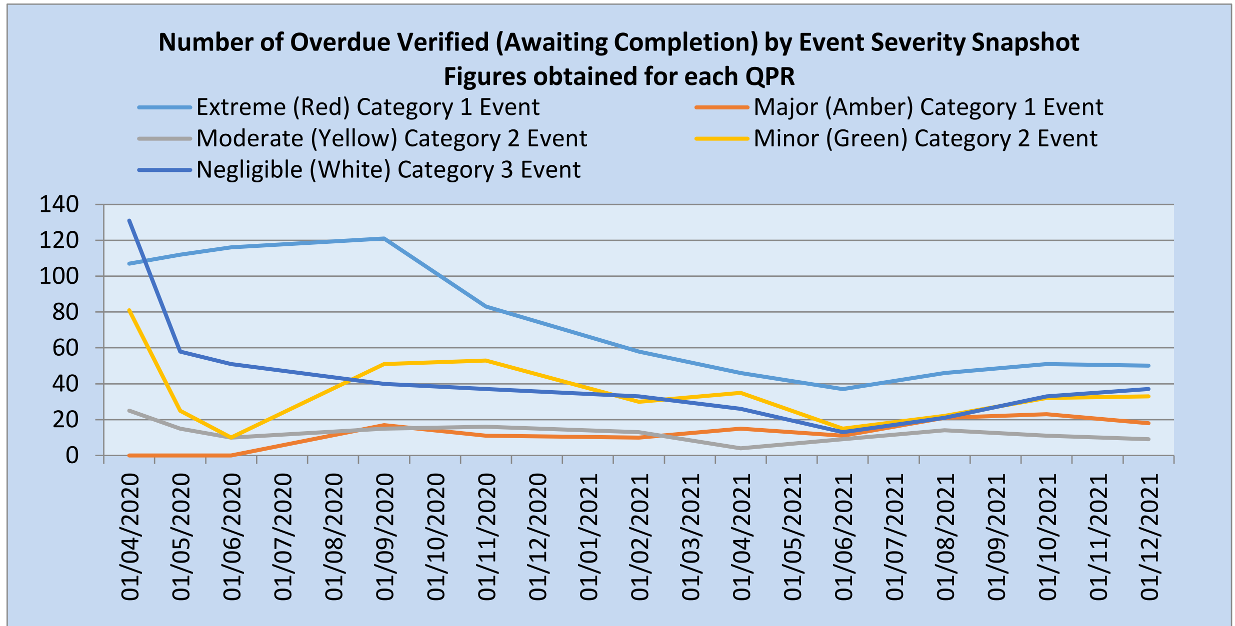
The community teams have reviewed this data due to the increase in pressure ulcers noted in November 2021. One incident is still under review and all of the others identified that these pressure ulcers were unavoidable with prevention measures in place or discussed with patients and carers and decisions were made by the patients not to follow the advice provided. One of the reported pressure ulcers was a moisture lesion, and education has been provided to this reporter to ensure accurate reporting and recording for pressure ulcers in the future. While these pressure ulcers have been identified as unavoidable, the Lead Nurse is taking forward work with the community nursing team to review all aspects of care related to pressure ulcers.

Never Event

b.4 There was one never event reported relating to inpatient care. This is currently being investigated and the clinical governance team are working with the clinical teams to determine the level of review required for this incident. The patient is making good progress with rehabilitation in the hospital environment.

Overdue verified events

b.5 The following graph shows the number of verified events that are overdue for completion over the past 12 months.

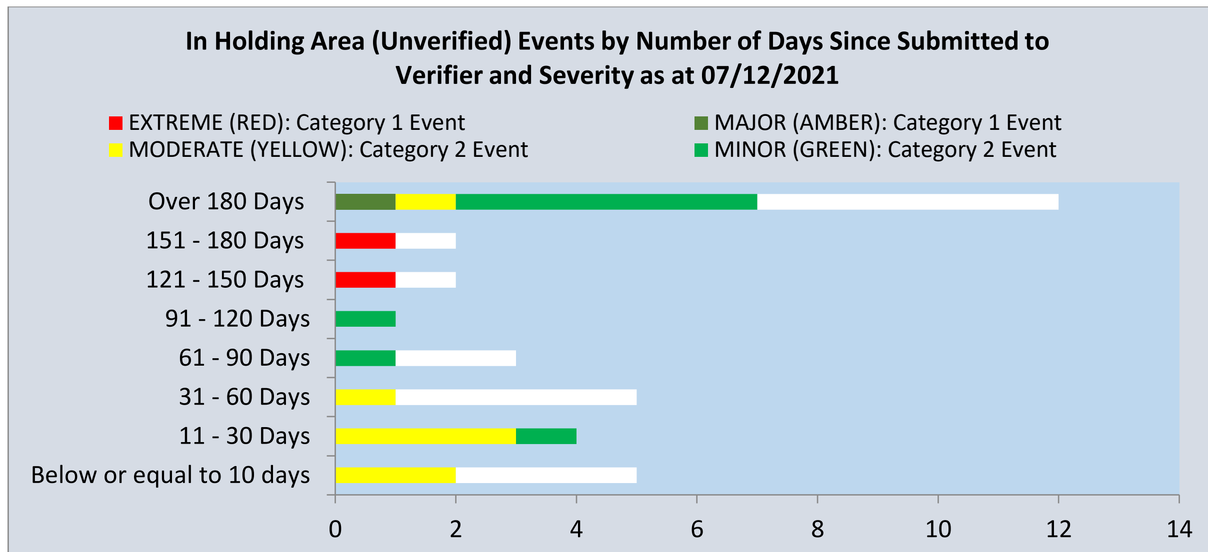


b.6 The table below shows the number of overdue events by the year they were reported. The numbers in brackets represent the number of overdue events by year as included in the last report, demonstrating that the number of historical outstanding reviews continues to reduce.

	2018	2019	2020	2021
EXTREME	1 (1)	5 (6)	11 (15)	23 (17)
MAJOR	0	0 (1)	4 (7)	14 (5)
MODERATE	0	0	4 (4)	5 (3)
MINOR	0	0	5 (5)	28 (24)
NEGLIGIBLE	0	0	0	37 (25)
TOTAL	1	5	24	107

The majority of overdue extreme and major events sit within the Mental Health Service and DDARS. As has been noted in previous reports, significant improvement has been noted in reducing the numbers of overdue adverse events. While historical events continue to slowly reduce, this report highlights a plateau in improvement over the past few months. Increased clinical demand and unplanned staff absence have contributed to this increase for 2021 Datixs, with the current Omicron variant of COVID-19 reducing staff's capacity to continue review of these incidents at previous rates.

Unverified Events



b.7 At the time of data extraction there were 34 unverified events that had exceeded the timescale of 72 hours for verification. The following graph shows the unverified events by the severity and the number of days overdue. Of these events 24 are graded either negligible or minor.

