ITEM No …9……..

REPORT TO: **PERFORMANCE & AUDIT COMMITTEE – 29 SEPTEMBER 2021**

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

REPORT BY: **CLINICAL DIRECTOR**

REPORT NO: **PAC24-2021**

1.0 PURPOSE OF REPORT

1.1 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

This report is being brought to the Committee to provide assurance on the clinical and care governance activities and arrangements across the Partnership as outlined in the Getting It Right For Everyone (GIRFE) 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 Performance and Audit 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 April to May 2021.

2.0 RECOMMENDATIONS

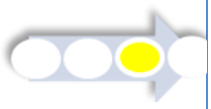
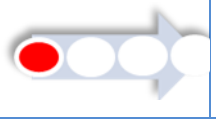
2.1 It is recommended that the Performance and Audit Committee (PAC):

- Note the Exception Report for the Dundee Health & Social Care Partnership Clinical, Care & Professional Governance Group as detailed in Section 4.

2.2 This report is being presented for:

- **Assurance**

As lead Officer for Dundee Health & Social Care Partnership (DHSCP) I would suggest that the level of assurance provided is: Moderate.

Level of Assurance		System Adequacy	Controls
Comprehensive Assurance		Robust framework of key controls ensures objectives are likely to be achieved.	Controls are applied continuously or with only minor lapses.
Moderate Assurance		Adequate framework of key controls with minor weaknesses present.	Controls are applied frequently but with evidence of non-compliance.
Limited Assurance		Satisfactory framework of key controls but with significant weaknesses evident which are likely to undermine the achievement of objectives.	Controls are applied but with some significant lapses.
No Assurance		High risk of objectives not being achieved due to the absence of key internal controls.	Significant breakdown in the application of controls.

3.0 FINANCIAL IMPLICATIONS

3.1 None.

4.0 MAIN TEXT

4.1 Situation

4.1.1 This report is being brought to the Committee 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 Performance and Audit 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 April to May 2021.

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

4.2 Background

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

4.2.2 The Getting It Right For Everyone Framework has been agreed by all three Health & Social Care Partnerships 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 Health & Social Care Partnerships, quality assurance is assessed against an agreed, prioritised common data set for each of the governance domains as detailed below. A Getting It Right For Everyone 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.

4.2.3 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, Healthcare Improvement Scotland 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

4.2.4 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

4.3.1 Clinical and Care Risk Management

4.3.1.1 Risk management across Dundee HSCP continues to be recorded across both a Health (service risks) and Local Authority (strategic risks) system. While this in itself does not prevent appropriate risk management processes being undertaken it does increase the required administration to link together risks and ensure visibility and connections between strategic and service risks. There are ongoing discussions to determine the most effective route forwards for risk management systems.

4.3.1.2 Top 5 Risks in Dundee 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

4.3.1.3 Four of the top 5 risks continue to sit with the Dundee Drug and Alcohol Recovery Service (DDARS). 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 and worsening recruitment and retention into the DDARS service.

Measures currently in place to support mitigation include:

- Agreement to reduce the number of new patients entering the DDARS (reduction from 4 access assessment clinics per week to 2). Patients are advised on alternative areas to seek support and the DDARS team have informed partners to ensure they are aware of the potential for increased referrals.
- Advertisement for additional specialist medical staff – 1.0 wte locum consultant, and 1.5 wte Speciality Doctor.
- There is ongoing recruitment to vacancies with new staff completing induction
- Contracts with GPs with an interest in substance misuse – one contract agreed and under discussion (in total will equate to between 0.3 and 0.5 wte).
- Service Level Agreements in discussion with a number of Community Pharmacists to enhance harm reduction provision.
- Workforce review has identified the requirement to uplift these 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.

4.3.1.4 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.

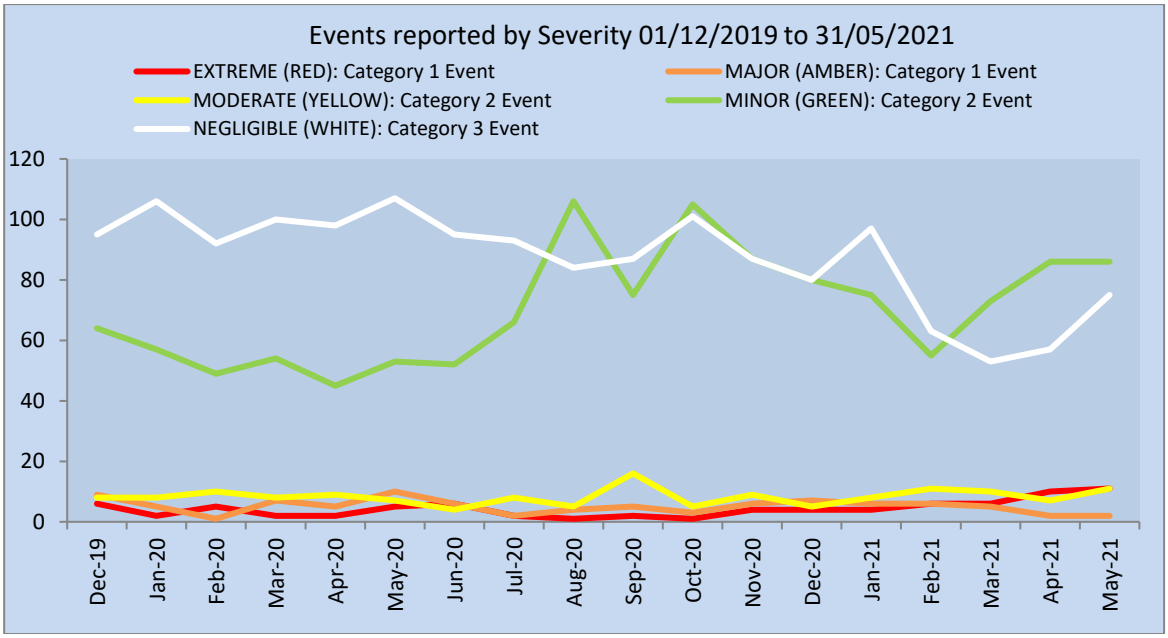
4.3.1.5 Risk 946: Clinical Treatment of Patients – Mental Health Service

