Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
CHILDREN, LEARNING DISABILITY AND AUTISM CLINICAL GOVERNANCE

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Name of Trust Strategy / Policy / Guidelines this SOP refers to:	• Procedure for the removal of Ligatures and Safe Use of ligature cutters • Rapid Tranquilisation Policy • Seclusion Policy • Safeguarding Children Policy • Safer Staffing Escalation Policy • Supervision Policy • Operational Procedure for Sharing Information • Caldicott and Data Protection Policy

VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1	*03/12/19*	*Date of review changed 05/04/21 from 04/12/2020 due to COVID pressures*
1.1	*September 2021*	*Addition of the Neurodiversity Service alongside the CAMHS services as the service has stepped out of CAMHS to be a stand-alone team*
Draft	*April 2023*	*Reviewed with major updates in: -* *Section 4.1 with additional paragraph added to include the divisional engagement lead post and reasonable adjustments/accessible information* *Section 5.4 – include the new meetings of Patient Safety and Clinical /Assurance Group and Patient Experience Group.* *Minor updates include review of meeting names, updates to current language used and additional information to clarify current process* *Approved through Divisional clinical networks March 2023-* *Taken to QPaS 3-May-23 and further information was required*
2.0	*May 2023*	*Further detail included in Appendix 2 regarding meetings within the divisional governance structure including clinical network chairs as per request from QPaS* *Approval At QPaS 15-June-23*

Contents

1. INTRODUCTION

As a Trust we are registered with the Care Quality Commission (CQC) and are required to maintain compliance with their regulatory standards. The CQC inspects a range of the Trust core services and undertakes Mental Health Act inspections across our inpatient mental health and learning disability wards on an annual basis. Services will be assessed under a single assessment framework against 35 Quality statements aligned to the five key standards of Safe, Effective, Caring, Responsive and Well-Led and rated as either inadequate, requires improvement, good or outstanding. It is the Trust ambition to maintain a rating of good overall and to move towards a rating of outstanding; to enable this, it is essential that effective governance processes are in place across all levels of the Trust.

Clinical Governance: The integrated systems, processes, leadership and culture that are at the core of providing safe, effective, accountable and person-centred healthcare underpinned by continuous improvement.

This document is an overview document to work alongside the individual ward specifications and the service specifications for all services within the Children, Learning Disability and Autism Division which includes:

1. Child and Adolescent Mental Health Services and the Children's Neurodiversity Service
2. Children's Therapy services
3. Universal Children's 0-19 Services
4. Learning Disability and Adult Autism Assessment Service

The purpose of the Governance SOP is to promote a transparent culture of patient safety, quality care from referral through to discharge, reduce avoidable harm and provide assurance that systems are in place to identify the good practice within the division's services and highlight any care concerns or service shortfalls.

The framework will take account of and be underpinned by national and local drivers including NICE guidance, individual professional guidelines and codes of professional conduct to ensure our service-users are provided with current and up-to-date best practice in care delivery.

2. SCOPE

This document provides governance structures and guidance for staff working across services within the Children, Learning Disability and Autism Division, which sits within the Humber Teaching NHS Foundation Trust.

The seven pillars of clinical governance are the structures that underpin the document:

1. Patient and Public Involvement
2. Staffing and Staff Management
3. Clinical effectiveness and research
4. Using informatics and IT
5. Education and Training
6. Risk Management
7. Audit

The five CQC quality standards measure the delivery of:

1. Safe
2. Effective
3. Caring
4. Responsive
5. Well Led

3. DUTIES AND RESPONSIBILITIES

Humber Teaching NHS Foundation Trust is committed to creating a culture of caring. This extends beyond caring for our patients and service users/carers to caring for each other. With this in mind the Trust has established a staff charter that sets out the Trust's mission and vision along with the values of **Caring, Learning and Growing**.

Caring: Our shared commitment to patient centred care, providing dignity and respect through our high quality and patient safety culture.

Learning: Our shared commitment to actively engage, listen, and learn from our people and empower them to use evidence-based teaching approaches.

Growing: Our shared commitment to be an organisation that is accountable, and which seeks collaborative work with others to support and grow health and social care systems.

Staff of all disciplines and grades within the service, have responsibilities and duties as part of the Clinical Governance framework for the Division. These are summarised below:

3.1. Divisional Clinical Leads and General Manager

Both the clinical leads and the general manager are responsible for ensuring that the group's aligned to the governance framework are well managed in respect of:

- Agendas and papers prepared and distributed in line with meeting terms of references (ToR)
- Ensuring quoracy of meetings
- Effectively chaired and minuted
- Actions arising from meetings are tracked and completed in line with agreed timescales.
- Ensuring assurances and any escalated items are provided to QPaS and the Operational Delivery Group (ODG) in line with their respective ToRs

3.2. Matrons, Professional Leads, Lead therapists and Service Managers

Matrons, professional leads, lead therapists and service managers are accountable for ensuring that governance is part of all meeting structures and ensure ownership of good governance and that appropriate dissemination and escalation is in place between unit/team and divisional governance group.

