SHSC Learning Disability Directorate
Governance Framework

A NHS Framework Ensuring High Quality Outcomes for Adults with Learning Disabilities.

Well-led, safe, responsive, caring & effective.

Dr David Newman: Clinical Director - LD
Anita Winter: Service Director - LD
Andy Bragg: Assistant Service Director – LD
Tania Tailor: Business Planning Partner

Date: 28th September 2015
Learning Disability Directorate – Governance Framework

Directorate Level (Receives & Reports to Trust level)

**Senior Management Team**
- Functions: Senior Ops, senior, interface with other SHSC directorates, SHSC Executive Team, communications & key partners.

**Business & Performance**
- Functions: Core & new business management, resource management, performance & assurance against KPIs & COUNs.

**Clinical Governance Group**
- Functions: Clinical quality & improvement, clinical leadership, patient safety, clinical effectiveness & service user & carer engagement.
  - Rotating Pathway Focus: 1 Health 1 Medicine 1 Mental Health 1 P & Q

Service & Team Level

**Programmes Meeting**
- Functions: Service headlines, practice development, communication & involvement.

**Provider Services Managers Meeting**
- Functions: Provider governance, quality, experience & service innovation.

**CLDT, ISS & OQCI Leadership Meeting**
- Functions: Provider governance, quality, experience & service innovation.

**Locality Quality Improvement Meeting**
- Functions: Provider governance, quality improvement & innovation.

**ISS Governance & Quality Improvement Meeting**
- Functions: Post/QI action implementation.

Professional Level

**Nurses Forum**
- Functions: Nursing bi-monthly

**AHP Forum**
- Functions: Includes SALT, OT & Physio breakout sessions.

**Psychology Forum**
- Functions: Bi-monthly

**Psychiatry & CD Forum**
- Functions: Bi-monthly

Individual Level

- Clinical Supervision
- Operational Supervision
- PDR & Job Planning
- CPD
- Professional Validation

LD Directorate – Governance Framework 2015
# Contents

The Governance Framework: 2

1. Introduction 4

2. What is Governance? 4

3. Quality Is Everyone’s Business 4

4. Responsibility & Accountability 5

5. How Are Quality Goals & Standards Set And Agreed? 6


7. How Do We Monitor Our Progress? 8

8. Conclusion & Forward Vision 9

Appendices - Agendas & Terms of Reference by Meeting: 10

- Senior Management Team: 11
- Business & Performance: 12
- Clinical Governance: 14
- Provider Services – Management Meeting 20
- CLDT, ISS (Comm) & OoCT Leadership Meeting 22
- Locality Quality Improvement Meeting (Provider Services) 25
- ISS Inpatient - Governance & Quality Improvement Meeting 26
1. Introduction
This framework is designed to support a culture of outstanding quality. It will help us to deliver well-led, safe, responsive, effective and caring services to the people we support. It will help us to know if there are any early signs of problems, as well as identifying examples of excellent practice that others can learn from.

The evidence log of agendas, papers, presentations and minutes is stored on datastore in the following location: ..\LD Governance. It is available for appropriate scrutiny and assurance by the SHSC Executive team.

2. What Is Governance?
Governance is a term that brings together many familiar concepts such as ‘quality assurance’, ‘service performance’, ‘service improvements’, ‘continuous quality improvement’, ‘quality and service monitoring’ etc.

It is sometimes defined as:

“making sure that we are doing the right things, in the right way, to the right quality at the right times”

Good governance brings together information about what we are doing with the resources we have got. It ensures that are making the best use of our resources for the benefit of the service users we serve.

3. Quality Is Everyone’s Business
We believe it is essential that the responsibility for governance is seen as everyone’s business. Opportunities for quality, care and innovation can come from all places within an organisation. Sometimes top down leadership is necessary in order to steer a service in the right direction. However, the experience of service users and front line staff is an equally if not more powerful means through which to learn about quality and drive change.

With this in mind we have set out a governance framework for the Learning Disabilities Directorate that is implemented across number of levels. These include:
• Directorate level
• Service & Team level
• Professional groupings level
• Individual practitioner level

This governance framework means that the directorate can supply quality assurance to higher levels within the trust such as the board as well as outside stakeholders (commissioners, CQC & the general public).

This framework will apply across the whole of the Learning Disabilities Directorate. It will cover diverse teams including residential care homes, supported living schemes, inpatient areas, respite care services, community teams, out of city teams etc.

Intelligence supplied by central corporate departments such as Finance, Human Resources, Incidents, Safeguarding, Complaints, Compliments and CQC inspection reports are all made available to help us monitor our quality performance.
4. Responsibility & Accountability

Directorate Level
The Service Director (Anita Winter) and Clinical Director (Dr David Newman) are ultimately accountable for the quality of service provision within the LD Directorate. The Assistant Service Director (Andy Bragg) provides focused operational management to our provider service. Together these three individuals form the Senior Management Team, responsible for ensuring that resources and capacity are coupled with the knowledge and capability to deliver high quality services.

The Service Director role has a strong emphasis on ‘operational quality’ and the Clinical Director role has a strong emphasis on ‘clinical quality’. The distinction between these two realms of focus is illustrated in the different agendas of the three directorate level meetings:

- Senior Management Team: Chair – Anita Winter
- Business & Performance: Chair – Anita Winter
- Clinical Governance: Chair – Dr David Newman

Service & Team Level
The responsibility for ensuring quality standards are being met within each service rests with the team service manager/team leader for that area. Within the LD Directorate the following service managers are accountable for their areas:

Clinical Services
- ISS (Inpatient) Melina Simmonite (Nurse Manager)
- ISS (Community) Julia Shepherd (Nurse Consultant)
- Out of City Team Lucy Harrison
- CLDT Anita Winter
- Older Carers Team Anita Winter
- LD Case Register Anita Winter

Provider Services
- Beighton Rd Karen Johnson
- Wensley St Mandy Mason
- Buckwood View Diane Staniforth
- Bungreave Dev Patricia Wright
- Mansfield View Mandy Johnson
- Steven Close Karen Johnson
- Respite services Wendy Hastings Quainoo

Support Services
- Business Support Louise Barber

Professional Level
The responsibility for ensuring quality standards are met within each professional group lies with the most senior professional within that group. Within the LD Directorate the following clinicians are accountable for the quality of our health care professionals:

AHP: Philipa Allen (SaLT), Lucy Harrison (OT) & Kate Scott (Physio)
Medical: Dr Catriona Murray – Lead Consultant Psychiatrist
Nursing: Julia Shepherd – Nurse Consultant
Psychology: Dr David Newman – Consultant Clinical Psychologist
Dev Workers: Supported via relevant service level management structure.

