Title of Report: **Clinical Governance Group Report January 2024 – December 2024**

Lead Author	Medical Director
Contributing Authors	Head of Clinical Quality PA to Medical Director
Approval Group	Clinical Governance Committee
Accountable Executive Director	Medical Director

1 CORE PURPOSE OF GROUP

The Clinical Governance Group has the following quality assurance/improvement remit:

- To identify and discuss clinical governance issues of concern; and to ensure the appropriate management of these.
- To ensure the Clinical Governance Committee is provided with information and advice to enable it to monitor and review the quality of clinical care.
- To review and prepare matters relating to the work of the Clinical Governance Committee
- 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 and any issues identified through external peer reviews.
- To monitor work of reporting groups as set out in the organisational chart (see Appendix 1).
- To facilitate consideration of stakeholder feedback relating to service improvement.

Terms of Reference for the Clinical Governance Group

The terms of reference for the Clinical Governance Group was considered at its meeting in August 2024. Minimal changes have been made to the organisational chart to bring it in line with current structures. The governance arrangements for the Clinical Governance 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 continues to oversee the decisions relating to standards and guidelines to ensure all relevant guidance is being considered.

Healthcare Improvement Scotland (HIS) published a scoping report into their Healthcare Standards that was presented to the June 2024 meeting.

Mental Welfare Commission/Scottish Government

There were two visit reports presented at the Clinical Governance Group. The first was at its May 2024 meeting with two recommendations noted to be progressed:

1) Managers and medical staff should ensure that all expired T2 and T3 forms are stored appropriately.
2) Medical staff should ensure that when a section 47 certificate is issued, a treatment plan is then completed.

The second visit report was presented at the October 2024 meeting, with four recommendations to be taken forward:

1) Care plan reviews should be completed on a consistent basis by nursing staff in line with the hospital target.
2) Care plans should be completed to ensure engagement with individuals, their named persons and relatives and that these views are reflected in the care plans.

3) Managers should ensure that all clinical team meetings held record who is in attendance.
4) Management should ensure the timely redecoration of the wards to ensure the environment remains welcoming and fresh for both individuals being cared for in the hospital and staff.

Work is underway to address each of the recommendations and details of these will be captured in an action plan and returned to the Mental Welfare Commission by the deadline dates.

The Mental Welfare Commission annual report was presented at the August 2024 meeting for information.

The Mental Welfare Commission Supported Decision Making Good Practice Guide was presented at the November 2024 meeting. The guidance discusses:

- What supported decision-making is and why it is relevant and important.
- The human rights framework that supports autonomy and supported decision-making.
- The role that supported decision-making can play in reinforcing principles that underpin Scottish legislation.
- What must be taken into account when providing supported decision-making.
- Examples of supported decision-making.

The Group asked for wide circulation of this Guide including Psychology, Realistic Medicine, AHPs and Practice Development.

Outstanding Actions from CAT1 and CAT2 reviews

A report was submitted to all meetings during 2024. The reports contain all the actions that have been agreed following a CAT1 or CAT2 review (with closed actions being highlighted in yellow), information on any outstanding reviews and any new recommendations since the last report. The reports also gave assurance that an action tracker relevant to each directorate is sent to each oversight group to ensure progress is made on each risk alongside an update to OMT.

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 the 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.
- Patient Safety.
- Transfer CPA/MAPPA.
- Activity Oversight Group.
- Supporting Healthy Choices.
- Medicines Committee.
- Rehabilitation Therapies.
- Physical Health Steering Group.
- Duty of Candour.

Also tabled were 6-monthly update reports 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 2024 included:

- Learning from Feedback.
- Learning from Complaints.
- Incident Reporting and Patient Restrictions.
- Infection Control Report (from October 2024).
- Nurse Resourcing.
- Bed Capacity.
- Corporate Risk Register - Clinical Update.

2.3 Trauma Champion

An update was provided at the January 2024 meeting. Most of the work to date has been around supporting capacity building and supporting staff wellbeing. In January 2024 there were 54 staff that had attended Trauma Informed Practice level 1 training and 45 had attended Trauma Skilled Practice level 2 training.

