Item No. 13

Meeting Date **Wednesday 9th September 2026**

Glasgow City
Integration Joint Board
Finance, Audit and Scrutiny Committee

Report By: **Kelda Gaffney, Depute Chief Officer (Operations and Governance) and Chief Social Work Officer**

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Clinical and Professional Quarterly Assurance Statement (Quarter 1 2026/2027)

Purpose of Report:	To provide the IJB Finance, Audit and Scrutiny Committee with a quarterly clinical and professional assurance statement for the period 1st April 2026 – 30th June 2026.
Background/Engagement:	The quarterly assurance statement is a summary of information that has been provided 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:	None
Implications for NHS Greater Glasgow & Clyde:	None

1. Purpose

1.1 To provide the IJB Finance, Audit and Scrutiny Committee with a quarterly clinical and professional assurance statement for the period 1st April 2026 – 30th June 2026.

2. Background

2.1 This report seeks to assure the IJB Finance, Audit and Scrutiny Committee that clinical and professional governance is being effectively overseen by the Integrated Clinical and Professional Governance Group which is chaired by the Chief Officer, Glasgow City Health and Social Care Partnership (HSCP).

2.2 The most recent quarterly clinical and professional assurance statement was provided to the IJB Finance, Audit and Scrutiny Committee on 10th June 2026.

2.3 This report provides the IJB Finance, Audit and Scrutiny Committee with information collated during Quarter 1 2026-27 (1st April to 30th June 2026).

3. Governance Structures and Processes

3.1 Glasgow City HSCP has robust professional and clinical governance structures around each of the service areas. These governance arrangements are overseen by the Glasgow City Integrated Clinical and Professional Governance Group.

3.2 The Public Protection arrangements across the city are overseen by the Chief Officers Group, chaired by the Chief Executive of Glasgow City Council, with representation from key partner agencies and the independent chair of both the Adult Support and Child Protection Committees.

4. Quarterly Updates from Governance Groups Quarter 1 2026/2027

4.1 Glasgow City Integrated Clinical and Professional Governance Group

4.1.1 The Glasgow City Integrated Clinical and Professional Governance Group meets quarterly. The Group is chaired by the HSCP Chief Officer, with membership of Depute Chief Officers, Assistant Chief Officers and Professional Leads. The group receives reports from the Social Work Professional Governance Board, Governance Groups for each Care Group (Children and Families, Older People and Primary Care, and Adult Services); and Mental Health and Primary Care Clinical Governance Groups.

4.1.2 In Quarter 1, the following issues/updates were noted:

- Progress in closing Significant Adverse Event Reviews (SAERs) with 28 closed in the quarter and 31 outstanding at 30th June 2026.
- Establishment of an Adverse Events Oversight Group to commission and monitor reviews for non-Mental Health Services.
- Approval of the Hoarding Protocol.
- Challenges in securing placements for Children and Young People, with escalation nationally to Chief Social Work Officers and Scottish Government.

- General Practice IT reprovisioning, challenges as roll out proceeds with use of escalation framework to support practices.
- Progress with Blood Borne Virus (BBV) Testing within Prison Healthcare.

4.2 **Mental Health Services Clinical Governance Group**

4.2.1 The Mental Health Services Clinical Governance Group's (MHSCGG) function includes whole-system oversight and oversight for some Board-wide services. The agenda items include governance assurance on Clinical Risk, Feedback and Investigations, Quality Improvement, Policy Development & Implementation, Research & Development, Medicines Governance, Legislation, Infection Control, Continual Professional Development (CPD) and Learning, and quarterly reporting from Care Groups. The MHSCGG meets monthly with 12 meetings scheduled annually.

4.2.2 **Medical/Nursing Staffing and Inpatient Bed Pressures**
Mental Health Services continue to experience significant pressures across inpatient sites, compounded by delayed discharges (21% for adult beds and 33% for Older People's Mental Health).

4.2.3 Bed use across all other patient groups is within expected occupancy rates but with a significant increase in demand for perinatal beds and adult eating disorder beds. The adolescent beds remain capped at 16 with full occupancy, which has impacted adult bed usage. There are a number of actions being undertaken including an appointment to a Board-wide Flow Manager post, review of function and staffing of the Integrated Discharge Teams and data collections on all delayed discharge as part of the Mental Health Strategy reset.

4.2.4 Referrals to Community Mental Health Teams (CMHTs) have increased by 15%.

4.2.5 **Suicide Risk and Design Group (SRDG)**
The rolling programme of ward decant work is ongoing, allowing substantial removal of ligature points. This work is being undertaken based on the risk profile of the wards as assessed clinically. Nairn ward at Stobhill Hospital is being utilised to enable this work.

4.2.6 Work is ongoing with clinical leads to identify future phases of ward decant work, the order of which will be dictated by risk prioritisation.

4.2.7 A targeted approach to increase compliance of GGC292: Ligature Awareness Learn-Pro Module has been implemented within Mental Health Inpatients and Acute settings. The Suicide Reduction and Management of Ligature Risks Policy has been updated and is available on the Health and Safety SharePoint page.

4.2.8 **Continuous Intervention (CI)**
All wards have participated in a recent 1-day quality assurance and learning audit. This was designed to provide a snapshot of current CI practice across all Mental Health, Forensic, Learning Disability, Child and Adolescent Mental Health Service and Alcohol and Drug Recovery Service wards, covering 65 wards in total. The audit has provided detailed information on staff training and

knowledge, patient and relative/carer involvement in decisions and documentation about CI, patient and relative/carer experience of CI, and any suggested learning points and actions from this. The Multidisciplinary Clinical Reference Group (CRG) has been established to support the implementation of the CI Policy and Practice Guidance. The Clinical Reference Group Terms of Reference focuses on the practice development and skills enhancement components that need to be considered or implemented to deliver effective and person-centred CI. The group will undertake agreed items of improvement and development work as directed by CIIMG and the one-day CI audit findings.