Matrons, professional leads, lead therapists and service managers are accountable for ensuring compliance with the CQC quality standards across their respective teams. In doing so they will ensure that there are systems and processes in place to audit and monitor standards and compliance.

Matrons, professional leads, lead therapists and service managers are accountable for ensuring that ward managers/team managers effectively share learning from incidents, complaints and compliments.

Matrons, professional leads and service managers will attend the appropriate service-level governance meetings and Trust-level committees, groups and forums where required.

3.3. Unit Managers/Team Managers

Unit managers/team managers must ensure that governance is part of all team/unit meetings with clear agendas that reflect the ToR for the group. They must ensure that they work with matrons, professional leads and service managers to undertake a range of audits to ensure high standards of care and compliance with CQC standards. Unit managers/team mangers must ensure that learning from incidents, complaints and compliments is effectively shared between and within their areas of responsibility.

3.4. All Clinical Staff

Each profession is accountable for ensuring that they attend the required governance meetings in line with ToRs, for ensuring they maintain high quality standards of care, leading and participating in governance, sharing the learning from compliments, complaints and incidents.

3.5. All Clinical and Non-Clinical Staff

All staff both clinical and non-clinical of all grades is responsible for ensuring that they attend governance meetings as per required meeting ToRs. They are responsible for ensuring that they deliver agreed actions from CQC inspections, patient safety incident and complaint investigations, and report safety and performance issues through agreed mechanisms such as Data.

4. PROCEDURES

The governance reporting will use real time information to inform, improve and strengthen involvement and ownership of all the services in their contribution to the delivery of safe, effective and person-centred care. It seeks to increase patient and carer involvement in the design and delivery of services to ensure outcomes meet their needs. The procedures and everyday operating systems will ensure the use of real time governance information is triangulated with incident reporting, patient experience, risk management, managerial information and the overall on-going clinical audit plan to provide service-level intelligence.

4.1. Patient and Family Involvement

To routinely seek feedback from individuals who access the services. This will include children and young people, families and carers, people with a learning disability and autistic people. To support the collection of feedback the division services will provide a range of formats for capturing comments which will include accessible easy read, pictorial, symbols, auditory and the use of IT options. Where information is required to be in an alternative language to English support will be provided by the translation services.

Engagement commences on referral to any of the services in the Division. Parents and carers of children accessing services within the Division will be invited to be involved in their on-going care and support as appropriate. Families and carers of adult patients accessing services within the Division will be engaged where appropriate with the consent of the patient. Where a patient is deemed to lack capacity to consent, a best interests meeting will be recorded to ensure the patient's wishes and requests are considered at all times.

A range of methods will be utilised to maintain contact by individual teams and will take account of the individual needs and circumstances of service users and those support them. These will include teleconferencing, video conferencing and supported telephone conversations. Consideration regarding reasonable adjustments and accessible information will inform this.

The services delivered by the Division will include advocacy support for the patient or the families/carers where needed to facilitate communication between the patient and the individual services accessed. Feedback on the care delivered will be encouraged at all times by all teams in the Division.

The Division is applying the principles of value-based recruitment when recruiting staff. Staff recruited to work in the Divisions services will be interviewed by service-users and/or family carers. The principles of including service users in recruitment will continue to be a standard embedded within the Divisions services.

The Division has an engagement lead in post that works closely with young people to capture their views to enhance our service delivery. The Division is working towards establishing a service user engagement group that will report into the divisional clinical governance structure that will include the engagement lead and representatives from each of the clinical networks within the Division.

4.2. Staffing and Staff Management

In addition to the community teams across the services which make up the Division, there are three inpatient units. Inspire CAMHS Unit, Townend Court Assessment and Treatment services and Granville Court, a nursing home for people with a severe and profound disability. These services in addition to the Crisis service provided through the Acute CAMHS pathway adhere to the principles of NHS safer staffing, ensuring that the services have sufficient numbers of qualified staff to provide the on-going clinical and operational leadership for each span of duty. The staff team rostering is managed and monitored electronically through e-roster and 'Employee on Line' and will be the responsibility of dedicated lead shift co-ordinators. The rota will be reviewed and confirmed by the Unit Manager and/or the Team/Service manager