**Individual Level**
Finally there is a responsibility for ensuring quality standards are being met by each individual employee. Attending to continuing professional development, seeking support and taking ownership and responsibility for raising concerns about practice are integral to all our roles. Every member of staff should have a job plan that details when and where they are delivering their input to ensure effective use of their expertise and resource.

**5. How Are Quality Goals & Standards Set And Agreed?**
Our quality framework is driven by a range of national and local sources. These include Department of Health strategy and guidance, NICE guidance, professional bodies, regulator frameworks set by CQC & Monitor. Ultimately we are accountable to our local customers in the form of service users, carers, commissioners and partner organisations.
Quality Goal Setting
For the remainder of 2015 our quality focus will be driven by the learning and recommendations from the ‘Culture & Practice Review’ and the CQC action plan.

In 2016 we will proactively set our Quality Improvement Goals and these will be refreshed at the start of every financial year. They will be focused, ‘must do’ priorities based upon our awareness of quality issues and opportunities. As well as external influences, our goals will be influenced by the experience of our service users and staff. This includes:

- Learning from serious incidents, compliments and complaints
- Service user and carer feedback
- Innovation and ‘bottom up’ ideas from staff within our services

Each goal will be SMART\(^1\), an acronym that stands for:

- **Specific** – target a specific area for improvement.
- **Measurable** – quantify or at least suggest an indicator of progress.
- **Assignable** – specify who will do it.
- **Realistic** – state what results can realistically be achieved, given available resources.
- **Time-related** – specify when the result(s) can be achieved.

### 6. How Will Managers and Clinical Leaders Improve Quality?
Staff in management and leadership positions have an exciting opportunity to take responsibility for and make a difference to quality. It is a great privilege to be entrusted to a position where you can develop the workforce and make a real difference in the lives of service users. Initiatives that support quality also support workplace well-being and job satisfaction for all concerned.

There are a number of key responsibilities that will help ensure continuous quality improvement. The most important of these is to ‘lead by example’. Positive modeling and nurturing a proactive culture within the service can achieve this. Positive modeling includes:

- Setting direction by being clear about what, why and how we deliver high quality care.
- Being clear about the fundamental standards of care and what quality ‘looks like and feels like’ in practice.
- Supporting and developing your staff by encouraging positive change and celebrating success.
- Supporting processes to ensure these standards are achieved by measuring and evaluating progress and looking for improved delivery based on findings.
- Working in partnership across the ‘triangle of care’ – bringing together service user, carer & service provider ideas.
- Developing a learning culture (rather than a blame culture) so that incidents and near misses are used to improve care and safety going forwards.
- Holding people to account when their performance or conduct falls below agreed acceptable standards.

---

Microsystems – Your Toolkit for Quality

SHSC is committed to continuous quality improvement and has invested in supporting its leaders and managers to successfully engage in positive change. Part of this investment includes being an active member of the Microsystems Coaching Academy at Sheffield Teaching Hospitals. This approach states that the quality of care in a big organisation such as SHSC can be no better than the services generated by the small systems it is composed of. A wide range of people influence quality. It is not just about the work of the multidisciplinary team. It is also about the crucial input of Development Workers and supporting staff (e.g., clerical, ancillary & domestics). We are ‘all in this together’ alongside our service users, their advocates and families/carers.

You can read more about the microsystem approach here: http://www.sheffieldmca.org.uk/

7. How Do We Monitor Our Progress?

Quality is a moveable feast. What was considered good or acceptable in the past or even one year ago may no longer reach the bar. With this in mind we will be monitoring and supporting team managers and professional leads across the year to focus on quality improvement. Each manager/lead will be responsible for reporting once a quarter on their team’s performance against the key Quality Improvement Goals. This reporting will take place during the LD Clinical Governance Meeting.

Reporting

The Quality Improvement Goals will be measured using a reporting framework. It is important that all SHSC staff are where practicable involved and engaged in this process. The team alongside their Team Manager/Lead will rate the outcome of their performance against the agreed measure with a colour coding. This highlights how the team/service is performing against their Quality Improvement Goals:

- **Blue**: there is evidence that the standard is fully embedded in practice
- **Green**: standard is complete and in place
- **Amber**: standard is partially met and progress is ongoing
- **Red**: standard is not met or there are barriers to progress

Evidence for the achievement of the quality goals and standards may come from a variety of sources (eg, CQC reports, service user feedback and forums, local audits, care plan reviews, service evaluations etc). Teams will identify and provide the evidence they consider relevant.

Action plans will be agreed for any Amber and Red standards and the relevant Service Manager/Lead will decide if the progress against quality goals needs to be escalated to the Senior Management Team or reported to the Risk Register.