Resources had also been allocated within the Corporate Training Plan to support delivery of 'Trauma Enhanced Level Practice' training. This includes 'Prolonged Exposure Training for PTSD', 'Safety and Stabilisation' training, and 'Survive and Thrive' training to upskill clinicians and support delivery of specific trauma interventions to patients in the hospital.

Supporting staff wellbeing has been progressed through providing strategic leadership for the development and implementation of the Board's 'Staff and Volunteer Wellbeing Strategy'. Creating the conditions for staff to experience their wellbeing as valued and prioritised, and ensuring access to relevant proactive, protective and reactive wellbeing support, is a key component in helping to embed and sustain a trauma-informed and responsive approach across the organisation. Implementation of the Wellbeing Strategy will help to ensure that a broad range of wellbeing support is available for staff.

2.4 Realistic Medicine

Updates were provided in March and September 2024. The most recent update in September 2024 included the following key objectives for the rest of the financial year:

- To continue to progress the individual projects within the Realistic Medicine Action Plan.
- Understand and address unwarranted variation and use of data to drive decision-making.
- Embed QI approaches.
- Progress work on BRAN questions.
- Increase completion rates of (shared decision-making) SDM module.

2.5 Clinical Care Policy

Reports on progress of this policy were received at the February and March 2024 meetings, with the policy going live on 1 May 2024. A further report was submitted to the November 2024 meeting giving details of the findings from an audit into aspects of the policy.

The report outlined that outcomes of the first audit cycle were discussed with Patient Safety Group members. An action plan has been developed for further discussion at the December 2024 meeting along with a wider discussion regarding the ongoing improvement journey required to support the ethos and principles of the policy to be realised in full.

The policy is due for a one-year formal review in May 2025 and as part of this process all relevant stakeholders (including patients) will be consulted and have the opportunity feedback on aspects of the policy that are working well in addition to areas that would benefit from further review.

2.6 Health Psychology Consultancy Model

Reports were submitted to the March and September 2024 meetings that gave details on the consultancy model that has been in operation between health psychology and the health centre since March 2023. The report summarised the main aims of this model and results to date.

Feedback from the practice nurse was very positive regarding the expertise provided by the Health Psychologist. In particular they reported:

- Enhanced knowledge regarding interactions between mental health formulation, physical health and management of long-term physical health conditions.
- Enhanced understanding and skills to explore ambivalence and support motivation of patients.
- Enhanced knowledge regarding health anxiety and how to respond to reassurance seeking behaviours.
- Enhanced knowledge regarding adaptations that can be made to practice to more effectively support patients understanding of long term conditions, especially in the context of intellectual disabilities and impaired cognitive functioning.

Three recommendations to progress this work were approved by the Group:

1) That the applied consultancy model continues in its current form between health psychology and the health centre and also with dietetics.
2) Complete evaluation and report through the psychological therapies service reporting structure to inform funding considerations.
3) Plan for expansion of the model to nursing keyworkers.

2.7 Digital Inclusion Update

An update paper was noted by the Group at the May 2024 meeting.

The paper included the following updates:

- The completed option appraisal along with the outcomes, costings and priorities determined from the Digital Inclusion workshop was presented to the Corporate Management Team (CMT) for discussion. In March 2024, the Project Manager provided feedback to the Patient Partnership Group that CMT have paused the Digital Inclusion programme due to the current financial situation. Work associated with the project would require to be phased and will unfortunately not be concluded within the timescales outlined within the option appraisal. It was acknowledged how much Digital Inclusion matters to the patients and the amount of time and effort that has been put into this project by patients and staff across the hospital.
- The Director of Finance and eHealth will be attending the Patient Partnership Group to inform them further on the discussions that took place at CMT.

- Due to the extensive engagement with both patients and staff a 'Road Map' is now available and will provide the necessary information as and when new funding becomes available in the future, informing what the Digital Inclusion priorities are.

