Item No. 9

Meeting Date **Wednesday 9th December 2020**

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:	None

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 This report seeks to assure the Integration Joint Board that clinical and professional governance is being effectively overseen by the Integrated Clinical and Professional Governance Board, chaired by the Interim Chief Officer.

2.2 This report provides the IJB Finance, Audit and Scrutiny Committee with information collated up to September 2020 attached at Appendix 1 for easier scrutiny. This cover report also provides an opportunity to offer more detail on issues relating to particular incidents and cases.

2.3 The most recent quarterly clinical and professional assurance statement was provided to the IJB Finance, Audit and Scrutiny Committee in September 2020.

2.4 This report also provides assurance that clinical and professional governance arrangements remain a priority during COVID with adjustments made to ensure operational and strategic oversight arrangements remain in place.

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 NHS Greater Glasgow and Clyde continue to operate within the agreed Significant Clinical Incident (SCI) policy reporting framework and as such compliment and support Glasgow HSCP governance arrangements ensuring continuous learning and improvement. This policy defines SCI's as events that have or could have a significant or catastrophic impact on a patient, adversely affect the organisation and its staff and have potential for wider learning.

3.4 The SCI policy also describes a range of features that must be considered in establishing a SCI has occurred and that this policy framework should then apply. In general a SCI is a potentially avoidable untoward event which has had significant patient impact rated in accordance with perceived risk of significant harm to others (e.g. near miss).

Clarity on the risk matrix and rating can be obtained in the following link: Risk Matrix. The Risk Assessment Matrix is attached at Appendix 2 of this report.

3.5 SCI investigations must be conducted in accordance with the SCI policy with considerable focus on shared learning. The shared learning summary describes what can/should be done to prevent recurrence rather than highlighting the issue/problem. This information is subsequently disseminated across agreed governance arrangements within Glasgow and will often vary dependent on the circumstances which led to the incident.

3.6 Common themes that arise from SCI are summarised and considered within respective care group governance structures. Arrangements are currently in place to review the dissemination of common themes and shared learning across care groups ensuring organisational learning wherever possible.

3.7 More recently Glasgow has consolidated the principles of shared learning in the development of board wide child protection arrangements with the key purpose of continuous improvement based on findings from local investigations. Similar arrangements are under way to replicate this process within the context of adult protection.

4. Significant Case Reviews

4.1 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. Glasgow Significant Case Review Panel has continued to operate throughout COVID using teleconference or Microsoft Teams.

4.2 All learning from SCR's are governed through mandated Adult and Child Quality Assurance groups which have continued to operate throughout COVID. Learning drawn from SCR's inform precise work plans which are reviewed within QA groups and ensure adherence to agreed action points.

4.3 On completion of SCR it remains the responsibility for the CPC/ASPC (with Chief Officers approval) to decide whether to publish the full report or just the executive summary. Influencing such decisions will include considerations about the need to restore public confidence, protections within the Data Protection Act 1998, sensitivities and balancing interests in terms of the right to respect private family life detailed in Article 8 of the European Convention on Human Rights.

4.4 From 1st April 2012 the Care Inspectorate have been required to produce triennial summary reports regarding national findings from SCR's and considered via Glasgow CPC/ASPC committees and local governance arrangements. The first of these reports was made available in 2016 based on a review of SCR's between 2012-2015.The most recent report was made available in 2019 based on the findings from SCR's during 2015-2018.

4.5 There are currently **four SCR**s to note in this quarterly assurance statement, two for Children's Services (Child D and Child E) and two for Adult Services (Adult A and Adult B)**.**

4.6 For the Child D SCR, the report has been completed and is progressing through governance processes with planning on the dissemination of learning.

4.7 The Child E SCR is ongoing and the review team are exploring the best methods for engaging the professional team involved with the child given the current restrictions.

4.8 The Adult A SCR is nearing completion and learning points have been identified.

4.9 The Adult B SCR report is completed and is progressing through governance processes with planning on the dissemination of learning.

4.10 There are three Initial Case Reviews underway, two in child protection and one in adult support and protection.

4.11 The evaluation of the dissemination of learning from the Child B SCR is complete, and the salient points around effective sharing of learning and the impact on practice is being discussed at relevant forums. The findings from this activity will help inform the work on improving learning from practice.

4.12 Work is ongoing on strengthening the interface between the various learning and review processes, with a working group established to direct and oversee these tasks.

4.13 There is presently a national consultation on Guidance for Undertaking Learning Reviews (which will replace the current SCR guidance). The implications for Glasgow will be considered at the forthcoming SCR Panel development session.

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. Both the MOG and SOG have continued to operate throughout COVID retaining the necessary governance arrangements.

5.2 Over the last reporting period there has been eight Initial Notifications submitted to the MAPPA SOG Chair for consideration. 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 Scottish Government advised that MAPPA Annual Reports would be published as normal this year on 13th November 2020. The Annual Report was presented to Glasgow City IJB on 25 November 2020. The information contained within this year's Annual Report when compared with the information of the previous year highlights that the number of RSOs are increasing. In 2019 Glasgow had 586 RSOs in the community whereas the following year this had increased to 647. This increase is replicated across the country and not unique to Glasgow. Performance remains high and in exceeds National targets.

5.4 The MAPPA budget received additional funding this year from Scottish Government with a stipulation that the money should be spent either promoting VISOR or supporting the work of the MAPPA Coordinator. Representatives from the Responsible Authorities met and the agreement was that the money would be spent employing a MAPPA Resource Worker to provide and collate statistical information in relation to MAPPA which is required for Scottish Government. It would also allow better planning for priorities in MAPPA and the post holder would assist with Audit Work. The Job Profile has be submitted.