At the end of the year our progress against Quality Improvement Goals will be reported to the LD Clinical Governance Meeting. It is good practice to ensure that the outcomes of performance reviews are reported to service users. Service Managers should ensure that teams have a process by which this will be done.
This process will support a proactive cycle of continuous quality improvement:

8. Conclusion & Forward Vision
Quality governance is a robust system that defines, checks and learns about quality. It supports a well-led and resilient culture that is open to positive improvements. It provides assurance at all levels from the ‘ward to the board’. This governance framework is driven by a desire to offer the best provision to our service users. The Microsystems approach means the ideas and contributions of all staff and service users are integral to what we do and how we do it. By placing the person at the centre of everything we do, we all have a real opportunity to develop high quality services that deliver safe & effective care and use our resources in an optimal manner.
**APPENDICES:**

**Agendas & Terms of Reference by Meeting:**

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Management Team:</td>
<td>11</td>
</tr>
<tr>
<td>Business &amp; Performance:</td>
<td>12</td>
</tr>
<tr>
<td>Clinical Governance:</td>
<td>14</td>
</tr>
<tr>
<td>Provider Services – Management Meeting</td>
<td>20</td>
</tr>
<tr>
<td>CLDT, ISS (Comm) &amp; OoCT Leadership Meeting</td>
<td>22</td>
</tr>
<tr>
<td>Locality Quality Improvement Meeting (Provider Services)</td>
<td>25</td>
</tr>
<tr>
<td>ISS Inpatient - Governance &amp; Quality Improvement Meeting</td>
<td>26</td>
</tr>
</tbody>
</table>
Service Meeting Terms of Reference

1. **Purpose of Group**

The purpose of the Directorate Service Meeting is to:

- Provide networking opportunities for staff across the Directorate
- Communicate service headlines
- Support a culture of collaborative working and service development
- Share learning and best practice through interactive practice development topics

2. **Membership**

Membership is open to anyone within the Directorate, however all clinicians and first line managers and above are expected to attend. The sessions will be planned and led by:

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Newman</td>
<td>Clinical Director</td>
</tr>
<tr>
<td>Julia Shepherd</td>
<td>Nurse Consultant</td>
</tr>
<tr>
<td>Anita Winter</td>
<td>Service Director</td>
</tr>
</tbody>
</table>

3. **Frequency of Meetings**

The Directorate Service Meeting will be held on a monthly basis for a period of 3 hours. There is no set day of the week or time for this meeting that has been set due to room availability.

4. **Agenda Setting**

Agenda items are welcome from anyone within the Directorate. Ideas should be forwarded to any of the leads noted in point 3 above.

5. **Reporting Arrangements**

The Directorate Service Meeting will report through its Chair to the Senior Management Team Meeting.

6. **Review Date**
These terms of reference will be implemented from September 2015 and will be reviewed 3 months after commencement – January 2016.
Business & Performance Meeting

CHAIR: Anita Winter - Service Director
MEMBERSHIP: Dr David Newman - Clinical Director
Andy Bragg - Assistant Service Director
Sharron Feather - Directorate Accountant
Sharon Booth - HR Adviser (14:30 slot)
Vin Lewin - Clinical Investigations and Risk
Denise Lindley - Business Support Manager
Julia Shepherd - Nurse Consultant
TBC - CLDT Nurse Manager

Copy of minutes to all Professional Leads & attendance by invitation to account for performance issues when required.

ADMIN: Wendy Lane – PA to HoS

FREQUENCY: Monthly – 1st Tuesday of the Month 14:00-16:00
DURATION: 2 Hours

Business & Performance Terms of Reference

1. Purpose of Group

The purpose of the Business and Performance Meeting is to scrutinise and review Directorate business and performance relating to:

- Quality (Patient safety, Risk, Experience and Outcomes)
- Financial planning and monitoring
- Activity and productivity including operational efficiency and effectiveness
- Workforce
- Information Management and Technology

2. Duties

- Setting quality, financial, activity and workforce business plans over the short, medium and long-term. This will include annual quality, financial, activity and workforce targets.
- Reviewing the development of future strategies and business plans.
- Monitoring in-year performance against the quality, financial, activity and workforce targets agreed by the Trust Board, discussing and agreeing corrective action where necessary. This will include cost improvement and other productivity improvement programmes.
- Monitoring the financial and performance implications of externally driven new legislation, performance targets and guidance impacting on the Directorate/Trust.
3. **Membership**

Membership of the Business and Performance Meeting will consist of senior managers who have a corporate functional responsibility or responsibility for a specific service area within the Directorate. The core membership will be as follows:

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Louise Barber</td>
<td>Business Support Manager</td>
</tr>
<tr>
<td>Sharon Booth</td>
<td>HR Business Advisor</td>
</tr>
<tr>
<td>Andy Bragg</td>
<td>Assistant Service Director</td>
</tr>
<tr>
<td>Sharron Feather</td>
<td>Directorate Accountant</td>
</tr>
<tr>
<td>Lucy Harrison</td>
<td>Clinical Lead, Out of City</td>
</tr>
<tr>
<td>Dani Hydes</td>
<td>Head of Contracts and Commercial Services</td>
</tr>
<tr>
<td>Wendy Lane</td>
<td>Personal Assistant</td>
</tr>
<tr>
<td>Vin Lewin</td>
<td>Investigation Lead</td>
</tr>
<tr>
<td>David Newman</td>
<td>Clinical Director</td>
</tr>
<tr>
<td>Julia Shepherd</td>
<td>Nurse Consultant</td>
</tr>
<tr>
<td>Melina Simmonite</td>
<td>Nurse Manager, ISS Inpatient</td>
</tr>
<tr>
<td>tbc</td>
<td>Business Planning Partner</td>
</tr>
<tr>
<td>Anita Winter</td>
<td>Service Director (Chair)</td>
</tr>
</tbody>
</table>

The Business and Performance Meeting will be chaired by Anita Winter, Service Director and serviced by Wendy Lane, PA.

4. **Frequency of Meetings**

The Business and Performance Meeting will meet on a monthly basis on the first Tuesday of every month between 2.00 p.m. and 4.00 p.m.

5. **Agenda Setting**

Standing agenda items will include the following:

| 1. 5 Year Plan                                                                 |
|-----|--------------------------------------------------------------------------------|
| • Core business (SCCG, SCC, Other partners). Review of service level agreements of services provided by the Learning Disabilities Directorate and make recommendations to Board.       |
| • Identify and recommend opportunity for new business.                      |
| • Receive and approve internal and external reports and make recommendations to Board. |
| • Approval of strategy and policies relating to business management including financial management, procurement, human resources, asset management, customer access/care and performance management. |
| • Determine and monitor investment priorities and programmes.                |

| 2. Service User/Carer Feedback                                               |
|-----|--------------------------------------------------------------------------------|
| • Monitoring complaints and compliments promoting learning and service improvements from the handling of complaints. |
| • Review of services standards, including consideration of recommendations from external reviewers. |

<table>
<thead>
<tr>
<th>3. Finance</th>
</tr>
</thead>
</table>
• Approve service improvement and value for money reviews and associated improvement/tapering plans.
• Develop, implement and monitor Cost Improvement Programme.

