THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL GOVERNANCE COMMITTEE ANNUAL REPORT

1 April 2023 – 31 March 2024

1. Introduction

The State Hospital, like all NHS organisations, has a statutory responsibility to establish clinical governance arrangements to ensure continuous improvement in the quality of care and treatment provided to patients. The national requirements for clinical quality have been the subject of substantial guidance, from the *Clinical Governance and Risk Management Standards* published by NHS Quality Improvement Scotland (NHS QIS) in 2005, to *Better Health, Better Care*, published by NHS Scotland in 2007, the Scottish Government's publication of the *Healthcare Improvement Strategy for NHS Scotland* in 2010 and subsequently through the NHS Healthcare Improvement Scotland *Making Care Better – Better Quality Health and Social Care for Everyone in Scotland 2017-2022. Further, the Mental Health Strategy 2017-2027 outlines the Scottish Governments vision to meet the challenges in delivering mental health care.*

The 5 main strategic priorities are:

1) Enable people to make informed decisions about their own care and treatment.
2) Help health and social care organisations to redesign and continuously improve services.
3) Provide evidence and share knowledge that enables people to get the best out of the services they use and helps services to improve.
4) Provide and embed quality assurance that gives people confidence in the quality and sustainability of services and supports providers to improve.
5) Make best use of all resources.

The underlying principle of effective clinical governance is that systems and processes provide the framework for patients to receive the best possible care. This report provides an overview of the work of the Clinical Governance Committee during 2023/24 and examples of good practice and matters of concern.

2. Committee Chair, Committee Members and Attendees

Committee Chair
Cathy Fallon, Non-Executive Director

Committee Members
Stuart Currie
David McConnell
Shalinay Raghavan

Attendees
Brian Moore, Chair of The State Hospitals Board for Scotland
Gary Jenkins, Chief Executive
Prof. Lindsay Thomson, Medical Director
Elizabeth Flynn, Head of Psychological Services
Monica Merson, Head of Corporate Planning and Business Support
Karen McCaffrey, Director of Nursing and Operations
Robin McNaught, Director of Finance & eHealth
Dr Khuram Khan, Chair, Medical Advisory Committee
Sheila Smith, Head of Clinical Quality
Margaret Smith, Head of Corporate Governance/Board Secretary

The Committee can decide to invite the Board Chair to sit as a member of the Committee for a meeting, should this be required for quorate decision-making. The Terms of Reference are reviewed annually and are attached.

3. Meetings 1 April 2023 – 31 March 2024

During 2023/24 the Clinical Governance Committee met on four occasions, in line with its terms of reference. Meetings were held on:

- 11 May 2023
- 10 August 2023
- 9 November 2023
- 8 February 2024

	Number of Meetings Present
Cathy Fallon	4
Stuart Currie	4
David McConnell	4
Shalinay Raghavan	2

4. Summary of Reporting

4.1 12 Monthly Internal Governance Reports

Infection Control
The infection Control Committee report was received and noted at the May meeting, covering the period 1 April 2022 - 31 March 2023. The primary focus during the review period had been to reduce the risk of Covid19 within the hospital through various stages of the pandemic and manage Covid19 outbreaks effectively to ensure there was a minimal spread of infection across the site. In addition, HIS Infection Prevention and Control Standards were published in May 2022 and the Infection Control Team had been reviewing current practice with the standards. The Infection Control Team and the Housekeeping and Linen service manager were reviewing the risk assessments, cleaning schedules and recording documentation for the entire site. A quality improvement project had commenced in a non-clinical area (i.e. the Management Centre) with successful outcomes. This was then being trialled in two clinical areas within the Skye Centre. It was anticipated that the project would be completed within the calendar year.

Research Committee/Research Governance and Funding
In May 2023 the Committee received and noted the 2022/23 Research Committee Annual Report. The reporting period covered was 1 April 2022 - 31 March 2023. The main areas of focus within report were the range of research activity and its dissemination undertaken by TSH staff over the period of 2022/23, and the mechanisms and roles in place to support research across the organisation. The report provided details of the annual Forensic Network Research conference, and the wide ranging contribution from State Hospital staff. In addition the report included detailed examples of studies that seek to identify the patient perspective and stakeholder experience of our patient population, and a practical example of the way in which research findings are used to positively influence practice. One specific example of research findings being used to support improvements in practice comes from the study: **"Forensic mental health nurses experience on the use of seclusion; implications for use and elimination in clinical practice.".** The study had recently been completed and the final report provided details of both short and long term implications for practice from the study findings, and a range of solutions to support these changes being made in practice.

Medicines Committee
The Medicines Committee annual report was submitted to the Clinical Governance Committee in May 2023, covering the period 1 April 2022 - 31 March 2023. The Committee received and noted the report and commended the service for being able to work within budget. The key

activities over the 12 months included: the successful implementation on the hospital electronic prescribing and administration system (HEPMA); maintaining and reviewing medicine supply processes; delivering Covid-19, influenza vaccine programmes for staff and patients as per national guidance; proactive work around reducing medicines incidents; ensuring all patients have regular review of all mental and physical health medicines; medicines policy and prescribing guidance updates and a significant range of clinical audit projects.