4.2.9 **Alcohol and Drugs Recovery Services (ADRS): The Thistle Service**
By the end of May 2026, the Thistle had registered 732 unique individuals and recorded 18,206 visits and 12,555 injecting episodes. Of registered individuals, 573 (78%) were male, and 36-45 years was the most common age range. The most commonly reported injected drugs were cocaine (70%), heroin (20%) and heroin+cocaine ("snowballing", 9%). Although cocaine has been the most reported drug used in the service, there is significant variance from month to month. In particular, from February 2026 onwards, the service recorded rising levels of heroin use.

4.2.10 The Thistle had recorded 171 Medical Emergencies (MEs) by the end of May 2026. These are predominantly the result of opioid overdose. There is marked variation each month depending on numbers using the service and drugs used. February, March, April and May 2026 witnessed the highest number of MEs, reflecting higher numbers of injecting episodes within the service, rising proportion of heroin use and street drugs.

4.2.11 The vast majority of MEs have been managed within the service, avoiding the need for ambulatory or Emergency Department intervention. Scottish Ambulance Service were called on only 28 occasions and transfer to Emergency Department (ED) was necessary only on 20 occasions. All medical emergencies inside the facility have been managed successfully with no fatalities.

4.2.12 **Safe Care**
The Mental Welfare Commission (MWC) for Scotland are undertaking national monitoring and reporting on the use of restrictive practices in inpatient mental health units as recommended in the Scottish Mental Health Law Review. The Commission will work with Boards to improve and standardise the collection of data relating to the use of restrictive practices with a view to gathering this data nationally.

4.2.13 A restrictive practice Short Life Working Group has been established which will ensure all inpatient areas in NHSGG&C have robust systems for defining use of restrictive practice, reviewing and reporting on its use and escalation pathways. This group will report into the MWC as well as local governance structures.

4.2.14 **Remote Monitoring and Virtual Hospital Pathways**
The Virtual Hospital Clozapine Initiation Pathway via DOCCLA (virtual care and remote patient monitoring provider)) is being piloted within NHSGGC. It has been developed within Specialist Mental Health Services with the pilot

phase being trialled in North East Glasgow Esteem. The pathway is now available to all community teams across Glasgow City. This is the first virtual clozapine pathway in Scotland. A pilot of the use of remote monitoring via DOCCLA and Redstar (digital healthcare platform) for ADHD physical health checks is being progressed to implement a remote pathway and release capacity within community mental health teams.

4.3 Social Work Professional Governance Board

4.3.1 The Social Work Professional Governance Board (SWPGB) meets every 4 weeks and receives governance updates from localities, Public Protection and Complex Needs, Adult Services, Children Services, Care Services, Criminal Justice Service, Homelessness Services, Organisational Development, Practice Audit, HR, Social Work School of Glasgow Caledonian University, Care Inspectorate, and Mental Welfare Commission.

4.3.2 The Supervision Policy Implementation strategy has been agreed with Personal Development Plans (PDP) being re-launched.

4.3.3 The Out of Hours Audit report was presented to the Board. The audit included a rise in the number of referrals to Out of Hours Homelessness Service (OHHS), an estimated two-thirds of which relate to service users already open to other services. OHHS is an emergency service, but many of their referrals relate to non-emergencies and situations that have arisen (and may have been partially dealt with) during office hours. A number of recommendations were made following the audit and will be monitored via the Safeguarding Board.

4.3.4 Report on the analysis of the Suicide Cluster file reading was presented. The report was commissioned by the Chair of the Cluster Response Group, as part of a coordinated response by Glasgow City Health and Social Care Partnership and partner agencies to a cluster of suspected suicides and suicide attempts at Glasgow's bridges. It provides additional contextual information on the demographic characteristics of those affected and the services with which they had prior contact. The findings will support the Cluster Response Group in informing and strengthening suicide prevention activity across the City.

The report is informed by a structured review of case records held across the EMIS and CareFirst systems utilised within Glasgow HSCP Social Work Services. The Practice Audit Team were provided with case identifiers for 21 of the 22 individuals in the cluster.

Summary of suggested actions**:**

- Development of suicide risk training or guidance for GHSCP staff.
- Review of the application of ASP for suicide risk cases.
- Engagement with University of Glasgow's missingness researchers and Deep End GP group about applying a missingness lens to GHSCP practice.

4.3.5 The Adult Support and Protection Care Home Risk Matrix Self Evaluation report was presented. The report focuses on the workstream in relation to developing an 'ASP Care Home Guidance and Risk Matrix Tool (RMT)' and its

implementation with key stakeholders within the care home sector in Glasgow City. To ensure appropriate governance, it was agreed that a pilot using the updated guidance and RMT would be completed and evaluated before a further roll out was considered.

4.3.6 Evaluation shows a 26-percentage point increase in the number of *appropriate* ASP referrals during the roll-out phase. This provides robust evidence that use of the RMT is positively improving the number of appropriate ASP referrals by care homes in the sample. Given the positive outcome from the pilot and initial roll-out stages, the proposal going forward is that the RMT is adopted for use by all Glasgow City HSCP Commissioned Care Homes. The Governance Board approved for a further roll out of the pilot with a further evaluation to come back in 12 months.

4.3.7 Places have been confirmed for Graduate apprenticeships for existing social work employees to undertake the Social Work qualification, with an allocation of 10 places this year and 10 for next year. The programme is fully funded.

4.3.8 A report was presented of Glasgow City Council's involvement in the Embedding Technology in Care Homes (ETECH) research programme, funded by the National Institute for Health and Care Research (NIHR). The report provides background and context to the programme, outlines the nature and extent of Glasgow City Council's participation, summarises the current position regarding legal and contractual matters, and sought approval to progress with involvement in the project, pending approval from Legal Services. ETECH is a nationally funded research project awarded by the National Institute for Health and Care Research (NIHR) to the University of Glasgow. The Board approved the report.

4.3.9 An update on the student research applications was presented. During the seven-month period from October 2025 to April 2026, the HSCP received ten applications requesting access to social work resources to carry out research. Six applications received final approval, one received in-principle approval, one is awaiting an in-principle approval decision, one was not progressed by the researcher due to issues with ethical approval, and one application was rejected. All six applications that received final approval were covered by the generic Data Protection Impact Assessment (DPIA) for external research and all but one was approved within 30 days of the application being received. It was agreed the research list is formally reviewed 2 yearly and additions and amendments can be made if required.

