Humber Teaching NHS Foundation Trust

FORENSIC SERVICES CLINICAL GOVERNANCE STANDARD OPERATIONAL PROCEDURE

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Name of Trust Strategy / Policy / Guidelines this SOP refers to:	

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

CHANGE RECORD

Version	Date	Change details
1.0	*03/12/19*	*New SOP*
1.1	*18/04/2021*	*Reviewed and new schematic added*
1.2	*19/04/23*	• *Reviewed, changes made to patient safety incident investigation reporting mechanisms,* • *Minor changes to wording around the trust mission and vision value statement reflecting their current position* • *There has been a change to the wording from KLOES to quality statements and the patient safety incident investigations (PSII) have replaced SI/SEAs.* • *The flow chart about sharing the learning updated in relation to the PSIRF methodology* • *4 appendicies removed* *Approved at QPaS 3 May 2023.*
1.3	*27/06/24*	*Reviewed and updated. Approved at QPaS (27 June 2024).*

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 undertake Mental Health Act inspections across our in-patient mental health and learning disability wards on an annual basis. Services are assessed against the CQC Quality Statements and 5 key questions 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 across the in-patient and community Forensic Teams.

The purpose of the Clinical Governance SOP is to promote a transparent culture of patient safety, quality care from referral through to discharge, and reduce avoidable harm. It should 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 identified 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 that meet their needs. It utilises 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 of and be underpinned by national and local drivers including NICE guidance; individual professional guidelines and codes of professional conduct to ensure that we collaborate with patients to provide current best practice in care delivery.

2. SCOPE

This document provides governance structures and guidance for staff working across services within the Forensic 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

3. DUTIES AND RESPONSIBILITIES

Humber Teaching NHS Foundation Trust is committed to creating a culture of caring within a trauma informed model of care This extends beyond caring for our patients and service users/carers to caring for each other.

The Trust has an established strategy describing the overarching long-term goals for Humber

Trust Mission
We are a multi-speciality health and social care teaching provider committed to Caring, Learning and Growing

Trust Vision
We aim to be a leading provider of integrated health services, recognised for the care compassion and commitment of our staff and known as a great employer and a valued partner.

Trust Values
Our internal values shape our behaviours and guide the way we work with our patients, staff, partners, within our community and with each other

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

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

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 accountable 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 Operational Delivery Group (ODG) in line with their respective ToRs

3.2. Matrons/Community Clinical Lead

Matrons are responsible for ensuring that each ward manager and team leader has ward/team level governance meetings in place, with clear agendas in line with the agreed ToR, achieve good attendance, and are effectively chaired and minuted.

Matrons and the Community Clinical Lead are responsible for ensuring compliance with the CQC Quality Statements across their respective wards/teams. In doing so they will ensure that there are systems and processes in place to audit and monitor standards and compliance.

Matrons and the Community Clinical Lead are responsible for ensuring that team and ward managers effectively share learning from incidents, complaints, and compliments.

Matrons and the Community Clinical Lead will attend the service level governance meetings and Trust level Committees, groups and forums where required.

3.3. Ward Managers/Team Managers

Ward managers/team managers must ensure that they have in place monthly governance meetings with clear agendas that reflect the Terms of Reference for the group.
All chairs to ensure that their governance meeting minutes are included within the papers for the divisional governance meeting. Managers must ensure that they work with their teams to undertake a range of audits to ensure high standards of care and compliance with CQC standards. Learning from incidents, complaints and compliments must be shared within teams their wards.

3.4. Psychiatrists, Psychologists, Social Workers, 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.

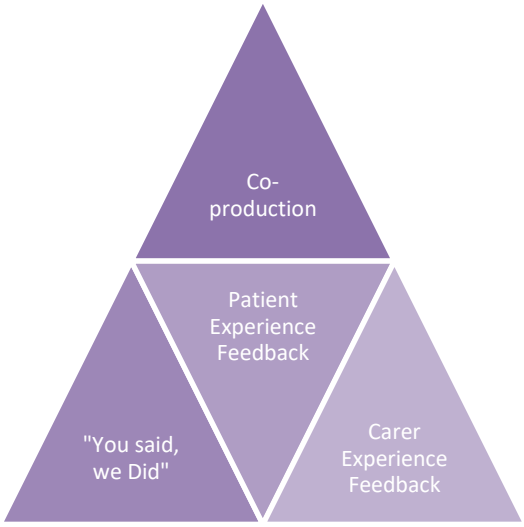
3.5. All Clinical and Non-clinical Staff

All staff both clinical and non-clinical of all grades are 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 and report safety and performance issues through agreed mechanisms such as Datix.