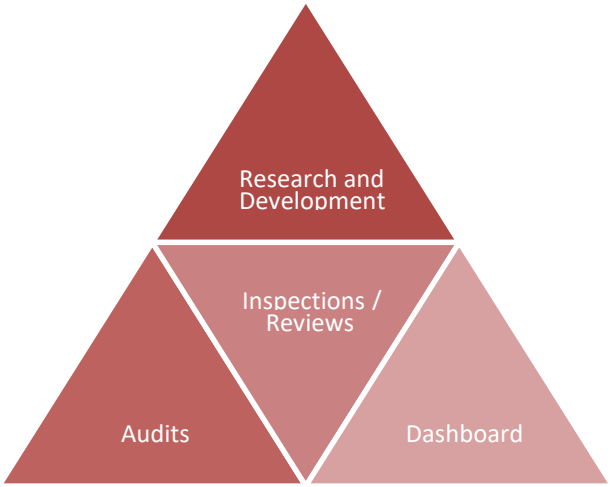
Nurses are aware of minimum safe staffing levels and how to escalate concerns if these are not met. These are reviewed and monitored on a regular basis. There are also regular booked meetings held to review the delivery of safer staffing levels on the units with any gaps in the rota being addressed. These are also reviewed at the weekly Trustwide safer staffing meeting to offer assurance and identify any anticipated gaps. The wider division's services are community-focussed. Staffing rotas will ensure sufficient skilled staff are in place to support the delivery of care pathways across all inpatient and community services. All staff will be supported to adhere to their professional standards.

A supervision structure and time for reflective practice is embedded into the division's services and monitored through supervision returns and through the division's clinical governance group. Sickness and absence is monitored through the Trust's Managing Attendance Policy and regular reviews with HR established to support direct management on the unit/teams. Following any long-term periods of sickness, staff are supported through return to work reviews and support provided by the Occupational Health Department. Any long-term cover arrangements are the responsibility of the Unit Manager.

The Humber Teaching NHS Foundation Trust asserts the importance of maintaining and supporting the safety of all staff as a key priority. The NHS has a policy for zero tolerance of discrimination, physical or verbal abuse. Where a staff member has been subjected to harm immediate and follow up support will be made available to support wellbeing and recovery of the individual. An incident form Datix will be completed to help review the incident monitor for any trends and achieve any learning needs for the service.

Safer staffing is a standard agenda item on both the Division's Clinical Governance and Operational Delivery Group and where required any escalations will be made to the Trust Quality and Patient Safety Group (QPaS) and exception reporting to the Trust Board.

4.3. Clinical Effectiveness, Research and Audit



The Trust is committed to ensuring all services are provided to a high quality and makes performance management a core function within all services. The Division's services will have established metrics for measuring clinical and non-clinical performance. This will be captured within the Division's accountability reviews and highlighted within the Division's service plans. The service plans will take account of:

- Quality Planning
- Activity Planning includes capacity and demand
- Workforce planning
- Financial planning

Accountability reviews will be conducted by the Executive Management Team on a three-monthly basis and will review the clinical effectiveness and operational performance of services within the Division. Services will establish a cycle of clinical audit utilising My Assure **as a tool** to capture real time reporting within the service. Other audits identified relevant to service delivery will be actively encouraged. Clinical teams will also be supported to undertake local and national research appropriate to the service linked to the Division's Quality Improvement Plan.

All audit proposals and research topics will be discussed at the Division's clinical networks for review and approval before being reviewed in the Trust's Audit and Effectiveness Group (AEG). Clinical care delivered in the service will be aligned to national best practice and follow where established NICE guidance. Staff competences will be reviewed through supervision and individual appraisal to ensure appropriate skill levels are maintained linked to clinical care delivery. The regulatory standards for the delivery of CQC single assessment framework will be embedded within the service delivery, any breaches in meeting regulatory standards will be notified to CQC as per notification and criteria procedures.

Any action plans arising from regulatory breaches will be agreed and monitored through Divisional governance meeting and overseen via the Audit and Effectiveness Group and any patient safety incident investigations will be agreed and monitored through the Clinical Risk Management Group and QPaS and monitored for delivery through the team governance structure.

4.4. Informatics and IT

All records regarding the multi-disciplinary care delivered by services within the Division will be electronically maintained on the Lorenzo IT or SystmOne system. All patient information will be used in accordance with the Accessing and Sharing Information with Service Users and Carers Policy, the Operational Procedure for Sharing Information to provide integrated Mental Health Services and the Caldecott and Data Protection Policy All records are managed under The Records Management Code of Practice for Health and Social Care (2016).

Health informatics will support the management of electronic records. Services will use the electronic record to collect and record the service-user's health information adhering to electronic information standards. Record keeping will be subject to monthly record keeping audits through MyAssurance and review to ensure that the information recorded is entered in a timely manner and captures an accurate care plan that identifies the treatment delivered by all staff and also captures any contemporary risks including safeguarding emerging.

Informatics will be used across services to improve the coordination of patient care information and management of treatment plans enabling live recording and co-ordination of

care delivered across the services. All patients including children accessing the services will be supported to be involved in their care planning. Copies will be shared where appropriate with service-users and families /carers with exceptions considered where risks are identified e.g. safeguarding concerns. Consent will be considered throughout all information-sharing decisions with an acknowledgment of the implementation of the Mental Capacity Act for those aged 16 years and over.

