# Item No: 20

**Meeting Date:** **Friday 9 December 2016**

# Glasgow City Integration Joint Board

**Report By:** **David Williams, Chief Officer**

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## QUARTERLY CLINICAL AND PROFESSIONAL ASSURANCE STATEMENT

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| **Purpose of Report:** | To provide the Integration Joint Board with a quarterly clinical and professional assurance statement. |

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| **Recommendations:** | The Integration Joint Board is asked to:<br><br>a) consider and note the report. |

**Implications for Integration Joint Board:**

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| **Financial:** | None |
| **Personnel:** | None |
| **Legal:** | This report contributes to the Integration Joint Board's duty to have clinical and professional oversight for its delegated functions. |
| **Economic Impact:** | None |
| **Sustainability:** | None |
| **Sustainable Procurement and Article 19:** | None |

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| **Equalities:** | None |

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| **Risk Implications:** | None |

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| **Implications for Glasgow City Council:** | The report provides assurance on professional governance. |

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| **Implications for NHS Greater Glasgow & Clyde:** | The report provides assurance on clinical governance. |

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| **Direction Required to Council, Health Board or Both** | Direction to: | |
| | 1. No Direction Required | ✓ |
| | 2. Glasgow City Council | |
| | 3. NHS Greater Glasgow & Clyde | |
| | 4. Glasgow City Council and NHS Greater Glasgow & Clyde | |

## 1. Purpose of Report

1.1 To provide the Integration Joint Board with a quarterly clinical and professional assurance statement

## 2. Background

2.1. The Integration Joint Board of 24 June 2016 considered and approved a statement format for the provision of specific and routine information with which the Integration Joint Board can be assured that clinical and professional governance is being effectively overseen by the Integrated Clinical and Professional Governance Board.

2.2 The first assurance statement was presented to the 21 September 2016 Integration Joint Board covering various periods up the end of August 2016, along with the agenda from the 6th September 2016 Integrated Clinical and Professional Governance Board, by way of assurance that all aspects of integrated practice were appropriately considered. The last meeting of this Governance Board was held on 6th December 2016, and details will be provided within the next quarterly statement to the Integration Joint Board in February 2017.

## 3. Clinical and Professional Assurance Statement

3.1 The following information provides specific data and narrative relative to activity covering the period July to September 2016.

3.1.1 **<u>Adult Services (homelessness; disability; and addictions)</u>**

***Homelessness***

**Number of Significant Care Reviews currently ongoing:** None

**Number of Significant Clinical Incidents currently ongoing:** 4

**Number of Significant Clinical Incidents / Significant Case Reviews commenced during the quarter:** 1

**Number of Significant Clinical Incidents / Significant Case Reviews concluded during the quarter:** None

**Routes used to ensure effective cascading/dissemination of learning:**
Core Leadership - Homelessness

**Workforce registration issues identified during the quarter:**
Residential Homelessness Team Leaders to obtain registration by 30 June 2017. Current position: 4 Obtained Registration; 5 awaiting Registration; 5 to submit applications by 31 December 2016.

**Any patient safety/ infection control issues identified in the quarter:** 0

- Monitoring of clients in temporary accommodation
- Review of support arrangements commissioned

**HSCP response to this:**
Learning will arise from the review being undertaken

**Issues highlighted in purchased clinical/social care provider services:**
Variable reporting arrangements for serious incidents. Revised guidance/reporting arrangement under development.

***Disability / Addictions***
No activity to report

3.1.2 **Older People Services**

**Number of Significant Case Reviews currently ongoing**: None

**Number of Significant Clinical Incidents currently ongoing:** 2

**Number of Significant Clinical Incidents commenced during the quarter:** 2

**Number of Significant Clinical Incidents concluded during the quarter:** 3

**Summary of learning points from concluded Significant Clinical Incidents:**

- **Incident 1** – None, the investigating team concluded that the incident could not have been predicted and the patient had received very good care
- **Incident 2** – Overall the investigating team concluded that the care provided was good, with clear evidence of joint working and multi agency assessments taking place. It was also concluded that some areas of communication between teams could be improved; and that the assessment request could have been followed up in a more timely fashion although it would not affected the outcome. These issues are being addressed.
- **Incident 3** – Overall the investigating team concluded that there were no issues which had a direct effect on the final outcome. Some learning was identified in respect of improving communications across a range of areas,

including that between professionals; the dissemination of information both on-line and printed; and areas around discussing confidentiality with patients and cares at an early stage.

