Item No. 12

Meeting Date **Wednesday 14th April 2021**

Glasgow City
Integration Joint Board
Finance, Audit and Scrutiny Committee

Report By: **Susanne Millar, Chief Officer**

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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.

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 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 December 2020.

2.4 This report also provides assurance that clinical and professional governance arrangements remain a priority during COVID-19 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 Since the previous reporting period NHS Greater Glasgow and Clyde have reviewed the Significant Clinical Incident (SCI) policy. In this regard the changes can be summarised as follows;

- SCIs will now be referred to as Serious Adverse Events (SAEs)
- The Rapid alert and Severity 4/5 template have been amalgamated into a Briefing Note template (attached at Appendix 2). The Report template has changed and the old template should not be used for Significant Adverse Event Reports (SAERs) commissioned after 1st October 2020.
- The accident causation model will no longer be required, this has been replaced by the updated timeline.
- The toolkit has been updated, referring to the documents on Staffnet and there are now less templates to complete and more guidance/checklists provided.
- Feedback from Patients/Families involved in SAERs will be obtained.

3.5 Significant Adverse Event investigations must be conducted in accordance with the 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.

4. Significant Case Reviews

4.1 There are currently four SCRs 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).

4.2 The Child D SCR has been presented to the Child Protection Committee (CPC) and the findings have been accepted. The Quality Assurance Subgroup has been charged with devising a strategy for the dissemination of learning points and the action plan to address the findings.

4.3 The Child E SCR is underway, and engagement with the staff group has begun.

4.4 The Adult A SCR is now complete and a committee meeting is being arranged to consider the findings.

4.5 The Adult B SCR has been presented to the Adult Support & Protection Committee (ASPC) and the findings have been accepted. The Quality Assurance Subgroup has been charged with devising a strategy for the dissemination of learning points and the action plan to address the findings.

4.6 The three complete SCR reports will be presented to the next Chief Officers Group.

4.7 The Committees' Support Team is liaising with the Communications Team and Press Office to develop a publication strategy.

4.8 Dissemination of learning will continue to adapt to COVID-19 related working arrangements and work remains underway via ASPC and CPC on effective training and learning delivery. '7 minute briefings' (attached at Appendix 3) have also been developed to ensure the workforce receive headline learning associated with SCRs and where necessary SCIs which will compliment a more comprehensive strategy.

5. Multi-Agency Public Protection Arrangements (MAPPA)

5.1 Over the last reporting period there has been three Initial Notifications submitted to the MAPPA Strategic Oversight Group (SOG) Chair for consideration. The decision was made not to progress any further in all three notifications. However there was a requirement for the Lead Agency (Justice Social Work) to provide additional information in one case which was required before the SOG Chair could make a decision. A number of Initial Notifications submitted by Justice Social Work over the past six months have highlighted that they would benefit from a guide or prompt as to the key information required when submitting these reports. This will be taken forward through the MAPPA Operational Group (MOG).

5.2 The Scottish Government confirmed that that the publication date for the MAPPA Annual Reports was 13th November 2020 at 10.00am. Glasgow published their report at this time and so far the Annual Report has not received any media interest.

5.3 The MAPPA budget received additional funding this year from the Scottish Government and it was agreed that the funding should be spent on a MAPPA Resource Worker. This post has been advertised and will support greater data analyses informing continuous improvement in response to national and local trends.

5.4 COVID-19 has presented significant challenges for MAPPA in the way that we deliver training because of the varying degrees of access that partners have to Microsoft Teams. This has meant that we have had to consider different ways to deliver training and as such we are working to deliver Risk Management Training which will commence this year. The format we are using places greater emphasis on Senior Managers to oversee the training.

6. Self-evaluation Activity

6.1 Glasgow Child Protection Committee (CPC) and Adult Support & Protection Committee (ASPC) have continued to receive the weekly data report also used to inform the Scottish Government of changing trends during COVID-19. Committees continue to reflect on this and identify emerging themes for further analysis.