Patient Learning Annual Report
At the May 2023 meeting, the Patient Learning annual report was presented, covering the period 1 January 2022 - 31 December 2022. The Committee noted the progress that had been made and acknowledged the planned future developments that are detailed within the report. The report noted that learning opportunities for patients had continued to be impacted by Covid and wider resourcing issues. However, positive progress has been made in a number of areas of patient learning within the State Hospital: the curriculum framework continued to provide access to a broad range of nationally recognised qualifications and accredited national units; learning opportunities, although limited during year, ranged from entry level through to further and higher education and included clear progression pathways; a total of 60 patients engaged in formal learning programmes and 53 formal qualifications were attained within 2022. A number of developments were noted for 2023 including the delivery and evaluation of the newly developed 'I Can Lead' Sports Leadership qualification and the completion and evaluation of the Volunteering Skills SQA Award pilot programme (within both the patient library and charity shop)

Duty of Candour
The fifth annual report for Duty of Candour was received and noted at the August 2023 meeting. The report covered information on the policy, training that had been implemented across the site as well as the governance and monitoring arrangements. For the period 1 April 2022 - 31 March 2023 the Risk Management Department forwarded 115 incidents for consideration by the Duty of Candour Group, up from 103 in the previous year. One of the incidents fulfilled the criteria for Duty of Candour, i.e. an unintended or unexpected act or incident that resulted in death or harm, as defined within the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 and did not relate directly to the natural course of a person's illness or underlying condition. At the time of the report being presented at Clinical Governance Committee, the incident was still under investigation. Once the report is published it will be shared with the relevant persons and any required changes implemented.

Patient Safety
In August 2023 the Committee received and noted the Patient Safety Report covering the period 1 July 2022 - 30 June 2023. The four principles remained: Communication; Leadership and Culture; Least Restrictive Practice and Physical Health. The main focus of the national programme included: creating the conditions for improvement within teams; the implementation of the 'From Observation to Intervention' national guidance; reducing the incidence of restraint, whilst improving this experience for staff and patients and reducing episodes of seclusion, whilst improving this experience for staff and patients. All these workstreams had been considered within the report with key priorities for 2023/24 being discussed and agreed at the meeting.

Mental Health Practice Steering Group
At the August 2023 meeting, members received and noted the report from the Mental Health Practice Steering Group. The report covered the period 1 January 2022 – 30 April 2023. Key areas noted within the report included: the standards and guidelines that had been reviewed by the Group; monitoring data for the psychological service; the trial of the Clinical Global Impression scale with the FORUM as outcome measures; the monitoring of grounds access in our patient population; the pre-admission specific needs QI project; review of the CPA process and a trial of carers clinics within Mull and Iona. The Committee also approved the activities and areas of work the Mental Health Practice Steering Group intend to focus on over the next 12 months.

Transfer CPA/MAPPA
At the November 2023 meeting the Committee noted the report covering the period 1 October 2022 - 30 September 2023 and supported the future areas of work. For the fifth consecutive year, 100% of transfers were managed through the CPA process during the reporting period. The report identified a number of key areas in relation to Multi-Disciplinary CPA attendance, Patient and Carer Involvement and Strategic Engagement and Representation. During the review period no patients had been identified as potentially meeting the MAPPA 'risk of serious harm' category, however all patients remain under consideration in this regard and consultation takes place with the relevant MAPPA Co-ordinators as appropriate. Areas of good practice included patient involvement in the process with 92% attending meetings (this was an increase from 77% the previous year) and Advocacy attending 84% (an increase from 81% the previous year). Inter-agency working was also highlighted with receiving services being well represented in transfer/discharge CPAs.

Rehabilitation Therapies Service
In August 2023 the Committee noted the report covering the period 1 October 2022 - 30 June 2023 and endorsed the future areas of work and service developments contained within it. The report provided a summary of the key areas of work that included: updates on the various staff groups that are included in the AHP service; leadership development within the service; staff and team development; the Nu 2 U Charity Project that has allowed a patient run shop to be opened with clothes that patients can purchase for a nominal cost; completion of training staff in Occupational Formulation to allow this to be embedded in clinical practices and a project looking at the potential, scope and limitations of digital inclusion as it relates to the care of our patients and explore what a more digitally inclusive environment would look like.

Child and Adult Protection
The Committee received and noted the report in November 2023 that covered the period 1 October 2022 - 30 September 2023. The report highlighted key areas of work that included key achievements in the areas of keeping children safe and adult support and protection. Other key areas included: ensuring training materials are kept updated and developed to ensure up to date information and practice guidance; liaising with colleagues across the high secure services as they seek to develop their child contact procedures; the State Hospital's successful inclusion in the rollout of the Adult Support and Protection Decision Making Tool and increasing the number of child contact visits. There were 48 child visits to the hospital during the reporting period which represents a significant increase in numbers when compared to the previous year (10). This was a positive development and visitors had commented upon the welcome they receive, the friendliness of supervising staff and the positive atmosphere within the Family Centre. 2024 will see the development and publication of The State Hospital Corporate Parenting Strategy 2024-26.

