Item No. 12

Meeting Date **Wednesday 19th February 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 Chief Officer.

2.2 This report provides the IJB Finance, Audit and Scrutiny Committee with information collated up to December 2019 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 2019.

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: https://glasgowcity.hscp.scot/sites/default/files/publications/Significant%20Clinical%20Incidents%20%20Policy.pdf. 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 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 arrangement are under way to replicate this process within the context of adult protection.

3.7 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 There are currently **four SCR**s to note in this quarterly assurance statement, two for Children's Services and two for Adult Services**.**

4.2 In respect of the Child B SCR, implementation of the action plan is almost complete with a progress update to the Child Protection Committee (CPC) scheduled for April 2020. An evaluation of the impact of dissemination of learning from the review is being planned, the primary component of which will be a multi-agency electronic survey.

4.3 For the Child D SCR, the learning points have been identified and it is projected that the report will be concluded in April with learning disseminated thereafter.

4.4 The two SCRs relating to Adults A and B remain ongoing. These have taken longer than anticipated due to the implementation of the new Learning Together model. It is projected that the reports will also be concluded by April 2020 with learning disseminated thereafter.

4.5 Work is currently underway via the respective Child/Adult Quality Assurance groups to ensure cohesive learning is obtained from all of the HSCP learning review processes ensuring integrated learning is achieved wherever possible.

4.6 Most reviews are based on a deficit model with the opportunities to learn from positive interventions and outcomes often being overlooked. More recently we have initiated a review of learning processes in order to enhance and streamline learning methods and culture in the city which has resulted in the commissioning of a learning review which will focus on best practice examples.

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 Over the last quarter there have been **six Initial Notifications** submitted to the MAPPA SOG Chair for consideration. In four of these the decision was made not to progress any further. The information contained within the notifications indicated that the cases had been robustly managed and that the offending could not have been prevented. However in two of the notifications, given the severity of the further offending (attempted murder and rape), Initial Case Reviews have been requested to further examine the management of the offenders. These reviews once completed will be considered by the SOG and a decision made as to what action to take.

5.3 The MAPPA Development Day will take place on 20th February 2020 at Hampden Stadium. Attendees will include Social Work, Police Scotland, Scottish Prisons Service, Health and key Voluntary Organisations. The day will include workshops on the Significant Case Review process, Learning Disability and Sexual Offending, Young People and Sexual Offending, Paraphilia's and Risk.

5.4 In the last update there was reference to two SCRs which had been published (one by Fife HSCP and the other by Edinburgh HSCP). The MOG and SOG have since met and reviewed the findings and actions from these SCRs. It was agreed that there was one recommendation from the Fife SCR that had relevance for Glasgow which was to review the MAPPA Level 1 process and paperwork. A meeting has been arranged with Level 1 MAPPA Chairs to review the MAPPA Level 1 minute template. With regards to the Edinburgh SCR the only relevant recommendation was in relation to Order of Lifelong Restrictions (OLR) and improved clarity on assessment process. Criminal Justice Service Managers were tasked with discussing this at Team Meetings. A further SCR was published by Fife in the last quarter which relates to a MAPPA Extension offender who had access to the Community on Home Leave and whilst on Home leave committed an Attempted Murder. The findings from this SCR will be reviewed at the MOG and SOG to consider implications for Glasgow.

6. Self-evaluation Activity

6.1 Child Protection Committee – The evaluation of the Assessment of Care Toolkit training rollout continues. The focus group with trainers is complete, with the majority expressing their enthusiasm to continue to deliver the training. The electronic survey for recipients has been designed and is due to launch at the end of January 2020. The focus of the survey is the impact of the training on the individuals' knowledge and understanding of neglect, their practice with children and families, and outcomes for children. There is also work ongoing in the three localities to evaluate and improve the quality of chronologies, which will be reported to the committee.

6.2 Adult Protection Committee – In respect of the Paid Professional/Service Provider audit action plan, work with contracted service providers continues with an audit of service providers' whistleblowing/reporting concerns policies about to commence. Briefings on principles and quality of chronologies are being provided in localities, and the audit will be repeated in September 2020 to measure improvement. The tripartite Adult Support and Protection audit is now complete and the report will be presented to the committee. The analysis of the casefile reading has highlighted a number of strengths in practice, and some issues which will require improvement activity.

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 - October - December 2019

Service	Number of Significant Clinical Incidents Investigations Commenced in reporting period (1 October – 31 December 2019)	Number of active Significant Clinical Incidents	Number of Significant Clinical Incident Investigations Concluded in reporting period (1 October - 31 December 2019)
Addictions	1	10	3
Children and Families	0	5	0
Homelessness	0	0	1
Mental Health Services	4	29	8
Older People and Primary Care	2	2	0
Prison Healthcare	3	0	0
Sandyford	1	0	0

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.**