A number of these incidents are linked to the vaccination program rather than Dundee HSCP, and the clinical governance team is supporting the management of these incidents. Reminders have been sent to verifiers regarding unverified incidents.

The extreme incidents are linked to the DDARS service and both form aspects of the recorded risks (612, 233) and are being managed as outlined in the DATIX risk system.

Significant Adverse Event Reviews (SAERs)

b.8 One SAER was finalised in this reporting period. This was in relation to a suspected suicide. A summary of the findings is listed below:

- The SAER concluded that no omission by staff can be identified which may have contributed to this incident or prevented this incident from occurring.
- The use of numerous separate healthcare and social work records, both electronic and paper-based, on this occasion did not lead to any breakdown or interruption in treatment plan, but the reviewer has identified this use of these multiple systems could potentially lead to problems with other healthcare and social work individuals accessing up to date relevant information.
- Events leading up to the incident were managed by staff appropriately given the patient's presenting condition.
- No evidence was found that this incident, although tragic for all concerned, could have been avoided as the patient was deemed to have capacity during the numerous assessments that took place prior to the incident.
- Previous self harm attempts had involved medication overdose.
- All contacts had involved symptoms of anxiety and/or low mood.
- Patient A had a history of alcohol misuse and associated impulsive acts whilst under the influence of alcohol.

b.9 The following areas were highlighted as areas for review and/or improvement.

- There are multiple electronic and paper-based healthcare records used by Health and Social Care Services that do not all connect with each other and staff do not have access to all the information within each system. A review of the systems in use and access to systems across the Health and Social Care Partnership and NHS Tayside is required to ensure timely sharing of information and seamless communication with all services.
- Review of communication at times of transition between services to ensure seamless care.

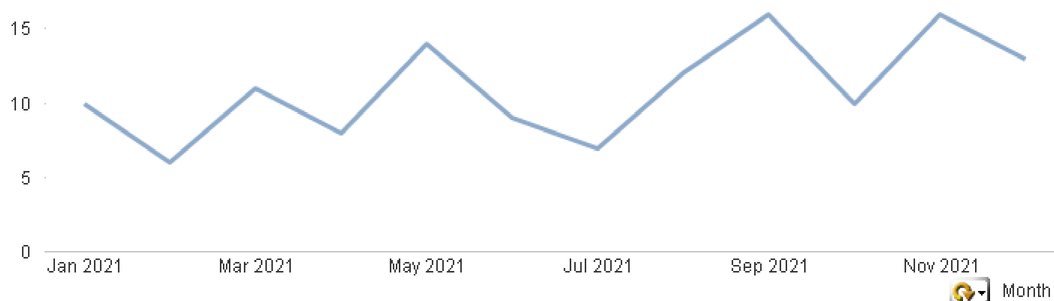
- The need for a flexible complex care whole system approach when many services and teams are involved to ensure a flexible joined up response and seamless care.

b.10 What we have learnt:

- Dundee Drug and Alcohol Recovery Service normally admits only people under 65 years old into the service. This requires to be reviewed.
- The NHS email system sees social work emails as from an external organisation – that takes longer to see "out of office" information which can have an impact on timely communication. This needs to be reviewed.
- Emails to GP practices should go to the generic email for the GP practice to be dealt with in a timely manner and not to a person-specific GP email who may be out of the practice.

Complaints and Feedback

b.11 Total number of new complaints received from Jan 2021 to Dec 2021



This graph shows a steadily increasing number of new complaints received throughout 2021.

b.12 Current Complaints as at 18/01/22 – Combined Stages 1 and 2

No. of Open Cases - 27

Clinical Care Group/Department	Days_Band	0-5 Days	6-10 Days	11-15 Days	16-20 Days	>20 Days	>40 Days	>60 Days	>80 Days	Total
Community Learning Disabilities Nursing - Dundee HSCP		-	1	-	-	-	-	-	-	**1**
Corporate (Dundee HSCP)		-	1	-	-	-	-	-	-	**1**
Mental Health (Dundee)		1	-	1	2	2	3	1	1	**11**
Dundee Drug and Alcohol Recovery Service		-	-	-	-	1	-	-	-	**1**
Allied Health Professionals (Dundee HSCP)		-	-	-	-	1	-	-	-	**1**
Community Nursing (Dundee HSCP)		-	-	1	-	1	-	-	-	**2**
General Practice - Dundee HSCP		-	-	-	1	1	-	-	2	**4**
Older People Services (Dundee)		1	1	-	-	2	-	1	-	**5**
CBIR		-	-	1	-	-	-	-	-	**1**
Total		**2**	**3**	**3**	**3**	**8**	**3**	**2**	**3**	**27**

b.13 Current Complaints as at 18/01/22 – Stage 2

No. of Open Cases - 24

Clinical Care Group/Department	Days_Band	0-5 Days	6-10 Days	11-15 Days	16-20 Days	>20 Days	>40 Days	>60 Days	>80 Days	Total
Community Learning Disabilities Nursing - Dundee HSCP		-	1	-	-	-	-	-	-	1
Corporate (Dundee HSCP)		-	1	-	-	-	-	-	-	1
Mental Health (Dundee)		-	-	-	2	2	3	1	1	9
Dundee Drug and Alcohol Recovery Service		-	-	-	-	1	-	-	-	1
Allied Health Professionals (Dundee HSCP)		-	-	-	-	1	-	-	-	1
Community Nursing (Dundee HSCP)		-	-	1	-	1	-	-	-	2
General Practice - Dundee HSCP		-	-	-	1	1	-	-	2	4
Older People Services (Dundee)		1	1	-	-	2	-	-	-	4
CBIR		-	-	1	-	-	-	-	-	1
Total		**1**	**3**	**2**	**3**	**8**	**3**	**1**	**3**	**24**

b.14 Current Complaints as at 18/01/22 – Stage 1

No. of Open Cases - 2				
Clinical Care Group/Department	**Days_Band**	0-5 Days	11-15 Days	**Total**
Mental Health (Dundee)		1	1	2
Total		**1**	**1**	**2**