6.2 The two thematic reviews (Mental Health Officer Detentions/Parental Mental Health as a risk indicator in child protection registration) are underway, with review groups comprised of HSCP staff.

6.3 The CPC has noted an overall reduction in the number of children subject to child protection registrations and further monitoring and analysis will be undertaken.

6.4 The Care Inspectorate has advised that it will be resuming its planned programme of inspection activity. Glasgow was listed in the previous Phase 1 of the programme for ASP inspection. In order to plan and prepare for eventual inspection, multi-agency oversight and operational groups have been established.

6.5 The number of Initial Referral Discussions (IRD) continues to be challenging for police, health and social work. Pre-COVID levels averaged just under 20 per week but the number now sits around the mid 20's and can be as high as 30 per week.

6.6 A weekly planning meeting is held between health, police and social work to oversee the IRD process and put plans in place to manage the weekly demand.

6.7 In addition, a small number of IRD's are quality assured by the multi-agency group to ensure quality assurance on an 8 weekly cycle.

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 Adverse Event Review Quarterly Reporting
October – December 2020

Service	Number of Significant Adverse Event Reviews Commenced in reporting period (1 October – 31 December 2020)	Number of Significant Adverse Event Reviews Concluded in reporting period (1 October – 31 December 2020)	Number of active Significant Adverse Event Reviews
Addictions	0	1	10
Children and Families	6	1	12
Homelessness	0	0	3
Mental Health Services	6	4	35
Older People and Primary Care	1	0	3
Police Custody Healthcare	1	0	1
Prison Healthcare	2	1	7
Sandyford	0	0	3

In October 2020, the Significant Adverse Event Review Policy replaced the previous Significant Incident Policy (SCI).

Appendix 2

Briefing Note

Mandatory for all severity 4 or 5 incidents

Datix ID		**Incident Date**	
Directorate/Service		**Division**	
Speciality		**Site/Base**	
CHI		**Patient Outcome**	
Note Completed By		**Date Completed**	

Summary of Incident
- **What** happened, **when**, **where**, **roles** of those involved, who reported it and to whom, including detail of any concerns and issues that were evident. Management teams may find it beneficial to request statements from those staff involved in the incident. These may be used to aid any subsequent investigation. - Any **pertinent background information** related to the situation e.g. patients admission dates, interventions/procedures, previous medical history, etc. - **Severity of the incident** (injury requiring further treatment, long term incapacity/disability, extreme impact resulting in death or major incapacity If this incident involved a Mental Health Patient, what was their legal status?
Departments Contacted Following the Incident

SAE Assessment Questions	**Yes**	**No**	**Unknown**
Is this a duty of candour incident?	☐	☐	☐
Was there a problem with any equipment involved in this case?	☐	☐	☐
Has there been a breach of policy or procedure?	☐	☐	☐
Could something have been done differently in this case that may have prevented the event?	☐	☐	☐
Is there any learning to be gained from investigating this event? (Would something be done differently next time?)	☐	☐	☐
Are there any patient / family concerns regarding the treatment/care/outcome?	☐	☐	☐
Are there any management concerns related to the event or individuals involved?	☐	☐	☐
Is there currently any interest from the Procurator Fiscal?	☐	☐	☐
Do you believe this event was avoidable?	☐	☐	☐
Please describe any other investigations that this incident has/will be subject to			
Will this incident progress to SAE Review?	☐	☐	

