Humber and North Yorkshire
Specialised Mental Health, Learning Disability and Autism
Provider Collaborative

NHS
Humber Teaching
NHS Foundation Trust

Humber and North Yorkshire Specialised Mental Health, Learning Disability and Autism Provider Collaborative

Quality Governance Framework

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1. Humber and North Yorkshire Specialised Mental Health, Learning Disability and Autism Provider Collaborative

1.1 Introduction

The NHS Long-Term Plan sets out a vision for greater local system integration and autonomy. Supporting this, specialised services have moved towards more integrated commissioning with local systems. The long-term ambition is to fully join up commissioning pathways for mental health, learning disability and autism to improve access, experience and outcomes for people and ensure that funding is used in the most effective way to achieve this.

The Humber and North Yorkshire Specialised Mental Health, Learning Disability and Autism Provider Collaborative (abbreviated to HNY PC) is a partnership between a range of NHS, Independent Sector and Social Enterprise care providers. Humber Teaching NHS Foundation Trust (HTFT) is the lead provider and is accountable through holding the Lead Provider Contract directly to NHS England.

The Provider Collaborative will be a catalyst for change to progress transformation across our geographical area working with all health, social care, community and voluntary sector partners.

1.2 HNY Provider Collaborative Vision

All partners are committed to overall purpose of the collaborative, which has been agreed as:

Working as an open and transparent partnership to improve access, experience and meaningful outcomes for all those who use our services and communities through true co-production, person centred care, supporting and empowering a collaborative workforce, and optimising the use of resources.

The aims of Humber and North Yorkshire Provider Collaborative are:

- Improve outcomes and experience for people using services, their families and carers
- Improve continuity in clinical pathways and ensure that financial incentives are focused on high quality and clinically effective patient outcomes
- Make services locally and clinically led, giving local health systems the freedom to innovate to improve services, whilst maintaining national consistency in clinical standards and quality
- Continue to reduce inappropriate out of area placements, avoidable admissions, and lengths of stay
- Ensure admissions are clinically necessary and focused, as short as possible and close to home in a high-quality service
- Improve value for money in specialised mental health spending and reinvest savings in community and step-down services for the local population

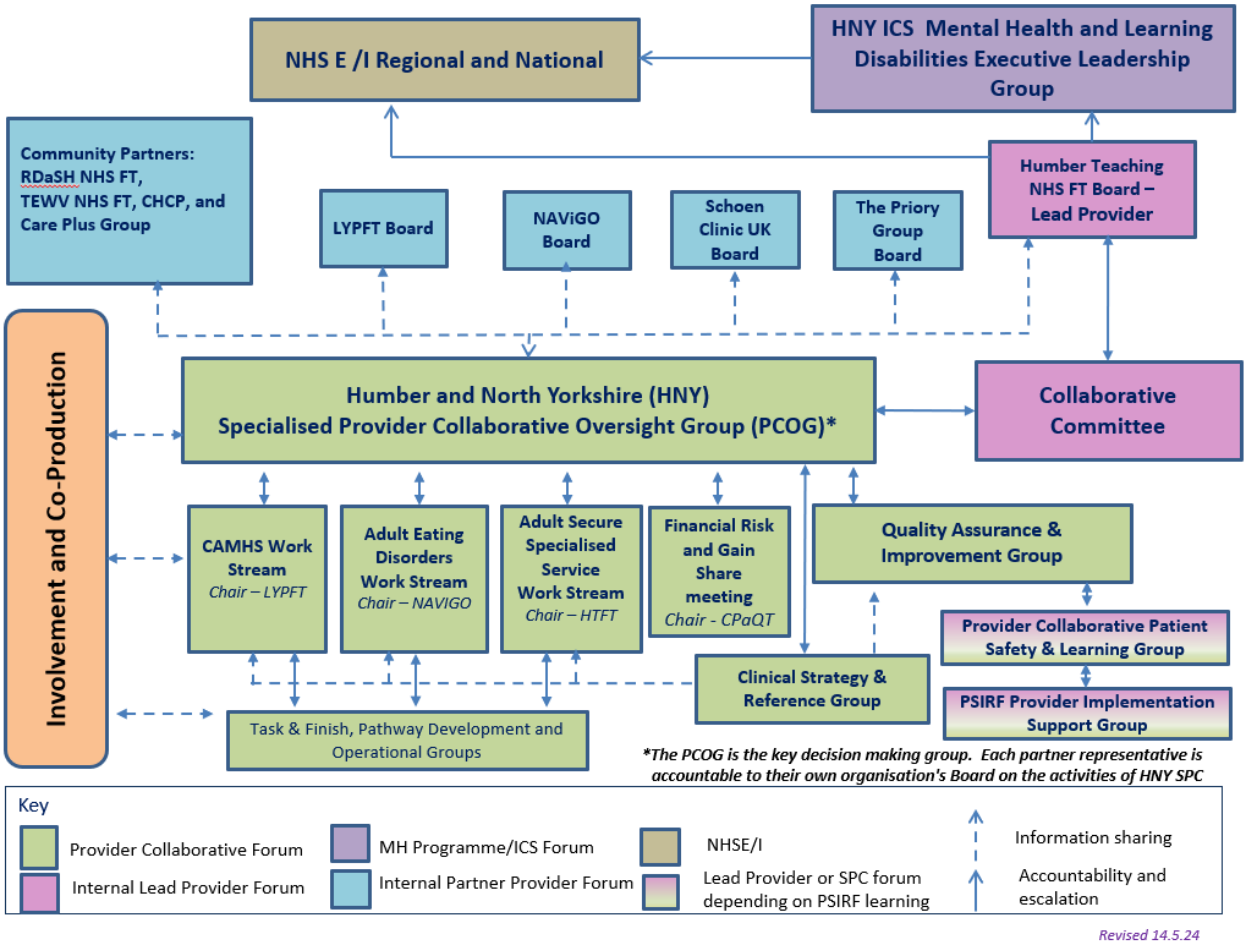
- Create a basis for and achieve further integration with other local commissioners and locally commissioned mental health services

