ITEM No …6……..

REPORT TO: **PERFORMANCE & AUDIT COMMITTEE – 28 SEPTEMBER 2022**

REPORT ON: **DUNDEE HEALTH & SOCIAL CARE PARTNERSHIP CLINICAL, CARE & PROFESSIONAL GOVERNANCE ASSURANCE REPORT**

REPORT BY: **CLINICAL DIRECTOR**

REPORT NO: **PAC22-2022**

1 Purpose

1.1 This is presented to the Committee for:

- **Assurance**

This report relates to:

- Government policy/directive
- Legal requirement

This aligns to the NHSScotland quality ambitions:

- Safe
- Effective
- Person-Centred

1.2 Recommendations

It is recommended that the Performance & Audit Committee (PAC):

- Note the Exception Report for the Dundee Health & Social Care Partnership Clinical, Care & Professional Governance Group as detailed in Section 2.

2 Report summary

2.1 Situation

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. The Committee is being asked to provide their view on the level of assurance this report 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 June 2022 to July 2022.

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

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.	✓

2.2 Background

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

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.

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

This report is assuring NHS Tayside Board and Dundee Integration Joint Board that clinical governance and risk management processes are in place, that reliable, safe,

effective, and person-centred care is delivered in all health and care settings, and learning is identified and shared thereby reducing harm to people.

2.3 Assessment

a. Clinical and Care Risk Management

a.1 The table below shows the top five service risks in the Dundee HSCP.

Title of Risk	Priority Level	Inherent Risk Score (without controls)	Current Risk Score (with current controls in place)
Increasing patient demand in excess of resources – DDARS	1	15	25
Risk that current funding would be insufficient to undertake the service redesign of the DDARS	1	20	20
Insufficient numbers of DDARS staff with prescribing competencies	1	25	16
Lack of resource to deliver the benzodiazepine dependence pathway compliant with guidelines	1	20	16
Negative media reporting increasing reputational, clinical and safeguarding risk	1	25	25

a.2 All five of the top five risks now sit with the Dundee Drug and Alcohol Recovery Service (DDARS). There are ongoing service pressures due to staff turnover that affect all of the key risks identified.

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 throughout and beyond the pandemic.

Recent band 5 recruitment saw the withdrawal of all candidates following publication of the Dundee Drugs Commission Report. Internal and external recruitment to this service are increasingly challenging with prospective employees indicating that negative perception of service influences career choices.

Staff morale remains very low. Staff are frequently moved within service to provide cover for absence of staff which has a significant impact on their job satisfaction.

A senior service manager role has been advertised to enhance to local leadership for this team and provide support to the two integrated managers currently in post.

a.3 Lack of available resource to deliver the benzodiazepine dependent pathway

Many people dying in drugs 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.4 Staff Resource

Staff availability continues to be a significant pressure across a wide range of teams and professions within the HSCP. This is managed well on a day to day basis and support is provided between teams, between HSCPs and across professional boundaries as required. This is not sustainable in the long term and staff are increasingly reporting fatigue and impacts on their wellbeing. This links to strategic risk HSCR00b1 which describes the risk across a range of staff groups and the control measures including the development of new models of care, organisational development strategy, service redesign and the ongoing development of the workforce plan.

b. Clinical & Care Governance Arrangements

The arrangements for CCPG in the Dundee HSCP are outlined in Appendix A: Dundee HSCP Governance Structure.

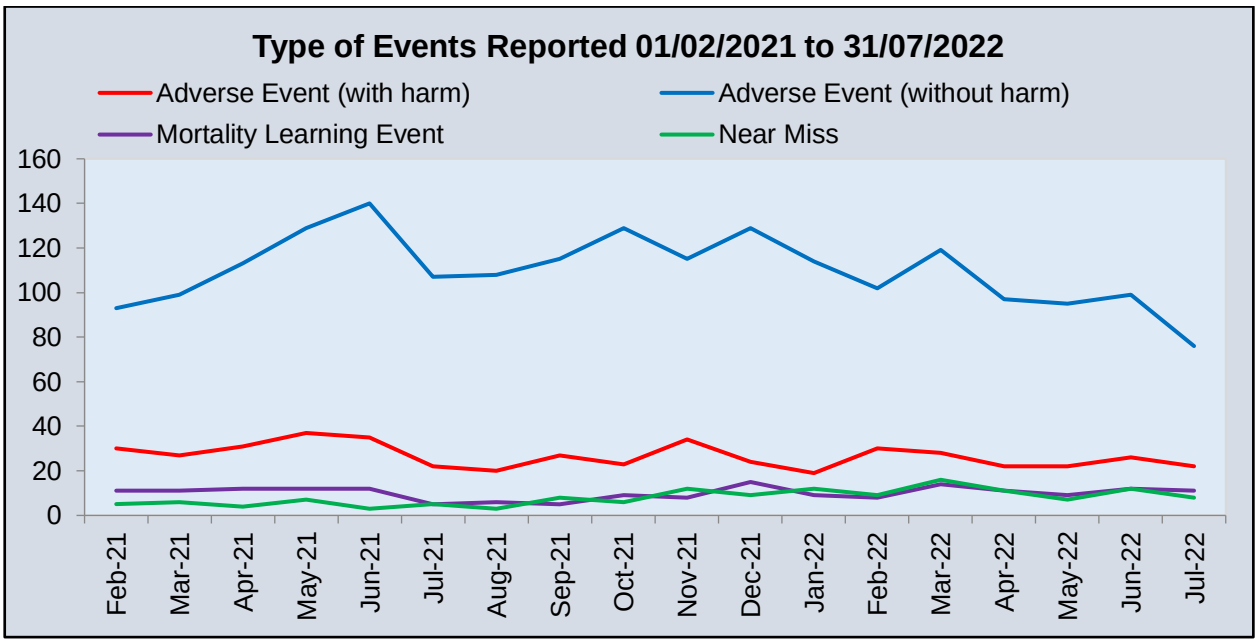
During this reporting period exception reports were presented to the CCPG Group form the following services:

- Nutrition and Dietetics
- Acute and Urgent Care
- Care Homes
- Community Services
- Drug and Alcohol Recovery Service
- In Patient and Day Care
- Mental Health and Learning Disability Services

