THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL GOVERNANCE COMMITTEE

Agenda Reference:

Date of Meeting: January 2022

Presented by: Medical Director

Title of Report: Clinical Governance Group Report January – December 2021

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Approval Group	Clinical Governance Committee
Accountable Executive Director	Medical Direcor

1 Core Purpose of Group

In 2016 the State Hospitals Board for Scotland agreed that there would be a change to the governance arrangements within the hospital. It was agreed that a Clinical Governance Group would be established with the following quality assurance/improvement remit:

- To identify and discuss clinical governance issues of concern; and to ensure the appropriate management of these
- To review and prepare matters relating to the work of the Clinical Governance Committee
- To ensure the Clinical Governance Committee is provided with information and advice to ensure it is able to monitor and review the quality of clinical care
- To provide a forum for discussion of new ideas
- To liaise with the Research Committee to identify mental health research priorities and to implement research findings
- To inform the development of the corporate training plan by identifying training priorities to ensure that clinical practitioners are skilled and competent in the delivery of mental health interventions
- To increase the proportion of care that is evidence based or best practice and provide guidance on mental health interventions in the areas of risk assessment
- To promote work on service design, redesign and development priorities
- To promote the principles of the Clinical Model
- To monitor National Standards and Guidelines external reviews issues identified
- To monitor work of reporting groups

Terms of Reference for the Clinical Governance Group
As part of the recovery plan from Covid-19 all Groups in the hospital were tasked with considering whether the Group was still required and whether the Terms of Reference accurately reflected the work of the Group.

At the August meeting, it was agreed that this Group is still required as it plays a key governance role within the hospital. One slight amendment was agreed to the Terms of Reference: it was agreed to remove bullet point 5 from the Remit of the group – 'To develop and manage outcome measures for mental health' as this will now sit under the Mental Health Practice Group. Within the organisational chart it was noted that the PMVA group has now been subsumed into the Patient Safety Group.

The governance arrangements for the group can be found in Appendix 1.

2 Summary of Core Activity for the last 12 months

2.1 Standing Items

National Standards and Guidelines
The Clinical Governance Group continue to oversee the decisions relating to Standards and Guidelines to ensure all relevant guidance is being considered. The NICE Guidelines on Shared Decision Making was tabled for information in July, with a number of suggestions being made by the Group for wider circulation.

Mental Welfare Commission
The Mental Welfare Commission Annual Report was tabled for information at the February meeting.

2.2 Monitoring Reports for Clinical Governance Committee

The following 12 monthly reports were tabled. The Clinical Governance Group gives feedback to the authors (and suggests any amendments/additional data requirements) prior to the reports being tabled at Clinical Governance Committee for approval. A summary of these reports can be found within the Clinical Governance Committee Annual Report:

- Research Committee
- Psychological Therapy Service
- Mental Health Practice Steering Group
- Patient Learning Annual Report
- Child and Adult Protection
- Infection Control
- Fitness to Practice
- Patient Safety
- CPA/MAPPA
- Medicines Committee
- Rehabilitation Therapies
- Physical Health Steering Group
- Duty of Candour

6 monthly update reports were also tabled to ensure that services were on track to deliver their key pieces of work and any actions outstanding in their action plans.

Standing items for the Clinical Governance Committee were also considered, with suggestions for enhancing the report sent to authors prior to the item being tabled at Clinical Governance Committee.

Standing items in 2021 included:

- Learning from Feedback
- Learning from Complaints
- Incident Reporting and Patient Restrictions
- Safe Staffing
- Covid 19 Updates

2.3 Realistic Medicine Action Plan

In January and June, papers were submitted by the Lead for Realistic Medicine. The Lead explained to the Group that the aims and objectives of this action plan are directly linked to the Chief Medical Officer's aim of: "By 2025, everyone who provides healthcare in Scotland will demonstrate their professionalism through the approaches, behaviours and attitudes of Realistic Medicine." The objective of the action plan is to provide the mechanism through which the implementation of the principles of Realistic Medicine will be monitored within the organisation.

The six key themes of Realistic medicine are:

1. Building a personalised approach to care
2. Changing our style to shared decision making
3. Reducing harm and waste
4. Becoming improvers and innovators
5. Reducing unwarranted variation in practice and outcomes
6. Managing risk better

The updated action plan was tabled at both meetings bringing together all the workstreams into one document. A number of updates were given to the realistic medicine lead at the meeting to allow a further update to the action plan. Although it was noted at the June meeting that there had been challenges recruiting to the Project Manager post, the post has now been successfully filled.