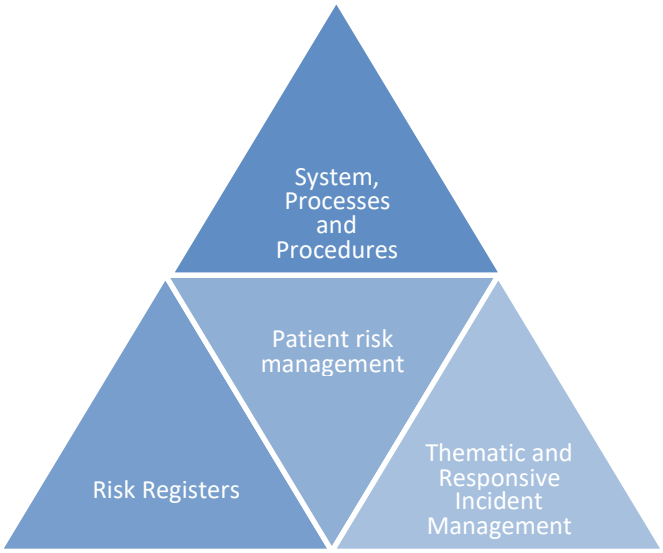
4.5. Education, Training and Staff wellbeing

All staff working in the Division will be supported to maintain the values of caring, learning and growing. Education, training and personal development will be individually and collectively identified through the appraisal process. Continuing professional development critical in ensuring that the staff team have the necessary skills and knowledge to support them to deliver the highest quality of care to patients and their families.

All staff will be appraised annually via the personal development process. The records of appraisals will be recorded on ESR. Regular clinical and managerial supervision structures will be in place to provide on-going developmental review and identify any emerging training or wellbeing support for individuals. All new staff will attend an induction programme. All staff will attend mandatory training sessions appropriate to their individual professional status. This will include the necessary level of training required to manage all areas of care delivery as identified for each individual service. A programme of ensuring SOPs are developed for each service is in progress within the Division.

Service-specific training will be facilitated and include practice-based learning opportunities for all staff. Training will be determined by the analysis of skills needed linked to the identified support needs of service-users. The service will maintain links with local universities and support student placements across all disciplines. This will include ongoing participation in local medical training programmes in addition to training programmes for other health professionals.

4.6. Risk Management Systems



The triangulation of all governance information is essential to risk management. The services will have robust Risk Registers in place to ensure that risks are identified, managed and reported through organisational governance arrangements. A monthly meeting has been established (please see appendix 2) for Divisional Leads to meet with the Division's governance officer to review any new risks, discuss updates in relation to existing risks and

identify queries for the service to address through team meetings and clinical networks. Following this meeting, extracts are taken from the live system and sent to each clinical network to facilitate review and updating of risks. The divisional process in place has been reviewed and once approved through the governance system, will be included in this document.

The information from these risk registers is essential due to the confounding impact risks have on other elements of the real time governance framework and to ensure that that risk ratings are reflective of real time service activity. The risk register will be reviewed at team meeting level, at clinical networks, Divisional Clinical Governance and ODG meetings, and escalation to QPaS, the Executive Management Team (EMT) and the Quality Committee as appropriate.

All incidents are reported via the Trust's Datix electronic reporting and investigation system. All Datix are reviewed at the Trust corporate safety huddle each morning by senior clinicians within the Nursing Directorate, Pharmacy and Safeguarding. Other senior clinical staff across the Trust join the huddle. All clinical staff across the Trust can join the huddle to participate in the review of Datix submissions. All submissions are reviewed and actions for further review in relation to any patient safety investigations identified.

This enables real-time reporting and alerting of incidents with set parameters on timescales for investigation. The huddle provides the opportunity to dial in to discuss Datix submissions made join the previous 24 hours. When services have made Datix submissions the matron, clinical lead or unit manager will join into the Corporate Safety Huddle to talk through the incident providing context and offering assurance that any immediate action has commenced. The management of the incident includes full duty of candour provided to the individual and their family and learning the lessons approach to improvement. Quality dashboards utilising Datix will be used by teams to identify risk themes and inform decision making.

Where there has been distress to the patient, staff or others, a debriefing opportunity will be facilitated immediately following the incident and repeated if necessary, at an appropriate time. Staff operational debriefs will be undertaken by the most appropriate person but usually this will be the unit/team manager. Staff psychological debriefs will be undertaken by the most appropriate person but usually this will be the unit/team psychologist. The Psychology team can offer, where appropriate and available, a further psychological debrief/support to individual staff members concerned if needed.

The in-patient services have in place routine meetings that facilitate regular review and discussion on the care and treatment of a patient presenting with a significant risk to themselves or others. Risk assessments will be reviewed and adjusted to ensure that the risks are effectively managed, and the risk of harm reduced.

Use of restrictive practices includes physical restraint, secluded care**,** long term segregation, Care Away From Others (CAFO) and the use of rapid tranquilisation will only be considered when de-escalation and other strategies to calm the patient have not been effective and the risk to self or others is high. The use of restrictive interventions must be reasonable and a proportionate response to the risk identified at the particular time. Use of restrictive interventions is monitored through the inpatient and Trustwide Reducing Restrictive Interventions group meetings.