4. Candour – Are we safe?
• Identify, monitoring and review risks and associated action plans, disseminating lessons learned to appropriate others.
• Monitor and review serious incidents/serious case reviews and respond to any outcomes and lessons learned.
• Ensure Business Continuity Plans are in place and monitored.

5. Workforce
• Review of staff supervision, PDR, Sickness, – Frequency, quality and training
• Review of training – completion, unmet needs, capacity issues
• Capacity and Capability
• Flexible Workforce issues

Performance Metrics
• Agree and monitor performance targets including: value for money savings; CPA, KPIs, CQUIN, delayed discharges.

6. **Reporting Arrangements**

The Business and Performance Meeting, through its Chair, will report to the Executive Directors Group and Quality Assurance Committee.

7. **Review Date**

These terms of reference will be implemented from September 2015 and will be reviewed 3 months after commencement – January 2016.

8. **Quorum**

The meeting will be quorate if 30% of members are present. This will include a mix of representatives from corporate and directorate functions.
Clinical Governance Group

CHAIR: Dr David Newman - Clinical Director
Deputy: Anita Winter or Andy Bragg
ADMIN: Ian Read - CD/Psy PA

FREQUENCY: Monthly – 3rd Monday of the Month 13:00-16:00
DURATION: 3 Hours

Clinical Governance Group – Terms of Reference

PURPOSE OF GROUP
1. To support a culture of clinical leadership based on a drive for innovation and excellence in providing safe & effective clinical services.

2. To support continuous quality improvement based on service user and carer feedback and engagement.

3. To support organisational learning based on candor, transparency and a willingness to monitor, scrutinise and improve clinical quality.

MEMBERSHIP
Membership of the Learning Disabilities Governance Group will include senior managers who have a responsibility for operationally supporting the delivery of clinical functions. The core membership will be:

<table>
<thead>
<tr>
<th>Who</th>
<th>Function &amp; Clinical Lead Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Director</td>
<td>Dr David Newman</td>
</tr>
<tr>
<td></td>
<td>Chair of meeting</td>
</tr>
<tr>
<td></td>
<td>Joint head of service</td>
</tr>
<tr>
<td></td>
<td>Psychology professional lead</td>
</tr>
<tr>
<td></td>
<td>• Directorate PBS lead</td>
</tr>
<tr>
<td></td>
<td>• Directorate NICE lead</td>
</tr>
<tr>
<td></td>
<td>• Service User Engagement Group (SUEG)</td>
</tr>
<tr>
<td></td>
<td>• Greenlight</td>
</tr>
<tr>
<td>Service Director</td>
<td>Anita Winter</td>
</tr>
<tr>
<td></td>
<td>Joint head of service</td>
</tr>
<tr>
<td></td>
<td>Deputy chair</td>
</tr>
<tr>
<td></td>
<td>• Directorate safeguarding lead</td>
</tr>
<tr>
<td></td>
<td>• Directorate MCA lead</td>
</tr>
<tr>
<td></td>
<td>• Carer engagement lead</td>
</tr>
<tr>
<td>Assistant Director</td>
<td>Andy Bragg</td>
</tr>
<tr>
<td>Provider Services</td>
<td>Provider services and respite management</td>
</tr>
<tr>
<td></td>
<td>Deputy chair</td>
</tr>
<tr>
<td></td>
<td>• Directorate infection control lead (Provider via Diane Staniforth)</td>
</tr>
<tr>
<td></td>
<td>• Peer Review Lead (Provider)</td>
</tr>
<tr>
<td>Consultant Psychiatrist</td>
<td>Dr Catriona Murray</td>
</tr>
<tr>
<td></td>
<td>Psychiatry leadership</td>
</tr>
<tr>
<td></td>
<td>• Directorate MHA lead</td>
</tr>
<tr>
<td></td>
<td>• Medicines management lead</td>
</tr>
<tr>
<td></td>
<td>• Suicide prevention lead</td>
</tr>
<tr>
<td>Consultant Nurse</td>
<td>Julia Shepherd</td>
</tr>
<tr>
<td></td>
<td>ISS Community Lead</td>
</tr>
<tr>
<td>Role</td>
<td>Name</td>
</tr>
<tr>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>Nurse professional lead</td>
<td>• Directorate clinical risk lead&lt;br&gt;• Directorate clinical audit lead&lt;br&gt;• Medicines management Deputy&lt;br&gt;• Directorate CPD lead</td>
</tr>
<tr>
<td>CLDT/Assistant CD Nurse</td>
<td>Vacant</td>
</tr>
<tr>
<td>ISS Inpatient Manager</td>
<td>Melina Simmonite</td>
</tr>
<tr>
<td>Professional Lead – Occupational Therapy</td>
<td>Lucy Harrison</td>
</tr>
<tr>
<td>Professional Lead – Physiotherapy</td>
<td>Kate Scott</td>
</tr>
<tr>
<td>Deputy Professional Lead – Psychology</td>
<td>Dr Suzie Beart</td>
</tr>
<tr>
<td>Professional Lead – SLT</td>
<td>Phillipa Allen</td>
</tr>
<tr>
<td>Provider Services Team Managers</td>
<td>On rotation?</td>
</tr>
<tr>
<td>Respite Manager</td>
<td>Mandy Mason</td>
</tr>
<tr>
<td>Clinical Director’s PA</td>
<td>Ian Read</td>
</tr>
</tbody>
</table>

The LD Governance Group will be chaired by the Clinical Director, and supported by their PA. Additional members will be invited, as and when appropriate.