2.8 Attend Anywhere Report

Update reports were presented and noted at the March and June 2024 meetings. The most recent report showed that three patients had attended their appointment through near me/attend anywhere, with no others being declined and no telephone consultations (April to June 2024 data). Going forward this data will be reported as part of the Physical Health Steering Group annual report.

2.9 Development of a Neurodevelopmental Pathway for the State Hospital

Updates on this piece of work were provided at the May, September and November 2024 meetings.

The November 2024 meeting saw the Group approving a 10 patient pilot (admission patients). The broader approach that has been agreed will:

- Allow much of the Fife Neurodevelopmental Questionnaire (FNDQ) to be populated by file review, reflecting the planned pathway and extending the information gathering already in place, offering time efficiencies.
- Allow an assessment of the feasibility of the additional components proposed namely; the collection and review of additional historical files and physical, sensory and motor and potentially language assessments.
- Allow a clear estimate of the time taken for each component and a comparison with the time taken to adhere to the current admission pathway.
- Provide an estimate of the proportion of admissions who will require further diagnostic assessment for neurodevelopmental disorders.

2.10 New to Forensics – Essentials of Psychological Care (N2F EoPC)

Updates were submitted to the May and November 2024 meetings. The main areas of work noted that:

- Link Nurses are enjoying their role and providing a valuable asset to Psychology, particularly in the delivery of group work and knowledge exchange with their peers in their substantive role. Link Nurses are working through the programme with the Consultant Nurse at their monthly line management meetings. They will commence their mentoring role on completion.
- A monthly online group EoPC programme that commenced in August 2023 at the State Hospital finished in the summer of 2024 with four mentees completing the programme. A mix of social work, pharmacy and medical records colleagues. Feedback was very positive.
- The Learning Centre supported the piloting of a two-day EoPC programme in August and September 2024 at the State Hospital. Twelve signed up for the training with 10 completing the two days. The remaining two will complete the programme at a subsequent date. Mentees were a mix of nursing, social work and allied health professionals. Feedback was very positive The Learning Centre is being liaised with in order to set three to four dates throughout 2025 to continue this delivery option for the hospital.

There is now a menu of format options in the delivery of the EoPC programme at the State Hospital. Staff and services have the choice of the traditional monthly 1:1 meetings with their mentor, monthly online group mentoring or the 2-day taught programme. Offering choice aims to continue the positive effect on uptake and completion of the programme. Fourteen staff have completed the programme since the last Clinical Governance Committee meeting including social workers, occupational therapists, nursing assistants, staff nurses, health records assistant, AHP support worker, pharmacist and dietician.

2.12 Clinical Model Oversight Group

Reports were presented at the June, August, September and November 2024 meetings. The most recent report gave an update on the six aims of the clinical model, including challenges that have been raised via the Service Leadership Teams:

1) More tailored security based on risk and clinical presentation, aligned with the least restrictive practice principles.
2) Streamlined integration between sub-specialty wards and the Skye Centre, enabling best use of resources to support physical health, therapeutic activity and treatment goals.
3) A sense of progression for patients through their clinical care journey in high security.
4) Improved clinical case mix, with admissions accommodated in specified wards.
5) The ability for staff to specialise in sub-specialty areas of care and practice.
6) Meeting the ID specific patient need through a more tailored and specialised environment. This involves distribution of patients across two wards rather than one to improve the therapeutic milieu.

Key areas of work that will be taken forward include:

- Pilot of new clinical team process within Treatment and Recovery.
- Winter planning to be completed to ensure activity remains a priority over the winter.
- Exploration of an admissions and activity plan within Admission and Assessment.
- Implementation of 4-6 week check-in within Admission and Assessment Service.
- Heads of Services and Service Leads to agree changes to the timetable activities to make the data more meaningful.
- Testing and implementation of debriefs in Arran 1.
- Clinical Model adherence tool to be tested across all services.

An interim evaluation report was presented and discussed at the July 2024 meeting with recommendations given to enhance the reports from the Clinical Model Oversight Group.