- Psychological Therapies
- Health Inequalities

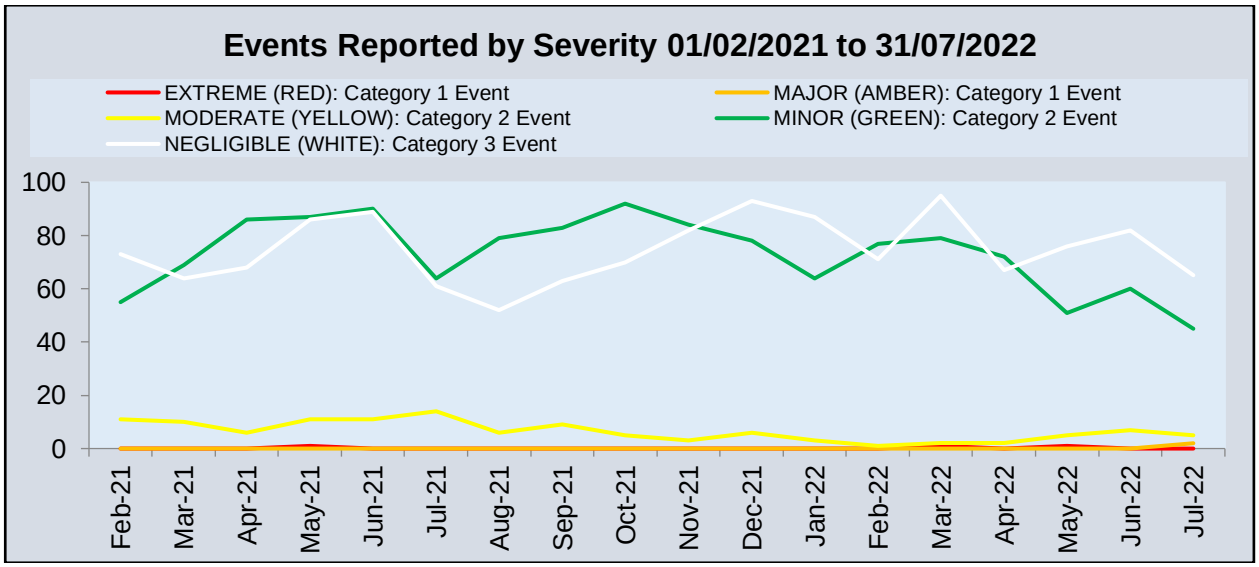
c. Adverse Event Management

c.1 The following graph shows the type of adverse events reported though Datix by month over the past 18 months.

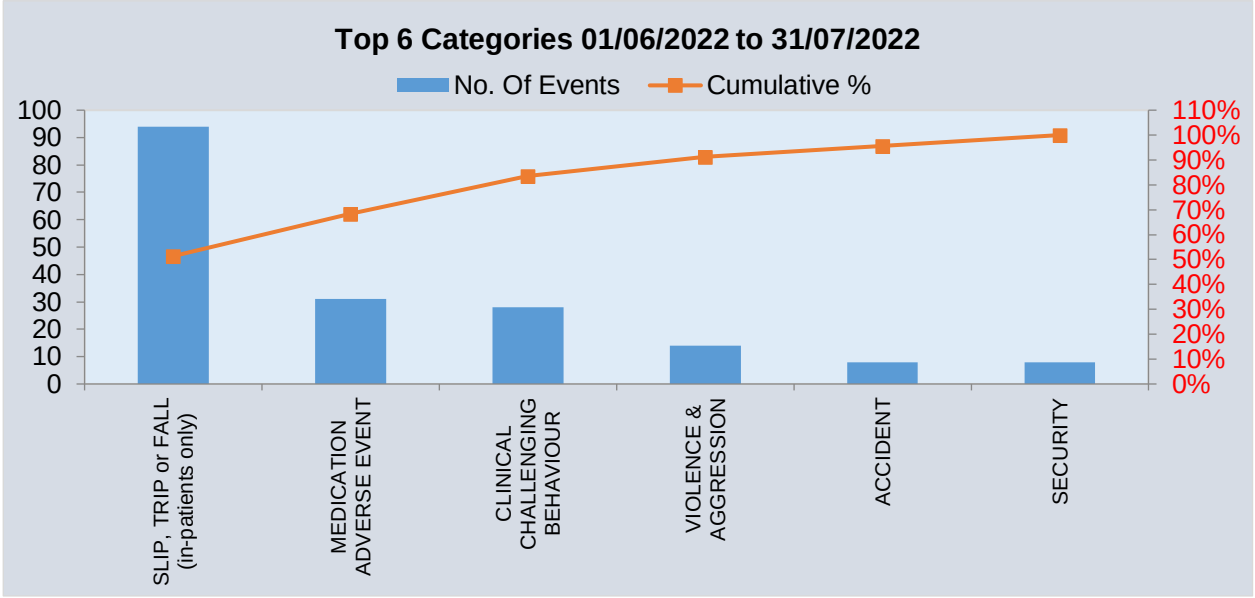


This shows a reduction in the number of reported adverse events.

c.2 The following graph shows the impact of the reported adverse events by month over the past 18 months, with low numbers of extreme, major and moderate events reported. The decline in minor and negligible events can be seen.