6. Self-evaluation Activity

6.1 Glasgow Child Protection Committee and Adult Support Committee have continued to receive the weekly data report at each meeting, and this is being used to identify emerging themes for further analysis.

6.2 The number of Initial Referral Discussions in child protection has increased since March, and is proving to be a pressure point for social work, police and health resources. The HSCP Child Protection Team are engaged in an evaluation of this.

6.3 Prior to COVID-19, the weekly average for Mental Health Officer detentions was 20. By week 12 of the lockdown period, this had risen to 24 and by week 21 this had increased to 30. The number of children placed on the Child Protection Register with a risk indicator of parental mental health has also increased. During 2018 – 2020, the percentage with this risk indicator was between 14 and 19%. By week 21 of pandemic restrictions, this had reached 30%. The number of Vulnerable Persons reports recorded by Police Scotland has risen by 39% during that period, with anecdotal evidence that much of this is due to people experiencing mental and emotional distress. These changes were discussed at both the Adult Support & Protection and Child Protection Committees. It was agreed that two thematic reviews would be undertaken into the increases in Mental Health Officer detentions and use of Parental Mental Health as a risk indicator in child protection registration. There are likely to be cross-cutting themes between the two reviews, therefore there will be cross-referencing throughout (including the samples) and the reports will form part of a self-evaluation package.

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 2020

Service	Number of Significant Clinical Incidents Investigations Commenced in reporting period (1 July – 30 September 2020)	Number of Significant Clinical Incident Investigations Concluded in reporting period (1 July – 30 September 2020)	Number of active Significant Clinical Incidents
Addictions	0	3	11
Children and Families	3	0	5
Homelessness	0	0	3
Mental Health Services	7	7	23
Older People and Primary Care	1	2	1
Prison Healthcare	2	0	5
Sandyford	1	0	2

Appendix 2

NHSScotland Risk Assessment Matrix

Descriptor	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Patient Experience	**Reduced quality of patient experience/clinical outcome not directly related to delivery of clinical care.**	**Unsatisfactory patient experience/ clinical outcome directly related to care provision – readily resolvable.**	**Unsatisfactory patient experience/ clinical outcome; short term effects – expect recovery <1wk.**	**Unsatisfactory patient experience/ clinical outcome; long term effects – expect recovery >1wk.**	**Unsatisfactory patient experience/ clinical outcome; continued ongoing long term effects**
Objectives / Project	**Barely noticeable reduction in scope, quality or schedule.**	**Minor reduction in scope, quality or schedule.**	**Reduction in scope or quality of project; project objectives or schedule.**	**Significant project over-run.**	**Inability to meet project objectives; reputation of the organisation seriously damaged.**
Injury (physical and psychological) to patient/visitor/ staff.	**Adverse event leading to minor injury not requiring first aid.**	**Minor injury or illness, first aid treatment required.**	**Agency reportable, e.g. Police (violent and aggressive acts).** **Significant injury requiring medical treatment and/or counselling.**	**Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling.**	**Incident leading to death or major permanent incapacity.**
Complaints / Claims	**Locally resolved verbal complaint.**	**Justified written complaint peripheral to clinical care.**	**Below excess claim.** **Justified complaint involving lack of appropriate care.**	**Claim above excess level.** **Multiple justified complaints.**	**Multiple claims or single major claim** **Complex justified complaint**
Service / Business Interruption	**Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service.**	**Short term disruption to service with minor impact on patient care.**	**Some disruption in service with unacceptable impact on patient care.** **Temporary loss of ability to provide service.**	**Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked.**	**Permanent loss of core service or facility.** **Disruption to facility leading to significant "knock on" effect**
Staffing and Competence	**Short term low staffing level temporarily reduces service quality (< 1 day).** **Short term low staffing level (>1 day), where there is no disruption to patient care.**	**Ongoing low staffing level reduces service quality.** Minor error **due to ineffective training/implementation of training.**	**Late delivery of key objective / service due to lack of staff.** Moderate error **due to ineffective training/implementation of training.** **Ongoing problems with staffing levels.**	**Uncertain delivery of key objective/ service due to lack of staff.** Major error **due to ineffective training/ implementation of training.**	**Non-delivery of key objective/service due to lack of staff.** **Loss of key staff.** Critical **error due to ineffective training/ implementation of training.**
Financial (including damage / loss / fraud)	**Negligible organisational/ personal financial loss. (£<1k).** (NB. **Please adjust for context)**	**Minor organisational/personal financial loss (£1-10k).**	**Significant organisational/personal financial loss (£10-100k).**	**Major organisational/personal financial loss (£100k-1m).**	**Severe organisational/personal financial loss (£>1m).**
Inspection / Audit	**Small number of recommendations which focus on minor quality improvement issues.**	**Recommendations made which can be addressed by low level of management action.**	**Challenging recommendations that can be addressed with appropriate action plan.**	**Enforcement action.** **Low rating.** **Critical report.**	**Prosecution.** **Zero rating.** **Severely critical report.**
Adverse Publicity / Reputation	**Rumours, no media coverage.** **Little effect on staff morale.**	**Local media coverage – short term. Some public embarrassment.** **Minor effect on staff morale/public attitudes.**	**Local media – long-term adverse publicity.** **Significant effect on staff morale and public perception of the organisation.**	**National media/adverse publicity, less than 3 days.** **Public confidence in the organisation undermined.** **Use of services affected.**	**National/international media/adverse publicity, more than 3 days.** **MSP/MP concern (Questions in Parliament).** **Court Enforcement.** **Public Inquiry/ FAI.**