Falkirk
Health and Social Care
Partnership

A meeting of the **Clinical and Care Governance Committee** will be held in the **Boardroom, Denny Town House** on **Thursday, 7 February 2019 at 9:30am**

BUSINESS

1. Apologies

2. Declarations of Interest

3. Draft Minute of the Clinical and Care Governance Committee meeting held on 6 December 2018

4. Action Log

5. Terms of Reference - for ratification

6. Draft Forward Plan

7. Drug Related Deaths and Suicides presentation
(Presentation by Dr Claire McIntosh, Consultant Addictions Psychiatrist)

8. EFFECTIVE OUTCOMES - ARE PEOPLE GETTING THE OUTCOMES WE EXPECT

8.1 Review of strategic outcomes from Health & Social Care Partnership
(Paper presented by Mr Joe McElholm, Head of Social Work Adult Services)

8.2 Forth Valley Alcohol & Drug Partnership governance arrangements
- *for discussion*

9. SAFE - ARE OUR SERVICES SAFE?

9.1 Internal

9.1.1 Care at Home Action Plan
(Paper presented by Mr Joe McElholm, Head of Social Work Adult Services)

Falkirk Council NHS Forth Valley

9.1.2 Performance relating to Adult Support & Protection
(Presentation by Ms Freda McShane, Independent Chair of the Adult Support & Protection Committee)

9.2 External Reviews & Standards

9.2.1 Healthcare Improvement Scotland (HIS) update on Falkirk Community Hospital

9.2.2 Adult Support & Protection Investigation Report - Falkirk Community Hospital
(Paper presented by Ms Ellen Hudson, Deputy Nurse Director)

9.2.3 Mental Welfare Commission Reports - see weblinks below
https://www.mwcscot.org.uk/media/438680/for_print_forth_valley_ward_final_report_.pdf
https://www.mwcscot.org.uk/media/438093/for_print_forth_valley_royal.pdf

9.2.4 Care Inspectorate Report - Summerford House
(Paper presented by Mr Joe McElholm, Head of Social Work Adult Services)

10. PERSON CENTRED

10.1 Complaints reports from health and social care
(Paper presented by Professor Angela Wallace, Nurse Director and Mr Joe McElholm, Head of Social Work Adult Services)

11. RISK

11.1 Risk Register

11.2 Significant Adverse Events Report
(Paper presented by Mr Andrew Murray, Medical Director and Ms Sara Lacey, Chief Social Work Officer)

12. Any Other Competent Business

13. Date of next meeting

1 May, Room 1, Learning Centre, Forth Valley Royal Hospital

Falkirk
Health and Social Care
Partnership

Agenda Item: 3

FALKIRK INTEGRATION JOINT BOARD
Clinical and Care Governance Committee

DRAFT Minute of the Clinical and Care Governance Committee meeting held on Thursday 6 December 2018 at 9.30am in the Room 1, Learning Centre, Forth Valley Royal Hospital.

Voting Members:	Mrs Julia Swan (Chair) Cllr Fiona Collie
Non-voting Members:	Ms Sara Lacey, Chief Social Work Officer Mr Andrew Murray, Medical Director Professor Angela Wallace, Nurse Director
In Attendance:	Mrs Margo Biggs, Lay Member Dr David Herron, Falkirk Clinical Lead Mrs Ellen Hudson, Deputy Nurse Director Mr Joe McElholm, Head of Social Work Adult Services Mrs Irene Graham (Notetaker)

CCG25. APOLOGIES

Apologies were noted on behalf of Patricia Cassidy, Rita Ciccu-Moore, Monica Inglis and Bette Locke.

CCG26. DECLARATIONS OF INTEREST

There were no declarations of interest.

CCG27. DRAFT MINUTE OF THE CLINICAL & CARE GOVERNANCE COMMITTEE MEETING HELD ON 2 OCTOBER 2018

The Committee approved the minute.

Decision:

The Clinical & Care Governance Committee:
1. **Approved the minute of the Clinical & Care Governance Committee meeting held on 2 October 2018.**

CCG27. ACTION LOG

Mr Murray agreed to develop and expand the action log.

Decisions:

The Clinical & Care Governance Committee:
1. **Mr Murray agreed to develop the action plan.**

CCG28. TERMS OF REFERENCE

The Clinical & Care Governance Committee considered the amended terms of reference and following discussion it was agreed that Ms Lacey and Ms Ellen Hudson would make further amendments and the document would be circulated virtually to members for their approval.

Mr Murray also agreed to circulate the assurance statement used by the NHS Clinical Governance Committee.

Decision:

The Clinical & Care Governance Committee:

1. **Agreed that Ms Lacey and Ms Hudson would incorporate further amendments to the terms of reference and circulate electronically to the members for approval.**
2. **Mr Murray agreed to circulate the NHS Clinical Governance Committee's assurance statement.**

CCG29. ADULT SUPPORT & PROTECTION - PROCESS & PROCEDURES

Mr McElholm gave a presentation which provided an overview of the governance arrangements in place and asked for Committee's approval to invite Freda McShane, independent chair of the Adult Support and Protection Committee, to the next meeting to focus on performance, specifically areas of improvement and good practice.

Mr McElholm gave an example of a case study to illustrate the legal definition of adults at risk as contained within the Adult Support & Protection (Scotland) Act 2007.

The legislation defines adults at risk through a 3 point test, as adults, aged 16 years or over, who:

- Are unable to safeguard their own wellbeing, property, rights and interests;
- Are at risk of harm; and
- Because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.

At present Adult and Support and Protection is reported to the Chief Officers Group who provide assurance to the Community Planning Partnership Board. For absolute clarity regarding governance structures and to minimise duplication, it was agreed that Ms Lacey would raise this with the Chief Officers Group to ask how they wish to give assurance.

Decision:

The Clinical & Care Governance Committee:

1. **Agreed Freda McShane be invited to the next meeting**
2. **Agreed that Ms Lacey would contact the Chief Officers Group to ask how we would get assurance.**
3. **Agreed Mr Murray would consider if Adult Support Protection training can be considered mandatory for NHS staff.**

OUTCOMES (EFFECTIVE) - ARE PEOPLE GETTING THE OUTCOMES WE EXPECT?

CCG30. Review of strategic outcomes from Health & Social Care Partnership

In Ms Cassidy's absence it was agreed to defer this item to the next meeting. Mr McElholm was asked to provide a short paper at the next meeting.

Decision:

The Clinical & Care Governance Committee:
1. **Agreed to defer this item to the next meeting.**
2. **Mr McElholm to provide a short paper.**

SAFE - ARE OUR SERVICES SAFE?

Internal

CCG31. Care standards in Falkirk Community Hospital and wider hospitals

Professor Wallace gave a demonstration of the central data repository and data visualisation dashboard that allows users to view and interact with the data. This system informs quality of care reviews at national and local levels and drives quality improvement in nursing and midwifery. The aim is that by March 2019 all NHS Boards and Health & Social Care Partners will have consistent and robust processes and systems for measuring, assuring and reporting on the quality of nursing and midwifery care and practice

Professor Wallace offered to spend time on the dashboard with individual Committee members which could also include a visit to the wards, Ms Lacey and Mr McElholm were keen to take up this invitation.

Decision:

The Clinical & Care Governance Committee:
1. **Ms Lacey and Mr McElholm accepted Professor Wallace's invitation to visit the wards and spend time on the dashboard.**

CCG32. NHS Forth Valley Healthcare Associated Infection (HAI) Quarterly Report

Mrs Swan stated that this paper had been brought as an example of what is presented to the NHS Forth Valley Clinical Governance Committee. It was a very comprehensive report which was easy to read.

There was discussion around what kind of report this Committee would require and Mr Murray suggested bringing a report every 6/12 months giving details of infection rates in the Falkirk area. It was agreed that a report should come to the May meeting and should include figures for flu and norovirus.

Decision:

The Clinical & Care Governance Committee:
1. **Agreed to bring an HAI report to the meeting in May 2019.**

External

CCG32. External reviews

Decision:

The Clinical & Care Governance Committee:
1. Agreed to carry forward to next meeting

CCG33. External standards

Decision:

The Clinical & Care Governance Committee:
1. Agreed to carry forward to next meeting

PERSON CENTRED

CGC34. Complaints report from Health & Social Care

Professor Wallace presented a paper which detailed the 53 complaints received in the Falkirk area from April – September 2018 which had been broken down by complaint theme.

She explained that it was the aim to respond to Stage 1 complaints within 5 days, for Stage 2 complaints it was 20 days although this was not always possible.
The paper also included a complaint which had been submitted to the Scottish Public Services Ombudsman (SPSO).

Following discussion it was agreed that a combined paper would come to future meetings and Mr McElholm would provide Professor Wallace with information to populate the paper.

Decision:

The Clinical & Care Governance Committee:
1. **Agreed a combined NHS and Social Work paper would come to future meetings.**
2. **Agreed Mr McElholm to provide Professor Wallace with information.**

RISK

CCG35. Risk Register Review

Mrs Swan stated that the whole organisation was looking at risk and it was agreed that this item would be deferred until a future meeting. Mr Murray agreed to bring a paper to the next meeting with an update

Decision:

The Clinical & Care Governance Committee:
1. **Noted that the risk register was still under review**
2. **Noted Mr Murray would bring an update to the next meeting.**

CCG36. Significant Adverse Events Report

Mr Murray presented a report which gave details of the type of event, progress of the investigation and actions taken. He explained that the NHS was in the process of taking a different approach to SAE whereby an anonymised learning summary would be published on the Intranet. He would also bring learning summaries to this Committee for information.

Ms Lacey said there was no serious case reviews currently being undertaken in Social Work but information could be provided if any occurred in the future. She agreed to share the National Guidance for Child Protection Committees Conducting a Significant Case Review with Mr Murray who would produce a 'compare and contrast' paper.

Decision:

The Clinical & Care Governance Committee:

1. **Agreed that Social Work and NHS would work together to produce a combined report for future meetings**
2. **Ms Lacey would provide Mr Murray with the Social Work guidance document**

CCG37. Future presentations

The Committee discussed and agreed topics for future presentations which would be added to the forward plan.

Decision:

The Clinical & Care Governance Committee:

1. **Agreed that a presentation on Drug Related Deaths would come to the meeting in February.**
2. **Agreed that a presentation on Population Health would come to the meeting in May.**

CCG38. ANY OTHER COMPETENT BUSINESS

Ms Lacey raised the topic of Scottish Government appreciative enquiry events which many Committee members attended in recent weeks. Events had now been completed in Edinburgh, Glasgow and Inverness.

A summary report on the key findings across all the events would be circulated to all attendees in late December/early January. The report would lay out next steps to support the delivery of effective clinical and care governance of integrated health and social care services across Scotland.

Decision:

The Clinical & Care Governance Committee:

1. **Agreed an overarching report to come to this Committee once the summary report is published.**

CCG39. DATE OF NEXT MEETING

7 February 2019 in the Boardroom, Denny Town House

Agreed dates for 2019:

2 May	NHS venue
22 August	Council venue
7 November	NHS venue

Falkirk
Health and Social Care
Partnership

CLINICAL & CARE GOVERNANCE COMMITTEE
7 FEBRUARY 2019

	Item	Action	Update	Responsible Officer	Due Date
Meeting on 2 October2018					
CCG07	Locality Reports Template	Template to be developed and come back to future meeting		PC	
CCG08	Review of strategic outcomes from H&SCP	Identify relevant outcomes		All	
CCG14	Mental Health	For future focus			01/05/19
CCG15	Learning Disability	For future focus			01/05/19
CCG18	Evidence from services/localities	Decision to be made at future meeting			Future meeting
CCG20	Service transforming	Noted social work risk register was still under discussion			
CCG27	Action log - ON AGENDA	Year planner development		AM	01/05/19
CCG28	Terms of reference	NHS Clinical Governance Committee assurance statement to be circulated to members	NHS Clinical Governance Committee Annual Report 2017-18 circulated on 22/01/19	AM	01/05/19
CCG29	Adult Support & Protection - process & procedures	Chief Officer's Group to ask how we would get assurance from them		SL	01/05/19
CCG36	Significant Adverse Events Report	Mr Murray to be provided with the Social Work guidance document		SL	01/05/19

Falkirk Health and Social Care Partnership

CLINICAL AND CARE GOVERNANCE COMMITTEE

TERMS OF REFERENCE

1. INTRODUCTION

1.1 The Clinical and Care Governance Committee will provide assurance to the Integrated Joint Board (IJB) on the systems for delivery of safe, effective, person-centred care in line with the IJB's statutory duty for the quality of health and care services.

2. REMIT

2.1 To provide assurance to the IJB that clinical and care governance is being discharged within the Partnership in relation to the statutory duty for quality of care and that this is being led professionally and clinically with the oversight of the IJB.

2.2 To provide the strategic direction for development of clinical and care governance within the Partnership and to ensure its implementation.

3. MEMBERSHIP

3.1 The Committee shall be established by the IJB and will be chaired by a voting member of the IJB.

The Committee shall compromise of:

Members of the Committee:

- 4 members of the IJB to include 2 voting members, a third sector or public representative and a staff representative

In attendance as professional advisors:

- Chief Officer
- Chief Social Work Officer
- Professional Lead – GP*
- Professional Lead – Nurse/AHP*
- Head of Social Work Adult Services
- Head of Clinical Governance

* The Medical Director and Director of Nursing will provide support and advice to the Professional leads.

3.2 The Chair and members of the Committee will be appointed by the IJB. Committee membership and Chairmanship will be reviewed annually.

3.3 Where a member is unable to attend a particular meeting, a named representative shall attend in their place.

3.4 The Committee may wish to invite appropriately qualified individuals from other sectors to join its membership as it determines or as is required given the matter under consideration. This may include NHS Board Professional Committees, Managed Care Networks and Adult and Child Protection Committees.

3.5 The Committee may co-opt additional advisors as required with approval of the Chair.

4. QUORUM

4.1 Half of the voting members will constitute a quorum.

5. FREQUENCY OF MEETINGS

5.1 The Committee shall meet quarterly and will meet at least 4 times a year.

5.2 The Chair may, at any time, convene additional meetings of the Committee.

5.3 Two development workshops/activities will be held each year.

6. CONDUCT OF BUSINESS

6.1 A calendar of Committee meetings, for each year, shall be agreed by the members and distributed to members.

6.2 The agenda and supporting papers shall be sent to members at least seven days before the date of the meeting.

6.3 Administrative support shall be provided by NHS Forth Valley or Falkirk Council, whichever organisation is providing support to the IJB.

7. AUTHORITY

7.1 The Committee is authorised on behalf of the IJB to seek assurance on matters that fall within its Terms of Reference and obtain professional advice as required.

7.2 The Committee may form one or more sub-groups to support the clinical and care governance function within the Partnership.

8. DUTIES

The Committee shall be responsible for the oversight of clinical and care governance within Falkirk Health and Social Care Partnership. Specifically it will:

8.1 Agree the Partnership's clinical and care governance priorities and give direction to clinical and care governance activities.