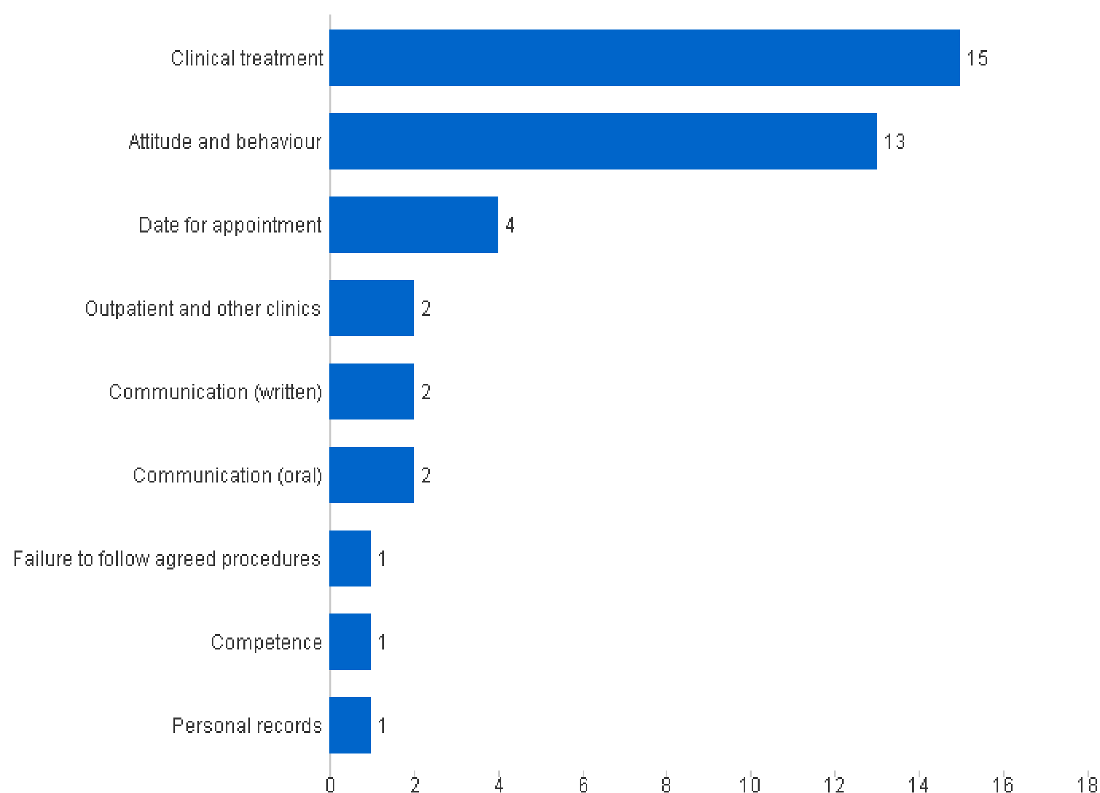
Complaints and Feedback are managed by service managers (including hosted services) with professional leads being sighted on responses, which support identifying/sharing learning and areas for improvement.

Feedback and positive reports from patients and carers are also being promoted for reporting at Primary Governance Groups as part of performance and learning focus.

Further work, in collaboration with the Complaints and Feedback Team, is underway to better understand where and why responses to some complaints take longer than the standard 20 days. The CCPG Group monitors response times, themes and supports the sharing of learning from complaints.

Learning and improvement from complaints and feedback.

b.15 The top themes associated with complaints across the Dundee HSCP are outlined in the table below:



The top subtheme is disagreement with treatment and/or care plan (11), followed by inappropriate comments (<5) and unacceptable time to wait for appointments (<5).

Examples of learning and improvement from complaints

Disengagement

b.16 Concerns were raised regarding disengagement with mental health services resulting in discharge. Nursing staff now ensure a disengagement plan is included within the risk management plan which includes a graded escalation plan for making contact should patients miss appointments. This can include contacting the patient's significant other, trying to contact again within an agreed timeframe, the nurse carrying out a home visit and, if required, the nurse contacting the police depending on the risk.

Telecommunication Access

b.17 A common theme identified is the difficulty patients and families experience in getting through to the two Duty Worker lines in the community mental health teams. Work with the telecommunications team has led to a change in how these calls are routed through the system and additional external lines being opened to better manage traffic through the system. This learning was also applied across other teams.

Complex whole system

b.18 Complex complaints across the Mental Health service lead to further complaints due to the amount of time it sometimes takes to get all the information to the right clinical team in a timeous fashion. The Mental Health team, the NHS Tayside Complaints and Feedback team and the Dundee HSCP Complaints team are working to ensure improved access and enhanced collaborative working to ensure all issues are fully addressed with colleagues across the whole system.

Interim Social Care Placement

b.19 To support flow and capacity through very challenging circumstances, patients have sometimes been placed to interim social care solutions. This potentially very emotional and distressing situation has been reviewed to ensure appropriate, early MDT messaging and an escalation pathway has been implemented to support complex cases, with the intention of keeping this work as patient-centred as possible.

Sexual Health Pathways

b.20 Pathways were reviewed and implemented around remote working and prophylactic antibiotic therapy within the Tayside Sexual and Reproductive Health Service.

c. External Reports & Inspections

There have been no inspections during this reporting period.

d. Adult Support & Protection

There are no exceptions to report during this reporting period.

e. Mental Health

Delayed Discharges

e.1 The level of delayed discharges across General Adult Psychiatry (GAP) and Learning Disability (LD) services has continued to significantly impact on capacity and flow. As of 16 January 2022 there are a total of 26. This equates to 16% of GAP beds, 38% of LD beds.

Health and Social Care Partnership	No of GAP Acute Admission and Rehabilitation Delayed Discharges	No of Learning Disability Delayed Discharges
Dundee	9	5
Angus	5	<5
Perth & Kinross	<5	<5
Other	<5	<5
Total	**17**	**9**

e.2 Actions taken by the services to address delayed discharge:

- Fortnightly meeting established with Senior Mental Health and Learning Disability Leaders from all three HCSPs, with commitment to work together to resolve delayed discharges.
- Agreement to use an updated standard delayed discharge template for Mental Health and Learning Disabilities. Template will be updated and shared weekly.
- Angus, Dundee and Perth & Kinross Leads will ensure sharing of information as to who would be part of the escalation process when delays occur.
- Readiness for Discharge Tool to be discussed in all areas to ensure awareness of use within inpatient services.
- Consideration being given to specific MDT for LD-specific delays (acknowledging complexity).
- Two Discharge Coordinators in post to support improving discharge planning (funded by winter pressure funding).
- Quality Improvement Advisor identified to support improving discharge planning across the services.

Models of Care

e.3 Mental health and learning disability care is delivered by multi-disciplinary teams. Medical input is only one part of the care and treatment delivered and it is not essential for all patients to be seen face-to-face by Consultants. Rather, it is important that medical time is used to guide and advise treatment plans with this achieved by members of the MDT being able to thoroughly assess a person's needs and consult with medical colleagues to together make decisions about the need, for example, for medication changes. By safely increasing consultancy models, there is an increased availability of medical time for those complex cases that do require assessment by a Consultant. This is in keeping with the concept of ‘right person, right place, right time’.

f. Drug and Alcohol-Related Deaths

Drug-Related Deaths

f.1 The service continues to work to support those at high risk. The Non-Fatal Overdose Rapid Response Service ensures priority access to assessment and treatment services. A recent contract with a third sector organisation will deliver Opiod Substitution Therapy to those who are self-isolating or unable to access their medication support through pharmacy.