2.4 Improving Observation Practice Policy

The group were given regular updates re this piece of work. The first draft of the policy has been written and has been updated in line with feedback received. Work paused in December as a result of Covid-19 and the restrictions in movement across the site. The draft policy will be shared with mental health nurse colleagues in other boards and also forensic lead nurses. It was agreed that a table-top exercise with each clinical team will take place to take them through the policy and procedures. It was agreed that the draft policy will go out for wider consultation following the table-top exercises.

2.5 Tableau Incidents Dashboard

A demonstration of the incident dashboard was given at the February meeting. It was noted that there are options to update daily, select a summary of incidents or select specific date ranges that can filter dependant on need. The data provided are anonymous therefore individual access can be given to those who request it.

This reporting mechanism was welcomed by members as a useful visual tool. It was noted that eHealth is working on a patient version but require to carry out some data cleansing first. There was a query regarding the hardware required to make use of this tool and it was confirmed that as it is an internet based tool it just requires log in details which eHealth would supply.

2.6 Operational Model Monitoring Group (OMMG) Updates

Regular updates from OMMG were tabled at the Clinical Governance Group. These updates included information on the frequency of the meetings, the areas of improvement that have been tested e.g. bringing together a weekly timetable group to look at patients in a more cohesive manner, physical activity initiatives to try and improve the number of patients meeting the physical activity targets. The weekly data are presented at the OMMG as well as summary data being tabled at Clinical Governance Group, Clinical Governance Committee and the Board through the Quality Assurance/Quality Improvement report.

2.7 Digital Inclusion Update

The Digital Inclusion Group presented its update at the March and August meetings. A number of areas were highlighted:

<u>Virtual Platforms for the Provision of Patient Groups</u>
Virtual platforms are presently used for a range of interventions including patient visiting, physical health interventions and clinical groups.

The video conferencing facility is used for the provision of clinical groups, along with meetings where patients are in attendance. In order to extend and support the delivery of this facility 5 additional Polycom units and associated equipment were purchased for each Multifunction room in the Hubs and an additional unit for the Vocational Activity room in the Skye Centre.

The use of Microsoft Teams as a platform for the provision of patient groups, is still being considered and a local Data Protection Impact Assessment (DPIA) is being progressed. A national DPIA is still not available for the use of this platform for clinical groups.

The Near Me platform is used widely across the NHS and within the State Hospital for the delivery of physical health consultations and clinical interventions. This platform is considered by members of the Digital Inclusion Group to be a suitable option for the delivery of clinical groups within the State

Hospital due to the controls and security measures that are already in place. The present functionality of this platform however is considered to be limited for what State Hospital clinicians would like to achieve. However, there are developments being taking forward regarding the functionality of the system and the State Hospital has indicated that it would be willing to be a test facility for this. The release date for the upgrades was expected in October 2021.

The following response was provided by the National Lead for the Near Me Team in relation to ongoing work related to the use of Microsoft Teams:

"We have extensively tested Teams Webinars recently as a potential tool to use with patient groups. In summary due to the additional settings and controls available within Teams Webinars (chat on/off, lobby controls, video & mic on/off, lock meeting etc.) then some of the IG concerns previously raised have been addressed. However, there are still concerns around the "digital footprint" left behind after a webinar and the challenges encountered in joining a meeting without needing a Teams/Microsoft account to log in with. Taking into account the above Teams Webinars do present us with a potentially good tool to offer group sessions to certain populations of patients (Educational groups for example). To this end we will be producing some interim guidance as soon as possible for clinicians to help further exploration and testing of this platform."

Patient Education

The equipment related to the patient education project has been identified and an IT request has been submitted. The upgrade of the Patient IT system and transfer to Windows 10 is progressing. Protocols and procedures for the initiative have been developed by the Lead Occupational Therapist and Patient Learning Manager and will be presented to the Digital Inclusion Group for approval. The DPIA for the project is being progressed with support provided by the Information Governance and Data Security officer.

Patient Internet Browsing Experience

The ongoing issues related to the software have been resolved and testing by Security has been concluded. The use of Sophos UTM provides controls that can provide managed internet access within security requirements. Estates have provided a solution for the safe installation of the equipment which will be located in the ward day room area. Arran 1 ward has been identified for the pilot site and review of the equipment and processes will take place over the month of September 2021. Feedback will be provided during this period from patients and staff prior to the equipment being rolled out to the remaining wards.