A record of the patient's physical health will require on-going recorded monitoring as detailed in the Seclusion /Restraint/Rapid Tranquilisation policies. This will include baseline observations recorded using the NEWS-2 for those aged over 16 years and the PAWS for those under 16 years. All occurrences will require medical reviews to be undertaken along

with MDT reviews as per policies. All incidents will require a Datix to be submitted detailing the actions taken. Further investigation of such incidents will be undertaken as advised by the corporate risk team and/or senior clinicians and operational management. A reflective review including learning the lessons will be part of each episode of restrictive practice.

4.7. Environmental Risks

The services will have in place regular environmental checks in line with Trust policy to ensure that the clinical areas including bedroom spaces in the inpatient services are routinely checked for all potential hazards that may result in self-harm including ligature risks. Trust-wide ligature risk assessments are undertaken and reviewed on an annual basis.

The storage of ligature cutters at Townend Court and Inspire CAMHS unit will be co-located with the resuscitation equipment.

4.8. Safeguarding

Safeguarding risks that are identified as a result of disclosure from all patients including children or observed during interaction with the patient or family will be immediately referred to the Trust safeguarding team and the appropriate local authority safeguarding team. The patient will be immediately protected from any further safeguarding concerns. All appropriate agencies will be involved in developing a safe plan for the patient.

5. DIVISIONAL GOVERNANCE STRUCTURE

In order to ensure good governance across the Child, Learning Disability and Autism Division, there are three main governance groups: the Clinical Networks, Divisional Clinical Governance Group and the Operational Delivery Group. A monthly risk register meeting has been established to facilitate oversight and review from the Divisional leadership team. A patient safety and clinical assurance group and patient experience group are also in development to contribute to this structure. The structure is shown in Appendix 2.

5.1. Clinical Networks

Each of the services within the Division attends one of the four Clinical Network meetings held across each month. The purpose of the Clinical Network meetings are to:

- Ensure that the service is delivering safe and effective services that are continuously improving through the implementation of learning from incidents, national enquiries and other quality improvement feedback mechanisms.
- Ensure implementation of nationally mandated clinical standards that require action within the Division e.g. Professional body standards/CQC/NICE
- Develop a Quality Improvement Plan for the service based on clinical priorities incorporating patient, carer and staff views to drive quality improvement activities
- Develop, ratify, implement and review the effectiveness of local policies, guidelines and standards
- To provide scrutiny and sign-off for patient, carer and public information leaflets produced by clinical professional experts in the field (with or through appropriate clinical speciality groups)
- Prioritise, agree and monitor clinical audit activities for the service in line with the Trust's Audit Strategy and ensure the recommendations from clinical audit are implemented and evaluated in terms of practice development and improvement.
- Inform and influence skills development and workforce transformation in line with local and national clinical standards and commissioning priorities.
- Identify and support areas for research and service evaluation to inform quality improvements.

A SOP escalation process has been developed in recognition of times when agreement regarding documents for approval cannot be reached by a clinical network which then requires escalation and support through the divisional leadership team. The process for this can be seen in Appendix 3.

Each of the four Clinical Networks within the Division have their own Terms of Reference which are available upon request. Details of chairing arrangements for each clinical network are included in Appendix 2 as this varies depending on the leadership composition of the services within the respective networks.

5.2. Divisional Clinical Governance

The purpose of the Divisional Governance meeting is to oversee governance issues within the Children, Learning Disability and Autism Division and take appropriate action as required to ensure safety and performance is maintained, and to escalate concerns/matters within the organisation.

The duties of the Clinical Governance Group are:

- To monitor quality, safety and risk within the Division, take any necessary action and escalate concerns as appropriate within the Trust
- To provide assurance to the organisation around quality, safety and risk
- To oversee and support improvements following CQC inspections (including MHA)

The Division's governance meeting is responsible for monitoring and holding individual services to account for all aspects of quality safety and performance and has multiple points of escalation both internally within the Division and through trust wide structures including QPaS and the Trust-wide Operational Delivery Group. An escalation process will be developed to facilitate identification and resolution of issues that occur through Clinical Networks through the deployment of appropriate support.

Terms of reference are held and reviewed annually and approved through the Quality and Patient Safety Group.

5.3. Divisional Operational Delivery Group

The divisional Operational Delivery Group will monitor the services' performance, finance, governance and HR issues. It will monitor progress against transformation, patient experience, staff well-being, quality and safety to support effective operational delivery across the Division.

The Operational Delivery Group reports directly to the Trust Operational Delivery Group.

