ITEM No …8……..

REPORT TO: **PERFORMANCE & AUDIT COMMITTEE – 2 FEBRUARY 2022**

REPORT ON **CLINICAL, CARE AND PROFESSIONAL GOVERNANCE (CCPG)**

REPORT BY: **CLINICAL DIRECTOR**

REPORT NO: **PAC5-2022**

1.0 PURPOSE OF REPORT

This is presented to the Committee for:

- **Assurance**

This report relates to:
- Government policy/directive
- Legal requirement

This aligns to the following NHS Scotland quality ambition(s):
- Safe
- Effective
- Person Centred

2.0 RECOMMENDATIONS

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

2.1 Note the Clinical, Care and Professional Governance exception report.

3.0 FINANCIAL IMPLICATIONS

3.1 None.

4 Report summary

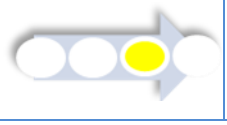
4.1 Situation

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 Care Governance 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 1 August 2021 to 30 September 2021.

The Care Governance Committee is advised of these key risks noted with this report:

- Dundee Drug and Alcohol Recovery Service (DDARS) continues to have four of our top five risks across the HSCP. While the scores remain high across all of these risks recruitment is noted to be improving for this service.
- Clinical Treatment of Patients within the Mental Health Service Risk is showing an improving picture in terms of recruiting to support an alternative model of care for this team.
- Recruitment challenges persist across a range of staff groups (medical, nursing, AHP, social care) increasing the challenges for service delivery considering the impact of COVID-19 and winter pressures.

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

Level of Assurance		System Adequacy	Controls
Moderate Assurance		Adequate framework of key controls with minor weaknesses present.	Controls are applied frequently but with evidence of non-compliance.

Systems are developing well across the HSCP although the Primary Governance Groups and associated reporting needs to develop to provide comprehensive reporting across all aspects of all services. The management of overdue adverse events continues to improve but is still significantly higher than we would expect from the HSCP. The number of outstanding actions linked to service risks across the HSCP remains high and needs to be reduced. These factors, once addressed, will support movement towards a comprehensive level of assurance.

4.2 Background

The role of the Dundee HSCP Governance Group 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.

The GIRFE Framework has been agreed by all three HSCPs and the recent refresh of the document was endorsed at Care Governance Committee. 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

There is a clinical governance strategic risk for NHS Tayside Clinical Governance Risk 16. The current risk exposure rating of this risk considers the Clinical and Care Governance reporting arrangements within the Partnerships and reflects the complexity in moving towards integrated Clinical and Care Governance arrangements within each of the HSCPs. The Interim Evaluation of Internal Control Framework Report No T09/20 identifies the need for greater consistency in reporting of performance and quality by the HSCPs.

4.3 Assessment

a. Clinical and Care Risk Management

a.1 Dundee HSCP Service Risks are considered within the Dundee Clinical, Care and Professional Governance Group (CCPG Group) every two months and are presented via the DHSCP Analysis Report provided by the Governance Team. This reports lists all risks and current risk level, it lists any new risks added to the register since the last meeting and details actions required to ensure risk management is up to date. Pending risks are also listed.

Each Primary Governance Group (PGG) will review risks for their service area on a monthly basis. The PGG has operational responsibility for managing the risks.

Review of the service level risk register on Datix is evident since the last report. Whilst the majority of risks still require action to ensure they are contemporary, there is evidence that review of the risks is in progress.

a.2 The last report highlighted 14 risks with no documented planned/proposed controls. This has reduced to 2 risks. Similarly, the number of risks overdue for review has reduced from 17 to 9. Work is ongoing to ensure risk management is better maintained across the HSCP.

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 Maintaining safe DDARS	1	12	15
Clinical Treatment of Patients – Mental Health Service (946)	2	15	15

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.

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, although this is seeing signs of improvement.

Measures currently in place to support mitigation include:

- Access assessments clinics continue to run at a reduced rate (four down to two). Priority is given to any person presenting with high risk behaviours including non-fatal overdose. Work is continuing on the overarching workforce plan to support a sustainable model and patients continue to be advised on sources of alternative support, where required.
- Appointment to 1.0wte consultant has been made (start date 1.11.2021). There was unsuccessful recruitment to additional 1.5 wte specialty doctors. The team are reviewing plans to readvertise and also investigating the opportunities for a locum post.
- Nurse recruitment is progressing. Three band 5 nurses have been appointed, one band 6 nurse interview date is set and one band 7 nurse is advertised. The total number of nurse vacancies across the current established service is 2.0 wte which shows a remarkable improvement.

- GPs with an interest in substance misuse are developing services in collaboration with the DDARS. This is in early development.
- Service Level Agreements continue to be discussed with a number of Community Pharmacists to enhance harm reduction provision.
- Workforce review has identified the requirement to uplift a number of posts from band 5 to band 6 to meet prescribing requirements and this has been agreed to be progressed which will support risks 612 and 233. This work has been presented to the Alcohol and Drugs Partnership and there is support for the model although further work has been requested on the workforce plan to support justification for the proposed model.

a.3 DDARS implemented the Dundee Drug Commission recommendations to increase access to treatment by introducing same day prescribing, and to improve retention by reducing unplanned discharges which has successfully increased numbers of people in treatment with DDARS to 1410. Unplanned discharges have proved challenging in that we are unable to discharge individuals who do not engage/attend appointments. The management of this results in increasing demands on various staff across the service. Further work has been commenced on an assertive outreach model with a variety of partner agencies to support those who have difficulties engaging with statutory services.

