Humber Teaching NHS Foundation Trust

STANDARD OPERATING PROCEDURE
MENTAL HEALTH DIVISION CLINICAL GOVERNANCE

Document currently under review – please continue to use this version until it is replaced by the next approved version

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

CHANGE RECORD

Version	Date	Change details
1.0	*Dec-19*	*New SOP*
2.0	*May-21*	*Updated to include current meeting names, update to staff psychology debrief; update CQC MHA visit informaiton in MHA section; update on Division meetings details and terms of reference* *Ratified and approved by QPaS (Quality and Patient Safety Group) 25-May-21*
3.0	*Feb-22*	*Update includes the additon of new division compliance meeting, updated terms of references; update meeting and governance structures.* *Approved at the MH Divisional Clinical Governance meeting 1-Feb-22*
3.1	*3 May 23*	*Updates, minor amends to Patient Expereince, MHA section and Sharing the Learning Flow chart* *Approved through MH Divisional Clinical Governance Meeting 28 March-23* *T0R removed as appendix* *Approved and ratified at QPaS (Quality & Patient Sfety Group) 3 May 2023*

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 are assessed against the key lines of enquiry (KLoEs), 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.

The document is an overview document to work alongside the individual ward specifications and the service specification for all services within the Mental Health Division.

The purpose of the Governance standard operating procedure (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 Governance structure developed within the Division will use real time information to inform, improve and strengthen involvement and ownership of all of 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. It also addresses gaps in current forms of governance, particularly around everyday systems and to ensure the use of real time clinical and operational information triangulated with incident reporting, patient experience, risk management, managerial information and the overall clinical audit plan to provide service level accessible intelligence.

The framework will take account and be underpinned by national and local drivers including NICE guidance; individual professional guidelines and codes of professional conduct to ensure our patients 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 Mental Health Division, which sits within the Humber Teaching NHS Foundation Trust.

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

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 will 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 three values, **Caring, Learning and Growing**.

Caring:
Caring for people while ensuring that they are always at the heart of everything we do

Learning:
Learning and using proven research as a basis for delivering safe, effective and integrated care

Growing:
Growing our reputation for being a provider of high-quality services and a great place to work.
Staff of all disciplines and grades within the service, have responsibilities and duties as part of the Clinical Governance framework for the service. These are summarised below:

3.1. Clinical Lead and General Manager

Both the clinical lead and the general manager are responsible for ensuring that the groups 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, Clinical Leads and Service Managers

Matrons, Clinical leads 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, clinical leads and service managers are accountable for ensuring compliance with the CQC KLoEs 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, clinical leads and service managers are accountable for ensuring that ward managers/team managers effectively share learning from incidents, complaints, and compliments.

Matrons, clinical 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, clinical 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. Consultants, Psychologists, Social Workers, Nurses and Allied Health Professionals (AHPs)

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.

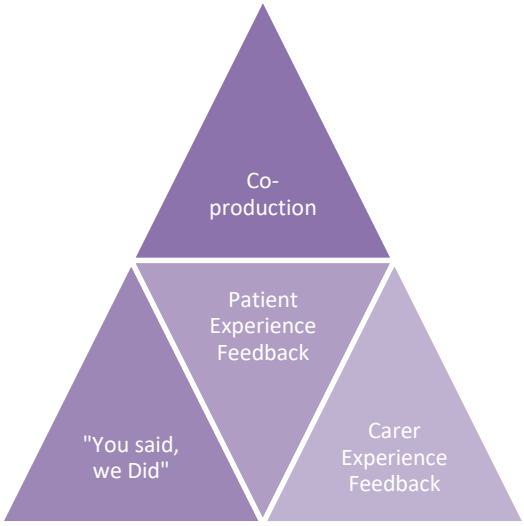
3.5. All Clinical and Non-Clinical Staff

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, incident and complaint investigations (SEAs/SIs) and report safety and performance issues through agreed mechanisms.

4. PROCEDURES

The governance reporting will use real time information to inform, improve and strengthen involvement and ownership of all of 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



Where possible engagement with all of the people who use the individual services. This will include patients, families, carers, and significant friends .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. . Services will identify Staff Champions of Patient Experience to ensure these systems are in place, that feedback is coming through and being discussed in team meetings.