There were less than five fatalities reported in this reporting period. They were across the categories of suicide (suspected), suspected drug-related death and expected death and were across both the Mental Health and DDARS services.

Medication Assisted Treatment (MAT) Standards

f.2 DHSCP have submitted an initial assessment to the MAT Improvement Support Team (MIST) setting out the progress made to date and the areas where further work is required. The information provided identified areas where further support, both financial and national guidance, would support progression. It is acknowledged that each Alcohol and Drug Partnership area will outstrip the resources available to the MIST Team. In addition to this support, funding was received for a MAT standards project worker for Dundee and job descriptions are currently being evaluated by DCC and NHS Tayside. In regards to specific standards, work progresses around primary care shared care and there are ongoing discussions with the Scottish Government; additional funding is being sought for residential rehabilitation pathways and work is progressing to support independent advocacy.

1.3.1 Quality/ Patient Care

The principle focus of all services is a desire to achieve the six dimensions of healthcare quality. These state that healthcare must be:

- Safe
- Effective
- Patient-centred
- Timely
- Efficient
- Equitable

The work being progressed will have a positive impact on the quality of care and services for staff and the population of Tayside.

1.3.2 Workforce

Remobilising continues to be challenging for staff in the HSCP, who are increasingly exhausted and feeling the impact of the past 22 months working through a pandemic. Senior and Service Managers are focusing on supporting their staff through this period.

As the new Omicron variant becomes more prevalent, increasing staff absence further compounds the workforce challenges.

1.3.3 Financial

Not applicable.

1.3.4 Risk Assessment/Management

Risks are included in the report above.

1.3.5 Equality and Diversity, including Health Inequalities

An impact assessment has not been completed. Promotion of Equity and Social Justice is one of the domains included in the GIRFE reporting assurance framework.

1.3.6 Other Impacts

There are no other direct impacts for this report.

1.3.7 Communication, Involvement, Engagement and Consultation

The Dundee HSCP has carried out its duties to involve and engage external stakeholders where appropriate.

1.3.8 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Dundee Health and Social Care Partnership Clinical, Care and Professional Governance Group, 20 January 2022.

1.4 Recommendation

This report is being presented for:

- **Assurance**

As lead Officer for Dundee HSCP I would suggest that the level of assurance provided is: Moderate

Appendix 2

Title: Dundee HSCP Clinical and Care Governance Assurance Report for Period 01.012.2021 to 31.01.2022

Responsible Officer David Shaw, Clinical Director
Diane McCulloch, Head of Health and Social Care

Report Author: Matthew Kendall, Allied Health Professions Lead

1 Assessment

a. Clinical and Care Risk Management

Title of Risk	Priority Level	Inherent Risk Score (without controls)	Current Risk Score (with current controls in place)
Increasing demand in excess of resources, DDARS	1	15	25
Insufficient numbers of DDARS staff with prescribing competencies	1	25	16
Current funding insufficient to undertake the service redesign, DDARS	1	20	20
COVID-19 impact: maintaining DDARS	1	12	12
Clinical treatment of patients – Mental Health Service (946)	2	15	15
Lack of resource to deliver the benzodiazepine dependence pathway compliant with guidelines	1	20	16

a.1 Insufficient numbers of DDARS staff with prescribing competencies: Current score for this risk has reduced from 25 to 16. Additional funding has been allocated to the service to recruit additional staff with prescribing competencies. Recruitment to these posts remains a challenge and training of staff in post will take time. One additional consultant has also recently joined the service.

COVID-19 impact: maintaining DDARS: Current risk score for this risk has reduced from 15 to 12. Stabilisation of the workforce in terms of an improved picture for recruitment and slightly improved retention has supported the reduction in this risk.

<u>New Risk in Top 5</u>

a.2 A new risk has been added in the DDARS team regarding the lack of available resource to deliver the benzodiazepine dependent pathway. Many people dying from drug deaths who are open to DDARS, have etizolam present in the PM toxicology. DDARS does not have access to the resources in the community or a stabilisation inpatient facility to deliver prescribed diazepam detoxes.

Clinical risks including overdose, could be increased by reduced access to prescribed diazepam withdrawals caused by:

- a lack of capacity / staffing resource to monitor for respiratory depression and substance use
- a lack of staffing resource for structured psychological interventions

- biochemistry drug screening not delivering results for substances commonly causing harm in a clinically useful timescale.

The team are currently working towards:

- Identifying the model and resources required for residential rehabilitation
- Agreeing the multiagency resources required to implement the benzodiazepine pathway
- Identifying the minimum resources required for DDARS to manage patients dependent on benzodiazepines in the community

a.3 Four of the top five risks continue to sit with the Dundee Drug and Alcohol Recovery Service. There have been further service pressures due to staff turnover that affect all of the key risks identified. Two of these risks have improved in this reporting period, with one new risk being added which now sits in the top five risks in the DHSCP, described above.

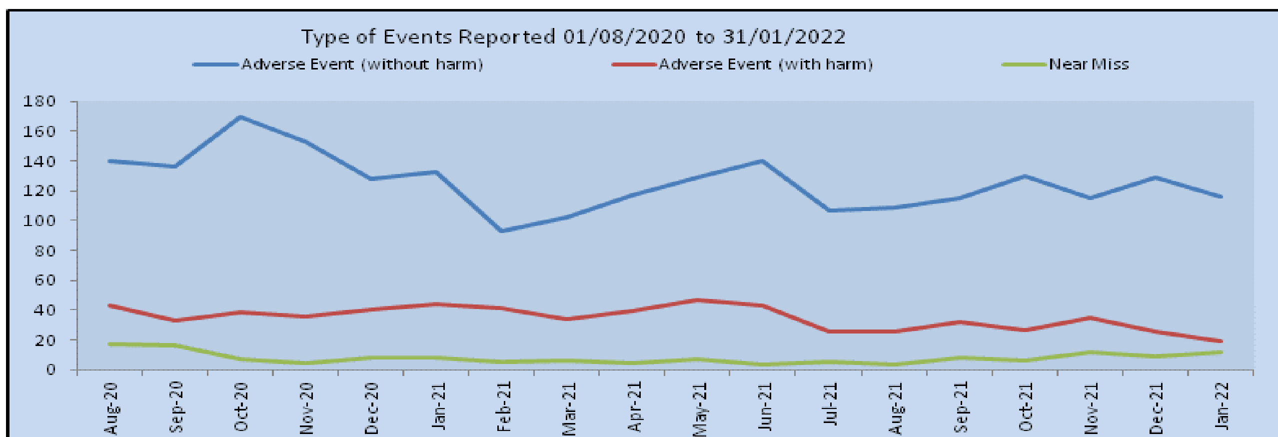
One of these risks continues to show a current risk score in excess of the inherent risk score. This is primarily due to ongoing challenges relating to recruitment and retention into the DDARS service combined with the increased referral rates through the pandemic.

