Item No. 17

Meeting Date **Wednesday 12th June 2019**

Glasgow City
Integration Joint Board
Finance, Audit and Scrutiny Committee

Report By: **Susanne Millar, Interim 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:	None

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:	N/A
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 The Integration Joint Board previously considered and approved in June 2016 a statement format for the provision of specific and routine information with which the Integration Joint Board can be assured that clinical and professional governance is being effectively overseen by the Integrated Clinical and Professional Governance Board, chaired by the Chief Officer. The report can be found at the following link: https://glasgowcity.hscp.scot/publication/item-no14-clinical-professional-assurance-statement

2.2 Quarterly clinical and professional assurance statements were subsequently provided to the IJB Performance and Scrutiny Committees and on 6th February 2019 a statement was made to the full IJB. The link to the most recent statement is available at the link below.

6th February 2019 Statement

2.3 This report provides the IJB Finance, Audit and Scrutiny Committee with the information as agreed within the June 2016 report. Since March 2017 the statements have been presented slightly differently. The format continues to be reviewed with the key information collated up to March 2019 attached in a separate Appendix (Appendix 1) to allow for easier scrutiny. This cover report provides an opportunity to offer more detail on issues related to particular incidents and cases.

2.4 The number of Significant Clinical Incidents (SCIs) in Mental Health Services may seem high however it should be noted that:

- Mental Health Services have a policy of investigating all suicides by people who had contact with Mental Health Services within a year of death: that comprises about 2/3 of the Mental Health SCIs.
- There has not been a significant change in SCI numbers in recent years.
- Despite high levels of deprivation, suicide rates in Greater Glasgow and Clyde are on the midpoint for Scotland overall, and the proportion associated with Mental Health care is similar to that found elsewhere in Scotland. The numbers quoted in the report are therefore consistent with other data sources and do not of themselves indicate cause for concern.

3. Integrated Clinical and Professional Governance Board

3.1 The integrated Clinical and Professional Governance Board continues to meet quarterly and the last meeting was held on 14th May 2019. The agenda is attached for information (Appendix 2). At the meeting, further scrutiny of the minutes from the following Governance meetings were considered.

- 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 Similarly, there is emphasis on ensuring that Significant Clinical Incident (SCI) and Clinical Incident Review (CIR) processes and procedures of the HSCP are aligned wherever possible and that investigations are joint when more than one service is involved.

4. Significant Case Reviews

4.1 Previous reports to the IJB Performance Scrutiny Committees have commented on a Child Protection SCR undertaken in 2015/16. The learning from this case could not be shared due to the ongoing criminal case. The criminal case concluded on 21st December 2018, with the birth mother and her partner convicted of willful neglect of three children, leading to the death of the youngest one, at age 2 years and 5 months. Sentencing took place in January 2019, and an Executive summary of the Significant Case Review was published and placed on the CPC website at that time. The Child Protection Committee(CPC) have now considered the Review report and are now overseeing the implementation of the recommendations across all partner agencies. In addition to this, the CPC held a Neglect Summit on 6th March 2019 attended by approximately 200 delegates from children's services, (both statutory and third sector providers) across the city and a presentation was made on the learning points from the SCR.

4.2 A child fatality highlighted in the September 2017 Quarterly Assurance Report is subject to a SCR. The process is well underway. Following discussion with the Procurator Fiscal, it is anticipated that a decision on whether a Fatal Accident Inquiry will follow, is likely to be taken once the SCR has concluded.

4.3 An Adult Support and Protection case emanating from the death in 2017 of a service user who had resided in a nursing home placement is also subject to a SCR. This investigation is also well underway, and is expected to report over the coming months.

4.4 A further Adult SCR is ongoing into the circumstances surrounding the death of a woman who had been cared for at home but died in hospital. There was considerable concern about her physical condition on arrival at hospital indicative of significant neglect. The investigation is proceeding and is also due to report over the coming months.

5. Multi-Agency Public Protection Arrangements (MAPPA)

5.1 In Glasgow the MAPPA arrangements are significantly supported by the role of the MAPPA Coordinator, and governance is provided through the MAPPA Operational Group, the MAPPA Strategic Oversight Group (MOG and SOG) and the Chief Officers Group.

5.2 There have been 7 Initial Notifications submitted to the SOG Chair for consideration between the period January-end of April. None of them required to progress to an Initial Case Review as all contained sufficient information to evidence that they had been managed robustly, in line with procedures, and that the offending could not have been prevented.