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.

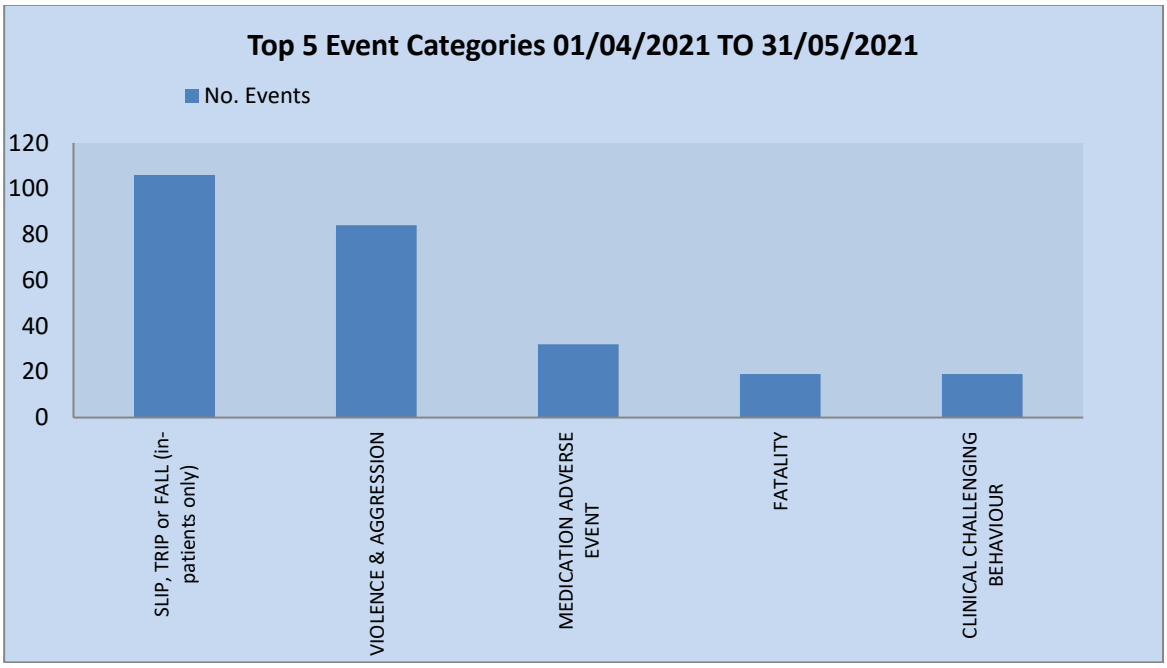
Traditional medical roles are being examined to determine what other professional groups can fulfil key function; primarily ANPs and NMP pharmacists. This will require release of funds from the medical budget and the recruitment of suitably qualified and experienced staff.

4.3.2 <u>Adverse Event Management</u>

4.3.2.1 The following graph shows the impact of the reported adverse events reported by month over the past 18 months.



4.3.2.2 The following graph shows the top 5 categories reported between 01.04.2021 and 31.05.2021. The top 5 categories are: slip, trip or fall (inpatients only); violence and aggression; medication adverse event; fatality; and clinical challenging behaviour.



These categories account for 260 of the 347 events (75%) reported within the time period.