Mental Health Risk

a.4 The Community Mental Health Team are medically staffed entirely by Locum Consultants but have a stability to this in people remaining longer-term in post than previously. There is currently one locum on paternity leave and the CMHT has a significant number of people awaiting first assessment. To begin to better mitigate the short-term risks and address the national shortage of psychiatrists in the longer term, the service have appointed two Advanced Nurse Practitioners and a specialist mental health pharmacist who is further supported by a pharmacy technician. The service have a further two ANPs in training and intend to graduate them into this role on qualification.

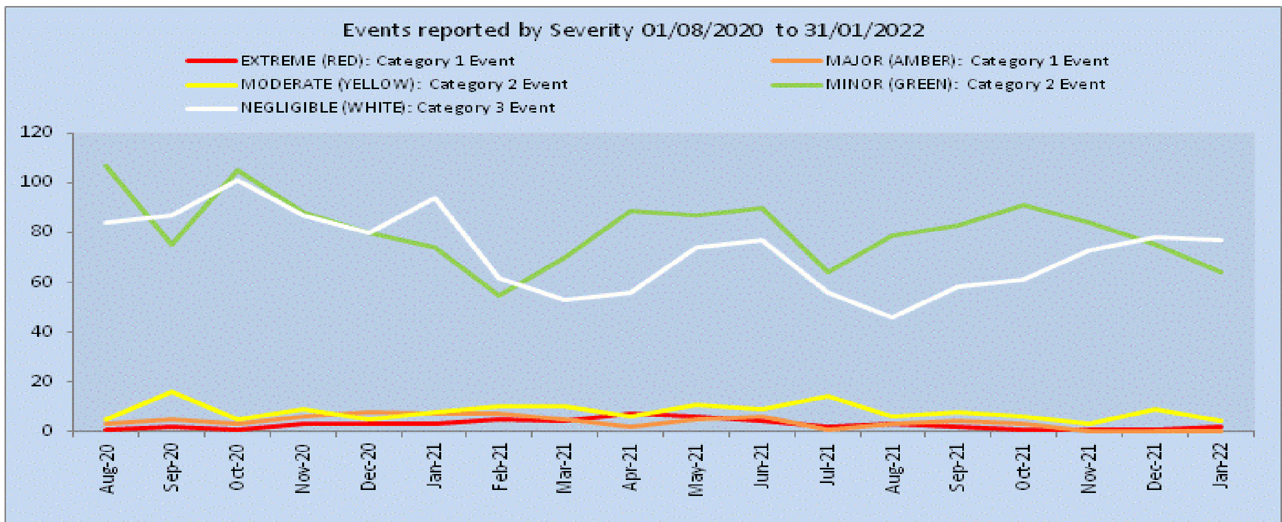
b. Adverse Event Management – Themes

b.1 There were 310 adverse events reported within the time period 01/12/2021 to 31/01/2022. The following graph shows the type of adverse events reported though Datix by month over the past 18 months.



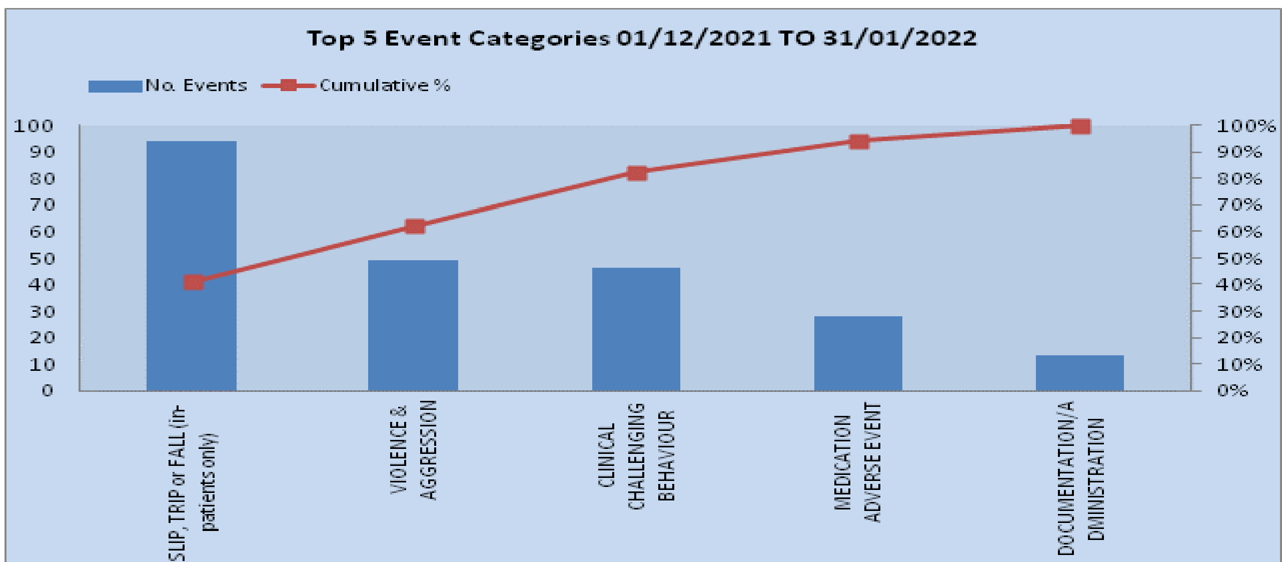
The ratio of events with harm to events with no harm is 1:4. This is an improvement from the last report where the ratio was recorded as 1:3.

b.2 The following graph shows the impact of the reported adverse events by month over the past 18 months, with low numbers of events in the extreme and major categories.