4. PROCEDURES

The Governance reporting will use relevant information to inform, improve and strengthen involvement and ownership of all the services in their contribution to the delivery of safe, effective and person-centred care within a trauma informed model 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 & co-production



Where possible engage with all the division's 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.

The Division will continuously seek to improve our commitment to co-production, which may include the appointment of existing patients and carers into voluntary roles, such as Patient Safety Partners, to enhance attendance at meetings and to contribute to specific projects, for instance PLACE inspections, SOP review and PSIRF.

Engagement commences on referral to each individual patient referred into the division's 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 always considered. 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 always encouraged by all wards and teams in the division.

Carers focussed engagement days will be facilitated throughout the year by the carers and user involvement lead, any issues or concerns raised will be escalated by the involvement lead and discussed within the divisional clinical governance meeting and any associated actions generated. The division facilitates a patients council meeting, the meeting is available for all patients within the Humber Centre, minutes, agenda items and actions from these meetings will feed into the divisional clinical governance meeting.

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 service users and or family carers. 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 division consists of medium and low secure inpatient services, forensic community services, and prison in-reach provision.
All the 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. The staff team rostering is managed and monitored electronically through e-

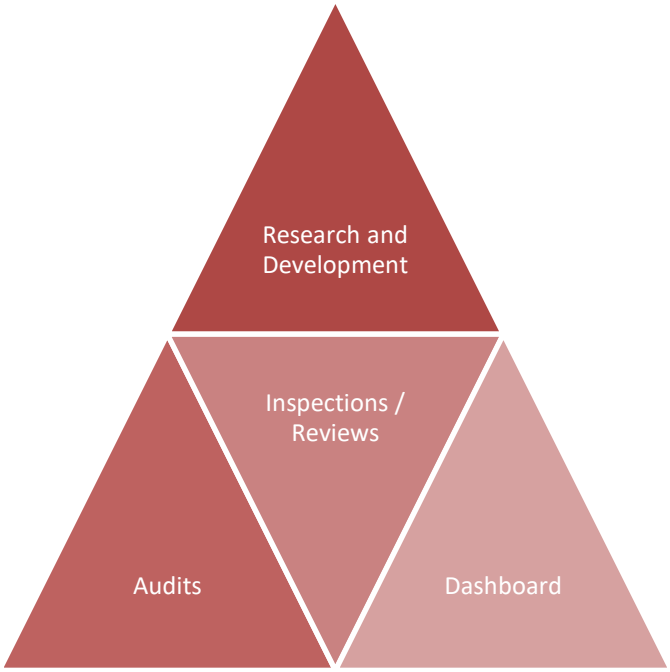
roster and ‘Employee online’ and will be the responsibility of the ward manager and their deputies. The rota will be reviewed and confirmed by the ward manager and service manager.

A morning safety huddle meeting is held daily, led by the duty manager to determine the staffing requirements, potential shortfalls, and mitigations for each ward. The duty manager completes the OPEL level for the division and submits for emergency planning, any change to community services OPEL level is included in the return; this will be recorded in the morning meeting log. Any concerns related to safer staffing are escalated to as per the safer staffing escalation policy. 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 by a Band 4 administrator. Sickness and absence are monitored through the Trust’s Managing Attendance Policy. Regular reviews with HR established to support direct management on the unit. 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 on the Clinical network and Secure Services Operational Delivery Group meetings and where required any escalations will be made to the Trust Quality and Patient Safety Group (QPaS) and exception reporting to the Trust Board.

4.3. Clinical Effectiveness, Research and Audit



The Trust is committed to ensuring all services are provided to a high quality and makes performance management a core function within all services. The division’s services will have established metrics for measuring clinical and non-clinical performance. This will be captured

within the division's accountability reviews and highlighted within the division's service plans. The service plans will take account of:

- Quality planning
- Activity planning includes capacity and demand
- Workforce planning
- Financial planning
- Benchmarking and gap analysis

Accountability reviews will be conducted by the Executive Management Team, and they will review the clinical effectiveness and operational performance of the division. The Division will establish a cycle of inpatient clinical and compliance audits utilising an appropriate data collection app for capturing and reporting within the service. The cycle of audits will be outlined in a separate 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 Clinical Network for review and approval and the audit schedule will be overseen in the Trust's Audit and Effectiveness Group and Research Group. We will specifically develop our participation in and leadership of rese

Clinical care delivered in the service will be aligned to national best practice and follow were 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 applicability of NICE and other practice guidance, and the review and implementation of therapeutic interventions, will be overseen by the Therapeutic Interventions and NICE Guidelines group (TING) which will in turn report to the Clinical Network for sign-off.

