Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

AGENDA FOR THE SPECIAL MEETING OF THE BOARD OF DIRECTORS
TUESDAY 15TH DECEMBER 2015
VENUE: THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 9.30 A.M.

Apologies for Absence

Standard Items (9.30 am)

Item 1	Declarations of Interest.		
Item 2	Chairman's Report.	**Chairman**	**Verbal**
Item 3	To consider any issues raised by Governors.	**Board**	**Verbal**

Quality Items (9.40 am)

Item 4	To consider the report of the Quality Assurance Committee.	**HG/EM**	**Attached**
Item 5	To consider the "Hard Truths" Nurse Staffing update report.	**EM**	**Attached**
Item 6	To consider the annual report on Medical Education.	**NL**	**Attached**
Item 7	To consider a report on the Trust's Culture Metrics.	**DL**	**Attached**
Item 8	To approve an increase in the frequency of Directors' visits from bi-monthly to monthly.	**MB**	**Verbal**

Governance (10.20 am)

Item 9	To approve changes to the Integrated Governance Framework.	**PB**	**Attached**

Items for Information (10.30 am)

Item 10 To note that the next meeting of the Board of Directors will be held in public on **Tuesday 26th January 2016** in The Durham Centre, Belmont Industrial Estate, Durham, DH1 1TN at 9.30 am.

Confidential Motion (10.35 am)

Item 11 **The Chairman to move:**

"That representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below:

Information relating to any particular applicant for, or recipient or former recipient of, any service provided by the Trust.

Information relating to the financial or business affairs of any particular person (other than the Trust).

Information which, if published would, or be likely to, inhibit -
(a) the free and frank provision of advice, or
(b) the free and frank exchange of views for the purposes of deliberation, or
(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs."

(Note: Please note that the monthly Finance and Performance Dashboard Reports will be provided to Board Members outside the meeting)

Mrs. Lesley Bessant
Chairman
9th December 2015

Contact: Phil Bellas, Trust Secretary Tel: 01325 552312/Email: p.bellas@nhs.net

FOR GENERAL RELEASE

Board of Directors

DATE:	**15 December 2015**
TITLE:	**To receive the assurance report of the Quality Assurance Committee**
REPORT OF:	**Dr Hugh Griffiths, Chairman, Quality Assurance Committee**
REPORT FOR:	**Assurance**

This report supports the achievement of the following Strategic Goals:	
To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing	✓
To continuously improve the quality and value of our work	✓
To recruit, develop and retain a skilled, compassionate and motivated workforce	
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve.	✓

Executive Summary:

The purpose of this report is to update the Board of Directors on the current key areas of concern and to provide assurance on reports considered by the Quality Assurance Committee.

Recommendations:

That the Board of Directors receive and note the report of the Quality Assurance Committee from its meeting held on 3 December 2015.

BOARD OF DIRECTORS

Date of meeting **Tuesday 15 December 2015**

Title: **To consider the report of the Quality Assurance Committee**

1. INTRODUCTION & PURPOSE

The purpose of this report is to advise the Board of Directors of the key issues, concerns, risks, exceptions and the mitigating actions in place to address these, together with assurances given, considered by the Quality Assurance Committee, at its meeting on 01 October 2015.

2. BACKGROUND INFORMATION AND CONTEXT

This report makes reference to the regular assurance reports from the clinical governance infrastructure, which includes the Locality Management and Governance Boards, together with the corporate assurance working groups of the Quality Assurance Committee, including progress reports of the Quality Account. Monthly compliance with the Care Quality Commission regulatory standards, with assurance reports to support the regulatory standards is also considered.

3. KEY ISSUES

The Committee received the bi-monthly updates from the Locality Directors of Operations around the principle risks and concerns, together with assurances and progress from Durham and Darlington and Tees localities.

3.1 Durham and Darlington LMGB – where key issues raised were:

1. The Financial position in the locality, which was reporting a forecast financial deficit of £2,022k up to 31 March 2016. The key matters underlying this were flexible staffing, use of agency staff - predominantly for medical staff, the historical un-delivery of CRES and some non-staff spend, including prescribing.
   Clinical Directors and Heads of Services were working on an agreed set of management actions, which had been reviewed by the Chief Executive and Director of Finance. This is being monitored closely.

2. CRES – Directorates had been looking at emerging CRES schemes for 2016/17 to prevent an adverse impact on the quality of service provision.

3. Provision of LD beds – the locality had considered plans and trajectories developed through the Transforming Care programme on the reduction of beds and the impact this would have on Durham and Darlington. The Directorate would be working closely with the Crisis Recovery House to support out of hours emergencies.

3.2 Tees LMGB – where key issues raised were:

1. Implications of the LD transformation. CCGs were currently meeting to discuss future bed requirements and until these details were known action plans could not be put into place.

2. Availability of nursing homes for patients with dementia. There had been a further recent closure of a 44 bedded nursing home and there was a lack of nursing home availability for patients with dementia.
3. Legacy cases in North Tees of patients who may have been wrongly diagnosed with ADHD. A complaint about late identification of this condition and misdiagnosis had been upheld.

   (i) There were approximately 2000 adults/children from North Tees area that this involved.
   (ii) The Committee were informed that diagnosis of ADHD is a complex area and that cognitive testing and ADHD diagnosis were subjective. In addition, some young people who may have correctly been diagnosed with ADHD may no longer have that diagnosis by virtue of age and their development. The committee was assured however any children known to services with ADHD would be re-tested if required.

4. QUALITY STRATEGY SCORECARD

1. The reporting of the Quality Strategy Scorecards would be reported in future from the Quality Governance Directorate.
2. Following feedback from the Board of Directors the indicators had been decreased from 26 to 18.
3. Work was underway with Sub Groups in order to revise the metrics of the Scorecards further, which currently showed a majority status of 'red' and a report would come back to QuAC in February 2016 with some suggested amendments.

4. The number of serious incidents at the end of November 2015 had exceeded the figure reported for the overall year of 2014/15, with the actual position at 20.61, (112 incidents per average monthly caseload of 54347) against a target of 14.15. Further work is required to be undertaken with regard to the presentation of this data and category of incidents in order to draw conclusions from this information.

5. It was reassuring to note that even though the number of serious incidents had gone up, there were no high level consistent themes and trends. Some comparative work and benchmarking would be undertaken retrospectively at the end of the financial year to compare the Trust with the national picture.

   On this matter assurance was given to the Committee that there had been marked improvement around the data quality over recent months and effective training had led to more rigorous and consistent categorisation of the data.

5 QUALITY ASSURANCE - EXCEPTIONS/ASSURANCE REPORTS FROM SUB-GROUPS OF THE COMMITTEE

The Committee received key assurance and exception reports from standing Sub-Groups of the Committee, highlighting any risks and concerns.

5.1 Clinical Effectiveness Group

1. There were 173 scheduled clinical audits for the 2015/16 programme, 96 of these were re-audits with 52 complete, 64 ongoing and 6 behind schedule.
2. There were 20 outstanding action points, (more than 31 days overdue) from 12 action plans from the completed programmed clinical audit activities.
3. The Clinical Effectiveness Group report would be replaced with one quarterly Clinical Audit and Effectiveness Report, which would include an exception report.

5.2 Patient Safety Group Report

1. There had been a long discussion at the recent Patient Safety Group meeting around Datix, ongoing issues and incident reporting and whether the system should be configured to allow multiple categories for incidents, when necessary.
2. The information received from York and Selby on serious incident actions plans would be reviewed.
   On this matter it was noted that it was too early to make a view on the quality of work around serious incidents from York and Selby.
3. Outstanding actions and progress updates around Trust wide incidents would continue to be actively followed up with operational services, with monitoring and escalation to EMT where necessary.
4. The monthly Patient Safety Bulletin would continue in the format of a 1 page summary approved by the Patient Safety Group - this would highlight key learning messages and to lessons learnt immediately from any incidents that had occurred.

Some further work and communication was needed on the Trust protocol around the Duty of Candour, to ensure a consistent and timely approach.

5.3 Patient Experience Group Report

There had been a lot of discussion at the Patient Experience Group around patients reporting ‘not feeling safe’, which had declined in recent months and had been highlighted in the free text on national community surveys. Feedback received from the wards reported individual patients causing disruption. Staff were being asked to think about what steps they were taking to ensure the safety of others around them when these instances occurred and this important matter would be picked up and continue to be monitored in future meetings.

5.4 Safeguarding Children and Adults

1. The service level agreement for NY would end on 31 December 2015.
2. Work was underway to look at the services in York to establish the need and demand around Safeguarding.
3. Demand is increasing with regard to Multi-agency risk Assessment Conference (MARAC) participation.
4. Female genital mutilation would now be reported as a national requirement and would go through the Safeguarding Team.

6. COMPLIANCE/PERFORMANCE – EXCEPTION/ASSURANCE REPORTS

6.1 Compliance with CQC Registration Requirements, including Mental Health Act visit feedback summary report.

1. The CQC would re-visit Bootham Park on 7 December 2015 to inspect the 136 suite in order to approve the application to register the 136 suite, with a view to opening services from 16 December 2015.
2. Following a CQC inspection in January 2015, it had been highlighted to Ofsted the potential need for the Trust to register the Holly Unit, West Park Hospital as a children's home.
   This was due to the fact that the unit was operating as a short break facility for children with learning disabilities or complex health needs with challenging behaviour. This requirement also affected Baysdale Unit at Roseberry Park.
3. There had been 7 MHA inspections and various associated monitoring reports had been received with action plans put into place.
   On this matter it was pleasing to note that 2 of the reports had resulted in no further actions to address, at both White Horse View, Easingwold and Roseberry Ward, Lanchester Road.
4. The seclusion room at Westwood, West Lane Hospital had been repaired to a safe standard.
5. The review of Bootham Park had been commissioned by Margaret Kitching, Chief Nursing Officer of the North of England, following concerns raised at the Overview and Scrutiny Committee.

6.2 Patient Safety Benchmarking Data

1. The information set out in the report had been requested by QuAC to look at comparative data, primarily for patient safety incidents relating to service users that had died.
2. The information from October 2012 to March 2015 had been obtained from the National Reporting and Learning System (NRLS).
3. The Trust had been consistently reporting a higher than average percentage of incidents when the results in 'no harm' and a lower than average percentage of incidents resulting in 'low harm'
4. The central approval team were looking more closely at what this data meant for the Trust.
5. It would be useful to provide some benchmarking data against other Mental Health Trusts of a similar size.