**Routes used to ensure effective cascading/dissemination of learning:**

- **Incident 2 –** Learning for the Health and Social Care Partnership will be routed through existing governance structures; learning in respect of the locality where the incident occurred, has been routed to the Adult Support and Protection Steering group for use in multi-agency Local Management reviews.
- **Incident 3** – Learning points will be tabled at the Partnership Clinical Governance Meeting; the Older Person's Mental Health Clinical Governance meeting and at the Health Board wide Clinical Governance Forum.

**Workforce registration issues identified during the quarter:**

- 1 Qualified Social Worker in North West Locality remains suspended by Scottish Social Services Council
- 4 Social Care Assistants unable to undertake full range of duties due to not being registered within six months of taking up post; being monitored by Partnership Human Resources and Service Managers

**Any patient safety/ infection control issues identified in the quarter:** 0

**Issues highlighted in purchased clinical/social care provider services and Health and Social Care Partnership response:**
1 Nursing Home manager was suspended and a referral made to the Nursing and Midwifery Council due to non-registration of care staff and falsification of care home registration cards.

3.1.3 **Children and Families Services**

**Number of Significant Case Reviews currently ongoing:** 2

**Number of Significant Case Reviews commenced during the quarter:** 0

**Number of Significant Case Reviews concluded during the quarter:** 0

**Summary of learning points from concluded Significant Case Reviews**
The learning point and report for case review 1 will go to the Child protection Committee for final sign off on 12th December 2016.
The report for case review 2 has Sub Judice status and although it has been signed off by the Significant Case Review Panel, it is not for further circulation until notification is received from the Procurator Fiscal's Office.

N.B. A Significant Case Review referral was tabled to the Significant Case Review Panel at the end of June 2016. The decision of the Panel was that a single agency review was appropriate and the case was referred to NHS Greater Glasgow and Clyde to progress. The investigation is being taken forward under NHS Clinical Incident procedures and is expected to conclude early 2017.

**Routes used to ensure effective cascading/dissemination of learning:**
A summary of learning points from the concluded Significant Case Reviews is being compiled; learning points to be agreed by the Child Protection Committee and then incorporated into an action plan, early 2017.

**Workforce registration issues identified during the quarter:**

- Scottish Government launch programme of degree level training for all residential child care workers in Scotland to commence January 2017
- 1 x Social Work Services Officer suspended by Scottish Social Services Council left Glasgow City Council 9th September 2016
- 1 x Qualified Social Worker registration lapsed by Scottish Social Services Council, now obtained registration and returned to post 30th August 2016
- 1 x Qualified Social Worker remains suspended by Scottish Social Services Council' redeployed to Social Care Worker post elsewhere within the service.
- 1 x Residential Worker in one Residential Home who failed to obtain registration within six months, obtained registration 20th September 2016 and returned to post

3.1.4 **Criminal Justice Services**

**Number of Multi Agency Public Protection Arrangements (MAPPA) Significant Case Reviews currently ongoing:** 0

**Number of Initial Case Report forms received and decision of Significant Oversight Group chair not to proceed to Significant Case Review:** 6

**Reasons for not proceeding to Significant Case Review:**
Despite the re-offending being of a level of significance meriting consideration, proceeding to a Significant Case Review was not viewed as a proportionate response. The information provided in the Initial Notifications and Initial Case Reports identified single agency rather than multi agency learning. These cases will be the subject of further discussion at the MAPPA Significant Oversight Group, in the broader context of multi agency responses to minimising reoffending.

**Routes used to ensure effective cascading/dissemination of learning:**
Learning is disseminated through multi agency learning events. The MAPPA Significant Oversight Group will be considering, at its November 2016 meeting, a proposal for a session specifically focused on internet offending for relevant staff.