Engagement commences on referral of each individual patient referred into the division services. Families and carers will be engaged in the planning and delivery of care where appropriate with the consent of the patient. Where a patient lacks capacity a best interest meeting will be recorded to ensure the patient's wishes and requests are considered at all times. Maintaining contact will be facilitated by the team using the means most appropriate to the needs of the patient. 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 service. Feedback on the care delivered will be encouraged at all times by all wards and teams in the Division. Patients, carers and

families will also be invited to sign up to the division's Adult Mental Health Involvement mailing list where they can hear about opportunities to be involved in the ongoing development, improvement and co-production of Adult Mental Health Services.

The division is working towards all services applying the principles of value based recruitment when recruiting staff. Staff recruited to work in the division's services will be interviewed by patients, service users, carers or family members. The principles of including service users in recruitment will continue to be a standard embedded within the division's services.

4.2. Staffing and Staff Management

The Mental Health Division consists of eight inpatient units, community mental health teams and a range of specialist mental health services for adults and older people. All services adhere to the principles of NHS safer staffing ensuring that the service has sufficient numbers of qualified staff to provide the on-going clinical and operational leadership for each span of duty. For all units and Crisis Intervention Team/Triage and Assessment team/Crisis and Intervention Team for OP (MHCIT/MHTAT/CITOP), the team rostering is managed and monitored electronically through e-roster and 'Employee on Line' and will be the responsibility of the Unit manager/team manager, and their deputies. The rota will be reviewed and confirmed by the unit/team manager and service manager.

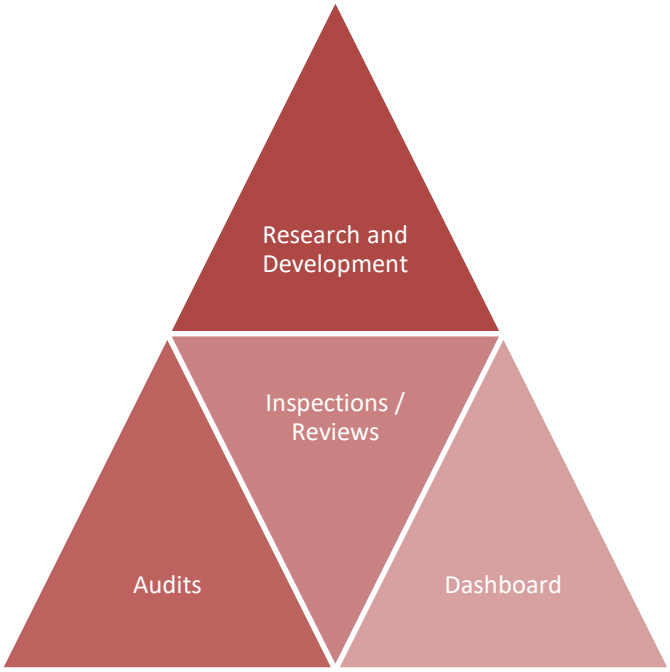
Inpatient unit managers will review staffing levels on a daily basis to determine the staffing requirements, potential shortfalls and mitigations for each unit. Any concerns related to safer staffing are escalated to as per the safer staffing escalation policy. Inpatient staffing will be discussed as part of weekly inpatient safety huddle to ensure appropriate forward planning and risk mitigation. Similarly the team manager for the community teams will escalate any staffing concerns where required. Staffing rotas ensure sufficient skilled staff are in place to support the delivery of care pathways across all services inpatient and community. 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 return and through the Division's clinical governance group. Sickness and absence is monitored through the Trust's Attendance Management 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.

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 in 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 the Clinical Governance and 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 service plans. The service plans will take account of:

- Quality Planning
- Activity Planning which 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 the services. The service will establish a cycle of inpatient and community clinical audit utilising MyAssurance as a tool to capture real time reporting within the service. The cycle of MyAssurance audits will be outlined in a separate MyAssurance SOP. Other audits identified relevant to the service delivery will be actively encouraged. The clinical team will also be supported to undertake local and national research appropriate to the service linked to the Division's Quality Improvement Plans.

All audit proposals and research topics will be submitted for discussion at the Division's Practice Network 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 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 quality domains 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 and complaints will be agreed and monitored through Divisional governance meeting and any incident investigations (SIs and SEAS) and will be agreed and monitored through the Patient Safety and Clinical Assurance meeting and monitored for delivery through the team governance structure.