7. IMPLICATIONS

7.1 Quality

One of the key objectives within the QuAC terms of reference is to provide assurance to the Board of Directors that the organisation is discharging its duty of quality in compliance with section 18 of the Health Act 1999. This is evidenced by the quality assurance and exception reports provided, with key priorities for development and actions around any risks clearly defined.

7.2 Financial/value for money

There were no direct financial implications arising from the agenda items discussed.

7.3 Legal and Constitutional (including the NHS Constitution)

The terms of reference, reviewed annually, outline compliance requirements that are addressed by the Quality Assurance Committee.

7.4 Equality and Diversity

The Committee receives quarterly assurance reports from working groups, one of which is the Equality and Diversity Steering Group.

8. CONCLUSIONS

The Quality Assurance Committee received and approved all the corporate assurance and performance reports that were considered.
All risks highlighted were being addressed with proposed mitigation plans or where they were currently being managed, additional information and assurances were requested.

9. RECOMMENDATIONS

That the Board of Directors note the issues raised at the QuAC meeting and the confirmed minutes of the meeting held on 8 October 2015, (appendix 1).

Jennifer Illingworth
Director of Quality Governance

Appendix 1

Item 1

MINUTES OF THE MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 1 OCTOBER 2015, IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 2PM

Present:
Mr Richard Simpson, Acting Chairman
Mrs Lesley Bessant, Chairman of the Trust
Mr Brent Kilmurray, Chief Operating Officer
Dr Nick Land, Medical Director
Mrs Elizabeth Moody, Director of Nursing & Governance
Mr David Jennings, Non-Executive Director

In attendance:
Mrs Karen Agar, Associate Director of Nursing and Governance, (for minutes)
Mrs Karen Atkinson, Head of Nursing
Mr Louis Bell, Back care Advisor, Quality and Risk,(for minute 15/175)
Dr Lenny Cornwall, Deputy Medical Director for Teesside
Mr Stephen Davison, Force Reduction Project Manager, (for minute 15/176)
Mrs Jo Dawson, Acting Director of Operations, Durham & Darlington, (for minute 15/164)
Miss Alexia Hardy, Project Manager, Quality & Risk, (for minute 15/167)
Mrs Jennifer Illingworth, Director of Quality Governance, (for minutes 15/166 & 15/168)
Mr Mark Lovell, Consultant Psychiatrist - Children & Young People Services (CYPS)
Ms Christine McCann, Associate Director of Nursing
Mrs Donna Oliver, Deputy Trust Secretary
Dr Ingrid Whitton, Deputy Medical Director (for minute 15/169)

Andrew Ellis, Jacqueline Sibanda, Jessica Shaw, Wallis Stabler and Lianne Savage - Students, University of Teesside.

15/161 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr Martin Barkley, Chief Executive, Mrs Barbara Matthews, Non-Executive Director, Mr Jim Tucker, Non-Executive Director and Dr Hugh Griffiths, Chairman of the Committee.

15/162 MINUTES OF PREVIOUS MEETING

Agreed – that the minutes of the meeting held on 3 September 2015 be approved and signed by the Chairman of the Committee, subject to the following amendments:
(i) *Mr Richard Simpson, be added to those in attendance.*
(ii) *15/151, Patient Safety and Patient Experience Data Report. The next report would be presented to the* ***November 2015*** *QuAC meeting.*

15/163 ACTION LOG

The Committee updated the QuAC Action Log, taking into account relevant reports provided to the meeting.

The following updates were noted:

15/55 "Assurance measures and KPIs to be developed for the Physical Healthcare and Wellbeing Working group"
This matter was covered in minute 15/167.

Completed

15/81 "The Force Reduction Report would come back to QuAC every 6 months"
This matter was covered in minute 15/176.

Completed

15/114 "Update on 'off the record' discussions with other providers to check if the Trust was an outlier".

Completed

15/115 "Locality reports to include the top 3 concerns and assurances around these".
The locality reports now included this information.

Completed

15/117 "Clinical Effectiveness Report to include more information around levels of assurance as well as information".
This matter was covered under minute 15/166.

Completed

15/125 "Workforce Staffing Report to go to QuAC quarterly, with the first report focusing on recruitment and retention".
This matter was covered under minute 15/174.

Completed

15/136 "Report to go to Board of Directors detailing the current position for Children's Services in North Yorkshire".
Mrs Coulthard would be taking a report to the October 2015 Board of Directors meeting on this matter.

Completed

15/140 "Clinical Effectiveness Group reports to include clear statement position at the beginning of the report and appendices to be presented in a different format".

Completed

15/141 "Patient Safety Group Report – explanation required around the 96 outstanding Datix.
This matter was covered under minute 15/168.

Completed

15/142 "Investigate the spike in complaints received by AMH (54)".
Mrs Whitton reported that there were no specific issues to report in relation to this spike in complaints.

Completed

15/143 "Carer Support Strategy"
Further work would be needed to scope out the correct strategy and metrics for a Carer Support Strategy, along with leadership and milestones and an update would come back to QuAC in March 2016.

15/144 "Any correlation between the outbreak of D&V on Springwood and the nil return of audits for 2 months".
It had been confirmed by email following the October 2015 QuAC meeting, that there had been no essential steps data submitted for April and May 2015 from Springwood Malton and the outbreak of D&V occurred in May 2015.
The IPC team would be conducting a further audit at Springwood on 8 October 2015 and the Modern Matron for the service would be informed. The outcome of this would then go to the Infection Prevention and Control Committee on 20 October 2015.

15/145 "Procedures – further discussion around the terms of reference for QuAC and the approval of clinical policies".
The outcome of these discussions would come back to the QuAC meeting in December 2015.

15/149 "CQC Compliance – discussion required at Board of Directors meeting in September 2015 around Bootham Park".

Completed

15/156 "Quarterly Force Reduction Report to be presented to October 2015 QuAC".
This was reported under minute 15/176.

Completed

15/164 DURHAM & DARLINGTON LMGB ASSURANCE/EXCEPTION REPORT

The Committee received and noted the Durham & Darlington Services LMGB Governance report.

Mrs Dawson highlighted the top 3 concerns at present, which were:

4. A difficult and challenging complainant from a community team, which had included the use of social media and threatening language directed at members of staff by name. The police had been involved.
   On this matter it was noted that things had settled down, however this had taken up a considerable amount of time and energy for staff.

5. The demand for services across CYPS and AMH. There were actions in place to address this, including discussions with Commissioners.
6. Recruitment continued to be a challenge, in particular for C&YPS Band 6 posts and an ED Community consultant.

Arising from the report it was noted that:

(a) Fast track plans for the implementation of Transforming Care were currently underway, looking
    at local plans and contingency services that would be needed in the community.
(b) There had been a very positive MHA review on Birch Ward, on 20 August 2015, with some positive feedback from patients.
(c) The crisis team had effectively dealt with some recent challenges, including a patient that had turned up to services in the early hours of the morning.
(d) There had been a case in the press recently regarding an NHS homicide review of a patient charged with the death of a lady in a home of residence.

(e) Care Plan scrutiny had revealed that 78 out of 166 patient records had been reviewed, however not in the previous 12 months and 22 of these records had no Care Plans, with only 50% including a Risk Assessment.

On this matter it was noted that there had been some further exploratory work undertaken by the service to check the validity of the data.

Following discussions it was noted that:

(i) Recruitment initiatives for CAMHS services in Peterlee for Band 5 and 6 posts were currently out to advert to recruit to vacant and temporary additional posts, with some re-training also being considered.
On this matter it was noted that some work was underway to look at how posts could be made more attractive for the future.

(ii) There was currently an issue in relation to a mismatch between those staff that had undertaken Safeguarding children training and methods of data collection. The data would be unpicked, as it was anticipated that the levels of compliance with this training was much higher.

(iii) There were currently delays for patients securing wheelchairs as there were pressures on the adaptation services.
The Trust Occupational Therapy lead was working actively with community services to try and come up with some solutions.

(iv) Training around Paris version 6 now included Clinicians in order to help with implementation and further support would be given to services, where staff would be guided in using Paris to ensure learning of the adaptations.

(v) Covert medication had been raised as an issue following a MHA report at Ceddesfeld MHSOP services.
This had been an isolated incident, which was disappointing; however an action plan had been developed.

15/165 TEES LMGB ASSURANCE/EXCEPTION REPORT

The Committee received and noted the Tees Locality Governance Report.

Dr Cornwall highlighted that the top 3 concerns at present were:

1. Capacity and demand – There were increased referrals to both access and affective services, particularly in SouthTees after TEWV had ceased the IAPT services at the end of June 2015.
Current activity levels would be compared with future demands and discussed with Commissioners. On this matter it was noted that some staff might have to be re-deployed.

2. Issues with access to EMI nursing beds due to long waiting lists in Hartlepool and the impact on MHSOP services. There were currently 2 EMI nursing homes closed to admissions; however 1 was expected to re-open shortly.

3. There had been significant improvement in waiting times in Stockton, however the key issue would be around sustaining these improvements with demand.

Following discussion it was noted that:

(a) There had been a collective grievance submitted from staff at Roseberry Park concerning staff breaks.

On this matter it was noted that this had now been dealt with and new rest break guidance had been issued to staff, this had been agreed at EMT, however had not been agreed with Staff Side. A proposal had been put forward that nurses could take a break away from the main clinical area or just off the Ward, whilst maintaining responsibility for the keys.

(b) There had been pressures on Westerdale South, due to vacancies and sickness.

Mrs Bessant suggested that more work should be done to address staff fatigue and this should be re-visited. Mrs Atkinson, Head of Nursing would be supporting staff going forward.

(c) The health quality framework, which was 100 pages in length, for proposed outcome measures would be reduced to a more practical size.
(d) The inpatient work from Bootham Park had effectively been absorbed by TEWV, which clearly demonstrated the hard work and commitment of staff, which should be recognised.
(e) The Trust had scored lowest in England regarding levels of "paired measure completion and consent being confirmed on Paris"
This related to Children's IAPT services and the impact on data. Paris would be checked to ensure there would be no further duplication.
(f) It was anticipated that the imminent plans to close the steel works on Teesside would have some impact on services, which would be absorbed in the normal workload in IAPT services.
(g) There had been a deterioration in resuscitation following some new guidelines and changes to training.

15/166 CLINICAL EFFECTIVENESS GROUP ASSURANCE REPORT

The Committee received and noted the Clinical Effectiveness Group Assurance Report for August 2015.

It was highlighted from the report that Baseline audits had revealed low compliance with recording the 6 physical healthcare parameters, which were a requirement of the Lester tool and would be monitored as part of the national audit in December 2015 for CQUIN 4a. The extensive Physical Healthcare Project would continue across the Trust and Specialties would facilitate clinical actions to mitigate identified risks.

