Item No: 20

Meeting Date: **Wednesday, 21st September 2016**

Glasgow City Integration Joint Board

Report By: **Susanne Millar, Chief Officer Strategy, Planning & Commissioning / Chief Social Work Officer**

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QUARTERLY CLINICAL AND PROFESSIONAL ASSURANCE STATEMENT

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

Recommendations:	The Integration Joint Board is asked to consider and note the report.

Implications for IJB:

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
Equalities:	None

Risk Implications:	None
Implications for Glasgow City Council:	The report provides assurance on professional governance.

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

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 previously considered and approved in June 2016 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 Governance Board, chaired by the Chief Officer.

2.2 The Integrated Clinical Governance Board last met on 6th September 2016 and the agenda is attached at appendix A by way of assurance that all aspects of integrated practice were appropriately considered at this meeting.

3. Clinical and Professional Assurance Statement

3.1 The following information provides specific data and narrative relative to activity covering various periods up to the end of August 2016. This is an evolving piece of work, and the report that comes to the December Integration Joint Board will focus specifically on the period July-September 2016.

3.1.1 **Adult Services (disability; homelessness; addictions)**

Homelessness

Homelessness has established a Health and Social Care Partnership Care Governance group. A number of critical incidents will be screened through the initial meeting in September 2016.

Disability/Addictions
No activity to report

3.1.2 **Older People Services**

Number of Significant Case Reviews currently ongoing: None

Summary of learning points from concluded Significant Case Reviews:
Historical Significant Case Reviews, including the most recent Review, published in September 2015, highlighted the lack of communication between agencies and professionals, and the lack of coordinated care planning and management. To ensure this learning and information has been disseminated the following actions have been undertaken in 2016:

- Single agency and multi-agency management reviews
- Local Management Reviews
- Training including single agency and multi-agency
- Dissemination through staff supervision arrangements
- Mentoring/shadowing and partnership working
- Self-evaluations, auditing both single agency and multi-agency levels
- Discussion at locality Adult Support and Protection forums/steering groups, City Wide Adult Support and Protection meetings and practitioner forums
- ASP development sessions; and ASP newsletter

Number of Significant Clinical Incidents currently ongoing: 5* (Older People's Mental Health and Older Adults Community Mental Health)
*This is a snapshot of current open Significant Clinical Incidents at 12/8/16)

Number of Significant Clinical Incidents commenced during the quarter: 1

Number of Significant Clinical Incidents concluded during the quarter: 0

Summary of learning points from concluded Significant Clinical Incidents -
Information on Datix (NHS information system) includes the action plans from concluded Significant Clinical Incidents based on their recommendations.

Workforce registration issues identified during the quarter:

- 1 Qualified Social Worker suspended by Scottish Social Services Council
- 6 Social Care Assistants in Older People's residential units unable to undertake full range of duties due to not being registered within six months of taking up post. One expected to be registered by end of August, HR monitoring and discussing with Service Managers the other five.
- 1 Registered Nurse referred to the Nursing Midwifery Council following fitness to practice concerns.

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

Norovirus outbreak in four wings at Hawthorn House week beginning 1st March 2016

Norovirus outbreak in 1 Older People's Mental Health admission ward within Gartnavel Royal Hospital week beginning 27th June 2016 resulting in the closure of the ward to admission / transfers for 4 days

Health and Social Care Partnership response to this:

For Norovirus outbreak and other infection control issues, Glasgow City Council Older People Residential and Day Services has a clear policy and procedure outlined in its Winter Planning Protocols, up to and including the possible suspension of new admissions. Public Health Scotland are also notified if more than two residents have symptoms of a potential infectious disease and the Care Inspectorate is also notified. Specific norovirus recording guidance is also in place along with Standard Infection Control Precautions. In addition to the aforementioned, staff also work with individual GP practices for each individual service user.

NHS Greater Glasgow & Clyde infection prevention and control measures are in place within all health facilities. For outbreaks standard procedures are followed in line with policy.

