



<b>Meeting</b>	<b>CLINICAL GOVERNANCE COMMITTEE (CGC)</b>
<b>Date</b>	Tuesday 08 November 2022
<b>Location</b>	Via Microsoft Teams

<b>Purpose and Ambition</b>	
To provide assurance to the Quality Patient Experience & Safety Committee that all National Clinical requirements and responsibilities with regard to Clinical treatment and Care, including responding to the CQC and NHSE/I	

Attendance	Title
<b>Present</b>	<b>Medical Director</b>
XXXX XXXX	Head of Nursing & AHPs Specialities – Interim
XXXX XXXX	Consultant Occupational Therapist
XXXX XXXX	Consultant Forensic Psychiatrist
XXXX XXXX	Associate Director of Ops ICCR
XXXX XXXX	Head of Infection Prevention and Control
XXXX XXXX	Associate Director for Allied Health Professionals and Recovery
XXXX XXXX	Consultant Forensic Psychiatrist & CCIO (Chief Clinical Info Officer)
XXXX XXXX	Head of Safeguarding - Interim
XXXX XXXX	Clinical Director of Acute Care
XXXX XXXX	Head of Nursing and AHPs - Interim
XXXX XXXX	Head Of Nursing & AHPs Integrated Community & Recovery (ICCR)
XXXX XXXX	Head of Mental Health Legislation
XXXX XXXX	Associate Clinical Director Specialties - Interim
XXXX XXXX	Deputy Medical Director (Quality and Safety)
XXXX XXXX	HON & AHPs – Acute and Urgent Care
XXXX XXXX	Clinical Director Acute Care
XXXX XXXX	Head of Health and Safety and Regulatory Compliance
XXXX XXXX	Associate Director of Governance
XXXX XXXX	Deputy Medical Director Quality and Safety
XXXX XXXX	Clinical Director ICCR
XXXX XXXX	Clinical Director ICCR – Solar/EIS
XXXX XXXX	Head of Nursing and AHPs Acute and Urgent care
XXXX XXXX	Chief Psychologist
XXXX XXXX	Associated Director
XXXX XXXX	Associate Director Urgent Care
XXXX XXXX	Clinical Director Secure Services & Offender Health
XXXX XXXX	Deputy Director of Nursing
XXXX XXXX	Head of Nursing and AHP's Secure Care and Offender Health
XXXX XXXX	Exec PA to Chief Nursing Officer
XXXX XXXX	Exec PA Support – Interim ( <i>note taker</i> )
<b>In Attendance</b>	
<b>Apologies</b>	XXXX XXXX Deputy Medical Director, XXXX XXXX Clinical Director – Specialties, XXXX XXXX, XXXX XXXX Director of Operations, Chief Pharmacist

Agenda Item	Discussion
	<b>WELCOME AND INTRODUCTIONS</b>
2	<p><b>Declarations of Interest</b> There were no interests declared relevant to items on the agenda.</p>
3	<p><b>Minutes of the previous meetings</b> Minutes of the meeting held on the 04 October 2022 were approved as a true and accurate record.</p>
4	<p><b>Action Log</b> The action log was received and updated.</p>
5	<p><b>Risk Register Review</b> The Associate Director of Clinical Governance gave an overview of the report that had been circulated to the meeting previously and taken as read.</p> <p>The Associate Director of Clinical Governance advised the group that an email had been sent out to a number of people to look at the score (these are 12 or above) with a lot of the risks not being updated for some time. The biggest issues being around Estates and Staffing. This is a concern with the upcoming Well Led Inspection. The Associate Director of Clinical Governance also made the group aware of the new Associate Director of Corporate Governance who will be picking up the risk register, there are currently around 2000 items on the register.</p> <p>The Associate Director of Clinical Governance also suggested looking at the risks of 12 and above and looking at task groups and moving through the different hierarchy. It was also advised that the CQC would want to see individual risk registers, staffing on Meadowcroft was used as an example.</p> <p>The Associate Director of Clinical Governance also advised that this would need to be looked at, at a more Directorate level. In addition, the Eclipse system is being looked at and adapted to make it easier to populate and report. The request is for the group to look at the risk register due to the number of current risks.</p> <p>Deputy Director of Nursing asked the current process for adding a risk to the register and the Associate Director of Clinical Governance replied to Deputy Director of Nursing and advised of training for senior managers across the trust, with a definite hierarchy of how it would work. It was also advised by the Associate Director of Clinical Governance obtains the 12 and above with localities working through the register with clinical governance facilitators. It was also advised of a Risk Register Management Group which would consist of individuals across the service meeting every month for next 3 – 4 months, also working with the deputies in the directorates, in terms of the committee structures to go through the risks.</p> <p>The Clinical Director of ICCR (Recovery) commented into the MS Teams chat that Risks are identified either between the local CGC meetings or during the LCGC - the governance facilitators then support in documenting the risks and the scoring. They are reviewed in the LCGC - mitigation plans discussed, and scores reviewed in every LCGC.</p> <p><b>Action:</b> For individuals to go through the risk register and if the owners could take out the risks which are no longer relevant. The Associate Director of Clinical Governance to bring this back to a future meeting.</p>
6	<p><b>Use of Force Act Update</b> The Consultant Forensic Psychiatrist representative gave an overview of the presentation that had been circulated to the meeting previously and taken as read.</p> <p>The Consultant Forensic Psychiatrist representative advised that the SDS data system of providing data to NHS digital around use of Force Act has begun. We are collecting data as of March 31st and the digital data set is being populated. Going forward as of March 2023, a dashboard would be available on seclusion, length of seclusion, ethnicity. Similarly, data would be available for different types of restraints. The Consultant Forensic Psychiatrist representative asked for this to be an agenda item for each clinical governance committee to look at their own dashboards and this is what the CQC would be looking at. The Consultant Forensic Psychiatrist representative also highlighted the use of other agents, and that data is not being captured and the need for this data to be collected. It was also mentioned that overall, the reporting needs to be improved. It was also advised that for each type of ward there would be</p>