Arising from discussion it was noted that:

(a) There were currently discussions underway around an effective strategic framework for monitoring NICE guidelines in the Trust.
(b) Items 4 and 6 in the report around strategic objective scorecard progress and monitoring of key performance indicators should include narrative and explanation to provide more assurance.
On this matter the Committee were assured that any matters not resolved would be brought back to QuAC for further consideration.

15/167 PHYSICAL HEALTH CARE AND WELLBEING REPORT

The Committee received and noted the Physical Healthcare and Wellbeing Group report for the period April to August 2015.

Arising from the report it was noted that:

1. One of the issues raised at the quarterly Physical Healthcare and Wellbeing Group was the need to develop an SBARD around an agreed data set for taking patient blood tests on admission to ensure standardisation.
2. The Procedures around the Early Detection and Management of the Deteriorating Patient had been updated.
3. Following recommendation by QuAC in April 2015 consideration had been given to developing some KPIs for the Physical Healthcare and Wellbeing Group; however it was not felt that this would be appropriate for this particular Sub group of the Quality Assurance Committee.

On this matter it was noted that:

(a) A review of this group, along with other Sub-groups of QuAC had commenced and would take place over the autumn months of 2015, with an anticipated outcome intended for December 2015/January 2016. It would be important to refresh the purpose of the Sub-groups in accordance with governance regulations, in order that they could report through and give assurance to the Committee.
(b) Consideration and debate had been given to the complexity in the detail around levels of assurance and providing 'safe' care for patients.

Following discussion it was noted that:

(h) With around 300 incidents reported onto Datix per month, it would be important to ensure that trends were examined, supportive action plans were in place and that lessons were being learned and shared.
(i) The guidance for the Trust set out in the key lines of enquiry provided definition around what is meant by 'safe' and well led and this would be the starting point for defining the Sub-groups.

15/168 PATIENT SAFETY GROUP ASSURANCE REPORT

The Committee considered and noted the report of the Patient Safety Group from the period August to September 2015.

Arising from the report it was highlighted that:

5. There were currently major changes taking place to the Datix system to improve the ability to give assurance and for analysis of any patterns and trends.
6. Following discussion by the Group to resolve outstanding Datix the Director of Quality Governance would be taking any issues to OMT with an up to date position provided by the Quality Team.
7. All outstanding incidents on Datix had now been cleared and the focus would be on monitoring the actions in place.
8. There was ongoing debate around SUIs and the need for clear and concise information to be entered onto Paris. All incidental findings would be reviewed by the Head of Nursing in localities to identify any patterns, which would be fed into Trust wide quality improvement work.
9. KPIs would now be managed within the Quality Data Team; however there was some question as to whether these were still the appropriate indicators to use.
10. The Patient Safety Bulletin, September 2015 had been included with the report, setting out incidents of patients care, (themes) and messages from lessons learned.

This would be reviewed regularly to provide the current set of themes and messages, intended to change behaviours and improve patient care.

11. There would now be a separate allegation stream within the Datix system. This would prevent it being reported to NRLS or IIC until it became a proven incident.

Following discussion it was noted that the Patient Safety bulletin had been well received by the Committee. Members had found it to be very informative, especially since challenging issues around Westwood had been picked up.

15/169 PATIENT EXPERIENCE GROUP ASSURANCE REPORT

The Committee received and noted the Patient Experience Group Assurance Report for the period 18 August to 18 September 2015.

Arising from the report it was highlighted that:

1. The outstanding actions around complaints had steadily decreased, with no overdue outstanding action plans in September 2015. 1 overdue complaint in Durham was currently being resolved by the Complaints Manager.
2. All Wards had achieved 100% Friends and Family results for 2 consecutive months, 5 CMHTs had achieved 100% and 1 at 90%.

15/170 SAFEGUARDING CHILDREN EXCEPTION AND ASSURANCE REPORT

Mrs Agar provided a verbal update around Safeguarding Children.

There were 5 ongoing serious case reviews that the Trust was involved in, 3 in Redcar around sexual exploitation and 2 in Durham, 1 which was almost complete involving the crisis team and a young baby.

A 'Review of health services for Children Looked After and Safeguarding in Middlesbrough' had been published on 15 September 2015 with a recommendation for TEWV and the CCG, which was to ensure that early help services for children requiring access to Tier 1 and 2 services for emotional health and well-being were strengthened'.
On this matter it was noted that CAMHS had submitted their action plan and good evidence had been found around multi-agency working, with positive feedback around adult mental health services.

15/171 SAFEGUARDING ADULTS ASSURANCE REPORT

Mrs Agar provided a verbal update on safeguarding adult issues:

The incident in Hartlepool involving 2 young girls and a vulnerable adult had been delayed to February 2016, due to social media issues around the trial.
For the teams working to support adults and children the workload had been increasing around domestic abuse, together with a large number of individuals known to the Trust that were reported on.

15/172 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS

The Committee considered and noted the position of compliance with Care Quality Commission registration requirements.

Arising from the report it was highlighted that:

1. The Trust awaited the full report following the CQC compliance inspection at Bootham Park, however there had been concerns identified around safety and environmental issues and patients had subsequently been moved to other Hospitals.
2. The formal agreement from the CQC had been received to register application for 7 services in the Vale of York, (except Bootham Park).
3. The report included a Mental Health Act Bulletin setting out specific topics around physical healthcare, medicines management and bed management.
4. There were ongoing CQC regulation breaches in connection with mixed sex accommodation at Acomb Garth, AMH rehabilitation Ward in York and Selby. Plans were in place to address these environmental issues, which also included ligature points.
5. A publication had been issued for consultation seeking views on the new 'National Guardian for the NHS', which the Trust would respond to in due course.

Following discussion it was noted that there had been some excellent feedback in recent MHA reports and staff should to be commended on their hard work.
On this matter it was noted that staff were emailed any positive feedback and some staff put forward for team of the week award.

15/173 FUNDAMENTAL STANDARDS PATIENT AND CARER GROUP REPORT

The Committee considered and noted the Fundamental Standards Patient and Carer Reference Group.

From the report it was highlighted that the programme of mock inspections had continued and members of the Group had been included in the inspections.

15/174 WORKFORCE STAFFING REPORT (RECRUITMENT & RETENTION)

The Committee considered and noted the Workforce Staffing Report focusing on recruitment and retention.

The report included a covering paper with 3 appendices, which were:

(1) The recruitment and retention report.
(2) Springwood Workforce Information.
(3) The medical staffing report for the period 1 April to 31 August 2015.

Mr Levy drew attention to the following from the report:

(a) Recruitment of nurses was an ongoing issue for the Trust. The number of newly qualified registered nurses appointed in the reporting period had fallen by 31% and further work would be undertaken to understand the impact on services.

    On this matter it was noted that between August 2014 to July 2015, 5 advertisements for staff nurses had resulted in 4 of the appointments not being made. Private Healthcare providers located in the York area were competitors for nursing vacancies and the messages coming into the Trust were that York offered an attractive working environment for nurses.

(b) A nurse recruitment plan for York services would be developed following the transfer of these services to TEWV.
(c) The Trust did not believe that paying recruitment and retention premiums for nurses should be pursued at the present time.

(d) It was recognised that International recruitment of nurses was proving difficult for Acute Trusts to gain sponsorship, however should recruitment prove increasingly difficult for TEWV then this would be considered.
(e) A publication 'Mind the Gap' highlighted the expectations of new nurses and the Trust would need to respond to these in order to recruit and retain nurses in the future.
It was clear that nurses expected more work life balance, with job sharing and flexible working and at the present time 30% of the Trust workforce was working part time hours.

Following discussion it was noted that:

(i) The Trust would work towards a nursing recruitment strategy, taking into account career frameworks, in partnership with local Universities.
(ii) A centralised recruitment process would enable the Trust to appoint people that had been interviewed on a "call off list".
(iii) Over appointing and employing 2 suitable candidates from 1 interview round would support the overall recruitment problems.
(iv) The nursing recruitment project would be discussed further with Nursing and Governance

Action: Mrs C McCann/Mr D Levy

15/175 MEDICAL DEVICES COMMITTEE REPORT

The Committee considered and noted the Medical Devices and Clinical Procedures Working Group for the period January to May 2015.

It was highlighted from the report that:

(1) SBARDS had been issued in relation to using needles and recording medication details in Care Records.
(2) Safer sharps would now have to be ordered through Cardea.
(3) A recent audit had identified that quality control checks in relation to the blood monitoring audit tool were not being completed. In response to this all in patient areas would be audited against the audit tool and the Infection Prevention and Control Nurses (IPCNs) would carry out validation checks as and when necessary for 2015/16.
(4) Audit North had completed the planned audit of medical devices management and the final report would be discussed at the Medical Devices Committee meeting in October 2015.

15/176 QUARTERLY FORCE REDUCTION REPORT

The Committee considered and noted the Force Reduction Project report.

It was highlighted from the report that:

(1) The project overall, whilst being challenging in some areas, had remained on track and was progressing well.
(2) Some tweaks had been made to the application of the project in Westwood, with more intense support for staff due to the complexity of patient care. This had given a better understanding of the depth of the issues that surround this work.

(3) Implementation of the original objectives had seen some positive results in the reduction of C&R in pilot areas where PBS and Safe wards had been introduced. Regular and transparent reporting was now also in place.
(4) There was currently a review underway to look at training models and policy, which would be key priorities for the project team.
(5) It was pleasing to note that the project team had been invited to present at the European Conference for Restraint Reduction in November 2015.
(6) A key element of the Project would be about identifying the best standardised process of debriefing, both for staff and patients following the use of restrictive intervention.
A working group was currently developing a draft process on debriefing that could be used across services.

Further to discussions it was noted that it was difficult to establish any direct correlation between the statistics that demonstrated seclusion going up, rapid tranquilisation and restraint going down.
This was being monitored closely and compared to the national picture.

Agreed: To make some comparisons with pilot sites and similar types of wards elsewhere in order to interpret the data more meaningfully.

Action: Mr S Davison

15/177 EXCEPTION REPORTING (LMGBs, QAC sub groups)

There was nothing to note under this item.

15/178 ANY MATTERS ARISING TO BE ESCALATED TO THE BOARD OF DIRECTORS, AUDIT COMMITTEE, INVESTMENT COMMITTEE OR TO THE CLINICAL LEADERSHIP BOARD

The matter of recruitment should be escalated to the Board Planning Day.

15/179 ANY OTHER BUSINESS

There was no other business to note.