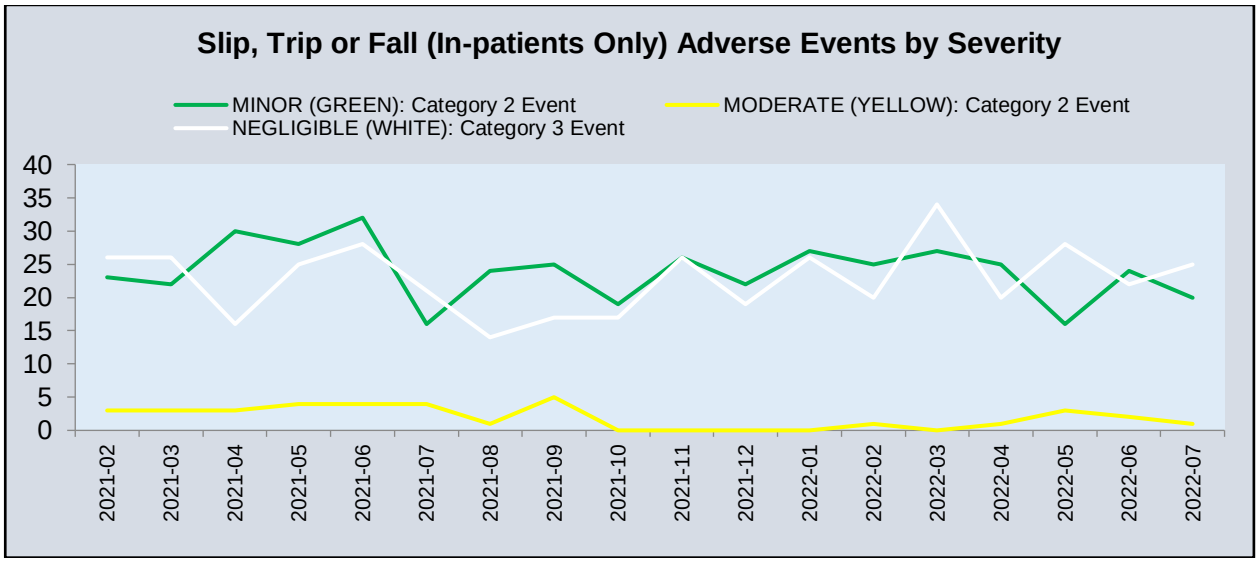


c.3 The following graph shows the top six categories reported between 01/06/2022 and 31/07/2022. These categories account for 183 of the 266 events (69%) reported within the time period.



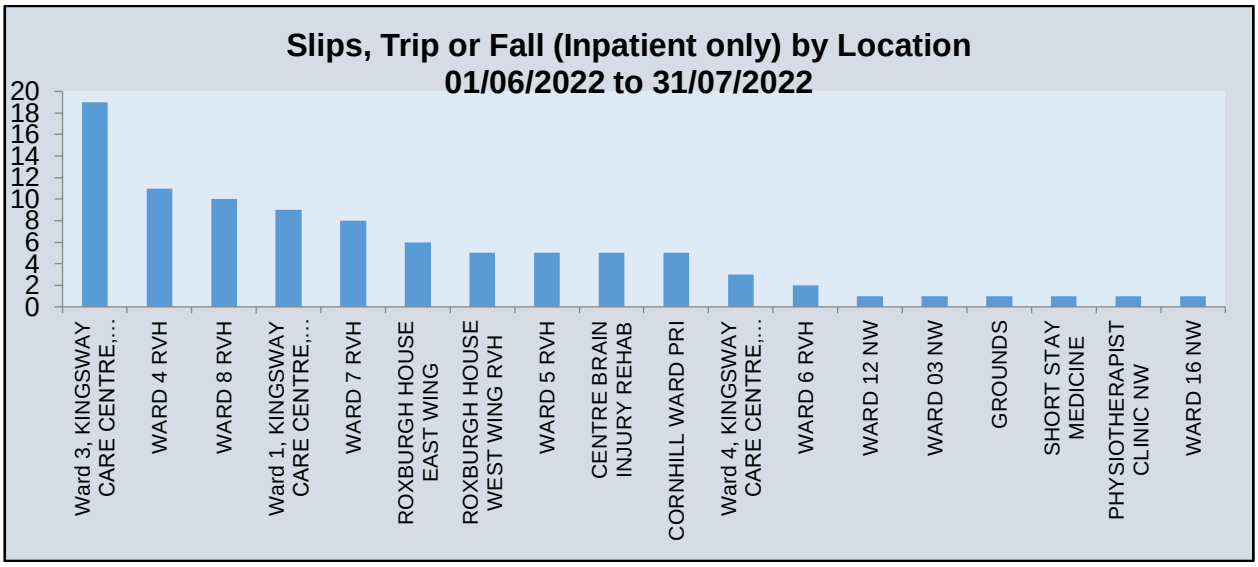
c.4 <u>Slips, Trips and Falls</u>

There were 94 events reported between 01/06/2022 and 31/07/2022.

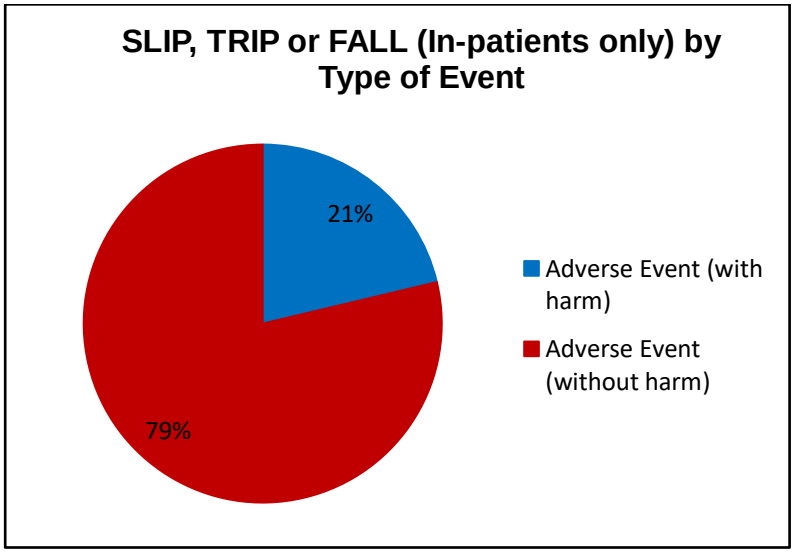


The majority of these events are negligible and minor. There continue to be no significant concerns relating to the falls data that require escalation. Inpatient falls groups across inpatient areas continue to meet and review falls screening work and post falls management.

c.5 The following table shows the number of slips, trips and falls (In-patients only) by location. The areas with the highest number of falls were Ward 3, Kingsway Care Centre (19), Ward 4 RVH (11) and Ward 8 RVH (10).