New Initiatives

The Digital Inclusion Group will be exploring the available options for Digital Media solutions for patients. The use of self-service kiosks is presently being used in other high secure settings such as Ashworth and the Prison service. These touch screen devices are specifically designed to meet the needs of a high secure environment and are located in patient rooms. They use biometric identification at log on and can provide access to educational resources, meal ordering, financial information that allows shopping and have the option to enable in room video visiting. A visit is being arranged to Addiewell Prison to view this facility in use and links have been established with Ashworth Hospital.

Digital Inclusion Project Support

It has been acknowledged that the ongoing work related to the Digital Inclusion agenda and the identified needs of our patient group would benefit from dedicated project support from the eHealth team. This has been discussed with the Director of Finance and the Head of eHealth and a proposal is being developed for presentation to the HMT to obtain support and approval for the development of a 12-month Project Lead post dedicated to supporting the development of the ongoing Digital Inclusion initiatives. The Head of eHealth has previously developed a generic Project Lead job description which

is being considered under Agenda for Change and would also be applicable for a eHealth post. Possible funding options for the post have also be identified.

2.8 Advance Statement Overrides Monitoring Report

The Mental Welfare Commission (MWC) Advance Statement Overrides Monitoring Report was provided to the March meeting. The MWC had highlighted some concerns about the number of overrides in the system. It was agreed at the Group that the Mental Health Practice Steering Group would take this piece of work forward to ensure the hospital is advising the MWC of any advance statement overrides.

2.9 Guidance on Management of Medical Devices

A report re the Guidance on Management of Medical Devices was tabled at the August meeting with the following recommendations being approved:

1) The health centre to lead on creating a register of medical devices located throughout the hospital including how these are monitored. This would include linking with AMD, wards and pharmacy.
2) This list to be examined by CGG to consider whether the roles described of Responsible Director and/or Risk Manager are required.
3) Responsibility of all clinical staff towards medical devices/equipment will be publicised via the Bulletin.
4) The Medicines Committee to be asked to formalise the National Patient Safety Alerts system within the State Hospital.

2.10 The Person Centred Improvement Service 12 monthly Report

The report was presented at the September meeting of the Clinical Governance Group. The main points included within the report were:

- 9 of 14 outcome measures have been achieved.
- 3 of those partially achieved are directly as a result of the impact of Covid-19.
- 1 outcome relates to wider service change. It is anticipated that this measure will be complete by April 2021.

The report highlights key achievements including:

- Supported patient engagement in TSH3030.
- Implemented ‘hire purchase scheme’ to provide patient TV/ Radios.
- Initiated plan to introduce electronic Grounds Access Applications.
- Informed review of process relating to withdrawal of patient newspapers.
- Implemented patient clothing donations scheme.
- Introduced tailored format of PPG for Intellectual Disability patients.
- Developed and implemented interim visiting process (Covid-19).
- Contributed to introduction of centralised visit booking system.
- Produced weekly Covid-19 Patient Update.

Actions for the next twelve months including:

- Tailor national ‘Interpretation and Translation Policy’ for implementation locally.
- Develop Carers’ Policy.
- Adapt local Volunteer Impact Assessment to incorporate national volunteering framework.
- Support Hospital wide working group to identify and explore options to develop an enhanced visiting experience aligned to the refreshed Clinical Service Delivery Model.
- Undertake QI project to increase the number of patients receiving visits.

- Publish Equality Outcome Report to national standards.
- Support progression of the digital agenda to enhance patient and carer involvement.
- Undertake service review to support service remobilisation and new visiting model.
- Support Hospital-wide Patient Activity project.

The group welcomed the report and acknowledged the continued hard work of this service.

2.11 Exceptional Circumstance Finance Report

The financial report for 2020/21 was tabled at the February and September meetings. This is monitored to ensure that the clinical negotiations required for this financial aspect of the EC system are followed through. The most recent report included the following:

- For the 2020/21 financial year, Ayrshire & Arran, Grampian, Lanarkshire and Lothian have paid the State Hospital, while balances remain outstanding from Forth Valley (£450k) and Glasgow (£375k). These balances have been acknowledged by these boards through NHSScotland's finance system when audited in their year-end inter-Board balance confirmations as at 31 March 2021.

- For 2021/22, the Q1 invoices have been issued as noted below and are now falling due, and the Q2 invoices which will be to Forth Valley and Ayrshire & Arran will be issued in early October 2021.

Board	Q1 invoice
Ayrshire & Arran	£ 35k
Forth Valley	£ 77k
Glasgow	£ 94k

The balances outstanding from Forth Valley and Glasgow are currently being addressed through the NHSScotland debtor recovery channels, being raised through CLO recovery.