The duties of the Children, Learning Disability and Autism Operational Delivery Group are:

- To build relationships and establish patterns of working across the divisional and corporate support services which harmonise activity and create consistency in order to achieve the delivery of the Trust's Operational Plan.
- To discuss and agree the effective implementation of plans/actions arising from the Operational Delivery Group as they relate to the division's services
- To ensure the adoption and application of the Trust's values
- To escalate to/feed-up matters requiring ODG decisions
- To monitor the care group financial status and be responsible for the delivery of the Care Group Financial Plan and Budget Reduction Schemes
- To support the development, implementation and delivery of the Trust's Estate Strategy as it relates to the division's services

- To maintain oversight on staffing and workforce within the care group including performance, compliance, recruitment and retention
- To support the delivery of the Workforce and OD Strategy and Health and Wellbeing Strategy
- To contribute to and influence the development of key Human Resource policy.
- To support the delivery of the Trust's Communication Plan
- To support the delivery the Trust's Annual Plan
- To coordinate the delivery of the divisional transformation plan
- Review and monitor the management of risk registers
- Review and monitor all performance targets that apply to the division's services including contractual/commissioning targets, quality standards, waiting times, and NHS Improvement targets.

To ensure the timely review and management of the divisional risk register, a process has been developed whereby divisional clinical leads and general manager meet every month with the divisional governance and performance officer. Any actions or updates from this meeting are sent to the relevant clinical networks along with an extract of items from the risk register that sit within their services. This will facilitate review of current risk ratings and determine if the necessary controls are in place to address the identified risk which will be reflected in updates to the risk register.

Terms of reference are held and reviewed annually and approved through the Trust ODG.

5.4. Divisional Governance Sub-Groups

The following sub-groups will be established within the Division to facilitate the effective review and oversight of key areas on the governance agenda:

5.4.1. Patient Safety and Clinical Assurance Group

The purpose of the meeting is to provide the Division with assurance that high standards of care are provided by the division and in particular, that adequate and appropriate governance structures, processes and controls are in place aimed at:

- Safeguarding patients and promoting excellence in patient care
- Identifying, prioritising and managing risk arising from clinical care
- Protecting the health and safety of Trust employees
- Review patient safety investigations and identify themes and learning

The duties include:

- There is an expectation that all patient safety investigations will be fed back through appropriate clinical team meetings and evidence provided through minutes
- To ensure that there is an appropriate process in place to monitor and promote compliance across the Division with clinical standards and guidelines.
- To identify and monitor any gaps in the delivery of effective clinical care ensuring progress is made to improve these areas
- To receive assurance that appropriate action is taken in response to adverse clinical incidents
- To monitor reporting against patient safety investigation action plans, ensuring that action plans are reviewed and implemented.
- To ensure that risks to patients are minimised through the application of comprehensive risk management
- To promote an environment of discussion, sharing of information and good practice
- To contribute to Trust wide patient safety activity through representation at:
  - Daily corporate safety huddle

- Clinical Risk Management Group (CRMG)
- Safeguarding Forum (SF)
- Reducing Restrictive Interventions Group (RRIG)
- Clinical Environments Risk Group (CERG)
- Drugs and Therapeutics Group (DTG)
- Physical Health and Medical Devices Group (PHMD)
- Health-Associated Infection Group (HAIG)

Terms of reference for this group will be reviewed through the divisional governance meeting.

5.4.2. Patient Experience Group

The Division has an engagement lead for children and young people in post that works closely with young people to capture their views to enhance our service delivery. The Division is working towards establishing a patient experience group that will report into the divisional clinical governance structure that will include the engagement lead and representatives from each of the clinical networks within the Division. The terms of reference for this group will be developed as part of the group being established.

5.5. Divisional Coverage of the Seven Pillars of Governance

Table 1 below shows how the three main Governance groups (Divisional Clinical Governance, Clinical Networks, and Children, Learning Disability and Autism Delivery Group) and their subgroups ensure that the 7 pillars of clinical Governance are addressed.