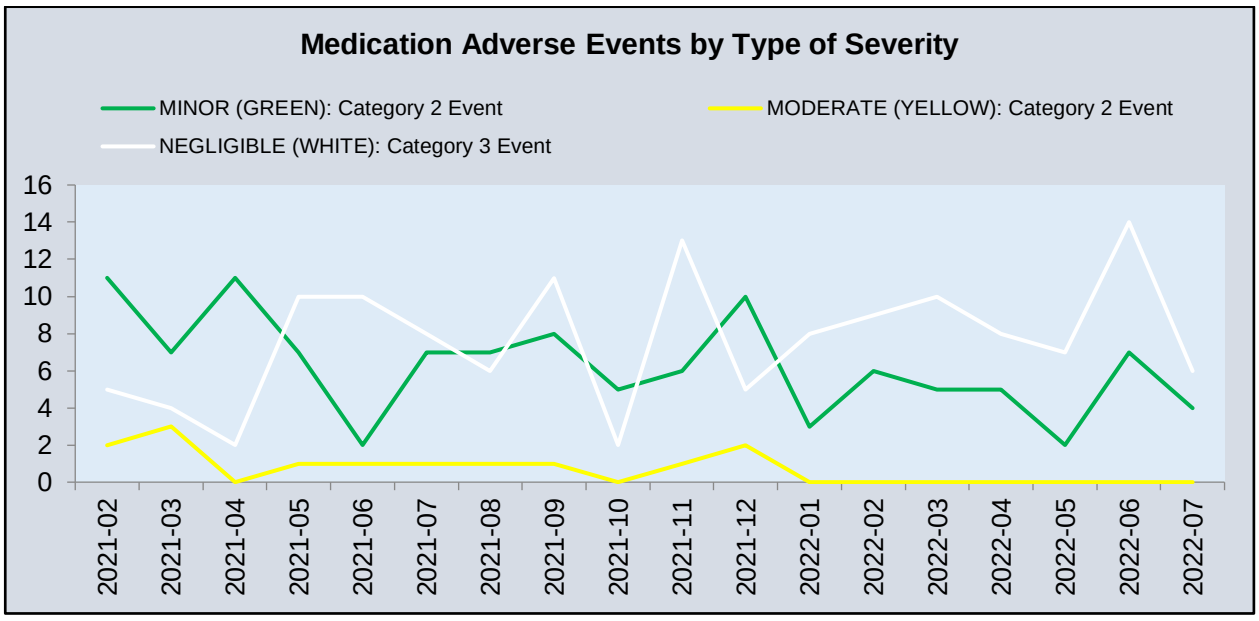
c.6 The chart below shows the falls events reported broken down by harm.



There were 20 adverse events reported with harm. Reviews are conducted following all falls. The levels of harm remain low with reports indicating harm in the form of bruising, skin flaps and discomfort. No patients required transfer for escalation of care following falls in this reporting period.

c.7 Medication Adverse Events

The chart below shows the medication adverse events reported by severity from February 2021.



There were 31 events reported during this reporting period.

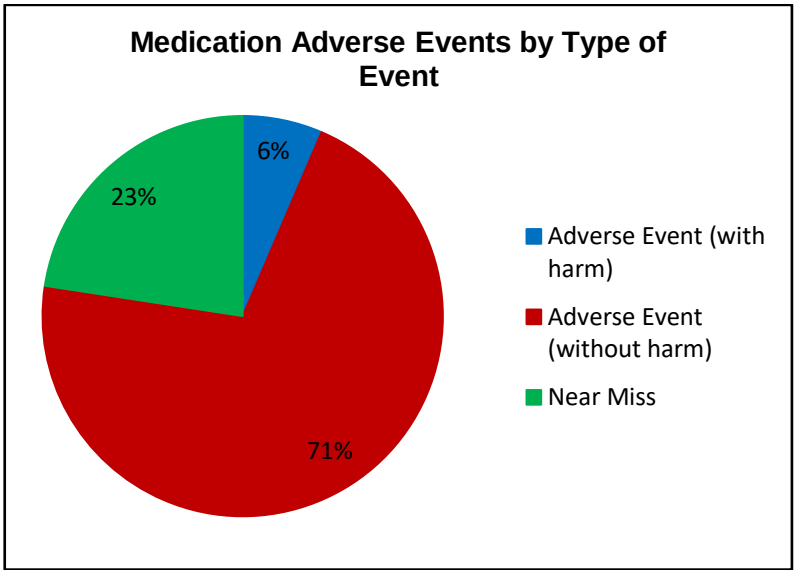
c.8 The following table shows the subcategory of event by reporting service. The area with the highest number of events was Palliative Medicine (9 Events), followed by adults and older people which is primarily community nursing, with 7 events.

A significant number of these events were very low in number and the individual detail is not provided in the table for numbers less than 5. The table has been included to indicate the breadth of services and wide variety of sub category events that have been reported.

Teams, including Palliative Medicine and Community Nursing, have regular reviews of medication adverse events and report through Primary Governance Groups that there are no patterns of significance to report. Teams continue to monitor and review all medication adverse events with those teams with higher numbers specifically reporting through primary governance groups.

Subcategory	Adults and Older People	Brain Injury Rehabilitation	Central (DDARS)	East (DDARS)	Intermediate Care - Older People Services (Dundee)	MFE (Medicine for the Elderly) - Older People Services (Dundee)	Other - Older People Services (Dundee)	Other - Specialist Palliative Care	Palliative Medicine	Psychiatry of Old Age - Older People Services (Dundee)	**Total**
MISSED DOSE BY STAFF											**7**
INCORRECT DOSE/RATE											**5**
CONTROLLED DRUG INCIDENT											**5**
INCORRECT LABEL											**<5**
POOR COMMUNICATION LEADING TO COMPROMISED PATIENT CARE											**<5**
SAME MEDICINE/DOSE ADMINISTERED TWICE											**<5**
INCORRECT STORAGE OF MEDICINES											**<5**
PATIENTS MEDICINES STORED IN WRONG PATIENT POD LOCKER											**<5**
INCORRECT TIME/FREQUENCY											**<5**
POOR DOCUMENTATION OF PLAN INVOLVING MEDICINES											**<5**
MEDICINE RECONCILIATION ON ADMISSION											**<5**
WRONG DISPENSING MODE											**<5**
INCORRECT INFORMATION											**<5**
INCORRECT MEDICINE											**<5**
OVERDOSE/SUSPECTED OVERDOSE											**<5**
Total	**7**	**<5**	**<5**	**<5**	**<5**	**5**	**<5**	**<5**	**9**	**<5**	**31**

c.9 The chart below shows medication adverse events by type.