8.2 Monitor the Partnership's Risk Register from a clinical and care governance/staff governance perspective and escalate to the IJB any unresolved risks that require executive action or that pose significant threat to patient /service user care, safety and service provision.

8.3 Have oversight of the processes within the Partnership to ensure appropriate action is taken in response to adverse events, scrutiny reports/action plans, safety action notices, complaints and learning. Also ensures that examples of good practice and lessons learned are disseminated within the Partnership and beyond if appropriate.

8.4 The Chief Social Work Officer will provide appropriate professional advice to the Clinical and Care Governance Committee in relation to statutory social work duties in terms of the Social Work (Scotland) Act 1968. In their operational management role the Chief Officer will work with and be supported by the Chief Social Work Officer with respect to quality of integrated services within the Partnership in order to then provide assurance to the IJB.

8.5 The Professional Leads nominated by NHS Forth Valley will be supported by NHS Forth Valley's Medical Director and Director of Nursing and Allied Health Professions through formal network arrangements. In their operational management role, the Chief Officer will work with and be supported by these Professional Leads with respect to quality of integrated services within the Partnership in order to then provide assurance to the IJB.

8.6 The Chief Officer has delegated responsibilities from both Chief Executives to ensure that that there are clear structures and lines of professional accountability from staff working in integrated services to the professional leads who are accountable for the professional standards of care. This includes responsibilities to ensure processes for the professional regulatory requirements of staff are in place. The Chief Officer, relevant Lead Professionals and the Chief Social Worker will work together to ensure there are robust professional leadership and accountability structures in place.

8.7 An important element of clinical and care governance is to ensure there is a robust system for assuring the quality and safety of health and social care delivered and for the Committee to drive a culture of continuous improvement. This includes having systems in place to identify and respond when standards are not being met and issues of poor performance identified and addressed.

8.8 Through the Clinical and Care Governance Committee, the Chief Officer will ensure that clear strategic objectives for clinical and care governance are agreed, delivered and reported through an annual clinical and care governance action plan. This will include actions to assure the quality of service delivery including that delivered through services procured from the third and independent sector.

9. REPORTING ARRANGEMENTS

9.1 The Clinical and Care Governance Committee will formally provide a copy of its Minutes to the IJB as part of its assurance processes. Regular reports will also go from the Clinical and Care Governance Committee to the Falkirk Public Protection Chief Officers Group and the NHS Forth Valley Clinical Governance Working Group.

The Minutes of the Clinical and Care Governance Committee will be made publicly available.

9.2 The Chief Officer will provide assurance to the IJB on the development and completion of the Annual Clinical and Care Governance Action Plan.

9.3 The Committee will provide assurance to the IJB, the NHS Clinical Governance Committee and Falkirk Council on the operation of clinical and care governance within the Partnership.

9.4 The Committee will conduct a review of its role, function and membership within the first year and then regularly at a frequency to be determined

DRAFT

FALKIRK CLINICAL & CARE GOVERNANCE YEAR PLANNER 2019

Meeting Date	7 February	1 May	22 August	7 November
Minutes	√	√	√	√
Complaints/SPSO	√	√	√	√
Locality Reports	√	√	√	√
Adult Support & Protection	√		√	
Risk		√		√
Healthcare Associated Infection	√		√	
Adult Support & Protection	√		√	
Falkirk Community Hospital	√		√	
Mental Health/Learning Disability		√		
Terms of Reference	√			
Forward Plan	√			

Agenda Item:

Falkirk
Health and Social Care
Partnership

Title/Subject:	**Home Care Inspectorate 2018/19 Action Plan**
Meeting:	**Clinical and Care Governance Committee**
Date:	**1st February 2019**
Submitted By:	**Head of Service**
Action:	**For Noting**

1. INTRODUCTION

1.1 The Home care Service is a registered care service with the Care Inspectorate and an annual inspection took place during May 2018, with a report published in August 2018.

1.2 This report provides an update on the Action Plan that is required by the Care Inspectorate in respect of the requirements and recommendations made by them at that time.

2. RECOMMENDATION

The Integration Joint Board is asked to:

2.1 note the update on the Care Inspectorate Action Plan for Home Care

3. BACKGROUND

3.1 The inspection process took into account a range of evidence, including a self-evaluation, information and intelligence received on performance from 66 questionnaires by people who use the service, conversations with staff, and direct observation of support being provided in peoples' homes. The inspection report noted that no complaints had been upheld since the last inspection. The report also found that no requirements or recommendations made at the last inspection remained outstanding at the time of the current inspection. The investigation was the first undertaken under the framework of the new National Health and Social Care Standards.

3.2 The grades awarded to services at inspection describe how well those services are performing against Care Inspectorate quality themes and statements. The grades for the service last year were as follows:

Care and support 2 – Poor
Management and Leadership 2 – Poor
Staffing 3 - Adequate
Environment - not assessed.

The grades reflected an overall theme of concern by the inspectorate that service users' personal outcomes were being met to an acceptable standard due to process failings.

4. MAIN BODY OF THE REPORT

4.1 The service was required by the Care Inspectorate to provide an action plan which details how the service will improve to meet the 2 requirements set this year. Progress with implementation of the work plan has been reported periodically to the Homecare Review Group, chaired by the Chief Officer. The actions which have been taken to address the issues raised in the Care Inspectorate's report include:

- Improving staff working patterns and rotas to increase staff availability at the times when people want to have service provided
- Redesign of our scheduling, better aligning staff resource to localities
- Moving towards all our staff becoming personal carers, increasing the availability of personal care
- Improve continuity through better use of information from our electronic scheduling system.
- Improving communication with service users around changes to their service which may prove necessary.

In all of the above improvement work we are implementing progress through close partnership working with staff and their Trade Unions and with our colleagues in the Care Inspectorate.

4.2 The action plan is attached at Appendix 1 and progress across specific objectives is highlighted to Committee as follows:

- Transfer of all staff to a revised working pattern better matching staff availability to peak demand periods. This change will provide improved continuity and availability of care.
- Replacement of Falkirk wide scheduling function with a three localities framework. This allows service delivery processes to be more responsive and flexible at a locality level.
- Support to significant numbers of staff to move to Extended Personal Carer grade as stepping stone towards a single grade of staff at Extended Personal Carer level, again increasing flexibility and responsiveness to need.
- Improved use of information from real time monitoring system to deliver more efficient scheduling giving enhanced continuity of care
- Improved communication with both staff and service users,

4.3 Management staff have met regularly with our Care Inspector since August 2018 to discuss progress and go through the updates to the Action Plan Key Stages document. She has been supportive of the changes made and the resultant outcomes evidenced for service users.

5. CONCLUSIONS

5.1. The above work continues to be taken forward on a basis of co-production with involvement and participation from staff, their trade unions, service users and carers. The Home Care Service remains committed to working with the Care Inspectorate to build a culture of continuous improvement that will deliver better personal outcomes for people who use our services and our Care Inspector this year has continued to support us with the work that we have been doing. A re-inspection of the service is expected in the near future and the outcome will be notified to a future meeting of the Clinical and Care Governance Committee.

Resource Implications
Resource implications are regularly considered by the Home Care review group and appropriate action taken when required.

Impact on IJB Outcomes and Priorities
The Home Care Service directly supports the Strategic Plan outcomes and priorities.

Legal & Risk Implications
The service is a registered care service with the Care Inspectorate.

Consultation
This was not required for the content of the report.

Equalities Assessment
The contents of this report do not require an EQIA. Any future decisions required will be considered as part of the equalities process and Equality Impact Assessments will be completed.

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Approved for Submission by: Joe McElholm,
Head of Social Work Adult Services

Author – Liz McGhee Service
Date: 29th January 2019

List of Background Papers: The papers that may be referred to within the report or previous papers on the same or related subjects.

Appendix 1 Care Inspectorate Action Plan – Key Stages

Falkirk Health and Social Care Partnership

Falkirk Health & Social Care Inspectorate 2018 Care Inspectorate Requirement Number 1
Continuity of Care - Timeline with Key Actions

1.	**Develop systems to ensure that the service will be consistent and reliable in who is getting the care including notifying service users in advance of any changes to the staff member or timing of support**			
	Actions	**Who?**	**When?**	**Status**
1.1.	We will improve working patterns for staff to increase capacity by addressing the outcomes from our staff engagement sessions in relation to roles and bands of availability to improve when carers are available and reduce variation in consistency.	**Lead Officer** Service Manager **Accountable Officer** Development Team Manager	Agreement reached with TU's in respect of patterns proposed. Aug 2018	**Green**
			We will roll out of new patterns for all staff by end of Dec 2018. The date for the roll out of the new working patterns has been shifted to 28th January 2019 and the work to enable this is on target for this date.	**Amber**
		Lead Officer Service Manager **Accountable Officer** Development Team Manager	Agreement reached in respect of new shift proposals. August 2018.	**Green Complete**
			We will roll out new shift patterns for all staff by end of Dec 2018 The date for the roll out of the new working patterns has been shifted to 28th January 2019 and the work to enable this is on target for this date.	**Amber**

Falkirk Health and Social Care Partnership

1.	Develop systems to ensure that the service will be consistent and reliable in who is getting the care including notifying service users in advance of any changes to the staff member or timing of support			
	Actions	**Who?**	**When?**	**Status**
1.2.	We have redesigned our approach to scheduling to a locality basis to better understand the local needs and be more pro active in forward planning.	**Lead Officer** Service Manager	Scheduling staff moved into locality areas to work with locality teams on 3rd August 2018.	**Complete**
		Accountable Officer Team Manager (West Locality)	We will analyse the impact of this move by interrogating our system and speaking with staff and report the findings by the end of December 2019. We have been consulting with staff and service users re. the positive impact of moving co-ordinators into locality areas and are in the process of drafting a report which will go to senior management in relation to a review of how all staff will be deployed into localities, inclusive of agency provision requirements and our out of hours service as a whole.	**Amber**
1.3.	We are re-designing the rotas in each locality as a result of the changes to working patterns.	**Lead Officer** Service Manager **Accountable Officer** Senior Worker(Central Locality)	This work is ongoing, dependant on staff changes to rotas, shifts etc. Target completion for the full exercise is March 2019.	**Amber**
1.4.	We have reviewed our staffing profile and agreed a move towards all staff being personal carers, which will improve the scheduling of staff and increase the availability of personal care across each locality.	**Lead Officer** Service Manager	Agreed at Leadership group on 22.8.18.	**Green Complete**
		Accountable Officer Team Managers Central and East Locality	Target completion for full staff change March 2019. Home Care Managers continue to progress this work with their Traditional carers and staff are attending training and being moved on to personal carer posts month on month.	**Amber**

1.	Develop systems to ensure that the service will be consistent and reliable in who is getting the care including notifying service users in advance of any changes to the staff member or timing of support			
	Actions	**Who?**	**When?**	**Status**
			Managers to provide an updated list of carers reluctant to make the change for Liz McGhee Service Manager to arrange appropriate meetings with them.	
1.5.	We will create a report on our CM2000 system which identifies service user continuity and we will use this to monitor how well we meet our continuity requirements.	**Lead Officer** Service Manager	Have the benchmarking report to work with	**Green Complete**
		Accountable Officer Systems and Performance Co-Ordinator	We will review/audit this information quarterly and include it in the suite of management information available to managers on a monthly basis. This report has been refined and is now fully up and running within the service and used to inform staff where we can improve service continuity.	**Green Complete**
1.6.	Team manager and absence officer will analyse absence issues and engage all staff teams enabling them to understand the impact of absence on consistency of care for service users.	**Lead Officer** Service Manager **Accountable Officer** Team Manager (East Locality)	We will gather the data on absence by the end of October 2018 and have engaged with all the staff by the end of November 2018. We have completed all of the staff meetings that have been arranged and a report is available in final draft form and is being used to influence changes within the service.	**Green**

2.	Improve staff attendance at work to enable a reduction in sickness absence.			
	Actions	**Who?**	**When?**	**Status**
2.1.	Team manager and absence officer will engage all staff teams to analyse absence issues to enable them to understand the impact of absence on workload and morale within teams.	**Lead Officer** Service Manager **Accountable Officer** Team Manager (East Locality)	In progress, aim to complete by end of November 2018. We have completed all of the staff meetings that have been arranged and a report is available in final draft form and is being used to influence changes within the service.	**Green**
2.2.	Team manager and absence officer will engage all staff teams to analyse the financial and resource impact that absence has on the service.	**Lead Officer** Service Manager **Accountable Officer** Team Manager (East Locality)	In progress, aim to complete by end of November 2018. We have completed all of the staff meetings that have been arranged and a report is available in final draft form and is being used to influence changes within the service.	**Green**
2.3.	At the above meetings the team manager will also re-communicate the service's absence/calling in sick procedures.	**Lead Officer** Service Manager **Accountable Officer** Team Manager (East Locality)	In progress, aim to complete by end of November 2018. We have completed all of the staff meetings that have been arranged and a report is available in final draft form and is being used to influence changes within the service.	**Green**
2.4.	We will audit the return to work reports – to ascertain theme's/patterns etc. to highlight any additional actions we need to take.	**Lead Officer** Service Manager **Accountable Officer** Team Manager (East Locality)	End of October 2018. This Audit is now complete and this work will feed in to the overall absence management report.	**Green**

2.	Improve staff attendance at work to enable a reduction in sickness absence.			
	Actions	**Who?**	**When?**	**Status**
2.5.	We will review our staff retention and turnover figures to identify possible areas for improvement that might assist in retaining staff.	**Lead Officer** Service Manager **Accountable Officer** HR Partner	End of October 2018 This Audit is now complete and this work will feed in to the overall absence management report.	**Green**
2.6.	Through team and management meetings we will monitor and identify where improvements can be made to staff attendance which will improve continuity of carers for service users.	**Lead Officer** Service Manager **Accountable Officer** Team Manager (East Locality)	We have completed all of the staff meetings that have been arranged and a report is available in final draft form and is being used to influence changes within the service.	**Green**
2.7.	The above information will be used with staff to get a better understanding and commitment to improving performance and be better placed to communicate more effectively with service users.	**Lead Officer** Service Manager **Accountable Officer** Team Managers Central, East and West Localities	We have completed all of the staff meetings that have been arranged and a report is available in final draft form and is being used to influence changes within the service.	**Green**

3.	Improve our communication with service users when there are changes to their carers or their service.			
	Actions	**Who?**	**When?**	**Status**
3.1.	We will establish a service users' forum, potentially across all three localities in order to give service users a more effective voice.	**Lead Officer** Service Manager **Accountable Officer** Team Managers Central, East and West Localities	End of February 2019 Our first Service user Newsletter has gone out. We are currently arranging a date for the first of our service users forums to be held in February.	**Green**

3.	Improve our communication with service users when there are changes to their carers or their service.			
	Actions	**Who?**	**When?**	**Status**
3.2.	Renew our annual service user questionnaire to test if it can improve our understanding of customer experience	**Lead Officer** Service Manager **Accountable Officer** Team Manager	End of February 2019 Work in Progress on this , inclusive of how this exercise fits in with the overall requirements of customer feedback across the service.	**Amber**
3.3.	We will explore innovative approaches to engaging with service users in an authentic and empowering way. e.g. by using regular feedback through outcomes focused planning during service reviews , telephone feedback etc.	**Lead Officer** Service Manager **Accountable Officer** Team Managers (East Locality)	End of March 2019 We have developed a process whereby staff will make telephone feedback calls and are discussing within service reviews regular feedback on the service received. This approach has been started and will continue to be embedded across the service.	**Green**
3.4.	We will communicate specifically with all our service users about service re-design changes that we are making and reassuring people that we are committed to improve.	**Lead Officer** Service Manager **Accountable Officer** Development Team Manager	End of September 2018 The first service user Newsletter has now gone out and it included information about the service changes that we are working with etc. 2nd Service user newsletter will be issued early Feb 2019	**Green**
3.5.	We will use the service users' forum to agree the medium for communicating the actions in 3.4.	**Lead Officer** Service Manager **Accountable Officer** Team Managers Central, East and West Localities	Convene in January to get this started We are currently arranging a date for the first of our service user forums to be held early in the new year.	**Amber**
3.6.	We will move to a position where staff will use their mobile	**Lead Officer**	End of February 2019	**Amber**

3.	Improve our communication with service users when there are changes to their carers or their service.			
	Actions	**Who?**	**When?**	**Status**
	phone to communicate with their service users in relation to times when they are running late or if an alternative carer will be calling instead.	Service Manager **Accountable Officer** Team Managers Central, East and West Localities	This is currently in draft form ready to go in February.	