15/180 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 5 November 2015,
2.00pm – 5.00pm in the Board Room, West Park Hospital.
Email to Donna Oliver donnaoliver1@nhs.net
The meeting concluded at 4.45pm

……………………………………………………………………..

Dr Hugh Griffiths
CHAIRMAN
5 November 2015

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 6

FOR GENERAL RELEASE

Board of Directors

DATE:	**Tuesday 15th December 2015**
TITLE:	**Quality assurance of Medical Education in the Trust**
REPORT OF:	**Dr Nick Land, Medical Director**
REPORT FOR:	**Information**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing	✓
To continuously improve the quality and value of our work	✓
To recruit, develop and retain a skilled, compassionate and motivated workforce	✓
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	✓
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve.	✓

Executive Summary:

This annual Board update is intended to provide an overview of the medical education activity over the last twelve months and outline targets for the next year, with the aim of providing assurance of medical education activity in the Trust to Board members.

Recommendations:

That the Board note the content of this paper.

MEETING OF:	Board of Directors
DATE:	Tuesday 15th December 2015
TITLE:	Quality assurance of Medical Education in the Trust

1. BACKGROUND INFORMATION

1.1 With the acquisition of York and Selby locality, the Trust now has just over 150 junior doctor placements approved for training under the different medical programmes. These programmes include Foundation training, GP training, Core training and Higher training. The Trust also hosts medical students from four universities offering 364 placements annually;

1.2 Internal governance of medical education continues to take place through Psychiatry Specialist Training Committees (PSTCs) and these represent the four localities in the Trust and oversee the delivery of all educational programmes. The Medical Education Quality and Strategy Committee (MEQAS) meets quarterly and oversees the locality groups and sets out its strategic intentions for the Faculty. The Director of Medical Education provides assurance of activity at the monthly held Medical Directorate Management Meeting chaired by the Medical Director;

1.3 In early 2016, the structure for the Faculty of medical education will be reviewed. This will be two fold. Firstly to ensure we have the same governance arrangements in York and Selby as in other parts of the Trust and secondly to consider the existing Faculty Tutor roles and whether these should be modified in light of continuing changes to medical education and new GMC standards that govern our work;

1.4 The ongoing cycle of quality control continues a pace and the process used to provide assurance to external bodies is through the Self Assessment Report (SAR) and Quality Improvement Paper (QIP). These reports are shared with Health Education North East (HENE) and Health Education Yorkshire and the Humber (HEY&H) and they set out how we aim to meet the GMC domains for training;

1.5 This year we have had more external visits to quality assure the medical education programmes. This includes a GP Scheme ADQM and a School of Psychiatry ADQM within HENE. Panels from regional bodies visit the Trust to monitor progress and set actions that must be strictly followed. The Trust continues to receive excellent feedback from HENE and at the Annual Deanery Quality Management visits;

1.6 In October this year, the Medical Development team, in collaboration with the Faculty of Medical Education, submitted the 2015/16 QIP and SAR and have set some challenging targets. You may notice the LETB has changed the reporting framework and will use the new GMC Standards for Medical Education to be introduced from 2016.

Ref 1 : 2015/16 Quality Improvement Plan (QIP)
Ref 2 : 2015/16 Self-assessment Report (SAR);

1.7 As always, a number of surveys have been undertaken by medical students and junior doctors in the last twelve months and they have mainly demonstrated an ***exceptionally high level of training across our programmes***, especially so when comparing us to other providers in our region and to other Mental Health Trusts.

The highlights this year from the feedback received includes:

The Trust was ranked as number one in 9 of the 14 GMC indicators by our junior doctors when comparing TEWV against all other Trusts in the North East.

Ref 3 : HENE GMC Trainee Survey Trust Report

The Trust was ranked as the number one provider of GP training when comparing all GP training schemes across the whole of the UK.

The Foundation School Director from HENE congratulated the Trust for the superb GMC results which contributed to excellent results overall for the Northern Foundation School. He summarised that TEWV featured five times in the Top 10 Trusts in the UK and that this was an exceptional performance. Those areas were:

Feedback at F2 level (2nd)
Induction at F2 level (4th)
Workload at F2 level (4th)
Adequate Experience at F2 level (8th)
Clinical Supervision at F2 level (8th)

The Trust has been ranked as the number one Trust in the North East for the last three years in GMC surveys when comparing all junior doctors.

The report also highlights that the Trust has been nationally ranked in the top 15 (out of all 205 NHS Trusts) for the last three years. The Trust was ranked a higher place than last year and is now ranked 11th in the UK.

Ref 4 : HENE GMC Trainee Survey Trust Report

2. KEY ACHIEVEMENTS IN MEDICAL EDUCATION

2.1 Previous initiatives are now embedded into routine operational processes and are therefore not included in this summary. The examples below outline specific areas
of innovation or best practice that have taken place in the last year;

2.2 **Feeder Scheme for Core Training**
Last year the Trust developed a unique and innovative programme to encourage Trust grade doctors to work in the Trust for an initial one year period. In this time they would receive close supervision and support and a

tailored development programme. The doctors were generally equivalent to that of FY2 level and predominantly had trained overseas. This year we invited NTW Trust to join our initiative.

To date, this approach has proved successful and the Trust has recruited 12 doctors. The scheme therefore has two benefits, one to fill vacant posts for service and to encourage those doctors to develop skills and apply for Core training in our regions. The Royal College of Psychiatrists have since informed the Trust that they wish to use this model and will pilot a UK programme in 2016.

Ref 4 : Trust doctor advert
Ref 5 : Trust doctor development tutor

2.3 **Leadership Programme now incorporates all Senior Health Care Practitioners**

The newly established Inter-Professional Health Education Group decided to expand the programme and invite specialist registrars and middle grade/senior health care practitioners to the programme to develop their knowledge and skills in leadership and management alongside the doctors. This comprehensive programme brought to life core management and leadership competencies, demonstrating how they can be applied in the workplace. The programme still covers the Medical Leadership Competency Framework five domains: Personal Qualities, Working with Others, Managing Services, Improving Services and Setting Direction.

Ref 6 : Leadership programme outline

2.4 **Core Clinical Skills Event**

The Core Clinical Skills event was a one-off event held on behalf of the School of Psychiatry. It was a unique training opportunity for Psychiatric Registrars to develop their skills in assessment formulation and presentation in clinical psychiatry. The event contributed to the development of a unique multimedia training package on core skills in Psychiatry. The programme involved Psychiatric Registrars participating in three extended case scenarios around core clinical disorders involving assessment and presentation to senior Tutors (who are also CASC examiners) and received detailed feedback on the day;

Ref 7 : Core Clinical Skills programme outline

2.5 **Clinical Assessment of Skills and Competencies (CASC) Club Event**

The CASC Club event was focussed on Core Trainees and Trust Doctors based within psychiatry and provided a unique learning opportunity, allowing trainees who were due to sit their CASC exam, the chance to practice their clinical skills and receive detailed feedback on the day from senior Consultants.

Ref 8 : CASC programme outline

2.6 **Trainee Led Medical Education Conference**
This year junior doctors were invited to project lead and deliver the conference from its initial concept. The group of junior doctors determined the theme as 'The role of psychiatry within physical health care', and staff from across all clinical disciplines were invited to attend the event with feedback being very positive from delegates and junior doctors. We aim to replicate this again in 2016 because of its success and the learning opportunities it provided to junior doctors.

Ref 9 : Medical Education Conference programme outline

2.7 **The Dragons Den**
The Faculty decided to replicate the popular TV programme, with a twist, and focussed the entrepreneurs energy on how an idea could radically improve clinical education and training, encourage recruitment into the mental health profession, generate ideas for collaborative training amongst clinical professionals, improve the quality of clinical training and enhance patient care, make TEWV a centre of excellence and well renowned for training health professionals or finally create innovative products that support learning and generated income. This year the opportunity was broadened and clinical professionals were invited to pitch their ideas to the dragons.

Ref 10 : Dragons Den programme outline

2.8 **Focussed induction for medical students**
The Undergraduate Tutors within the Faculty identified that it would be beneficial to have an introduction to mental health as part of their induction that is delivered to all medical students on placement in TEWV, irrespective of University programme. The Faculty were invited to share comments on existing approaches used throughout the organisation and the key messages we wanted to focus on. A senior Undergraduate Tutor has led on this work, attending all existing programmes. The new programme will be rolled out from February to all medical students.

3. IMPLICATIONS:

3.1 Compliance with the CQC Fundamental Standards:

3.1.1 The QIP outlines the quality objectives to be delivered in the next reporting period;

3.1.2 Additional areas of quality assurance not covered in the references (above) are in the supporting evidence folder.

3.2 Financial/Value for Money:

3.2.1 The Trust receives over ***£4 million*** each year to support the salaries and educational infrastructure required to deliver quality medical education placements;

3.2.2 Should the Trust not meet the targets set in the learning and development agreement, it would ultimately see a reduction in the funding received.

3.3 Legal and Constitutional (including the NHS Constitution):

3.3.1 The Trust has a responsibility through the Learning and Development Agreement to quality assure the delivery of medical education.

3.4 Equality and Diversity:

3.4.1 There are no implications to consider.

3.5 Other implications:

Not applicable.

4. RISKS:

4.1 To ensure the senior medical management team are kept abreast of issues affecting medical staff, Medical Development produce a quarterly position statement in regard to progress against QIP targets and areas of risk. These are reported to the Medical Director with RAG rating identified;

4.2 A new junior doctor contract will be implemented in the forthcoming year and this will undoubtedly affect the status quo. There is also a requirement for the Trust to complete a new template work schedule for each post and this will set out the expected service commitments and those parts of the relevant training curriculum which can be achieved in each post;

4.3 The new contract will dictate that the work schedule is discussed at the trainee’s regular educational meetings. This to ensure the workplace experience delivers the anticipated learning opportunities and the trainee can report exceptions to Educational Supervisors where day-to-day work varies significantly or routinely from that in the work schedule either in their hours of work (including rest breaks); or the agreed working pattern, including the educational opportunities available.

5. CONCLUSIONS:

5.1 The Trust continues to have a pro-active and strong Faculty of Medical Education. Feedback demonstrates more than ever that we continue to achieve high results in relation to the delivery of medical education across all programmes.

6. RECOMMENDATIONS:

6.1 It is recommended that the Board note the content of this paper.

Bryan O’Leary, Associate Director of Medical Development
Dr Jim Boylan, Director of Medical Education

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 7

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**15th December 2015**
TITLE:	**Culture Metrics Report**
REPORT OF:	**Director of Human Resources and Organisational Development**
REPORT FOR:	**Information**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and wellbeing	
To continuously improve to quality and value of our work	
To recruit, develop and retain a skilled, compassionate and motivated workforce	√
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefits of the communities we serve.	