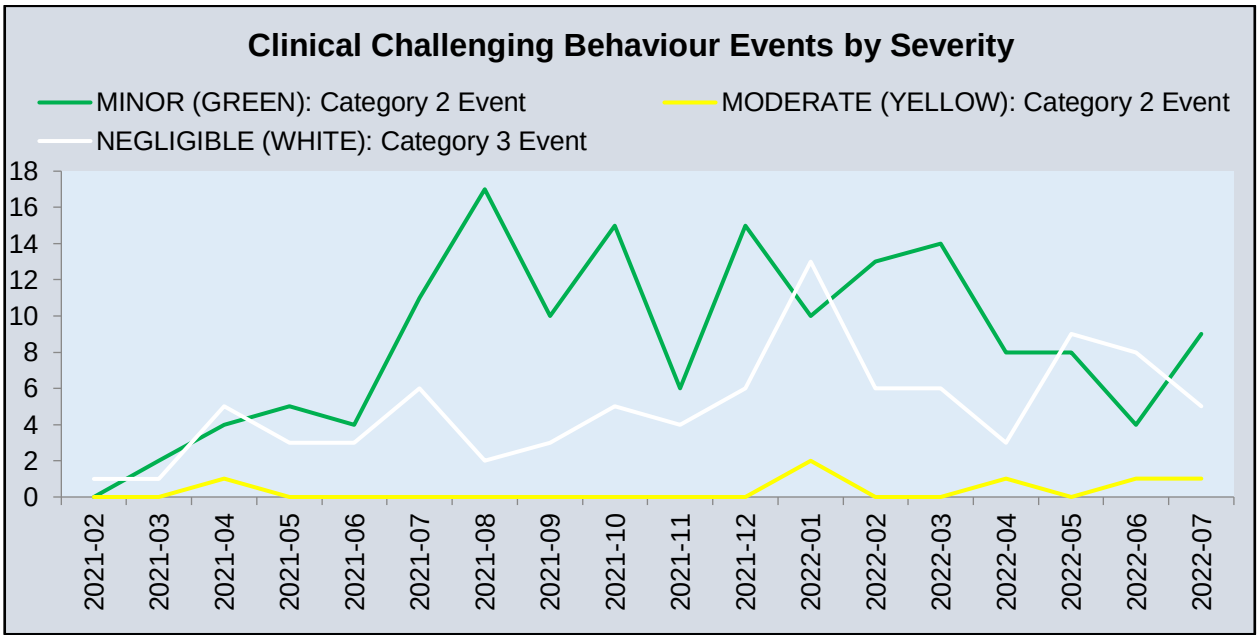


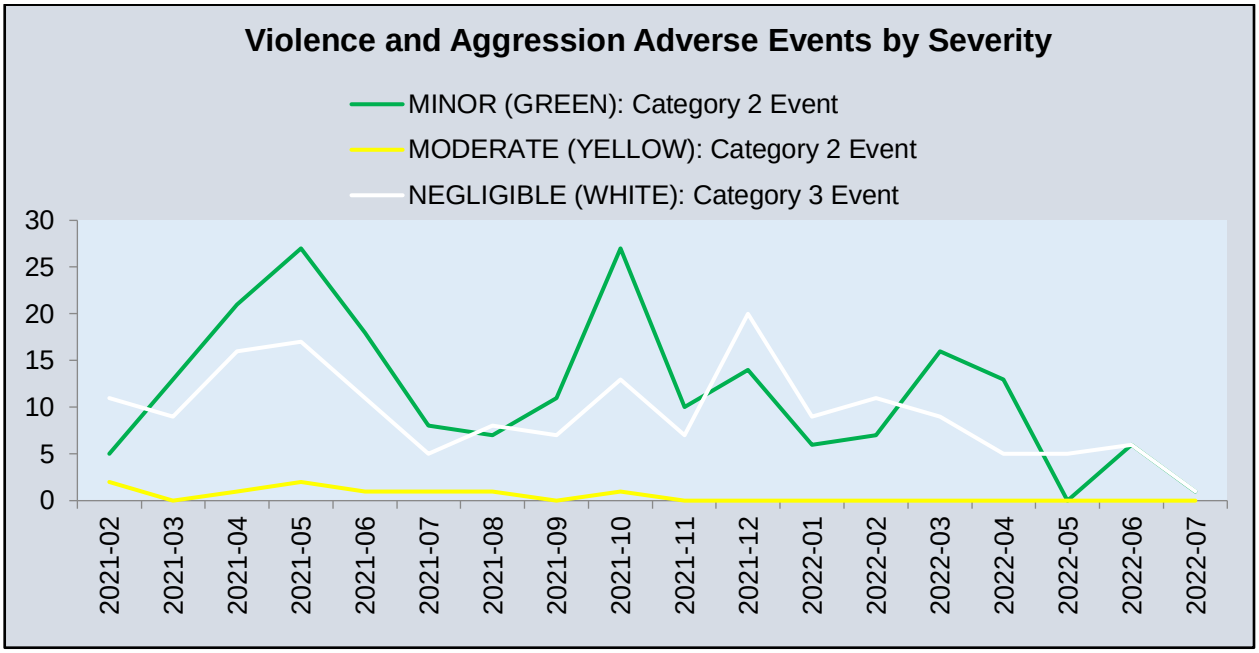
The events with harm were both investigated. The levels of harm were related to changes in blood sugar levels and there was no longer term harm noted. Patients and families were informed of the incidents.

The reviews led to changes in the induction process for rotating staff members, enhanced levels of senior review for new staff and contingencies developed for medicine reconciliation process.

c.10 <u>Clinical challenging behaviour and violence and aggression adverse events</u>

The charts below show clinical challenging behaviour (28) and violence and aggression (14) adverse events during this reporting period.





Work across the Partnership has reduced the number of violence and aggression adverse events which are now more appropriately reported as clinically challenging behaviour events. The charts above show the respective changes for these incident types.

There is a reduction over the past four months across both of these event types. This is due to the nature of the patients in the in-patient units. Higher numbers of incidents are usually linked to individuals being responsible for multiple events and this has not been portrayed over recent months.

Support to staff continues regardless of incident type where this is required. Ongoing training, enhanced levels of training and post incident debrief and support are provided to ensure staff wellbeing.

c.11 Accident

There were eight adverse events reported in the accident category in this reporting period. There were 8 different services reporting these incidents across adverse events including road traffic accidents, equipment/machinery related, animal/insect bites and struck by another person.