3.1.5 **Mental Health Services**

**Number of Significant Clinical Incidents commenced during the quarter**: 13

**Number of Significant Clinical Incidents/Significant Case Reviews concluded during the quarter:** 20

**Routes used to ensure effective cascading/dissemination of learning:**
Recommendations and arrangements for shared learning are produced following each Significant Clinical Incident. All recommendations and actions are logged and are followed up by the Clinical Risk team with the appropriate service at 3

months and 6 months to ensure progress has been made. If after this timescale the recommendation is still outstanding, the issue will be highlighted to the appropriate Directorate management structure.

**Any patient safety/ infection control issues identified in the quarter:** None

**Workforce registration issues identified during the quarter:**
*Older Peoples Mental Health:*

- A referral has been made to the Nursing & Midwifery Council in respect of an employee's Fitness to Practice on health grounds.

*Adult MH*

- An employee's registration lapsed for a period of 1 week due to non-payment of fees. The employee was suspended from duty in line with organisational policy until such times as their registration had been restored.
- A registrant was referred to the Nursing and Midwifery Council received a formal caution following the outcome of a Fitness to Practice hearing.

3.1.6 **Hosted Services**

**Prison Healthcare**

***HMP Barlinnie/Greenock/Low Moss***

**Number of Significant Clinical Incidents/Significant Case Reviews currently ongoing:** 0

**Number of Significant Clinical Incidents/Significant Case Reviews commenced during the quarter:** 0

**Number of concluded Significant Clinical Incidents/Significant Case Reviews during the quarter:** 0

**Summary of learning points from concluded Significant Clinical Incidents/Significant Case Reviews:** N/A

**Workforce registration issues identified during the quarter:** 0

**Any patient safety/ infection control issues identified in the quarter:**
Infection control audits completed in the Treatment Rooms in all three prisons in the last quarter.
Results as follows:

- HMP Barlinnie – 95% Gold
- HMP Greenock – 89% Green
- HMP Low Moss – 68% Amber

**HSCP response to this:**
HMPs Barlinnie and Greenock will be re-audited in 12 months' time and HMP Low Moss re-audited in 6 months' time.

**Learning from these incidents:**
All three establishments have individualised Action Plans based on their audit findings.

**Issues highlighted in purchases clinical/social care:**
National Procurement Product recall Notification received on 16th September 2016 for Clinitex Detergent Wipe Packs and Buckets

**HSCP response to this:**
All Primary Health Care staff made aware of the product recall via email and at team meetings with a copy of the notification posted on the staff notice board. All packs and buckets were quarantined immediately and replacements sought as per National Procurement Notification.

3.1.7 **Police Custody Healthcare Service:**

**Number of Significant Clinical Incidents/Significant Case Reviews currently ongoing**: 0

**Any patient safety/ infection control issues identified in the quarter:** None

3.1.8 **Sandyford Services**

**Number of Significant Clinical Incidents/Significant Case Reviews currently ongoing:** 0

**Number of Significant Clinical Incidents/Significant Case Reviews commenced during the quarter:** 0

**Number of Significant Clinical Incidents/Significant Case Reviews concluded during the quarter:** 0

Staffing shortages have been highlighted in a paper to Chief Officers within the six Health and Social Care Partnerships within NHS Greater Glasgow and Clyde. As a result of the shortages services will be reduced in 4 of 15 locations one day per week for a period of 3 months from 5th December 2016 to allow the induction of newly appointed staff and to enable the service to be run safely.

## 4. Healthcare Associated Infection

4.1 There have been no ward closures or significant HAI issues within the reporting time frame. A national point prevalence survey of Healthcare Associated Infection and antimicrobial prescribing is underway within in-patient areas in the Health and Social Care Partnership. This will be completed in December 2016 and a report available in spring 2017.

4.2 A new monitoring system has been established to monitor Standard Infection & Prevention Standards (SIPS) compliance. This updated system will complement the cleaning and environmental standard audits that are part of the suite of assurance measures in place.

## 5. Recommendations

5.1 The Integration Joint Board is asked to:

a) consider and note the report.