4.4. Informatics and IT

All records regarding the multi-disciplinary care delivered on the Units and in the community teams will be electronically maintained on the Lorenzo Electronic Patient Record system, PCMIS for IAPT services and Iaptus for Veterans (TILS). All patient information will be used in accordance with the Information Sharing with Carers and Significant Others SOP (SOP16-007) and the Caldecott and Data Protection Policy (N-027) in line with General Data Protection Regulations (GDPR). 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. Record keeping will be subject to monthly record keeping audit and review through our electronic audit platform, Myassurance. The audit will ensure that the information recorded is entered in a timely manner and captures an accurate co-produced care plan that identifies the treatment delivered by all staff and also captures any contemporary risks including safeguarding emerging.

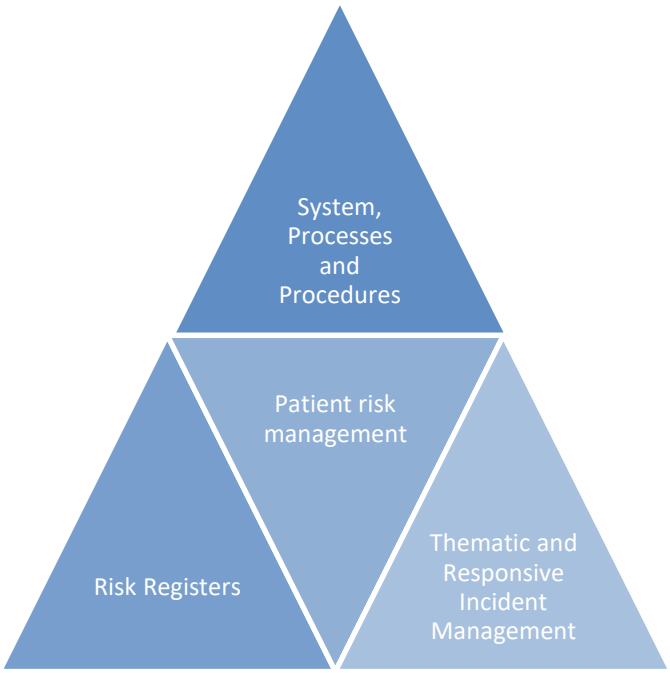
Informatics will be used across the services to improve the coordination of patient care information and management of treatment plans enabling live recording and co-ordination of care delivered across the services. All patients accessing the services will be supported to be involved in their care planning. Copies will be shared with the patient and where consent is given their families/carers. Consent will be considered throughout information sharing with an acknowledgment of the implementation of the Mental Capacity Act.

4.5. Education, Training and Staff Wellbeing

All staff working in the service 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 is 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 professional and managerial supervision structures will be in place to provide ongoing 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 in the individual service's operational SOP.

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



4.6. Risk Management Systems

The triangulation of all governance information is essential to risk management. The service will have a robust risk register in place to ensure that risks are identified, managed and reported through organisational governance arrangements. The information from the risk register is essential due to the confounding impact risks have on other elements of the real time governance framework and to ensure that risk ratings are reflective of real time service activity. The risk register is reviewed at team meeting level, Division ODG and Clinical Governance, with 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 from each division join the huddle (in person or virtually) to participate in the review of Datix submissions. All Datix submissions are reviewed and actions for further review include the following:

- Initial Incident Review (IIR)
- Serious Incident (SI)
- Significant Event Analysis (SEA)

This daily review of incidents enables real time reporting and alerting of incidents with set parameters on timescales for investigation. The huddle provides the opportunity to discuss Datix submissions made in the previous 24 hours. When services have made Datix submissions the Division Clinical Lead/Matron/ Service Manager/Governance Lead will attend the Corporate Safety Huddle to talk through the incident providing context and offering assurance that an immediate action has commenced. The management of the incident includes full duty of candour (for moderate and above incidents) provided to the individual and their family and learning the lessons approach to improvement.

Where there has been distress to the patient, staff or others a debriefing opportunity will be facilitated as soon as possible following an incident. 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.

All incidents of moderate harm and above reported via Datix will also be reviewed at the Weekly Inpatient Senior meeting chaired by Inpatient Service Manager. The meeting will explore themes and trends including wider system risk management approaches ensuring the service is well resourced to deal with that level of risk. The Service Manager/Matrons will escalate anything that needs further escalation and cascade the information accordingly..