c.12 Security

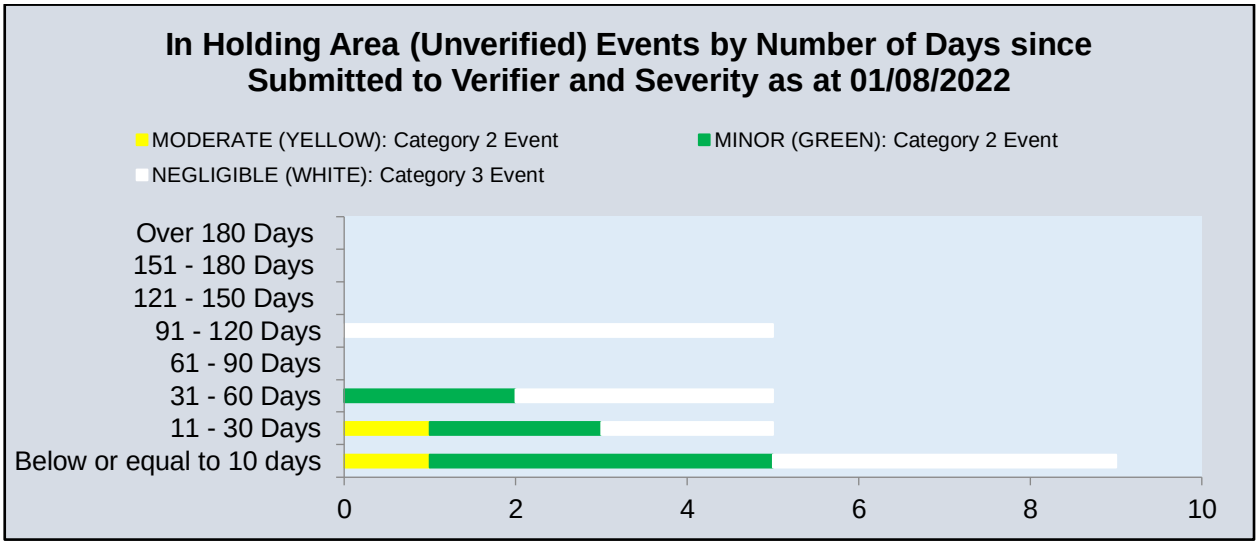
There were eight adverse events reported in this category. They include property loss or damage, attempted absconding, contraband items, missing cutlery and building left unsecure.

All incidents were reviewed with appropriate action taken to address.

d. Adverse Event Management - Systems and Processes

d.1 Overdue Unverified Events

At the time of data extraction, there were 24 unverified events. Out of the 24, 19 unverified events 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 the 24 unverified events, 22 of these were graded Negligible or Minor. This does show an improving picture although further work is required to reduce this further.



d.2 Overdue Verified Events

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.

Event Severity	2018	2019	2020	2021	2022
EXTREME (RED): Category 1 Event	0(0)	0(7)	1(9)	0(14)	2(1)
MAJOR (AMBER): Category 1 Event	0	0	1(4)	0(9)	2(1)
MODERATE (YELLOW): Category 2 Event	0	0	2(2)	8(4)	12(22)
MINOR (GREEN): Category 2 Event	0	0	2(2)	3(9)	19(8)
NEGLIGIBLE (WHITE): Category 3 Event	0	3(0)	9(0)	40(25)	85(67)
(blank)	0	0	0	0	0(2)
Total	**0 (0)**	**3 (7)**	**15 (17)**	**51 (61)**	**120 (101)**

e. Significant Adverse Event Reviews (SAERs)

None in this reporting period.

f. Complaints and Feedback

f.1 The table below shows the number of complaints by service area and how long they have been open. An increasing number of complaints are not meeting the 20 day standard.

No. of Open Cases - 38												
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	>100 Days	>182 Days	**Total**
Mental Health (Dundee)		-	-	3	2	5	1	2	1	-	-	**14**
Allied Health Professionals (Dundee HSCP)		-	3	-	1	1	2	-	-	-	-	**7**
General Practice - Dundee HSCP		1	1	1	2	2	-	-	-	1	-	**8**
Specialist Palliative Care		-	-	-	1	1	-	-	-	-	-	**2**
Older People Services (Dundee)		-	-	-	-	2	-	1	-	-	1	**4**
Dundee Drug and Alcohol Recovery Service		-	-	-	-	1	-	-	-	-	-	**1**
CBIR		-	-	-	-	-	-	-	-	1	-	**1**
Tayside Sexual and Reproductive Health		-	-	-	1	-	-	-	-	-	-	**1**
Total		**1**	**4**	**4**	**7**	**12**	**3**	**3**	**1**	**2**	**1**	**38**

The longest open complaint is currently sitting at 304 days. This complex complaint spans a number of clinical teams across NHS Tayside and the Dundee HSCP. A final draft has been complete with information from Information Governance and will signed off by the Acute Nurse Director.

f.2 The table below shows complaint responses in the HSCP.

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Performance
No of complaints received	13	17	11	17	14	13	20	19	16	14	13	17	
No of complaints closed	13	17	10	17	14	13	18	19	14	11	11	3	
No of complaints responded to within 20 working days	7	10	5	10	8	6	10	12	8	10	8	3	
%age closed and responded to within 20 days	53.8	58.8	50.0	58.8	57.1	46.2	55.6	63.2	57.1	90.9	72.7	100.0	↑
Target	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	68%	

The table suggests that DHSCP are managing non-complex complaints well, in terms of responding within 20 days. There are, however, a number of complaints each month that remain open and will be closed in subsequent months, which will show a significantly reduced compliance with the 20 day standard. The Dundee HSCP Feedback Team continues to liaise with the Tayside Feedback team for support in improving this performance.

f.3 The following table outlines the principle and sub themes for complaints received in this reporting period, which is consistent with previous reports.

Feedback per ISD Themes			
Division/Partnership	**Principal Themes**	**Sub Theme**	
Dundee HSCP (Health and Social Care Partnership)	Clinical treatment	**Total**	**18**
		Disagreement with treatment / care plan	7
		Problems with medication	4
		Co-ordination of clinical treatment	3
		Poor medical treatment	2
		Poor aftercare	1
		Poor nursing care	1
	Attitude and behaviour	**Total**	**13**
		Lack of support	4
		Insensitive to patient needs	3
		Conduct	2
		Abruptness	1
		Member of staff has not apologised to patient	1
		Not listening	1
		Rushed - not time to see patient	1
	Communication (oral)	**Total**	**9**
		Telephone	4
		Lack of a clear explanation	2
		Patient not being verbally told things	2
		Other	1
	Date for appointment	**Total**	**5**
		Unacceptable time to wait for appointment	3
		Appointment date continues to be rescheduled	1
		Cancellation of appointment	1
	Communication (written)	**Total**	**4**
		Letter wording	2
		Lack of information provided	1
		Patient has been sent no communication	1
	Personal records	**Total**	**3**
		Accuracy of records	2
		Gaining access to records	1
	Competence	**Total**	**1**
		Not involved in the patient's care plan	1
	Admissions / transfers / discharge procedure	**Total**	**1**
		Delays in external transfer (hospital to hospital)	1
	Outpatient and other clinics	**Total**	**1**
		Waiting time too long in reception to see consultant / doctor / nurse	1
	Consent to treatment	**Total**	**1**
		Patient has insufficient info to give informed consent	1

f.4 Compliments

Staff continue to receive very positive comments from those they care for, despite all the pressures currently felt across the system. This comment from relatives of a patient in Roxburghe House is typical of the positive messages we receive.