2.13 Excellence in Care

The Group noted an update re the hospital's ongoing engagement with Excellence in Care (EiC) at the May 2024 meeting. The update included that the State Hospital continues to engage with partners at Health Improvement Scotland to support implementation of the EiC programme. Over the course of 2023 programme remobilisation remained a priority with a number of short life working groups (re)-established in order to either support evaluation of existing measures or with a focus on developing new measures. The State Hospital was involved in two of these groups – the Person Centred Advisory Group and the Secure Environment Short Life Working Group. Unfortunately, in February 2024 national pieces on work began to slow again in response to pressure across NHS Scotland, and more recently all short life working groups have been paused again. At the moment there is no indication of when work will re-begin.

In the meantime, the State Hospital continues to submit data on all measures applicable to this setting (inpatient falls rate; pressure ulcer rates; predictable absence allowance; supplementary staffing use; and establishment variance).

2.13 35 Point Testing System for Oral Fluid Tests

An update paper was presented at the June 2024 meeting for noting. The update noted that:

- A new policy is currently out for consultation, EQIA is completed, and DPIA with Data protection team for sign off, and the SLA with GGC for final sign off.
- All required equipment has been discussed with procurement and orders raised.
- Ongoing discussions with Estates department surrounding delivery of samples, resourcing for sample delivery proving to be a challenge.

- Policy will not go live until staff have received refresher training, planned for going live in mid-August 2024 (went live in October 2024).

2.14 Daytime Confinement

Reports from the Chair of the Activity Oversight Group were received in February, April, August, September and November 2024. The most recent report included:

- Data to show that spikes are being seen when clinical acuity is high (SRKs/outings/seclusions).
- Feedback received from Service Level Teams (SLTs) re the use of Daytime Confinement (DTC) within their services.
- Assurance that the escalation process is being managed well.
- Details on a considerable piece of work being carried out within the nursing directorate to create a robust dataset to enable them to understand the demand and capacity of the nursing workforce and identify areas for improvement.
- An update on the recruitment of a member of staff to join the outings team. Early reports are that this has had a positive impact for outings.

The report did acknowledge that DTC is not in a stable enough position to consider a move to business continuity at this stage.

2.15 Healthy Living Group Update

Papers were received and noted at the February and September 2024 meeting. In February 2024, the authors presented three proposals for the Healthy Living Group (HLG) moving ahead that were welcomed and endorsed:

1) Retain the HLG at the State Hospital as a low-intensity group, representing the first level of group support offered to patients who are contemplating making changes to support their health and weight.
2) Amend HLG prior to its next facilitation with a focus on review of the group aims, inclusion criteria, group referral process, evaluation process, exclusion of cooking sessions, physical activity supported within the group, group content and materials, and the addition of maintenance sessions to support behaviour change maintenance.
3) Continue work that develops a pathway of interventions appropriate for different stages of change: specialist groups (for example for disordered patterns of eating, body image, long term conditions, counterweight plus group), maintenance groups to support ongoing behaviour change and peer support.

The September 2024 update confirmed that work has been ongoing to meet these aims. To date this has focused on aim two, updating the protocol and group procedures. This has been a collaborative effort between the three authors. It was anticipated that this review would be completed by mid to late summer 2024, however this has now been delayed due to staff absence, uncertainty surrounding the ongoing funding of the Health Psychologist post (now confirmed as 0.8 WTE permanent from October 2024) and competing clinical and service demands. Since August 2024, a renewed focus has been placed on this work and the authors began meeting to work through the review. It is anticipated that the review will be completed by the end of 2024 and ready for patient participation in early 2025.

2.16 Care of patients with Physical Health Needs within the State Hospital

A short life working group was formed in February 2023 to develop guidance on nursing care within the hospital of patient's physical health needs. An update paper was presented at the February 2024 meeting of the Group. The update was based on the four recommendations that had been approved through the Group in 2023:

1) Review Death of a Patient/Palliative and End of Life Care (Including Sudden Death) Policy and Procedure (CP49) to strengthen practice around life limiting conditions and implementation of this policy upon diagnosis - the review of the Policy and Procedure is underway.