4.3.2.3 Slip, Trip or Fall (Inpatients) Events

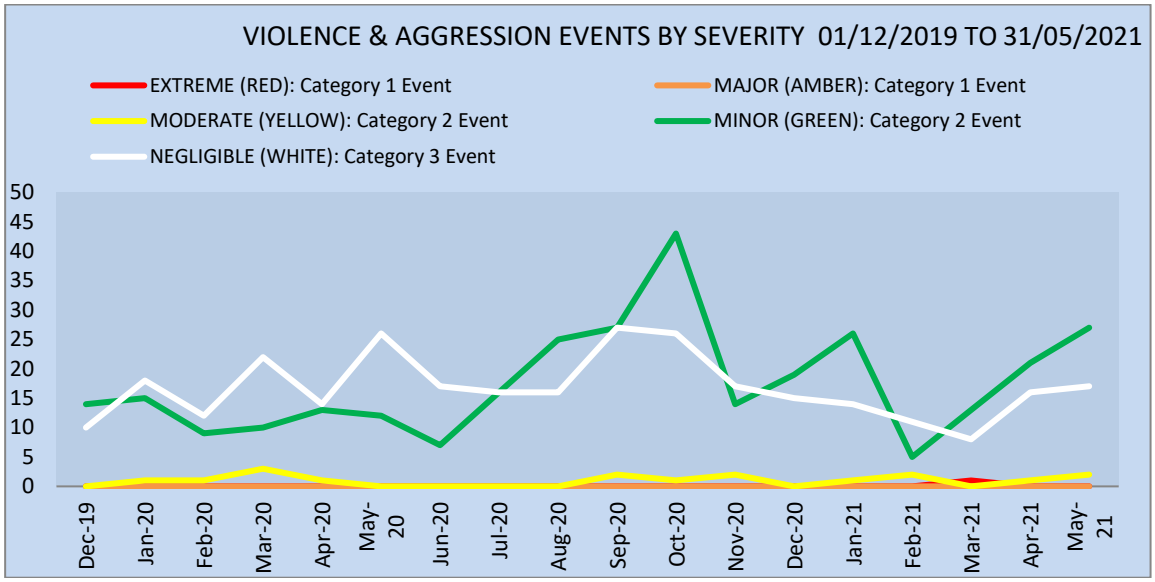
There were 106 events reported within the time period.

The majority of adverse events are reported through Older Peoples Services, with the majority of these being in Psychiatry of Old Age and more specifically in ward 3 at Kingsway Care Centre which had 35% of in-patient falls during this period. Review of these adverse events has identified a small number of patients who are responsible for multiple events, which is a common pattern across Psychiatry of Old Age and medicine for the elderly ward areas.

Discussions at the clinical, care and professional governance forum supported managers in sharing of learning and best practice for these patients. Comprehensive falls risk assessments (including eyesight, continence, footwear, strength and balance etc), falls plans, physiotherapy intervention, use of technology (falls sensors), bed location on ward and a positive rehabilitation based culture all contribute to positive management for this patient group.

25% of falls in this period were reported as incidents with harm. A review of this has identified no serious injuries requiring further medical input. A number of bruises, laceration and grazes were noted.

4.3.2.4 Violence and Aggression



4.3.2.5 There were 84 events reported within the time period. The majority of the events related to physical aggressive behaviour by patients, and were reported within Psychiatry of Old Age.

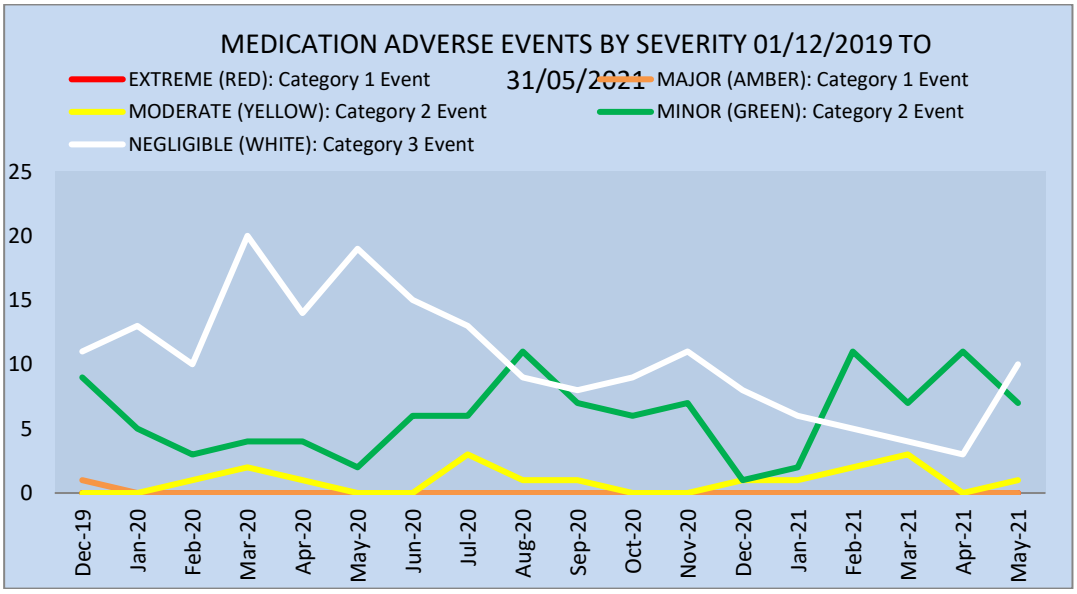
We have seen an increase during this reporting period which is down to a small number of patients having multiple incidents. The levels of harm remain low, although these events can be challenging for both staff and patients.

There are some very complex presentations currently resulting in frequent assaults on staff and patients, which has led to some patients being nursed in isolation.

The team continue to work closely with NHS Tayside's violence and aggression lead to ensure best practice and ongoing support for both staff and patients.