> *"My family & I would like to thank all of the nursing, medical, support staff and nursing students of Ward 4 Ninewells Hospital and Roxburgh House for their kind, caring and professional care of my dad. NHS Tayside you have amazing wonderful staff working in these areas especially your nurses, health care assistants, support staff and volunteers, who are the faces that family and patients see work hard and are professionals. NHS Tayside should be Proud of them."*

g. External Reports & Inspections

No external reports in this reporting period.

h. Mental Health

h.1 Staffing

The service has successfully recruited to a locum vacancy, although are currently required to support acute shortages in Angus, where there are currently no medical staff in Community Mental Health Teams. This does have an impact on routine care across services.

There have been no applicants for the Substantive Consultant post in the Tayside Eating Disorder Team. The current locum has now left the service and there has been no success securing a further locum. Complex cases are supported from Community Mental Health Teams across Tayside. The team are exploring other methods to support this team including possible GP sessions.

There continue to be shortages across the nursing workforce in the Crisis Resolution and Home Treatment Team. Collaborative working with community mental health colleagues is supporting at this time.

There continue to be challenges recruiting social care staff, both internally and externally.

Recruitment for the Director of Psychology is moving into the third round of recruitment, following two unsuccessful rounds. A Deputy Director post will be advertised in parallel during this round of recruitment. Clinical Lead, Dr Linda Graham continues to act into this role as interim director.

h.2 Delayed Discharges

There are significant capacity challenges within in-patient care resulting in a focus on Delayed Discharges. We are fully engaged with this work and Dundee patients truly in this category all have agreed discharge plans.

Issues have been with achieving safe staffing levels within newly commissioned buildings, and the phase across to full time placements is taking place.

h.3 Medication Assisted Treatment (MAT) Standards

Significant work is ongoing for the development of a different service model to support compliance with MAT standards mainly focussed on standards 1 - 5 with a proposed implementation date of the 19th September. An Improvement Quality workshop with the MAT Implementation Support Team (MIST) is being held on the 7th September with all Drug and Alcohol Services to further support this work.

MAT Standards 1-5 are:

1. All people accessing services have the option to start MAT from the same day of presentation.
2. All people are supported to make an informed choice on what medication to use for MAT, and the appropriate dose.
3. All people at high risk of drug-related harm are proactively identified and offered support to commence or continue MAT.
4. All people are offered evidence based harm reduction at the point of MAT delivery.
5. All people will receive support to remain in treatment for as long as requested.

The national system for recording, the Drug and Alcohol Information System (DAISy), does not capture all the reporting requirements. As a result, there is a small group looking at an outcome measurement tool that is being proposed by MIST and which will be locally updated as required.

There is no current data for MAT Standards, as the proposed date for implementation would be the 19th September and the team will commence reporting from the end of September.

2.3.1 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.

2.3.2 Workforce

There continue to be significant pressures on staff across all teams due to vacancies and workload.

2.3.3 Financial

No direct impact.

2.3.4 Risk Management

Risks are included in the report above.

2.3.5 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.

2.3.6 Other impacts

There are no other relevant impacts.

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 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.

- DHSCP Clinical, Care and Professional Governance Group, 27 July 2022.

2.4 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

3 Risk Assessment

Risk 1 Description	The risk of not providing sufficient assurance through governance assurance routes will reduce confidence in the ability of the HSCP to deliver safe, quality care.
Risk Category	Governance
Inherent Risk Level	Likelihood (2) x Impact (4) = Risk Scoring (8)
Mitigating Actions	Systems in place for all operational teams to provide exception reports to the clinical, care and professional governance group.

(including timescales and resources)	'Getting It Right' Group established to support development of reporting framework for HSCP.
Residual Risk Level	Likelihood (2) x Impact (4) = Risk Scoring (8)
Planned Risk Level	Likelihood (1) x Impact (3) = Risk Scoring (3)
Approval recommendation	The risk level should be accepted with the expectation that the mitigating actions are taken forward.

4 Consultations

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

5 List of Appendices

The following appendices are included with this report:

Appendix 1: Dundee HSCP Governance Structure

Dr. David Shaw DATE: 14 September 2022
Clinical Director

Diane McCulloch
Chief Social Work Officer / Head of Health and Community Care

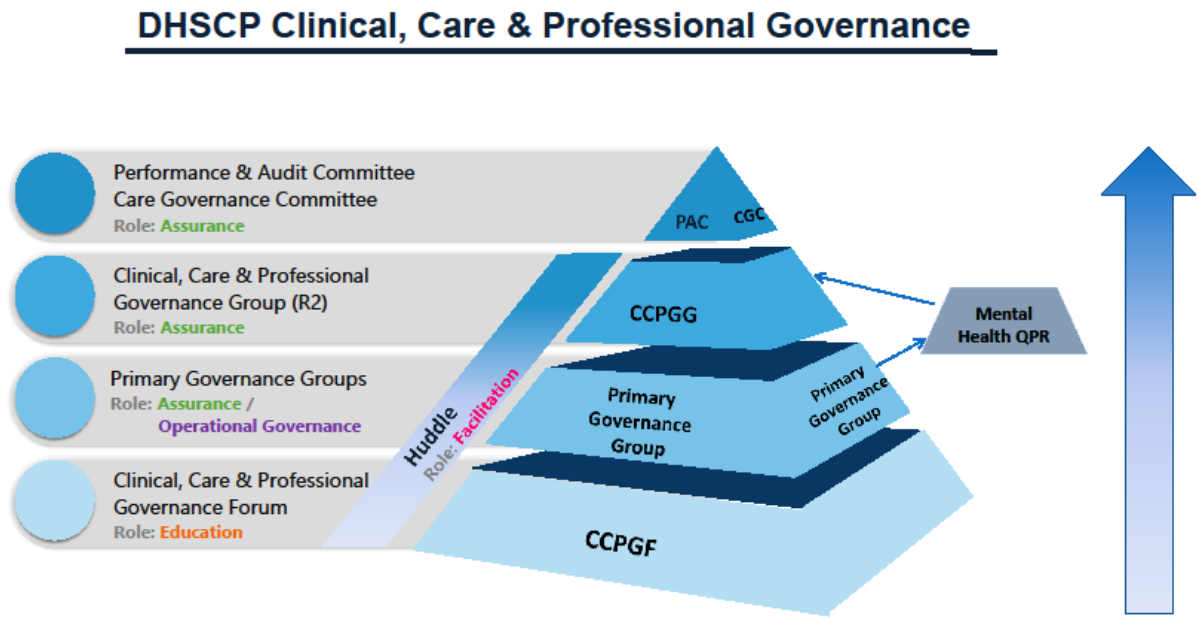
Report Author: Matthew Kendall, AHP Lead

Level of Assurance		System Adequacy	Controls	✓
Substantial Assurance		A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited	Controls are applied continuously or with only minor lapses.	
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.	✓
Limited Assurance		Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.	Controls are applied but with some significant lapses.	
No Assurance		Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.	Significant breakdown in the application of controls.	