2) Review the documentation available on the intranet and RiO and update if necessary – this is being reviewed as part of the new SharePoint.
3) Issue communication regarding the change in practice from automatic placement on level 3 observations for physical health needs to a more tailored care package based on the individual needs of the patients - patients will not be placed on enhanced observations via the clinical care policy however patients will be allocated additional resources to meet physical health needs as required. This is in place and has been evidenced during this period.
4) Commission a review of the unscheduled/emergency outings from 2022-2023 – this was completed with the following conclusions:

- We are unlikely to be able to reduce the frequency of medical outings, nor is this appropriate with our current medical provision.
- There needs to be a shared clear understanding regarding the ceiling of care that the State Hospital provides, and we do not propose enhancing the medical care any higher than that which would be safely provided in the community.
- Clinical judgement and patient safety/safe practice should always be the priority in determining need for general hospital assessment rather than staffing levels.
- The communication between the State Hospital and the general hospitals should be standardised.
- Given that the ongoing clinical responsibility for patient care will be passed back to medical staff at the State Hospital we think there should be a medic:medic handover prior to transfer back to the State Hospital to allow safe ongoing care (rather than via nursing staff).
- Anticipatory care planning (proactive not reactive) formulation for the State Hospital aging population should be undertaken.
- We do not feel ongoing audit of emergency outings is required; it would be low yield and not provide meaningful information.

A straightforward action point detected by this audit was that all wards should have working thermometers, and this should be checked regularly. An earlier audit of clinical tools in each ward detected that these were often missing or broken. The system for review of this equipment on a regular basis should be strengthened.

This piece of work was presented at CMT and subsequently a SLWG was established to take tit further.

2.17 Advance Statement Overrides

A paper was presented at the September 2024 meeting updating the Group that the centralised system implemented in 2023 had not been followed when an advance statement had been overridden. This is being taken forward through the Chair of the Medical Advisory Committee to consider improvements to make the process more robust.

2.18 Clinical Quality Strategy and Workplan

The Clinical Quality Strategy was presented at the June 2024 meeting of the Group as part of the consultation exercise and the July 2024 meeting for approval prior to submission to the Clinical Governance Committee and the Board.

The Quality Strategy included:

- Our quality aims.
- Our quality ambitions.
- How we will create the conditions.
- How realistic medicine fits into the Strategy.
- What our quality management system looks like including our approach to quality planning, control, assurance and improvement.
- What success will look like (this will be broad themes in the Strategy with a detailed delivery plan sitting under the strategy). The plan will be monitored through the Clinical Governance Group.
- Where accountabilities and responsibilities will sit within the hospital.

The Quality Strategy was approved at Board level at their August 2024 meeting. A first draft of the workplan that will be used to evaluate the strategy was presented at the November Clinical Governance Group meeting.

2.19 Psychological Therapies Governance Group Terms of Reference, Membership and Reporting Structure

The terms of reference for the Psychological Therapies Governance Group was presented at the September 2024 meeting. It was noted that the purpose of the Psychological Therapies Clinical Governance Group is to ensure that there is governance of the psychological therapies being provided in the State Hospital. This group will oversee governance of all psychological interventions/ therapies being delivered by staff who will be from a variety of professional backgrounds.

There were minimal changes suggested by the Clinical Governance Group and they asked that the new Psychological Therapies Governance Group reports 6-monthly into the Clinical Governance Group and annually to the Clinical Governance Committee.

2.20 Medical Devices Service Level Agreement

An update paper was noted by the Group at their November 2024 meeting. The paper noted that the SLA runs from May 2022 to March 2027. It was noted that all required maintenance had been completed as per the specification.