Physical Health Steering Group
In November 2023 the Committee received and noted the 12 month rolling report from the Physical Health Steering Group covering the period 1 October 2022 - 30 September 2023. The report noted the developments and progress made in the five key strands for which the Physical Health Steering Group had responsibility. These related to Primary Care (including long term conditions); Physical Activity; Nutrition and Weight Management; Food, Fluid and Nutrition and National Guidelines and Standards. Quality improvement activity included the further development of patients undertaking the Level 4 Sports Leadership course allowing them to become Sport Volunteers; the change of the Physical Activity KPI moving from 60% having 150 minutes per week to 70% and the GP continuing to provide venesection on 2 patients which had significantly reduced external clinical outings. 2024 will see the GP also provide minor surgery on the patient group within the hospital, which again will reduce the need for external clinical outings.

Person Centred Improvement Service
The Committee warmly received and noted the Person Centre Improvement Report at its February meeting. The report covered the period 1 November 2022 - 31 October 2023. Key areas of work included: facilitation of the 'What Matters to You' initiative; reviewing the visitor travel support arrangements and developing new Volunteer Driver Scheme; supporting the development and implementation of 'Nu 2 U' Patient Charity Shop; the successful bid for capital funds for renovation of Family Centre garden; continuing to support the Patient Partnership Group (PPG) Chair to ensure that the patient experience influences the Clinical Model implementation plans; developing and implementing the new 'Supporting Patient and Carer Involvement' Policy and the successful completion of 'Talking Mats' Training, which is now in use with the Intellectual Disability PPG.

Clinical Governance Group
At the February 2024 meeting the Committee received and noted the 12 monthly report from the Clinical Governance Group covering the period 1 January 2023 - 31 December 2023. The report provided a summary of the work of the Clinical Governance Group over the past 12 months. As well as overseeing the reports that go to the Clinical Governance Committee other key pieces of work included: monitoring the realistic medicine action plan; receiving updates on the Clinical Care Policy; receiving updates from the Activity Oversight Group; commenting on the digital inclusion updates; receiving updates on the ongoing engagement with Excellence in Care (EiC); receiving updates on daytime confinement and the decrease we have seen with this over recent months and receiving updates on the scoping exercise in relation to the 35 point testing system for oral fluid tests. The areas of future work included: evaluating the Clinical Model; ongoing focus on QI, Realistic Medicine and TSH 3030 initiative; monitoring the use of daytime confinement and monitoring the implementation of the Clinical Care Policy.

Psychological Therapies
A 6 month update was provided at the August 2023 meeting, with the 12 monthly report being noted at the meeting in February 2024. The 12 monthly report highlighted in particular, the improved staffing position and benefits from this although some vacancies remained; the publication of the National Psychology Specification which was launched by Scottish Government in 2023. Along with this, was a document for patients describing what they could expect to receive following referral to psychological therapies. It was also noted that from April 2024, psychological therapies waiting times would be reported on to Scottish Government. Other key pieces of work included: the increase in the number of sessions delivered by 27% compared with the previous year; the increase in variance analysis tool completion rates; the improvement in the target where no patient should wait more than 18 weeks – this has been zero for some time and the attendance data for psychology staff attending the patients' Care Programme Approach (CPA) meetings.

Key pieces of work agreed for 2024 include: recruitment to full department capacity; supporting the implementation of the supporting healthy choices workplan; increasing the number of State Hospital staff trained in trauma-informed care; review of the Relaxation Group and reviewing current risk assessment process and making recommendations for change as appropriate.

4.2 Standing Items Considered by the Clinical Governance Committee during the Year

Clinical Model Progress Updates
The Committee received update reports re the Clinical Model at the February, May and November meetings during 2023. After the hospital moved into the new Clinical Model in July, the Clinical Model Oversight Group reported into the Committee. Some of the key issues noted were: patient flow through each of the services; the requirement for a centralised referral process for movement of patients between clinical services, and the most appropriate forum for

the discussion of those patient referrals; ongoing concerns about the impact of Daytime Confinement (DTC) across each of the services and potential disparity of ward closures across each of the services; the ongoing work to create a more accurate reporting system within RiO for the monitoring of daytime confinement and the increase in clinical demand/requirement for patients to leave the site for physical health investigations and treatment and the impact this is having on patients (i.e. Daytime Confinement). A large scale quality improvement project looking at improving Daytime Confinement was agreed.

Learning from Complaints
The quarterly Learning from Complaints report was considered and noted by the Committee at every meeting. Actions arising from all complaints are included within the report to share the learning which enables the organisation to develop services which take cognisance of complaint outcomes. The report is based on the two stage model that enables complaints to be handled either locally by front line staff, allowing for *Early Resolution* (Stage 1) within 5 working days, or for issues that cannot be resolved quickly or are more complex, by *Investigation* (Stage 2) within 20 working days. The main themes for complaints during the year were staff shortages (as these resulted in patients bring confined within their bedroom for longer periods of time), staff attitude/behaviour/conduct, written/oral communication and clinical treatment (this covers a wide range of subjects including involvement in care plans and time taken to go through the grounds access process). An annual report demonstrating themes and outcomes
will be prepared and published once available.

Learning from Feedback
The quarterly Learning from Feedback report was considered and noted at every Clinical Governance Committee meeting. These reports highlight the feedback received, encompassing concerns, comments and suggestions, (including evaluation forms) and any compliments/positive feedback received. The report noted the outcome from all feedback and any lessons that have been learned by the hospital. The Committee members were happy to see the positive feedback from patients around reverting back to face to face tribunals within the hospital and what the new Webex option provided that the old system did not.

