Item No. 16

Meeting Date **Wednesday 8th February 2023**

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 considered by relevant staff groups.

Governance Route:	The matters contained within this paper have been previously considered by the following group(s) as part of its development. HSCP Senior Management Team ☐ Council Corporate Management Team ☐ Health Board Corporate Management Team ☐ Council Committee ☐ Update requested by IJB ☐ Other ☐ Not Applicable ☒

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:	None
Equalities:	None
Fairer Scotland Compliance:	None
Financial:	None
Legal:	None
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's Finance, Audit and Scrutiny Committee 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 information collated up to December 2022 (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 Committee on 14 December 2022.

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
- Adult Clinical and Care Governance Group
- Mental Health Quality & Clinical Governance Committee
- Police Custody Healthcare Clinical Governance Committee
- Prison Healthcare Clinical Governance Committee
- Homelessness Care Governance Group
- Sexual Health 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) / Learning Reviews and Significant Adverse Event Review (SAER) Activity Summary

4.1 **Adult B Action Plan –** The Quality Assurance (QA) Sub-group will seek agency updates regarding the implementation of the Adult B Action Plan early in 2023 and consider the impact on practice development. The themes from

both Significant Case Reviews (Adult A and Adult B) will also help to inform the refresh of Council Officer training (currently underway).

4.2 **Adult A Action Plan –** Work is ongoing to implement the Adult Action Plan/ disseminate learning. This includes the recent planning and delivery of Practice Development Sessions (Local Management Reviews) within the three main Social Work areas (early December 2022) based around the key themes. This involved a multi-agency audience and presentations by Willie Munro (HSCP Service Manager, and one of the lead Reviewers in the Adult A SCR), and Julie Fitzpatrick (Professional Nurse Lead, Specialist Learning Disability Services). The events also included small group discussions led by identified facilitators and focused on key improvement points identified within the SCR and use of the Learning Pack resources to help ensure a consistent approach to disseminating the learning. Work is ongoing to evaluate these events and compile a Summary Report that will be submitted to the QA Sub-group for consideration and monitoring purposes. Similar briefings will be held for frontline and provider staff, again based around the Learning Pack materials. A Short Life Working Group has also been convened to explore ways of strengthening communication for adults with complex needs at the point of key transitions (such as admission to acute) and improving understanding of respective roles and responsibilities. The Working Group will look to drive forward improvement actions and reflect outcomes within an updated Action Plan which will be shared via related governance arrangements (including the QA Subgroup).

4.3 Following presentation of the previous quarterly assurance statement to Committee, comments were received regarding increased SAER activity in mental health. We can report that SAERs are frequently related to complex, multifactorial issues that require reviewing several months or years of care, for this reason they have always taken longer to complete and can maintain higher figures of open cases for that reason. This compares with a SAER in acute services which may arise from a single incident of care (e.g., incorrect medicine administered, or a shorter admission period). Reviewers looking at a surgical admission may only be reviewing 2 or 3 days of care with limited staff input.

In addition, Mental Health patient groups are often highly complex involving multiple agencies, and the nature of positive risk taking means there are often situations where patients are at risk (appropriately so) which require careful review. Patients are involved with multiple staff members in a Multidisciplinary Team (MDT) all of whom require interview, which again adds to time and complexity of review.

4.4 **Learning Review Protocol –**

- The joint Learning Review with South Lanarkshire Child Protection Committee is complete and is currently going through governance processes prior to publication.
- A newly created Service Manager post (being recruited to) will strengthen governance arrangements in this crucial area of practice. This will include providing additional capacity for undertaking Learning Reviews and achieving more robust timescales for completion, which in turn, will help drive practice improvements.

- The committees' Quality Assurance Subgroups will be reviewing the progress of implementation of the multi-agency action plans arising from the learning identified in the Adult B and Child D SCRs.
- Practitioner participation in the Child H and Child S Learning Reviews is complete and the review reports are anticipated.
- Two Thematic Learning Reviews are underway (care-experienced young people/exposure to domestic abuse) plus a scoping exercise for a third (maternal deaths).

5. Multi-Agency Public Protection Arrangements (MAPPA)

5.1. MAPPA Glasgow continues to meet performance indicators outlined within the National MAPPA Guidance (2022).

5.2. Since the last report, the number of Registered Sex Offenders and Extension cases managed at level 2 and 3 have remained static.

5.3. The Significant Case Review commissioned by the Glasgow Strategic Oversight Group (SOG) is complete and in the process of final redactions in advance of publication. The final report will be circulated to IJB members.

5.4. The national ViSOR information sharing agreement implementation has been extended until the introduction of MAPPS (replacement for ViSOR) in May 2024, this will enable further consultation and planning to occur.

5.5. From 1st January 2023, Police inputting into ViSOR on behalf of responsible authorities ceased. There are risks and resource implications because of this decision, however local plans have been developed to mitigate this risk.

5.6. The Glasgow Annual MAPPA report was published on 14th November 2022.

6. Self-evaluation Activity

6.1 A Tripartite Audit of Adult Support and Protection (ASP) arrangements commenced week beginning 28th November 2022. This includes 50 Health, Social Work and Police records being subject to closer scrutiny based on a detailed audit tool that closely resembles that used by the National ASP Inspection programme. The audit tool has also been amended to place particular scrutiny on service user participation and chronology recording, as they were identified as key areas for improvement in the recent external Inspection. Focus Groups will also be convened as part of a wider approach to the Tripartite Audit and will be looking to engage frontline staff more actively in our improvement agenda. Audit findings will be available around early February 2023.