4.3.2.6 Medication Adverse Events

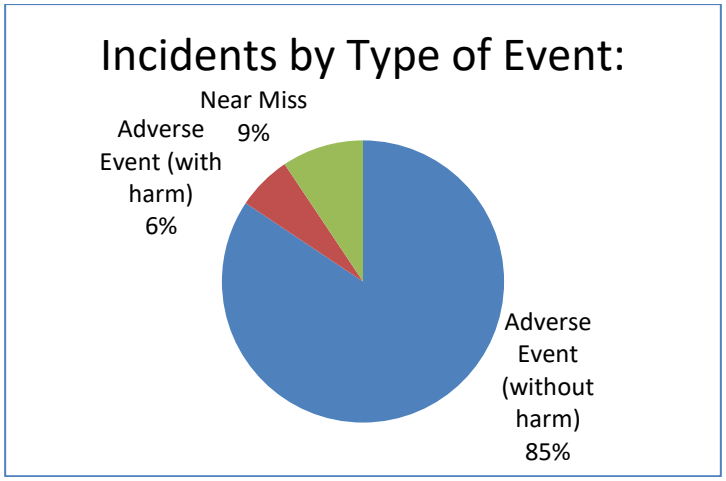
32 medication adverse events were reported in the time period. The following graph shows the number of events by severity over the past 18 months.



Medication adverse events have been reported across seven different service areas and include 14 different sub-categories of incidents. There do not appear to be any clear themes or specific areas of concern relating to medication adverse events.

4.3.2.7 The following graph shows the type of event reported. 27 were reported as adverse event (without harm), 2 as adverse event (with harm), and 3 as near miss.

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.



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.

4.3.2.8 Fatality Events

See Mental Health Section of report.

4.3.2.9 Clinically Challenging Behaviour Events

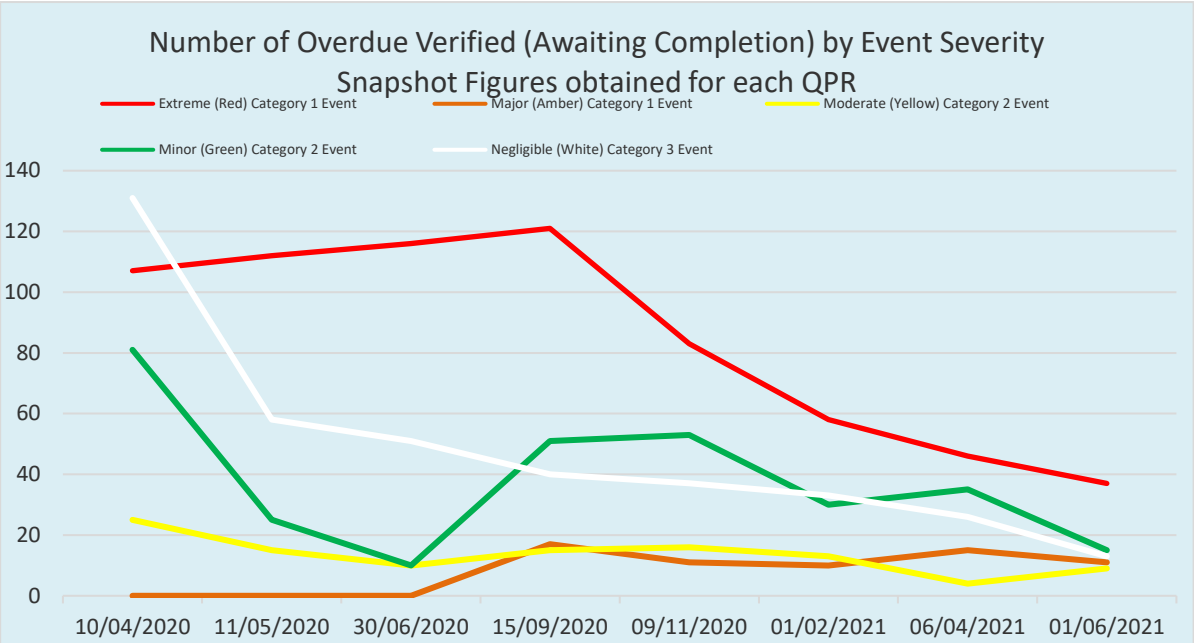
There were 19 events reported within the time period. These are primarily related to impaired cognition and were reported across six clinical areas. Themes reported include sexual disinhibition, repeatedly lying on the floor and making false accusations against staff.

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.

4.3.2.10 Overdue Adverse Events

The following graph shows the number of verified events overdue for completion over the past 12 months. The graph continues to show a decrease in overdue adverse events.

The introduction of adverse event review groups has driven this improvement in overdue adverse events. Not only has this supported the reduction in the number of overdue events but also brings the team together more frequently to review adverse events, identify themes and have multi-professional support to drive improvements.



There are 85 events that are verified but overdue for completion within Datix, compared with 126 in the previous report.

4.3.2.11 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.

	2017-2019	2020	2021
Extreme	21 (25)	16 (21)	-
Major	1 (1)	10 (14)	-
Moderate	-	4 (4)	5 (0)
Minor	0 (1)	8 (15)	7 (19)
Negligible	0 (1)	2 (11)	11 (14)
TOTAL	**22 (28)**	**40 (65)**	**23 (33)**

The majority of overdue extreme and major events sit within the Mental Health Service and Dundee Drug and Alcohol Recovery Service. As has been noted in previous reports significant improvement has been noted in reducing the numbers of overdue adverse events.

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 on-going, rapid improvement work took place with Team Leaders to ensure that clear disengagement plans are in place for all open cases with multidisciplinary involvement.