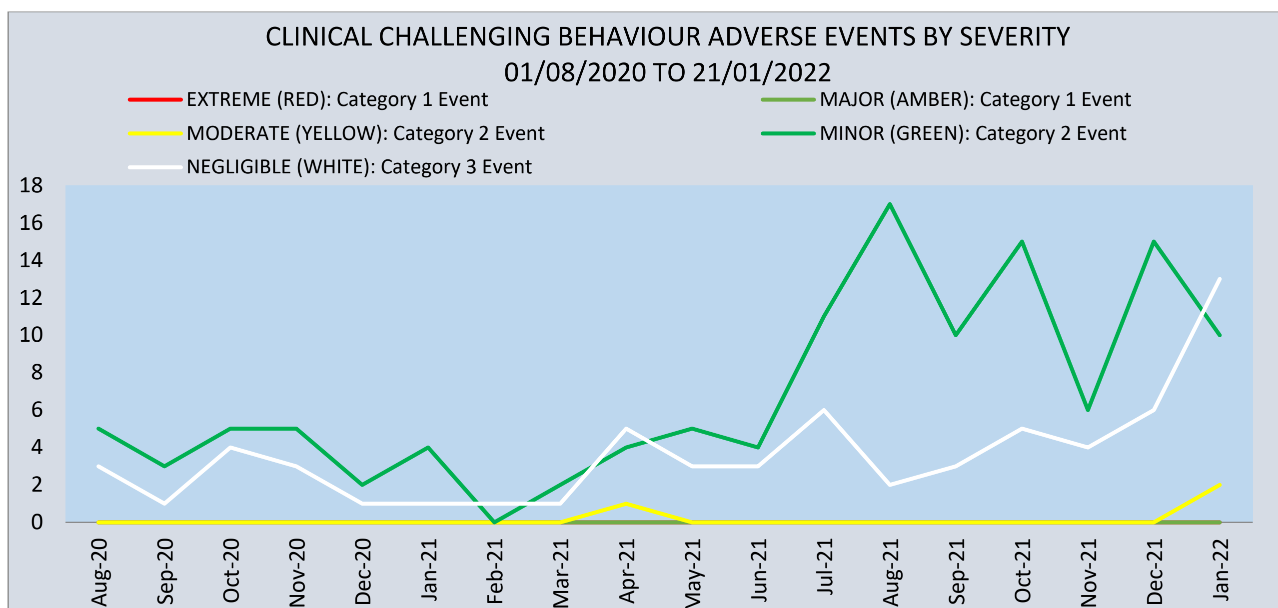
Top Five Categories of Adverse Events

b.3 The top five categories reported between 01/12/2021 and 31/01/2022 are slip, trip or fall (in patients only), violence and aggression, clinical challenging behaviour, medication adverse event and documentation/administration. The following graph shows the top five categories.



There are no significant concerns relating to this data for escalation. Teams continue with quality improvement work in relation to falls and violence and aggression (V&A) / clinically challenging behavior (CCB), with a specific focus on accurate reporting for V&A and CCB. There are two wards where reporting of CCB remains inaccurate and further discussion has been held with these wards for support and education.

b.4 The graph below shows the impact of education in the Dundee HSCP regarding accurate reporting for CBB adverse events.



Medication Adverse Events

b.5 The community nursing service reviewed a 13 month period for medication adverse events. Over this time they had 28,327 visits where medication was administered (often multiple medications per visit). Within the review period there were 66 medication adverse events (0.2%). Not all of these incidents are related to actions of the community nurse service, some relate to pharmacy, delivery of drugs or transfer of drugs between environments.

The subcategories are listed below:

Subcategory	**Total**
MISSED DOSE BY STAFF	**17**
INCORRECT DOSE/RATE	**11**
INCORRECT TIME/FREQUENCY	**6**
DUPLICATION OF DOSE	**5**
INCORRECT MEDICINE	**5**
SAME MEDICINE/DOSE ADMINISTERED TWICE	**4**
DISCREPANCIES IN CONTROLLED DRUG RECORD	**4**
POOR COMMUNICATION LEADING TO COMPROMISED PATIENT CARE	**3**
CONTROLLED DRUG INCIDENT	**3**
DRUG STOCK DISCREPANCY	**2**
INCORRECT FORM	**1**
TRANSCRIPTION ERROR	**1**
SELF ADMINISTRATION ERROR	**1**
INCORRECT USE	**1**
MISSED DOSE NOT DOCUMENTED	**1**
INCORRECT PATIENT	**1**
Total	**66**

The process following a medication adverse event would include a review (individual, team, service) and staff involved undertake a reflective account. Advice is sought from medical staff regarding appropriate actions to be taken following the event.

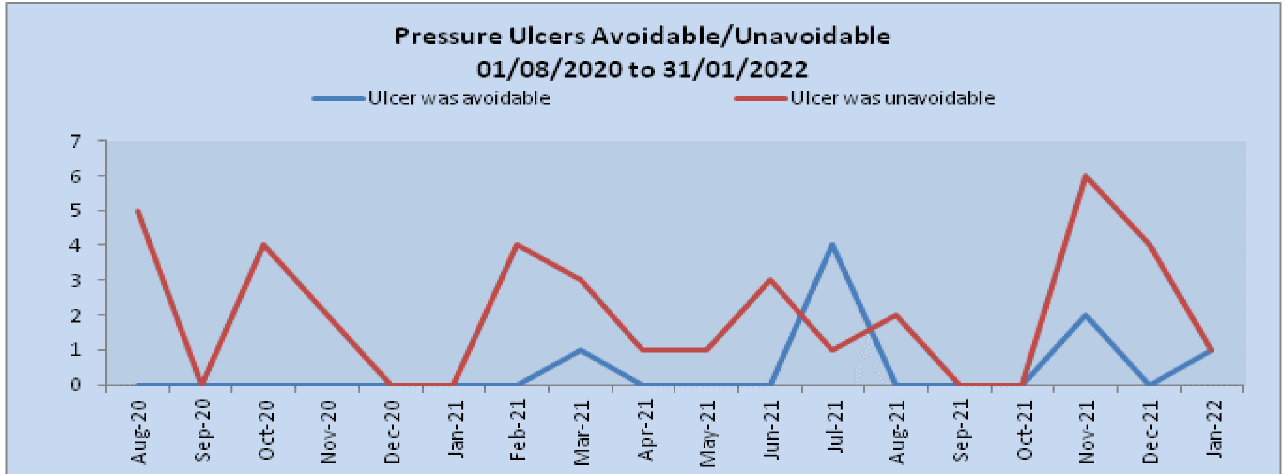
There are no specific patterns in terms of staff involved, specific drugs, specific patients, route of administration etc. The community nursing service are currently, and have been for some time, exploring the use of electronic patient records and electronic diary management systems and it is anticipated that the implementation of these may support the reduction of medication adverse events. They report the

chaotic and high demand services that are provided contribute to the errors made by staff in relation to medication administration.

The community nurse service is committed to ongoing monitoring and review of medication adverse events.

Pressure Ulcers

b.6 There have been seven pressure ulcer events reported within the time period. The number of pressure ulcers reported over the past 18 months is shown in the following graph, categorized as those that were determined as avoidable and those that were determined as unavoidable.