4.3.10 The Chief Social Work Officer presented a report on Social Work Out of Authority Placements Governance Framework. There are significant numbers of out of authority placements and concerns had been raised in relation to financial oversight and safeguarding. The framework now governs Out-of-Authority (OOA) and high-cost placements commissioned by Children's, Adult and Older People's services. The framework ensures OOA placements are exceptional, time-limited, outcome-focused, compliant, and actively plan for safe and timely repatriation to Glasgow City.

4.3.11 A new OOA governance group has been established to monitor OOA placements and oversee care planning to repatriate children or adults to Glasgow. The meeting will provide quarterly assurance on all out-of-area

(OOA) or out-of-contract placements, ensuring that each individual's care needs and well-being are being met. It will approve actions to support people returning to their communities, considering all alternatives, taking account of service user and family/carer views. The group will review financial planning and address any issues from incident reporting or complaints.

4.3.12 Glasgow City Health and Social Care Partnership Hoarding Protocol was approved. The updated protocol sets out the approach to be taken by staff in Housing and the Health and Social Care Partnership when working with people who may be experiencing a 'hoarding disorder' or living in extreme clutter situations.

4.3.13 All new Social Work policies and procedures are overseen by the Social Work Professional Governance Board, and all research projects are monitored by the Governance Board. Over the last 3 months the following was discussed/approved:

- The Newly Qualified Social Worker Supported Year Handbook.
- The new Families for Children Adoption pack, there has been a refresh of the documents. The criteria and process within the document is the same, the biggest change is being around the support that is offered.
- Guidance on the Transfer Process for Foster Carers becoming Supported Carers 2025.
- Guidance and Procedures for the use of Section 13ZA (Social Work (Scotland) Act 1968). Briefings will be arranged for staff and a communication will be issued.

4.4 Multi-Agency Public Protection Arrangements (MAPPA)

4.4.1 Scottish Government and Chairs of the Strategic Oversight Group (SOG) meet quarterly as a National SOG to develop and evaluate strategic plans, discuss practice issues, and ensure the arrangements for MAPPA are robust.

4.4.2 MAPPA is overseen by the Strategic Oversight Group (SOG) in Glasgow which meets quarterly. The MAPPA Operational Group (MOG) meet every 6 weeks with representation at an appropriate level from the responsible authorities. The NASSO (National Accommodation for Sex Offenders Group) meet quarterly to manage the complexities in relation to housing individuals subject to sex offender registration.

4.4.3 As of 30th June 2026, Glasgow MAPPA was managing four Category 1 Level 2 offenders and two Category 3 Level 2 offenders within the community. Within this reporting period there has been one Initial Notification Report (INR) which has progressed to Initial Case Review (ICR).

4.4.4 There are currently 4 risks on the Glasgow risk register, 1 sitting as high and the other three as medium. These risks are reviewed at the MOG and SOG.

4.4.5 The National Performance Indicators (NPIs) of MAPPA have continued to be reviewed monthly, within the reporting period and all NPIs have been met. Audit activity has also continued during this reporting period to provide assurance on practice.

4.4.6 Continuous improvement continues to be driven via the MOG through regular training. Within this reporting period, justice social work staff and officers from Glasgow's Sex Offender Policing Unit received an input from a clinical psychologist on working with offenders with autism.

4.4.7 The Multi Agency Public Protection System (MAPPS), which is the replacement for ViSOR, remains scheduled for 2028. Glasgow City Council has been identified as an early adopter to test the new MAPPS system. Glasgow users will have the opportunity to provide feedback and influence the new MAPPS system ahead of launch in 2028. Whilst Glasgow is committed to being early adopters, work remains ongoing to establish the practical arrangements, including confirming timescales for National Identity and Access Management, the Home Office's specified identity and access management solution for law enforcement. As a result, there is a risk of delay entering the early adopter phase.

4.5 Prevent

4.5.1 Prevent forms part of the UK Government's wider counter-terrorism strategy known as 'CONTEST'. The purpose of Prevent is to safeguard and support individuals susceptible to becoming terrorists or supporting terrorism. Prevent is an enhanced multi-agency approach with all local authorities taking responsibility for delivery of the Prevent Multi-Agency Panel (PMAP) processes in their area. Prevent Business Groups are held quarterly, and the group discuss all cases and Prevent-related concerns. The communication strategy is now active; implementation of the strategy will be reviewed quarterly at the Prevent Strategic Oversight Group.

4.5.2 The Prevent Multi-Agency Panel (PMAP) continues to review active cases and cases following closure from PMAP. In the reporting period case numbers and referrals have increased slightly.

4.5.3 The Annual Threat Report (January 2026) aims to provide Local CONTEST Boards with an understanding of the current counter terrorism threat and risk picture in Scotland. The purpose is to support the review of work plans to ensure they remain fit for purpose tackling relevant issues as well as ensuring compliance with the Prevent Duty Guidance.

4.5.4 The Annual PMAP Assurance Report was shared with the Glasgow Prevent Strategic Oversight Group for review and feedback. Following feedback received, the report was submitted to the Home Office by the required deadline of 15th June 2026.

4.5.5 The Home Office Situational Risk Assessment template, developed to support all local authorities in assessing and managing Prevent related risks, is currently being completed for Glasgow City. Once finalised, the document will be presented to the Prevent Strategic Oversight Group for review and approval at its next meeting in August 2026.

4.5.6 The GOLD Prevent Awareness Training was launched on 11th November, followed by the wider Glasgow City Council Prevent Awareness Training launch, which was communicated through a Manager Briefing on 8th January

2026 and subsequently promoted in Staff News on 4th June 2026. Training completion rates continue to be actively monitored.

4.5.7 The communication strategy is now active and is being implemented across relevant services and partner agencies. Progress against the strategy, including its reach, impact, and key communication objectives, will be reviewed quarterly by the Prevent Strategic Oversight Group to ensure continued effectiveness and identify any areas for development. In addition, work is underway to explore opportunities for the wider dissemination of Home Office developed Prevent leaflets and posters. These materials are intended to raise awareness of Prevent, improve understanding of the support available through the programme, and promote awareness of the signs that may indicate vulnerability to radicalisation among staff, partners, and local communities.