Patient Movement Statistical Information
The Committee received and noted two reports during the year at its May 2023 and November 2023 meetings. The May 2023 report covered the reporting period 1 October 2022 - 31 March 2023 and the November 2023 report covered 1 April 2023 - 30 September 2023. These reports provided an overview of bed occupancy, area and source of admission, delay if any between referral and admission, admissions of young people (under 18), 'exceptional circumstances' admissions, appeals against excessive security, discharges and transfers and number of patients on the transfer list.

Incident Reporting and Patient Restrictions Report
The quarterly Incident Reporting and Patient Restrictions report was considered at every Clinical Governance Committee meeting. The report showed the type and number of incidents received through the incident reporting system DATIX, as well as all the restrictions applied to patients during the periods under review. The report provided more information on the various incidents that had occurred in relation to PAA activations; the use of handcuffs; patient seclusions; withheld mail; urinalysis results; security incidents; communication/information incidents and incidents relating to equipment, facilities and property. At the November meeting, it was agreed that this report, going forward, would only focus on clinical rather than all incidents, in other words those relevant to the Clinical Governance Committee. The first reviewed report was welcomed at the February 2024 meeting. The Committee continue to welcome the trend graphs that are included within the report that allows them to see incidents over time.

Safe Staffing Report – Clinically Focussed

The staffing and care report was presented at all the meetings during 2023/24. The reports included any challenges with staffing; including the number of times a ward had to close due to staff shortages (this would mean patients being cared for in their rooms for the duration of the shift – Day Time Confinement) and the challenges the hospital has recruiting an acceptable gender mix due to the small numbers of males going into mental health nursing. The report evolved into a Nurse Resource Report during the year.

Corporate Risk Register – Clinical Update

The Clinical Corporate Risk register was received and noted at every Committee meeting. The most recent paper at the February 2024 meeting showed that all clinical risk assessments were within their review date; ND71 Failure to assess and manage the risk of aggression and violence effectively – this risk had been updated to better reflect the risk of violence and aggression within the hospital. All current control measures and Datix data were considered with the risk assessment now focusing on serious injury from violence and aggression incidents, a change from the previous focus of all violent incidents. The assessment highlighted that the majority of incidents are managed without issue or injury and therefore the risk to staff and other patients should reflect this. After analysing the data the risk had been reduced from High to Medium (Moderate x Possible) and will be monitored regularly; MD30 Failure to prevent/mitigate obesity – it was noted that there are multiple approaches in place across the organisation to address this issue and ND70 Failure to utilise our resources to optimise excellent patient care and experience - implementation of E-Rostering continued across the hospital; Full time project manager has been appointed to complete the rollout of the project.

4.3 Other Items discussed During the Year

Overview of the Trauma Champion Role

The Committee received and noted a report at the February 2024 meeting which gave an overview of the role of the Trauma Champion. Key contributions of the Trauma Champion to date included: supporting capacity building with 54 staff attended level 1 training and 45 staff attending level 2 training and supporting staff wellbeing through providing strategic leadership for the development and implementation of the Board's 'Staff and Volunteer Wellbeing Strategy'. The Committee were also asked to note additional guidance that had been published to help services and organisations reflect on progress and identify strengths and opportunities for embedding a trauma-informed and responsive approach across policy and practice. Included within the guidance is a self-assessment checklist and a roadmap of activities that, based on growing evidence, are most effective in supporting organisations in their journey towards becoming trauma-informed and responsive. Going forward, the guidance will enable the Trauma Champion to support the Transforming Psychological Trauma Implementation Coordinator (TPTIC), senior leaders and other key stakeholders, to review and assess progress and identify further actions required to ensure that trauma-informed and responsive practice is effectively embedded and sustained across the State Hospital.

Update to Telephone System

In response to a recommendation from a CAT 2 review where a patient misused the patients' telephone system within the ward, the Committee received a report at its November 2023 meeting. The report confirmed the available options and decision-making processes by the Corporate Management Team (CMT). Option 3: to replace the current recording hardware and software, using the Mitel Interaction Call Recording Solution was approved at CMT and noted by the Committee. This will give increased functionality, at a lesser cost than a completely new system. It was also noted that the costs involved for this would be within the remit of the Capital Group, and would not need formal Board approval. It will be included in routine reporting to the Board in respect of capital spend.

4.4 Presentation Items During the Year

Clinical Model
The May 2023 meeting saw a presentation that provided an overview of the preparation that had gone into the successful implementation of the new Clinical Model. The presentation gave key updates on:

- Details of the four sub specialties and benefits and intentions aimed to be achieved through the new model, such as increased patient physical activity for the betterment of their physical health, feeling of progression for patients, effective use and deployment of available resources, enhanced treatment environment with a more tailored and individualised approach.
- Progress against the Project Plan such as individual contingency, workforce, service and communication plans, as well as the leadership approach and the movement of patients to the appropriate service.
- Clinical guidance updates which consisted of a section that described the configuration and working of the model, followed by specific guidance for each service. It was noted that the overarching document was being finalised by a Task and Finish Group. The next step would be for the final draft to be approved by the Project Oversight Board, with ownership sitting with the Clinical Model Oversight Group.
- Other key current work strands involved were contingency planning and arrangements, service leadership, movement of patients, patient engagement and communication, staff engagement and communication, next steps and learning.

Members thanked those involved in this area of extensive work and for the very interesting and reassuring presentation.