Two additional nursing posts (Advanced Nurse Practitioner and Specialist Nurse with NMP) have been agreed to support this model and improve efficiency and safety of decision-making and ensure early access to assessment and treatment for hard to reach individuals.

a.4 Risk 946: Clinical Treatment of Patients – Mental Health Service

As a result of the demand for medical review outweighing current capacity, people will not receive appropriate treatments, with this resulting in poorer mental health outcomes for people and their carers.

Progress to date: Dundee HSCP has successfully secured a fifth Locum Consultant Psychiatrist (0.8 wte) who is deployed within the East Community Mental Health Team. This is a replacement for a retiring member of staff (0.6 wte) and represents a small overall rise in availability of medical time.

Importantly, we have made significant progress in modernising models of care to become less dependent on medical staff time, having appointed two Advanced Nurse Practitioners and a Specialist Mental Health Pharmacist. Work is currently underway to clearly define the unique roles of each to ensure service users see the right person at the right time in the right place.

<u>New or Emerging Risks</u>

a.5 There are 36 services risks recorded on Datix at the time of the data extraction. Of these, 26 are current service risks. There were three new current risks added to Datix since the last report:

- 1050 Psychiatry of Old Age – Older People Services (Dundee) – Workforce – rated Yellow (Category 2) – Medium

  RMN ward posts have had to be re-advertised. Each ward now has two CNs which will allow for senior support on night shift.
- 1052 Psychiatry of Old Age – Older People Services (Dundee) – Pathways of Care/Complex Needs Patients – rated Amber (Category 2) High

  Learning themes being developed around community pathways between disciplines and transitions, and a review of the changing demographics of the patient population.
- 1060 Psychiatry of Old Age – Older People Services (Dundee) – Ligature Risk - rated Yellow (Category 2) – Medium

  Ongoing risk due to new works being considered for building as part of the rolling improvements being made throughout Tayside.

a.6 Risks relating to workforce availability have been noted across a number of services and professional groups including medical, nursing, AHP and social care. Workforce plans, escalation processes and working with our Partners across Tayside have supported ongoing service delivery. As the COVID-19

pandemic continues this becomes more challenging with impacts on staff health and wellbeing being noted more frequently.

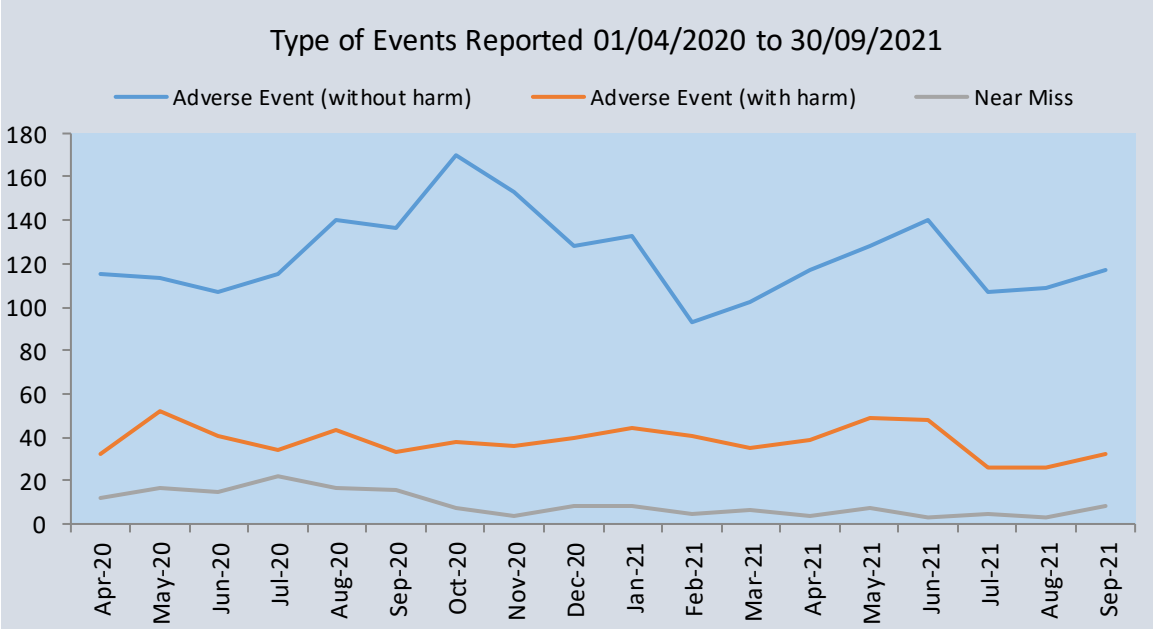
b. Clinical & Care Governance Arrangements

Dundee HSCP Governance arrangements are outlined in Appendix 1. All services across Health and Social Care report into the CCPG Group via the Primary Governance Groups. Due to management changes within the HSCP the Primary Governance Groups continue to be reviewed and updated.