2018 Care Inspectorate Requirement Number 2
Internal Auditing Systems - Timeline with Key Actions

4.	We will improve management and oversight of key service delivery, processes and risks.			
	Actions	**Who?**	**When?**	**Status**
4.1.	Analyse the reporting options information available to us through the CM2000 system to ensure managers have appropriate management/performance information.	**Lead Officer** Service Manager **Accountable Officer** Team Manager(East Locality) Systems and Performance Co-Ordinator	End of September 2018 Complete, process of sharing information now in place.	**Complete**
4.2.	Undertake a staff training needs assessment to identify and meet the service training needs, inclusive of SSSC registration requirements.	**Lead Officer** Service Manager **Accountable Officer** Workforce development Manager Training Officer	End of December 2018 In Progress	**Amber**
4.3.	Improve customer feedback arrangements by using surveys, feedback and monitoring compliments/complaints.	**Lead Officer** Service Manager **Accountable Officer** Team Managers Central, East and West Localities	End of October 2019 Complete.	**Green**
4.4.	Improve our existing reporting systems for the	**Lead Officer**	End of January 2019	**Amber**

4.	We will improve management and oversight of key service delivery, processes and risks.			
	Actions	**Who?**	**When?**	**Status**
	overview of complaints, accidents and incidents, adult support and protection issues, service review and review of personal outcomes by reviewing trends etc. on a quarterly basis.	Service Manager **Accountable Officer** Team Manager (East Locality)	Auditing work complete on this, information being pulled into a report.	
4.5.	We will audit supervision, practice observations and team meeting arrangements/recording as part of a wider performance management approach to inform continuous improvement	**Lead Officer** Service Manager **Accountable Officer** Service Manager	End of October 2018 Report to be finalised.	**Green**
4.6.	Improve consistency of regular team meetings and staff supervision.	**Lead Officer** Service Manager **Accountable Officer** Service Manager	November 2018 Report to be finalised.	**Green**
4.7.	Engage staff in service developments and transformation. Series of locality events will be organised in January/February 2019.	**Lead Officer** Service Manager **Accountable Officer** Service Manager	Feb/March 2019 Dates and venues currently in the Diary for Feb /March 2019. This is to allow time for the new working patterns to have taken effect.	**Amber**

Falkirk Clinical & Care Governance Committee
Thursday 7th February 2019

Item No. 9.2.2 **Inquiries under Adult Support and Protection (Scotland) Act 2007 Involving Falkirk Community Hospital**

Seek Assurance

Author: **Ellen Hudson, Deputy Nurse Director, NHS Forth Valley (On behalf of Angela Wallace, Executive Nurse Director & Andrew Murray, Medical Director)**

Executive Summary:

The Scottish Government notified Falkirk Health and Social Care Partnership (HSCP) and NHS Forth Valley (NHS FV) of two matters of concern reported to the Government regarding care at Falkirk Community Hospital (FCH) which originated as complaints. The first concern related to care of a patient at Unit 1 referred in December 2017 and the second to the care of a patient in Unit 2 of FCH, referred in May 2018.

Following consideration of the concerns by the HSCP the matter was taken forward by Falkirk Council under the local authority's statutory duty to make enquiries in terms of the Adult Support and Protection (Scotland) Act 2007. Ian Kinsley, Lead Officer for Adult Support and Protection in Falkirk Council was identified to coordinate and lead on the inquiry process in these two cases.

A confidential report was prepared by Ian Kinsley, ASP Lead Officer on the 21st November 2018 which outlined the methodology used and an analysis of the findings of each inquiry which were conducted concurrently.

In respect of both inquiries the overall findings were that the information gathered did not indicate the need, in terms of the Adult Support and Protection (Scotland) Act 2007, to progress either inquiry into adult support and protection investigations into the care of all patients in each unit. From the inquiries made there was no evidence that current patients are currently at risk in Unit 1 and Unit 2. The inquiry concluded with a number of recommendations and that further assurance remained necessary in respect of effectiveness of the improvement plans and that this should be considered across all units within FCH.

This report was presented to the Chief Executive of NHS Forth Valley where she asked the Executive Nurse Director and Medical Director to consider the findings and recommendations. This paper outlines the subsequent response and actions arising from the recommendations. These are designed to provide assurance to the NHS Board and Integrated Joint Boards that there are robust processes in place to ensure the quality and safety of care in FCH across all Units and that there is a continuous focus on care improvement.

Recommendations:
Falkirk IJB Clinical & Care Governance Committee is asked to:-

- *Note the content of this paper.*
- *Note the response and proposed actions for improvement in relation to the recommendations.*

Key Issues to be Considered:

NHS Forth Valley welcomes opportunities which arise from any external reviews that support the identification of improvements that are required to ensure the continuous delivery of safe, effective and person-centred care. Although the overall findings of the inquiries were that the information gathered did not indicate the need to progress either inquiry into adult support and protection investigations or that there was any evidence of patients being currently at risk in Unit 1 and Unit 2, there were a number of findings from the inquiries in the form of recommendations which identify areas where improvements can be made or processes clarified. NHS Forth Valley also welcomes feedback from such reports to identify where it can improve and strengthen existing assurance and ultimately governance systems and processes.

This paper outlines the recommendations from the report and the subsequent response and proposed actions to be taken forward.

Recommendations:

Recommendation 1: Independent review of Better Care Scorecard to evidence improvement. The variance identified between the evidence gathered by the Better Care Scorecard and that gathered by the external reviewers indicates the need to review the efficacy of the scorecard. NHS FV should consider an independent review of their system of reviewing and assuring the care offered to patients in FCH.

Response: The Better Care Scorecard is an electronic dashboard which contains data on a number of indicators which provide information to illustrate at a glance the quality of patient care and provide assurance on the standards of care provided by NHS Forth Valley and any actions being taken to address any areas where targets are not being achieved. This is monitored at ward level, discussed at SCN meetings and then fed into the Clinical Care Governance Working Group where the information is discussed and challenged. This care assurance system is recognised nationally as an exemplar framework and is currently being adopted by the CNO in Scotland as part of the development of a national nursing assurance framework in Scotland entitled – 'Excellence in Care'.

NHS FV recognises that the efficacy of the dashboard is predicated on the timely inputting of the data and that any analysis of the findings and improvements to be developed must be correlated with care assurance visits to the care environments too as a way of identifying any variance. This ensures that the key measures that demonstrate high quality safe, effective and person centred care is being delivered, are being reported, monitored and reviewed.

Actions:
NHS FV does not consider there is a need to undertake an independent review of its system as currently it is already embarking on a programme of work to strengthen its care assurance system which includes:

- investment in posts to lead the development of further quality indicators and align the national 'Excellence in Care' assurance framework;
- development of a SCN 'Leading Better Care' programme to enhance leadership skills as SCNs are the key drivers and guardians of quality care and promote ownership of the scorecard;
- undertaking a programme of unannounced care assurance visits throughout the year across all clinical areas involving panels of senior nurses, practice development staff and SCNs;

Recommendation 2: Review of improvement in relation to the main themes identified across Unit 1 and Unit 2, FCH. Further assurance is required regarding the improvement in the main areas identified in the report, namely: caring with dignity & respect, communication with families, caring for people with dementia/delirium, falls prevention, recording practice and escalation of concern for the deteriorating patient. Scope of the review should be across all four units in FCH.

Response: NHS FV has recognised that there are a number of co-existing factors which impact the provision of safe quality care across the 4 units of FCH. Due to emerging concerns a decision was

made by the Nurse and Medical Director to establish a FCH leadership and management short life working group. This FCH Management SLW Group is led by the Deputy Nurse Director to provide an overview and a robust system to monitor and manage all the various actions and improvements that are being taken forward. This will also incorporate other related intelligence such as complaints, adverse events and audits. This will support a more cohesive and focussed approach to delivering and monitoring the improvement work as identified above going forward.

Actions:

This SLWG has met continuously and in addition a dedicated interim senior manager has been in place from the medical directorate to assure the Deputy Nurse Director there is visible management support and ensure that the day to day focus in the delivery of safe and effective care is in place. This oversight group will continue to provide regular progress reports to the Directorate Clinical Governance Group and the Clinical Care Governance Working Group. This group will remain in place and be reviewed as we further develop shadow integrated management arrangements.

Recommendation 3: Provision of Adult Support and Protection training for acute staff. This is based on the omission of reference to the Adult Support and Protection Act and local multiagency procedures in any of the documents analysed.

Response: NHS FV has role specific mandatory online modules on 'Adult Support and Protection' on its LearnPro system that are designed for all staff groups. However these are not easily accessible. A number of face to face training sessions have also been delivered previously by the Public Protection Training Co-ordinator for social work services, Falkirk Council but this has been on an ad hoc basis.

Actions:

A training plan which will support all staff requiring role specific training will be developed and delivered over the next 6 months. In addition to develop and commission a bespoke face to face training session for staff at FCH (which could be across the partnership with social care colleagues) which could then be developed into a rolling programme to staff across NHS FV. To build this face to face training into the overarching training plan.

Recommendation 4: Re-launch of NHS Adult Support and Protection sub group. Whilst it is understood that this group continues to meet, it is unclear what the terms of reference are and the membership of the group is. It is recommended that this group has a clear plan to raise the profile of Adult Support and Protection with NHS staff and should report into both the Falkirk ASP Committee and the Clinical and Care Governance Committee.

Response: As outlined above there is an existing NHS Forth Valley Adult Support & Protection Group which is chaired by a Consultant Psychiatrist. There is a Terms of Reference for the Group which includes membership but it is recognised that this group meets infrequently and often attendance is poor.

Actions:
Refresh the Terms of Reference of the Group including the membership and review the frequency and format of the meetings to ensure better representation and engagement across the range of key stakeholders and health practitioners as appropriate.

Clarify reporting arrangements into other ASP Committees and other Clinical and Care Governance Committees/ groups.

Recommendation 5: Staff members' ability to raise concerns about care/systems. The family of one of the complainants reported that several NHS employees expressed some concerns about the care within Unit 1, FCH. The inquiry found no evidence that staff came forward to raise any of issues of concern within the NHS system. NHS FV should review the effectiveness of processes and systems for staff to raise concerns.

Response: As part of the original complaint investigation process into the raised issue that several NHS employees expressed some concerns about care within Unit 1, this was followed through with the individuals identified to explore if these concerns were true. NHS FV found in this particular case that the staff identified did not have concerns. That was why the inquiry found no evidence that staff came forward to raise issues of concern.

Actions:
It is both as an employee and as part of a professional code and standards that NHS employees are responsible for raising concerns and that they are aware of the processes to be able to do this. This ensures there can be learning from feedback to continuously improve the care and experience of patients, families and staff too.

As part of its clinical and care governance arrangements NHS FV will review the use of and monitoring of the Incident Review system (IR1) used by staff to raise any concerns about the safety and quality of care. As part of this review we will engage with HIS and explore where evidence of best practice from other organisations can be used to further develop and improve our approach.

Recommendation 6: Investigation into unresolved matters in the case of Mrs X. NHS FV should consider whether there needs to be further investigation of the apparently unresolved issues relating to the care of Mrs X which included the use of the Abbey Pain Scale in Unit 2; alleged inaccurate recording in nursing notes; the issue of timeous and accurate care plan completion and whether the allegations made could have justified the development of a specific improvement plan for Unit 2.

Response: NHS FV did progress to resolve the issues relating to the care of Mrs X that had been raised by her family. An action plan was developed and there was regular communication and face to face meetings with the family until 17th July 2018 when the complaint was closed as the issues were resolved. The manager also made the commitment in a letter to the family that learning from the issues raised would be applied for every person requiring care from NHS FV.

Actions
No further action required.

Next Steps:

It is proposed that the actions identified will form a specific action plan which has a dedicated lead. The Deputy Nurse Director would continue to have an oversight for assurance of delivery of this plan under the auspices of the FCH Management SLW Group. This would ensure there is robust monitoring and oversight of all the various actions and improvements that are being taken forward in line with the reporting of progress to a number of Clinical and Care Governance Committees/Groups.

Agenda Item:

Falkirk
Health and Social Care
Partnership

Title/Subject:	**Summerford Care Home Inspectorate Report**
Meeting:	**Clinical and Care Governance Committee**
Date:	**07 February 2019**
Submitted By:	**Head of Social Work Adult Services**
Action:	**For Noting**

1. INTRODUCTION

1.1 The terms of reference of the Clinical and Care Governance Committee encompass a responsibility to oversee issues and concerns arising around quality of care provided by services in the scope of the H&SCP. The present report informs the Committee of concerns which were reported in a recent report by the Care Inspectorate into Summerford Care Home. The report provides an overview of the concerns raised, a perspective on any applicability of the inspection findings across other services and an account of the actions taken in response to the report.

2. RECOMMENDATION

2.1 The Clinical and Care Governance Committee is asked to:

- Note the action which has been undertaken to deliver immediate improvement in standards at Summerford Care Home
- Request a report on progress to follow upon a forthcoming re-inspection by the Care Inspectorate
- Request a future report on activity around improvement to resources and capabilities for quality assurance and control across Social Work Adult Services
- Request a report on activity around improvement and innovation across the Partnership's reablement and intermediate care services.

3. BACKGROUND

3.1 Summerford House is an internally run care home and intermediate care facility providing care to a small number of permanent residents and to service users who are being supported through reablement in temporary placements. The IJB has received previous reports around a planned new build intermediate care development which would replace the existing Summerford building. The reablement programme is facilitated by joint working inputs from relevant NHSFV colleagues. The service has additionally provided respite care placements up until now. The Care Inspectorate inspected Summerford in December 2018 and published a report on 7 January 2019.