Table 1: Seven Pillars of Governance aligned to Governance Groups

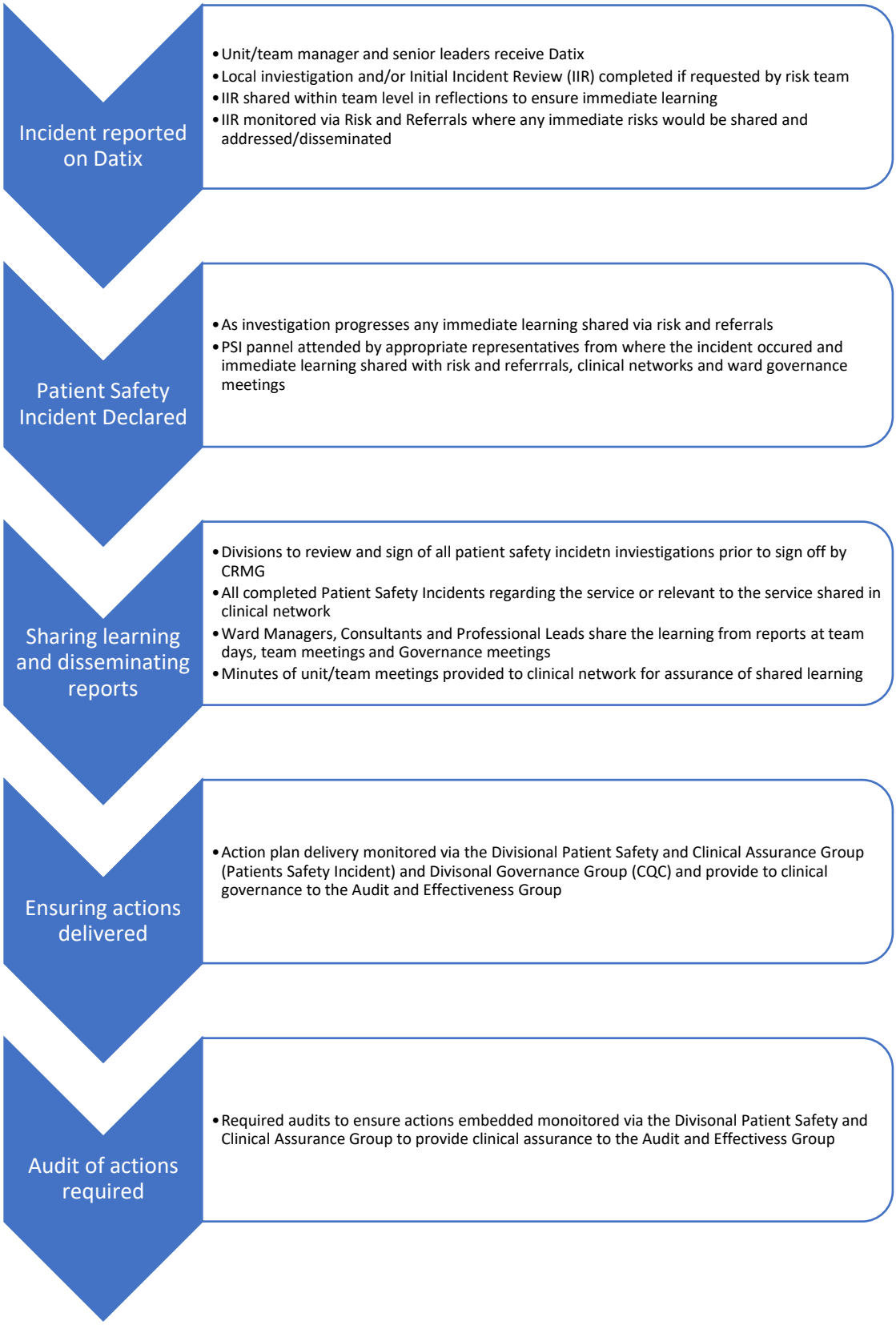
Pillar	Governance Group Responsible for assurance	Chair	Frequency	Sub - groups reporting to the Governance Group	Frequency
Clinical Effectiveness and Research	Clinical Networks	Professional Lead/ Modern Matron	Monthly		
Audit	Clinical Networks Clinical Governance	Professional Lead/ Modern Matron Clinical Lead	Monthly		
Education and Training	Clinical Governance	Clinical Lead	6-weekly	Clinical Network	Monthly
	Divisional ODG	General Manager	Monthly	Service Meetings Team Leaders Meetings	Monthly
Risk Management	Clinical Governance Divisional ODG	Clinical Lead General Manager	6-weekly Monthly	Patient Safety and Clinical Assurance Group	Monthly
				Reducing Restrictive Interventions	Monthly

				Team Meetings	weekly
				Clinical Network	Monthly
Patient and Public Involvement	Clinical Governance Divisional ODG	Clinical Lead General Manager	6-weekly Monthly	Clinical Network Patient Experience Group	Monthly Monthly
Information and IT	Divisional ODG Clinical Governance	General Manager Clinical Lead	Monthly 6-weekly	Service Meetings	Monthly
Staffing and Staff Management	Divisional ODG	General Manager	Monthly	E-Rostering Review	Daily
				Team meetings	Weekly
	Clinical Governance	Clinical Lead	Monthly	Daily Huddles	Daily
				Leads Meetings	Weekly