All unit managers/team managers and their deputies have access to Datix for the management and investigation of reported incidents. It is essential that they review reported incidents on a daily basis to ensure incidents not closed by the corporate huddle are investigated and closed in a timely manner.

The inpatient 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. Care plans will be reviewed and adjusted to ensure that the risks are effectively managed and the risk of harm is reduced.

The learning from initial incident reviews will be disseminated via the divisional quality and governance team and learning from Serious Incident investigations, SEAs and complaints will be disseminated via the patient safety & clinical assurance and clinical governance meetings and shared with the wider staff team through ward and team level meetings. Assurance that the learning has been shared will be provided through unit/team meeting minutes. The flowchart in Appendix 1 shows the process for sharing learning.

A 1 page learning the lessons briefing is completed in easy read format after each SI/SEA and made available to share across the teams within the Division. They summarise areas of concern, areas of good practice, learning for professionals, changes to practice and areas to progress.

The monthly Patient Safety and Clinical Assurance (PS&CA) meeting provides the Division with assurance that high standards of care and patient safety are provided by the Division and that adequate and appropriate governance structures, processes and controls are in place to promote learning and ownership of serious incident reviews, significant event analysis, initial incident reviews, mortality reviews and S42 with the added process of Testing the Learning.

Testing the Learning has been introduced the divisional SEA/SI action monitoring and evaluation process as a new governance process to develop a systematic approach of monitoring actions from incidents and service improvement through lessons learned and this is reviewed monthly through the PS&CA meeting.

Evidence from actions is reviewed regularly and approved by the divisional quality and governance Lead and sent to the corporate patient safety team for a further review at Closing the Loop.

The MH Division runs a quarterly Practice Development Day with interesting events which bring together practitioners of all grades and disciplines to hear about relevant, contemporary and innovations in practice. They also helps to share the learning across the Division. These are popular events with the agenda showcasing all the good work colleagues are all doing right across the Division with attendance of between 40-50. The move to MS teams has changed though not diminished the event. The Practice Development Days contribute to the Well Led criteria for the KLoEs.

In addition the division runs a monthly My Assurance and Clinical Compliance meeting which has been established to improve the level of interrogation, compliance and assurance on MyAssurance Audits, CQC Key Lines of Enquiry (KLOEs) and regulatory requirements, delivery of national and local guidelines and policies. The Group will interrogate and receive assurance of compliance with MyAssurance audits and review monitoring arrangements and action plans. The group will oversee the peer review actions with a focus on demonstrating compliance with CQC KLOEs quality standards, closed culture action plan to ensure clinical effectiveness and learning is embedded in practice.

Use of restrictive practices which include 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 monthly through the Reducing Restrictions Group.

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 on NEWS2, all occurrences will require medical reviews to be undertaken along with MDT reviews as per policies. All restrictive 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. Particular emphasis will be placed on the security of bedroom spaces and the type and amount of property that patients have in their rooms. Staff are asked to refer to the Patient Property Procedure in order to manage property risks. This is monitored monthly through the Clinical Environmental Risk Group (CERG)

4.8. Safeguarding

Safeguarding risks that are identified as a result of disclosure from all patients or observed during interaction with the patient or family will be sent to the safeguarding team in Humber Teaching NHS Foundation Trust and further discussions may take place to consider whether a referral to the relevant local authority safeguarding team Is required in line with legislation, policy and procedure.. Actions will be taken to reduce the risk of harm to the patient and a safety plan created, working with appropriate agencies to do this. The safeguarding process will focus on the views and wishes of the patient in line with Making Safeguarding Personal.

4.9. Mental Health Act

All professionals have a requirement to be familiar with and operate in line with the MHA and the Code of Practice as stated in Section 118 of the Act.

The CQC undertake unannounced Mental Health Act visits across our inpatient mental health and learning disability wards periodically in order to monitor use of the Mental Health Act and ensure standards are being met. Services are assessed against the MHA Code of Practice' overarching principles.

On receiving an MHA visit from the CQC the ward manager/senior in charge must inform the Governance and Patient Safety Team, Matron, Service Manager, and the Mental Health Legislation Team immediately.

Following the visit the Ward Manager/Senior in charge will receive initial feedback from the CQC inspector and this should be written up and sent via email to the Governance and Patient Safety Team, Matron, Service Manager, and the Mental Health Legislation Team at the earliest opportunity. The Governance and Patient Safety Team then distribute this information accordingly. Any serious issues identified should be rectified immediately.