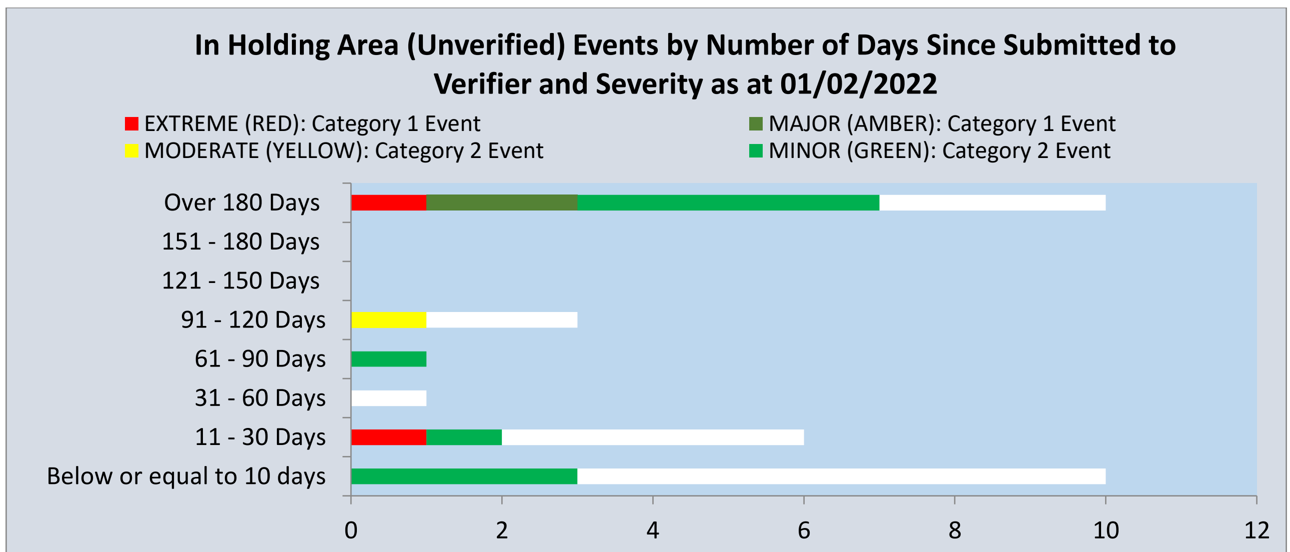


The avoidable pressure ulcer was incorrectly assessed by a newly graduated practitioner and was a moisture lesion. A review of this event highlighted good practice in terms of the assessment new patients received when transferred between hospitals incorporating person centred care and relatives involvement. Support and education has been provided to staff to enhance future skin care assessments.

c. Adverse Event Management – Systems and Processes

Overdue Unverified Events

c.1 At the time of data extraction, there were 31 unverified events that had exceeded the timescale of 72 hours for verification, down from 34 last month. The following graph shows the unverified by events by the severity and the number of days overdue. Of these events, 26 are graded either negligible or minor.



A number of these incidents are linked to the vaccination program rather than Dundee HSCP, and the clinical governance team is supporting the management of these incidents. Reminders have been sent to verifiers regarding unverified incidents.

The extreme incidents are linked to the DDARS service and both form aspects of the recorded risks (612, 233) and are being managed as outlined in the DATIX risk system. These have both now been actioned and are no longer outstanding.

Overdue verified Events

c.2 The table below shows the number of overdue events by the year they were reported. The numbers in brackets represent the number of overdue events by year as included in the last report, demonstrating the number of historical outstanding reviews continues to reduce.

A total number of 163 events are overdue based on verified events awaiting completion.

	2018	2019	2020	2021	2022
EXTREME	1 (1)	7 (5)	11 (11)	25 (23)	1
MAJOR	0	0	4 (4)	14 (14)	0
MODERATE	0	0	2 (4)	11 (5)	2
MINOR	0	0	4 (5)	15 (28)	14
NEGLIGIBLE	0	0	0	44 (37)	8
Total	1	7	21	109	25

The majority of overdue extreme and major events sit within the Mental Health Service and DDARS. As has been noted in previous reports, significant improvement has been noted in reducing the numbers of overdue adverse events. Improvement in this area has slowed. With more stable staffing being embedded across DDARS and MH services a renewed focus and priority will be given to this work.

d. Complaints and Feedback

d.1 Complaints and Feedback are managed by service managers (including hosted services) with professional leads being sighted on responses, which support identifying/sharing learning and areas for improvement.

Feedback and positive reports from patients and carers are also being promoted for reporting at Primary Governance Groups as part of performance and learning focus.

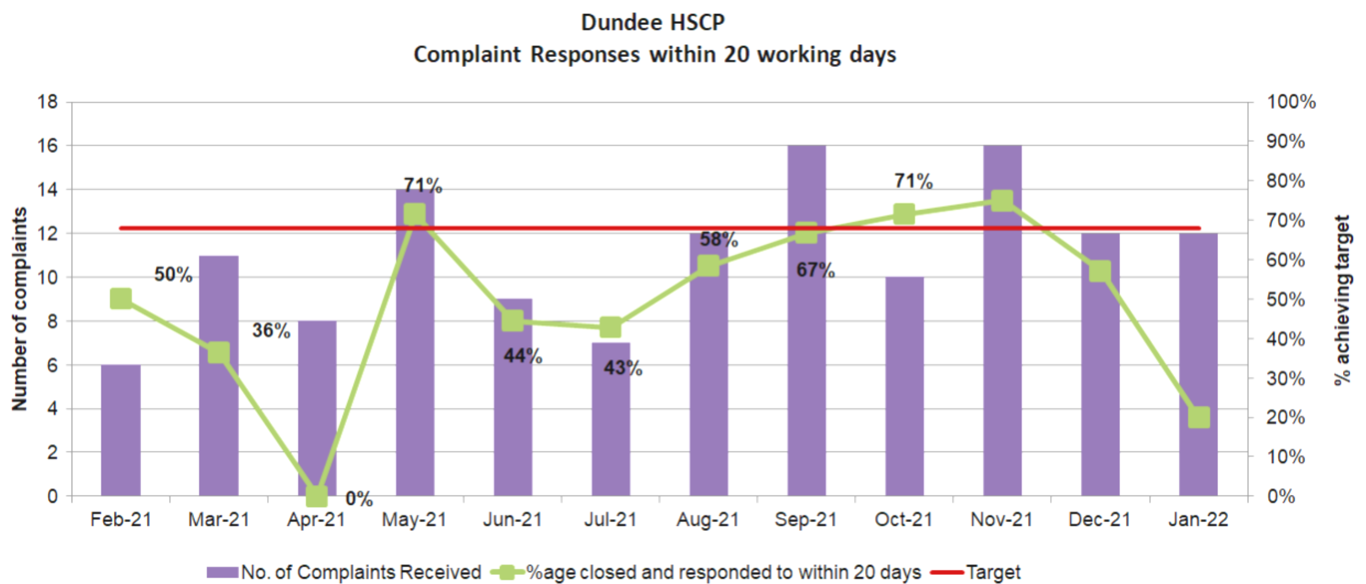
Further work, in collaboration with the Complaints and Feedback Team (CAFT), is planned (this has been delayed due to reduced staffing in the CAFT) to better understand where and why responses to some complaints take longer than the standard 20 days. The CCPG Group monitors response times, themes and supports the sharing of learning from complaints.

d.2 Number of closed complaints by month:

Dundee													
	Feb-21	**Mar-21**	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Performance**
No. of Complaints Received	6	11	8	14	9	7	12	16	10	16	12	12	

No. of Complaints closed	6	11	8	14	9	7	12	15	7	12	7	10	□
No. of complaints responded to within 20 working days	3	4	0	10	4	3	7	10	5	9	4	2	□
%age closed and responded to within 20 days	50.0	36.4	-	71.4	44.4	42.9	58.3	66.7	71.4	75.0	57.1	20.0	□
Target (%)	68	68	68	68	68	68	68	68	68	68	68	68	□

d.3 Performance through December and January has reduced significantly with only 20% of complaints being managed within a 20 day timeframe in January.



d.4 The following tables show complaints broken down by clinical team and days open, with 10 of the 18 stage 2 complaints waiting longer than the 20 day target.