4.6 Adult Support and Protection (ASP)

4.6.1 The ASP Committee (ASPC), as per section 42(1) of the Adult Support and Protection (Scotland) Act 2007, is a key multi-agency strategic governance arrangement for ASP activity in Glasgow City. It reports to the Chief Officers Group (COG) on a quarterly basis.

The ASPC meets quarterly to receive assurances from all partners on ASP activity (typical standing agenda items are: ASP National Minimum Dataset (NMD), self-evaluation activity, Learning Reviews and any associated improvement plans, national updates etc.). It is chaired, as per s. 41(1) and (6) of the Act, by an Independent Convener.

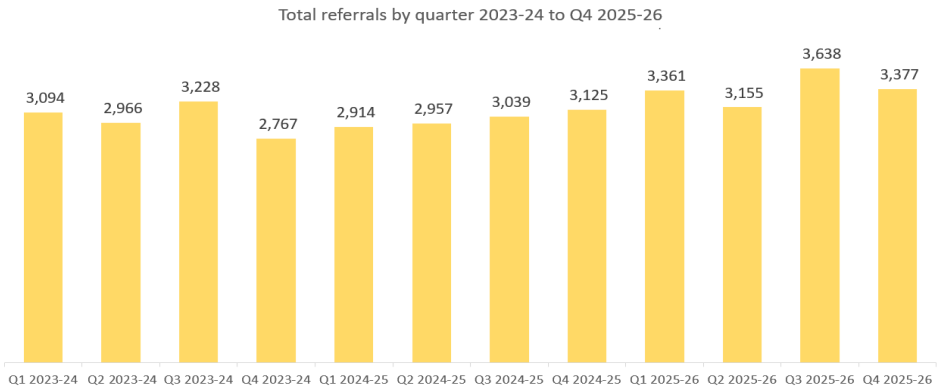
It is supported by various multi-agency sub-groups:
- Quality Assurance (quarterly meeting)
- Learning Review Panel (joint panel with Child Protection Committee (CPC) (quarterly meeting)

In addition to ASPC governance, the ASP team reports directly to the following groups to ensure oversight of ASP activity:

- Social Work Professional Governance Board (as required)
- Public Protection Core Leadership meeting (quarterly)
- ASP Citywide Meeting (quarterly meeting with Assistant Service Managers and Service Managers across the city)
- Safeguarding Board

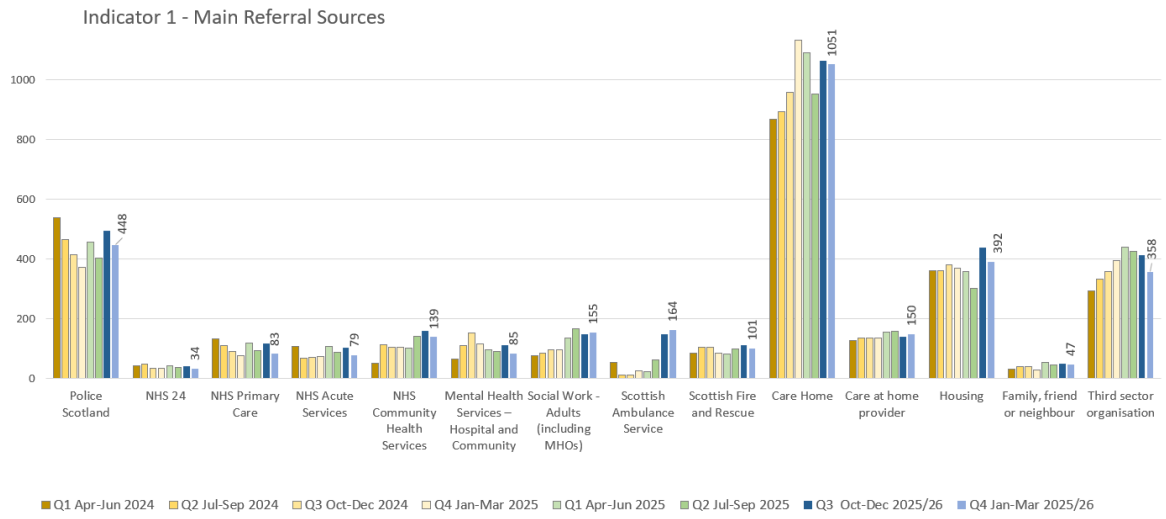
4.6.2 Q4 data was submitted to the Scottish Government on 15th May 2026, covering the reporting period January – March 2026. Within the period, Social Work Services received a total of 3,337 ASP referrals. Whilst this represents a reduction from Q3 (3,638), activity remains at a sustained high level and continues to reflect significant demand across the Adult Support and Protection system (when considered over a longer period, as indicated in the graph below). The figures presented relate to completed ASP activity and therefore include work relating to referrals received in earlier quarters.

Indicator 1 - ASP referrals submitted to ASP Service - completed in quarter and year