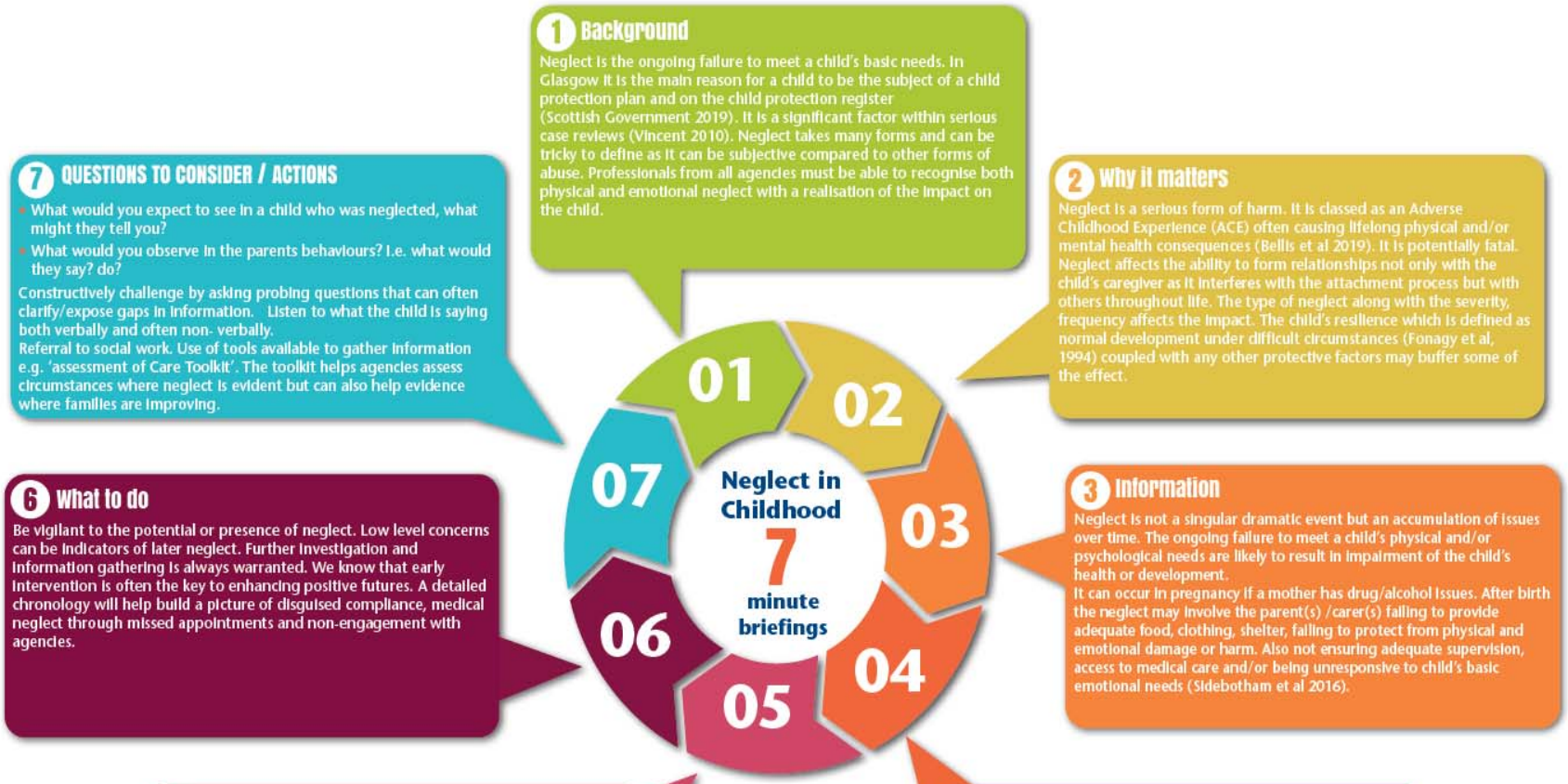
If you have answered "Yes" to any of the assessment questions or if there are a significant number of unknowns about the case, consider escalating to SAE Review. If this is a Duty of Candour event then an SAE Review is mandatory.

Rationale *Provide a clear reason below if the decision is to **NOT** proceed to SAE Review*	
Consultation *List name and role below of those involved in the decision making*	
Approved by	
Date	

Please include Clinical Risk in the distribution of this alert, who will in turn attach it to Datix.

Send to: clinical.risk@ggc.scot.nhs.uk

Neglect in Childhood-A Seven Minute Briefing



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