4.3.2.12 Greater detail was requested via the Care Governance Committee on the themes identified through adverse event review. It should be noted that nearly all red events in mental health arise from patient suicide. Although rightly classed as an adverse event, a significant proportion of reviews will find that there is no act, error or omission on the part of the service that contributed to the suicide, this reflecting the multi-factorial causes of suicide and an acceptance that the prediction of the suicide is not actually possible. It is possible to provide good, evidence-based treatment and still experience patient suicide. Where recommendations are made, these

often reflect secondary service improvements that the case has highlighted. Notwithstanding that, key themes which emerged from the adverse event reports were as follows:

- Lack of coordinated care
- Ineffective communication with inadequate procedures and processes to enable sharing of information across and between statutory services and with external organisations
- Lack of clarity in reporting systems in particular escalation strategies
- Inconsistent referral processes between disciplines and with partner agencies
- Individuals not being seen in a consistently timely manner upon discharge from inpatient care.

4.3.2.13 Recommendations from the reviews included:

- Facilitation of interagency working particularly in relation to individuals presenting with co-occurring mental health and substance misuse issues
- A standard should be set that all individuals discharged from psychiatric inpatient should be followed up within seven days of post discharge
- Review of standard operating procedures, including referral protocols, transition and models of care, developing a whole systems approach to joint working
- Communication whether it is interdisciplinary, with primary care and other partner agencies services, and most importantly individuals presenting to services should be clear, concise and delivered in a timely manner
- Depot clinics to have clear risk management plans in place when individuals do not attend with this to be included in the monthly audit.

In all cases the standard of care was acceptable. Positives examples of good practice were:

- Evidence of delivery of person centred care
- Assertive and proactive follow up when individuals disengaged or were difficult to engage
- Good collaboration with family members and carers.

4.3.2.14 Progress Made to Date

Improvements that have already been put in place to address the recommendations made include:

- The establishment of the Dundee Adult Mental Health Discharge Hub (the Discharge Hub) providing a supportive and safe transition from hospital to home. All adults who have had an inpatient stay or contact with the Crisis Resolution Home Treatment Team (CRHTT) as an alternative to admission are referred to the Discharge Hub, which operates six days a week, excluding Sunday from 09:00 to 17:00. Importantly, this includes people being discharged without formal follow-up from mental health services as the identified risk in the literature comes from having been an in-patient, not an in-patient with an identified mental health problem.
- Closer working between Community Mental Health Services and the Dundee Alcohol & Drug Recovery Service. There is now more regular contact between Integrated Managers/Teams Leaders within these services and work is underway to establish a shared-care protocol between the services and undertake Adverse Event Reviews jointly. The recently successful CORRA bid will test the effectiveness of more integrated service provision for those people experiencing mental health and substance use challenges. The MHO Team have been shadowing the work of the CRHTT to improve relationships and allow mutual education of the roles and responsibilities of each service. Mental health patients now have disengagement plans which clearly set out what action and when that action will take place, should an appointment or appointments be missed.

4.3.2.15 Further Recommended Developments

The backlog of cases requiring review has resulted in less engagement with families than is reflected in National and Local Policy. There is recognition of the importance of family carer engagement in the process of adverse events and the adoption of the principles of Being Open NHS Scotland would help guide this work. There is currently intent to develop a small, dedicated resource comprising a mental health professional well experienced in Adverse Events Work and a Peer Support Worker (who has experienced being bereaved by suicide) to specifically link with and support families affected by mental health suicide. This should allow the service move beyond the simply inclusion of family questions as part of the Review process to a point where there is more timely and robust involvement of families with a feeling of reciprocity in terms of the support offered.

The four partner organisations in Tayside now have an agreed forum for learning to be shared locally and organisationally with staff with a view to this leading to improved practice. Where agreed and appropriate, there is a wider sharing of learning wider within NHS Scotland via Healthcare Improvement Scotland (HIS) Adverse Events Community of Practice website. However, it is considered that the volume of events within DHSPC – which identify both good practice and areas for improvement – justify a more regular learning focus with it ensured that this is addressed directly to the teams delivering care. It is therefore recommended that consideration be given to establishing regular "Mortality and Morbidity" team discussions across the City to enhance the level of learning from events. This will allow issues to be highlighted and encourage Teams to develop their own additional improvement plans.

4.3.2.16 <u>Complaints</u>

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.

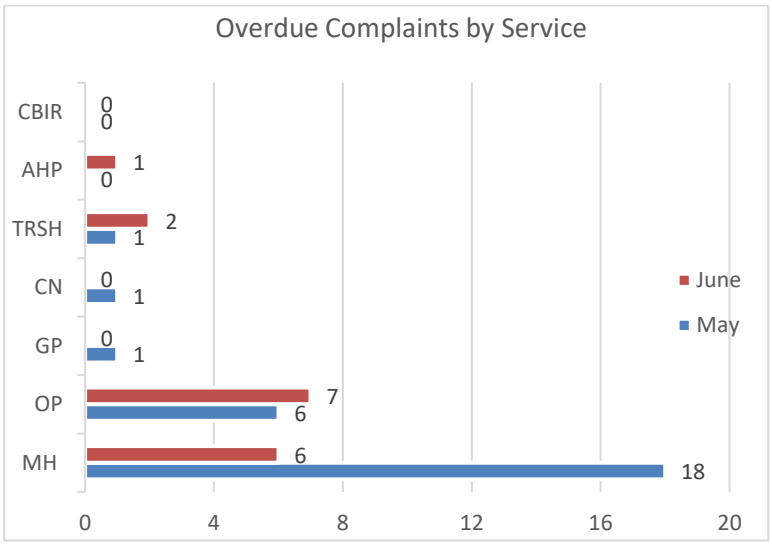
Learning from service complaints / service-user experiences are expected to be reported via the exception reporting template system.