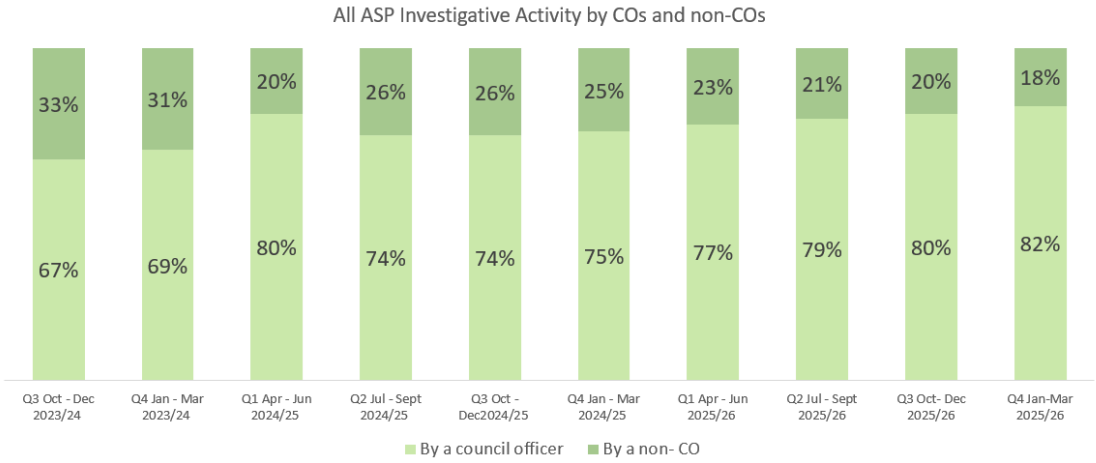
4.6.3 The team continue to monitor referral source trends to target improvement activity appropriately. Care Homes remained the largest source of ASP referrals during the quarter, accounting for 1,051 completed referrals. This remains broadly consistent with the previous quarter and reinforces the importance of the Care Home Risk Matrix Tool rollout. Referrals numbers from Care Homes when considered over the same period in the previous year, has reduced. Referral activity from Scottish Ambulance Service continued to increase following work undertaken through the Tripartite Audit Improvement Plan, whilst referrals from Police Scotland, Housing and Third Sector organisations reduced slightly from Q3 levels

Indicator 1 – All ASP Referrals Completed Q4 2025-26 (main referrers)



4.6.4 Of the 3,377 completed ASP referrals, the majority continued to be progressed without the use of Council Officer investigatory powers. Of those referrals where investigatory powers were used, 82% were undertaken by Council Officers, demonstrating continued progress towards ensuring investigations are undertaken by appropriately designated staff. This is the highest proportion in 3 years, which shows the efforts to ensure statutory compliance.

Indicators 2 and 3 - Use of Investigative Powers by COs and non-COs



4.6.5 A total of 136 ASP Case Conferences were held during the quarter, comprising 60 Initial Case Conferences and 76 Review Conferences. At the reporting point, 123 adults were being supported through an ASP Protection Plan. Self-neglect remained the most frequently occurring harm type amongst adults subject to a Protection Plan.

4.6.6 The overall profile of harm remains relatively consistent with previous reporting periods. Physical harm and self-neglect continue to be the most commonly recorded harm categories. Where investigatory powers were used, self-neglect remained the most frequently recorded primary harm. The adult's own home continues to be the most common location associated with harm

4.6.7 <u>Self-evaluation/Audit Work</u>
The Adult Support and Protection Team has continued to progress a significant programme of quality assurance and improvement activity during the quarter.

4.6.8 As part of the ongoing Adult Interagency Referral Discussion (IRD) pilot, a second phase evaluation was completed. This reviewed IRD activity between September 2025 and February 2026 (multi-agency file reading commenced April – June 2026). The full evaluation report is in draft and will make its way through governance fora during quarter 2, having been completed in quarter 1. Notwithstanding, initial indications are as follows:

4.6.9 The evaluation identified strong evidence of effective multi-agency information sharing, improved risk identification, enhanced decision-making and meaningful outcomes for adults at risk. Whilst the evaluation highlighted some areas for improvement relating to recording, administration and consistency of process application, overall findings continue to support the value of the IRD model and informed the decision to extend the pilot.

4.6.10 The Adult Support and Protection Team continues to deliver against the Tripartite Audit improvement plan and has commenced preparatory work for the next Tripartite Audit cycle. We have done this alongside our partners in health, Police Scotland and the Scottish Ambulance Service. Activity this quarter has focused on embedding learning from previous audit findings,

strengthening quality assurance arrangements and improving consistency across agencies.

4.6.11 The Care Home Risk Matrix Tool continues to be rolled out across Glasgow City following the positive findings from the pilot evaluation, reported on in the last report. The evaluation demonstrated improved consistency and appropriateness of referrals, increased confidence amongst staff and evidence of more targeted decision-making. Progress remains on track to achieve implementation across all care homes by the end of 2026, with 19 care homes remaining to be onboarded at the end of the reporting period.

4.6.12 Staff Engagement and Learning

A further Adult Support and Protection Team Leader Development Session was held in May 2026. The session brought together Team Leaders from across adult services to consider learning arising from the Adult IRD Evaluation and the Care Home Risk Matrix Evaluation, alongside wider quality assurance activity. The session focused on demonstrating the impact of quality assurance activity on practice, sharing learning from multi-agency audits, supporting consistent decision-making and strengthening understanding of how quality assurance contributes to improved outcomes for adults at risk. Feedback from participants indicated that Team Leaders value the opportunity to come together to discuss strategic Adult Support and Protection priorities and learn from emerging quality assurance findings.

4.6.13 The new Adult Support and Protection training programme for Social Care Workers was successfully delivered during the quarter. The programme was developed to address an identified gap in learning provision for staff undertaking Adult Support and Protection inquiries. Initial evaluation feedback has been overwhelmingly positive, and arrangements are now underway to support wider implementation across the social care workforce.

4.6.14 Alongside this work, a review of the wider Adult Support and Protection learning and development framework has commenced. This review aims to ensure training provision remains aligned with emerging practice developments, learning review recommendations, quality assurance findings and workforce needs. The review is in its infancy and updates will be provided to a future Committee.

4.6.15 The ASP Team has also continued to deliver targeted learning opportunities through practice forums, awareness raising activities and specialist development work, including ongoing planning for spotlight sessions focused on information sharing, public protection and emerging areas of practice (such as national changes to hoarding).

4.6.16 Policy and Procedures

There have been no substantive changes to Adult Support and Protection policy or procedures during the reporting period.

Work has continued, however, on strengthening related governance arrangements. This includes ongoing development of Adults with Incapacity (AWI) quality assurance activity, data and performance reporting arrangements, and implementation of the AWI Practice Framework.

4.7 Child Protection (CP)

4.7.1 The Child Protection (CP) governance arrangements are held under the overarching governance arrangements within the HSCP Public Protection structure and the Child Protection Committee (CPC). The CPC is supported by a Committee Team and a CP Team.

