Item No. 8

Meeting Date **Wednesday 11th December 2019**

Glasgow City
Integration Joint Board
Finance, Audit and Scrutiny Committee

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CLINICAL AND PROFESSIONAL QUARTERLY ASSURANCE STATEMENT

Purpose of Report:	To provide the IJB Finance, Audit and Scrutiny Committee with a quarterly clinical and professional assurance statement.

Background/Engagement:	The quarterly assurance statement is a summary of information that has been provided to, and subject to the scrutiny of the appropriate governance forum. The outcome of any learning from the issues highlighted will then be taken back into relevant staff groups.

Recommendations:	The IJB Finance, Audit and Scrutiny Committee is asked to: a) consider and note the report.

Relevance to Integration Joint Board Strategic Plan:

Evidence of the quality assurance and professional oversight applied to health and social care services delivery and development as outlined throughout the strategic plan.

Implications for Health and Social Care Partnership:

Reference to National Health & Wellbeing Outcome:	Contributes to: **Outcome 7.** People using health and social care services are safe from harm. **Outcome 9.** Resources are used effectively and efficiently in the provision of health and social care services.

Personnel:	The report refers to training and development activity undertaken with staff, and references operational implications from Significant Case Reviews in Fife and Edinburgh.
Carers:	Offers assurance to carers that quality assurance and professional and clinical oversight is being applied to the people they care for when using health and social care services.
Provider Organisations:	No impact on purchased clinical/social care provider services.
Equalities:	None
Fairer Scotland Compliance:	N/A
Financial:	None
Legal:	This report contributes to the Integration Joint Board's duty to have clinical and professional oversight of its delegated functions.
Economic Impact:	None
Sustainability:	None
Sustainable Procurement and Article 19:	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.

1. Purpose of Report

1.1 To provide the IJB Finance, Audit and Scrutiny Committee 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 and Professional Governance Board, chaired by the Chief Officer. The report can be found at the following link: https://glasgowcity.hscp.scot/publication/item-no14-clinical-professional-assurance-statement

2.2 The most recent quarterly clinical and professional assurance statement was provided to the IJB Finance, Audit and Scrutiny Committee in September 2019 and can be viewed at the following link: https://glasgowcity.hscp.scot/publication/item-no-13-clinical-and-professional-quarterly-assurance-statement-september-2019

2.3 This report provides the IJB Finance, Audit and Scrutiny Committee with the information as agreed within the June 2016 report. The format continues to be reviewed with the key information collated up to September 2019 attached at Appendix 1 to allow for easier scrutiny. This cover report provides an opportunity to offer more detail on issues related to particular incidents and cases.

3. Integrated Clinical and Professional Governance Board

3.1 The Integrated Clinical and Professional Governance Board allows further scrutiny of the minutes from the following Governance meetings.

- Social Work Professional Governance Sub Group
- Children & Families / Criminal Justice Clinical and Care Governance Leadership Group
- Older People & Primary Care Clinical and Care Governance Leadership Group
- Mental Health Quality & Clinical Governance Committee
- Police Custody Healthcare Clinical Governance Committee
- Prison Healthcare Clinical Governance Committee
- Homelessness Care Governance Group
- Sandyford Governance Group.

3.2 The HSCP, through the Integrated Clinical and Professional Governance Board, and the other Governance forums, continues to emphasise the need to embed a reflective, quality assurance expectation within all sections of the HSCP.

3.3 Similarly, there is emphasis on ensuring that Significant Clinical Incident (SCI) and Clinical Incident Review (CIR) processes and procedures of the HSCP are aligned wherever possible and that investigations are joint when more than one service is

involved. This remains a key development for Glasgow ensuring our governance arrangements continue to reflect our integrated structure.

3.4 Glasgow's Adult and Child Protection Committees have a Significant Case Review (SCR) Panel which is chaired by the Chief Officer or designated vice chair (currently the Assistant Chief Officer for Public Protection and Complex Needs). The protocol for SCRs can be accessed at the following link: https://www.glasgowchildprotection.org.uk/CHttpHandler.ashx?id=12887&p=0. The role of the panel is to oversee, on behalf of the committees, all matters relating to SCRs in accordance with SCR National Guidance.

4. Significant Case Reviews

4.1 In respect of Child B SCR, the dissemination plan is now complete and implementation of the action plan is in progress. This will be monitored by the Child Protection Committee (CPC) Quality Assurance Subgroup, with further reporting to the committee scheduled for April 2020. The second Glasgow CPC Neglect Summit took place as planned on 5th September 2019, with 230 delegates attending on the day. The event evaluated extremely well, with over 90% responding that it had been valuable to them and had increased their knowledge and understanding around the subject.

4.2 The CPC SCR into the child fatality in 2017 (known as Child D) is at the stage where learning points have been identified and the report is in the process of being written. Once completed and considered by the committee and Chief Officers Group (COG), action and dissemination plans will be drawn up and a decision will be made as to what may be published.

4.3 The Adult Protection Committee (APC) SCR on Adult A, who died while in receipt of 24 hour care, remains in progress. The Social Care Institute for Excellence's (SCIE) Learning Together model used for the review has, as noted previously, proven to be repetitive and time-consuming and has resulted in the review over-running its projected timescale.