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.

A weekly complaints summary is compiled by the HSCP Complaints team to support managers identify and manage overdue complaints.

Learning from complaints tends to be shared via Primary Governance Groups and via exceptions to the Clinical, Care and Professional Governance Group. The complaints team are seeking to include learning in the weekly overdue report to support a more widespread sharing of learning from complaints.

4.3.2.17 Overdue Complaints by Service



4.3.2.18 DHSCP Stage 2 Complaints closed within 20 working days

	Stage 2 (Non escalated)			Stage 2 (Escalated)		
	% Closed in timescale	**Number closed in timescale**	**Total number**	**% Closed in timescale**	**Number closed in timescale**	**Total number**
	29.8%	**14**	**47**	**28.6%**	**2**	**7**
Jan 2021	25.0%	2	8	-	0	0
Feb 2021	44.4%	4	9	0.0%	0	2
Mar 2021	50.0%	3	6	0.0%	0	2
Apr 2021	20.0%	1	5	-	0	0
May 2021	18.8%	3	16	50.0%	1	2
Jun 2021	33.3%	1	3	100.0%	1	1

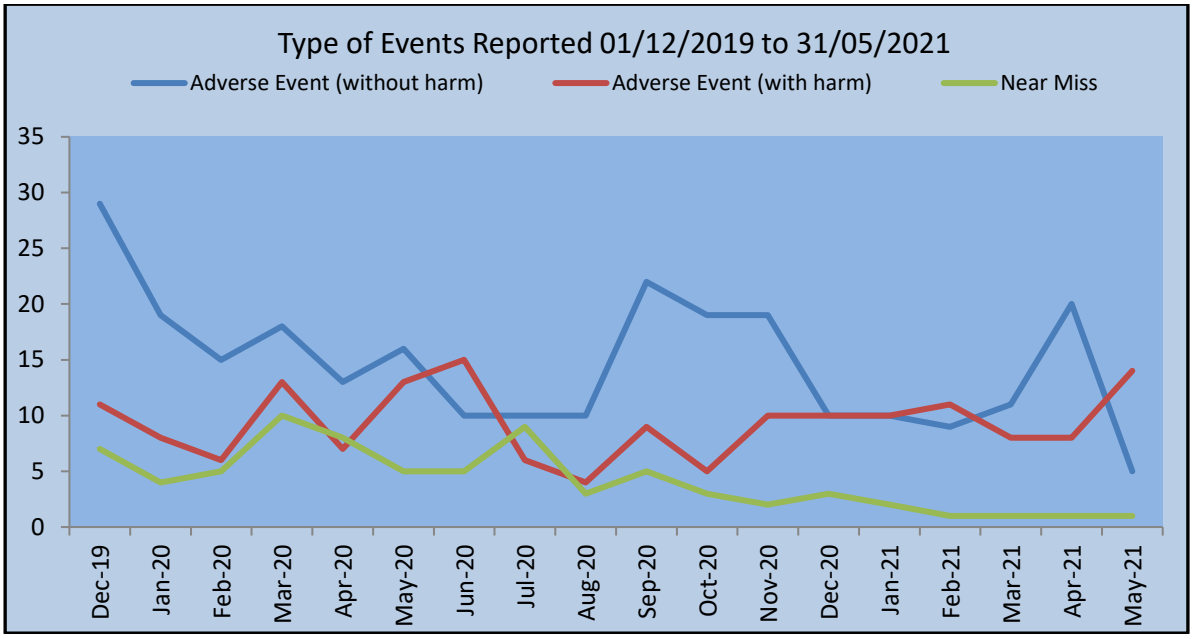
4.3.2.19 Mental Health

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.