4. MAIN BODY OF THE REPORT

4.1 Summerford House Care Inspection report and Improvement Plan

The inspection report found several concerns around compliance with health and safety standards, safety of some equipment, quality of care planning and management and leadership. This resulted in the inspector grading the service:

How well do we support people's wellbeing?	1 - Unsatisfactory
How good is our leadership?	1 - Unsatisfactory
How good is our staff team?	1 - Unsatisfactory
How well is our care and support planned?	1 - Unsatisfactory

The service has taken immediate action in response to the issues highlighted by the Care Inspectorate. The Service has made changes to the care home management team, to enhance capacity for improvement and support staff to respond to the challenge of achieving immediate and continuous improvement. In the short term a Service Manager has been based at Summerford for significant periods of the working week, overseeing the improvement programme. All health and safety related issues were immediately addressed, with support from the Council's health and safety function and in partnership with colleagues from Scottish Fire and Rescue. Staff have reviewed and updated service users' personal records and care plans.

Provision of respite care is being relocated to other settings, enabling staff to focus on two strands of work, provision of intermediate care and support for permanent residents. Staffing levels have been increased and steps taken to optimise the deployment of the staffing resource. Positive feedback from service users has been reported in regard the changes which have enabled staff to spend more time engaged in meaningful activity with service users.

The improvement work is being taken forward in a spirit of close partnership working between health and social work staff, reflecting observations in the report on the need to optimise opportunities from integrated working. Training programmes have been delivered to staff with further training inputs underway, including from health colleagues. Issues around standards of staff supervision are being addressed urgently, with a satisfactory programme of staff supervision now in place.

Senior management of the service have held a meeting to which relatives of all current service users were invited. This forum provided an opportunity for relatives to voice concerns and have their questions answered. Attendees received assurance at the meeting, including from frontline staff within the care home who gave feedback to relatives on their own experience of benefitting from effective guidance and support through the post inspection improvement report. Frontline staff also described to relatives the improved outcomes which they considered were already being realised for service users.

The report found that although the service seeks to offer an integrated reablement approach there was insufficient evidence of reablement being achieved. This finding

reflected the inspector's reading of care plans and case records and observations of integrated working. The findings have been followed by further work between relevant service managers to improve on the existing approach to reablement and intermediate care. As the approach to reablement should be service wide it is recommended that Committee request a future report on how learning from the report about reablement is embedded across the whole system.

The Service has directly asked the Care Inspectorate whether they consider their findings regards quality of care to have a more general applicability to other areas of service provision. On the basis of their having completed inspections of all Council run care homes the inspectorate have confirmed it is not their view that similar issues are present in the other care homes. Summerford is one of six internally run residential resources all of which have been inspected by the Care Inspectorate team. The other five services have received positive inspection reports. It is in Summerford alone that serious concerns have been highlighted by the inspection process.

The service has co-operated fully with the Care Inspectorate, accepted their findings and will continue to work closely with them to achieve the necessary improvements by their deadline of March 2019. On 28th January 2019 the inspector visited Summerford to monitor the action plan and has reported being pleased with the progress achieved in a short space of time, it being clear that outcomes for people have improved and considerable progress in place to meet all the requirements made at the inspection. The findings of the report highlight a need for wider analysis of quality assurance resources, capabilities and practice to lead to recommendations for improvement in this area.

5. CONCLUSIONS

5.1 The Care Inspectorate's report on Summerford identified serious concerns around adherence to standards and achievement of outcomes which have been addressed through immediate action where appropriate, and continue to be addressed through a continuing action plan where the issues require change over the medium term. Learning from the report indicates a need to undertake further work around improvement in the area of resources, capabilities and practice around quality assurance and review of the Partnership's reablement and intermediate care model.

Resource Implications
The above work had entailed the commitment of some additional resourcing to support the action plan response.

Impact on IJB Outcomes and Priorities
The development of bed based intermediate care and reablement has formed a core component of the Partnership's strategic planning and the action plan improvement work will support continued achievement of agreed outcomes.

Legal & Risk Implications

The action plan has immediately addressed some risk issues highlighted by the report.

Consultation
The action plan is underpinned by close engagement with staff in Summerford and by effective communication with service users and their families.

Equalities Assessment
No equalities assessment is deemed necessary in regard the content of this report.

_____
Approved for Submission by: Title and Organisation

Author – Joe McElholm, Head of Social Work Adult Services
Date:

List of Background Papers: The papers that may be referred to within the report or previous papers on the same or related subjects.

Summerford House Action Plan
27th December 2018

Subject	Details	Care Inspectorate Comment	Action	Date	Responsible
Staffing	• There is not enough staff on duty. • Staff appear to always be busy. This effects quality time with residents and implementing care plans • There is a lack of activities to stimulate residents. • Residents are mobilising without support when they require staff input because of a lack of staff presence.. • Lounges are empty after lunch. • Residents do not feel in control of their lives when they come to Summerford – (direct quote to care inspectorate from a resident.) • Staff are carrying out tasks that re-able residents could and should be doing for themselves or with support to help their progression	• Care plans – There is no information about hobbies, interests or preferences. • Residents are not being kept informed of their progress. • Residents are not been informed of exercises to do. • Summerford processes are risk averse and based on keeping safe rather than building on the residents ability and skills	• A system must be put in place to allow residents to manage their own money and medication if they have the capacity to do so. • Review risk management processes and support staff to understand the relevance risk assessments enabling residents to achieve their goals and plans to return home. Staff culture to change to enable residents to do more	31/03/19	Operations manager. Operations manager overseeing senior social care workers Operational manager overseeing Staff team.

Partnership Working	• There could be improvement in the communication systems between health and social care staff.	• Staff members need to be informed of the work being done by health colleagues and the outcomes for individual residents so they can support care plans and exercise programmes.. • Staff were observed supporting people to make choices that put them at risk. This was due to inaccurate recording of support plans, not following through on action plans from accident/incident reports and not managing risk in a way that enables. NHS have also offered assistance in terms of training. – Nikki has contacted the lead educator and awaits their response. The Scottish Nursing Guild have offered staff to care of elderly services in support of partnership working.	• Set up reablement training for staff. • Set up joint written guidance & partnership working processes for staff to adhere to. • Staff to be involved in the weekly meetings held with the manager and health professionals where possible. • AWI training to be organised and actioned for staff at Summerford • BSS training to be organised for staff at Summerford to inform them of the appropriate use of CRISP and Risk Assessment forms. • Summerford will have a recruitment drive in the early new year for a number of posts to support the service provision.	Jan – Mar 19 18/12/18 14/1/19	Service manager and operations manager
Medication	• Review medication procedures and protocols. There have been a number of medication errors that appear to be increasing in recent months. • Medication, tissue viability, nutrition and falls	• During their visit the Care Inspectorate were concerned at the medication procedures in place at Summerford. Staff did not have a procedure in place that was safe on the issue of controlled drugs. • The Care Inspectorate recommended these 4 areas needs to be addressed through	**Care Inspectorate Requirement** • Ensure that medications are properly labelled so each medication can be	31/3/19 Jan – Mar	Operations manager overseeing the seniors

		individual care plans.	accurately identified • Regular audits of medication must be carried out by the manager & management team (set up an audit rota) • Medication training to be undertaken by Summerford staff	19 An email has been sent to all managers detailing a list of checks to be done by staff while administering. medication, 27/12/18. A medication audit was carried out on 29/12/18 and will be done monthly. Anew controlled Roll on programme by	Management team at Summerford

				Falkirk Council	
Risk Management			**Care Inspectorate Requirement** • Develop positive risk training plans to include physical, psychological, social and emotional need	31/03/19	Operations manager overseeing the seniors and the staff team
Health & Safety	• Fire Evacuation plans for individual residents. • Fire evacuation/drills	• There was not enough information in the personal evacuation plans of residents about their individual needs. • Fire drills were not been kept up to date and no recent evacuation has been carried out.	• All evacuation plans for each individual resident have been reviewed and updated since the inspection. • Fire drills must be carried out and detailed action plans developed form them. They must be carried out in accordance with policy and the law. Parallel fire evacuation carried out on 19/12/18. • All PEEPS have been reviewed and updated.	31/03/19 Details of fire evacuation carried out on 19/12/18 in fire log DEC 18	Management team and staff team at Summerford
Premises Manager	• Health and Safety • Health & Safety inspections of equipment • Accident/incident form action plans were not been acted on	• The Care Inspectorate were concerned that equipment checks are not happening • The Care Inspectorate were concerned that actions were not implemented resulting in increased risk of it happening again, when accident/incident forms were not acted on.	• Equipment found to be faulty was replaced at the point of inspection and further purchases made. • Invite Health and Safety officer to inspect	December 18	Service manager and operations manager

	• Bath and sink temperature were not running to the required levels	• The Care inspectorate raised concern that this was dangerous for residents as temperatures were too low.	the premises manager policies and carry out a H/S inspection. • These were checked on 21/12/18. The water heater had 1 module not working. An urgent repair request has been made and a contingency plan is in place **Care Inspectorate Requirement** • Develop robust and effective quality assurance systems	12/12/18 Inspection follow up meeting with M.Durrington – H&S & NIKKI Harvey 19/12/18 21/12/18	Service manager and operations manager Management team at Summerford
Supervision and Training	• Supervision needs to be carried out in line with Falkirk Council policy and procedures • The service needs to develop a training plan for staff members and action it. • Staff need to be more aware of the responsibility to health and safety and risk management • Residents meetings need to be recorded and residents views acted on	• The Care Inspectorate could find little evidence of formal recorded supervision, EDRs for staff development • The Care Inspectorate has concerns that there is no concise training plan for staff members. • The Care Inspectorate would like to see	• Ensure staff know their role • Ensure the services is managed with robust systems of supervision, training and health and safety. • Ensure regular H/S checks are carried out and that systems comply with Premises Manager requirements • Staff to be trained in quality assurance recording systems to demonstrate they understand their role • Establish a folder with	21/03/19 31/03/19 31/03/19	Service manager and operations manager

		evidence that residents view are been respected	minutes of residents meetings that is easily accessible to residents • Appropriate folders to be developed, detailing supervision, training and other support activities		Staff team and Seniors
Care & Support	• Care planning is not reflecting the need and wishes of individuals	• The Care Inspectorate found that individuals are not being involved in their care plan	• Care plans are to reflect on the following; • Life stories • Personal achievements • Interests and preferences	31/03/19	Operations manager overseeing the Seniors and staff team
Support Plans & Audits	• Support plans are too basic and do not reflect the person or their goals in a detailed way	**Advice from the Care Inspectorate** • Where people are assessed as lacking capacity to consent to medical treatment a consent to medical treatment form and treatment plan should be put in place by their own GP or appropriate health professional	• Care plan audits to be implemented • Carry outa review on all care plans so that in line with best practice and reflect individual needs • Permanent residents must have 6 monthly reviews to endure that they have o Clear goals and aims o A plan to get the person home o Systems in place to measure progress	31/03/19 31/03/19	Operations manager overseeing the seniors
The Staff Team	• Staffing levels and mix were questioned by the care inspectorate. • There is more pressure on the morning shifts, seniors do support but this effects	The Care Inspectorate commented staffing levels are low and staff were not able to meet needs. • The Care Inspectorate highlighted staff being too busy at meal times	• Staff levels at Summerford are being effected by absence • Develop an action plan with HR and OH to support staff members		Service Manager and HR staff

	their work load • Staff should be supporting residents to do more for themselves • There is a lack of understanding of reablement • Staff should support people to make their own snacks and drinks • Staff should be aware and encouraging people to do their agreed exercises identified in their care plans • Staff need guidance on how to support the need of their residents	• Staff appear to be absent from the units during the rest of the time • Regarding choice, residents were not able to get up when they chose as their disability meant they needed staff support but staff could only do this at times that suited staffing and the work programme due to a lack of staff • Staff appear to have a lack of understanding of their role particularly around communication with residents and health colleagues and understanding the effects of dementia and positive risk taking. The Care Inspectorate stated a previous requirement was not met on from an inspection. This is covered in this action plan ACTIVITIES – A range of activities have been on offer from the	on return to work and maintain their attendance at work **Care Inspectorate Requirement** • Review staffing levels at Summerford • Arrange training on communication and implement it into care plans to suit need • Arrange Dementia Awareness training • Develop communication support plans • Develop a training plan for each staff member • Care plans must contain an assesment of needs • Details on how to achieve the personal aims & goals of the individual must also be in the care plan • Management to audit and review support plans	31/03/19 31/1/19	Service manager and operations manager Seniors and staff team Manageme nt team

		12/12/18. With various singers/bands/dancers and reminiscence activities taking place. A planner has been established outlining monthly activities on offer at Summerford and in the Community for 2019. i			

Falkirk Health & Social Care Partnership

Complaints Performance
April – November 2018

During the period April to November 2018, a total of 77 complaints (excluding complaints transferred/withdrawn/consent not received) were received by the Patient Relations Team relating to the delegated functions for Falkirk Health & Social Care Partnership.

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Year to Date
Total No of Complaints	10	8	6	8	8	12	17	8					77
Total no responded within 20 working days	7	8	4	6	6	9	11	5					56
% responded within 20 working days	70.00	100.00	66.67	75.00	75.00	75.00	64.71	62.50					72.73

A breakdown of the performance into Stage 1 and Stage 2 complaints is provided in the table below:

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Year to Date
Total No of Stage 1 Complaints	3	4	1	1	2	2	4	4					21
Total no responded within 5 working days	2	3	1	0	2	2	3	4					17
% responded within 20 working days	66.67	75.00	100.00	0.00	100.00	100.00	75.00	100.00					80.95
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Year to Date
Total No of Stage 2 Complaints	7	4	5	7	6	10	13	4					56
Total no responded within 20 working days	4	4	3	5	4	6	8	1					35
% responded within 20 working days	57.14	100.00	60.00	71.43	66.67	60.00	61.54	25.00					62.50

If a complainant remains unhappy with the response received from NHS Forth Valley, they have the right to contact the Scottish Public Services Ombudsman (SPSO) to request an investigation into their complaint. The SPSO is the final opportunity for the complainant in the NHS complaint process and offers an independent view on whether the NHS have reasonably responded to a complaint.

The SPSO has received one case relating to Falkirk Health & Social Care Partnership complaints during April – November 2018. The SPSO are currently investigating the concerns raised which relates to Dental Services.

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Year to Date
Total No of SPSO Cases Received	0	0	0	1	0	0	0	0					1

Comparison of Complaint Themes and Departments

A breakdown of the complaint themes and departments are provided in the table detailing the number of issues raised against each theme. A complainant can raise multiple issues within their complaint and these themes can crossover into a variety of departments. The table provides a clearer understanding of the issues raised by complainants and areas for the Directorates to focus any key learning required or improvements to be made to services provided.

In total there are approximately 59 departments listed against the delegated functions. During the period April – November 2018, 27 departments have received complaints.