2.12 Governance Report

The Governance Assessment report was presented to members at the November meeting. The survey was undertaken with response rate from the Clinical Governance Group quite low at 6 out of 20. Although responses were quite low the overall impression was that the Clinical Governance Group is functioning well, although it was acknowledged that it has a very full agenda and making time for full discussions can be very challenging.

3 Comparison with Last Year's Planned QA/QI Activity

Planned QA/QI Activity	Update
Implementation of the Clinical Model including preparation of guidance on the 4 ward types, patient flow, model fidelity and development of measures to monitor the model	A mapping exercise was completed with regards to the hospital's current population. At the time of the mapping exercise there were too many patients to fit into the current model. Further actions were agreed in December: • Meeting to be established with relevant parties to arrange a desktop exercise to look at financial position of clinical model • Workforce implications and finance to be considered • Rework the clinical guidance documents • Revisit the clinical / service leads document • Written agreement in ID service guidance of potential MMI patients use of the wards should there be surplus.

Development of new plan to address healthy choices and obesity problem	The latest Health Choices action plan has been developed and will require consultation / engagement. A Project Manager will be recruited to assist with this piece of work to ensure all the strands are taken forward in a timely manner.
Continued work on patient activity	The initial process mapping exercise was presented to CMT with recommendations being made to take this work forward. A winter programme of activities is being implemented to help and support patients meeting their physical activity targets.
Ongoing focus on Quality Improvement, Realistic Medicine and TSH3030 initiative	The Quality Forum continues to meet and discuss quality improvement ideas for the hospital. They are currently looking at the best way to deliver QI training virtually due to the current restraints with social distancing. The hospital's TSH3030 project won Best QI Team at the Royal College of Psychiatrists annual awards.

4 Performance against Key Performance Indicators

There are currently no key performance indicators (KPIs) that sit directly with the Clinical Governance Group. The KPIs sit within the Service Reports that are presented to the meeting and any required improvements will be discussed as part of the Service Report.

5 Quality Assurance Activity

Clinical Effectiveness Annual Report
The report was presented at the June meeting and set out the work of the Clinical Effectiveness Department between 1 April 2020 and 31 March 2021. Some of the main work areas included:

- 18 Clinical audits completed. These aim to provide feedback and assurance to a range of stakeholders that clinical policies are being adhered to. All clinical audit reports contain recommendations to ensure continuous quality improvement and action plans are discussed at the commissioning group.
- There have been 219 pieces of standards, guidance and reports issued during the reporting year that have undergone relevancy checks by the Standards and Guidelines Co-ordinator. From these, 88 were found to be relevant to the hospital's patient population, 6 of which required completion of an evaluation matrix.
- All admission, annual and intermediate and discharge case reviews are monitored via a VAT (admission, treatment & rehabilitation and discharge) with reports being supplied monthly to senior management. In addition, detailed reports on individual patients are sent to department heads and senior charge nurses to allow them to have the data to support continuous quality improvement.
- 24 policies were uploaded for staff consultation and 17 policies were finally approved by PAG.
- 20 additional projects were supported, working with approximately 45 staff to support them to implement QI approaches and understand more fully the data that they collect.

CPA Audit Report
The CPA audit report was tabled at the May meeting with the action plan being agreed by the Group. The main areas for improvement were:

- PANSS completion.
- More accurate transference of information from RiO into the CPA document.

- Completion of the Risk Management Plan (additional sections).
- HCR-20 table (some use just codes whilst others use code and text).

An action plan was agreed with clear responsibility given to individual staff members.

Variance Analysis Tools
The reports and action plans from the Admission, Discharge and Treatment and Rehabilitation Variance Analysis Tools were presented to various meetings during 2021. Areas of Good Practice and Areas of Concern were included in all the reports with these being highlighted to the Service Leads for action. Data provided included:

Overall professional attendance at the patient's Case Review has increased.

	2018/19	2019/20	2020/21	Increase/Decrease
RMO	90.9%	89.4%	80.7%	-8.7%
KW/AW	63.6%	77.2%	67.5%	-9.7%
OT	64.2%	85.6%	76.5%	-9.1%
Pharmacy	59.4%	60.7%	65.1%	4.5%
Psychology	84.5%	70.9%	66.9%	-4.0%
Security	41.2%	52.0%	45.8%	-6.2%
Social Work	80.8%	72.9%	85.6%	12.6%
Dietetics	23.6%	60.2%	74.8%	14.6%
Hospital Wide	63.5%	71.5%	70.5%	-1.0%

Both Pharmacy and Social Work achieved their LDP attendance target.