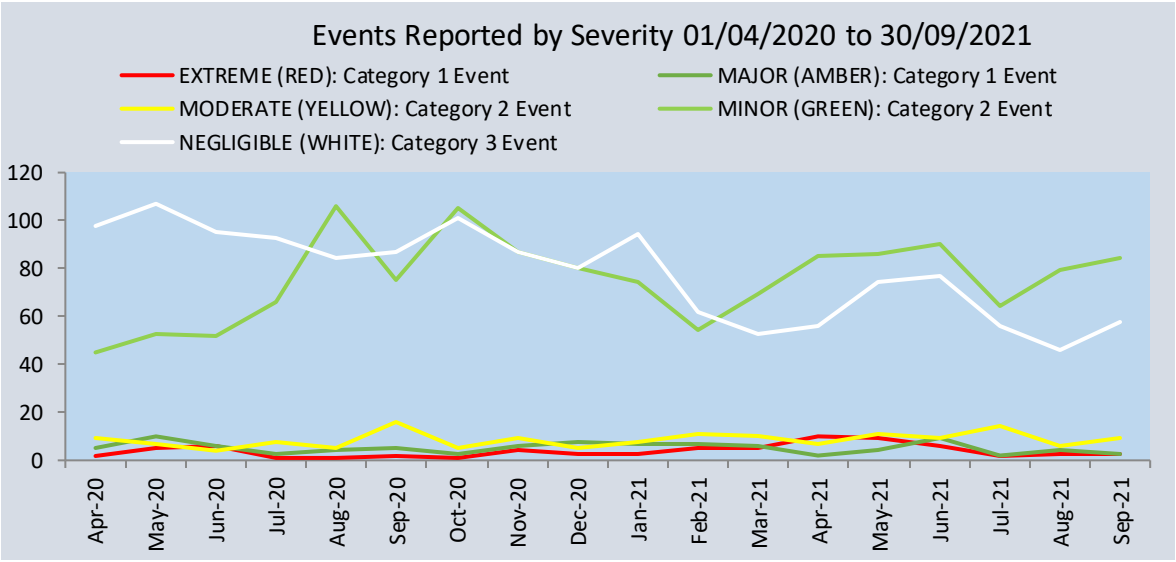
It continues to be challenging to ensure comprehensive reporting across Health and Social Care Integrated Teams in terms of access to comparable data, integration of cultures and access to and use of systems within integrated teams (i.e. electronic patient records)

c. Adverse Event Management

c.1 There were 295 adverse events reported within the time period. The following graph shows the type of adverse events reported though Datix by month over the past 18 months. There is a reduction in the number of incidents when compared with August and September 2020.

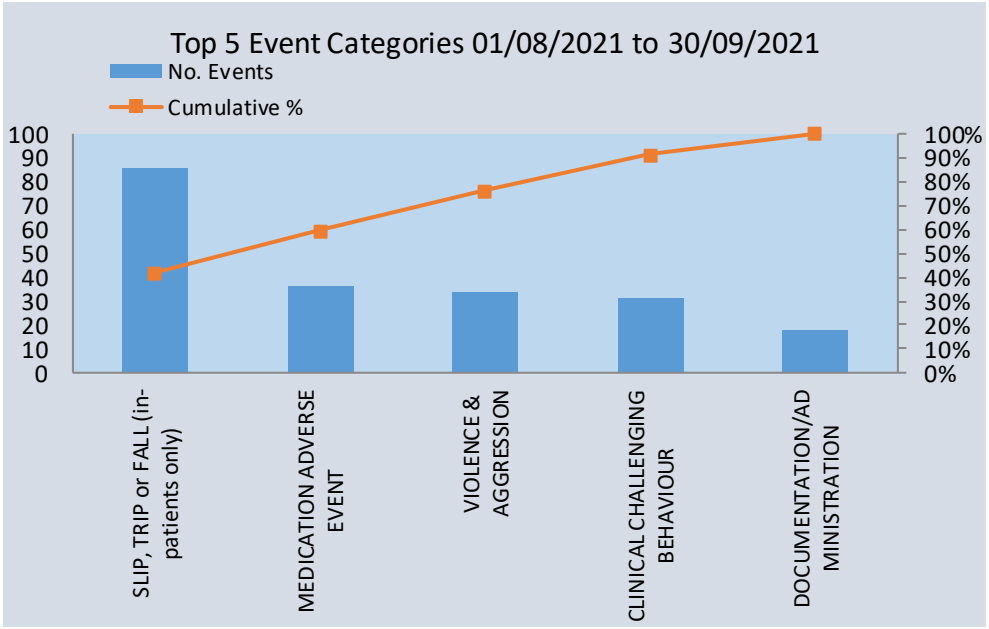


c.2 The following graph shows the impact of the reported adverse events by month over the past 18 months, which shows a relatively low number of red and amber incidents.