6.2 The public protection committee team has completed an evaluation of the ASP conference held on 2nd November 2022. Responses indicate that the event was viewed very positively by attendees, including those who accessed it online.

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.

7.3 **Publication of the Revised ASP Code of Practice –** A national pilot has been undertaken involving five Partnership areas, overseen by the Scottish Government, to help promote more consistent reporting of ASP data across local authorities, and greater opportunity for bench-marking and identification of trends. The wider roll-out will commence in 2023 and will eventually replace current reporting arrangements, including the SOLACE reporting, and will involve quarterly reports. Further national discussions are planned to help provide fuller details of the new reporting arrangements, prior to roll-out

7.4 **Launch of a new Health and Social Care Connect Service** - Work is ongoing to actively monitor transition arrangements for ASP referrals including a weekly file reading exercise and related meetings to quality assure and strengthen governance arrangements, during the early transition period.

8. Child Protection Updates

8.1 **National Guidance for Child Protection in Scotland 2021 was published in September 2021**

- The child protection team have developed an implementation plan that will include an update of the Glasgow Child Protection Procedures based on the information contained in the national guidance and the findings from the consultations.
- A succession of consultations has taken place with children and families staff from the HSCP representative of the citywide teams across Children's Services staff groups and grades. Heads of Service also attended the consultation.
- A working group has been established led by the Principal Officer, Child Protection, to take this forward. The outcome will be a robust implementation of updated Child Protection Procedures.
- The working group has completed the first draft of Glasgow's Child Protection Procedures, in consultation with partner agencies. The final draft will be circulated across the HSCP and partners for consultation.
- Concurrent to this, there is a plan to consult with our partners in the child protection sphere, to hear their experience of the process and listen to any suggestions that would enable Glasgow to promote best practice.
- The Social Work Practice Audit Team have begun their audit of Child Protection (CP) practice, which has been approved at the QA Sub Group and Child Protection Committee. It is anticipated that this comprehensive audit of CP will be completed within 12 to 14 weeks, and will help to inform CP practice in the city.

8.2 **Interagency Referral Discussions (IRD)**

- This remains an area of priority for the child protection team along with colleagues from the HSCP and partners from Police Scotland, Health and Education.
- We are currently undertaking along with Police and Health colleagues a review of the IRD Triage Pilot, and a sampling of 45 IRD's that took place over a four week period in August/September 2022.
- Update of the IRD guidance will be undertaken jointly with partners following an agreed piece of audit work. This will reflect developments in practice with regard to IRD, and the inclusion of Education Services in the IRD process. Additionally, the National Guidance sets out an expectation that IRD's will now be held in the context of:

    - CP Pre-birth assessment
    - Accumulation of concern
    - 16 to 17 year old young people

8.3 **Scottish Child Interview Model (SCIM)**

- The Glasgow Child Interview Team (GCIT) was established in October 2021. This is a joint team of social workers and police officers who are trained in the SCIM model, and has begun to implement this model of joint investigative interview.
- The GCIT currently undertake 50% of the Joint Investigative Interviews in the city, and there is an ongoing recruitment plan in place to reach the aspiration for all children in Glasgow to be interviewed using this model.
- There is oversight of the implementation of the model and the team via the Strategic, and Operational, groups established to take forward and roll out the model across Glasgow.

8.4 **Devolved Decision Making (DDM) Pilot**, National Referral Mechanism, (NRM)

- There has been agreement that Glasgow's participation in the pilot will be extended for a further year, until March 2024. Ten further local authorities in Scotland had noted interest in being part of the pilot, as the Home office were seeking a further 10 sites across the UK. However, disappointingly, no other local authority in Scotland was successful.
- There is an ongoing programme of training from the Home Office for DDM decision makers, to ensure there is ongoing capacity for decision makers for the future.
- The feedback we have received from the Home Office to date remains positive, in that the quality of the decisions Glasgow are making are above average. We have also improved on our timescales for organising meetings and returning decisions to the Home Office, which we hope to achieve through the additional training for decision makers.
- Practitioners appear to be more confident in their assessments in identifying child exploitation and trafficking, and the number of referrals have increased over the second year and include young people who are sexually and/or criminally exploited.
- The practice audit team are working on our own evaluation of the pilot as we are aware, being the only Scottish Authority, the learning from the Ipsos Mori report is likely to be more reflective of the English and Welsh authorities who make up the majority of the cohort.
- In terms of training to the wider staff groups and partners:

- in year one we ran awareness raising training sessions to all staff and were able to assist Scottish Fire and Rescue in developing bespoke training for their staff with the assistance of Barnardo's.
- in year two, we have focused on Deep Dive sessions focused on Trafficking and Exploitation, which to date have included Ukraine- Spotting the Signs, and most recently Cyber Trafficking.

9. Recommendations

9.1 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 2022

Service	Number of Significant Adverse Event Reviews Commenced in reporting period (1 October – 31 December 2022)	Number of Significant Adverse Event Reviews Concluded in reporting period (1 October – 31 December 2022)	Number of active Significant Adverse Event Reviews Ongoing as at 31 December 2022
Addictions	2	0	7
Children and Families	1	2	22
Homelessness	0	1	1
Mental Health Services	8	6	53
Older People and Primary Care	1	3	14
Police Custody Healthcare	0	0	1
Prison Healthcare	1	0	13
Sandyford	1	2	2