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	<p>a median score which then can be scored against the national score. The CQC view is that they would inspect those wards which are outside of that range within their group.</p> <p>XXXX XXXX did raise the issue about Family and Carer and the importance around no force in terms of engagement.</p> <p>XXXX XXXX also advised that the Use of Force Act requires year on year a reduction in the restrictive practices.</p> <p>The Medical Director summed up that in terms of the seclusion date this would be reported to QPES which would then be fed through to Clinical Governance which would be welcome for the agenda for this meeting. The Medical Director also advised that the PowerPoint presentation to be shared to each directorate group.</p>
7	<p><b>Q340-2022 Practice Guidelines for Crisis Line Response, Crisis Line Response &amp; HTTs</b></p> <p>This item was not discussed. To be added to a future agenda.</p>
8	<p><b>QI Strategy</b></p> <p>This item was not discussed. To be added to a future agenda.</p>
9	<p><b>Update inquests</b></p> <p>This item was not discussed. To be added to a future agenda.</p>
10	<p><b>Service Area CGC Escalation Reports</b></p> <p>The Clinical Director of ICCR (EIS and Solar) gave an update regarding Integrated Community Care around the point the Wolverhampton Addiction Service has been recognised providing an excellent service.</p> <p><b>Redacted paragraph - exemption Section 38 (b) health and safety applied.</b></p> <p>Secondly a conversation was previously had around Eclipse forms and the harm to the organization, and it was asked if a discussion could be had around Eclipse forms and escalation.</p> <p>The Medical Director fed back that when recording Eclipse forms there is a link to the form reporting to the police and how this is not being completed in some areas.</p> <p>The Medical Director advised that a meeting could be set up with the police and the Clinical Director of ICCR to discuss this matter.</p> <p>The Deputy Medical Director of Quality and Safety mentioned there is a Police Interventions Policy which would inform around processes to be followed. This can be found on Connect.</p> <p>Police Interventions Policy.pdf</p> <p>The Clinical Director of ICCR (Recovery) also raised the concern of access to beds especially for Assertive Outreach Team. The Medical Director replied to the Clinical Director of ICCR (EIS and Solar) and advised that a discussion would need be had around this concern and for this to be held outside of the meeting.</p> <p>The Clinical Director of Acute Care gave an update for acute care and highlighted around risky patients being admitted on to inpatient wards and acknowledging the level of acuity and continuing to see bed pressures, also optimal treatment plans on admission and whether people are going to the right level of ward on admission.</p> <p>Also, the ongoing pressures around staff issues.</p> <p>The Clinical Director of Secure Care and Offender Health gave an update from Secure care, the highlighted risks around access to secondary mental health care for people in police custody. This has become an issue again and a meeting is planned for next week to look at this. If this cannot be resolved, it may need to come back.</p> <p>The Clinical Director of ICCR (Community) added around the staffing issues. In terms of medical posts, 2 Consultant posts that are uncovered, 8 non-substantive consultants in CMHT's, 6 non-substantive</p>