2.21 Soft Restraint Kit (SRK) Use with the State Hospital

A paper was presented at the November 2024 meeting advising the Group that SRK usage within the Hospital was seeing an increase, both in episodes and the number of patients using SRK. The Group agreed to three recommendations within the paper:

1) Further investigatory work to be carried out through the Patient Safety Group to establish full extent of SRK usage, inclusive of clinical outings, and to better understand the reasons behind this. Findings from this piece of work will be fed back to the Patient Safety Forum, in the first instance, and then Clinical Governance Group thereafter.
2) As part of that work, a review of the SRK policy (and associated paperwork) to ensure there is clear guidance on the initiation, maintenance and governance processes attributed to using that equipment should be undertaken.
3) In the interim, a reminder to all clinicians regarding roles and responsibilities throughout the SRK process, including notifying the Mental Welfare Commission should be issued through the Patient Safety forum.

3 COMPARISON WITH LAST YEAR'S PLANNED QUALITY ASSURANCE (QA) AND QUALITY IMPROVEMENT (QI) ACTIVITY

Planned QA/QI Activity	Update
Measuring the success of the Clinical Model.	Work has progressed during 2024 to ensure we are in a position to measure the success of the model. Electronic referral forms are now in use, with waiting lists discussed at SLTs. This links with the patient flow aim. SLTs are also testing a clinical model adherence tool as part of the evaluation exercise. A full evaluation was presented at the Board in November 2024.
Oversee the implementation of the QI Physical Activity Project to ensure activity within the patients objectives are reflected in the activities delivered to the patient.	This is ongoing and will be taken forward further during 2025.
Ongoing focus on QI, Realistic Medicine and TSH3030 initiative.	The Group keeps abreast of all QI work, and gets regular updates from Realistic Medicine. There are provisional plans that TSH3030 will run in May 2025
To monitor the Service Leadership led driver diagram through the Activity Oversight Group.	This is monitored through the work of the Activity Oversight Group and reported through their annual report.
To monitor the use of DTC.	This is monitored through the Activity Oversight Group with reports going to every meeting. This reporting mechanism is being updated. Clinical Quality Department also send daily and weekly data to the Lead Nurses to support them in understanding the DTC our patients have experienced and assure themselves that the escalation process has been followed.
To monitor the implementation of the Clinical Care Policy including changes in practice	A first cycle audit report has been presented to the Group with assurance that the outcomes have been discussed at the Patient Safety Group and an action plan developed to progress these. A formal review of the policy will take place in May 2025.

4 PERFORMANCE AGAINST KEY PERFORMANCE INDICATORS

Currently there are 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 Quality Department Annual Report

The report was presented at the June 2024 meeting and set out the work of the Clinical Quality Department between 1 April 2023 and 31 March 2024. Some of the main work areas included:

- Nineteen Clinical audits were 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 177 pieces of guidance issued during the reporting year that have undergone relevancy checks. From these, 30 were found to be relevant to the hospital's patient population. Of the remaining 12, eight required completion of an evaluation matrix whilst the need for a full evaluation matrix is currently being reviewed for the final four guidelines.
- All admission, annual and intermediate and discharge case reviews are monitored via a VAT (admission, treatment and 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.
- Fourteen policies were finally approved by PAG and 58 review date extensions for 41 policies were approved.
- Approximately 30 additional projects were supported, working with staff across many disciplines to support them to implement QI approaches and understand more fully the data that they collect.

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 2024. Areas of Good Practice and Areas of Concern were included in all the reports with these being highlighted to the Service Leads for action.

The table below shows which professions have met their LDP attendance target at Annual and Intermediate reviews. Once again, only Social Work met/exceeded its LDP attendance target. In the last four years, Social Work have exceeded their target each year and Pharmacy have exceeded it on two occasions.