2 Governance Infrastructure

2.1 Overarching Governance Arrangements

The HNY PC Quality Governance Framework can be seen in Figure 1. This strucutre outlines how partners, the PC and the Lead Provider will discharge their duties in the commissioning of NHS funded specialised services across Humber and North Yorkshire, including where accountabilty exists within a realtionship between groups. It is this stucture that will guide the escalation and communication of issues pertaining to planning, quality, performance and risks.

Figure 1: Overall governance arrangements for Humber and North Yorkshire Provider Collaborative



2.2 Purpose of each group

The key purpose of each group are outlined below. Where applicable Terms of Reference or SOPs can be found in the appendices.

Table 1: Key purpose of each group in HNY PC Quality Governance Framework

Group	Key purpose
Provider Collaborative Oversight Group (PCOG) (Terms of Reference in Appendix 1)	• Collectively steer the strategy and operational delivery of the Provider Collaborative programme • Makes decisions in relation to quality assurance and improvement; finance; planning and contracting • Holds to account the three Service Work Stream Groups (CAMHS, Adult Secure, Adult Eating Disorder) • Sets the remit of each of the Service Work Stream Groups to determine what decisions will be taken there and which must be referred back to PCOG for recommendation/ratification • Ensures developments are in line with the assessed population needs and can be met from within the resources available • Review and amend the overall HNY PC risk register ensuring collective responsibility for its content and subsequent actions • Provides assurance to the Collaborative Committee • Develop and oversee the Partnership Agreement between the provider organisations including the risk and gain share agreement.
Collaborative Committee (Terms of Reference in Appendix 2)	• As a sub-committee of the Humber Teaching NHS FT Trust Board (Lead Provider), this group is internal to HTFT and receives assurance in relation to quality assurance and improvement; finance; planning and contracting • Offers assurance to HTFT Board as Lead Provider
Humber Teaching FT Board	• Reviews and signs the Lead Provider contract with NHS E • Overall accountable to NHS E for the HNY Provider Collaborative • Ensure the appropriate assurance of governance to each partner organisation's Board, NHSE/I and other appropriate regulatory bodies
Quality Assurance and Improvement Group (Terms of Reference in Appendix 3)	• Bring together providers to prepare for, respond to and manage system quality issues across the Provider Collaborative • Facilitate mutual accountability, support and learning between providers • Ensure appropriate links and flow and review of information with wider quality structures in the ICS/CCGs, Local Authorities, CQC and NHSE/I • Provide assurance to the Provider Collaborative Oversight Group and the Collaborative Committee
Provider Collaborative Patient Safety and Learning Group	• Oversee and manage the commissioning function and oversight of patient safety. • Ensure robust implementation and embedding of the PSIRF process across all Humber and North Yorkshire Provider Collaborative in line with national policy.