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, patient safety incident investigations and complaints will be agreed and monitored through the Forensic Clinical Assurance Group FCAG and delivery, assurance and escalation overseen through the Clinical Governance meeting.

4.4. Informatics and IT

All records regarding the multi-disciplinary care delivered to patients will be electronically maintained on the Trust's Electronic Patient Record system.
All patient information will be used in accordance with the Accessing and Sharing Information with Service Users and Carers Policy, the Operational Procedure for Sharing Information to provide integrated Mental Health Services and the Caldicott and Data Protection Policy. All records are managed under the Records Management Code of Practice for Health and Social Care (2016).

The BeDigital Team will support the management of electronic records. Record keeping will be subject to monthly record keeping audit and review through our electronic audit platform. 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 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 and outcomes. 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.

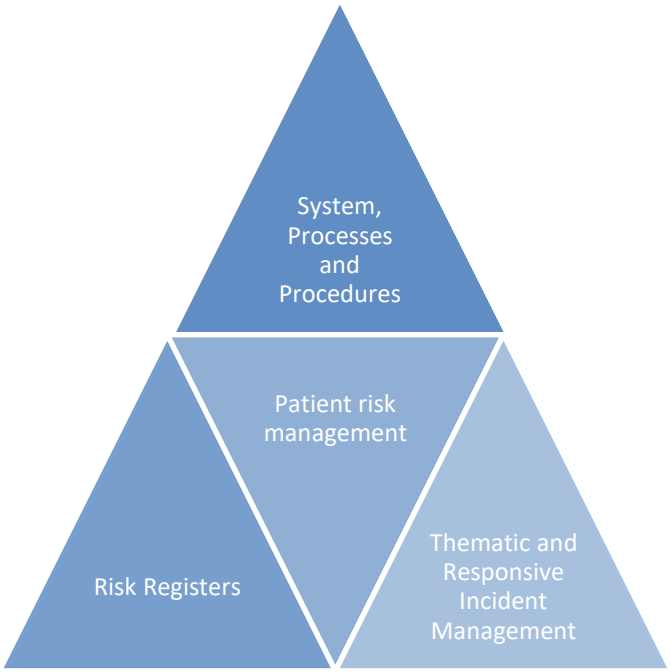
The use of informatics and IT will be reviewed in the Divisional Digital and Data Group (D3G) which takes place monthly and feeds into both the Forensic ODG and the Trust Digital and Data Delivery Group.

4.5. Education, Training and Staff Wellbeing

All staff working in the division will be supported to maintain the values of caring, learning and growing. Education, training, and personal development will be individually and collectively identified through the appraisal process. Continuing professional development 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 and managerial supervision structures will be in place to provide on-going developmental review and identify any emerging training or wellbeing support for individuals. All new staff will attend an induction programme. All staff will attend mandatory training sessions appropriate to their individual professional status. This will include the necessary level of training required to manage all areas of care delivery as identified in the individual service's operational SOPs.

Service specific based training will be facilitated and include practice-based learning opportunities for all staff. Training will be determined by the analysis of skills needed linked to the 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 that risk ratings are reflective of real time service activity. Risks are allocated to handlers who review allocated risks and manage associated actions The risk register is reviewed and overseen at divisional ODG (with risk management support) with escalation to Trust ODG, QPAS, the Executive Management Team (EMT) and the Quality Committee as appropriate.

All incidents are reported via the Trust Datix electronic reporting and investigation system. All Datix are reviewed at the Trust corporate safety huddle each morning by senior clinicians within the Nursing Directorate, pharmacy, and safeguarding. Other senior clinical staff across the Trust join the huddle to participate in the review of Datix submissions. All Datix submissions are reviewed and actions for further review are considered within the current incident reporting framework, further investigations to explore or understand patient safety issues will be conducted under the Patient Safety Incident Response Framework (PSIRF)
Any escalations and requirements for enhanced investigations triggered from the safety huddle are also alerted to the Collaborative Planning and Quality Team (CPaQT).