**REMIT**

- To support an informed model of service delivery through the identification and dissemination of key national and local clinical and strategic priorities with particular emphasis on “what outstanding care looks like” for people with a learning disability.
- To report on progress and innovation in relation to delivering excellent clinical quality across the areas of clinical leadership, patient safety, clinical effectiveness and service user/carer engagement.
- To support continuous quality improvement through the setting of proactive “quality goals” supported by SMART action plans. To monitor the delivery and impact of these goals and to stretch targets or adjust direction where necessary.
- To support continuous quality improvement through the setting of reactive “quality action plans” following feedback from CQC.
- To support an ethos of transparency and candor where constructive challenge is balanced with shared problem solving and support.
- To review feedback and learn lessons enabling quality improvement from:
  - Clinical audit.
  - Serious incidents, complaints, safeguarding investigations.
Service user and family carer feedback.
- Visits to services from trust Executives, external review or peer review.
- Organisational learning from other services provided by SHSC.
- Visits to services outside of the trust.
- Feedback from conferences and training.
  - To identify, celebrate and share good practice.

FREQUENCY OF MEETINGS
The LD Governance Group will meet on the third Monday of every month for three hours (1 p.m. – 4 p.m.)

Non Attendance
Attendance at meetings is mandatory with an annual attendance rate of 75% expected. If attendance is not possible apologies are to be given in advance via email to the Clinical Director’s PA.

If members cannot attend and the meeting is awaiting feedback then written updates against outstanding actions should be forwarded to the Chair, or conveyed via another member in the meeting.

Quoracy
The meeting requires a Chair plus a minimum of six people to function. The LD Governance Group will be considered quorate when over 50% of its core membership is present. This must include at least one representative from each of the core service areas (ISS, CLDT, Provider). In the event of all members being present and a tie occurring upon a voting matter, the Chair will have the casting vote.

AGENDA SETTING
An agenda setting process will be initiated 2 weeks prior to the meeting by the Clinical Director’s PA. A formalised agenda will be forwarded for all members approximately 1 week before the meeting.

Any agenda items that are proposed by a member who cannot attend the meeting must be accompanied by a cover sheet explaining the nature and purpose of the item.

Action Log
The meeting will run an action log in the format below:

<table>
<thead>
<tr>
<th>Date</th>
<th>Item No:</th>
<th>Action Required</th>
<th>Responsible</th>
<th>By When</th>
<th>Date Completed</th>
</tr>
</thead>
</table>

Completed actions will be archived and form an evidence archive of the work of the meeting.

AGENDA

<table>
<thead>
<tr>
<th>No</th>
<th>Item</th>
<th>Paper</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Apologies</td>
<td>Minutes from the last meeting</td>
<td>Matters Arising / Action Log</td>
</tr>
<tr>
<td></td>
<td>Clinical Leadership – Strategy &amp; Culture</td>
<td>Review of key strategic drivers: Valuing People Now, Death by Indifference – 74 Deaths</td>
<td></td>
</tr>
<tr>
<td>SHSC - Our Response To The Francis Report</td>
<td>ALL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sign up for Safety, 6 Cs, Positive &amp; Proactive Care, PMLD</td>
<td>ALL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transforming care</td>
<td>ALL</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1.2. Feedback from Professional Forums/National Guidance
- Medical / Psychiatry
- Nursing
- OT
- Physiotherapy
- Psychology
- SaLT

2. Quality Improvement Work Streams
0.1. Update on progress against action plans from Culture & Practice, CQC & ISS Service Review:
- ISS Inpatient (Jan, May, Sep)
- ISS Community & OoCT (Feb, June, Oct)
- CLDT (Mar, July, Nov)
- Provider Services (Apr, Aug, Dec)

0.2. Microsystem work

3. Quality Review
3.1. Incidents, SI, lessons learnt
- LD Directorate
- Wider SHSC

3.2. Clinical audit
- Annual timetable & upcoming plans
- Results
- Action plan review

3.3. Quality Tour / Peer Review

3.4. CQC feedback

4. Patient Safety (Updates by lead)
- 4.1. Safeguarding
- 4.2. MHA & MCA
- 4.3. NHS Safety Thermometer / Sign Up for Safety
- 4.4. Infection control
- 4.5. Med management
- 4.6. Positive & Safe – Reducing Restrictive Interventions
  - Respect governance
- 4.7. Dysphagia
- 4.8. Falls
- 4.9. Ulcers
- 4.10. Suicide
- 4.12 Self-harm
- 4.13 Environmental risk management

5. Clinical Effectiveness
5.1. NICE

5.2. Pathway focus & evidence based practice (in rotation)
- Health & Medication & LD (Jan, May, Sep)
- Mental Health, Recovery & LD (Feb, June, Oct)
- Challenging Behavior & RRI (Mar, July, Nov)
- Dementia, Dysphagia, Falls & ASD (Apr, Aug, Dec)

5.3. Outcomes – embedding routine outcomes into practice

| Quality Improvement Work Streams | 
| MS | 
| JS | 
| AW/Tbc | 
| AB | 

| Quality Review | 
| AW & Lead | 
| Tbc | 

| Clinical Effectiveness | 
| DN | 

| Patient Safety (Updates by lead) | 
| AW | 
| CM/AW | 
| Tbc | 
| AB & MS | 
| CM | 
| SB | 
| PA | 
| KS | 
| KS | 
| CM | 
| SB | 
| MS & AB | 

| Clinical Effectiveness | 
| DN | 

| Patient Safety (Updates by lead) | 
| Lead by area | 
| DN & LH |
6 Service User/Carer Engagement

6.1 Service user & advocacy involvement with quality
6.2 Carer Governor feedback
6.3 Survey feedback, friends and family

7 Research & Innovation

7.1 New research, service evaluations
7.2 Innovative practice developments

8 Candour – Are we safe?

8.1 Open & honest – duty of candor. Sign off by area:
• ISS Inpatient
• OoCT
• ISS Community
• CLDT
• Provider

8.2 Risk register & escalation?

9 AOB

ACCOUNTABILITY & REPORTING ARRANGEMENTS

The minutes of this meeting will be available for scrutiny and assurance to the board at any time. Scrutiny will also be available via the following channels:

- Quarterly Service Review with the Exec via an integrated report including Business & Performance Meeting.
- Input into Quality Assurance Committee.
- This process will be guided by governance arrangement set up by the Director of Performance.