Issues highlighted in purchased clinical/social care provider services and Health and Social Care Partnership response:

- One care home reported a registration issue whereby 8 staff were found to be unregistered. The matter has been robustly responded to by the provider and all registrations are now pending, the Scottish Social Services Council and Care Inspectorate are aware and the manager has been suspended and reported to the Nursing and Midwifery Council, and an investigation is ongoing. The provider has altered the system of logging registrations and is also checking all other areas of the manager's performance.
- There has been one Large Scale Investigation due to a number of care quality issues including violent outbursts and a serious fire. The home was also operating out with its registered status. The Large Scale Investigation has concluded and measures are in place to align the resident population with the registration. The Investigation has highlighted weaknesses in cross agency reporting, particularly where a provider withholds crucial information.
- New reporting systems have been implemented. Currently only one commissioning team is involved in multi agency Adult Support and Protection forums as a conduit for reporting to all the teams. Efforts are underway to resolve this by the Adult Support and Protection Service Manager.
- There are a number of Adult Support and Protections referrals and quality of care concerns around one care home, mainly about poor tissue viability care. These have been raised by the NHS Liaison Nurse and the home is conducting its own internal investigation. The locality is considering whether a Large Scale Investigation is appropriate and this has been reported as a standing item on the multi agency Adult Support and Protection Forum.

3.1.3 **Children and Families Services**

Number of Significant Case Reviews currently ongoing: 2 plus 1 single agency report (Health)

Number of Significant Case Reviews commenced during the quarter: 0

Number of Significant Case Reviews concluded during the quarter: 2 (The reports and the Significant Case Review panels have been completed for the 2

ongoing Reviews. The Reviews have not been fully concluded as there are Police/Procurator Fiscal decisions pending)

Summary of learning points from concluded Significant Case Reviews: The learning points from the 2 reports have not been shared yet due to the status of the reports. However, both cases centre on neglect issues and non-engaging/hostile carers. Detailed learning points will be provided once the reports have been to the Child Protection Committee.

Routes used to ensure effective cascading/dissemination of learning: The route for dissemination is through Locality Learning Events. Once the learning points are shared fully, the Locality Child Protection Forums will include relevant actions in their Locality Child Protection action plans. The Child Protection Committee and the Child Protection Committee Quality Assurance sub group overview the Significant Case Review learning points which is a priority area within the Child Protection Committee action plan.

Workforce registration issues identified during the quarter: 1 Officer suspended by the Scottish Social Services Council (Registration not required for current post; legacy from previous role as Qualified Social Worker)

- 1 Qualified Social Worker registration lapsed – working as a Social Care Worker pending a Scottish Social Services Council investigation

- 1 Qualified Social Worker (Children &Families) failed to register with the Scottish Social Services Council within six months and is still sitting as an applicant, pending their investigation – redeployed as Social Care Worker as part of a disciplinary disposal

- 1 residential worker not registered within six months of taking up post – redeployed to Social Care Worker pending registration.

- 1 Registered Nurse referred to the Nursing Midwifery Council following fitness to practice concerns raised through internal disciplinary procedures.

3.1.4 **Criminal Justice Services**

Number of Multi Agency Public Protection Arrangements (MAPPA) Significant Care Reviews currently ongoing: None

Summary of learning points from concluded Significant Case Reviews: Glasgow has only undertaken 1 MAPPA Significant Case Review, and this was 3 years ago. The learning points were disseminated through locality learning events. Some of the learning points required national action, and related to environmental scanning and the housing of Registered Sex Offenders.

Routes used to ensure effective cascading/dissemination of learning: As above. The MAPPA Strategic Oversight Group ensures that routes for dissemination of learning are clear. More single agency activity has been undertaken in recent months, and reported back to the Strategic Oversight Group.

Number of Initial Report Forms received and decision of Significant Oversight Group chair not to proceed to Significant Case Review: 7 (June to August 2016)

Reasons for not proceeding to Significant Case Review: The main reasons for not progressing to a Review relate to:

- the case not providing multi-agency learning
- the issues highlighted within the Initial Case Review relate to previous issues covered within the Significant Oversight Group e.g. the completion of stable assessments, recording on the Violent and Sex Offender register (ViSOR)
- a single agency action plan is the most appropriate response

3.1.5 **Mental Health Services**

Number of Significant Clinical Incidents commenced during the quarter: 11

Number of Significant Clinical Incidents/Significant Case Reviews concluded during the quarter: 9

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:
Norovirus outbreak in 2 wards within Parkhead Hospital resulting in ward closures for 1 week in total week beginning 22nd August 2016.