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 dial into discuss Datix submissions made in the previous 24 hours. A member of the division's management team will attend the daily safety huddle to talk through the incidents providing context and offering assurance that any 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 immediately following the incident. In relation to staff debriefs this will be undertaken by the duty manager and repeated, if necessary, by the ward manager at an appropriate time. A debrief form will be completed by the duty manager and emailed to the ward/team manager and the psychology team. The Psychology team will offer a further psychological debrief to the staff member concerned.
The forensic patient safety and risk management meeting will monitor individual patient risks across the service, whence information will inform OPEL levels and feed into considerations for admissions, transfers and discharges based on clinical acuity in addition to bed availability in the Referrals and Bed Management meeting. The service will review themes and trends through the Datix dashboard within Clinical Network and at ward governance meetings, taking action to address themes where required.

All ward managers and their deputies have access to Datix for the management and investigation of reported incidents and datix dashboards have been provided for all ward managers. It is essential that they review reported incidents daily to ensure incidents not closed by the Corporate Huddle are investigated and closed in a timely manner.

The learning from incident reviews will be disseminated across the Division to relevant teams via the most appropriate routes, which may include Clinical Governance, Clinical Network or team level governance meetings. Assurance that the learning has been shared and recommendations have been implemented will be provided through the records of the Forensic Assurance Group and the aforementioned meetings.. The flowchart in Appendix 1 shows the process for sharing learning.

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 reduced.

All care will be considered within the least restrictive principles and within a trauma informed approach. Where specific restrictions such as seclusion, long term segregation or the use of rapid tranquilisation are utilised then these must be reasonable and proportionate in response to the risk identified at the time. Use of restrictive interventions is monitored through the weekly Risk and Referral Meeting and monthly through the Reducing Restrictions group.

A record of the patient's physical health will require ongoing 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.

4.6.1. Environmental Risks

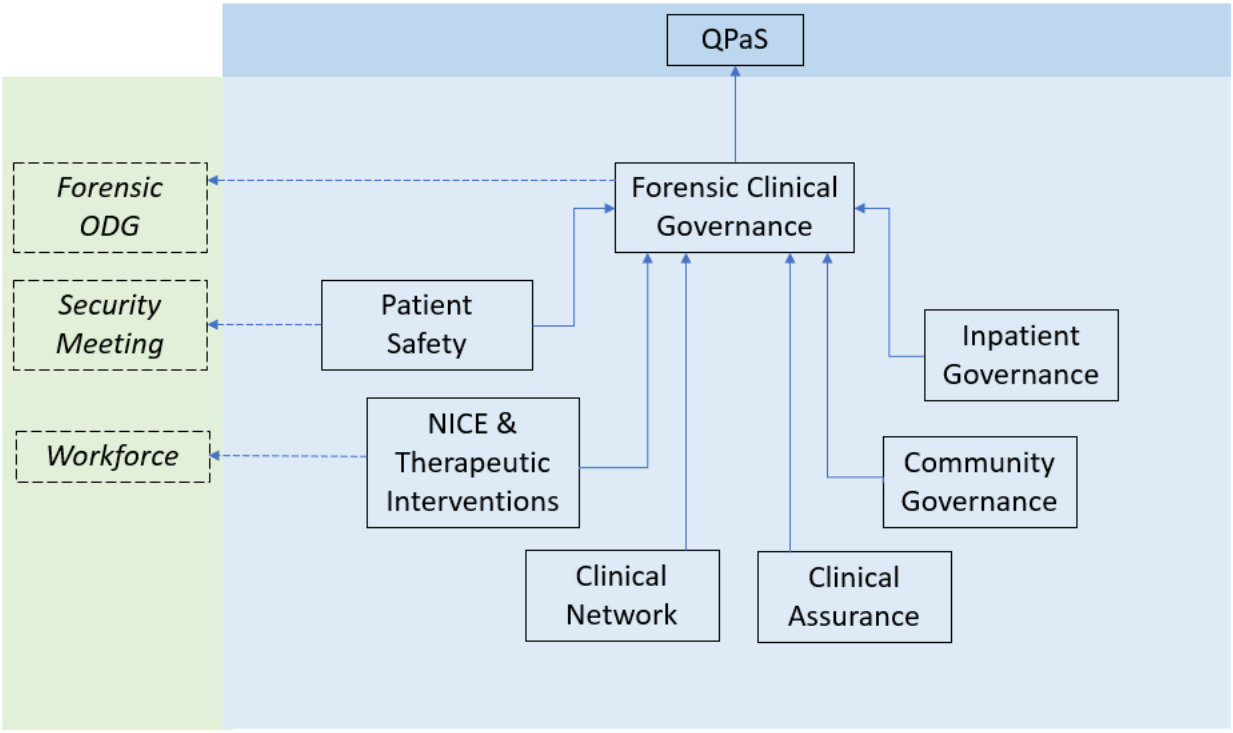
The services will have in place regular environmental checks in line with Trust policy to ensure that the clinical areas including bedroom spaces in the inpatient services are routinely checked for all potential hazards that may result in self-harm including ligature risks. Emphasis will be placed on 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 SOP to manage property risks.