(Terms Of Reference in Appendix 4)	• To support learning across systems, and to share insight and information across organisations to improve safety. • To continue to monitor current SI reports, until all providers have transitioned to PSIRF.
Service Work Streams (Terms of Reference in Appendix 5)	• Review the needs of the care group population and develops proposals, business cases and programme plans improved approaches to provision • Oversee the progress of approved business cases and revised pathways • Ensure alignment between national and regional forums specific to the clinical area and HNY PC activity • Support and oversee Task and Finish or Operational Groups that focus on specialised areas of practice and report to the Service Work Stream Groups. • Review and amend works stream risk registers ensuring collective responsibility for their content and subsequent actions

Risk and Gain Share Finance Group (Terms of Reference in Appendix 6)	• A forum for the participating partners of the Financial Risk and Gain Share to come together to make collective recommendations relating to the financial Risk and Gain share of the SPC, and to monitor the financial sustainability of the HNY SPC.
	• The Group will contribute to the HNY SPC overall aims by:
	  • ensuring the financial sustainability of the SPC
	  • making recommendations for reinvestment of SPC funds

2.3 Frequency of meetings and Chair

The below table shows the frequency of meetings detailed within the HNY Provider Collaborative governance framework and details of who will be the chair.

Table 2: Frequency and chair of meetings

Title of Meeting	Frequency	Chair
Provider Collaborative Oversight Group	Bi-monthly for finance and performance reporting	HNY Provider Collaborative Provider SRO
Collaborative Committee	Quarterly	HTFT Non-Executive Director
Humber Teaching FT Board	Monthly (alternating public board bi-monthly, and strategic board bi-monthly)	Chair of HTFT
Quality Assurance and Improvement Group	Bi-monthly	Assistant Clinical and Quality Director
Provider Collaborative Patient Safety and Learning Group	Monthly	Clinical And Quality Director
Service Work Streams	Bi-monthly	Work stream clinical lead or Provider SRO
Risk and Gain Share Finance Group	Bi-monthly	Programme Director

Clinical Strategy and Reference Group	Bi-monthly	Clinical And Quality Director

2.4 Lived experience, involvement, and co-production

A key strategic aim for HNY PC is ensuring lived experience and meaningful involvement influence all planning. There is a range of activity across the HNY to ensure the service user, staff and carer voice is represented within the governance framework and this will continue to be enhanced and developed further as the PC matures. Within the Provider Collaborative there is the Involvement Network who feed into quality assurance, liaison with providers and commissioning decisions.

3 Commissioning and quality functions

3.1 Lead Provider Delineation

It is important to demonstrate and enact a clear delineation between the *commissioning* and the *provider* functions of the Lead Provider. Humber Teaching FT Board has two elements for commissioner and provider functions which are discussed separately, and membership is appropriate depending on the function.

3.2 Collaborative Planning and Quality Team (CPaQT)

The delineation between commissioning and provision in Humber and North Yorkshire Provider Collaborative has been operationalised through the creation of the Collaborative Planning and Quality Team (CPaQT), with agreement by all partners. This team (formerly the commissioning team) carries out the roles and responsibilities traditionally grouped together as commissioning and does this through collaboration, partnership working and system support. The team serves two broad functions within the collaborative, each represnted below in orange or green. The team is co-led in partnership by the Planning Director (for the areas identified in green below) and Clinical and Quality Director (for the areas identified in orange).

Figure 2: Core functions of the Collaborative Planning and Quality Team (CPaQT).

3.3 Case management and quality assurance

In its capacity as a 'placing' Provider Collaborative, HNY PC is responsible for the case management for all people from the six HNY 'places' who are in Adult Secure Care inpatient, CAMHS inpatient and AED inpatient services regardless of the geographical location of their care. It also has responsibility as a 'host' Provider Collaborative for quality monitoring of all services within HNY geography and to be aware of emerging themes indicative of a quality or safety concern that requires highlighting.

Case managers are professionally qualified members of the team. They are vital in providing credible, robust, regular oversight of care and treatment. They do this through direct contact and ongoing relationships with service users, families, clinical teams, staff and providers across the pathway. They are also part of a wider network of case managers across the country. It is through regional and national networks that any concerns about quality can be exchanged between placing and hosting PCs.