Executive Summary:

This is the sixth culture metrics report produced and reported to Directors since 2012. The report presents the position as at October 2015 and for the first time include a breakdown of culture metrics scores by locality in addition to reporting the overall Trust position.

Of the six metrics five reported lower scores in October 2015 when compared to March 2015.

The most significant changes have been in respect of the Commitment to Quality Value score which increased from 74.5% in March 2015 to 81.8% in October 2015 and in the Wellbeing Value score which reduced from 72.2% in March 2015 to 69.2% in October 2015, the fourth consecutive reduction in this value score.

Durham and Darlington had the most consistently positive culture metrics scores as at October 2015.

Recommendations:

To note the contents of this report and to comment accordingly.

MEETING OF:	BOARD OF DIRECTORS
DATE:	15th December 2015
TITLE:	Culture Metrics Report

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to provide Directors with the latest available culture metrics information as at October 2015.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 This is the sixth culture metrics report presented to Directors since November 2012. The Overall Staff Experience measure and the five Trust Values have remained constant during the reporting period however, the particular information used to populate each of the metrics has continued to be refined as developments, such as the Staff Friends and Family Test, have occurred. This report includes, for the first time, culture metrics reported on a locality basis in addition to the overall Trust position. The intention is to include culture metrics information about the York and Selby locality in future reports.

2.2 The information used to populate the culture metrics is drawn from existing information sources only within the Trust, including staff and patient feedback. Local commissioning organisations are routinely provided with copies of the culture metrics report.

3. KEY ISSUES:

3.1 Appendix 1 provides information about the six Trust culture metrics at Trust and locality level as at October 2015.

3.2 The six metrics include one for each of the Trust's five values plus an overall staff experience metric. The metrics are not weighted and are based upon related 2014 staff survey results, Staff FFT results from Q1 and Q2 of 2015/16, disciplinary and grievance case registers information and Datix reports concerning physical violence and aggression and verbal abuse. Patient experience reports and complaints data concerning staff attitudes and privacy and dignity are also used.

3.3 The Trust scores of three of the five values reduced as at October 2015 compared to the March 2015 position, as did the Overall Staff Experience score. The Commitment to Quality Value score increased by 7.3% as at October 2015 compared to March 2015.

3.4 When compared to the Trust average scores since 2012 the October 2015 scores were lower for all, with the exception of the Commitment to Quality Value score which has risen by 6% during this time. The statistical significance of the reductions is limited with the most significant being the

Wellbeing Value score that deteriorated by 3% between March and October 2015 and which deteriorated by 20.8% between November 2012 and October 2015.

3.5 The culture metrics scores for Corporate Services are consistently higher than those of the localities. This is not too surprising given previous annual staff survey and Staff FFT scores. The range of information sources used for localities is significantly greater than that of Corporate Services for the Respect Value, the Commitment to Quality Value and the Wellbeing Value.

3.6 Information about locality scores prior to the year to October 2015 reporting period has not been included in this report.

3.7 Amongst the localities Teesside, North Yorkshire and Durham and Darlington each scored the highest in two of the six metrics. Durham and Darlington locality had the most consistently positive scores as at October 2015, always being ranked first or second, whilst Forensic Services had five of the six lowest scores. A significant amount of activity has been, and continues to be, undertaken within Forensic Services to bring about cultural change and there is evidence of improvements being made. The inclusion of information about the number of reports concerning violence and aggression and injury at work within the Respect, Commitment to Quality and Wellbeing Values is likely to have a more negative impact upon the Forensic locality scores that those of other localities.

3.8 At present it is planned to provide a further culture metrics report to Directors at the April 2016 meeting. The intention is to also develop a revised culture metrics report by Q2 of 2016/17 that will include weighted scores as part of efforts to improve the quality of the feedback that is provided. Earlier this year a comparison was undertaken with the Director of Nursing and Governance between the Culture of Care Barometer, a staff survey tool, produced by the National Nursing Research Unit and the Trusts culture metrics. The conclusion reached was that the Trusts current approach ought to be continued and refined.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** None identified.

4.2 **Financial/Value for Money:** None identified.

4.3 **Legal and Constitutional (including the NHS Constitution):** None identified.

4.4 **Equality and Diversity:** Embedding the Trust’s values assists efforts to provide an environment that is free from discrimination and which promotes equality of opportunity.

4.4 **Other implications:** None identified

5. RISKS: None identified.

6. CONCLUSIONS:

6.1 The culture metrics report can be regarded as being something of an organisational temperature test and ought to be considered alongside other staff and patient feedback and performance information**.** The most statistically significant changes in the culture metrics scores since 2012 have been an improvement in the Commitment to Quality Value score and a deterioration in the Wellbeing Value score. These changes ought to inform thinking about future related activities.

6.1 The October 2015 culture metrics

7. RECOMMENDATIONS:

7.1 To note the contents of the report, to comment accordingly and to receive an update report at the April 2016 meeting of the Board of Directors.

David Levy
Director of Human Resources and Organisational Development

Background Papers:

Trust Culture Metrics Update – October 2015 APPENDIX 1

2014 Staff Survey results and internal data sources – October 2015

		Trust	Teesside	N Yorks	D & D	Forensics	Corporate
Overall Staff Experience	Current rating	80.0% *(84.3%)	79.1%	76.4%	78.3%	73.2%	83.2%

Staff survey results – recommending the Trust as a place to work, adherence by colleagues and senior managers to Trust values and compact.

		Trust	Teesside	N Yorks	D & D	Forensics	Corporate
Respect Value	Current rating	86% *(88%)	80.6%	90.0%	87.1%	73.9%	99%

Fourteen information sources: Patient experience reports (OP and community), complaints data concerning attitude, privacy and dignity. Staff survey results concerning discrimination, number of related disciplinary and grievance cases. Datix reports concerning violence and aggression, and verbal abuse.
Corporate Services based on four information sources as patient experience and incident data not applicable.

		Trust	Teesside	N Yorks	D & D	Forensics	Corporate
Involvement Value	Current rating	69% *(68%)	68.9%	65.7%	66.6%	65.9%	72.7%

Nine information sources: Staff survey results concerning communication, ability to contribute to work improvements, management visibility. The number of related disciplinary and grievance cases.

		Trust	Teesside	N Yorks	D & D	Forensics	Corporate
Teamwork Value	Current rating	80.96% *(83.6%)	78.8%	86.8%	87.3%	71.9%	93.6%

Three information sources: Staff survey results concerning effective team working and clinical and non-clinical staff working well together. The number of related disciplinary and grievance cases.

		Trust	Teesside	N Yorks	D & D	Forensics	Corporate
Commitment to Quality Value	Current rating	81.8% *(74.5%)	77.9%	83.7%	80.9%	72.3%	88.7%

Ten information sources: Staff survey results concerning ability to contribute to improvement at work, satisfaction with quality of care provided, Friends and Family Test – Patients, number of potentially harmful incidents witnessed, error reporting and the fairness of reporting procedures. The number of related disciplinary and grievance cases. Datix reports concerning information and medication issues.
Corporate Services based on six information sources as patient experience and incident data not applicable.

		Trust	Teesside	N Yorks	D & D	Forensics	Corporate
Wellbeing Value	Current rating	69.2% *(72.2%)	65.4%	68.1%	69.2%	59.9%	82.8%

Nine information sources: Patient experience reports (inpatients) concerning safety. Staff survey results concerning working hours and stress and effective action taken by the employer. The number of related disciplinary and grievance cases. Datix reports concerning violence and aggression, injuries and lifting.
Corporate Services based on four information sources as patient experience and incident data not applicable.

*March 2015 Trust scores in brackets

ITEM NO. 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**15th December 2015**
TITLE:	**Integrated Governance Framework**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Decision**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing	
To continuously improve the quality and value of our work	
To recruit, develop and retain a skilled, compassionate and motivated workforce	
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve.	✓

Executive Summary:

The Board is asked to approve amendments to the Integrated Governance Framework.

The proposed amendments fall into three broad categories:

- To reflect changes in the regulatory environment.
- To update the document in response to changes in the Trust e.g:
  - The expansion into York and Selby.
  - Changes to membership of the Board's Committees (August 2015).
  - The introduction of the revised corporate report template.
  - An update to the staff briefing on the Duty of Candour.
  - Changes to the committee/group structure supporting the Council of Governors.
- To support the Risk Register (DATIX) project through changes to the Risk Management Policy.

Recommendations:

The Board is asked to approve the revised Integrated Governance Framework.

MEETING OF:	The Board of Directors
DATE:	15th December 2015
TITLE:	Integrated Governance Framework

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to seek the Board's approval of changes to the Integrated Governance Framework (IGF).

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The IGF describes the governance arrangements of the Trust providing a comprehensive and cohesive framework with regard to behaviours, structures and systems and processes.

2.2 The present version of the IGF was approved by the Board at its meeting held on 24th February 2015 (minute 15/46 refers).

2.3 The document now requires updating in response to internal and external changes and to support work being undertaken on risk management.

3. KEY ISSUES:

3.1 A copy of the draft revised IGF, including relevant appendices, is attached as Annex 1 to this report.

(Note: a full copy of the document has also been made available either on Boardpad (in the Board "reading room") or by email for information).

3.2 The key changes proposed to the IGF are as follows:

(a) The Framework document:
- The inclusion of a cross reference to the Trust's "Quality Governance Arrangements" (updated version approved by the Executive Management Team on 2nd December 2015).
- Amendments to the narrative on the Statutory and Regulatory Framework (section 1.5) to reflect Monitor's approach to "well-led" reviews and how these are aligned to the "well-led" domain for CQC inspections.
- Additional narrative on declarations of interests in response to previous Board discussions.
- The inclusion of information on the role of the Senior Independent Director.
- Changes to reflect the expansion of the Trust into York and Selby.
- Updated information on the committee/group structure supporting the Council of Governors.

(b) The inclusion of an updated version of the briefing note for staff on the Duty of Candour (Appendix 3).

(c) The inclusion of the revised corporate report template introduced on 1st December 2015 (Appendix 5).

(d) A minor amendment to the terms of reference of the Quality Assurance Committee (Appendix 11.6).

In accordance with minute 15/258 (29/9/15), the terms of reference of the Committee were reviewed by the Chairman, the Chairman of the Committee, the Chief Executive and lead officers at a meeting held on 3rd December 2015. The only change proposed is to include the Director of Quality Governance as a full (voting) member of the Committee.