4.4 In recognition of the delays caused by the introduction of the SCIE methodology framework an interim abbreviated report will be provided to the APC and CPC. This report will capture high level learning for Glasgow and ensure clearly defined actions are well articulated to adults and children's services.

4.5 Likewise, the APC SCR on Adult B who had been cared for at home also remains in progress and out with timescales for the same reasons.

4.6 Given the delays in completing the SCRs, the evaluation of the Learning Together model has not yet begun. It is anticipated that the findings of the evaluation will lean towards a recommendation that we do not adopt the model in its entirety. Rather, that we extract the positive elements of it to develop our own staged process which can be applied to a variety of situations. To this end, a new model of learning review has been commissioned by the SCR panel on a recent referral and consideration is being given to applying it to a new referral which demonstrates positive practice.

4.7 The Scottish Government launched the 'Interim National Framework for Adult Protection Committees for Conducting a Significant Case Review' on 5th November

2019. Essentially, it replicates the existing framework for APCs, upon which our local protocol is based.

5. Multi-Agency Public Protection Arrangements (MAPPA)

5.1 In Glasgow the MAPPA arrangements are significantly supported by the role of the MAPPA Co-ordinator, and governance is provided through the MAPPA Operational Group, the MAPPA Strategic Oversight Group (MOG and SOG) and the Chief Officers Group.

5.2 In the last update there was reference to an outstanding Initial Case Review (ICR) which involved a charge of murder. The MAPPA Strategic Oversight Group (SOG) met and agreed that there would not be merit in progressing to a Significant Case Review (SCR). This was following advice from Scottish Government. Over the last quarter there have been three Initial Notifications submitted to the MAPPA SOG Chair for consideration. In all three of these the decision was made not to progress any further. The information contained within the notification indicated that the cases had been robustly managed and that the offending could not have been prevented.

5.3 The MAPPA Annual Report was published on 1st November 2019 and to date there has been no media response to the publication. The Annual Report was presented to the Glasgow City Integration Joint Board on 20th November 2019: https://glasgowcity.hscp.scot/publication/item-no-15-multi-agency-public-protection-arrangements-mappa-annual-report-2018-19

5.4 Over the last quarter the actions from the MAPPA Audit Action Plan have been progressed. Training sessions have been delivered to Criminal Justice staff by the Risk Management Authority in relation to Risk Formulation and Risk Management as these were areas for development highlighted in the Audit. A training event was also delivered to Criminal and Youth Justice Staff which included an overview of MAPPA and the expectations of staff attending MAPPA meetings. Briefings have also been delivered to Criminal Justice Team Leaders in respect of the findings of the Audit, the action plan and their responsibilities.

5.5 Over the last quarter two SCRs have been published. One was in relation to a double murder committed by a Registered Sex Offender (RSO) in Fife and the other was in relation to the rape of a woman in Edinburgh by an RSO. Both these SCRs will be tabled at the MAPPA Operational Group to discuss implications if any for Glasgow.

6. Self-evaluation Activity

6.1 Child Protection Committee – The multi-agency casefile audit analysis is in progress. Preliminary findings indicate that initial screening and decision-making at Social Care Direct is generally very good, with referrals being passed to the area teams appropriately. 87% of the cases dealt with at area team level had evidence of multi-agency contact. In those cases which proceeded to child protection, 80% were deemed very good or excellent in terms of practice and decision-making. The Assessment of Care Toolkit training rollout is now complete and the evaluation process is underway. This will include electronic survey, focus group and toolkit audit activity.

6.2 Adult Protection Committee – The action plan for the audit of ASP investigations where a Paid Professional/Service Provider was identified as the source of harm has been completed and the tasks are in progress. This includes work with contracted service providers, which is being led by the Commissioning Team. The audit of the quality of chronologies in ASP investigations has concluded and the findings have been accepted by the Adult Protection Committee. The action plan to address the issues raised centres around increased provision of training and a review of management oversight of investigation processes. The annual audit of ASP practice is ongoing. The casefile reading is complete, with the data being analysed currently.

7. Assurance Areas

7.1 Workforce Registration

Workforce registration issues, including conduct and fitness to practice information are reported to the relevant Governance groups. Where necessary detail is also provided to the Integrated Clinical and Professional Governance Board. There are currently no outstanding workforce registration issues.

7.2 Healthcare Associated Infection

Matters associated with healthcare associated infection are routinely tabled during the integrated Clinical and Professional Governance Board. During the last quarter there has been nothing to report in this area.

8. Recommendations

8.1 The IJB Finance, Audit and Scrutiny Committee is asked to:

a) consider and note the report.

Appendix 1

Significant Clinical Incidents Quarterly Reporting July – September 2019

Service	Number of Significant Clinical Incidents Investigations Commenced between 1 July 2019 – 30 September 2019	Number of Significant Clinical Incidents Started prior to 1 July 2019	Number of Significant Incident Investigations Concluded between 1 July 2019 – 30 September 2019
Addictions	**1**	**11**	**2**
Children and Families	**0**	**4**	**0**
Homelessness	**0**	**2**	**1**
Mental Health Services	**9**	**25**	**10**
Older People and Primary Care	**0**	**2**	**0**
Prison Healthcare	**0**	**0**	**2**
Sandyford	**0**	**0**	**1**