Daytime Confinement
Daytime confinement (DTC) was the subject of the presentation item at the August and November meeting. The Committee were advised that 4 workstreams were included within the project. These were to:

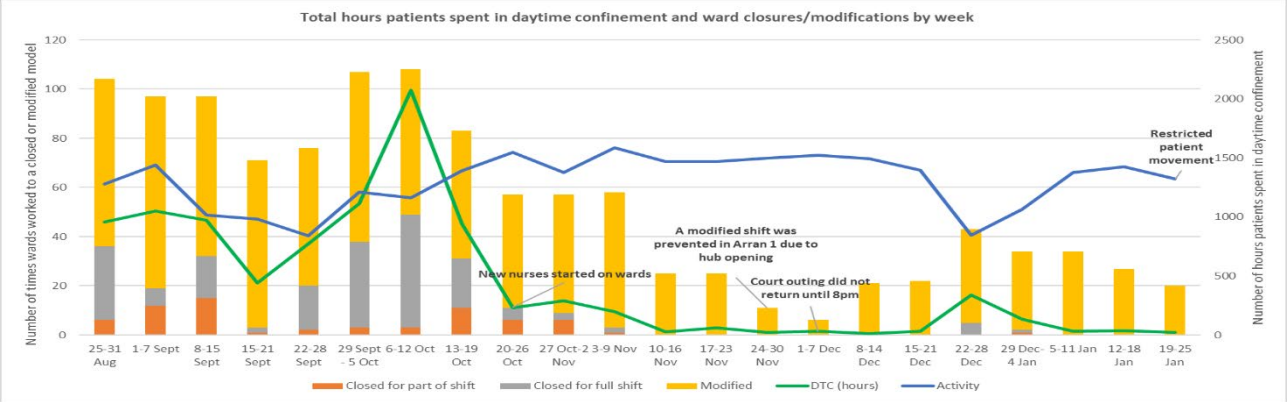
1. Maximise efficiency and effectiveness of patients boarding out.
2. Fully understanding the extent of the use of daytime confinement.
3. Implement tailored approaches to risk assessment and management.
4. Develop a culture based upon trust, connectivity and ‘one team’ that motivates and engages all staff.

Each workstream provided a report to the Daytime Confinement Short Life Working Group at its monthly meeting.

Recruitment was noted as the core solution along with reducing sickness absence. The Committee were pleased to note that the hospital had implemented a system that allowed the recording of daytime confinement so this could be measured during, and after, the project. The data can be looked at across the full site, over services and over individual wards and patients. Posters are sent out every week to the wards to allow them to see longitudinal data of their daytime confinement over time. The 0830 huddle ensures that a multidisciplinary approach is taken to try and minimise the use of daytime confinement.

The Chair of the Committee emphasised that the successful outcome would be where daytime confinement was a never event.

At the meeting in February 2024, an update paper was presented. The paper showed positive steps in reducing the amount of daytime confinement experienced by patients at The State Hospital. It was noted that the project had been extended until March 2024 to ensure thorough escalation processes are in place. It is planned that a project closure report will be presented at the May meeting of the Committee. DTC will be monitored through the Clinical Governance Group.



Patient Activity
The February 2024 meeting saw the Committee receiving and noting a paper on activity from the Activity Oversight Group covering the period 14 September 2022 to 30 September 2023. This paper formed the basis of the presentation item at the meeting. Key achievements from this Group in its first year included: an agreed definition and classification of activity; an agreed single unit of measurement; improving consistent delivery of activity within the Skye Centre; a reduction in manual and duplicate processes and the inclusion of activity as part of site safety meetings.

Key future areas of work agreed during the discussion were: developing measure definitions for KPIs and testing these; engagement with Service Leadership Teams to build the will for the KPI and agreed standards for each service; each service to look at timetable data and identify where they would like to see improvements and to take forward the use of the interest checklist in partnership with security.

The Committee also noted during the discussion item, the collaborative efforts among the Physical Health Steering Group, Patient Partnership Group and the Clinical Model Oversight Group.

4.5 Special Topics

Clinical Governance Annual Stock Take
At its May 2023 meeting, the Committee received and noted: the Clinical Governance Reporting Structures 2023/24; the Programme of Work for 2023/24 subsequent to any changes that may arise at future meetings; the Clinical Governance Committee Terms of Reference; and the Clinical Governance Annual Report 2022-23. The Annual Report summarised the work of the Committee during the financial year 1 April 2022 - 31 March 2023.

Category 1 Review Reports
No Category 1 reviews were presented to the Clinical Governance Committee during the reporting period.

5. Areas of Good Practice/Concern identified by the Committee

Good Practice:

- Positive feedback from SQA under the Patient Learning Annual Report
- All About Me passports
- Positive atmosphere within the Family Centre for visiting
- Transfer CPA report being at 100% complete as was detailed in the CPA Annual Report.
- Increased visibility of the Complaints Officer and access to telephone line.

- The extensive work and efforts by the Catering Service as was detailed within the Learning from Feedback Report.
- Corporate Services Complaints Team and the Patient Partnership Group around positive working practices and confidence built between the two links and the complaints process itself.
- The extensive work by the Quality Department and eHealth Department around their efforts in pulling together information and the extensive background work involved with producing Flash Reports and Tableau Dashboards.