Case managers monitor and review the quality and safety of provision via:

a) Regular reviews with each service user and their clinical team. For CAMHS this must be no less than 6-weekly and for adult services no less than 8-weekly. These are the **6-8 weekly reviews.**

b) Reviews and visits of every patient on their caseload subject to seclusion and long-term segregation (LTS) and review progress during the 6-8 weekly review visits These are the **LTS reviews**.

c) **Attendance at clinical meetings**, including CPAs, MDT meetings, CTRs and C(E)TRs and professionals' meetings.

d) **Observing providers in practice**, including environmental audits/quality reviews and individual case review deep dives where indicated.

e) The Head of Quality and Case management has **monthly quality meetings** with each of the providers.

f) **Bi-monthly meetings with Case Managers nationally** who have service users in our hosted services.

g) Monitoring and reviewing quality information and local intelligence.

h) Links and networks with regional and national network to exchange information about quality concerns.

Case managers hold a key function in identifying system gaps and issues across pathways meaning that they hold critical information for planning. Where system wide issue (e.g., gaps in provision; system fragmentation) are identified this will be taken to the relevant work stream for initial discussion and planning. The case managers also provide information to inform annual commissioning plans.

3.4 Escalation and reporting of quality matters

The Provider Collaborative via the CPaQT is responsible for responding appropriately and proportionately to quality concerns and immediate risks. The following structures and processes ensure that information from front line provision via case managers is appropriately escalated via CPaQT or on a routine basis forms part of collaborative discussions between CPaQT and individual providers, CQC and NHSE.

i. The **weekly clinical brief** is a document produced by Case Managers to provide weekly updates about a variety of clinical and service areas, to the Assistant and Clinical and Quality Director. These include updates on safeguarding concerns, waiting lists, service users that are Clinically Ready for Discharge, CAMHS transition cases, long term segregations, data on the 6-8 weekly review compliance and when services have been visited.

ii. The **weekly brief of complex cases** is produced by the Clinical and Quality Director, based on information from the weekly Clinical Brief and shared with the Humber Teaching NHS Foundation Trust Executive Team to highlight any case or service issues that the Executive Team need to be made aware of.

iii. CPaQT have a **monthly Quality Assurance Team meeting** for briefings from case managers of 'live' quality matters or soft intelligence and actions taken to date as assurance. Issues pertaining to complex clinical cases can also be escalated. Information from this meeting feeds into the Service Workstream Groups and then wider governance arrangements. See Appendix 7 for the agenda and scope of the Quality Assurance Team meeting.

iv. CPaQT have a **monthly full Collaborative Planning and Quality Team meeting** which provides updates around quality assurance, Service Workstreams, finance, contracting and planning. See Appendix 7 for the agenda and scope of the CPaQT meeting.

v. There are **bi-monthly clinical case discussions** with members of the clinical and quality team from CPaQT. These forums enable case managers to discuss complex cases and working together to generate ideas and possible solutions.

vi. There are **bi-monthly meetings between the CPaQT and the CQC** to share information.

vii. The **bi-monthly Quality Assurance and Quality Improvement Group** has been established to ensure transparency and system wide collaboration in supporting system learning in the safe delivery of high quality and continuously improving services. The group's role is to bring providers together to prepare for, respond to and manage to completion quality issues across the Provider Collaborative.

viii. The **bi-monthly Risk Register Formal Review** enables members of CPaQT, to review the risk register and consider if the processes in place are reducing the risk. This risk register is then reviewed and shared at Service Workstreams, Collaborative Committee and Provider Collaborative Oversight Group.

ix. Each provider will meet with CPaQT in a **Quarterly Quality and Contract Review Meeting** where the details of any quality matters will be discussed and jointly planned for on an ongoing basis. This will include understanding patterns or exceptions in the data returns and review of any agreed action plans including Quality Improvement plans. It will also incorporate reviews of finance and activity positions, including agreeing reconciliation differences and under/overspends led by the Programme Lead or Heads of Commissioning. Additional quality specific meetings may be arranged based on need and context. Prior to this meeting the KPI and SSQD submissions will be reviewed, and any queries will be sent to providers. Responses from these queries will be discussed at this meeting.

x. CPaQT have **Quarterly Quality Assurance meetings with NHSE**. Within these meetings CPaQT with provide both quantitative and qualitative quality assurance data to NHSE, around processes and procedures the Provider Collaborative has in place for all of the providers.