4.7.2 Key functions of the CP team include the responsibility for ensuring direction of flow between respective CP governance arrangements with locality teams, undertaking case reviews at the request of localities and the CPC, and translating national policy and legislation into practice in a Glasgow context.

4.7.3 Child Protection Committee Strategic Groups
The Child Protection Committee has fully implemented three strategic sub-groups on i) Neglect, ii) Young Person's Support and Protection and iii) Interagency Referral Discussion.

4.7.4 The Neglect Strategic group have been considering how to support practitioners to have a clear understanding in relation to the impact and hidden harm of neglect on children, and how to support effective interventions with families in relation to this.

4.7.5 The Young Person Support and Protection (YPSP) Strategic group is continuing to explore the development of a multi-agency toolkit for practitioners in relation to Exploitation and Trafficking.

4.7.6 The Interagency Referral Discussion (IRD) Strategic group has been planning a Development Session for practitioners for the four key partner agencies (Social Work, Health, Police and Education) in September 2026. The final phase of Glasgow schools being invited to all IRDs was implemented on 20th April 2026. The next phase of this implementation will be to support all nursery attendance at IRDs. A quality assurance (QA) audit was undertaken on 22nd April 2026, with the four key partner agencies contributing to this. The next QA session is planned for 25th August 2026.

4.7.7 Audit and quality assurance
In addition to the work within the respective strategic groups, the CP team are currently involved in several pieces of audit and quality assurance including:

- A Young Person Support and Protection (YPSP) audit which was requested by the CSWO following a significant reduction in the number of children being supported by YPSP at the start of the year and the need to understand this change. Preparation for the audit had taken place in June 2026, with the file reading taking place in July 2026 and the subsequent analysis and evaluation is to be concluded by September 2026.

- An evaluation of the National Referral Mechanism for Child Victims of Trafficking/Exploitation: Devolved Decision Making Pilot was completed by the CP Team and is awaiting sign off from the Public Protection Board before being shared with the Social Work Governance Board and the CPC.

4.7.8 The Child Protection Team continues to ensure that existing overarching Child Protection and Public Protection policy and procedures/guidance are in accordance with national and local drivers for change, and changes in legislation and policy frameworks. The current policies/ guidance being updated are:

- Young Person Support and Protection Procedures have been reviewed to align with the National Guidance for Child Protection in Scotland 2021 (Updated 2023) to ensure that it incorporates Care and Risk Management processes (CARM). CARM is a risk management framework to support the critical few children (aged 12-18) who pose a risk of serious harm to others. The final draft of the procedures has been completed and is awaiting final sign off by the Public Protection Board before proceeding to the Social Work Governance Board. Following this there is a plan for a full implementation of the YPSP Framework for Practice to C&F services, as well as multi agency partners.
- Female Genital Mutilation Guidance is being completed jointly with the NHSGGC Public Protection Service, and it is planned that this should be finalised within the next quarter.
- Notification of the Death of a Child Procedures were updated in light of changes to the national guidance from the Care Inspectorate. The revised guidance is in final draft prior to final sign off by the Public Protection Board before proceeding to the Social Work Governance Board.
- A whistleblowing/ escalation guidance for staff has been developed and is in its final draft. The final draft of this guidance is awaiting final sign off by the Public Protection Board before proceeding to the Social Work Governance Board.

4.7.9 The CP team continue to provide a suite of training, alongside Learning and Development, and meet bi-weekly to ensure that training in relation to child protection is meeting the needs of staff, the organisation, and national developments in terms of policy and practice (e.g. National Framework for Child Protection Learning and Development in Scotland 2024).

4.7.10 HALT and the Family Support Service continue to provide a suite of specialist training to staff and partners. Following a needs analysis of the HALT service, they have recently developed lunchtime briefings in relation to “Talking with young people about consent” and “Talking with young people about pornography”. The HALT service is currently developing an intranet resource which provides information, learning and resources to practitioners. The Family Support Service recently provided a briefing in relation to sexual abuse to all Child Protection Coordinators within Glasgow schools which received very positive feedback.

4.8 Public Protection Governance

4.8.1 A review of Public Protection governance and roles and responsibilities has taken place and has led to the development of a Public Protection Board, which will act on behalf of the Executive Management Team on public protection governance, oversight and decision-making.

4.8.2 The Board is chaired by the Chief Social Work Officer and brings together senior operational and professional leadership, including Assistant Chief Officers across care groups and the Chief Nurse. Its remit is to provide visible, organisation-wide oversight of public protection; monitor delivery and impact of HSCP improvement plans or actions; ensure that risks, barriers, delay or lack of progress are identified, challenged and addressed; and approve public protection policies, processes and guidance.

4.8.3 The Public Protection Board provides a clear route for assurance and escalation. It complements, rather than replaces, the statutory multi-agency responsibilities of the Chief Officers Group, Child Protection Committee, Adult Support and Protection Committee and MAPPA governance arrangements. Matters requiring wider partnership action or formal statutory oversight will continue to be referred through those established routes.

4.8.4 The Board will maintain oversight of agreed actions, seek evidence that improvements are embedded in practice and outcomes, and provide direction where themes cut across service or professional boundaries. This strengthens executive accountability while supporting appropriate professional challenge, consistent organisational learning and a more coherent approach to public protection assurance across the HSCP.

4.9 Glasgow City HSCP Safer Staffing

4.9.1 Glasgow City HSCP has a wide range of health and social care services that are required to comply with the legislative requirements of the Health and Care (Staffing) (Scotland) Act 2019 (HCSSA). Implementation continues with quarterly reporting to the NHSGGC Board. The current overall compliance position remains at reasonable assurance.

4.9.2 The Senior Management Team has agreed to further develop the organisational infrastructure and move towards a business-as-usual approach for health and care staffing. This will include widening engagement with clinical and professional leads, identifying key contacts across services and departments, and strengthening collaboration across systems to support delivery of the full range of HCSSA duties.

4.9.3 A key development for 2026/27 is the phased roll-out of the SafeCare/Optima system for all NHS staff to digitise reporting and escalation of staffing issues and risks, while also supporting operational processes such as rostering, bank staff use and annual leave booking. Once fully implemented, the system should reduce the administrative burden for frontline health leaders and managers and provide greater transparency and oversight of staffing levels across the HSCP.