Top Five Categories of Adverse Events

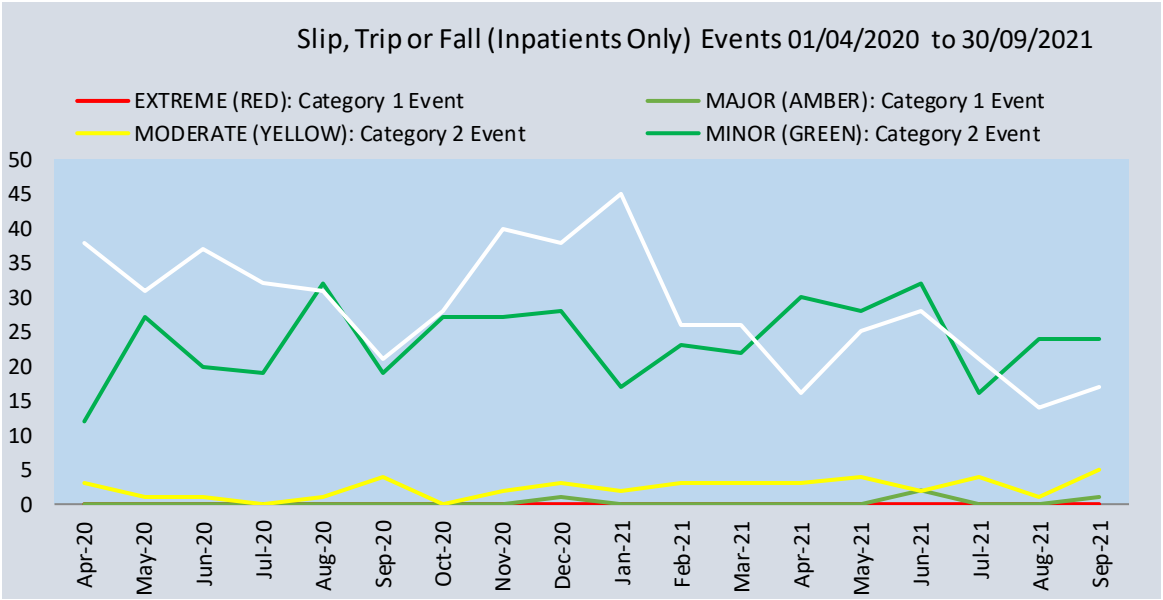
c.3 The following graph shows the top five categories reported between 1.08.2021 and 30.09.2021. The top five categories are: slip, trip or fall (inpatients only), medication adverse event, violence and aggression, clinical challenging behaviour and documentation/administration.



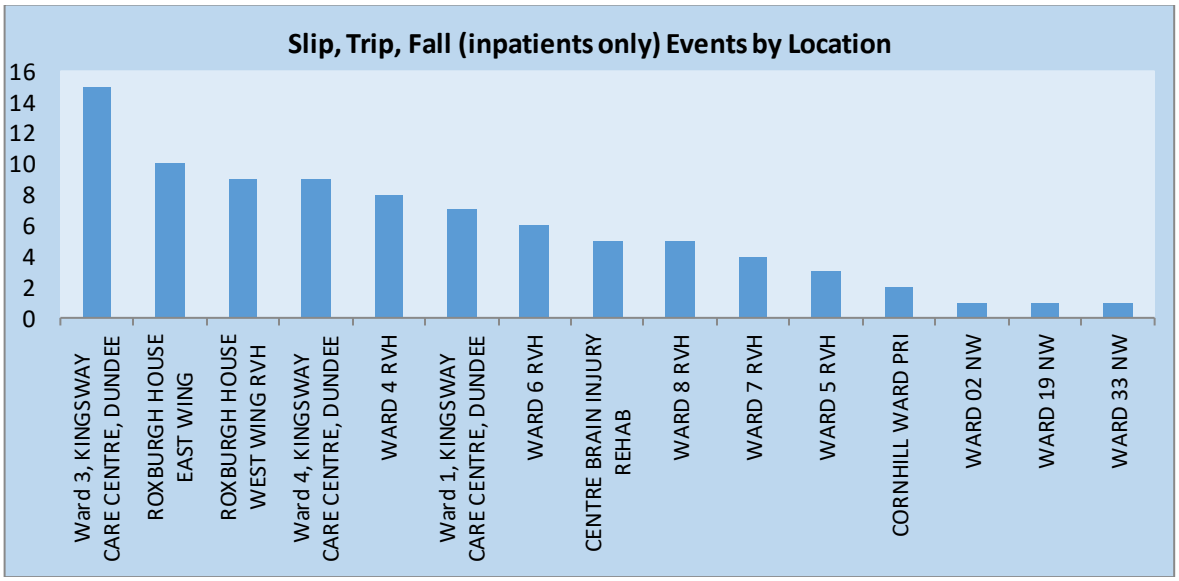
These categories account for 205 of the 295 events (69%) reported within the time period.