Health and Social Care Partnership response
Standard procedures were followed in line with policy

Workforce registration issues identified during the quarter:

1 Registered Nurse who had been previously dismissed from the organisation following disciplinary procedures received a 'striking off' order from the Nursing and Midwifery Council

3.1.6 **Hosted Services**

Prison Healthcare

HMP Barlinnie/Low Moss/Greenock

Number of Significant Clinical Incidents/Significant Case Reviews currently ongoing: 1 (just commencing)

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: 1

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

Routes used to ensure effective cascading/dissemination of learning: Emails, staff meetings, staff notice boards and discussed at any relevant team meetings

Workforce registration issues identified during the quarter: 0

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: 1
Defective pregnancy test kits used by Police Custody Healthcare Service identified through a Medical Device Alert; local investigation identified one person as potentially at risk of receiving incorrect test result due to this.

Health and Social Care Partnership response to this: Person potentially affected contacted via GP and addiction team to highlight this issue. No issues reported back to service. Defective kits removed from all clinical areas and replaced with alternative product.

3.1.8 **Sandyford Services**

Number of Significant Clinical Incidents/Significant Case Reviews currently ongoing: 1

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

4. Revalidation for Nurses

4.1 A system of revalidation for nurses was introduced by the professional regulator in April 2016. The model of revalidation builds upon the previous post registration and practice requirements, and whilst revalidation is the professional responsibility of an individual registrant, it has implications for employers. To successfully revalidate, nurses are expected to demonstrate that they meet the practice and continuing professional development hours; have a professional discussion with another Nursing and Midwifery Council registrant as well as have someone to act in the confirmer role (who may or may not be the line manager); and, also ensure they have professional indemnity insurance in place. It is necessary to complete this process every 3 years.

4.2 Employers are required to support their registered nursing staff to maintain their registration, which will enhance professional practice and improve care. The Health

and Social Care Partnership has put systems in place to support this new requirement. To date a number of nursing staff have successfully been revalidated with larger numbers expected to go through the process during September and October 2016.

5. Recommendations

5.1 The Integration Joint Board is asked to consider and note the report.

Appendix A

GLASGOW CITY HEALTH & SOCIAL CARE PARTNERSHIP
Integrated Clinical and Professional Governance Group

2.30pm on Tuesday, 6th September 2016 in the Sir Peter Heatly Boardroom, Commonwealth House, 32 Albion Street, Glasgow G1 1LH

AGENDA

	Enclosure
1. Apologies for Absence David Wylie, Gwen Agnew and Pauline McGough	
2. Minutes of the Previous Meeting	
To approve the minutes of the meeting held on 7th June 2016.	02 GHSCP IGG(M) 07/06/16
3. Governance Group Minutes/Reports	
(a) Social Work Professional Governance Sub Group	
i) Meeting 12th May 2016	Paper 2016/026
ii) Meeting 7th July 2016	Paper 2016/027
(b) Children & Families / Criminal Justice Clinical & Care Governance Leadership Group	
i) Meeting 15th June 2016	Paper 2016/028
ii) Meeting 3rd August 2016	Paper 2016/029
(c) Older People & Primary Care Clinical & Care Governance Leadership Group	Paper 2016/030
(d) Mental Health Quality & Clinical Governance Committee	Paper 2016/031
Note: No Recent Meeting of the following Groups - Police Custody Healthcare Clinical Governance Committee - Prison Healthcare Governance Committee - Homelessness - Sandyford Services	
4. SCR and Critical Incident Reporting A review of the various arrangements in place across the HSCP in respect of SCR and Critical Incident reporting. (Sheena Morrison)	Paper 2016/032

5. NHS GG&C Partnerships Clinical Risk Report	
Provide an update on the clinical risk activity across Partnerships within the NHS GG&C Board (Paul Ryan)	Paper 2016/033 (a)-(b)
6. NHS GG&C Clinical Governance Structures	
Provide an update of the Terms of Reference & reporting arrangements for NHS GG&C Clinical Governance Structures (Paul Ryan)	Paper 2016/034 (a)-(b)
7. NHS GG&C - Child Protection Update	
Provide an update on Child Protection issues within NHS GG&C area and progress on SCRs. (Paul Ryan)	Paper 2016/035
8. Scrutiny / Assurance Statement	
To review the draft assurance statement for the IJB	Paper 2016/036
9. Next Meeting	
Tuesday 6th December 2016, 2.30 pm – 5.00 pm	