(e) Updates to the membership of the Board's Committees in accordance with minute 15/232 (15/8/15) and (d) above.

(f) Minor amendments to the terms of reference and membership of the Executive Management Team (Appendices 12 and 13) to reflect the establishment of the York and Selby Locality.

(g) The changes to the committee/group structure supporting the Council of Governors i.e. the introduction of arrangements based on task and finish groups.

(h) Revisions to the Risk Management Policy (Appendix 15) to support the Risk Registers (DATIX) Project and to reflect discussions at the Board Seminar held on 14th July 2015.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** The Quality Governance arrangements described in the IGF are designed to provide assurance to the Board on compliance with the Fundamental Standards.

4.2 **Financial/Value for Money:** There are no financial implications arising from the changes to the IGF.

4.3 **Legal and Constitutional (including the NHS Constitution):** The IGF supports statutory and regulatory compliance.

4.4 **Equality and Diversity:** There are no equality and diversity implications associated with this report.

4.4 **Other implications:** There are no other implications associated with the report.

5. RISKS:

5.1 Failure to put in place and maintain robust and effective governance arrangements increases the risk of regulatory action being taken against the Trust.

6. CONCLUSIONS:

6.1 The IGF has been updated to reflect changes since the major review undertaken in February 2015.

7. RECOMMENDATIONS:

7.1 The Board is asked to approve the changes to the IGF highlighted in Annex 1 to this report.

Phil Bellas, Trust Secretary

Background Papers:
The Trust's Constitution (October 2015)
Monitor's Risk Assessment Framework (August 2015)
Monitor's Well led framework for governance reviews (April 2015)
Report of the Task and Finish Group on how the Council of Governors conducts its business (September 2015).

Integrated Governance Framework

(including the Risk Management Policy)

DOCUMENT CONTROL – Integrated Governance Framework

Application	This framework pertains to all areas, departments and services of Tees, Esk and Wear Valleys NHS Foundation Trust
Associated policy reference and title	
Date of Ratification	24th February 2015
Date of Review	December 2015
Replacing	Integrated Governance Framework (February 2015 Edition)
Lead	Martin Barkley
Members of working party	Executive Management Team

This policy has been agreed and accepted by: (Director)			
Name	Designation	Signature	Date
Martin Barkley	Chief Executive		

This policy has been ratified by:	
Board of Directors or Board of Directors Sub Committee (specify)	Date of Board of Directors or Sub Committee
Board of Directors	
This policy has gone through an equality impact assessment (EqIA)	Date of EqIA **1 April 2008 (remains relevant)**

Tees, Esk and Wear Valleys NHS Trust

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PART 1 – INTRODUCTION, AIMS AND CONTEXT

1.1 Introduction

The Integrated Governance Handbook, produced by the Department of Health, defines integrated governance as the:

"Systems, processes and behaviours by which trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of service and in which they relate to patients and carers, the wider community and partner organisations."

This document describes the overarching integrated governance arrangements of Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) and the means by which these provide assurance to the Board of Directors, the Council of Governors, Members and other stakeholders that the organisation is identifying and managing the principal risks to the delivery of its Strategic Direction as they arise, be they strategic, clinical, operational or financial.

TEWV is a large and complex organisation and operates in a challenging and constantly evolving environment.

It would be impracticable for the Integrated Governance Framework to describe each element of the Trust's governance arrangements in detail. To attempt to do so would risk obscuring its central themes.

This document, therefore, seeks to provide an overview of the Trust's integrated governance arrangements and how these support and contribute to good governance.

This framework should be read in conjunction with the Trust's ""Quality Governance Arrangements".

1.2 Key Objectives of the Integrated Governance Framework

The integrated governance arrangements described in this document have been designed to:

- Support the delivery of the Trust's principal purpose and its Strategic Direction.
- Ensure statutory and regulatory compliance and that the Trust's obligations to regulators, commissioners and other stakeholders are met.
- Be robust, resilient and deliver good governance.
- Facilitate maximum use of the freedoms and flexibilities available to Foundation Trusts.
- Provide the benefits of scale which come from TEWV being a large Foundation Trust (learning, resilience and consistency) whilst delivering and maintaining a local focus.
- Be adaptable and capable of replication to new circumstances with relative ease.

1.3 The Principles of Good Governance

The Trust's arrangements described in this Framework are based on the principles of good governance identified by the Independent Commission on Good Governance in Public Services (2004).

Good governance means:

- Focussing on the organisation's purpose and on outcomes for citizens and service users.
- Performing effectively in clearly defined functions and roles.
- Promoting values for the whole organisation and demonstrating the values of good governance.
- Taking informed, transparent decisions and managing risk.
- Developing the capacity and capability of the Board of Directors and Council of Governors.
- Engaging with stakeholders and making accountability real.

1.4 Strategic Context

TEWV was formed in 2006 and, in 2008, it became the first mental health and learning disability trust in the Region to be authorised as an NHS Foundation Trust.

As an NHS Foundation Trust its principal purpose is "the provision *of goods and services for the purposes of the health service in England".*

TEWV's governance arrangements have been developed to meet this purpose and to deliver its Strategic Direction (our mission, vision, strategic goals and values) as set out below:

Our Mission:

To improve people's lives by minimising the impact of mental ill health or a learning disability.

Our Vision:
To be a recognised centre of excellence with high quality staff providing high quality services that exceed people's expectations.

Our Strategic Goals:

1. *To provide excellent services, working with the individual users of our services and their families to promote recovery and wellbeing.*

2. *To continuously improve the quality and value of our work.*

3. *To recruit, develop and retain a skilled, compassionate and motivated workforce.*

4 *To have effective partnerships with local, national and international organisations for the benefit of the communities we serve.*

5 *To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve.*

Our Values:

- ***Commitment to quality***
- ***Respect***
- ***Involvement***
- ***Wellbeing***
- ***Teamwork***

1.5 **The Statutory and Regulatory Framework**

As a Foundation Trust, TEWV's governance arrangements must comply with a number of statutory, regulatory and best practice requirements including those set out in the following documents:

- **The NHS Constitution:**

  The NHS Constitution establishes the principles and values of the NHS in England. It sets out the rights to which patients, public and staff are entitled and pledges which the NHS is committed to achieve together with responsibilities for delivering them.

  The governance arrangements support the Trust meet its commitments under the NHS Constitution and to guard against failure to comply with them in accordance with the its Licence (see below).

- **The National Health Service Act 2006**

  The National Health Service Act 2006 (as amended by The Health and Social Care Act 2012) sets out the statutory basis for the governance arrangements of the Trust.

  In summary Schedule 7 to the Act provides that the Trust must have:
  - A legally binding Constitution.
  - A Board of Directors comprising a Non-Executive Chairman, Non-Executive Directors and Executive Directors.
  - A Council of Governors comprising elected Public and Staff Governors and Governors appointed by the Trust's key stakeholders.

- A Public and Staff Membership grouped into constituencies (public) and classes (staff).

The Act also establishes the regulatory framework within which the Trust must operate.

- **The Trust's Constitution**

The Constitution sets out the overarching governance arrangements of the Trust (based on the requirements of the NHS Act 2006) and incorporates:

- The Standing Orders for the practice and procedure of the Board of Directors (including the scheme of delegation and tendering and contracting procedures).
- The Standing Orders for the practice and procedure of the Council of Governors.

The Trust's Standing Financial Instructions (SFIs) have effect as if incorporated into Standing Orders.

This Framework and all related structures, strategies, frameworks, terms of reference, policies and procedures are required to comply with the Constitution.

Failure to comply with the Constitution will have legal and regulatory consequences.

- **The Provider Licence and supporting frameworks**

All providers of NHS services must hold a Licence provided by Monitor, the health sector regulator.[1]

To continue to hold its Licence the Trust must meet a number of obligations including those related to standards of corporate governance and financial management.

In summary the conditions imposed by the Licence cover the following matters:

- **General Conditions** – These conditions apply to all providers and impose certain requirements e.g. that Directors and Governors of the Foundation Trust must be "fit and proper" persons and that providers must respond to information requests from Monitor.
- **Pricing** – These conditions oblige providers, for example, to record information that Monitor needs to set prices, to check that data is accurate, and where required, charge commissioners in accordance with the national tariff documents.

[1] In 2016 Monitor's functions and those of the Trust Development Agency will be combined in a new organisation called "NHS Improvement".

- **Choice and Competition** – These conditions oblige providers to help patients to make the right choice of provider, where appropriate, and prohibit anti-competitive behaviour where it is against the interests of patients.
- **Integrated care** – This condition obliges providers not to do anything detrimental to enabling integrated care where this is in the interests of patients.
- **Continuity of Service** – These conditions apply to providers of Commissioner Requested Services (services whose absence would have a significant impact on the local population). They set out how these services will be protected if the provider gets into financial difficulties.
- **General Conditions for Foundation Trusts** – These conditions impose obligations around appropriate standards of governance for Foundation Trusts.

Failure to comply with the Licence provisions can result in enforcement action being taken against the Trust. Loss of the Licence would mean that the Trust would no longer be able to provide NHS services.

Monitor's "Risk Assessment Framework" sets out the regulator's approach to assessing compliance with the continuity of services and governance licence conditions.

This approach is based on four stages:

- **Monitoring** including requirements for the preparation of forward plans, the submission of annual assurance statements and in-year reporting.
- **Risk Assessment** of a provider's financial sustainability and governance.
- **Investigation** when it is suspected that a breach of a licence condition has occurred.
- **Action** including informal engagement, formal enforcement action and trust special administration.

The Risk Assessment Framework also includes Monitor's expectation that Foundation Trusts will undertake external reviews of their governance arrangements every three years.

The framework for these "Well led" reviews (which replace the Quality Governance Framework and Board Governance Assurance Framework) focusses on four domains: strategy and planning; capability and culture; measurement; and processes and structures.

Any material concerns arising from a review must be shared with Monitor together with the Foundation Trust's plans to address them.

The characteristics of a well-led organisation, as defined by Monitor, are identical to those of the CQC. This enables information to be shared

between the regulators and for the outcomes of the reviews to be used in the CQC's inspections (see below).

- **The Foundation Trust Code of Governance**

  The Foundation Trust Code of Governance, published by Monitor, provides guidance to Foundation Trusts to help them deliver effective corporate governance, contribute to better organisational performance and ultimately discharge their duties in the best interests of patients.

  It is modelled on the UK Corporate Governance Code published by the Financial Reporting Council.

  The Code is based on a "comply or explain" approach e.g. its provisions do not represent mandatory guidance but deviations from its specific conditions are required to be explained, for example, in the Annual Report.