Slip, Trip or Fall (Inpatients Only) Events

c.4 There were 86 events reported within the time period.



c.5 The following table shows the number of slips, trips and falls (inpatients only) by location. The areas with the highest number of falls were Ward 3 Kingsway Care Centre (15 falls), Roxburghe House East Wing (10 falls), Roxburghe House West Wing (9 falls) and Ward 4 Kingsway Care Centre (9 falls).



c.6 A local falls group has been convened for all the inpatient areas within Royal Victoria Hospital, Kingsway Care Centre and Specialist Palliative Care Services (SPCS). This is inclusive of the MDT. All wards within Medicine for the Elderly have nominated falls champions and a daily FUN (Falls, Unwell patients, New patients) huddle looking at high risk patients and relevant interventions. Safety huddles are established in SPCS where patients at risk of falls are identified.

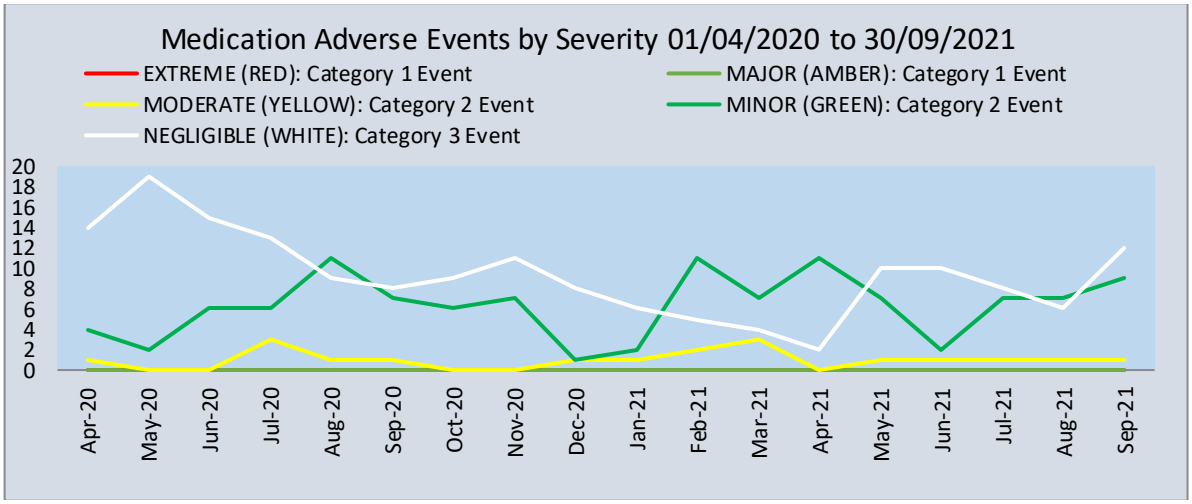
Further quality improvement work is being reviewed regarding person-centred care plans, patient observation SOPs, technology and staff education.

Local ward reviews will take place to understand rates of falls, potential risk factors and any other contributing factors. Extra equipment has been purchased to help prevent those patients who are identified as falls risks to be monitored more closely to minimise the risk. All learning will be shared at primary governance meetings.

The falls within Roxburghe House were higher than usual in this report. Reviews of these falls have been undertaken. In August one individual was responsible for a number of the falls. July showed a number of separate individuals falling. Risk assessments and preventative measures were always implemented where indicated and safety briefs were used to ensure staff awareness of risk. The staff at Roxburghe House will join the inpatient falls group to support ongoing review and management of falls.

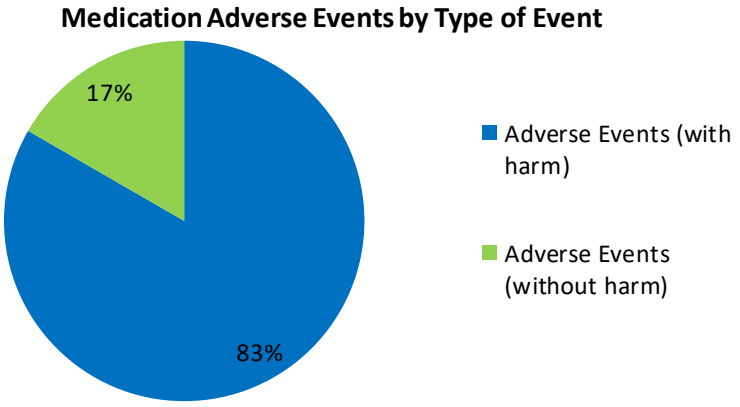
<u>Medication Adverse Events</u>

c.7 There were 36 events reported within the time period.



Medication adverse events have been reported across eight different service areas and include 15 different sub-categories of incidents. There do not appear to be any clear themes or specific areas of concern relating to medication adverse events.