4.6.2. Safeguarding

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

5. SERVICE LEVEL CLINICAL GOVERNANCE STRUCTURE

The Division ensures effective Governance via two oversight groups – the Forensic Operational Delivery Group (ODG) provides assurance regarding operational governance, and reports directly into the Trust wide Operational Delivery Group, the Forensic Clinical Governance Group provides assurance regarding clinical governance, reporting directly into the Trust wide Quality and Patient Safety (QPaS) meeting. Each group has a number of subgroups to fulfil delegated functions, the Divisional meeting structure is included in appendix 2. The Clinical Governance structure is shown below:



5.1. Clinical/Practice Network

The Forensic Service Clinical Network has been established to oversee and ensure the delivery of Clinical Governance and quality improvement across the Service. The Clinical Network will also be

responsible for defining and achieving a set of overarching clinical priorities on an annual basis. The annual clinical priorities will be set in line with national and locally agreed requirements and actions.

The Clinical network group reports to the divisional governance group

The duties of the Clinical Network are as follows:

- Develop and monitor delivery of the Quality Improvement plan for the service based on clinical priorities incorporating patient, carer, and staff views to drive quality improvement activities.
- To ensure that patients' and carers' views are heard at all levels and across all parts of the service to help create and deliver better health and care services.
- Ensure implementation of nationally mandated clinical standards that require action within the service, 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.
- Develop, implement, and review the effectiveness of clinical policies, guidelines and standards which will be ratified by QPAS.
- To provide scrutiny and sign-off for patient, carer and public information leaflets produced by clinical professional experts in the field (with or through appropriate clinical speciality groups).
- Prioritise, agree, and monitor clinical audit activities for the 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.
- To oversee the development and implementation of clinical models
- Identify and support areas for research and service evaluation to inform quality improvements.

5.2. Clinical Governance

The purpose of the Clinical Governance meeting is to oversee governance issues within the Forensic Mental Health Services; take any action required and escalate concerns/matters within the organisation.
The clinical governance meeting reports directly to QPAS

The duties of the Clinical Governance Group are as follows:

- To monitor quality, safety, effectiveness, and risk within the Forensic Division; take any necessary action and escalate concerns as appropriate within the Trust.
- To provide assurance to the organisation around quality, safety, effectiveness and risk.
- To receive assurance from the Clinical Assurance group that improvements following events such as CQC inspections (including MHA) are implemented within the required timescales.
- To receive assurance from the Clinical Assurance group that improvements following PSIRF and complaint investigations are implemented and within the required timescales.

The Clinical Network/Governance meetings delegate responsibility for monitoring NICE guidelines and evidence based practice to the TING. This group will be responsible for reviewing the applicability of guidelines and evidence and overseeing their implementation, reporting regularly to the Clinical Network.

The Clinical Governance meeting delegates responsibility to the Clinical Assurance Meeting to provide oversight and monitoring of clinical action plans within the Forensic Division, and to ensure the ongoing implementation of learning from the action plans ('testing the learning' processes).

The Clinical Network/Governance meeting delegates responsibility for a focus on reducing restrictive interventions and increasing relational security/psychological safety to the Patient Safety meeting. This meeting will review SafeWards implementation and address learning from incidents, and will have an explicit focus on co-production.

5.3. Forensic Services Operational Delivery Group

The Forensic Service Operational Delivery Group will monitor the secure services performance, finance, governance, and HR issues. It will monitor progress against transformation, patient experience, staff wellbeing, and quality and safety to support the effective operational delivery across the Forensic service. It will ensure good information flow and provide ward to board communication.