Month	Category Type	Category	Department
April	Clinical Treatment	Co-ordination of Clinical Treatment	Ophthalmology OPD
		Disagreement with treatment/care	AHP Mental Health
			Acute Hospital Old Age Psychiatry
			AHP Out-patients Care Group
		Nursing Care	Unit 1, FCH
		Problems with Medication	Woodlands Resource Centre
		Treatment Outcome Not as Expected	Ophthalmology OPD
		Wrong Diagnosis	Out-patients
	Staff Communication (Oral)	Patient Not Verbally Told Things	AHP Rehab Care Group
		Telephone	Audiology
	Staff Competence	Negligent	Acute Hospital Old Age Psychiatry
	Waiting Time/Date of Appointment	Unacceptable Waiting Time for Appointment	AHP Rehab Care Group
May	Clinical Treatment	Disagreement with treatment/care	Unit 2, FCH
		Nursing Care	Unit 3, FCH
	Env/Dom Bed Shortages	Lack of Single Rooms	Unit 1, FCH
	Env/Dom Patient Property	Lost Property	Unit 2, FCH
	Staff Attitude & Behaviour	Lack of Support	Ward B 21, FVRH
	Transport	Transport Arrangements Including Ambulance	Ward A11, FVRH
	Waiting Time/Date of Appointment	Unacceptable Waiting Time for Appointment x 2	Ophthalmology OPD x 2
June	Clinical Treatment	Falls	Unit 3, FCH
		Nursing Care	Unit 2, FCH
			Unit 3, FCH
		Problems with Medication	Woodlands Resource Centre
	Env/Dom/Patient Catering	Availability of Food	Unit 3, FCH
	Env/Dom/Property	Lost Property	Unit 3, FCH
	Staff Attitude & Behaviour	Lack of Support	Unit 2, FCH
		Staff Attitude	Unit 3, FCH
			Ward A11, FVRH
	Staff Communication (Oral)	Face to Face	Ward 3, SCH
	Waiting Time/Date of Appointment	Unacceptable Waiting Time for Appointment	AHP Rehab Care Group
			Woodlands Resource Centre
July		Disagreement with treatment/care	AHP Mental Health x 2
			Out of Hours
			Ward B21, FVRH
			Ward 3, FVRH
			Ward 1, FVRH
		Falls	Ward A21, FVRH
		Nursing Care	AHP Rehab Care Group
		Problems with Medication	Out of Hours
	Staff Attitude & Behaviour	Not Listening	Out of Hours
		Staff Attitude	Ward B21, FVRH
	Staff Communication (Oral)	Lack of Clear Explanation	Ward B21, FVRH
	Waiting Time/Date of Appointment	Witing Time/Date of Appointment/Other	Substance Misuse Services
	Waiting Time/Test Results	Waiting Time/Test Results/Other	AHP Childrens Care Group
August	Clinical Treatment	Addiction Problems	Substance Misuse Services
		Disagreement with treatment/care	Out of Hours
			Unit 4, FCH
		Falls	Ward 4, FVRH
		Waiting Time for Test to be Carried Out	Ward 4, FVRH
	Env/Dom Aids/app/equip	Availability of Items	AHP Rehand Care Group
	Staff Attitude & Behaviour	Not Listening	Out of Hours
		Staff Attitude	Out of Hours
		Inappropriate Comments	Out of Hours
	Staff Communication (Oral)	Patient Not Verbally Told Things	AHP Mental Health
	Waiting Time/Date of Appointment	Unacceptable Waiting Time for Appointment	Child & Adolescent Mental Health
			Pain Management Suite x 2
Sept	Clinical Treatment	Disagreement with treatment/care	AHP Out-patients Care Group
			Out of Hours x 2
			Pain Management Suite
			Ward A11, FVRH
			Ward B21, FVRH
		Nursing Care	Ward A11, FVRH
		Problems with Medication	Ward B21, FVRH
	Delays in at Adm, Tras, Dis, Pro	Delays in Discharge	Ward B22, FVRH
		Env/Dom/Premises	Trystview
	Staff Attitude & Behaviour	Staff Attitude	AHP Out-Patients Care Group
			Ophthalmology OPD
		Staff Attitude & Behaviour Other	Ophthalmology OPD
			Out of Hours
			Pain Management Suite
	Staff Communication (Oral)	Lack of Communication	Ophthalmology OPD
			Out of Hours
			Ward B21, FVRH
	Staff Communication (Written)	Lack of Explanation	Ward A32, FVRH
	Waiting Time/Date of Appointment	Cancellation of Appointment	Woodlands Resource Centre
		Unacceptable Wait for Appointment	Pain Management Suite
			Woodlands Resource Centre
Oct	Clinical Treatment	Disagreement with treatment/care	Out of Hours
			Pain Management Suite
			Unit 1, FCH
			Ward 3, FVRH
		Medical Treatment	Unit 1, FCH
		Nursing Care	Unit 1, FCH
			Ward A11, FVRH
		Patient Being Restrained/Controlled	Trystpark
		Problems with Medication	Substance Misuse Services
	Env/Dom/Personal Records	Accuracy of Records	Unit 1, FCH x 2
	Staff/Attitude and Behaviour	Insensitve to Patient Needs	AHP Out-Patients Care Group
		Lack of Support	Ward A11, FVRH
		No Assistance from Staff in Feeding	Unit 1, FCH
			Ward A11, FVRH
		Staff Attitude	Out of Hours
			Phlebotomy
	Staff Communication (Oral)	Lack of Clear Explanation	Out of Hours
			Unit 1, FCH
			Ward 1, Bo'ness
		Staff Communication (Oral)/Other	Unit 1, FCH x 2
	Staff Communication (Written)	Test Results not communicated to Patient	Out of hours
Nov	Clinical Treatment		AHP Out-patients Care Group
		Disagreement with treatment/care	Ward 1, FVRH
		Nursing Care	Unit 3, FCH
		Poor Choice on Menus	Unit 3, FCH
	Env/Dom/Catering	Availability of Food	Unit, 4, FCH
		Condition of Poremises	Ward 3, FVRH
		Noise Pollution	Ward 3, FVRH
	Env/Dom/Premises	Smoking	Ward 3, FVRH
		Lack of Clear Explanation	Unit 3, FCH
		Patient Not Verbally Told Things	Woodlands Resource Centre
	Staff Communication (Oral)	Telephone	AHP Rehab Care Group
		Misunderstanding	AHP Rehab Care Group
		No Communication sent to Patient	Woodlands Resource Centre
	Staff Communication (Written)	Staff Communication (Written)	Woodlands Resource Centre

Falkirk Health & Social Care Partnership

Complaints Performance
April – September 2018

During the period April to September 2018, a total of 53 complaints (excluding complaints transferred/withdrawn/consent not received) were received by the Patient Relations Team relating to the delegated functions for Falkirk Health & Social Care Partnership.

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Year to Date
Total No of Complaints	10	8	6	8	8	13							53
Total no responded within 20 working days	7	8	4	6	6	9							40
% responded within 20 working days	70.00	100.00	66.67	75.00	75.00	69.23							75.47

A breakdown of the performance into Stage 1 and Stage 2 complaints is provided in the table below:

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Year to Date
Total No of Stage 1 Complaints	3	4	1	1	2	3							14
Total no responded within 5 working days	2	3	1	0	2	3							11
% responded within 20 working days	66.67	75.00	100.00	0.00	100.00	100.00							78.57
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Year to Date
Total No of Stage 2 Complaints	7	4	5	7	6	10							39
Total no responded within 20 working days	4	4	3	5	4	6							26
% responded within 20 working days	57.14	100.00	60.00	71.43	66.67	60.00							66.67

SPSO

If a complainant remains unhappy with the response received from NHS Forth Valley, they have the right to contact the Scottish Public Services Ombudsman (SPSO) to request an investigation into their complaint. The SPSO is the final opportunity for the complainant in the NHS complaint process and offers an independent view on whether the NHS have reasonably responded to a complaint.

The SPSO has received one case relating to Falkirk Health & Social Care Partnership complaints during April – September 2018. The SPSO are currently investigating the concerns raised which relates to Dental Services.

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Year to Date
Total No of SPSO Cases Received	0	0	0	1	0	0							1

Comparison of Complaint Themes and Departments

A breakdown of the complaint themes and departments are provided in the table detailing the number of issues raised against each theme. A complainant can raise multiple issues within their complaint and these themes can crossover into a variety of departments. The table provides a clearer understanding of the issues raised by complainants and areas for the Directorates to focus any key learning required or improvements to be made to services provided.

In total there are approximately 59 departments listed against the delegated functions. During the period April – September 2018, 23 departments have received complaints.

Month	Category Type	Category	Department
April	Clinical Treatment	Co-ordination of Clinical Treatment	Ophthalmology OPD
		Disagreement with treatment/care	AHP Mental Health
			Acute Hospital Old Age Psychiatry
			AHP Out-patients Care Group
		Nursing Care	Unit 1, FCH
		Problems with Medication	Woodlands Resource Centre
		Treatment Outcome Not as Expected	Ophthalmology OPD
		Wrong Diagnosis	Out-patients
	Staff Communication (Oral)	Patient Not Verbally Told Things	AHP Rehab Care Group
		Telephone	Audiology
	Staff Competence	Negligent	Acute Hospital Old Age Psychiatry
	Waiting Time/Date of Appointment	Unacceptable Waiting Time for Appointment	AHP Rehab Care Group
May	Clinical Treatment	Disagreement with treatment/care	Unit 2, FCH
		Nursing Care	Unit 3, FCH
	Env/Dom Bed Shortages	Lack of Single Rooms	Unit 1, FCH
	Env/Dom Patient Property	Lost Property	Unit 2, FCH
	Staff Attitude & Behaviour	Lack of Support	Ward B 21, FVRH
	Transport	Transport Arrangements Including Ambulance	Ward A11, FVRH
	Waiting Time/Date of Appointment	Unacceptable Waiting Time for Appointment x 2	Ophthalmology OPD x 2
June	Clinical Treatment	Falls	Unit 3, FCH
		Nursing Care	Unit 2, FCH
			Unit 3, FCH
		Problems with Medication	Woodlands Resource Centre
	Env/Dom/Patient Catering	Availability of Food	Unit 3, FCH
	Env/Dom/Property	Lost Property	Unit 3, FCH
	Staff Attitude & Behaviour	Lack of Support	Unit 2, FCH
		Staff Attitude	Unit 3, FCH
			Ward A11, FVRH
	Staff Communication (Oral)	Face to Face	Ward 3, SCH
	Waiting Time/Date of Appointment	Unacceptable Waiting Time for Appointment	AHP Rehab Care Group
			Woodlands Resource Centre
July		Disagreement with treatment/care	AHP Mental Health x 2
			Out of Hours
			Ward B21, FVRH
			Ward 3, FVRH
			Ward 1, FVRH
		Falls	Ward A21, FVRH
		Nursing Care	AHP Rehab Care Group
		Problems with Medication	Out of Hours
	Staff Attitude & Behaviour	Not Listening	Out of Hours
		Staff Attitude	Ward B21, FVRH
	Staff Communication (Oral)	Lack of Clear Explanation	Ward B21, FVRH
	Waiting Time/Date of Appointment	Witing Time/Date of Appointment/Other	Substance Misuse Services
	Waiting Time/Test Results	Waiting Time/Test Results/Other	AHP Childrens Care Group
August	Clinical Treatment	Addiction Problems	Substance Misuse Services
		Disagreement with treatment/care	Out of Hours
			Unit 4, FCH
		Falls	Ward 4, FVRH
		Waiting Time for Test to be Carried Out	Ward 4, FVRH
	Env/Dom Aids/app/equip	Availability of Items	AHP Rehand Care Group
	Staff Attitude & Behaviour	Not Listening	Out of Hours
		Staff Attitude	Out of Hours
		Inappropriate Comments	Out of Hours
	Staff Communication (Oral)	Patient Not Verbally Told Things	AHP Mental Health
	Waiting Time/Date of Appointment	Unacceptable Waiting Time for Appointment	Child & Adolescent Mental Health
			Pain Management Suite x 2
Sept	Clinical Treatment	Disagreement with treatment/care	AHP Out-patients Care Group
			Out of Hours x 2
			Pain Management Suite
			Ward A11, FVRH
			Ward B21, FVRH
		Nursing Care	Ward A11, FVRH
		Problems with Medication	Ward B21, FVRH
	Delays in at Adm, Tras, Dis, Pro	Delays in Discharge	Ward B22, FVRH
		Env/Dom/Premises	Trystview
	Staff Attitude & Behaviour	Staff Attitude	AHP Out-Patients Care Group
			Ophthalmology OPD
		Staff Attitude & Behaviour Other	Ophthalmology OPD
			Out of Hours
			Pain Management Suite
	Staff Communication (Oral)	Lack of Communication	Ophthalmology OPD
			Out of Hours
			Ward B21, FVRH
	Staff Communication (Written)	Lack of Explanation	Ward A32, FVRH
	Waiting Time/Date of Appointment	Cancellation of Appointment	Woodlands Resource Centre
		Unacceptable Wait for Appointment	Pain Management Suite
			Woodlands Resource Centre

Social Work Adult Services Complaints Performance

Complaints Process

Stage 1 – Frontline resolution

Most staff can record a complaint that can be handled at the first stage. The main focus will be to try to resolve the complaint to the customer's satisfaction. The customer should receive a communication about their complaint within 5 working days and if they are happy with the outcome the complaint is closed, if not the complaint will progress to stage 2.

Stage 2 – Investigation

If a complaint cannot be resolved through the first stage or is complex in nature it will move to the second stage. The customer should receive communication within 3 working days stating that the complaint has been recorded. Staff will then investigate the complaint and respond to the customer within 20 working days. If the situation is very complex or key staff are temporarily unavailable the customer may be asked to accept that it will take longer than 20 days for the organisation to decide what to do.

Stage 3 – SPSO

If the customer is happy with the decision reached the complaint is closed, if not they can take their complaint on to the Scottish Public Services Ombudsman (SPSO), who will independently investigate and resolve the complaint.

We currently have 2 measures that we use to monitor our performance relating to complaints. The percentage of complaints completed within the timeframe set by the SPSO, and the percentage of complaints that have been upheld.