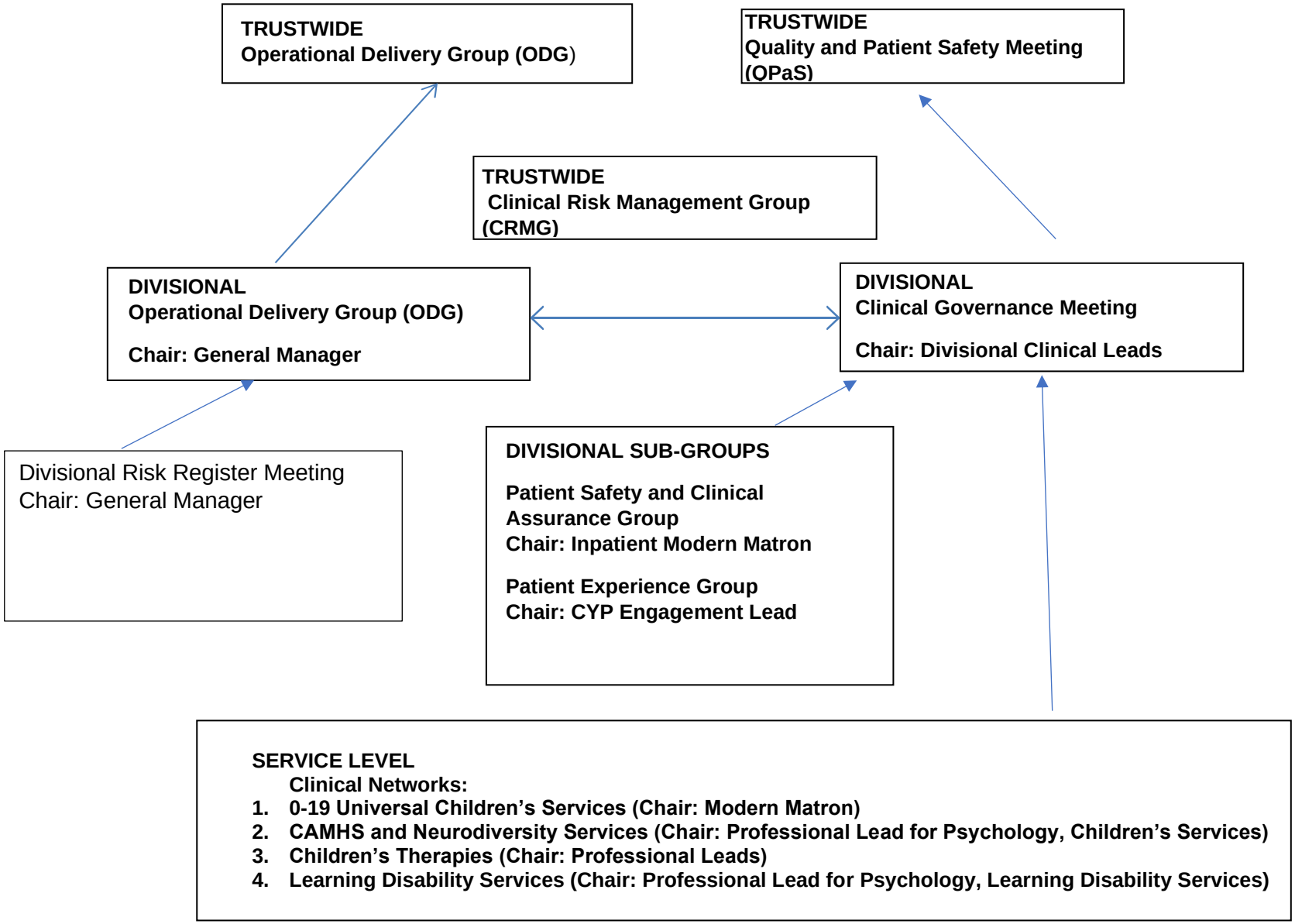
6. REFERENCES

- Divisions Service Plan
- Local SOPs
- Accountability Review
- Service Specifications
- Operational Procedure for Sharing Information
- General Data Protection Regulations (2016)
- The Records Management Code of Practice for Health and Social Care (2016)

Appendix 1: Sharing the Learning Flowchart



Appendix 2: Children, Learning Disability and Autism Clinical Governance Reporting Structure



Appendix 3: Escalation Process for SOPs/Protocols when Agreement at Clinical Network cannot be reached

Rationale:

This process will oversee the governance of clinical documents as relevant to the division/networks when the SOP/protocol/guidance cannot be agreed on. Thus, ensuring robust governance structures are in place to facilitate timely input, reviews, and approval of local documents. The SOP/protocol/guidance will have been through the appropriate consultation pathways to be then brought to the clinical network for approval.

1. Document is brought to the clinical network for approval

2. No agreement reached after amendments made (max two times through Clinical Networks meeting)

3. If no approval received, then document to go to Divisional Clinical Leads and General manager to approve the document. A joint decision will be made between the clinical leads and the General manager. Taking into consideration the evidence base for the document and the operational processes and resources available for implementation of the SOP/Protocols/guidance.

4. Clinical expertise (Clinical expertise means the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice in any particular area)
may need to be sought to aid this process and offer clinical advice, experience, and knowledge to ensure decisions are evidence based.

5. SOP finalised and approved and brought back to next Divisional Governance meeting for noting.

6. Reviewing date to be within 6mths to ensure monitoring of the clinical document addresses the clinical practice areas of disagreement.

7. SOP sent to Governance and Performance Officer in our division to follow document process.

8. SOP to follow process for reviewing documents. Clinical network approval and Divisional Governance approval.

Other guidance to follow:
Procedure for the Control, Review, Approval and Dissemination of Clinical Policies, Procedures, Protocols, Guidelines and SOP