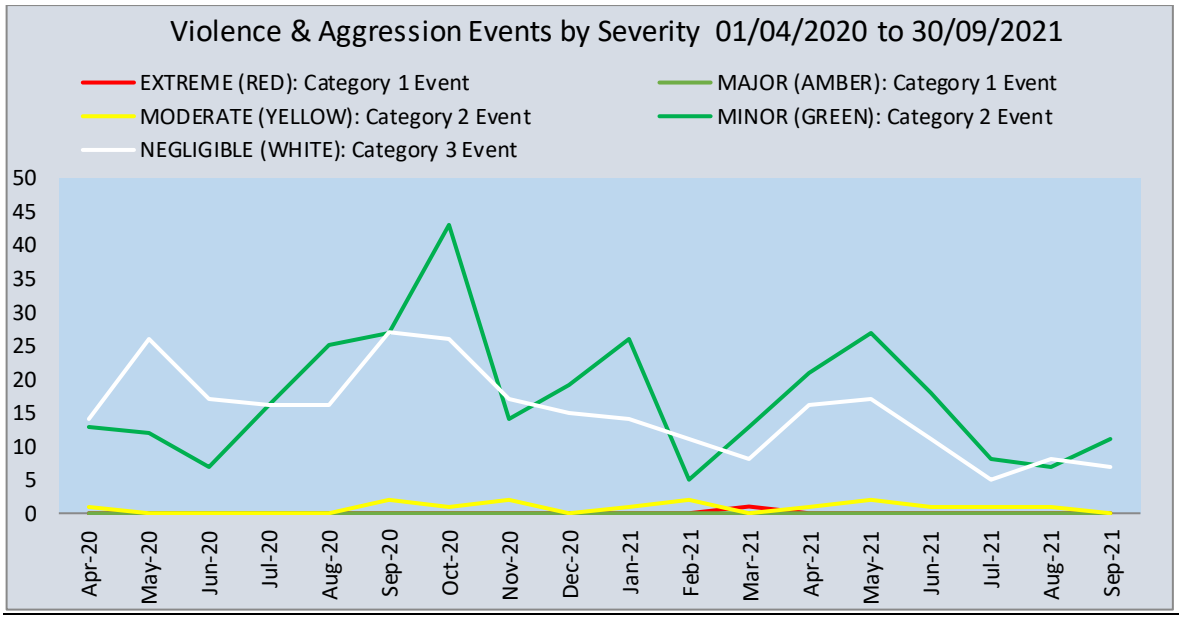
c.8 The following graph shows the type of event reported. Thirty were reported as adverse event (without harm), six as adverse event (with harm), and zero as a near miss. The adverse events with harm showed minimal impact. Medical staff were involved in the observation and monitoring of patients and there were no long term effects. On every occasion the error was noted immediately, corrected and monitored. Patients and families were informed.



Medication adverse events are reported and discussed through Primary Governance Groups with exceptions being raised through the CCPG Group. Following medication adverse events the reporter is expected to undertake a reflective account. These have supported the development of additional standard operating procedures, review of equipment used, replacement of equipment and ongoing training and support for staff. The future development of an electronic patient record and booking system for community nursing will support an improvement for these adverse events.

Violence and Aggression

c.9 There were 34 events reported within the time period.



There were 34 events reported within the time period, compared with 84 events in the previous report. While this is, in part, down to the those patients having multiple incidents being discharged from the inpatient areas, it also signifies the work undertaken by the teams with enhanced training, more

proactive management of complex cases and the sharing of good practice across different clinical areas.

Violence and aggression incidents occur across the Psychiatry of Old Age, Medicine for the Elderly and the Dundee Drug and Alcohol Recovery Services. The majority of events are physical in nature (27) with verbal aggression coming from patients and visitors in seven incidents.

Clinically Challenging Behaviour

c.10 There were 25 events reported within the time period. These are primarily related to impaired cognition and were reported across seven clinical areas.

While there is no current direct impact on delivery of care associated with these incidents they will continue to be monitored to ensure this. Staff managed the situations well through their violence and aggression and de-escalation training. Support is offered to staff as required as part of the verification process.

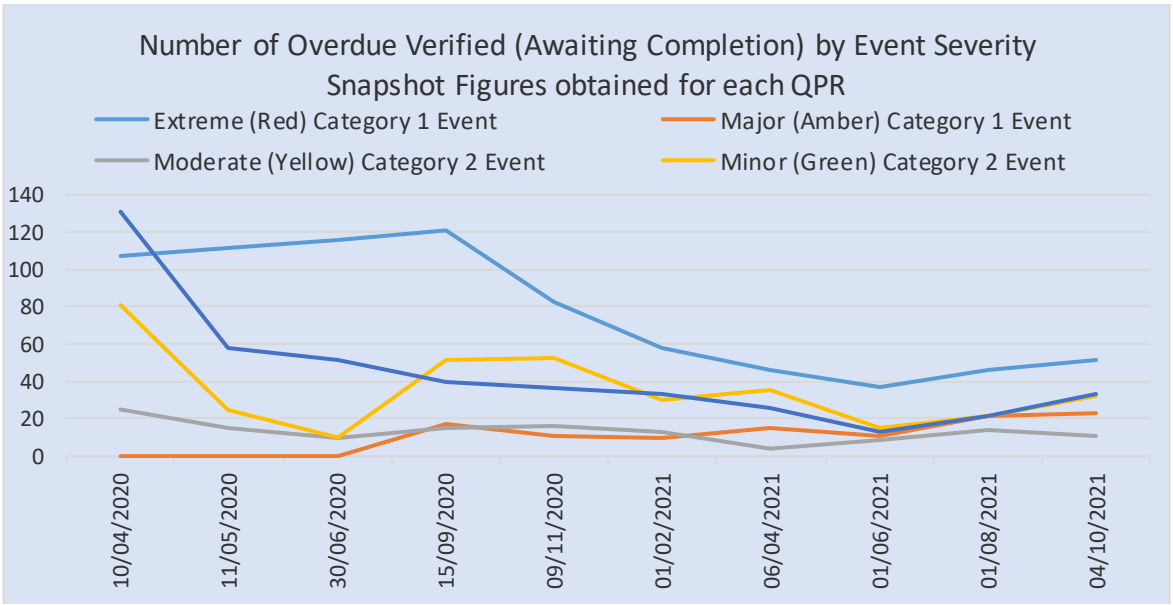
A review of both the violence and aggression and clinically challenging behavior incidents shows a degree of overlap of types of incidents with a number in the violence and aggression category being identified as clinically challenging behavior incidents. Education to staff via the Clinical, Care and Professional Governance Forum has highlighted this to ensure more accurate reporting of these two types of incidents.