  Under Standing Orders both the Board of Directors and Council of Governors have a duty to seek to comply with the Foundation Trust Code of Governance at all times.

- **The Health and Social Care Act 2008 and supporting regulations**

  Under the Health and Social Care Act 2008 and the Provider Licence the Trust must be and remain registered with Care Quality Commission.

  To be registered the Trust must comply with the fundamental standards of care. These require providers to establish and operate effective governance systems.

  The CQC undertakes inspections to test compliance with the fundamental standards based on whether services are safe, caring, responsive to people's needs and well-led.

  As such, whilst Monitor's "well-led" assessments focus primarily at Board and Committee level, the CQC's inspection framework provides an independent check of patient experience at ward and service level to see whether outcomes demonstrate that the Board's policies are operating effectively.

  Following its inspection in 2015 the CQC rated the Trust as "outstanding" in its well-led domain.

  Regulations made under the Health and Social Care Act require, amongst other matters, the Directors and staff of the Trust to be "fit and proper persons" to provide services. They have also introduced the Duty of Candour (see section 2.5 below).

1.6 Conclusions

The Trust has placed significant emphasis on its approach to governance in recent years recognising its important contribution to the provision of safe and effective services.

The Trust's arrangements have been strengthened based on learning from external independent evaluations.

However, it is recognised that the arrangements must be dynamic to reflect the constantly changing environment.

The following sections describe our approach based on the key aspects (behaviours, structures and systems and processes) of integrated governance.

PART 2 – BEHAVIOURS

2.1 The Importance of Behaviours

Sound structures and systems are not, on their own, enough to secure good governance. "Behaviours" are also critical to ensuring that the Trust achieves and sustains high quality care and sound financial management.

2.2 Leadership

The Board of Directors provides overall leadership and vision to the Trust and is ultimately and collectively responsible for all aspects of performance, including clinical and service quality, financial performance and governance.

All Board Members (and Governors) are required to observe the Seven Principles (the "Nolan Principles") published by the Committee on Standards in Public Life:

- Selflessness
- Integrity
- Objectivity
- Accountability
- Openness
- Honesty
- Leadership

The Trust has developed actions to support and encourage its:

- Leaders to be visible, approachable, motivational, receptive, decisive, a team builder, challenging, communicate well and influence improvement.
- Managers to be visible, people and performance orientated, accountable, challenging, committed and inclusive.

(Extract from the Trust's Leadership Strategy)

2.3 Conduct

As a public body, the Trust and its office-holders and employees must be impartial and honest in the conduct of their business and be beyond suspicion.

Required standards of conduct are set out in:

- The Constitution.
- Standing Financial Instructions.
- "The Standards for members of NHS Boards and Clinical Commissioning Group governing bodies in England" published by the Professional Standards Authority."
- The Governors' Code of Conduct.
- "Standards of Business Conduct for NHS Staff".

In order to avoid any suggestions of misconduct, these standards provide guidance on:

- The declaration and management of any conflicts of interest (i.e. where a person's private, commercial or professional interests might conflict with those of the Trust).
- The treatment and registration of any gifts and hospitality including commercial sponsorship.

2.4 Organisational Culture

The Trust promotes an organisational culture which is open, fair and promotes learning. It encourages all staff to adopt a responsive and open approach towards identifying and understanding potential risks and responding to them. This includes requirements to report unsafe acts or conditions and untoward incidents and near misses using the Trust's incident reporting process.

The Trust's Values (see section 1.4) were developed following consultation with service users, carers, Governors and Staff.

The Trust has identified expected behaviours to support each of these Values as set out in Appendix 1.

A staff Compact has also been developed (Appendix 2) which sets out the psychological contract between the Trust and its staff.

All nursing and healthcare staff are expected to comply with the six enduring values and behaviours of 'compassion in practice' (NHS England) as follows:

- **Care:**

  Care is our core business and the care we deliver helps the individual person and improves the health of the whole community. Caring defines us and our work. People receiving care expect it to be right for them consistently throughout every stage of their life.

- ***Compassion:***

  Compassion is how care is given through relationships based on empathy, respect and dignity; it can also be described as intelligent kindness and is central to how people perceive their care.

- ***Competence:***

  Competence means all those in caring roles must have the ability to understand an individual's health and social needs and the expertise, clinical and technical knowledge to deliver effective care and treatments based on research and evidence.

- ***Communication:***

  Communication is central to successful caring relationships and to effective team working. Listening is as important as what we say and do and essential for "no decision about me without me". Communication is the key to a good workplace with benefits for staff and patients alike.

- ***Courage:***

  Courage enables us to do the right thing for the people we care for, to speak up when we have concerns and to have the personal strength and vision to innovate and to embrace new ways of working.

- ***Commitment:***

  A commitment to our patients is a cornerstone of what we do. We need to build on our commitment to improve the care and experience of our patients to take action to make this vision and strategy a reality for all and meet the health and social care challenges ahead.

2.5 Duty of Candour

Candour in health care is about being open and transparent and all our staff have a responsibility to be open and honest with those in their care.

However, the Duty of Candour is a requirement that the Trust has to carry out if it believes or suspects that a patient has died or come to harm because of something that the Trust has done or not done that it should have done. The Trust has a duty to make sure that patients and, where appropriate, their families are told.

A briefing note prepared for staff on the Duty of Candour is attached as Appendix 3.

2.6 Raising Concerns

Any member of staff who has a concern about risks to quality of service or the safety of colleagues, service users, or the public should raise it, in the first place, with their line manager. The response to the concern should be managed through the Trust's risk management procedures and/or the Assurance and Escalation Framework (see section 4.5).

The member of staff may also raise a concern using the Trust's Whistleblowing Procedure or the Trust's "concerns" system.

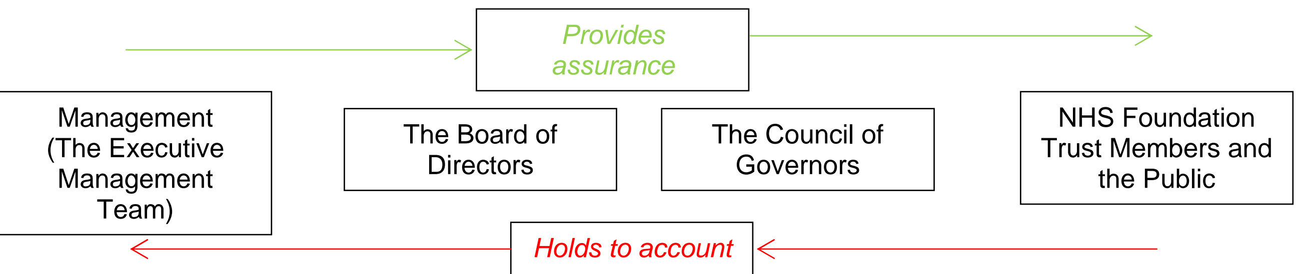
PART 3 – GOVERNANCE STRUCTURES AND ROLES

3.1 Introduction

The Trust's governance structures and roles are based on:

- Statutory and regulatory requirements and best practice (e.g. the NHS Act 2006 and the Code of Governance).
- Locally determined arrangements which have been developed in response to the environment in which the Trust operates e.g. the Trust's quality governance arrangements recognise that there will always be some degree of "tension" between how the Trust ensures a strong locality focus whilst maintaining consistency, learning and resilience across our five major clinical specialties.

Fundamental to our governance structures and roles are the "chains" of assurance and accountability as shown below:



3.2 The Scheme of Delegation

Under the NHS Act 2006 all the powers of the Foundation Trust are exercised by the Board of Directors.

The Constitution includes a schedule of those matters which the Board has reserved to itself and those which it has delegated to Committees and to the Chief Executive.

Those powers and duties delegated to the Board's Committees and other groups are included in their terms of reference. The terms of reference of the Trust's core committees and, where appropriate to facilitate understanding of their roles, other significant boards and groups are appended to this document and highlighted in the following sections.

The Council of Governors also has powers in its own right (e.g. power to appoint the Trust's External Auditor) or to be undertaken in conjunction with the Board (e.g. powers to amend the Trust's Constitution).

3.3 The Roles of the Chairman, Chief Executive and Trust Secretary

Before examining the component parts of the Trust's governance structures, it is important to highlight the key roles and duties of the Chairman, Chief Executive and Trust Secretary as follows:

- **The Chairman:**

  The Chairman of the Trust has a dual role leading both the Board and the Council of Governors. In doing so they:
  - Ensure their effectiveness on all aspects of their roles and setting their agenda.
  - Ensure the provision of accurate, timely and clear information.
  - Ensure effective communication with staff, patients, members and other stakeholders.
  - Arrange, at least annually, the evaluation of the performance of the Board, its Committees and individual Non-Executive Directors.
  - Facilitate the effective contribution of Non-Executive Directors and ensure constructive relationships between Executive and Non-Executive Directors and between the Board and the Council of Governors.

- **The Chief Executive:**

  The Chief Executive's role and responsibilities cover:

  - ***Leadership*** - Helping to create the vision for the Trust, to communicate this vision to others and fostering a culture which empowers them to deliver the Trust's Strategic Goals.
  - ***Delivery planning*** - Ensuring that the Board has sufficient information to agree the Business Plan and contracts that meet national and local priorities and are based on realistic estimates of physical resources, workforce, financial capacity and patient and public involvement.
  - ***Performance management*** - Ensuring that the Board's plans and objectives are implemented and that progress towards implementation is regularly reported to the Board using accurate systems of measurement and data management. This is achieved by agreeing the objectives of the Executive Management Team and reviewing their performance.
  - ***Governance*** - Ensuring that the systems on which the Board relies to govern the Trust are effective. This will enable the Chief Executive to sign the Annual Governance Statement on behalf of the Board to provide assurance that the Trust's systems of governance, including financial and quality governance and risk management, are properly controlled.

As the Accounting Officer the Chief Executive has responsibility for ensuring that the Trust meets all its statutory and legal requirements and adheres to guidance issued by the Department of Health, NHS England and Monitor in respect of governance. This responsibility encompasses the elements of financial control, organisational control, quality governance, health and safety and risk management.

Whilst this overall responsibility is maintained, responsibilities for some aspects of governance and assurance have been delegated by the Chief Executive to Executive and Corporate Directors.

In accordance with the Code of Governance the Board has agreed a statement setting out the respective responsibilities of the Chairman and Chief Executive. This can be found at Appendix 4.

The Chairman and Chief Executive are supported by the Trust Secretary.

The role of the Trust Secretary is to act as an independent source of advice to the Board and Council of Governors on all legal and governance matters.