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	<p>doctors. As of October 2022, the caseload for BSMHFT is 20,783 patients and all workforce calculated to look between 15,000 and 16,000 patients.</p> <p>The Clinical Director of Specialties gave an update around Dementia and Frailties and the planning for a Specialist Older Peoples Suicide Prevention piece of training and a dementia care map within the dementia pathway. The Clinical Director of Specialties also mentioned one item from the safeguarding report about a particular care home and the need for all staff to make sure all risks are fed through to the tabletop review. Also from the Specialties report, the Bipolar service has completed training for the Newcastle NHS Trust, with our service being reviewed as a service of excellence.</p> <p>The Clinical Director of Specialties also updated the group around the multiple issues around clinical health psychology, in particular a concern around cancer services where their clinical space has been redesigned as office space, with the alternative not suitable for face-to-face cancer psychology appointments and now can only offer video and telephone appointments.</p>
11	<p><b>Infection Prevention and Control</b></p> <p>The Head of Infection, Prevention and Control gave an update on the report that had been circulated to the meeting previously and taken as read.</p> <p>It was advised that the audits across the trust were continuing and there had been 14 visits and 48 spot checks and also visiting the areas showing as below average. Noted were several aspects that require improvement from a visit from NHSI. Cleaning across the trust and issues with Estates, laundry, and sewage. A review with SSL and AMEY has taken place around next steps to address issues. There is a full action plan around this.</p> <p>The Board Assurance Framework has not been updated and there is now a new format. Relating to microorganisms, the main issue being COVID, with the number of outbreaks reducing. The recommendations would be the Board Assurance Framework and updated version or an alternative. Working with SSL and AMEY to ensure cleaning and maintenance are delivered with the required specifications. Also, there are limitations regarding not being digital enabled and a request has been made to IT with the requirements.</p> <p><b>Action:</b> For this to be brought back in February for an update.</p>
12	<p><b>Resuscitation</b></p> <p>This item was not discussed. To be added to a future agenda.</p>
13	<p><b>Quality Metrics</b></p> <p>This item was not discussed. To be added to a future agenda.</p>
14	<p><b>CQC Update</b></p> <p>The Head of Health and Safety, and Regulatory Compliance gave an update on the report that had been circulated to the meeting previously and taken as read.</p> <p>The group were updated regarding the section 31. There were no anchor point incidents from the self-harm dashboard.</p> <p><b>Redacted paragraph - exemption Section 38 (b) health and safety applied.</b></p> <p>The inspection is still going on, looking at all Dementia and Frailty this week.</p> <p>The Deputy Medical Director of Quality and Safety informed the group of the Suicide Prevention Strategy which refers to ligatures which would link in with the Restrictive Practice, which could then be cross referenced.</p> <p>The Head of Health and Safety, and Regulatory Compliance raised the point of the Risk and Safety Review group which was previously held, which would be helpful to resolve some of these matters.</p>

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	<p><b>Action:</b></p> <p>A meeting to take place for further discussion as soon as possible with the Associate Director of Clinical Governance, the Deputy Director of Nursing, the Interim Director of Nursing and the Associate Director of Acute and Urgent Care.</p>
15	<p><b>Health &amp; Safety Annual Report</b></p> <p>The Head of Health and Safety, and Regulatory Compliance gave an update on the report that had been circulated to the meeting previously and taken as read.</p> <p>It was noted that this paper is for 2021/2022, which is around covid risk management and covid secure risk assessments and trying to keep these up to date and inline with any national and trust guidance. Risk assessments were all kept up to date within this period, which being completed with clinical staff and estates. Also mentioned was the use of the Management of Unacceptable Behaviors Policy, which was implemented last year which has been used successfully in issuing a number of amber warnings to service users. This has proved to be successful in preventing unwanted behaviors. The new Concierge Service has been approved in principle, looking at changing the current security provision that we have in acute care, which would be looking more to what is in secure care. The Health and Safety investigation based on the death of our colleague at Reaside was also included.</p> <p>The Clinical Director of Acute Care asked the question around when to put practice alerts out and the mechanism for reviewing that and when they are done what the is process for reviewing this in 6 – 12 months.</p> <p>The Head of Health and Safety, and Regulatory Compliance replied to the Clinical Director of Acute Care and advised that this would be based on a near miss and examples were given of this. The Head of Health and Safety, and Regulatory Compliance also advised that in terms of reviewing the process that this would be checked and shared with the correct people and that ongoing work is happening to improve this process longer term.</p> <p>The Head of Health and Safety, and Regulatory Compliance added the link to the internal and external alerts on Connect XXXXXX.</p>
16	<p><b>National Letter from the National Mental Health Director</b></p>
17	<p><b>CPA Policy and Transitions</b></p> <p>The Clinical Director of ICCR (Community) gave an update on the report that had been circulated to the meeting previously and taken as read.</p> <p>It was highlighted that this is about moving away from the Care Programme Approach. NHS England had issued a position statement; however no further guidance has been received. Central Northwest London FAQ paper and their position statement were used as references. The caveat is that this does not affect any assessments under the Care Act also it doesn't affect any of the responsibilities on the Section 117. It was pointed out the items for discussion are the where is ownership across BSMHFT, who would need to be involved and what would be the time frame. The recommendations made were that the current CO1 policy would be agreed as an interim policy until work has been undertaken and to look at a specific working group that cuts across all services and Directories with an identified sponsor or responsible Executive who would support the work and any resource.</p> <p>The Chief Clinical Information Officer pointed out that CPA will continue to be used in a handful of services and The Clinical Director of ICCR (Community) identified that ultimately what's being proposed is that all patients have a minimum standard of care and to be able to demonstrate that this is delivered and a meaningful intervention for the needs identified, and that CPA will be continued in those areas the approach being used in other areas which then can be adopted.</p> <p>The Clinical Director of ICCR (Recovery) made the point that 1 key worker would not solve everything and that there could potentially be more than 1 key worker.</p> <p>The Clinical Director of Acute Care asked around time scales, and the transition time.</p>