Documentation/Administration

c.11 There were 18 events reported within the time period. These were reported across 13 service areas and included seven different incident categories. The most common incidents were documentation error and failed communications (both less than five incidents). Local reviews are undertaken for these incidents and where applicable improvements are implemented including additional training, development/revision of Standard Operating Procedures and awareness raising regarding these types of incidents.

Overdue Adverse Events

c.12 The following graph shows the number of verified events overdue for completion over the past 12 months.



c.13 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 mostly the number of historical outstanding reviews continues to reduce.

	2017	2018	2019	2020	2021
Extreme	<5	<5	6 (6)	13 (15)	30 (17)
Major	-	-	0 (1)	4 (7)	19 (5)
Moderate	-	-	-	4 (4)	7 (3)
Minor	-	-	-	5 (5)	27 (24)
Negligible	-	-	-	-	33 (25)
TOTAL	**<5**	**<5**	**6 (7)**	**26 (31)**	**115 (74)**

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 an increase in reports from 2021 from 74 to 115. Increased clinical demand and unplanned staff absence have contributed to this increase for 2021 Datixs.

The teams are currently focussed on balancing time between ensuring new adverse events are comprehensively reviewed to ensure current risks, challenges and issues in the service are identified and managed while also aiming to dedicate some time to reviewing legacy adverse events. While this will mean a longer timeframe to reduce overdue adverse events, it will also focus our limited resource into current events ensuring a focus on mitigation of current risk. In line with the current SOP, each red and amber adverse event has been subject to initial scrutiny to allow risk-based decision making with regard to priority for review. Where this identifies the likely need for immediate improvements, reviews begin immediately. For example, two recent events highlighted that appointments had been missed in the period prior to death without timely follow-up to this (one death from natural causes; one from overdose); whilst the formal detailed reviews remain ongoing, rapid improvement work took place with Team Leaders to ensure that clear disengagement plans are in place for all open cases with multidisciplinary involvement.

d. Complaints

d.1 Stage 2 Complaints at 28.10.2021

No. of Open Cases - 21								
Division/Partnership	**Days_Band**	**Total**	5-9 Days	15-20 Days	21-25 Days	31-35 Days	36 - 40 Days	40+ Days
Total		**21**	**2**	**1**	**2**	**2**	**2**	**12**
Dundee HSCP		**21**	2	1	2	2	2	12

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

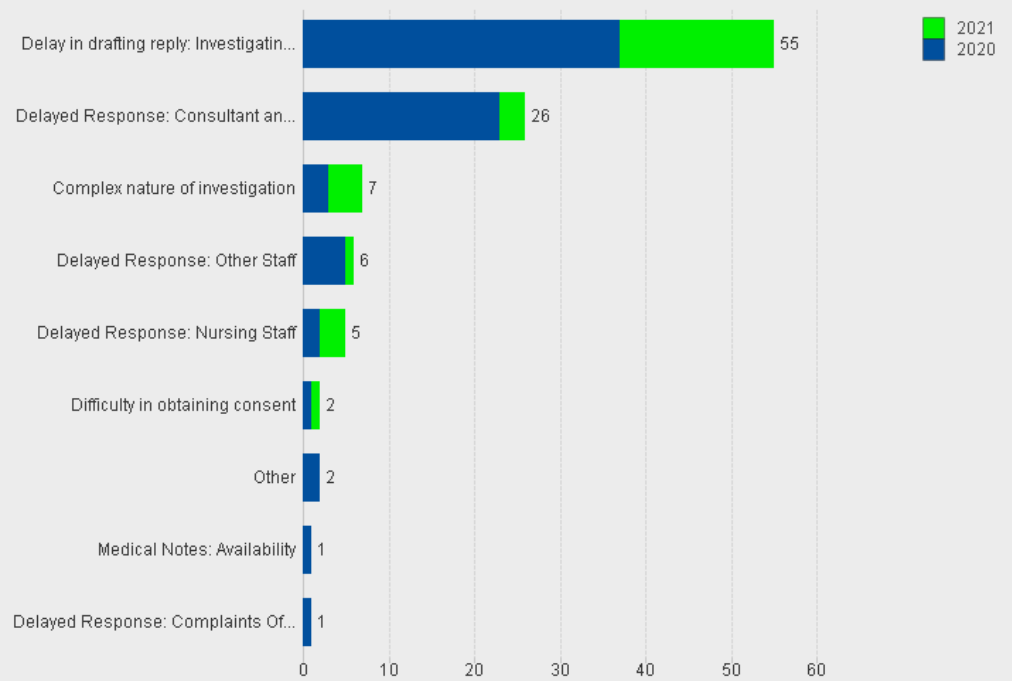
Feedback and positive reports from patients and carers are also being promoted for reporting at Primary Governance Groups as part of performance and learning focus.