Once the report is received from the CQC the MHA CQC Reports Process should be followed with regards to completion of the Provider Action Statement, which needs to be submitted back to the CQC within a tight timeframe.

The MHA Clinical Manager monitors progress in line with the closing dates for actions and reviews evidence with the Matron and unit manager; the actions are closed off by the MHA Clinical Manager once sufficient evidence of completion of actions is provided. The actions are monitored through use of a CQC MHA tracker, which enables a regular update report to be completed for the Mental Health Legislation Steering Group, Mental Health Legislation Committee, Audit and Effectiveness Group, and Clinical Governance Groups as requested. The MHA Clinical Manager attends each division's clinical governance meeting in order to contribute to the governance relating to mental health legislation.

In addition to the above controls the MHA Clinical Manager and the Mental Health Legislation Manager carry out MHA support visits to every inpatient unit on a quarterly basis. The main focus of these visits is to ensure compliance with patients being given their rights regularly, S17 leave authorisations, and completion of capacity to consent to treatment forms (Z48) by the Responsible Clinician (general themes identified by the CQC at Trusts nationally). The MHA Managers then provide immediate feedback to the nurse in charge and follow this up in writing in the form of an action plan for immediate attention.

Any exceptions to the Mental Health Act will be reported via the monthly exception report, which is monitored via the MHLSG. Learning from such exceptions is addressed in the development of practice notes, amendments to forms/checklists, and through use of relevant scenarios within the bespoke MHA training packages etc.

In order to meet the monitoring requirements of the Mental Health Act Code of practice (2015) a performance report on the Mental Health Act will be provided to the Trust Mental Health Legislation Operational Group, and a quarterly report to the Trust Mental Health Legislation Committee. Exception reports will be made through the same process as well as in the Clinical Risk Management Group as required.

The Mental Health Legislation Steering Group monitors the number of admissions, detentions, discharges, CTOs, seclusions, duration of seclusions, regrades and all other relevant information pertaining to detained patients.

Regular MHA audits are built into Trust audit programme in MyAssurance. The units audit five sample notes per month and the MHL managers audit all inpatient records on every unit on a yearly basis.

In addition, the Mental Health Legislation Team receives regular audit information regarding the implementation for the following areas:

- Seclusion, long term segregation and CAFO
- Use of Section 4
- Holding powers
- Certificates for treatments
- Any exceptions, non-compliance is initially reported via a Datix report, which then informs the decision whether any further review is required.

5. SERVICE LEVEL GOVERNANCE STRUCTURE

In order to ensure good governance across the Mental Health Division, there are five main governance groups: Practice Network, Divisional Governance, Patient Safety and Clinical Assurance, Myassurance and Compliance and Mental Health Divisional Operational Delivery Group. Three of the five have subgroups aligned to them. The structure is shown in Appendix 2 and the five overarching groups are detailed in sections 5.1-5.5.

5.1. Practice Network

The Mental Health Practice Network has been established to oversee and ensure the delivery of Clinical Governance and quality improvement across the Mental Health Division. The Practice Network will also be responsible for defining and achieving a set of overarching clinical and practice priorities on an annual basis approved by the Division. The annual clinical and practice priorities will be set in line with national and locally agreed requirements and actions.

The duties of the Practice Network are as follows:

- Develop a Quality & Clinical Governance development plan for the Division based on clinical and practice priorities incorporating patient, carer and staff views to drive quality improvement activities.
- To ensure that patients', carers', and the publics' views are heard at all levels and across all parts of the Division to help create and deliver better health and care services.
- Ensure implementation of nationally mandated clinical standards that require action within the Division e.g. Professional body standards / CQC / NICE.
- To ensure development, implementation and regular review of evidence based clinical pathways and interventions.
- To ensure that the Trust 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.
- Review clinical SOP/Guidelines/Procedures/Policies to ensure quality, suitability and relevance. Ensure affected services have opportunity to comment to ensure all system works together. To advise /highlight when a SOP/Guidelines/Procedure is needed.
- To provide scrutiny and sign-off for patient, carer and public information leaflets produced by clinical and professional experts in the field (with or through appropriate clinical and professional speciality groups).
- Prioritise, agree and monitor clinical audit activities for the Division 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.