Matters of Concern:

Matters of concern	Update
Recurrence of issues with clinical waste	Infection Control is undertaking a quality improvement project that will look to reduce the number of clinical waste issues.
Staff incidents at security due to prohibited items	Assurance was received that these were everyday items such as personal mobiles and umbrellas

6. Conclusion

From the review of the performance of the Clinical Governance Committee, it can be confirmed that the Committee has met in line with the Terms of Reference and has fulfilled its remit. Based on assurances received and information presented to the Committee, adequate and effective Clinical Governance arrangements were in place throughout the year.

Appendix 1

The State Hospitals Board for Scotland

CLINICAL GOVERNANCE COMMITTEE

TERMS OF REFERENCE

1 PURPOSE

The Clinical Governance Committee is a standing committee of the Board and shall be accountable to the Board. Its purpose is to provide the Board with the assurance that clinical governance mechanisms are in place and effective within the State Hospital.

2 COMPOSITION

2.1 Membership

The Clinical Governance Committee is appointed by the Board and shall be composed of at least three Non-executive Board members, one of whom shall act as Chair.

Members:

- Stuart Currie
- David McConnell
- Shalinay Raghavan
- C Fallon (Chair of the Clinical Governance Committee)

In Attendance

- Brian Moore, Chair of The State Hospitals Board for Scotland
- Gary Jenkins, Chief Executive
- Prof. Lindsay Thomson, Medical Director
- John Marshall, Head of Psychological Services
- Monica Merson, Head of Planning, Performance and Quality
- Karen McCaffrey, Director of Nursing and Operations
- Robin McNaught, Finance & eHealth Director
- Dr Khuram Khan, Chair, Medical Advisory Committee
- Sheila Smith, Head of Clinical Quality
- Margaret Smith, Head of Corporate Governance/Board Secretary

2.2 Appointment of Chair

The Chair of the Committee shall be appointed at a meeting of the Board in accordance with Standing Orders.

2.3 Attendance

Members shall normally attend meetings and receive all relevant papers. All Board Members, the Chair of the Medical Advisory Committee and the Chair of the Research Committee, will have the right to attend meetings and have access to all papers, except where the committee resolves otherwise.

If attendance at the meeting is only required on a periodic basis, this should be agreed with the Committee Chair in advance. Apologies should be tendered to the Chair of the Committee via the minute secretary at least 2 working days prior to the meeting unless an exceptional event prevents this level of notice.

Where a member who is due to present a paper is not able to attend, they should ensure that another person is suitably briefed in order to deal with this item. The arrangement made should be discussed and approved by the Committee Chair.

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. If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee.

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

3 MEETINGS

3.1 Frequency

The Clinical Governance Committee will meet quarterly to fulfil its remit and shall report to the Board following each meeting. The Chair of the Committee may convene additional meetings as necessary.

The Accountable Officer of the Board may ask the Chair of the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

3.2 Agenda and Papers

The agenda and supporting papers will be sent out at least three full working days in advance to allow time for consideration of issues.

The lead Executive for co-ordinating agendas and papers is the Medical Director.

All papers will clearly state the agenda reference, the author, and the purpose of the paper, together with the action to be taken. Cover papers should be prepared in the format set out in Corporate Document Standards, to draw out the main issues for the Committee, and will be subject to document control.

The secretariat for this Committee will maintain a master file of documents, in line with Policy for Management, Retention and Disposal of Administrative Records.

3.3 Quorum

In the event of the Committee making decisions, two members need to be in attendance to be quorate.

3.4 Minutes

Formal minutes will be kept of the proceedings and submitted for approval at the next Board meeting. The Board Secretary is responsible for minute taking arrangements. The draft minutes will be cleared by the Chair of the Committee and the nominated lead Executive (Medical Director) prior to approval by the Committee and notification to the Board.

Following approval, minutes will be submitted to the Board and then published on the hospital's website.

4 REMIT

4.1 Objectives

The main objectives of the Clinical Governance Committee are to provide the Board with the assurance that clinical governance mechanisms are in place and effective within The State Hospital; and that the principles of clinical governance are applied to the health improvement activities of the Board.

Existence and effective operation of this committee will be demonstrated in continuous improvement and compliance with clinical standards, in delivery of improved services for patients, and ultimately in improved outcomes for patients as evidenced through the clinical key performance indicators reported in the Annual Delivery Plan.

4.2 Systems and Accountability

- To ensure that appropriate clinical governance mechanisms are in place throughout the hospital in line with national standards.
- To ensure that clinical risks are managed in accordance with the corporate risk management strategy, policies and procedures.
- To ensure that staff governance issues which impact on service delivery and quality of service are appropriately managed through clinical governance mechanisms.
- To ensure that systems are in place to meet information governance standards.
- To ensure that systems are in place to meet research governance standards.

4.3 Safe and Effective Care

To provide assurance to the Board in respect of clinical risk management arrangements, that:

- Structures are in place to minimise potential problems such as effective risk assessment and management, incident reporting, critical incident reviews, and complaint procedures.
- Lessons are being learned from adverse events and near misses.
- Systems are in place to measure and monitor duty of candour and any lessons to be learned.
- Complaints are handled in accordance with national guidance and lessons will be learned from their investigation and resolution (including reports of the Scottish Public Services Ombudsman and the Mental Welfare Commission).
- Arrangements are in place to support child and adult protection obligations.