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

The duties of the Forensic Services Operational Delivery group are as follows:

Operational

- To ensure that the service delivery operational plans are delivered and monitored
- To contribute and agree business cases and change cases
- Update/feedback from clinical lead – to highlight exception reporting re: NICE applications, CQC action plan, complaints, Patient Safety Incident Investigation incidents and escalate any outcomes or actions which require an operational plan and lead to ensure actions are completed.
- Receive and review monthly operational feedback from service leads or their representatives (nursing, psychology, medics, therapies, social work, and community) – to include the exception reporting for: safer staffing/e-roster/performance/electronic systems/service developments. Also, to include escalation of issues and risks for consideration for submitting on the risk register.

Finance

- To review financial performance against activity and income plan to ensure successful delivery against the annual budgets and ensure that remedial action is taken when required.
- To monitor financial performance including the delivery of budget reduction schemes and other plans for improving productivity and efficiency ensuring that remedial action is taken when required.

Performance – Operational Contractual/Commissioning

- To monitor the delivery of CQUIN performance and ensure remedial actions are taken as required to address areas of underperformance and ensure that any risks to achievement are escalated to ODG.
- To monitor all commissioning and contractual and performance indicator including quality indicators ensuring that remedial actions are taken to address any areas of underperformance.

Risk Management

- To review the risk registers and ensure timely and appropriate actions to manage and mitigate risks are being taken. To ensure that operational risks rated 12 or above at escalated to ODG and accurately reflected on the Corporate Risk Register and the Board Assurance Framework.

Divisional Strategic Workforce group
The duties of this group are as below

- To consider staffing benchmarking information and use this to support skill mix change and workforce efficiencies, coordinating workforce re-design programme linking to transformation changes and development of work force plans.
- To be responsible for the delivery of vacancy management which supports budget reduction strategies while ensuring patient safety and quality of service provision.
- To review e-roster use and reporting to maximise workforce efficiencies
- To receive and review reports which set out the use of flexible staffing and identify operational mechanisms to control spend on bank and agency staff and monitor the effectiveness of these.
- To identify and develop operational mechanisms at team and service level which will support the achievement of workforce efficiencies.
- To identify reporting developments that will support the achievement of optimal and efficient workforce usage.
- To understand the workforce implications of the budget reductions schemes and transformation change programmes to develop appropriate management of change plans.
- To oversee the implementation of the management of change plans to ensure they are coordinated and effective.
- Leadership
- Mapping cross to CPD and appraisals

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

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

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	Clinical Network	Clinical Lead	Bi-monthly	TING	Monthly
Audit	Clinical Network	Clinical Lead	Bi-monthly	n/A	N/A
Education and Training	Clinical Network	Clinical Lead	Bi-monthly	Training and development group	Monthly
				TING	Monthly
	Forensic Operational delivery Group (FODG)	General manager	Monthly	Strategic Workforce	
Risk Management	Clinical Network	Clinical Lead	Bi-monthly	Referral & bed management meeting	weekly

Pillar	Governance Group Responsible for assurance	Chair	Frequency	Subgroups reporting to the Governance Group	Frequency
				Patient Safety Group	Monthly
	Forensic ODG	General manager	Monthly	Security Group	Monthly
	Clinical Governance	Clinical lead	Bi-monthly	Forensic Clinical Assurance Group	Monthly
Patient and Public Involvement	Clinical Network	Clinical Lead	Bi-monthly	Patient Council Patient Safety Group	Monthly
Information and IT	Forensic ODG	General Manager	Monthly	Divisional Data and Digital Group (D3G)	Monthly
Staffing and Staff Management	Forensic ODG	General Manager	Monthly	Ward managers meeting.	Monthly
				Strategic Workforce meeting	Monthly
				Vacancy Review	Quarterly
	Clinical Governance	Clinical Lead	Bi-monthly	Safer staffing reviews	6-monthly