Percentage of complaints (stage 1 and 2) completed within timescales

Baseline 2015/16	All 2017/18	2017/18 Stage 1	2017/18 Stage 2	All 2018/19 to Q3	2017/18 to Q3 - Stage 1	2017/18 to Q3 - Stage 2
73.4%	63.1%	63.6%	58.3%	59.7%	59.7%	60.0%

Percentage of complaints upheld

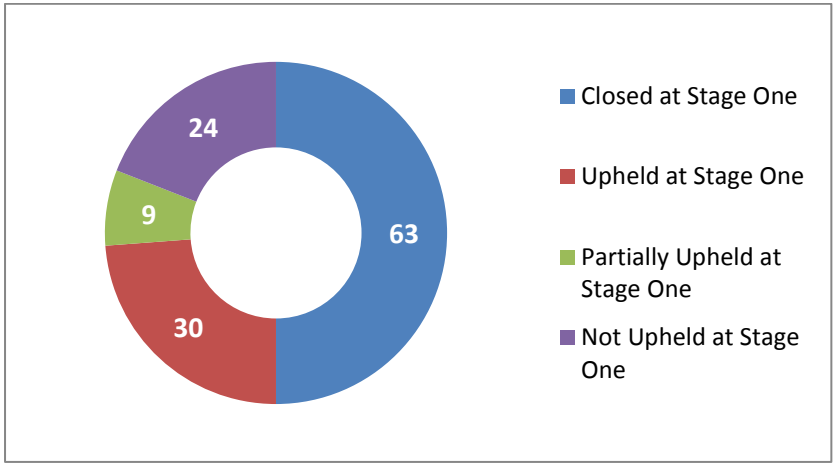
	2017/18		2018/19 to Q3	
	Stage 1	Stage 2	Stage 1	Stage 2
% upheld	36.4%	33.3%	48.4%	60.0%
% partially upheld	26.4%	41.7%	16.1%	10.0%
% not upheld	37.2%	25.0%	35.5%	30.0%

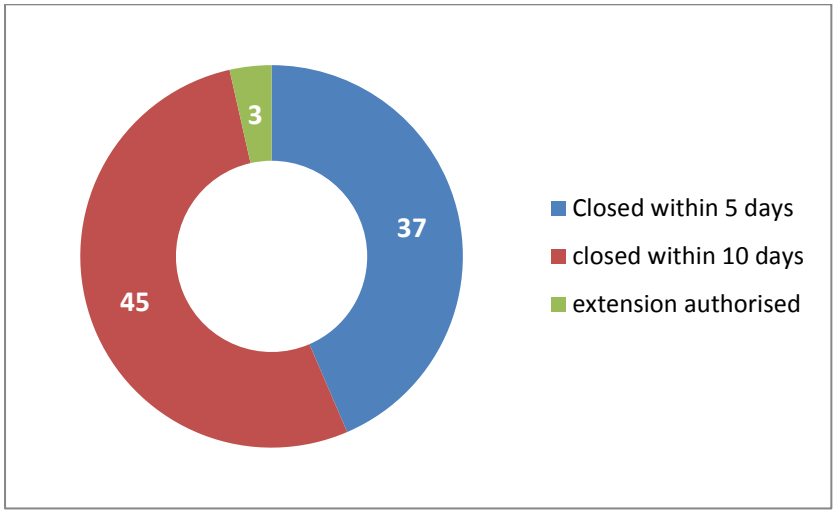
Future Improvement Actions on Complaint Handling

The Service has in place reporting systems to oversee compliance with timescales for completion of complaint responses.

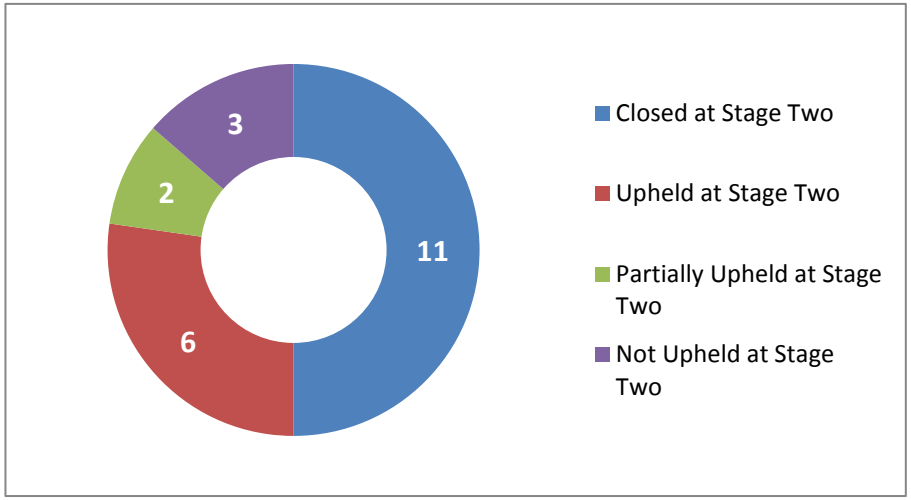
From the period 1 April 2018 to 31 December 2018 a total of 77 SWAS complaints were received, 65 at Stage 1 and 12 at Stage 2.

STAGE ONE SWAS COMPLAINTS 01/04/18 – 31/12/18





STAGE TWO SWAS COMPLAINTS 01/04/18 – 31/21/18



Future Improvement Actions on Complaint Handling

The Service has in place reporting systems to oversee compliance with timescales for completion of complaint responses. The Service has had limited capacity in place around quality assurance functions and this has been recognised as an area requiring additional resource inputs as part of our business planning process. Committee are asked to note that a report providing a qualitative analysis of complaint themes will be available to the next meeting.

NAME OF MEETING: Falkirk Clinical and Care Governance Committee
DATE OF MEETING: 7th February 2019

Agenda item 11.2 Significant Adverse Events Report
For Assurance

Executive Sponsor: Mr Andrew Murray, Medical Director

Author: Mrs Monica Inglis, Head of Clinical Governance

Executive Summary
This report provides the Falkirk Clinical and Care Governance Committee with information on significant adverse events (SAEs) and the actions being taken to continually improve the quality of clinical care and reduce harm to patients.

Recommendation:
The members of the Falkirk Clinical and Care Governance Committee are asked to note and comment on the key issues highlighted below.

Key Issues to be considered:
- The update on the review of current SAE reviews

Financial Implications
None

Workforce Implications
N/A

Risk Assessment
N/A

Relevance to Strategic Priorities
Part of Clinical Governance and Risk Management arrangements.

Equality Declaration
N/A

Consultation Process
N/A

1. Significant adverse events

Current significant adverse event reviews.

The significant adverse event (SAE) reviews that are currently in progress are summarised in table 1**.** SAE reviews that have exceeded the timescale from decision to proceed to completion of the report (90 working days) are highlighted on the table. SAE reviews that have been completed but where progress with recommendations and actions has yet to be reported to the Clinical Governance Working Group are shaded. Information on reasons for delays has been added to the comments section of the report.

TABLE 2: Community Services Directorate

Time to Commission Target 10 working days after the event	Date Review commissioned	SAER number	Event	Report due 90 working days from date SAE commissioned	Status	Immediate actions taken	Comments
41 working days	19/10/18	00042	IP death	Report due – 28/02/19 70 working days at 31/01/19	In Progress	Immediate action taken to reduce future risk of recurrence.	Family meeting 16/11/18 Further staff interviews 31/01/18 +01/02/19

TABLE 3: Medical Directorate

Time to Commission Target 10 working days after the event	Date Review commissioned	SAER number	Event	Report due 90 working days from date SAE commissioned	Status	Immediate actions taken	Comments
106 working days	20/12/18	00043	Delayed Diagnosis	Report due 06/05/19 26 working days at 31/01/19	In Progress	Patient admitted for surgery after GP referral	Staff interviews 14/02/19 and possibly 15/02/19
41 working days	20/12/18	00044	Possible detergent ingestion	Report due 06/05/19. 26 working days at 31/01/19	In Progress	Safe storage of liquid detergent reinforced Secure door closure fitted to ward kitchen doors	Awaiting outstanding PM results.

2. Reporting baseline for adverse events

The Health and Sport Committee published a report on the Governance of the NHS in Scotland – ensuring the delivery of the best healthcare for Scotland in July 2018. The report contained commentary and recommendations regarding the mangment of adverse events by NHS Boards and the role of Healthcare Improvement Scotland and its assurance function. Responses to this report by the cabinet secretary include actions for Healthcare Improvement Scotland. These comprise the development of a reporting baseline to establish the status of adverse event management processes in NHS boards as set out in the *Learning from adverse events through reporting and review: A national framework for Scotland*, revised in July 2018.

NHS HIS are utilising an adapted version of the Quality of Care Approach self-evaluation tool to request information specific to the management of adverse events from NHS Boards. If required, they may follow this with teleconferences with NHS boards to ensure they fully understand their responses to the questions posed.

This information will be collated and reported by NHS HIS to inform a number of purposes:

- to inform Scottish Government in response to the Health and Sport Committee Report
- to inform the revision of the national framework
- to further develop the adverse events external assurance component of the Quality of Care approach,
- to identify focused improvement support either bespoke or aligned to an existing ihub portfolio, and
- to identify areas of good practice and areas of challenge

Information has been submitted to NHS HIS with a request for some additional clarification being progressed.

Monica Inglis
Head of Clinical Governance
January 2019

NHS FORTH VALLEY

Management of Adverse and Significant Adverse Events Policy

This policy replaces all previous policies concerning adverse, near miss and significant adverse event reporting and management.

Date of First Issue	03/12/15
Approved	
Current Issue Date	24/05/16
Review Date	Currently under review
Version	V3.2
EQIA	Yes 19/01/2017
Author / Contact	Clinical Governance Department
Group/Committee - Final Approval	NHS Forth Valley Clinical Governance Committee

This document can, on request, be made available in alternative formats

NHS Forth Valley

Management of Policies Procedure control sheet

Name of Policy	Adverse Event and Significant Adverse Event Management Policy		
Area to be added to			
Type of document	Policy		
Immediate	2 days	7 days	30 days
Priority	Default setting		
Questions			
Understanding	Yes	No	Default setting
Options			
Where to be published	External and Internal		
Target audience	NHSFV wide		

Consultation and Change Record

Contributing Authors:	Norma Wilson, Peter Mackie, Karen Tarn
Consultation Process:	CGWG
Distribution:	

Change Record		
Date	**Change**	**Version**
30/07/2015	Merge the adverse event and significant adverse event policies (Karen Tarn)	Version 1.0
12/08/2015	Review by Norma Wilson and Peter Mackie	Version 1.1
27/08/2015	Editorial changes to SAE described process following discussion with Norma Wilson	Version 1.2
25/09/2015	Editorial changes following review by Tracey Gillies	Version 1.3
22/10/2015	Update to language and format request contact details	Version 1.4
27/11/2015	Review by Norma Wilson and Peter Mackie	Version 1.5
03/12/2015	Updates from specific departments	Version 1.6
24/05/2016	Hyperlinks updated	Version 2.0
12/01/2017	Front page dates completed	Version 2.1
	Review by Norma Wilson and Peter Mackie incorporating new HIS guidance on timescales for SAESs	Version 3.0
21/01/18	Addition of Duty of Candour	Version 3.1
24/05/18	Amended text following comments from CGWG	Version 3.2

LIST OF HYPERLINKS

NHS Forth Valley's Infection Control Policies	NHS Forth Valley's Infection Control Policies
Professional Duty of Candour	Professional Duty of Candour
Quantification and Investigation Guide	Quantification and Investigation Guide
Adverse Event Report Form (With Appendix A – Decision Form for SAEs)	Adverse Event Report Form
Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR)	RIDDOR
Reporting of Deaths to the Procurator Fiscal and Midwifery Adverse Events	Procurator Fiscal
Flowchart Chart – Management of Adverse Events	
Decision making form for Duty of Candour	
Guidance for the Completion of an Adverse Event Form (Safeguard User Guide)	
Post-Incident Aide-Memoire Form	
Healthcare Implementation Scotland (HIS) Adverse Event Community of Practice Website	HIS adverse events community of practice.
Being Open – NHS Forth Valley Guidance (SAE Guidance 1)	
Healthcare Facilities Scotland – Incident Reporting and Investigation Centre Reporting Form	
Health and Safety generic mailbox	
Review Guidance for Suicide/Clinical and Adverse Event Management	
National Fraud Initiative	
Definitions of Serious Hazards of Blood Transfusion	
Forth Valley Transfusion Policy	
Healthcare Associated Infections (HAI)Events and Report of Infectious Diseases	Healthcare Associated Infections (HAI) Events and Report of Infectious Diseases
Infection Control Policy for the Investigation, Management and	Infection Control Policy for the Investigation, Management and Control of Incident/Outbreak of

Control of Incident/Outbreak of Infection	Infection
National Confidential Alert Line (Scottish Government)	
Child Protection - Guidance on Reporting	Child Protection - Guidance on Reporting
NHS Forth Valley Effective Policy Implementation	NHS Forth Valley Effective Policy Implementation
National Patient Safety Agency Training Resources – Management of Adverse Events	http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/
SAE Patient and Family Information Leaflet (Form 1a)	
SAE Patient and Family Letter (Form 1b)	
SAE Staff Information Leaflet (Form 2)	
Structured Tabular Timeline Template (SAE Form 3)	
Written Account Template (SAE Form 4)	
SAE Report Template (Form 5)	
Action Plan Template (SAE Form 6)	
Change Analysis Template (SAE Form 7)	
External Reporting Guidance (SAE Guidance 2)	
SAE Review process and Roles and Responsibilities	
Written Account Guidance (SAE Guidance 4)	
SAE Report Writing (Guidance 5)	
SAE Review Reporting Guidance (Guidance 6)	

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1. Purpose

NHS Forth Valley has an ambition to deliver the highest possible quality and standard of care experience and services for the people of NHS Forth Valley. Our aim is to be the safest organisation in the NHS.

However, provision of healthcare is complex, and adverse events can and do occur which do or could have a major effect on the people involved. The purpose of this policy is to ensure that a consistent approach is taken by all services and in all settings to the management and review of adverse events when they do occur, or could have occurred and, of equal importance, to ensure that learning form adverse events is identified and shared, and that improvements are put in place to minimise the risk of recurrence and improve the safety of healthcare provided in NHS Forth Valley.

The policy can be summarised as follows:

- It is the responsibility of all staff to report all adverse events and near-misses, and to be actively involved in review and learning from adverse events as appropriate and relevant to their role;
- All adverse events require to be actively managed in a timely way, at different levels of the organisation. Reporting processes are in place to give assurance that lessons have been learned and that this learning has been routinely shared with all relevant groups;
- Feedback will be given to staff and will inform decision making. The principles of a just culture will underpin this;
- Actions are reviewed by senior management in a manner that allows the NHS Forth Valley Clinical Governance Committee and the NHS Forth Valley Health and Safety Committee to provide the Forth Valley NHS Board with an assurance statement.

It is recognised both throughout NHS Scotland and locally that there are challenges in reliable implementation of best practice, as described in this policy, in managing and learning from adverse event and applying that learning. NHS Forth Valley will therefore continue to work with staff to improve systems and processes and build capacity and capability through ongoing development.

This document brings together previous separate policies for the management of adverse events (AE) and significant adverse events (SAE).

2. Scope

Requirements for the reporting, recording, review and monitoring of Adverse and SAEs, either clinical or non-clinical, which occur in all managed services in NHS Forth Valley, are described.

The responsibility for reporting Near Miss, Adverse and SAEs applies to all NHS Forth Valley staff and independent contractors. This policy is applicable to all areas of service within NHS FV including staff, patients, visitors, contractors, local partnerships and all others interacting with NHS FV regardless of age, disability, gender, race/ethnicity, religion/belief or sexual orientation.