4.4 Health, Wellbeing and Care Experience

- To ensure that the environment supports delivery of high-quality care with a culture and appropriate mechanism to allow staff and others to raise concerns on the standard of care provided, including the performance of clinical colleagues, in the knowledge they will be addressed without detriment to themselves or prejudice to the principles of confidentiality.
- To ensure systems are in place to monitor and measure the mental health and physical health requirements of our patient population, including medicine management, psychological therapies, and rehabilitation services.
- To ensure that arrangements are in place to embed Person Centred Improvement activities, including equality and diversity issues pertinent to clinical governance.
- To ensure that care is provided by appropriately trained and skilled professionals with the competencies required to deliver the required care.
- To ensure that clinical policies and procedures are developed, implemented, and reviewed.
- To ensure that poor performance of clinical care will be identified, and remedial action taken.

4.5 Control Assurance

- To ensure that quality of clinical care drives decision making and that clinicians are involved in planning, organising, and managing services.
- To ensure that the planning and delivery of services has taken full account of the perspective of patients and the general public.
- To ensure that systems are in place to measure and monitor performance to foster a culture of quality and continuous improvement.
- To ensure that research and development programmes are initiated, monitored, and reviewed.
- To ensure a comprehensive information governance framework is in place which ensures the Codes of Practice on Openness and on Confidentiality of Personal Health Information are fully applied.

The Committee will manage its business through a workplan, agreed by the Chair of the Committee. This will ensure that the full remit is covered on a rolling basis.

5 AUTHORITY

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

6 PERFORMANCE OF THE COMMITTEE

The Committee shall annually review and report on:

- Its own performance, effectiveness, and the level of input of members to the Committee relative to added value achieved.
- Proposed changes, if any, to the terms of reference.

7 REPORTING FORMAT AND FREQUENCY

The Chair of the Committee will report to the Board following each meeting of the Clinical Governance Committee.

The Chair of the Committee shall submit an Annual Report on the work of the Committee to the Board.