xi. Each service will receive a minimum of three visits per year from senior CPaQT officers, including:

a. **Site visit:** The aim is to support relationship development between CPaQT, providers and service users and be an opportunity to stay connected to the environments, cultures challenges, successes, and issues at the front line of provision. In addition, it is anticipated that these visits will allow all stakeholders to have shared experience and understanding of the of units and wards. The aim and focus of the visits will be mutually agreed beforehand based on Quarterly Quality and Contract Review Meetings and feedback from case managers, the provider and any other stakeholder.

b. **Annual Quality Review**: The aim is to support services with a yearly 'check in' and review the development of any plans in place focused on service development or quality improvement. This is in addition to any CQC inspections or peer and service accreditation reviews, and efforts will be made to avoid duplication and ensure co-ordinated approaches to actions plans. Annual visits will have engagement from the Lead Case Manager for each service and one other Case Manager from the CPaQT team, and the Involvement team will also be present. The Clinical and Quality Director and Assistant Clinical and Quality Director will be invited to join the annual quality visits. See Appendix 8 for the template that will be used to inform the Annual Quality Review.

c. **Bi-Annual Review**: The recommendations and subsequent actions from the annual visits will form the bases of the monthly quality meetings and there will be an extended bi-annual quality meeting. Attendees with be the senior leads from the providers, the CPaQT case managers and the Clinical Director and/or Assistant Clinical & Quality Director will be present. The bi-annual meetings will be minuted and action plans from the annual visit will be updated. The action plans will then feed into the subsequent monthly meetings to review and measure progress. Case managers will also be reviewing aspects of the annual review action plan throughout their routine visits to providers, and information and themes from these visits will then be explored in the monthly quality meetings.

xii. Services will take part in a **Responsive Quality Review** where concerns arise This may result in ongoing Quality Support meetings at an agreed frequency and for an agreed duration. The nature and intensity of the review will be determined by the gravity of the concerns raised – see section 3.5 for further details.

xiii. The Provider Collaborative have agreed a process for **Escalation, briefing, dispute resolution and arbitration,** where quality concerns or clinical complexity arise. This includes adverse media events or those that are likely to attract media attention. It also details how the CPaQT can escalate to the Lead Provider Executive Team and/or NHSE/I where necessary. See Appendix 9 for the document.

3.5 Support and Oversight Levels and Matrix

There are four levels of *Support and Oversight:*

1. Routine
2. Routine Plus
3. Enhanced
4. Enhanced Plus

As can be seen in Table 3 each of the Support and Oversight levels has parameters in terms of how swift and intense the system response needs to be to any concerns.

To determine which of the four levels is most proportionate, a *Quality Response Matrix* will be used as seen in Table 4. The matrix outlines the likelihood and the impact of any potential harm related to the quality concerns raised. There is guidance in Appendix 10 to determine the likelihood the consequence of potential harm form quality concerns. For ease and parsimony, the matrix parallels the risk registers held in the Provider Collaborative governance.

Table 3: Support and Oversight: to be used to guide response to any quality concerns raised

Support and Oversight Level	Routine	Routine Plus	Enhanced	Enhanced Plus
In response to	No/Low Level Quality Concern(s)	Moderate level Quality Concern(s)	High level Quality Concern(s)	Severe level Quality Concern(s)
Possible ICB response	-	-	*Enhanced quality assurance and support for improvement*	*Intensive quality assurance and support for improvement*
Support and oversight	• 6-8 weekly reviews by case managers • Seclusion reviews • MDT attendance, CPA and professionals' meetings, CTRs, CETRs • Monthly Quality and Contract Review Meetings • Six monthly CPaQT visit • Annual Quality Reviews	**As Level 1 plus:** • Responsive Quality Review by case managers and contact with staff, service users and carers **within 7 days** • Ongoing Quality Support meetings at agreed frequency • Contact with CQC inspectors • Additional Information Requests	**As Level 2 plus:** • Responsive Quality Visit by case managers within **2 days** of alert – including contact with staff, service users and carers	**As Level 3 plus:** • Responsive Quality Visit by case managers within **24 hours** of alert – including contact with staff, service users and carers • Communication via System Quality Improvement Board (in line with NQB guidance) in partnership with NHSE and ICS
Briefing and escalation expectations	• Case managers routine reporting to Quality Lead and via fortnightly CPaQT Quality meetings and line management/supervision • Quality Lead reporting to Service Workstream Groups, QA&QI Group and PCOG	As Level 1 plus: • Briefing and assurance by Quality Lead to CPaQT Clinical Director and Programme Lead **within 24 hours** of change to Level 2 • CQC notified **within 48 hours**	As Level 2 plus: • Briefing to PCOG chair, relevant Collaborative Committee members and NHSE **within 24 hours** of change to Level 3 • Briefing and invitation of involvement to CQC, NHSE and ICS quality representatives urgently **within 24 hours** of notification	As Level 3 • Contact with NHSE Regional colleagues **within 24 hours** of escalation • Meeting with NHSE Regional Colleagues **within 2 days** of escalation • Liaison with HNY ICB • Adhere to national guidance on Quality Risk Response and Escalation in Integrated Care Systems (June 2022)