5.2. Sub-Practice Networks

To ensure effective service improvement and to encourage clinical development is embedded, the Practice Network is:

- Acute Care Forum
- Community and Liaison Care Forum
- OPMH Practice Network Sub Group

5.3. Divisional Governance

The purpose of the divisional governance meeting is to oversee governance issues within the Mental Health Division; take any action required and escalate concerns/matters within the organisation.

The Clinical Governance Group reports directly to QPaS.

The duties of the Clinical Governance Group are as follows:

- 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 support improvements following CQC inspections (including MHA) are implemented.

5.4. Patient Safety and Assurance Meeting

The purpose of the meeting is to provide the Division with assurance that high standards of care are provided by the Division and, that adequate and appropriate governance structures, processes and controls are in place to promote learning and ownership of serious incident reviews, significant event analysis, initial incident reviews, mortality reviews, s42 action plans and:

- Safeguard patients and promote excellence in patient care.
- Identify, prioritise and manage risk arising from clinical care.
- Promote the health and safety of Trust employees
- Review SIs, SEAs, IIRs, S42 action plans and MR and identify themes
- and learning

The duties include:

- There is an expectation that SIs, SEAs, IIRs, S42 action plans and MRs 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 SIs/SEAs, 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.
- Contribute to: Any request for information from QPaS and CRMG; Trust wide clinical and practice policy

5.5. Mental Health Division Operational Delivery Group

The Executive Management Team has agreed that an Operational Delivery Group (ODG) be established to bring together deputies from across corporate support and operational services in order to support the effective delivery of operational services.
The Mental Health Operational Delivery Group is established to both support the work of the Trust ODG, and to receive and escalate items relevant to the Mental Health Services Division.
The duties of the Mental Health Operational Delivery group, see appendix 5.

5.6. MyAssurance & Compliance Meeting

The MyAssurance & Clinical Compliance meeting (MACC) has been established as a sub-group of the Division's Clinical Governance Meeting. The group is authorised by Clinical Governance to engage in activities within its terms of reference.
The duties include:

- To provide leadership and be responsible for ensuring CQC, MyAssurance and clinical compliance priorities are agreed and implemented as relevant to the MH Division.
- To oversee and monitor MyAssurance audit activities across the division to ensure demonstration of best clinical practice and effective systems to support audit, implement changes and share findings.
- Informing or communicating relevant issues that require action from a practice network perspective through to the Practice Network
- To escalate significant compliance concerns to the Divisional Clinical Governance Group.
- To monitor and report compliance levels and action to be taken for non-compliance and report to the Clinical Governance Group by exception.
- To contribute to elements of the Care Quality Commission Standards ensuring that the Division can effectively monitor compliance or non-compliance with the relevant standards.
- To review CQC KLOES in order to plan and support future CQC inspection of services.
- To receive regular assurance and exception reports on delivery of CQC actions in relation to MHA inspections themes and actions.

- To have oversight of the implementation of Safety Huddles across the division.
- To review approaches to incorporate learning into divisional services.

5.7. Seven Pillars of Governance mapped against the Clinical Governance Structure

Table 1 below shows how the seven pillars of governance are mapped across the 4 main governance groups and their sub groups,

Table 1: Seven Pillars of Governance aligned to Governance Groups

Pillar	Governance Group Responsible for assurance	Chair	Frequency	Subgroups reporting to the Governance Group	Frequency
Clinical Effectiveness and Research	Practice Network	Clinical Lead/ Professional lead for Psychology	Monthly	Acute Care Forum; Community and Liaison Care Forum; OPMH Practice Network Sub Group; and for information AHP Forum and AMHP Forum	Monthly
Audit	Myassure& Compliance Practice Network Divisional Governance	Clinical Lead Quality & Governance Lead	Monthly		
Education and Training	Divisional Governance	Clinical Lead	Monthly		
	Mental Health Division Operational Delivery Group (MHOODG)	General Manager	Monthly		
Risk Management	Divisional Governance and Division ODG	Clinical Lead General Manager	Monthly	Risk and Referrals	Weekly
				Reducing Restrictive Interventions	Monthly
				QPAS	Monthly
Patient and Public Involvement	Division Governance	Clinical Lead	Monthly		Monthly
Information and IT	Mental Health Division ODG Division Governance	General Manager Clinical Lead	Monthly	Divisional Digital Delivery Group CCIO Update	Monthly
Staffing and Staff Management	Mental health Division ODG	General Manager	Monthly		
	Divisional Governance	Clinical Lead			