Current Complaints as at 03/03/2022 – Stage 1

No. of Open Cases - 4			
Clinical Care Group/Department	**Days_Band**	6-10 Days	**Total**
Mental Health (Dundee)		3	**3**
General Practice - Dundee HSCP		1	**1**
Total		**4**	**4**

Current Complaints as at 03/03/2022 – Stage 2

No. of Open Cases - 18

Clinical Care Group/Department	Days_Band	0-5 Days	6-10 Days	11-15 Days	16-20 Days	>20 Days	>40 Days	>60 Days	>80 Days	Total
Allied Health Professionals (Dundee HSCP)		-	-	-	-	-	-	1	-	**1**
CBIR		-	-	1	-	1	-	-	-	**2**
Mental Health (Dundee)		1	-	2	1	3	1	2	2	**12**
General Practice - Dundee HSCP		-	1	-	-	-	-	-	-	**1**
Older People Services (Dundee)		1	-	-	-	-	-	-	-	**1**
Community Nursing (Dundee HSCP)		1	-	-	-	-	-	-	-	**1**
Total		**3**	**1**	**3**	**1**	**4**	**1**	**3**	**2**	**18**

Learning and improvement from complaints and feedback

d.5 A LAER was held following a complaint within the Psychiatry of Old Age Services, following the death of a patient. The complaint centred primarily around poor and inappropriate communication from a range of staff on and visiting the ward. It should be noted that the death itself was not a part of the complaint and the care provided did not contribute to this. Sharing of this information via the governance forum identified that this was an isolated incident and this type of communication is not widespread across the Partnership.

The key aspects identified were focussed on a lack of patient-centred care and poor communication with the patient and their family.

A number of actions have been implemented following review including:

- Training (Oral Health Education, ALERT, Verification of Death)
- SBAR Developed to support enhanced communication between medical and nursing staff
- Enhanced Junior Doctor's Induction (To support communication within ward team)
- Reflection on Conduct and Professionalism for staff involved.
- This learning has been shared across Dundee HSCP via the CCPG Forum.

e. External Reports & Inspections

There have been no inspections.

f. Adult Support & Protection

No exceptions to report.

g. Mental Health

CMHT are currently not subject to RTT reporting, however it is likely that the Mental Health Service Standards which the Government are consulting on, will introduce this. There is currently marked variation in waiting times between CMHT East & CMHT West (where it is longer). It is likely that this is consequent of a number of issues, including less availability of medical staff (2 WTE as opposed to 2.8 WTE) at a time of increased referral rates and different ways of working. A significant piece of work has now taken place to review every waiting case (senior nurses and ANPs) and different criteria applied to the decision making to offer entry into the system through a different discipline. For general cases, this has reduced the number waiting from 364 to 161. ADHD referrals are a system stressor across the whole of Tayside and consume a disproportionate amount of medical time as prescribing for adults is 'off licence.' As around 80% of referrals are for people under 25, it is hoped that we may be able to Commission alongside ASC diagnostic services.

h. Drug and Alcohol-related Deaths

Drug-Related Deaths

h.1 The service continues to work to support those at high risk. The Non-Fatal Overdose Rapid Response Service ensures priority access to assessment and treatment services. A recent contract with a third sector organisation will deliver Opioid Substitution Therapy to those who are self-isolating or unable to access their medication support through pharmacy.

Fatality Learning Events

h.2 There were 22 fatality learning events reported during this period. 14 Fatality learning events were reported in December 2021; 8 Fatality learning events were reported in January 2022 and include information from relevant service areas including, but not exclusively substance use and mental health services.

The table below shows the Subcategory by Incident Category (Fatality)

	FATALITY
EXPECTED DEATH	5
SUICIDE (CONFIRMED)	1
SUICIDE (SUSPECTED)	2
SUSPECTED DRUG-RELATED DEATH	7
UNEXPECTED/TRAUMA-RELATED DEATH	7
Total	22

Fatality Events

*h.*3 There were 2 fatality events reported within the time period.
Both events were reported as Unexpected/Trauma-related death and were in Mental Health and Learning Disability services.

Medication Assisted Treatment (MAT) Standards

h.4 DHSCP have submitted an initial assessment to the MAT Improvement Support Team (MIST) setting out the progress made to date and the areas where further work is required. The information provided identified areas where further support, both financial and national guidance, would support progression. It is acknowledged that each Alcohol and Drug Partnership area will outstrip the resources available to the MIST Team. In addition to this support, funding was received for a MAT standards project worker for Dundee and job descriptions are currently being evaluated by DCC and NHS Tayside. In regards to specific standards, work progresses around primary care shared care and there are ongoing discussions with the Scottish Government; additional funding is being sought for residential rehabilitation pathways and work is progressing to support independent advocacy.

1.3.1 Quality/ Patient Care

The principle focus of all services is a desire to achieve the six dimensions of healthcare quality. These state that healthcare must be:

- Safe
- Effective
- Patient-centred
- Timely
- Efficient
- Equitable

The work being progressed will have a positive impact on the quality of care and services for staff and the population of Tayside.

1.3.2 Workforce

Delays in Agenda for Change approvals for new & changed job descriptions are having an increasingly problematic impact on service developments including the ability to spend Government or externally funded programmes of work and redesign.

Recruitment continues to pose challenges across all areas of service.

12.3.3 Financial

Not applicable.

1.3.4 Risk Assessment/Management

Risks are included in the report above.

1.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed. Promotion of Equity and Social Justice is one of the domains included in the GIRFE reporting assurance framework.

1.3.6 Other impacts

There are no other direct impacts for this report.

1.3.7 Communication, involvement, engagement and consultation

The Dundee HSCP has carried out its duties to involve and engage external stakeholders where appropriate.

1.3.8 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Dundee Health and Social Care Partnership Clinical, Care and Professional Governance Group, 24 March 2022.

1.4 Recommendation

This report is being presented for:

- **Assurance**

As Lead Officer for Dundee HSCP I would suggest that the level of assurance provided is: Reasonable.