APPENDIX 1

Dundee HSCP Governance Structure

Dundee HSCP governance structures are outlined in the diagram below. The following narrative explains how each of the aspects functions to provide assurance to NHS Tayside and the Dundee IJB.



Dundee Health and Social Care Partnership Clinical, Care and Professional Governance Group is responsible for directing, collating and monitoring governance arrangements and ensuring that there are effective and embedded systems for Clinical, Care & Professional Governance in all services within Dundee Health and Social Care Partnership. It is chaired by the Clinical Director, and membership, as referenced in the terms of reference, extends to Head of Health and Community Care Services, Associate Nurse Director, Associate Medical Director, Locality Managers (4), Lead Allied Health Professional, Lead Nurse, Lead Pharmacist, Clinical Governance Lead, Senior Officer – Business Planning and Information Governance, NHS Business Support Representative and Third Sector representative.

Management structures across Dundee HSCP have been redesigned over the past three months and the members of the CCPG Group will be updated to reflect this and the Primary Governance Group Structure which sits beneath the CCPG Group.

At each CCPG Group meeting each Primary Governance Group will present an exception report highlighting key areas of concern across the six domains listed in GIRFE. They will also reference exceptional pieces of work undertaken, current challenges and future potential issues identified through triangulation of data reviewed through Primary Governance Group meetings.

Each Primary Governance Group will produce an annual report in line with the reporting programme.

A range of additional reports are also reviewed at the CCPG Group, which includes DHSCP Analysis Report (Adverse events and Risks), Complaints, Infection Prevention and Control and Inspection Reports.

Further assurance is sought with a range of reports/discussions relating to topics such as professional registration, GDPR, SPSO, contemporaneous issues for example Dundee Drugs Commission review and Trust and Respect Report.

Primary Governance Groups (PGG)

There are currently nine PGGs:

- In Patient Services (MfE, POA, CBIR, Palliative)
- Community Services
- Acute and Urgent Care
- Mental Health & Learning Disabilities
- Care Homes
- Psychological Therapies
- Health Inequalities
- Nutrition and Dietetics
- Dundee Drugs and Alcohol Recovery Services

Each Primary Governance Group will meet monthly and the remit of the Primary Governance Group is to:

- Provide assurance to the Clinical, Care and Professional Governance Group on the systems and processes for clinical, care and professional governance activities.
- Develop, prioritise, implement, monitor and review the annual work plan for clinical, care and professional governance activities.
- To create the learning environment and conditions within [XXX] Services by dedicating time to allow staff to share learning, tools and other resources and encourage the dissemination of good practice.
- Ensure that clinical and care leadership underpins [XXX] Service assurance processes and that clinical and care leaders are supported to share tools and resources to spread good practice.
- Encourage an integrated approach to quality improvement across [XXX] Services.
- Ensure appropriate actions in relation to clinical, care and professional governance and quality activities are taken in response to internal reports and external reports from bodies such as NHS Healthcare Improvement Scotland, Care Inspectorate, Audit Scotland, Mental Welfare Commission and Scottish Public Services Ombudsman.

- Ensuring that there is a robust reporting and assurance mechanism for [XXX] services which are hosted within the partnership but do not solely operate within Dundee Health and Social Care Partnership.
- Undertake the management, escalation or cascading of issues/risks/concerns as appropriate.
- Collate, review and analyse core and service specific datasets to inform exception report to the CCPGG, reflecting the six domains described in the Getting It Right for Everyone – A Clinical, Care and Professional Governance Framework.
- The exception report should include, but is not limited to:

    - Emergent issues of concern identified
    - Adverse Events:
        - Recurring themes, Major and Extreme Incidents
        - Incidents that trigger Statutory Duty Of Candour
    - All Red Adverse Events
    - Adverse Event Reviews, Significant Case Reviews
    - Complaints
    - Risks
    - Inspection Reports and Outcomes
    - Changes to standards, legislation and guidelines
    - Outcomes of care
    - Adherence to standards
    - Sharing of learning

A representative from each PGG will represent the group at the Dundee HSCP CCPG Group and present and talk to the exception report and, where required, the annual report. The representative will act as a conduit between the PGG and CCPGG ensuring effective communication between groups.

Due to the recent redesign of the management structure, there have been changes in the organisation of the PGGs. The Governance team, alongside the professional leads in the HSCP are working closely with the new chairs of these PGGs to support development of these groups.

<u>Governance Huddle</u>

There is a weekly governance huddle attended by the professional leads and the governance team. A high level review of all adverse events is undertaken with the intention of identifying themes or patterns and triangulating knowledge of service pressures, governance scorecards and service data to identify services who may be struggling, who require support to manage adverse events or who may display a change in their current performance in relation to managing adverse events. This allows for early support to be provided to teams from both a governance and managerial perspective to undertake early management of developing potential risks.

The huddle is open to managers to attend to gain an enhanced overview of the governance arrangements across the HSCP. Managers can also attend to discuss specific aspects of clinical, care and professional governance as required.

The huddle will also undertake work to review risk management, complaints process and quality and any other governance-related theme as required.

Clinical, Care and Professional Governance Forum

The forum is used as an education forum for managers and lead governance staff across the HSCP. The format allows for review of scorecard data, encouraging discussion around works of excellence and challenging areas, with managers peer-reviewing one another and sharing learning across a range of themes.

Each forum will also have a dedicated educational element to improve knowledge and understanding of governance systems and processes across the HSCP. Subjects to date have included: Qlikview, Risk Management System, Datix system report building and scorecard development.