4.9.4 Work is continuing to streamline risk registers, ensure appropriate escalation, and strengthen oversight of the staffing position across HSCP services. There is also work ongoing with Healthcare Improvement Scotland (HIS) to further develop the Staffing Level Tool for MH Inpatients, which will involve observation studies in some identified wards. In parallel, there is agreement to further promote use of the Care Opinion platform to capture service-user feedback and inform future strategies and service developments. The 2026

Quarter 1 Health report is currently being collated and will be submitted to the Board by the end of July 2026, in line with legislative requirements.

5. Duty of Candour

5.1 During quarter 4 of 2025/26, 28 SAERs (significant adverse event reviews) were closed, 11 of these were Duty of Candour Incidents.

5.2 In 10 cases an apology was given. Apologies were not given in the remaining case due to legal proceedings. Seven incidents took place in Mental Health Services, two incidents in Children & Families and two incidents in District Nursing. The incidents took place between July 2023 and November 2025.

5.3 Table 1 - Duty of Candour Incidents

Type of Unexpected or Unintended Incident	Number of Times an incident has happened
Someone has died	5
A person needing health treatment in order to prevent further injuries	2
A person's treatment increased	3
The structure of a person's body changed	1

5.4 Action plans were developed from the incidents, with 58 actions identified. 21 actions have been closed and 37 are ongoing.

5.5 Learning identified from these included:

- **Communication & Information Sharing** – 11 items (e.g. Improved discharge communications, Handover processes, Communication with care homes, Family/carer communication, Notification of serious incidents, Information-sharing SOPs, Police-to-CMHT handovers, Clinic outcome communication)
- **Documentation, Record Keeping & Care Planning** – 10 items (e.g. CRAFT completion, Assessment paperwork, Care plans, Pressure ulcer documentation, Discharge letters, NEWS2 documentation, Recording rationale for decisions)
- **Staff Training, Education & Competency** – 8 items (e.g. Pressure ulcer training, Sepsis training, ASP training, Risk management training, Junior doctor induction improvements)
- **Multi-agency / Multi-disciplinary Working** – 7 items (e.g. Joint MDTs, Health and social work collaboration, Third-sector involvement, Police, forensic and mental health pathway development).
- **Policy, Procedure & Standard Operating Procedure (SOP) Compliance** – 5 items (e.g. DNA and Was Not Brought policies , Bed Transfer SOP, Development of administrative SOPs)
- **Risk Assessment, Risk Management & Escalation** – 5 items (e.g. Escalation pathways, Clinical risk management processes, Missing person procedures, High-risk patient decision-making)
- **Governance, Audit & Assurance** – 3 items (e.g. Quality assurance monitoring, Dashboard audits, Caseload management oversight)
- **Workforce, Capacity & Service Processes** – 2 items (e.g. Workforce planning, Referral screening and waiting list management)

- **Patient Safety & Quality Improvement** – 2 items (e.g. Specialist seating/funding model review)
- **Safeguarding & Professional Curiosity** – was also noted to be a secondary theme in 10 of the actions noted above.

6. Learning Reviews

6.1 Learning Reviews are commissioned by the ASP and CP committees. The processes and oversight of reviews are delegated to the Learning Review Panel, which meets six times per year. The panel appoints a lead reviewer and review team members from relevant agencies, who analyse agency records and information from staff and families to identify learning which may lead to improvement in public protection systems and practice. The committee reports to the Chief Officers Group, and reports are also submitted to the Care Inspectorate.

6.2 During Quarter 1, the Learning Review Panel considered:

- New notifications of cases which meet the criteria for a review; and
- Progress in commissioned reviews.

There were 2 Adult Notifications and 2 Child Notifications under consideration.

- No further review was recommended for one of the adult cases, the second was deferred for further agency information.
- For both Child cases, decision was deferred for further agency information.

6.3 Learning Reviews in progress included 6 Adult reviews and 3 Child reviews.

6.4 One review was published during Quarter 1 – Family C Learning Review. This is a very significant review detailing an inconceivable level of abuse.

Strengths that were identified in the review included:

- Evidence of commitment from professionals working with the family
- Positive engagement in parts of the intervention
- Structures for multi-agency working were in place

However, significant learning was identified and the key areas for improvement are:

- Strengthening analytical practice, particularly around cumulative harm
- Ensuring consistent and effective information sharing
- Improving quality of multi-agency planning, with clear outcomes and timescales
- Maintaining a strong focus on the child's lived experience
- Reducing drift and delay through clearer accountability and oversight
- Staff confidence in recognising and responding to neglect as harm
- Achieving the conditions children need to disclose sexual abuse, and equipping staff to confidently consider what might be happening

Nationally, the review challenges the government and the Crown Office to be accountable for the protection of children's rights within judicial systems

A Family C Learning Review Executive Group, chaired by the HSCP Chief Officer and comprising senior representatives from the key partner agencies, has been established to oversee the partnership response. The Group

maintains a live multi-agency improvement action log, coordinates activity across agencies, addresses barriers and duplication, and provides a route for senior scrutiny and escalation. Improvement planning is being aligned with the findings of the joint inspection and other recent learning reviews where themes overlap, so that action is coherent and evidence of impact can be considered across the wider child protection system.

Immediate actions include strengthening multi-agency quality assurance and audit activity; reviewing arrangements for professional dissent and escalation with an immediate change that dissent be escalated to CSWO whilst a review is undertaken; introduction of the Public Protection Board; a commitment to a three year audit programme to benchmark and provide assurance around social work practice. Alongside these measures, the Executive Group will allow a deliberate period of reflection on organisational culture, including the conditions that support constructive challenge, professional curiosity, shared accountability, staff wellbeing and psychologically safe learning. This is intended to ensure that the improvement plan addresses not only process and compliance, but the leadership behaviours and working environment required to sustain safer practice.

6.5 Learning review training was delivered to 48 members of the multi-agency workforce, with further sessions available as required.