Further work 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 support the sharing of learning from complaints. The key themes in this reporting period are clinical treatment (14), attitude and behaviour (5), communication (oral) (<5) and date for appointment (<5). Subthemes for clinical treatment include disagreement with treatment, poor nursing care, co-ordination of treatment and waiting to see doctor/nurse once admitted – all categories received less than 5 complaints.

Learning from complaints tends to be shared via Primary Governance Groups and via exceptions to the CCPG Group.

The DHSCP complaints team are seeking to include learning in the weekly overdue report to support a more widespread sharing of learning from complaints.

d.2 The following chart shows the reasons for breaches for 2020 and 2021.



This shows improvements in 2021 across the majority of breach reasons. The main area that requires further improvement relates to the delay in drafting a reply from the investigating officer, although the projected figure for 2021 will be significantly reduced compared with 2020. The work the HSCP Complaints team are leading with their weekly summary reporting is supporting managers better prioritise management of complaint responses and work has commenced with the NHS Tayside complaints team to further examine how best to support an improved performance in relation to complaints management.

e. External Reports & Inspections

There have been no inspections in this time period.

f. Mental Health

f.1 A Quality and Performance Review (QPR) process is in operation within Mental Health Services and incorporates a system-wide review focusing on shared learning across all three HSCPs and Inpatient areas.

This new format commenced in October 2021 and the Dundee HSCP Mental Health Team presented on Early Follow-Up On Discharge from Inpatient Care. Evidence shows that 15% of post discharge suicides occurs within the first weeks of leaving hospital, with the highest number (22%) occurring on the second full day of discharge from hospital.

A discharge clinic, wraparound model has been designed. Good discharge planning remains essential to support this process. Contact post-discharge should occur within 24 hours (Discharge Clinic) with up to two weeks of post-discharge follow up provided, with the intensity of support being matched to patient need. The Community Mental Health Team should review within seven days to support plans regarding longer term management.

This process is currently being designed and will be audited through the CCPG Group.

<u>Staffing</u>

f.2 Medical staffing remains a significant cause for concern. NHS Tayside is unable to recruit permanent staffing with a recent high-profile recruitment campaign resulting in no success other than agreement to support two Locums to work towards RCPsych membership.

There are currently 19 vacancies in Psychological Therapies. Whilst we are hopeful of an improved position over the next six months, there isn't the workforce to recruit at these levels (increased access monies means increased posts nationwide). Work is underway to improve retention (ending fixed term posts) and the development of a MH & LD employment microsite (similar to the one used in Primary Care) & proactive engagement with staff about to qualify to improve recruitment.

Delays in Agenda for Change Job Description approval are holding up a move to recruitment for the Director of Psychology and a Consultant Clinical Psychologist post for Neurodiversity.

Despite recruitment challenges in a number of disciplines, there has been good success in recruiting to the nursing vacancies that had previously been reported as a cause for concern, and were clustered in one Community Mental Health Team.

f.3 Dundee HSCP MH Leadership are being asked to host an increasing number of key service developments (for example, Perinatal, Maternal, Neonatal and Infant Mental Health; Early Intervention in Psychosis; likely Personality Disorder Service) and there is increasing pressure around leadership capacity, both in terms of local developments and Living Life Well Tayside workstreams. Due to the level of strategic workstreams led within the team both locally and Tayside wide, increased capacity requires to be created. This risk will escalate further as two members of the team retire in 2022.

A series of discussions has commenced to review the skill mix / posts within the local team, and plans to introduce additional roles are under consideration. These actions are required to ensure the pace of change required can be delivered on.

4.3.1 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.

4.3.2 Workforce

Remobilising continues to be challenging for staff in the HSCP, who are tired and feeling the impact of the past 18 months working through a pandemic. Senior and Service Managers are focusing on supporting their staff through this period. Work commenced through Silver COVID group on staff wellbeing and reflection.

Challenges:

- Delays in recruitment
- Competing priorities and workload

4.3.3 Risk Assessment/Management

Risks are included in the report above.

4.3.4 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.

4.3.5 Other Impacts

There are no other direct impacts for this report.

4.3.6 Communication, Involvement, Engagement and Consultation

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

4.3.7 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, 23 September 2021.

4.4 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.

5.0 POLICY IMPLICATIONS

5.1 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	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 (including timescales and resources)	Systems in place for all operational teams to provide exception reports to the clinical, care and professional governance group. '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.

7.0 CONSULTATIONS

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

8.0 BACKGROUND PAPERS

None

Responsible Officer Dr David Shaw, Clinical Director
Diane McCulloch, Head of Service, DHSCP

Report Author: Matthew Kendall, Allied Health Professions Lead