Item No. 15

Meeting Date **Wednesday 8th September 2021**

Glasgow City Integration Joint Board Finance, Audit and Scrutiny Committee

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

Contact: **Pat Togher, Assistant Chief Officer, Public Protection and Complex Needs**

Phone: **0141 276 5756**

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

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 June 2021 (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 June 2021.

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.

4. Significant Case Reviews (SCRs)

4.1 In respect of the Child D SCR, the redacted version has been produced and is published on the Child Protection Committee's website. Learning events are planned to disseminate the learning and allow multi-agency discussion of the implications for practice.

4.2 The Child H SCR is progressing, and key themes have been identified.

4.3 The Adult A SCR is now complete, and the findings have been accepted by the committee. The report will be presented to the next Chief Officers Group.

4.4 The redacted version of the Adult B SCR report is complete and has been published on the Adult Support and Protection Committee's website. Learning events are planned to disseminate the learning and allow multi-agency discussion of the implications for practice.

4.5 The Learning Review Panel (previously the SCR Panel) has commissioned a thematic review of the deaths of four older young people under similar circumstances.

5. Multi-Agency Public Protection Arrangements (MAPPA)

5.1 Glasgow has had one Initial Case Review (ICR) in the past reporting period which was in respect of a Cat 1 Level 1 MAPPA offender who has been charged with a sexual assault and murder of a female. Given the severity of the offence and the potential media scrutiny, Glasgow Strategic Oversight Group (SOG) have made the decision to progress this to an SCR. Glasgow SOG is in the process of setting the Terms of Reference for the SCR and identifying someone to take on this task.

5.2 National Systems have forwarded the updated MAPPA figures for the reporting period 1 April 2020 until 31 March 2021. For the first time it would seem that the total number of sex offenders managed by Glasgow has declined. The figures provided on 31 March 2020 indicates that there were 894 MAPPA Registered Sex Offenders whereas on 31 March 2021 this had reduced to 859.

5.3 The number of MAPPA Level 2 offenders has remained fairly static as has the number of Level 3 MAPPA offenders. This information will be expanded for the Annual Report which will be published later this year. Scottish Government have still to confirm a publication date.

5.4 The new MAPPA Coordinator for Glasgow took up post on 9 August 2021. Her name is Jennifer Butler and she has a background in psychology having previously worked at HMP Barlinnie.

5.5 There is no update in relation to when the new MAPPA Guidance will be published although it is expected to be later this year.

6. Self-evaluation Activity

6.1 Review of the Initial Referral Discussion (IRD) process continues and a test of change is currently underway introducing a daily triage of notification concerns forms. Police, social work and health are involved in reviewing the referrals and agreeing what needs to progress to IRD. This process is due to be reviewed, but to date the triage is reducing the number of referrals requiring IRD and timescales have been reduced for those case that meet the threshold for IRD.

6.2 Multi agency IRD audit takes place on an 8-weekly cycle.

6.3 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.

6.4 The thematic reviews of the increases in parental mental health as a risk indicator in child protection registration and Mental Health Officer detentions are complete. They have been presented to the committees and Chief Officers, and 7-minute briefings have been devised to summarise the key points.

6.5 The rapid reviews of the decrease in neglect as a risk indicator in child protection registration and the children with 3+ periods of child protection registration are complete and have been presented to the Child Protection Committee Quality Assurance group.

6.6 Preparation and planning for the forthcoming external inspection of Adult Support and Protection by the Care Inspectorate continues, and a workplan has been devised.

6.7 Areas identified for future self-evaluation activities are:

- The impact of the rollout of Assessment of Care Toolkit training
- ASPC/CPC Learning & Development Programme
- Quality of chronologies
- Dissemination of learning from SCRs

6.8 An internal audit of Adult Support and Protection (ASP) referrals progressed via the respective ASP Duty Teams (North East, South, and North West), involving a sample of 60 cases at Duty to Inquire stage. This will provide greater scrutiny on how each Duty Team progresses ASP referrals in line with the Duty Protocol which was introduced in 2019. The audit tool has been based on the approach taken by the Care Inspectorate in their thematic inspection of Six Local Authorities, but also includes specific questions linked to duty arrangements. The aim will also be to strengthen duty arrangements for supporting and protecting adults at risk of harm.

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
April - June 2021

Service	Number of Significant Adverse Event Reviews Commenced in reporting period (1 April– 30 June 2021)	Number of Significant Adverse Event Reviews Concluded in reporting period (1 April – 30 June 2021)	Number of active Significant Adverse Event Reviews
Addictions	0	0	8
Children and Families	1	0	14
Homelessness	1	0	4
Mental Health Services	15	4	50
Older People and Primary Care	1	0	5
Police Custody Healthcare	0	0	1
Prison Healthcare	0	0	9
Sandyford	0	0	2

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