Whilst the Scottish Prison Service (SPS) carries out its own review of SAEs, NHS healthcare staff working within the Prison Environment must adhere to NHS Forth Valley policy. Adverse events and SAEs that occur in a custodial setting therefore must be managed in line with this Policy. The exception to this is in the event of a suicide where a joint "DIPLAR" (Death in Prison Learning and Review) will take place. The outcome of the review is reported to SPS and Health Improvement Scotland and NHS Forth Valley Clinical Governance Working Group.

Infection control outbreaks and cases of Clostridium Difficile Infection (CDI) must be managed in line with the appropriate NHS Forth Valley Infection Control policies.

3. Introduction

NHS Forth Valley (NHS FV) is committed to the health, safety and wellbeing of its staff, patients, visitors and all users of its premises and services through a culture that supports learning and continuous improvement to systems. This supports improvement in the quality and safety of healthcare provided and protects the health and safety of those who use our premises and services. Where an AE or SAE occurs, NHS Forth Valley aims to minimise the impact on the patient, families, carers, staff and the organisation, and maximize learning and improvement.

NHS Forth Valley's continuing commitment to a just and fair culture is set out in its Quality Improvement Strategy 'Better Every Day'. Openness and involvement is encouraged to ensure all key stakeholders, including patients, families, carers and staff engage in learning from all events (adverse, near miss, SAE) and complaints.

4. Duty of Candour

The Professional Duty of Candour[1] binds healthcare professionals to be open and honest with patients (or people in their care) when something goes wrong with their treatment or care causes (or has the potential to cause) harm or distress.

On 1st April 2016, the Health (Tobacco, Nicotine etc and Care) (Scotland) Act received Royal Assent and introduced a new organisational duty of candour on health, care and social work services. This was implemented on **1st April 2018.**

The overall purpose of this is to ensure that organisations are open, honest and supportive when there is an unexpected or unintended incident which has resulted in or could result in:

- Death of the person
- A permanent lessening of bodily, sensory, motor, psychologic or intellectual functions
- An increase in the person's treatment
- Changes to the structure of the person's body
- The shortening of life expectancy of the person

[1] GMC and NMC Openness and honesty when things go wrong: the professional duty of candour (2015)

- An impairment of the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days
- The person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days
- The person requiring treatment by a registered health professional in order to prevent:
    - The death of the person, or
    - Any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.

A decision making flow chart has been developed for guidance *(add hyperlink).*

The Act also states that the organisation (i.e. the responsible person) must publish an annual report including information about the number and nature of incidents to which the duty of candour has applied and it should also demonstrate learning which has taken place.

In NHS Forth Valley, Safeguard must be used to log duty of candour incidents including information on what communications have taken place.

5. Definitions and categories

Adverse Event

An event which gives rise to unwanted and/or unexpected outcomes and may involve:

- the safety or well-being of any person either on NHS FV Premises, employed by NHS FV or who is being treated by a person employed by NHS FV or by contracted services
- loss or damage to property, records, data or equipment on NHS FV premises or owned by NHS FV
- any event causing injury or ill health, specific “clinical” type events, security breaches, episodes of violence and any other categories such as failure of medical or other equipment which resulted in harm or loss and/or
- a team identifying a recurring theme

Near Miss Event

Events that could, or have the potential to, result in harm or loss but did not. A near miss could include any of the examples listed above or any event that, although something went wrong, caused no actual harm.

Significant Adverse Event (SAE)

SAEs are events that have either resulted in or had the potential (significant near miss) to result in:

- unexpected **death** or
- **significant harm** (harm includes negative physical and emotional impact) to a patient, family, carer or staff or other
- **intervention to save life** (where treatment is provided or a process employed to protect the safety of a person) or
- a team identifying a recurring theme

A SAE may be real time i.e. identified at or near the time of occurrence or a SAE may be retrospective i.e. there may be a delay in recognising the significance of the outcome of an earlier action/inaction.

Category and level of investigation

The Quantification and Investigation Guide (**Appendix 1**) is used to determine the level of investigation and action required. Real time and retrospective SAE will have a category/risk grade of 'Major' or 'Extreme'.

The level of review may not only be mandated by the categorisation of the event. The characteristics of the event, the patient or service user, the service, the outcome and the potential for learning will inform a decision about the appropriate level of investigation.

Table 1 below shows the NHS FV four categories, associated levels of harm and the likely investigation level.

Table 1

HIS category	NHS FV Category (Risk Grade)	Level of harm (outcome)	Level of investigation
I	Extreme Risk (Red)	Extremely Serious Event causing significant harm to patients, persons or staff or others and having considerable impact on the	Directorate/Corporate Decision needed re possible SAE review
I	Major Risk (Amber)	Serious Event, major injury, ill health, loss or harm to patients, persons or staff and measurable impact on patient care	Service Manager/General Manager (GM) Directorate/Corporate Decision needed re
II or III	Moderate Risk (Yellow)	Minor injury, ill health, loss or no major impact on patients, persons or staff	Ward/Local and Line Manager investigation near miss/adverse event
II or III	Minor Risk (Green)	No injury, ill health, loss or detriment to patients, persons or staff	Ward/Local

Column 1 of the above table shows the Health Improvement Scotland (HIS) categories used for national reporting purposes as follows:

Category I – events that may have contributed to or resulted in permanent harm, for example unexpected death, intervention required to sustain life, severe financial loss (£>1m), ongoing national adverse publicity (likely to be graded as major or extreme impact on NHS Scotland risk assessment matrix, or Category G, H or I on National Coordinating Council for Medical Error Reporting and Prevention (NCC MERP) index).

Category II – events that may have contributed to or resulted in temporary harm, for example initial or prolonged treatment, intervention or monitoring required, temporary loss of service, significant financial loss, adverse local publicity (likely to be graded as minor or moderate impact on NHS Scotland risk assessment matrix, or Category E or F on NCC MERP index).

Category III – events that had the potential to cause harm but no harm occurred, for example near miss events (by either chance or intervention) or low impact events where an error occurred, but no harm resulted (likely to be graded as minor or negligible on NHS Scotland risk matrix or Category A, B, C or D on NCC MERP index).

6. What to report

All events (adverse, near miss and SAE) must be reported through the Safeguard system using the Adverse Event Report Form (**Appendix 2**).

Adverse and Near Miss Events

It is not possible to provide a fully comprehensive list of adverse or near miss events. Where there is doubt, err on the side of caution and always report an event.

The following are **examples** of situations that could lead to an adverse or near miss event and where a form must be completed and the event reported:

- slip, trip, falls or contact injuries
- unwanted physical contact, threat of physical contact or any verbal threat or intimidating behaviour that puts an individual in fear for their safety or wellbeing
- an event resulting in loss or injury to individuals or property even where injuries may be minor such as abrasions or light bruising
- Medication errors
- Other clinical adverse events

Significant Adverse Events

Examples of situations that may be considered for an SAE review are listed in Table 2 below. Further information about Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013, and deaths reportable to the Procurator Fiscal and Midwifery Adverse Events is in **Appendix 3 and 4** respectively.

Table 2

Events that should never happen	Surgery or invasive procedure performed on the wrong body part
	Surgery or invasive procedure performed on the wrong patient
	Wrong procedure performed on a patient
	Unintended retention of a foreign object after surgery or a procedure
	Test requested for wrong patient
Unexpected events related to care and treatment that have caused death, significant harm or required intervention to save life	Unexpected anaesthetic, intra-operative or immediate post-operative death
	Medication error – wrong drug, wrong dose, wrong patient, wrong time, wrong administration rate, wrong preparation or wrong route of administration
	Haemolytic reaction due to the administration of incompatible blood
	Death of patient in theatre complex
	Death following elective admission (medical or surgical)
	Failure to recognize and respond to patient deterioration (including sepsis)
	A death in mental health where the severity is felt to be significant
	Death of an inpatient in the Mental Health Directorate (physical health cause excluded)
	Death to others whilst under the care of mental health services
	Missed diagnosis of cancer or a life limiting condition
	Unplanned return to theatre
	Diabetic keto-acidosis developing following admission to hospital
Cases requiring to be reported to the Procurator Fiscal	Death of patient after an inpatient fall
	Maternal death
	Intra-partum stillbirth or unexpected early neonatal death (0-7 days)
	Death of a detained patient (physical health cause excluded)
	Death or significant harm of a child or vulnerable adult due to physical neglect or intentional harm
	Medication - death or serious harm related to recreational drug use
	Medication - death or serious harm related to clinical drug use

Cases requiring to be reported to RIDDOR (Environmental events that have caused death, specified injury, significant harm or require intervention to save life, dangerous occurrence, over 7 day absence or occupational disease following an accident / exposure at work)	Electrocution including whilst receiving healthcare
	Contact with, exposure to, or inhalation of hazardous substances as defined under CoSHH (e.g. Legionella)
	Burns and scalds including whilst receiving healthcare
	Death or significant injury or harm to staff whilst at work
Other events	Events where there is a significant near miss or recurring theme that the senior clinical team in conjunction with the General Manager (GM), Associate Medical Director (AMD) and Head of Nursing (HoN), agree warrant review using the SAER process. The rationale for review will be due to the potential to cause significant harm or death.
	End of life care – poor quality
	Quality of care – referred to Procurator Fiscal
	Serious information breaches or loss of data

7. Responsibilities and key actions

This section identifies responsibilities and key actions to ensure that the following six stages of Adverse Event management are completed:

1. Risk assessment and prevention
2. Identification and immediate actions following an Adverse Event
3. Initial reporting and notification
4. Assessment and categorisation
5. Review and analysis
6. Improvement planning and monitoring

Individuals and managers

There must be consistency in the approach to and management of **every event** (adverse, near miss, SAE) and **Appendix 5** is a flow chart of the process.

- all events (adverse, near miss, SAE) must be reported as soon as practical by completing the Adverse Event Report Form on Safeguard
- the route to report an event is via Safeguard; follow this link to access the user guide to report using Safeguard

- for purposes of business continuity a paper copy of the reporting form may be used and Managers should hold a small number of printed paper copies locally; if used, the paper copy must be uploaded to Safeguard on restoration of the system
- if it is not possible for the person(s) involved to complete the Adverse Event Report Form, it should be completed by the line manager with help from witnesses where required/applicable
- in any case, the Adverse Event Report Form(s) should be completed before the personnel involved finish their shift/working day and at the latest **within 3 days** of the event occurring
- information recorded on the form must be statements of fact and not statements of opinion; completed Adverse Event Report Forms and any attached information may be used in a court of law as evidence of any mitigating circumstances or otherwise
- findings of all investigations or reviews must be shared with those staff and services directly involved as well as the patient(s) involved and (where appropriate) relatives
- the clinical governance/risk management reporting structure within Directorates must review the content and findings of investigations to ensure that appropriate action is taken and information is effectively disseminated and escalated for corporate learning and action where appropriate

The Line Manager/Designated Manager to whom the event is reported will review, confirm and record the event level grading using the Quantification and Investigation Guide that will inform the decision on the level of investigation needed and whether a SAE review is required. All events (adverse, near miss, SAE) **must** be investigated or reviewed using the guidance referenced above. When additional investigation is required, individuals must be identified and tasked to carry out the additional investigation and where to report their findings. In the case of a SAE the review process as described in **Section 7** must be followed.

Individual

If you become aware of an event, you must act rapidly to ensure that:

- an alarm is raised to secure support from other clinical professionals
- patient(s)/staff member(s)/other(s) and the environment is/are safe to prevent further harm
- clinical care is provided as required
- arrangements are made to ensure that the environment will rapidly be made safe
- any faulty equipment should be labelled, removed and isolated
- the event and action taken is documented in the patient's case notes

- the event is reported using the Safeguard Adverse Event Report Form within **3 days** of the event occurring and a record of any actions taken is started and maintained
- the appropriate line manager, or deputy is contacted and, in the case of a potential SAE, the Service/Department Manager is contacted immediately (to make sure that the appropriate GM, AMD and HoN are informed and provided with the Adverse Event Report Form **within three working days of the event occurring)**
- where necessary, in retrospective cases and in some real-time events, immediate escalation to the GM, AMD, HoN either face to face or by telephone is undertaken and a summary of the event noted on the Adverse Event Report Form

Manager

As a line manager or deputy, you must act timeously as soon as you become aware that an event has taken place to ensure that:

- individuals involved and the immediate environment are safe or that arrangements have been made to ensure safety
- staff are appropriately supported with access to occupational health as required
- the appropriate General/Service Manager is aware of the event and of any action taken to date
- in the case of a SAE, you must escalate the event to the appropriate member of the Directorate Management Team i.e. GM, AMD, HoN
- the required documentation is completed and forwarded to the relevant line managers or other relevant person
- the need for further investigation of the circumstances surrounding the event is assessed and, where required, further investigation is carried out in line with the quantification and investigation guide
- ensure ongoing local actions as appropriate
- there is a system in place to record the event and maintain any action taken
- the Health and Safety Department is informed if an employee is off work for more than 7 days as a result of the event or where RIDDOR might apply
- under both the professional and organizational duty of candour, findings of all investigations or reviews must be shared with those staff and services directly involved as well as the patient(s) involved and (where appropriate) relatives content and findings of investigations or reviews must be considered through the Directorate Clinical Governance/Risk Management reporting structures to ensure that decisions are made and action taken to disseminate information effectively and escalate issues as appropriate for corporate learning and action.

Directorate Management Team (DMT)

For all adverse events, the GM, AMD or HoN must ensure that, for decisions not to progress to a SAE review (as agreed with the Executive Directors), the event is correctly graded and the associated level of investigation is progressed as per the quantification and investigation guide.

For all adverse and significant adverse events, the DMT must ensure that:

- there is an effective system in place to share findings of all investigations or reviews with those staff and services directly involved as well as the patient(s) involved and (where appropriate) relatives
- the content and findings of investigations or reviews are timeously considered at Directorate Clinical Governance/Risk Management groups and that decisions, actions, and dissemination of information is effectively monitored and issues escalated as appropriate for corporate learning and action
- the patient, family, staff and others are kept informed as appropriate as the review progresses
- staff are appropriately supported and, where required, a referral to the Occupational Health Service is completed
- the patient's named Consultant and GP have been informed where appropriate
- the Communications and Complaint Departments are informed where required
- actions are documented and that the 'Post Incident Aide Memoire' tool is completed
- a Review Report is produced in accordance with the quantification and investigation guide
- decide, in consultation with Police Scotland, on the timing and level of SAE review required by NHS Forth Valley, where evidence is available of criminal activity and/or someone is taken into custody

Executive Director

An executive director must:

- acknowledge, via email, all Directorate Management Team recommendations to commission or not to commission a SAE review
- seek progress reports of any commissioned SAE review
- provide assurance through the Clinical Governance and Risk Management structure that findings and lessons to be learned are appropriately actioned.

In the event of a SAE, the review process as described in **Section 8** must be followed.

8. Managing a SAE Review

Principles

It is important to keep in mind that the spirit of a SAE review is that of a 'just culture' with a desire to be open and transparent to identify important lessons and required improvements. The purpose is to identify system and root causes. Unless there is clear evidence of flagrant malpractice, a complete disregard for the safety of others, maliciousness, intent to harm, or theft or fraud then the disciplinary policy will not be used for investigation purposes. Staff will not be blamed for system failures or the consequences of failures. Individuals however do retain responsibility for their own actions or inactions in accordance with the professional practice codes that apply to them.