7. Audit Activity

7.1 An audit programme is submitted annually to the Social Work Professional Governance Board for approval. Following the meeting any actions agreed at the Board are then taken to the next meeting of the Safeguarding Board. The Principal Officer (Practice Audit) is responsible for implementation and management of the audit programme, maintaining an overview of Audit activity, progress of individual Audits and production of reports on Audit outcomes/findings. The Principal Officer attends the SWPGB meetings to provide an update on the programme.

7.2 During Quarter 1:

- Work undertaken in respect of Service Prioritisation and Cost Effectiveness Programme with file reading exercise carried out in respect of the Enhanced Drug treatment service & Complex Needs Service this quarter.
- An audit in respect of Safeguarding Service users currently residing in Bed & Breakfast accommodation within Glasgow, with completion in July 2026.

- Report into Suicide Cluster Completed and signed off by Social Work Governance Board.
- Work started in respect of an Audit into Alcohol and Drug Recovery Service Parental Assessment, draft plan completed. This will involve Literature review, extensive file reading, quality review of current assessments and staff interviews and is part of the Family C response audit programme.

8. External Scrutiny (Visits and Inspections)

8.1 Mental Welfare Commission

8.1.1 During quarter 1, the Mental Welfare Commission (MWC) undertook 7 local visits to mental health services in NHSGG&C; 2 of the visits were announced and 5 were unannounced. Visits took place to: Fruin and Katrine Wards, Vale of Leven Hospital; Rowanbank Clinic, Stobhill Hospital; Banff and Balmore Wards, Leverndale Hospital; Low Secure Forensic, Leverndale Hospital; Arran Ward, Dykebar Hospital; IPCU, Gartnavel Royal Hospital; and Cuthbertson and Timbury wards, Gartnavel Royal Hospital. *(Hyperlinks are included for those reports which have been published.)*

Upon completion of the visit, services are issued a final report by the Mental Welfare Commission, which may include recommendations for improvement. Services are then required to submit a formal action plan addressing these recommendations, including specified timescales for implementation, within three months of receiving the final report.

8.2 Care Inspectorate

8.2.1 During quarter 1, there were 11 inspections undertaken by the Care Inspectorate; all were unannounced. Inspections took place to Children's Services at Broomfield Crescent; Chaplet Avenue; Dalness; Hinshaw Street; Milncroft Road; Mosspark Drive; Newlands Road; and Netherton; to Older People's Day Care at Focal Point Day Care; and Riverside Care Home; and to Older People's Services at North West - HSCP - Community Support Service.

8.2.2 During quarter 1, of the reports received, no inspections scored 2 or lower.

8.2.3 The Care Inspectorate can issue areas of requirements and improvements to be made by the services. Services are required to develop action and development plans in response, including timescales for completion. During quarter 1 of the reports received, all inspections scored 4 or higher.

9. Recommendations

9.1 The IJB Finance, Audit and Scrutiny Committee is asked to:

a) Consider and note the report.

mental welfare commission for scotland

Organisation/Name of Service: Leverndale Hospital, Balmore and Banff wards

Visit Date: 28 April 2026

Date final report sent to service: 3 June 2026

Action Plan Response to Local Visit Recommendations: 25 August 2026

Recommendation	Self-Evaluation (where we are at currently in relation to this recommendation)	Activity (what do we need to do to meet this recommendation)	Audit (how will we know we have met this recommendation)	Completion Date/Projected Completion Date (when will this identified activity be implemented/ completed)	Who is responsible (for driving this improvement activity)
1. Managers should audit care plans and risk assessments to ensure these contain sufficient detail to reflect and support the high standard of person-centred care being delivered.	Audit is in place to ensure CRAFT is completed but does not audit the quality of information within the assessment. PCCP are audited for quality at present. Yearly patient and carer feedback from Mental Health Network and Practice Development Nurse yearly questionnaire.	CRAFT training for ALL staff will be prioritised and the line managers will start to audit quality of information contained within the during the audit process. Ensure the changing needs are captured accurately Reminders will be sent by SCNs to ensure the quality of information is appropriate to reflect the changing needs of the patients and recorded within PCCP and CRAFTs. SCNs will continue with current audits within the ward and have more focus on quality of info/changes in presentation:- Weekly checklists of paperwork 2 monthly care plan audits Line management supervision and discussions re quality of information recorded takes place Complex case discussions that currently take place with medical staff to focus on quality of CRAFT completion. Audit of CRAFT completion and quality of information captured will be undertaken jointly by Nursing and Medics with review of findings in 6 months.	Improvements will be noted in :- Weekly checklists of paperwork 2 monthly care plan audits Line management supervision and discussions re quality of information recorded Development of any recommendations will be based on results.	1 December 2026 1 March 2027	Pauline McCulloch Sarah Farmer Andrew Cunningham Dr James Herron Relevant line managers during supervision As above

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2. Managers should audit section 47 certificates to ensure that these record consultation with proxy decision makers.	Weekly checklist is in place for legal paperwork. CCAAT audits have shown improvements	Wards will continue to ensure the checklists are done regularly and thoroughly. Medics and senior nursing staff will be prioritising accurate paperwork completion at MDTs Communication will be sent round to medics and juniors regarding accuracy and all fields being completed especially when review is taking place.	100% completion of all aspects of legal paperwork noted in future audits	1 December 2026	As above
3. Managers should ensure that requests for repairs are addressed promptly to maintain an environment which is safe and dignified.	Requests are made for repairs promptly	Discussion Operations Coordinator re repairs HOS will be updated on environmental issues which are H&S or Infection Control Risks to make a case for funding to upgrade.	Environmental improvements noted	1 March 2027	As above

We would also ask that you provide further information in the box below regarding how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved e.g. community meetings, displayed on notice boards, discussed at carer group etc.
Poster to be displayed in both wards to highlight recommendations. Visitors will be offered a copy of report on request. Report will be sent round all OPMH inpatient and Community staff. Standing agenda item in ward meetings and OP Business meetings will remain in place. Mental Health Network contacted for their input/views. – Shona from Mental Health Network will come to Wards QI meetings and continue to do yearly patient and carer feedback on both wards with PDN.

Name of person completing this form:

Signature: P McCulloch Date: 25 August 2026

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