5.3 MAPPA Audit

Towards the end of 2018, a review was undertaken into the provision of MAPPA minutes for level 2/3 cases within Glasgow, including the Risk Management Plan. In total fifteen cases were reviewed. The findings highlighted that minutes were heavily weighted to either pre read information and/or a detailed case discussion that took place during the meeting but were light in detail on sections in relation to risk assessment, risk management and contingency planning. The findings highlighted concerns in the quality of the Risk Management Plans, particularly with regards to the plans provided for the Initial MAPPA meeting.

The Audit findings have been tabled and discussed at the MAPPA Operational Group and an Action Plan is being developed to address some of the findings which will be taken to the Strategic Oversight Group for agreement.

6. Self-evaluation activity

6.1 For 2019-2020, the Child Protection Committee has so far identified several pieces of self-evaluation work. The first, and largest, is a multi-agency casefile audit of 100 referrals to Social Work Services, with a focus on quality of referral information, use of assessment tools and multi-agency decision-making. There will also be an evaluation of the citywide rollout of Neglect Toolkit training and an evaluation of the dissemination of learning points from the recently-published Significant Case Review (SCR), the effectiveness of which will be evaluated using both quantitative data and staff surveys/focus groups.

6.2 In addition to this, there will be joint evaluation with the Adult Protection Committee (APC) on the Social Care Institute for Excellence (SCIE) “Learning Together” model for conducting SCRs, which has been implemented in the three reviews that commenced in 2018, and are due to report this year.

6.3 The APC carries out an annual audit of Adult Support and Protection (ASP) practice and performance using the Care Inspectorate’s inspection model, and this will be repeated in 2019-2020. Based on the findings of last year’s audit and the regular management information reports presented to the committee, three further areas have been identified for evaluation activity – the quality of service user chronologies, sources of harm in ASP investigations, and aids and barriers in ASP practice.

7. Assurance Areas

7.1 <u>Workforce Registration</u>

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

There were two confirmed cases of Group A Streptococcus within Stobhill Older Adult Mental Health Ward in February 2019. Incident Management Team Meetings were held in February. The Ward was terminally cleaned and there has been no further reported cases.

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 Jan – Mar 2019

Service	**Number of Significant Clinical Incidents Investigations ongoing (Started prior to 1 January 2019)**	**Number of Significant Incident Investigations Concluded between 1 January 2019 – 31 March 2019**	**Number of Significant Clinical Incidents Investigations Commenced between 1 January 2019 – 31 March 2019**
Addictions	3	4	3
Children and Families	2	0	0
Homelessness	3	0	1
Mental Health Services	23	3	10
Older People and Primary Care	3	0	0
Prison Healthcare	2	0	0
Sandyford	2	3	0

Appendix 2

GLASGOW CITY HEALTH & SOCIAL CARE PARTNERSHIP
Integrated Clinical and Professional Governance Group

2.00pm on Tuesday, 14th May 2019
in the Triathlon Room, Commonwealth House,
32 Albion Street, Glasgow G1 1LH

AGENDA

		Enclosure
1.	**Apologies for Absence** A-M Rafferty, S Fitzpatrick, M Culshaw, S Priyadarshi, R Stocks & S Tennant	
2.	**Minutes of the Previous Meeting** To approve the minutes of the meeting held on 19th February 2019.	Paper
3.	**Matters Arising**	
4.	**eHealth** (Anne Malarkey)	
5.	**Governance Group Minutes/Reports**	
	(a) Social Work Professional Governance Sub Group	Paper
	(b) Children & Families / Criminal Justice Clinical & Care Governance Leadership Group	Paper
	(c) Older People & Primary Care Clinical & Care Governance Leadership Group	Paper
	(d) Mental Health Quality & Clinical Governance Committee	Paper
	(e) Sandyford Governance Group	Paper
	(f) Homelessness Care Governance Group	Verbal
	(g) Prison Healthcare Clinical Governance Committee	No Recent Meeting
	(h) Adult Clinical Governance Committee	No Recent Meeting
	(i) Addictions	No Recent Meeting
	(j) Police Custody Healthcare Clinical Governance Committee	
6.	**Primary Care and Community Clinical Governance Forum** (J Nugent/A Buchanan)	Papers (a)-(c)
7.	**Remit and Membership of the Group - Review**	Papers (a)-(b)

8.	**Involvement of Public Partner Volunteers in Clinical Governance Forums - Guidance Document** (A Buchanan)	Paper
9.	**Annual Report** (A Buchanan)	Paper
10.	**Use of Restraint Within NHS Facilities** (M Smith)	Verbal
11.	**Any Other Competent Business**	
12.	**Next Meeting**	

Schedule of Meeting Dates 2019

All Meetings 2.00 p.m. – 4.00 p.m. in the Triathlon Room, Commonwealth House

Tuesday 13th August
Tuesday 19th November