6. WARD/TEAM LEVEL CLINICAL GOVERNANCE

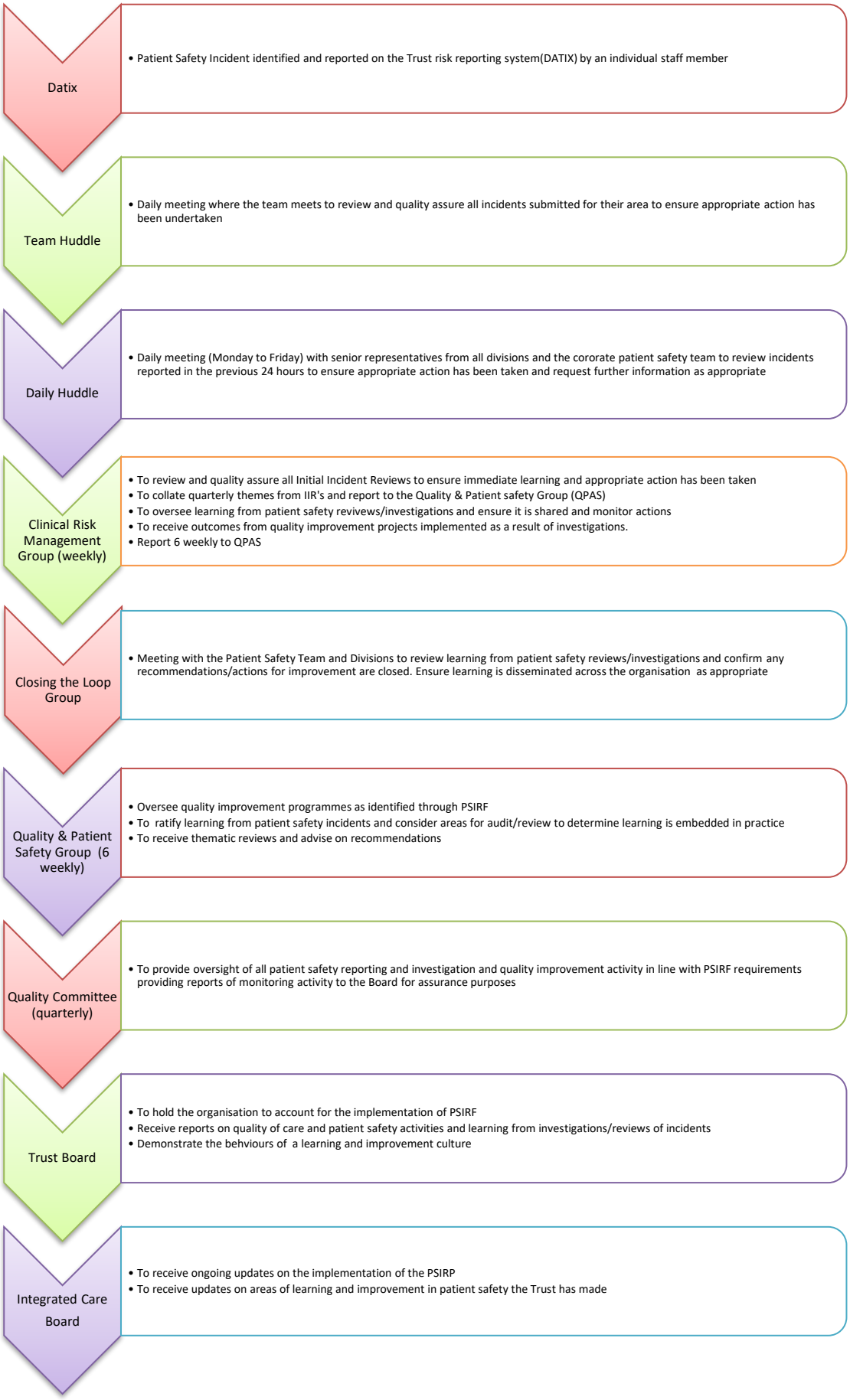
To ensure ward to Board governance the inpatient and community sectors of the Division hold monthly governance/practice meetings chaired by the appropriate professional/manager.

The aim of these sub-group meetings is to review the operational, clinical,safety and quality performance of the teams, share learning from incidents, reviews, investigations and complaints and provide a two-way communication between the Divisional level governance groups and the teams.