This information is considered alongside wider learning disabilities governance arrangements focusing on service performance and the efficient and effective management of resources.

ISS, Out of City Team, CLDT and Provider Services report into the Directorate Governance meeting, and actions agreed at Directorate Governance meeting will be implemented at a local level by the appropriate service managers, team leaders and professional leads and reported back to the Governance meeting.

All members of the LD Governance Group are accountable for the appropriate reporting and feedback arrangements and ensuring that actions are implemented within and beyond their working environment.

REVIEW DATE

These terms of reference will be reviewed 12 months after commencement (September 2016).
Provider Services – Governance Meeting

CHAIR: Andy Bragg - Assistant Service Director
ADMIN: June Joel
FREQUENCY: Monthly – 4th Tuesday of the Month 09:30-12:00
DURATION: 2½ Hours

MEMBERSHIP: Mandy Johnson – Locality Manager, Supported Living Service
Pat Wright - Locality Manager, Supported Living Service
Karen Johnson - Locality Manager, Supported Living Service and
Registered Manager, Beighton Road
Mandy Mason – Registered Manager, Wensley Street
Helen Robinson – Deputy Manager, Beighton Road
Wendy Hastings Quainoo – Registered Manager, Respite Services
Diane Staniforth – Registered Manager, Buckwood View
Mark Thain – Connections Worker
Sharon Booth – Human Resources Advisor

PROVIDER SERVICES GOVERNANCE GROUP – TOR (2015)

PURPOSE OF GROUP
4. To support a culture of leadership based on a drive for innovation and excellence in providing safe & effective social care and nursing services.

5. To support continuous quality improvement based on service user and carer feedback and engagement.

6. To support organisational learning based on candor, transparency and a willingness to monitor, scrutinise and improve service quality.

MEMBERSHIP
Membership of the Provider Services Governance Group will include Registered Managers and Locality Managers who have a responsibility for operational delivery of service. The LD Governance Group will be chaired by the Clinical Director, and supported by their PA. Sharon Booth will be a member of the group, providing HR information to the group and advice to support the purpose of the group.
Additional members will be invited, as and when appropriate. Deputies, Co-ordinators and Team Leaders will deputise for Registered Managers and Locality Managers.

REMIT
- To support an informed model of service delivery through the identification and dissemination of key national, Trust and commissioner priorities with particular emphasis on “what outstanding care looks like” for people with a learning disability.
- To report on progress and innovation in relation to delivering excellent quality across the areas of safety, service user and carer engagement, health outcomes, support outcomes, and workforce development
- To support continuous quality improvement through the setting of proactive “quality goals” supported by SMART action plans. To monitor the delivery and impact of these goals and to stretch targets or adjust direction where necessary.
- To support continuous quality improvement through the setting of reactive “quality action plans” following feedback from CQC, commissioners, and Directorate audit.
• To support an ethos of transparency and candor where constructive challenge is balanced with shared problem solving and support.
• To review feedback and learn lessons enabling quality improvement from:
  o Directorate/Trust audit.
  o Incidents, complaints, safeguarding investigations.
  o Service user and carer feedback.
  o Visits to services from trust Executives, external review or peer review.
  o Organisational learning from other services provided by SHSC.
  o Visits to services outside of the trust.
  o Feedback from training.
• To identify, celebrate and share good practice.

FREQUENCY OF MEETINGS
The Provider Services Governance Group will meet on the fourth Tuesday of every month for 2½ hours (9:30 – 12:00)

Non Attendance
Attendance at meetings is mandatory. If attendance is not possible apologies are to be given in advance to June Joel. Each service area should be represented and Deputies, Co-ordinators or Team Leaders should deputise for managers unable to attend

AGENDA SETTING
An agenda setting process will be initiated 2 weeks prior to the meeting by June Joel, Business Support. A formalised agenda will be available on datastore for all members approximately 1 week before the meeting.

Action Log
The meeting will run an action log in the format below:

AGENDA

<table>
<thead>
<tr>
<th></th>
<th>Apologies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Minutes from the last meeting</td>
</tr>
<tr>
<td></td>
<td>Matters arising and reporting back on actions</td>
</tr>
<tr>
<td>2</td>
<td>Service User Safety</td>
</tr>
<tr>
<td></td>
<td>Review of previous months incidents to identify clusters and themes, and review actions</td>
</tr>
<tr>
<td></td>
<td>Review of current serious incidents / recent incident investigations</td>
</tr>
<tr>
<td></td>
<td>Lessons learnt from other Directorate / Trust incidents</td>
</tr>
<tr>
<td></td>
<td>Risk Register</td>
</tr>
<tr>
<td>3</td>
<td>Quality Review</td>
</tr>
<tr>
<td></td>
<td>Review of recent complaints / recent complaint investigations</td>
</tr>
<tr>
<td></td>
<td>Lessons learnt from other Directorate / Trust complaints</td>
</tr>
<tr>
<td></td>
<td>CQC feedback</td>
</tr>
<tr>
<td></td>
<td>Contract Monitoring feedback</td>
</tr>
<tr>
<td></td>
<td>Audit feedback</td>
</tr>
<tr>
<td>4</td>
<td>Quality Improvement Work Streams</td>
</tr>
<tr>
<td></td>
<td>Update on progress against action plans from Culture &amp; Practice</td>
</tr>
</tbody>
</table>
|   | Review, CQC Inspections and Contract Monitoring  
|---|---|
|   | • Other Quality Improvement initiatives eg Microsystems work  
| 5 | Service User/Carer Engagement  
|   | • Service user/ carer engagement project  
|   | • Carer Governor feedback  
|   | • Survey feedback (individual service and friends and family)  
| 6 | Service User Health  
|   | • Feedback from Directorate and Trust Physical Health Groups  
|   | • Feedback from Infection Control Group  
| 7 | Workforce  
|   | • Review of staff supervision – Frequency, quality and training  
|   | • Review of PDRs  
|   | • Review of training – completion, unmet needs, capacity issues  
|   | • Capacity and Capability  
|   | • Flexible Workforce issues  
|   | • HR issues  
| 8. | AOB  

**ACCOUNTABILITY / REPORTING ARRANGEMENTS**

The minutes of this meeting will be presented to the Directorate Senior Management Team for review, scrutiny and assurance. Provider Services also report into the Directorate Governance meeting.