Table 4: Quality Response Matrix: to be used to determine Support and Oversight Level

			IMPACT OF QUALITY ISSUE(S)				
			Negligible	Minor	Moderate	Severe	Catastrophic
			1	2	3	4	5
LIKLIEHOOD OF HARM OF QUALITY ISSUE(S)	Almost Certain	5	5 x 1 = 5 Routine Plus	5 x 2 = 10 Enhanced	5 x 3 = 15 Enhanced Plus	5 x 4 = 20 Enhanced Plus	5 x 5 = 25 Enhanced Plus
	Likely	4	4 x 1 = 4 Routine Plus	4 x 2 = 8 Enhanced	4 x 3 = 12 Enhanced	4 x 4 = 16 Enhanced Plus	4 x 5 = 20 Enhanced Plus
	Possible	3	3 x 1 = 3 Routine	3 x 2 = 6 Routine Plus	3 x 3 = 9 Enhanced	3 x 4 = 12 Enhanced	3 x 5 = 15 Enhanced Plus
	Unlikely	2	2 x 1 = 2 Routine	2 x 2 = 4 Routine Plus	2 x 3 = 6 Routine Plus	2 x 4 = 8 Enhanced	2 x 5 = 10 Enhanced
	Rare	1	1 x 1 = 1 Routine	1 x 2 = 2 Routine	1 x 3 = 3 Routine	1 x 4 = 4 Routine Plus	1 x 5 = 5 Routine Plus

The CPaQT, with support and involvement from the wider system, will gather information from a range of sources to discuss with providers in determining the Support and Oversight Level. It will also consider sources of assurance and mitigating factors, or any gaps in these. The data used to make decisions can be seen below in Figure 3, with specific considerations in Table 5 below.