	LDP Target	20/21	21/22	22/23	23/24	% LDP target achieved/not achieved
RMO	**90%**	80.7%	87.2%	83.8%	88.4%	**-1.6%**
*Medical	**100%**	81.3%	90.3%	91.0%	91.7%	**-8.3%**
KW/AW	**80%**	67.5%	58.5%	57.6%	57.0%	**-23.0%**
*Nursing	**100%**	95.2%	97.0%	96.3%	96.1%	**-3.9%**
OT	**80%**	76.5%	77.4%	41.4%	67.0%	**-13.0%**
Pharmacy	**60%**	65.1%	81.5%	58.1%	54.7%	**-5.3%**
Clinical Psychologist	**80%**	66.9%	68.7%	59.2%	73.2%	**-6.8%**
*Psychology	**100%**	78.4%	84.7%	80.0%	84.2%	**-15.8%**
Security	**60%**	45.8%	41.0%	43.0%	52.0%	**-8.0%**
Social Work	**80%**	85.6%	84.6%	80.7%	81.0%	**1.0%**
Dietetics	**80%**	74.8%	58.3%	63.5%	61.9%	**-18.1%**

*This is attendance by any member of the discipline

A piece of work was progressed through the Group to ensure targets were fit for purpose, with some amendments made to these for the new financial year.

Review of Clinical Quality Indicators

A review paper was submitted to the August 2024 meeting of the Group. After reviewing the content of the report, the Group:

- Approved the archiving of some of the weekly indicators that are not adding value to Clinical Teams, Service Leadership Teams, Clinical Model Oversight Group or Activity Oversight Group.
- Agreed that the data can run from Monday to Sunday to bring it in line with other hospital data (e.g. nurse resourcing).

6 QUALITY IMPROVEMENT ACTIVITY

Nutrition and Physical Health Care Plans

Papers were presented at the May and September 2024 meetings to update the Group on the proposed changes to the Health and Wellbeing Plans evolving into Nutrition and Physical Health Care Plans. A number of recommendations were noted by the Group:

- The Nutritional Care Plan Process (NCPP) covers the State Hospital needs for all patients to have a Nutritional Screening Tool (NST) and Nutritional Care plan (NCP).
- The NCPP supports information for patient's annual health reviews and also now clozapine monitoring needs (weight and blood pressure).
- Once Lewis hub is trained and plans completed, audit will occur in November 2024 before any agreed movement to Iona and Mull hubs.
- Information from the checklist has been shared with Medical Records and Clinical Quality Department with a view to this information being obtained once a patient in accepted for transfer into the State Hospital as part of improving and obtaining physical health information on new admissions which is often negligible at this current time.
- The NCPP will continue to be audited via Clinical Quality Department as part of VAT recording.
- The information within NST and Nutritional Care Plans (as part of the NCPP) will be shared at admission, annual and transfer/discharge CPA's within existing reports. A sub review will seek to identify if this effective or an alternative approach needs to be considered.
- Consideration may be given to Nutrition and Physical health care plans (NPHCC) to be linked via RiO (when utilised across the whole site) and available for weekly CTMs to support discussion regarding patient's physical health care.
- Annual audit supported by a QI approach will continue with monthly audits until process is assured.

The Group noted and supported the next steps for the Nutrition and Physical Health Care Plans project,

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
Measuring the success of the Clinical Model.
Ongoing focus on QI, Realistic Medicine and TSH3030 initiative.
To monitor the Service Leadership led driver diagram through the Activity Oversight Group.
To monitor the use of DTC.
To monitor the implementation of the Clinical Care Policy including changes in practice.

8 NEXT REVIEW DATE

The next annual report will be presented at the January 2025 meeting of the Clinical Governance Group.

APPENDIX 1

GOVERNANCE ARRANGEMENTS

1 GROUP MEMBERSHIP

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

- Head of Psychology.
- Head of Allied Health Professionals.
- Head of Pharmacy.
- Head of Social Work.
- Head of Corporate Planning and Business Support.
- Medical Director (Chair).
- Director of Nursing and Operations.
- Director of Security, Estates and Resilience.
- 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.
- Board Secretary.

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 Group on the approval of the Group Chair.

2 MEETINGS AND FREQUENCY

There were 11 meetings held during 2024.

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 CMT, taking into account the evidence base, best practice, clinical governance, etc., and make proposals for their resolution.
- To advise the NHS Board and/or CMT 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 would 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 charts below, this group forms part of organisational governance, as led by CMT.

The State Hospitals Board for Scotland – Organisational Group Structure