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	<p>The Clinical Director of ICCR (Community) replied to the Clinical Director of Acute Care around the committee guidance to identify who is overall responsible for this and the removal of the 2-tier system would make health and equalities better.</p> <p>The Clinical Director of ICCR (Community) also offered reassurances from the literature and that the care coordination and the high-quality care planning needs to be retained but also strengthened with safety planning included in the care planning with a shared ownership across the MDT but also any outreach into primary care and that there are clear links between all MDT.</p> <p><b>Action:</b> The Medical Director to discuss with the Executive Team in terms of a trust wide plan and the need for representatives.</p>
18	<p><b>Managing Risk and Safety planning letter</b> This was circulated previously and taken as read.</p> <p>The Medical Director advised around a meeting that had taken place last week about deaths that had happened and that there was a plan to look at suicide prevention campaign, especially with the cost-of-living crisis and that around 80% of suicides are very low risk patients.</p> <p>The Chief Clinical Information Officer brought up the risk assessment tool and the use of this and how valuable they are and whether this should be discussed as part of the CPA processes.</p> <p>The Consultant Forensic Psychiatrist representative made the point of clinical decisions being made from the high/low risk of that patient is daily and that the presentation of the decision making would need a radical change.</p> <p>The Medical Director summed up the discussion and agreed with all points made and that this would be interesting around other trusts and if we have a collective approach.</p>
19	<p><b>QPES Summary</b> This item was not discussed. To be added to a future agenda.</p>
20	<p><b>Policies for Ratification</b> It was agreed Polices would be read and comments made to the policy mailbox - for ratification Deadline Monday 14 November 2022.</p>
21	<p><b>AOB</b> The Medical Director invited the group to share any 'thankyous and good news'.</p> <p>The Chief Clinical Information Officer shared with the group around, around a series of of international surveys on our electronic health records with a company called KLAS, with over 300 staff responding and the score being 36 which is an improvement from 2021. This gives the perspective that staff are satisfied with our clinical systems, in turn helping provide good quality care.</p> <p>The Medical Director shared that the Executive Director of People and Strategic Partnerships had received an MBE.</p> <p>The Clinical Director of ICCR (Recovery) advised that the Early Intervention Team being nominated for Team of the Year.</p> <p>The Chief Psychologist noted that 12 mental health wellbeing practitioners who are training to qualify as Mental Health Practitioners for our Community teams working in Adult CMHT's. Also, 27 Assistant Psychologists recruited on to the BANK teams and 3 Clinical Associates in psychology.</p> <p>The Associate Director of Clinical Governance commented around a piece of work looking at Forward Planning for future CGC committee meetings., working through how to prioritise items.</p> <p>The proposal being one month around assurance reports and one month with workshop type topics.</p>



Agenda Item	Discussion
	<p>This is due to length of the agendas. This would be implemented from the new year.</p> <p>The Medical Director agreed with the Associate Director of Clinical Governance moving forward with the meeting changes and for this to be brought in, in the new year.</p> <p>The Clinical Director of Specialties (Recovery) also added and asked the question around what our trust Clinical Governance system is and what is working well and what isn't and due to the length of agendas conversations that are needed aren't happening.</p> <p><b>Action:</b> The Medical Director asked the group to contact Associate Director of Clinical Governance with ideas for future Clinical Governance Committees and this will feed back at the next meeting.</p>
22	<p><b>Matters of Escalation to the Board of Directors</b> None</p>
23	<p><b>Snapshot/feedback on Committee</b></p> <ul style="list-style-type: none"> <li>• Were items appropriate?</li> <li>• Were timings appropriate?</li> <li>• Are there any items for inclusion on the action log?</li> </ul> <p><b>Were the papers, clear, concise, and aided decision making?</b></p>

#### Next Meeting

<b>Date</b>	6 <sup>th</sup> December 2022 2pm - 4pm
<b>Location</b>	Via Microsoft Teams