	LDP Target	2020/21	% LDP target achieved/not achieved
Social Work	80%	85.6%	5.6%
Pharmacy	60%	65.1%	5.1%

Health and Wellbeing Plans (HWP)
An audit into the health and wellbeing plans was tabled at the March meeting. Following discussions, the following recommendations were agreed by the group to take this piece of work forward:

- The Health and Wellbeing Plans continue to be embedded into clinical practice.
- Nursing staff should complete all Nutritional Screening Tools (NST's) and then subsequently commence completing a patient's HWP. This role should be fulfilled by the key worker or associate worker.
- Day 14 sign off by the RMO/clinical team requires to be actioned to ensure compliance with the FFNC standards.
- The Guidance the Implementation of Patient Health and Wellbeing Plans should be updated.
- The Shop field of the F&D section of the HWP requires each patient to have a shopping list agreed and listed by nursing.
- All NST scores that are incorrect and have resulted in the patient being in the wrong risk category should be corrected
- All patients who do not have respective sections completed by OT, Dietetics and/or Sports to be done so by end of February 2021.
- Future audit/QI project will look at other disciplines input

6 Quality Improvement Activity

Bespoke Dementia Care Training
A paper was tabled at the September meeting outlining the work that has been carried out to date in relation to Dementia Care Training. The following recommendations were approved by the Clinical Governance Group to further improve the dementia services within the hospital:

- Further training to increase staff's knowledge and skills to enable them to support changes in a patient's care needs as their Dementia progresses.
- Development of resources to support staff in Arran 2.
- Adaptations to the clinical environment.

7 Planned Quality Assurance/Quality Improvement for the next year

The following pieces of work will be included in the work of the Clinical Governance Group:

Core Activities for next 12 months	Risks to Completion of Core Activity
Implementation of the Clinical Model including preparation of guidance on the 4 ward types, patient flow, model fidelity and development of measures to monitor the model	Restrictions associated with Covid-19 resulting in patients from different wards not being able to mix
Oversee the implementation of the QI Activity Project to ensure activity within the patients objectives are reflected in the activities delivered to the patient	Delay in the CPA review by the Mental Health Practice Steering Group may impact on this piece of work
Ongoing focus on Quality Improvement, Realistic Medicine and TSH 3030 initiative	Continued restrictions around Covid-19 and the mixing of patients from different wards

8 Next review date

The next annual report will be presented at the January 2023 meeting of the Clinical Governance Group.

Appendix 1

GOVERNANCE ARRANGEMENTS

1 Committee membership

Membership is reviewed annually and reported as part of normal monitoring mechanisms.

- Chief Executive
- Clinical Operations Manager
- Head of Psychology
- Head of Allied Health Professionals
- Head of Pharmacy
- Head of Social Work
- Head of Corporate Planning & Business Support
- Medical Director (Chair)
- Director of Nursing and Allied Health Professionals
- Security Director
- Person Centred Improvement Lead
- Associate Medical Director
- Head of Clinical Quality
- Hub and Skye Centre Clinical Leads
- Professional Nursing Advisor
- Research and Development Manager as required
- Learning and Development representative as required

To fulfil its remit, the group may obtain whatever professional advice it requires and invite, if necessary, external experts and relevant members of Hospital staff to attend meetings.

Others may attend the Committee on the approval of the Committee Chair.

2 Meetings and Frequency

There were 11 meetings held during 2021.

The meetings are held monthly, on a Wednesday. No meeting was held in December.

The Chair may convene additional meetings as necessary.

3 Aims and objectives

At the request of the NHS Board or Corporate Management Team, the Clinical Governance Group may also be called upon to perform one or more of the following functions:

- To investigate and take forward particular issues on what clinical input is required on behalf of the NHS Board and/or SMT, taking into account the evidence base, best practice, clinical governance, etc., and make proposals for their resolution
- To advise the NHS Board and/or SMT on specific proposals to improve the integration of services, both within local NHS systems and across health and social care.

It was agreed that the Clinical Governance Group will manage its business through a work plan, agreed by the Chair of the Committee. This will ensure that the full remit is covered on a rolling basis.

4 Authority

The Clinical Governance Group is authorised by the Clinical Governance Committee to investigate any activity within its terms of reference. It is authorised to seek any information required to meet its terms of reference from any employee and all employees are directed to co-operate with any request made by the Group.

5 Communication and Links

As outlined in the organisational chart below, this group sits between the Senior Management Team work and the Clinical Governance Committee.

ORGANISATIONAL CHART – CLINICAL GOVERNANCE GROUP