5.8. Unit/Team Level Clinical Governance

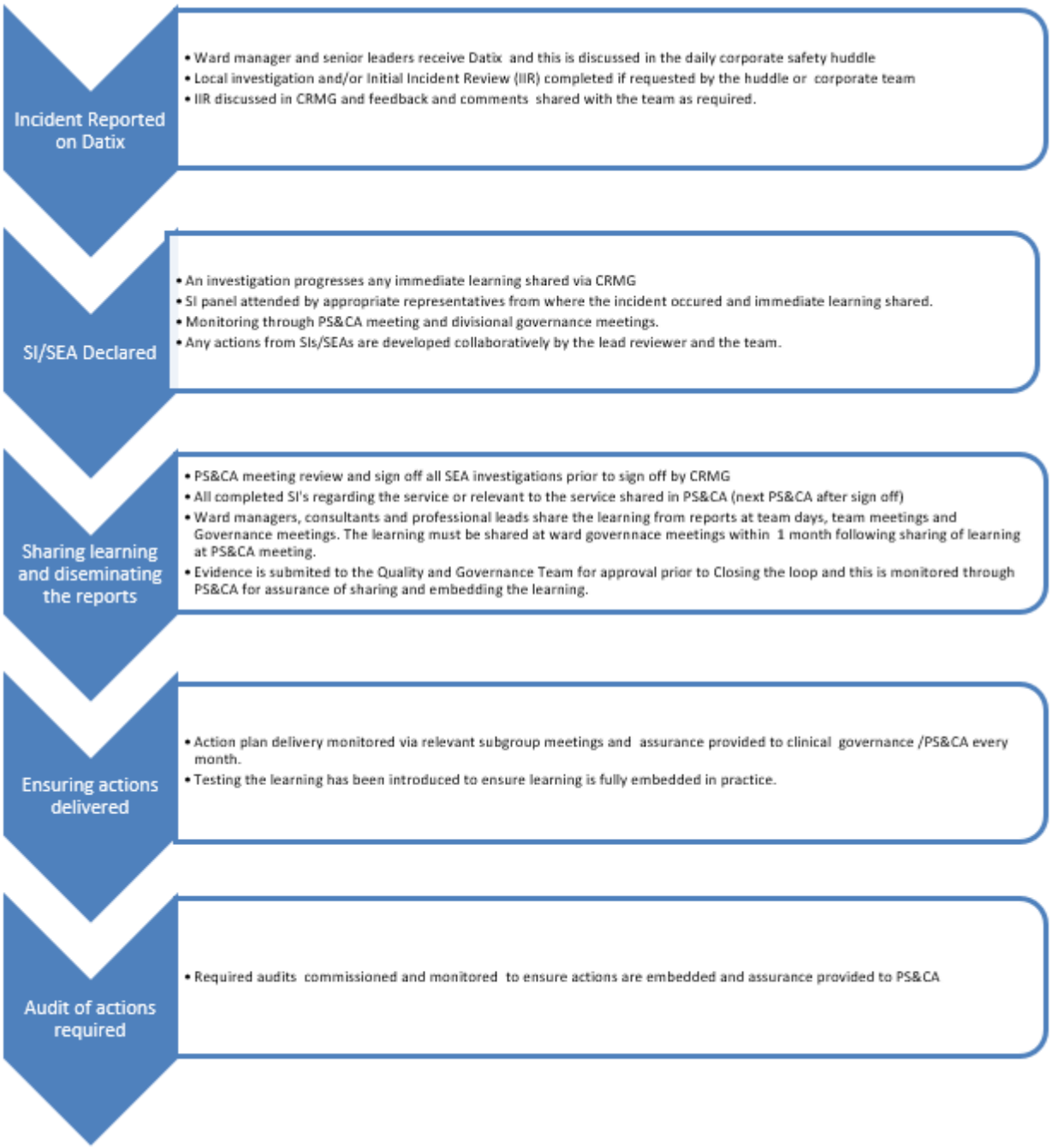
In order to ensure ward to Board governance each Unit/team holds a monthly governance meeting chaired by the ward manager/team manager.

The aim of the ward/team level governance meetings is to review the operations and quality performance and safety of the ward, share learning from SIs, SEAs and complaints and provide a two-way communication between the four governance groups and the operational teams/units.