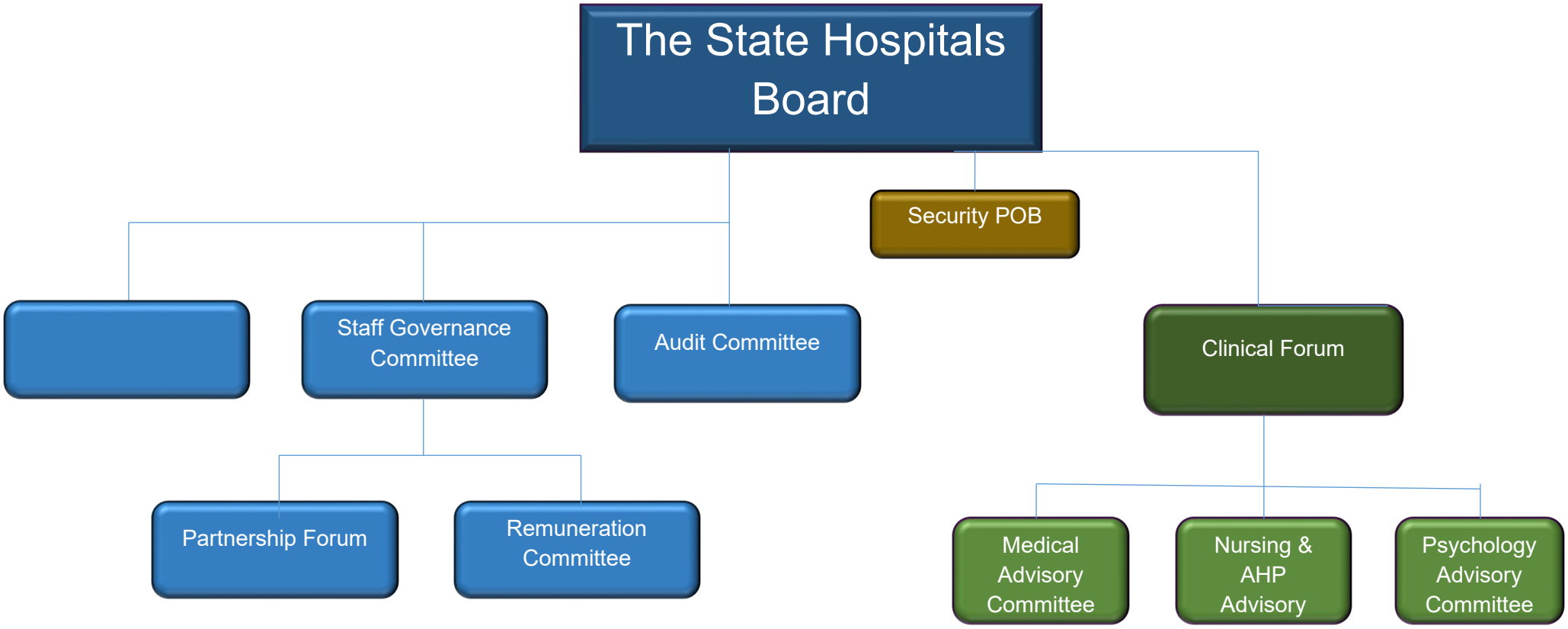
8 COMMUNICATION AND LINKS

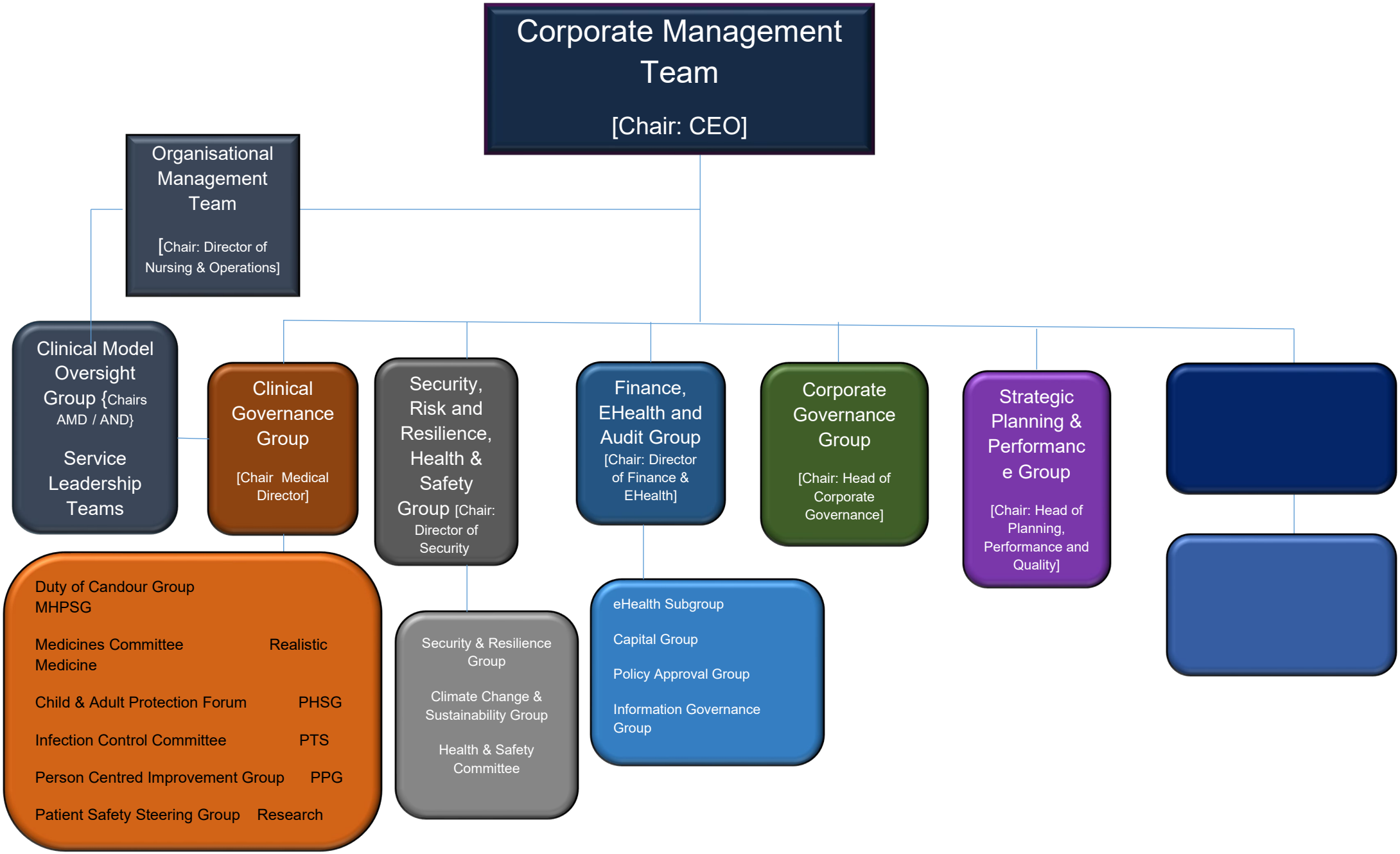
The Chair of the Committee will ensure that relevant issues are shared with the Staff Governance Committee.

The Chair of the Committee will be available to the Board as required to answer questions about its work.

The Chair of the Committee will ensure arrangements are in place to provide information to the Scottish Government as required to meet their reporting requirements.

Subject to annual review.
Next revision: May 2024.


The State Hospitals Board
Security POB
Staff Governance Committee
Audit Committee
Clinical Forum
Partnership Forum
Remuneration Committee
Medical Advisory Committee
Nursing & AHP Advisory
Psychology Advisory Committee


Corporate Management Team
[Chair: CEO]
Organisational Management Team
[Chair: Director of Nursing & Operations]
Clinical Model Oversight Group {Chairs AMD / AND}
Service Leadership Teams
Clinical Governance Group
[Chair Medical Director]
Security, Risk and Resilience, Health & Safety Group [Chair: Director of Security
Finance, EHealth and Audit Group
[Chair: Director of Finance & EHealth]
Corporate Governance Group
[Chair: Head of Corporate Governance]
Strategic Planning & Performanc e Group
[Chair: Head of Planning, Performance and Quality]
Duty of Candour Group
MHPSG
Medicines Committee
Realistic Medicine
Child & Adult Protection Forum
PHSG
Infection Control Committee
PTS
Person Centred Improvement Group
PPG
Patient Safety Steering Group
Research
Security & Resilience Group
Climate Change & Sustainability Group
Health & Safety Committee
eHealth Subgroup
Capital Group
Policy Approval Group
Information Governance Group