Multi-Board Reviews

HIS has developed guidance for undertaking multi-board SAE reviews. **Section 14** details the approach where a SAE involves more than one health board. Each case would be assessed to agree the need for a collaborative approach based on the circumstances of the SAE if, for example, the patient had contact with more than one NHS board in relation to the Adverse Event.

HIS will maintain a list of the primary points of contact at each NHS board for multi-board reviews. This list is available on the HIS adverse events community of practice website (Adverse Events/Timescales).

Exclusion from the scope of a SAE

Staff are expected to follow policies and procedures and, where there is evidence of willful departure from these policies and procedures, this will be addressed through the NHS Forth Valley Managing Employee Conduct Policy.

If the SAE Review Team identifies that a staff member's performance is below a standard that would be expected, this must be reported to the appropriate GM who will determine what action, if any, will be taken. If it is agreed that there are potential performance or conduct issues then the GM will ensure that the appropriate line manager and HR representative are informed. Thereafter, the SAE Review Team has no locus of responsibility. Recommendations will not therefore refer to management action in relation to poor performance and management of employee conduct issues.

Individuals and Managers

Key actions are the same for all events (adverse, near miss and significant). The manager must confirm, where appropriate, that all necessary immediate actions have been taken to ensure safety, care, relevant escalation and communication. **Appendix 6**, a 'Post Incident Aide Memoire', will be a helpful tool if completed to ensure that all actions are taken. Where a SAE review is to be undertaken a number of additional key steps over and above those for other events should be undertaken as follows:

- hold an immediate (as quickly as possible) debrief with all staff present and ensure those involved write a reflective account, this may be used to produce a

factual written account if requested

- contact other departments if there are issues identified that may affect other areas and ensure any immediate actions required are completed
- staff contributing as part of the review can be accompanied by a representative of their choice
- record actions taken to date on the Adverse Event Report Form

Service/Department Manager

Confirm or action the following to ensure that:

- the GM/AMD/HoN is aware and will make a recommendation about the need for a SAE review the Adverse Event Report Form on Safeguard is completed within 3 working days of the event
- the patient/family/others have been informed that an event has occurred and the NHS FV Being Open guidance is being followed
- the 'add notify' for the GM, AMD and HoN has been ticked on Safeguard
- the case notes are marked 'Not for Destruction'
- all documentation relating to the review to date is shared with the SAE Lead Reviewer when identified
- the patient's named Consultant and GP have been informed

Directorate Management Team

As soon as the GM, AMD, or HoN become aware of a potential SAE, they must:

- inform other members of the DMT
- review the Adverse Event Report Form and complete a SAER decision form with a recommendation to either proceed or not with a SAE review within 10 working days of the event being reported on Safeguard (Healthcare Improvement Scotland (HIS) Guidance)
- inform the relevant Executive Director of the outcome of the investigation and seek agreement on the recommendation made to progress with an SAE or not
- record the outcome of the investigation in the 'decision making' section (Appendix A) of the completed Adverse Event Report Form
    - If the recommendation is **not to proceed** to an SAE review, the reason for not progressing must be entered on the above form and the appropriate level of review commenced (in line with the quantification and investigation guide)
    - If the decision is taken by the Executive Directors to **progress to an SAE review,** the SAE Review Process Guidance and Roles and Responsibilities (hyperlink to Guidance 3) should be followed and the 'add notify' box should be checked on Safeguard.

- ensure that an action plan is produced that will address the SAE Review report recommendations
- nominate a lead to ensure that the action plan is delivered by the identified individual or group
- ensure that the report and action plan are considered through Directorate or Corporate Clinical Governance and Risk Management Committees (CGRMC) as appropriate.

General Manager
The GM will be responsible for ensuring:

- that the SAE Review Report, Action Plan, and all associated forms and documentation are uploaded to the Safeguard system
- that all appropriate actions to undertake a SAE review are monitored, updated and delivered in line with the required timelines
- delivery of the overall achievement of the SAE Review Report and Action Plan
- that, where appropriate, local and corporate risk registers are updated to reflect issues identified during a SAE Review.

Learning from a SAE review

In the first instance, learning is shared at the Directorate Clinical Governance Group meeting and then a learning summary is presented to the Clinical Governance Working group on the NHS Forth Valley Learning Summary (hyperlink).

For clinical SAE Reviews, the Clinical Governance Working Group (CGWG) will provide assurance on at least quarterly basis to the NHS Board Clinical Governance Committee on the effective implementation of this policy, outcomes of investigations and reviews and resulting action plans.

The CGWG will identify corporate learning/improvement themes from SAE Review Reports and confirm the mechanism through which these will be taken forward and monitored. In addition, the CGWG will commission regular audits to confirm compliance with this policy for the Management of AEs and SAEs.

It should also be noted that the person completing the adverse event report form on Safeguard can also request feedback on the event (both adverse and significant adverse events) and the line manager has to complete this mandatory field.

9. Reporting non-clinical events

NHS Forth Valley Royal Hospital (NHSFV)

Staff based within FVRH, or those reporting an issue that occurred within FVRH, reporting an event that was affected by or had an impact on the fabric of the building,

the local environment or the servicesprovided by SERCO, must contact the **SERCO helpdesk on internal Extension 67888** to report any identified problems. This contact should be added as an action to the Adverse Event Report Form together with the 'unique job number' provided by SERCO.

Information Computing and Technology (ICT) issues

Issues with any ICT equipment, systems or software must be logged with the ICT Service Desk. The 'unique job number' provided must be added to the Adverse Event Report Form if a report is still deemed necessary.

Information Governance issues

For all events involving breaches of the Information Governance legislation, the Information Governance Team will be made aware via the Safeguard notification system and will, where appropriate, conduct an investigation.

Human Resource (HR) issues

There are some events that due to their nature are already covered by our HR policies. These types of event should be discussed with your HR Adviser and not reported via the Adverse Event system e.g. bullying or harassment unlessthe event meets some other reportingcriteria.

If an event is reported via the Safeguard system and it falls within existing HR policy and therefore may be dealt with via that route, the Health and Safety Department will contact HR for their action. The event will then be closed on the Safeguard system and feedback will be given to the reporter advising them of the action taken. All others will be dealt with as per policy.

Learning from a non-clinical event

For staff and non-clinical SAE Review, the Health and Safety Committee (HSC) will provide assurance on at least quarterly basis to the NHS Board Staff Governance Committee on the effective implementation of this policy, outcomes of investigations and reviews and resulting action plans.

The HSC will identify corporate learning/improvement themes from SAE Review Reports and confirm the mechanism through which these will be taken forward and monitored. In addition, the HSC will commission regular audits to confirm compliance with this policy for the Management of Adverse Events and SAEs.

10. Morbidity and Mortality (M&M) reporting system

Relevant clinical events should be recorded and reviewed through the M&M system by a clinician. The outcome of the M&M can be used to determine if a review, and what level of review, is required. The approved NHS Forth Valley electronic system is currently MoSES which allows consistent reporting and enables thematic learning but

an Adverse Event Report Form must be completed through the Safeguard system for any AEs, near misses and SAEs.

11. External reporting

There are several adverse event types where it is mandatory to report externally in addition to internal reporting requirements.

Health and Safety Executive (HSE)

If the event is reportable, under RIDDOR, i.e. death, specified injury, dangerous occurrence, over 7 day absence or occupational disease following an accident / exposure at work, then a report must be sent to the HSE.

Contact the Health and Safety Department as soon as is practical after the event has occurred, to allow them to advise you on anything else that is required e.g. over 3 day injuries must still be recorded and enable them to report to the HSE. This should be followed up quickly by completing an Adverse Event Report Form.

For Occupational Disease, the optional reporting route to HSE is via the NHS Forth Valley Occupational Health Department and each case will be considered individually and reported by the appropriate Department.

Healthcare Facilities Scotland (HFS)

If the Adverse Event occurs as a result of a problem with, or failure of, medical device/equipment including infusion devices or healthcare product failures, the Medical Physics Department (or other appropriate person) must be informed immediately or as soon as possible if the event occurs out with normal working hours. This is to make sure that the equipment is labelled and withdrawn from use (although this should happen immediately following the failure) and the event is recorded in the relevant register within the Medical Physics department including any subsequent action taken.

Line Managers/Supervisors should ensure that all Adverse Events involving medical, scientific and estates equipment are reported to Health Facilities Scotland (HFS) using the form (paper or electronic) available on their website alongside additional information and guidance at http://www.hfs.scot.nhs.uk/online-services/Adverse Incident-reporting-and-investigation- centre-iric/ HFS will investigate and issue advice.

Further support and guidance on any event can be provided by either the Medical Physics Department or the Health and Safety Department. A paper copy of the Adverse Event Report Form can be used to gather information. Once reported, a copy of the email confirmation response to the reporter should be forwarded to the Health and Safety Department generic mailbox at Fv-uhb.fvsafetyandrisk@nhs.net

Suicide

When made aware of a death by suicide of a person known to Mental Health Services within the past 12 months, an Adverse Event Report Form must be completed on Safeguard by the Senior Nurse on duty/Clinical Nurse Manager and forwarded to the Suicide Review Coordinator. The process within the "Review Guidance for Suicide / Clinical and Adverse Event Management" must be followed.

The Suicide Review Coordinator will request the following reports on behalf of the Suicide Review Group:

- Timeline
- Medical Report
- Nursing Report
- Procurator Fiscal Report
- Police Report
- Post Mortem Report
- Other reports as necessary (e.g. GP/Social Work)

These are required to enable the group to determine if a Suicide Review or Significant Adverse Event Review is indicated. These reports should include:

- Background report and timeline
- Contact with Services
- Summary of Treatment

The Suicide Review Group will discuss the reports received (including drug-related deaths) on a weekly basis and agree next steps i.e.:

- No further action
- Proceed to Suicide Review Panel
- Recommend full Significant Adverse Event Review

In the event of a Significant Adverse Event, Section 7 of this NHS FV Policy must be followed.

A member of the Suicide Review Panel will share the outcome of the Suicide Review process and forward this to Health Improvement Scotland, even if it is agreed that no further action is required.

Theft, Fraud or Corruption

In all cases, an Adverse Event Report Form should be completed and also reported to the Director of Finance who will investigate in line with NHS Forth Valley's Fraud, Theft and Corruption Policy and the National Fraud initiative at: http://intranet.fv.scot.nhs.uk/web/files/policiesareawidefinancepolicies/fraud action plan.pdf http://intranet.fv.scot.nhs.uk/home/Employment/NationalFraudInitiative.asp

Blood Transfusion

It is compulsory that any serious events and reactions associated with blood collection and transfusion (and associated activities) should be reported to the Medicines and Healthcare Products Regulatory Agency (MHRA). Definitions of serious hazards of transfusion can be found in **Appendix 8**.

The *EU Blood Safety Directive* introduced a legal requirement for *serious adverse reactions* (SAR) and *serious adverse events* occurring within EU Member States to be reported to the relevant Competent Authority. The Department of Health has designated the MHRA as the UK Competent Authority. It is, therefore, the responsibility of the MHRA to provide a mechanism for the reporting and recording of these Adverse Events. For this purpose the MHRA has developed an online reporting system: *SABRE* (Serious Adverse Blood Reactions & Events) which allows the drafting, editing saving and submission of notifications and subsequent confirmations of blood related adverse events and adverse reactions.

All Adverse Events relating to Blood Transfusion must be reported by the Safeguard Adverse Event Report Form and must also be notified to the Transfusion Department as soon as possible. The event will be reported to SABRE and/or SHOT via the MHRA website by registered users in the Transfusion Department i.e. the Transfusion Manager, Transfusion Practitioner, Department Manager, and Consultant Haematologist.

More information on transfusion and management of possible transfusion reactions is available in the Forth Valley Transfusion Protocol

Radiation events

Requirements for reporting certain radiation incidents can be found in the IR(ME)R Regulations – Employers procedure 15 (insert hyperlink)

Healthcare Associated Infections (HAI) and Infectious Diseases

Appendix 9 provides details of the risk of HAI and infectious diseases and organisms that must be reported. Further details can be found in the Infection Control Policy for the Investigation, Management and Control of Incident/Outbreak of Infection

(http://www.nhsforthvalley.com/__documents/qi/ce_guideline_infectioncontrol/outbreakofinfection.pdf) and also the Public Health Website

Sudden Unexpected Death in Infancy (SUDI)

There have been changes made to the review process for SUDI events. NHS FV will ensure that these changes are reflected in their procedures.

12. Confidential (Safe Haven) Reporting

For occasions when the employee does not feelcomfortable or confident in raising a concern or completing an Adverse Event Report Form in the workplace, this can be done by telephoning **08451302836** which is the NHSFV Safe Haven confidential answer phone. This is hosted by the NHSFV Health and Safety Department. An employee reporting an issue in this manner will, where applicable, have the event pursued anonymously on their behalf bythe appropriate adviser.

A summary of these reports and any actions taken will be provided to the HSC and CGC whereappropriate. These committees will be asked to consider the issues and subsequent actions to be taken for governance purposes.

A new National Confidential Alert Line for NHS Scotland employees is now available on **0800 008 6112** which provides an additional level of support for those who wish to raise a concern about practices in NHS Scotland.

The Alert Line, run as a pilot by the charity Public Concern at Work, offers independent, confidential advice from legally trained expert staff on whether and how to raise a concern. Further details about the Alert Line can also be found on the Scottish Government website.

13. Child Protection

Standard 8 of the Framework for Standards, Scottish Executive 2004, states that "Agencies should rigorously monitor and review their work in protecting childrenand implement steps, which lead to continuous improvement"

NHSFV is committed to improving its services and supporting staff when identifying child protection events and identifying those areas where learning can occur. **Appendix 10** provides guidance on reporting.

14. Effective policy implementation

The responsibility for ensuring the effective implementation of this policy is shared across the organisation. **Appendix 11** identifies roles for all employees, specific committees and Caldicott Guardian.

15. Multi-Board Review

Detailed guidance and a flow chart have been developed and is currently being evaluated. That guidance has been designed for a SAE review. However, if the event review is likely to yield worthwhile learning and useful improvements, it may be appropriate to follow this approach for events not classified as a SAE; evaluation will confirm this. The Clinical Governance Department can provide further advice and clarification.

HIS will maintain a list of the primary points of contact at each NHS board for multi-board reviews. Up to date information on the developing multi-board guidance and

primary contacts in boards is available on the HIS adverse events community of practice website.

16. Training and Resources

NHS Forth Valley provides training in the management of all events as required. There are also online National Patient Safety Agency training resources for root cause analysis and other root cause analysis investigation resources: http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/

Publications in Alternative Languages and Formats

NHS Forth Valley is happy to consider requests for publications in other language or formats such as large print.

To request another language or format please:

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Text 07990 690605,

E-mail - fv-uhb.nhsfv-alternativeformats@nhs.net