6. REFERENCES

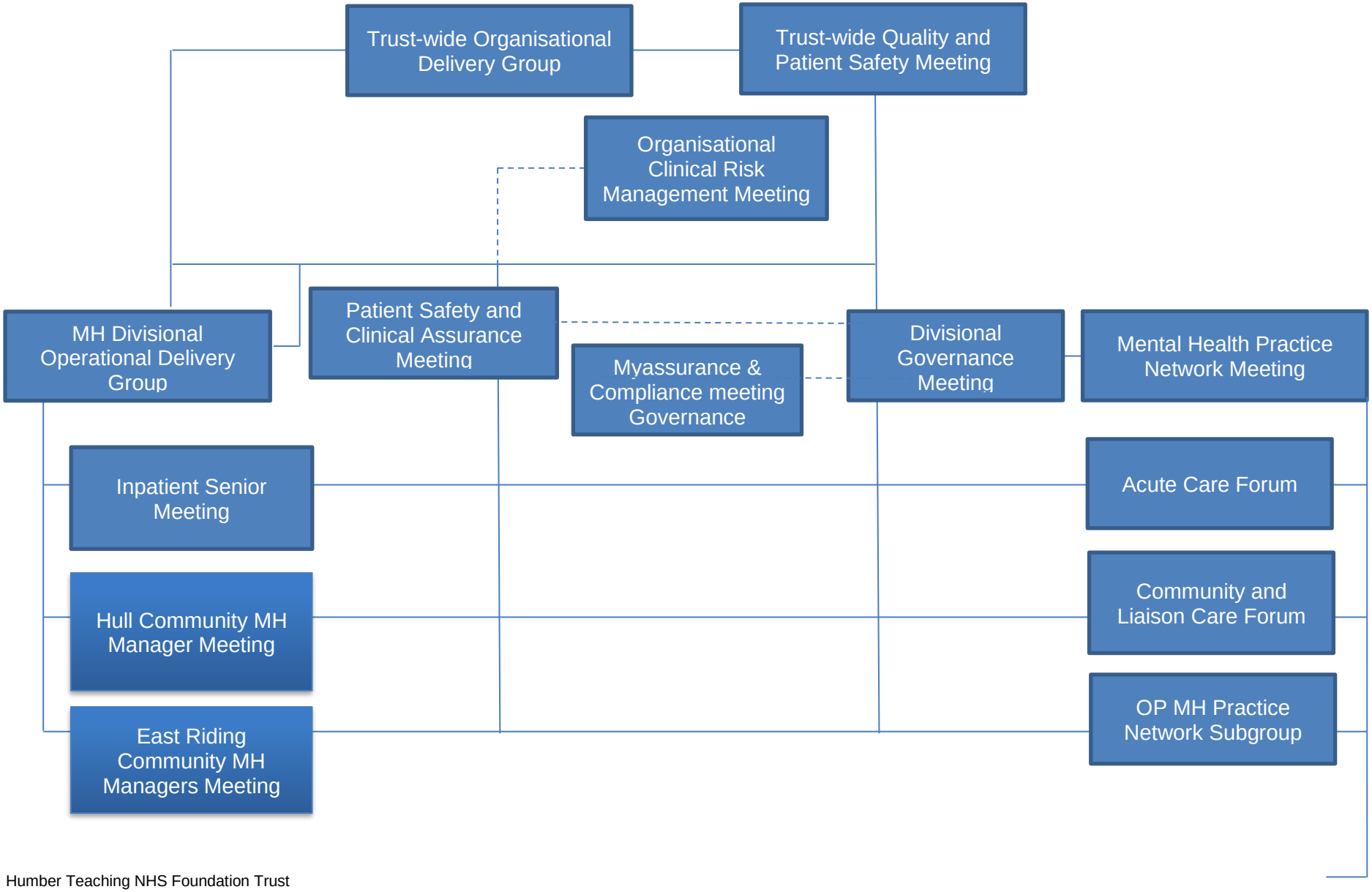
Divisions Service Plan
Local SOPs
Accountability Review
Clinical Model
Service Specifications
Operational Procedure for Sharing Information
Caldicott and Data Protection Policy
General Data Protection Regulations (2016)
The Records Management Code of Practice for Health and Social Care (2016)
Procedure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

Appendix 1: Sharing the Learning Flowchart



Appendix 2: Mental Health Governance Group Structure

GOVERNANCE GROUP STRUCTURE



Appendix 3 – MH Governance Reporting Structure