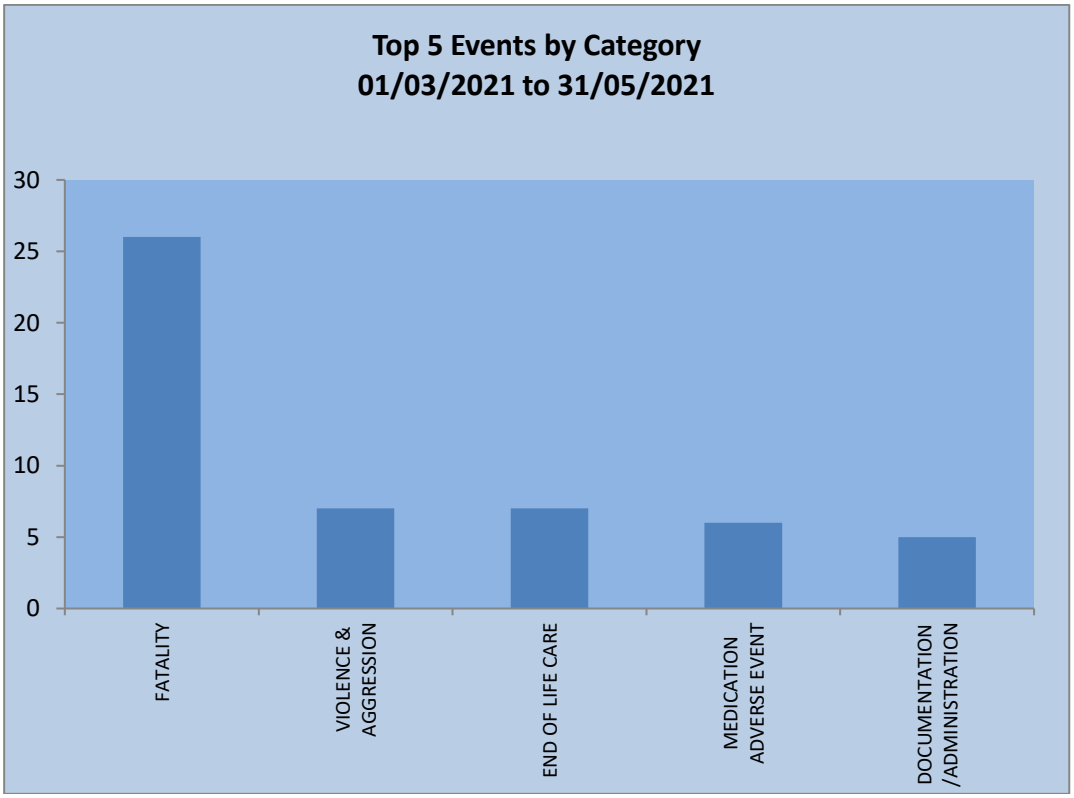
At the most recent QPR meeting in June 2021, the Leadership Panel noted that Dundee HSCP continues to make progress in addressing incomplete verified events and have completed a thematic review of the last 20 adverse events with improvements progressed in relation to shared care and communication. The Panel, whilst noting the work required, were assured by the robustness and oversight of the process within Mental Health Services within DHSCP.

4.3.2.20 Adverse Events

69 adverse events were reported within the time period 01/03/2021 and 31/05/2021. The following graph shows the type of events reported over the last 18 months.



4.3.2.21 The following chart shows the top 5 category of events reported within the time period.



Events reported in these 5 categories account for 74% of the total number of adverse events reported.

4.3.2.22 Adverse Events Recorded as Fatalities

There were 26 fatalities reported within the time period. However, not all of these are patient suicides or care and treatment related deaths; many are deaths from natural causes. The last thematic analysis of reported fatalities in Mental Health revealed (20 cases in total) that 50% of these involved death from underlying physical health causes.

As outlined elsewhere in this report, there is a specific Adverse Event Management Group for Mental Health and Learning Disabilities. This is a sub-group of the primary Clinical Care and Professional Governance Group and meets fortnightly. An initial appraisal of all red and amber adverse events is a standing agenda item. This initial appraisal informs the level of prioritisation for Review. Importantly, it allows for the early identification of emergent themes which require immediate action.

This same Group is responsible for setting Terms of Reference for Reviews, identifying Reviewers, reviewing draft Review Reports and agreeing final sign off for Review Reports.

4.3.2.23 Strategic Risks

Following a series of workshops held during 2020, an overall strategic risk and eight system wide risks were agreed.

The new Strategic Risk for Mental Health and Learning Disabilities was activated on 17 May 2021.

The eight system-wide service risks are as follows:

- Delivery of Tayside Mental Health and Wellbeing Strategy
- Workforce
- Ligature anchor points
- Environment and infrastructure
- Pathways of care
- Doctors in training
- Stakeholder and partnership engagement
- Prescribing

These system-wide risks will be incorporated within the risk register of each HSCP as well as the register for NHST delivered services.

Local approaches to the system-wide risks will be reviewed as part of the Mental Health QPR process. This will enable recognition of the respective levels of risk pertaining to each of the above areas within each HSCP but also within each area of the Mental Health family. Local risks that reflect these service-wide risks are in the process of development.

4.3.3 **Clinical & Care Governance Arrangements**

4.3.3.1 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. Since the last report, the Mental Health and Learning Disability Groups have amalgamated to form one Primary Governance Group.

4.3.3.2 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)

4.3.4 **External Reports and Exceptions**

4.3.4.1 There have been no external inspections during this time period.

4.3.4.2 The Care Inspectorate has a programme of reports through Care Homes and Registered Services across Dundee. These are reported via an annual report through the Clinical, Care and Professional Governance Group. On review of this position it was decided that a more

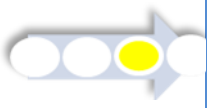
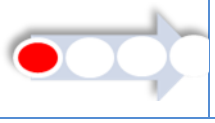
frequent reporting mechanism was required and the CCPG Group now receives a report at each meeting detailing the inspections and outcomes for each two-monthly reporting period.

There is an expectation from the HSCP that following any external inspection, a copy of the report and drafted improvement plan would be presented to the Clinical, Care & Professional Governance Group and ongoing updates provided within exception reports.