All members of the Provider Services Governance Group are accountable for the appropriate reporting and feedback arrangements and ensuring that actions are implemented within their service.

**REVIEW DATE**

These terms of reference will be reviewed approximately 12 months after commencement (September 2016).
Community Learning Disability Teams (CLDT’s), Out of City Team and Intensive Support Service (ISS) - Leadership and Management Group

CHAIR: TBC - CLDT Nurse Manager
MEMBERSHIP: Anita Winter - Service Director
Andy Bragg - Assistant Service Director
Julia Shepherd - Nurse Consultant
Melina Simmonite – Nurse Manager ISS Inpatient
Dr Zara Clarke - Clinical Psychologist (minutes to Dr Suzie Beart)
Lucy Harrison – OT Professional Lead
Phillipa Allen – SaLT Professional Lead
Kate Scott – Physio Professional Lead

Minutes to and attendance as required (due to identified agenda need)
Dr David Newman - Clinical Director
Dr Catriona Murray - Locum Consultant Psychiatrist
Sharron Feather - Directorate Accountant

Terms of Reference

1. Purpose of the Group

1.1 To provide leadership and management to the Community Learning Disability Team (CLDT); Out of City Team and Intensive Support Service (ISS), ensuring efficient and effective teams to deliver a quality, person centered services via:

- The development of a person centered, strategic vision.
- Implementation of relevant Governance Standards.
- Ensuring effective management practice, including human resources, finance, business planning and implementation etc.
- Ensuring teams meet their performance targets and legal and statutory responsibilities.
- Monitoring and implementing Safeguarding Adults Procedures.
- The development of effective interfaces with other specialist teams/services.
- Ensuring continuous, evidence based professional development across all professions.
- Leading and supporting the implementation of key workstream plans, for example, Positive Behaviour Support and DES.

1.2 Implementation of other relevant national, regional and local strategies e.g. Autism Strategy.
1.3 To identify trends and defining priorities and using these to influence and improve local and city wide service delivery.

1.4 To prioritise and develop service plan objectives for the Directorate.

1.5 To identify and implement audit and research priorities and disseminate results.

1.6 To develop and monitor appropriate links and network with Sheffield’s health and social care community.

1.7 To monitor the implementation of agreed service action plans.

1.8 To provide direction on the health agenda for people with learning disabilities in Sheffield, via:
   - Influencing the objectives of SHSC and CCG.
   - Ensuring that the specialist health needs of people with learning disabilities are identified and met.
   - Implementing national and local objectives for example Transforming Care and the delivery of Care and Treatment Reviews.
   - Influencing and supporting the work of other key forums such as the Learning Disability Partnership Board Sub Groups.

2. Reporting Arrangements

The Leadership and Management Group will, through its Chair, report to the LD Governance Meeting and Senior Management Team meeting.

3. Membership

Membership of the group is outlined below:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Julia Shepherd</td>
<td>Nurse Consultant</td>
</tr>
<tr>
<td>Melina Simmonite</td>
<td>Nurse Manager ISS Inpatient</td>
</tr>
<tr>
<td>Dr Catriona Murray</td>
<td>Locum Consultant Psychiatrist (as required)</td>
</tr>
<tr>
<td>Suzie Beart</td>
<td>Psychology Clinical lead</td>
</tr>
<tr>
<td>Kate Scott</td>
<td>Physiotherapy Clinical Lead</td>
</tr>
<tr>
<td>Lucy Harrison</td>
<td>Out of City Team Clinical Lead and Professional Lead for OT</td>
</tr>
<tr>
<td>Phillipa Allen</td>
<td>Speech and Language /Occupational Therapy Clinical Lead</td>
</tr>
<tr>
<td>David Newman</td>
<td>Clinical Director</td>
</tr>
<tr>
<td>Anita Winter</td>
<td>Service Director</td>
</tr>
<tr>
<td>Louise Barber</td>
<td>Business Support Manager</td>
</tr>
<tr>
<td>Wendy Lane</td>
<td>PA and Minute Taker</td>
</tr>
<tr>
<td>Sharron Feather</td>
<td>Directorate Accountant (as required)</td>
</tr>
</tbody>
</table>
The group can co-opt other people on to it when required. Deputies may be sent to the meeting in the event of unavailability.

4. **Frequency and Servicing of Meetings**

4.1 Meetings will be held on a monthly basis, on the last Tuesday of the month from 2.00 p.m. to 5.00 p.m. at Fulwood House.

4.2 Meetings will be minuted and those minutes will be circulated to group members with 10 days of the meeting.

4.3 All agenda items should be submitted one week prior to the meeting accompanied via an Agenda Items Front Sheet to explain the purpose of the item being tabled.