7. REFERENCES

Division's Service Plan
Local SOPS
Accountability Review
Clinical Model
Service Specifications
Operational Procedure for Sharing Information
Caldicott and Data Protection Policy
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

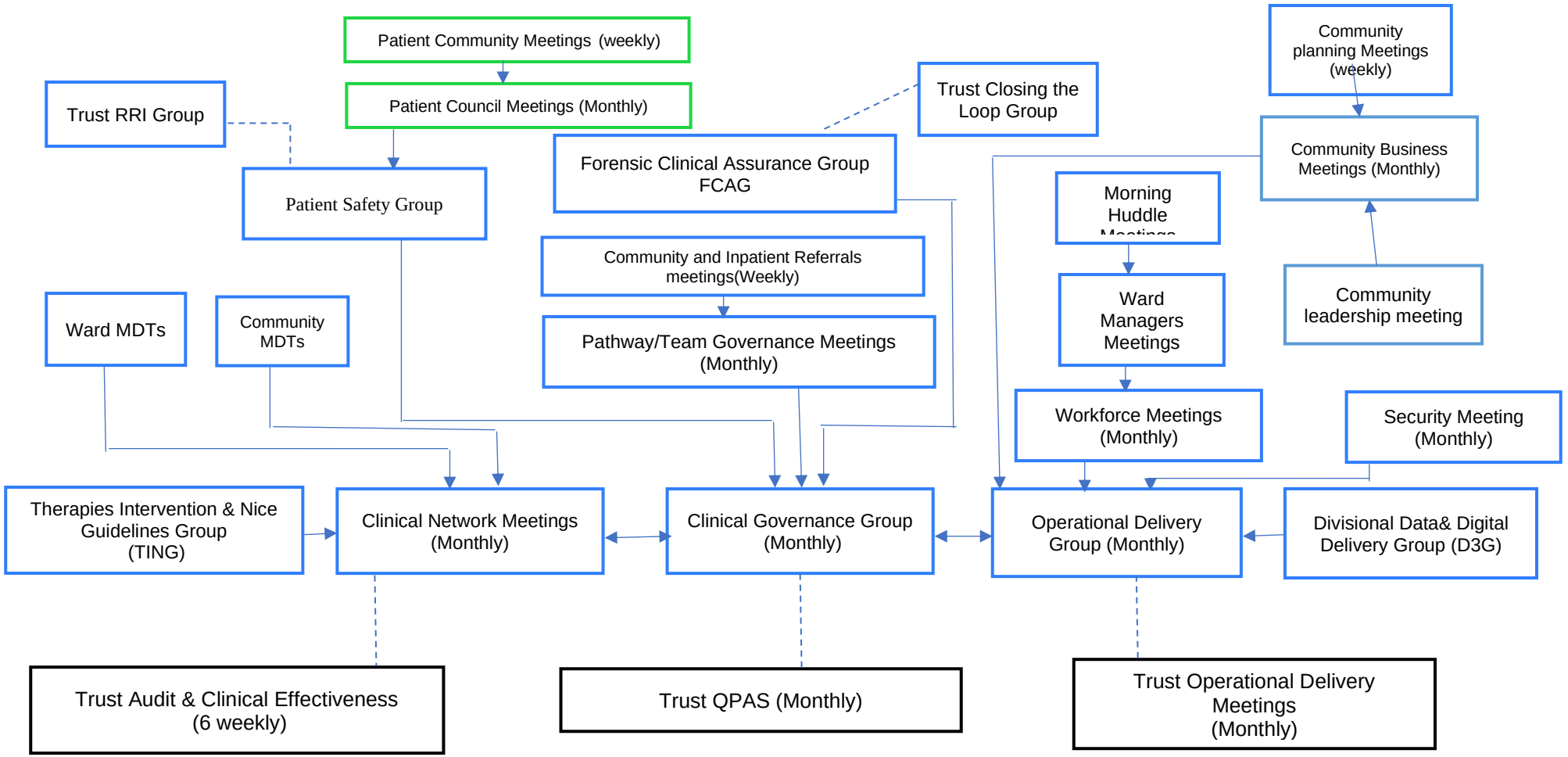
Appendix 1: Sharing the Learning Flow Chart



Appendix 2: Forensic Services Governance Group Structure

GOVERNANCE GROUP STRUCTURE

Secure Services Meeting Structure



Appendix 3: Governance annual plan

	January	February	March	April	May	June	July	August	September	October	November	December
Clinical Governance meeting		x		x		x		x		x		x
Clinical Network	x		x		x		x		x		x	
Forensic Operational Delivery Group	x	x	x	x	x	x	x	x	x	x	x	x
Forensic Clinical Assurance Group	x	x	x	x	x	x	x	x	x	x	x	x
Therapeutic Interventions and NICE guidelines	x	x	x	x	x	x	x	x	x	x	x	x
Clinical Governance by exception	x		x		x		x		x		x	
Clinical Network by exception		x		x		x		x		x		x