Learning from Inspection recommendations/learning summaries across Tayside are considered and reflected by the CPGG Group and are shared with Primary Governance Groups for cascading.

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

The level of assurance should be provided for each heading under assessment (2.3).

Level of Assurance		System Adequacy	Controls
Comprehensive Assurance		Robust framework of key controls ensures objectives are likely to be achieved.	Controls are applied continuously or with only minor lapses.
Moderate Assurance		Adequate framework of key controls with minor weaknesses present.	Controls are applied frequently but with evidence of non-compliance.
Limited Assurance		Satisfactory framework of key controls but with significant weaknesses evident which are likely to undermine the achievement of objectives.	Controls are applied but with some significant lapses.
No Assurance		High risk of objectives not being achieved due to the absence of key internal controls.	Significant breakdown in the application of controls.

4.4 **Quality/Patient Care**

4.4.1 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 Dundee and Tayside.

4.4.2 <u>COVID-19</u>

Services continue to manage well, in very challenging circumstances due to the effects of COVID-19. The demobilisation and remobilisation of services has supported those most vulnerable and supported the delivery of safe, effective services.

The teams have balanced urgent needs alongside COVID pressures, as well as supporting vaccination rollout across Tayside. The complexities of working across a Health and Social Care system, often with different guidance provided, has been challenging, however staff have risen to this challenge time and time again.

Staff support is critical in ensuring ongoing wellbeing across the workforce and staff are reporting increased fatigue. The wellbeing framework is essential in supporting staff at this crucial time.

4.5 **Workforce**

Remobilising is challenging for staff in the HSCP who are tired and feeling the impact of the past year working through a pandemic.

- Senior and Service Managers are focusing on supporting their staff to recover
- Work commenced through Silver COVID group on staff wellbeing and reflection

Challenges:

- Delays in Recruitment
- Competing Priorities and Workload

4.6 **Financial**

N/A.

4.7 **Risk Assessment/Management**

Risks are included in the report above.

4.8 **Equality and Diversity, including Health Inequalities**

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

4.9 **Other Impacts**

There are no other direct impacts of this report.

4.10 **Communication, Involvement, Engagement and Consultation**

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

4.11 **Route to the Meeting**

This has been previously considered by the following group 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 HSCP CCPG Group, 22 July 2021

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

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

8.0 BACKGROUND PAPERS

8.1 None.

Dr. David Shaw
Clinical Director

DATE: 18 August 2021

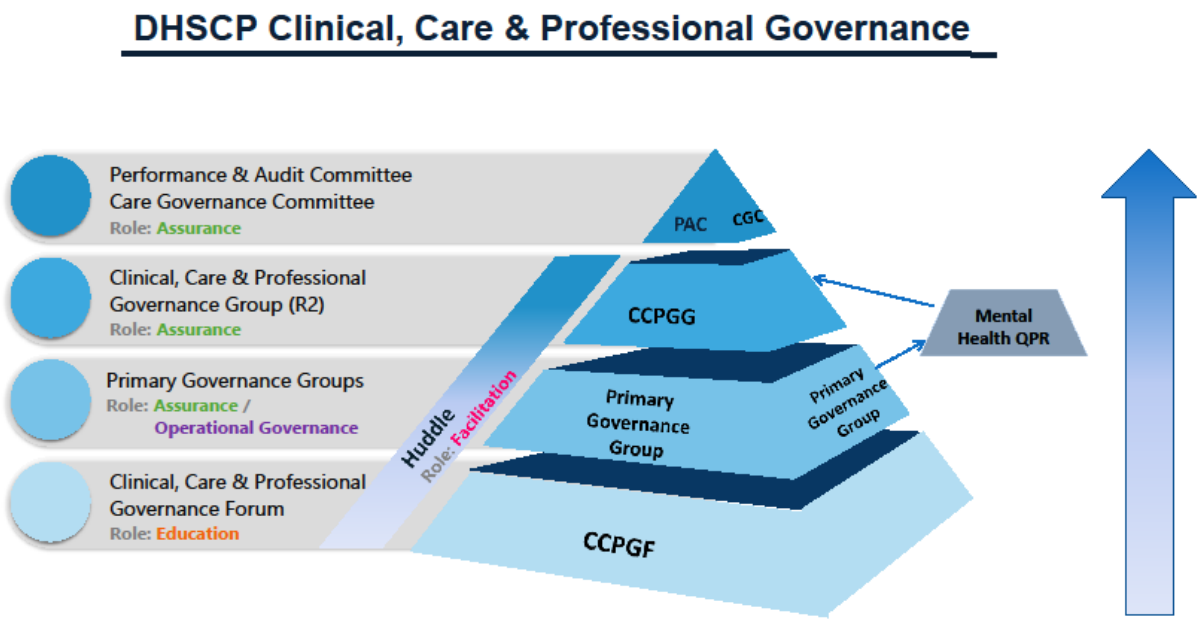
Diane McCulloch
Chief Social Work Officer / Head of Health and Community Care

Report Author: Matthew Kendall, AHP Lead.

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)
- Adult Community Services
- Acute and Urgent Care
- Mental Health
- Learning Disabilities
- 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.