4.4 The minutes of the meeting will be made available to all team members via the Clinical Leads.

4. **Agenda Setting**

Standing agenda items will include the following:

<table>
<thead>
<tr>
<th>Apologies</th>
<th>Minutes from the last meeting</th>
<th>Matters Arising / Action Log</th>
</tr>
</thead>
</table>

1. **Budget Update (Sharron Feather - Directorate Accountant)**
2. **LD Sickness Statistics**
3. **Innovation & developments**
4. **Performance metrics (Caseloads, waiting lists across stepped care model)**
   - Activity data & contacts
   - CLDT - Waiting list overview < 18 weeks
   - ISS (Community) - Waiting list overview < 18 weeks
   - ISS (Inpatient) - Bed state, delayed transfer of care
   - OoCT – N being reviewed & N actively engaged in return
5. **Governance Headlines**
   - Patient safety
   - Lessons Learnt (Complaints, SI, Audits)
   - Falls, ulcers, med management
   - Effectiveness
   - Outcome focused practice
   - Service user & carer involvement
   - Client Satisfaction Survey
6. **The Stepped Care Model - Interface**
   - Assessment Clinic
   - CLDT – prevention, early detection & long term support
   - ISS – community intensive work & crisis management
     - preventing unnecessary admissions
     - supporting appropriate discharges
   - Out of City Team
7. **Standing Agenda Items – For Information**
   - Partnership Board Minutes
   - Chief Executive Staff Briefing
5. Review Date

These terms of reference will be implemented from September 2015 and will be reviewed 3 months after commencement – January 2016.

6. Quorum

The meeting will be quorate if 30% of members are present.
Frontier Quality Improvement Meeting (Provider Services)

CHAIR: Locality Managers
FREQUENCY: Monthly
DURATION: ? Hours

AGENDA
- Apologies
- Minutes from the last meeting
- Matters Arising / Action Log

TOR
Awaiting information from Andy Bragg.
ISS Inpatient - Governance & Quality Improvement Meeting

CHAIR: Melina Simmonite – Nurse Manager
MEMBERSHIP: Dr David Newman – Deputy
ADMIN: TBC / Denise Lindley - Business Support Manager

FREQUENCY: Monthly – 1st Monday of the Month 14:30-16:30
DURATION: 2 Hours

• Purpose of Group

The purpose of the ISS Governance Meeting is:

- To support a culture of clinical leadership based on a drive for innovation and excellence in providing safe & effective clinical services.
- To support continuous quality improvement based on service user and carer feedback and engagement.
- To support organisational learning based on candor, transparency and a willingness to monitor, scrutinise and improve clinical quality.

• Membership

Membership of the ISS Inpatient – Governance and Quality Improvement Meeting consist of senior managers who have a corporate functional responsibility, Chaired by Inpatient Nurse Manager, Consultant Psychiatrist, Nurse Consultant, Speech & Language Therapy Professional Lead, Deputy Ward Manager, Staff Nurse, Development Worker, Business Support/Buildings Manager.

The core membership will be as follows:

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Newman</td>
<td>Consultant Clinical Psychologist</td>
</tr>
<tr>
<td>Anita Winter</td>
<td>Service Director</td>
</tr>
<tr>
<td>Melina Simmonite</td>
<td>Inpatient Nurse Manager – (Chair)</td>
</tr>
<tr>
<td>Dr Catriona Murray</td>
<td>Consultant Psychiatrist</td>
</tr>
<tr>
<td>Phillipa Allen</td>
<td>SALT Professional Lead</td>
</tr>
<tr>
<td>Julia shepherd</td>
<td>Nurse Consultant</td>
</tr>
<tr>
<td>Staff Nurse</td>
<td>Dependant on Rota</td>
</tr>
<tr>
<td>Development Worker</td>
<td>Dependant on Rota</td>
</tr>
<tr>
<td>Denise Lindley</td>
<td>Business Support/Buildings Manager</td>
</tr>
</tbody>
</table>

The ISS Inpatient – Governance and Quality Improvement Meeting will be chaired by Melina Simmonite, Inpatient Nurse Manager and serviced by Denise Lindley, Business Support Manager.

• Frequency of Meetings
The ISS Inpatient – Governance and Quality Improvement Meeting will meet on a monthly basis on the first Monday of every month between 2.30 p.m. and 4.30 p.m.

- **Agenda Setting**

Standing agenda items will include the following:

<table>
<thead>
<tr>
<th>Audits</th>
<th>• PRN</th>
<th>• MHA</th>
<th>• Medication</th>
<th>• DRAM</th>
<th>• Care Plans</th>
<th>• Infection control</th>
<th>• Medicines Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Improvement Goals</td>
<td>• Achieving the vision and outcomes from team development Day</td>
<td>• Micro systems</td>
<td>• Improving the Therapeutic Environment</td>
<td>• Interface with community services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality review</td>
<td>• Incidents, Serious Incidents, New lessons learnt</td>
<td>• CQC Feedback</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Safety</td>
<td>• Safe staffing</td>
<td>• Safeguarding</td>
<td>• MHA &amp; MCA</td>
<td>• Infection Control</td>
<td>• Medicines Management</td>
<td>• Dysphagia</td>
<td>• Falls</td>
</tr>
<tr>
<td>Clinical Effectiveness</td>
<td>• NICE</td>
<td>• Holistic PBS Outcomes</td>
<td>• Physical Health</td>
<td>• Mental Health</td>
<td>• Challenging Behaviour</td>
<td>• Risk reduction</td>
<td>• Quality of Life</td>
</tr>
<tr>
<td>Patient/Carer Engagement</td>
<td>• Service user focus group feedback</td>
<td>• Sharing &amp; Caring work stream with carers</td>
<td>• Advocacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Candor – Are We Safe?</td>
<td>• Sign off</td>
<td>• Risk Register and Escalation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Reporting Arrangements**
The ISS Inpatient Governance and Quality Performance Meeting, through its Chair, will report to the Learning Disabilities Governance Meeting.

- **Review Date**

These terms of reference will be implemented from October 2015 and will be reviewed 12 months from date of agreement.

- **Quorum**

The meeting will be quorate if 30% of members are present. This will include a mix of representatives.

- **Agenda**

An agenda setting process will be initiated 2 weeks prior to the meeting by the Business Support Manager. A formalised agenda will be forwarded for all members approximately 1 week before the meeting.

Any agenda items that are proposed by a member who cannot attend the meeting must be accompanied by a cover sheet explaining the nature and purpose of the item.

**Action Log**

The meeting will run an action log in the format below:

<table>
<thead>
<tr>
<th>Date raised</th>
<th>Action</th>
<th>Responsible</th>
<th>Date completed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Completed actions will be archived and form an evidence archive of the work of the meeting.