Figure 3 Data to triangulate to inform response level

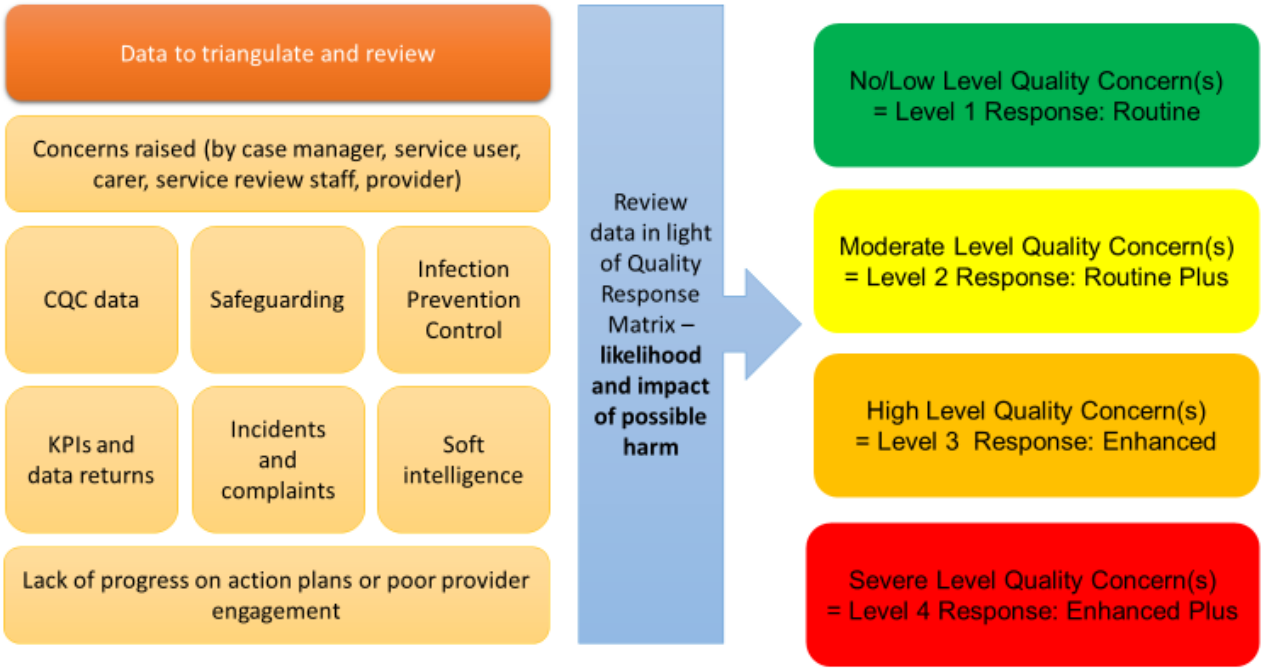


Table 5: Specific considerations for each area of data

Data type	Consideration
CQC data	• Rating from CQC and date of last inspection • Content of CQC reports • Any restrictions in place • Information from liaison with CQC inspector
Safeguarding	• Levels of reporting • Concerns or strengths in safeguarding practice • Concerns or strengths in reporting • No of Section 42 • No of strategy meetings • Whistleblowing reports
Infection Prevention & Control	• Levels of IPC training • Nature of IPC policies and practices • No of outbreaks and provider response • IPC measures in place
KPIs and data returns	• Patterns of data and/or exceptions

Incidents and complaints	• Never events and STEIS reportable incidents • Concerns or strengths in reporting • Concerns or strengths in provider response to incidents or complaints • No of upheld complaints • Systems for learning from incidents and complaints
Soft intelligence	• Reports from staff, service users, families/carers or other stakeholders • Case manager reports form reviews and observations • Reporting from placing and hosting Provider Collaboratives • Reporting on historic information from NHSE and CQC
Provider engagement	• Indicators of open or closed culture and engaging with quality assurance processes • Open to visits, learning and feedback / dialogue • Evidence of progress and embedding meaningful change and continuous improvement
External reviews	• Outcomes and feedback from reviews

The ongoing gathering and reviewing of information between Providers, CPaQT and wider stakeholders will guide changes to the Support and Oversight Level. This support and oversight may take a range of forms including those outlined in Section 3.3 and 3.4.

Where concerns have emerged, ongoing assurance of sustained improvement would likely lead to a move into a lower level of oversight and support from CPaQT and a change in level. Where there are escalating concerns or progress is lacking, then a higher level and increased support and oversight from CPaQT may be required. There will be open discussion, collaboration and transparency from CPaQT throughout.

3.6 System learning and transparency across the Collaborative

Throughout all assurance processes there will be ongoing discussion and negotiation between provider and CPaQT about joint communication with partners and system responses and support to any issues, where necessary and/or appropriate. Moreover, discussions will be had to consider how learning can be distributed across the system via the quality assurance and improvement group.

4 Appendices

Appendix Number	Attached Documents
4.01 Appendix 1: Provider Collaborative Oversight Group Terms of Reference	 PCOG ToR Updated 2024.pdf
4.02 Appendix 2: Collaborative Committee Terms of Reference	 CC ToR updated 2024.pdf
4.03 Appendix 3: Quality Assurance and Improvement Group Terms of Reference	 QAQI ToRS V4 Dec 23.pdf
4.04 Appendix 4: Provider Collaborative Patient Safety and Learning Group Terms of Reference	 Patient Safety and Learning Group ToR  PSIRF Provider Implementation Sup
4.05 Appendix 5: Service Work Streams Terms of Reference	 AED workstream ToR Nov 23.pdf  AS workstream ToR Jan 24.pdf  CAMHS workstream ToR Nov 23.pdf
4.06 Appendix 6: Risk and Gain Share Finance Group Terms of Reference	 Risk & Gain Share ToR Feb 24.pdf
4.07 Appendix 7: Agenda for CPaQT meetings	 CPaQT Team meeting Agenda.pd  Quality Assurance Team meeting Agen
4.08 Appendix 8: Annual Quality Review Template	 Annual Quality visist template for se
4.09 Appendix 9: Escalation, briefing, dispute resolution and arbitration document	 Escal briefing dispute resolution a
4.10 Appendix 10: Quality Response Matrix guidance	 Quality Response Matrix guidance HC'