On behalf of the Chief Executive, the Trust Secretary also has responsibility for overseeing the governance and assurance arrangements of the Trust.

3.4 Standard Processes and Documentation

The Trust has put in place guidance and standard documentation to support its committees and other bodies. These are as follows:

- Standard reporting template (Appendix 5).
- The sequence of meetings to support its quality governance arrangements (Appendix 6).
- Standard Action Plan (Appendix 7).
- Standards for agendas and minutes of meetings (Appendix 8).
- Standard agenda templates for the Quality Assurance Groups and Specialty Development Groups (Appendices 9 and 10).

3.5 **The Board of Directors**

Non-Executive Directors			Executive Directors		
	The Chairman	1		The Chief Executive	1
	The Deputy Chairman	1		The Finance Director	1
	The Senior Independent Director	1		The Medical Director (A doctor)	1
	Non-Executive Directors	4		The Director of Nursing & Governance (A nurse)	1
				The Chief Operating Officer	1

The Board of Directors comprises the Chairman, the Chief Executive and Executive and Non-Executive Directors.

One of the Non-Executive Directors is appointed by the Board (in consultation with the Council of Governors) as the Senior Independent Director (SID). The SID's role is:

(a) To be available to Governors if they have concerns that contact through the normal channels of the Chairman, Chief Executive, Director of Finance or Trust Secretary have failed to resolve, or for which such contact is inappropriate.

(b) To lead the performance evaluation of the Chairman, within a framework agreed by the Council of Governors and taking into account the views of Directors and Governors.

In addition, the Directors of Planning, Performance and Communication and HR and Organisational Development attend its meetings in a non-voting capacity.

The Board may also appoint Associate Non-Executive Directors (non-voting) to provide specific advice or expertise.

The Board and each individual Director has a general duty to:

"... act with a view to promoting the success of the corporation so as to maximise the benefits for the members of the corporation as a whole and for the public"[2]

[2] Health and Social Care Act 2012

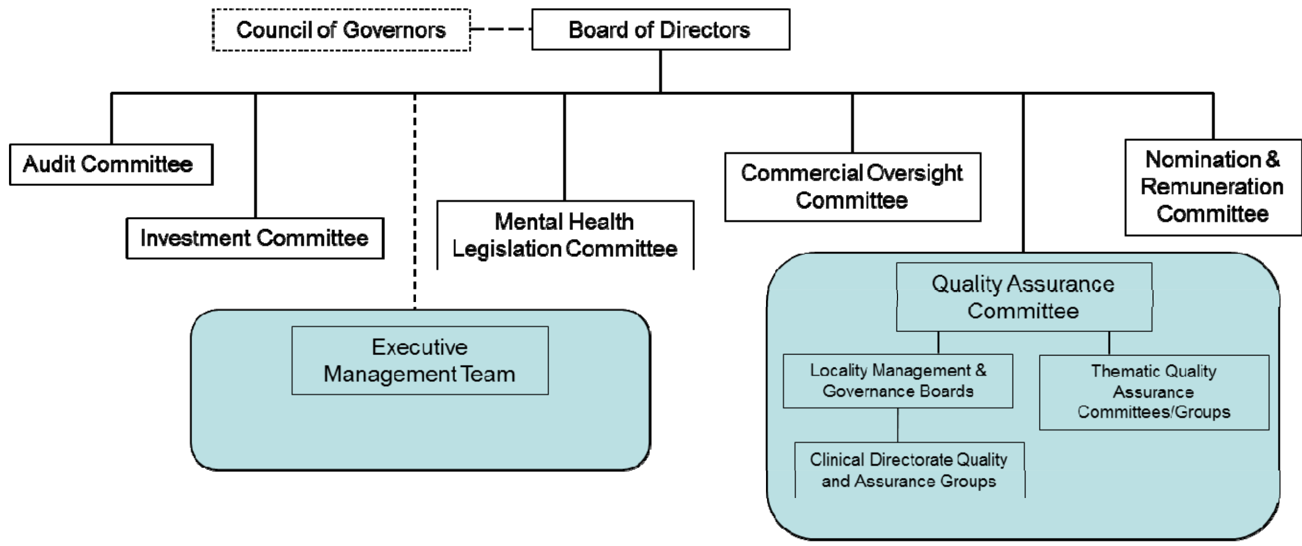
As a unitary Board, both Executive and Non-Executive Directors have collective responsibility and liability for all aspects of the performance of the Foundation Trust, including financial performance, clinical and service quality, management and governance.

All Board Directors have responsibility to constructively challenge the decisions of the Board and help develop proposals on priorities, risk mitigation, values, standards and strategy. However, Non-Executive Directors have particular responsibilities for ensuring challenge takes place.

The role of the Board of Directors is defined as:

- Collective responsibility for adding value to the organisation by promoting its success and by directing and supervising the Trust's affairs.
- Providing active leadership within a framework of prudent and effective controls which enables risk to be assessed and managed.
- Looking ahead by setting the Trust's Strategic Direction and Forward Plans (taking into consideration the views of the Council of Governors) and ensuring that the necessary financial and human resources are in place for the Trust to meet its objectives through the effective review of management performance and implementation.
- Setting and maintaining the Trust's values and standards and ensuring that its obligations to patients, Members and other stakeholders are understood and met.
- Ensuring the Trust complies with the pledges of the NHS Constitution.
- Ensuring compliance with the Foundation Trust's Licence, its Constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations.
- Ensuring the quality and safety of healthcare services, education, training and research delivered by the Trust and that the principles and standards of quality set out by NHS England, the Care Quality Commission and other relevant NHS bodies are applied and met.
- Ensuring the Trust complies with Monitor's Quality Governance Framework.
- Ensuring the Trust exercises its functions effectively, efficiently and economically.

3.6 **Committees of the Board of Directors**



The Board of Directors has established a number of Committees (core committees) which, together with the Executive Management Team, assist the Board in fulfilling its role.

In addition to their delegated powers, all Core Committees have responsibility for:

- Keeping an overview and providing assurance on the activities within their terms of reference.
- Identifying risks and gaps in control and assurance.
- Seeking assurance that risks are being managed effectively.
- Drawing potential risks that could impact significantly on the Trust's ability to deliver its Strategic Direction to the attention of the Board.

In summary the roles of these Committees are as follows:

Audit Committee:

- Overarching responsibility for the provision of assurance to the Board of Directors on the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's Strategic Direction.
- Oversight of both External and Internal Audits and provision of assurance to the Council of Governors on engagement with, and the performance of, the External Auditors.

Quality Assurance Committee (QuAC):

- The principal provider of assurance to the Board of Directors and Council of Governors on the quality and safety of the operational clinical services as outlined in the Quality Strategy.
- Assurance is delivered by the Locality Management and Governance Boards, based on the clinical governance systems in the Localities, and by the thematic groups that report to the QuAC.

Investment Committee:

- Oversight and provision of assurance to the Board of Directors on business development, including tendered and non-tendered business opportunities, medium term financial planning, capital planning and expenditure and capital developments.
- Oversight of the Trust's Charitable Trust Funds.

Mental Health Legislation Committee:

- The provision of assurance to the Board of Directors on compliance with the Mental Health Act, and associated Codes of Practice, and the Mental Capacity Act.
- Responsibility for ensuring appropriate arrangements are in place for the appointment of Associate Managers and the administration of Managers' Hearings.

Nomination and Remuneration Committee:

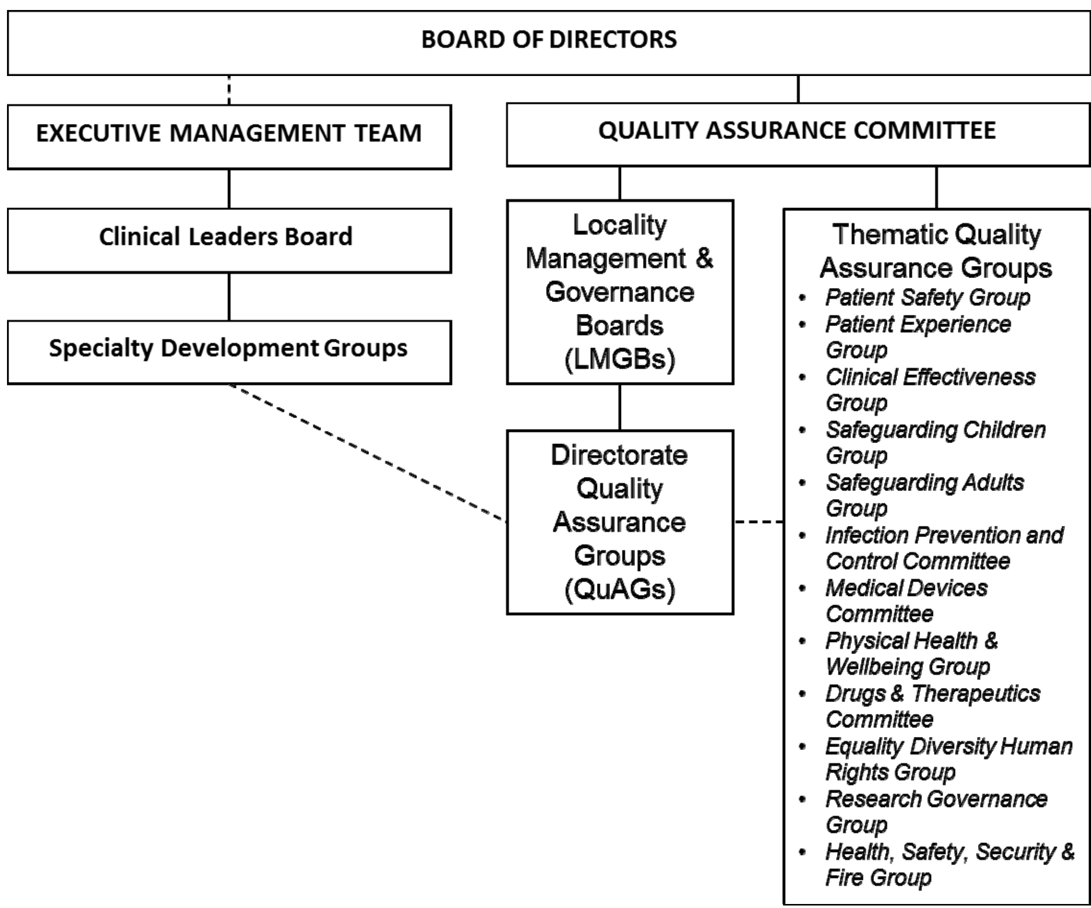
- The appointment and agreement of the terms and conditions of service of the Chief Executive and Directors reporting directly to the Chief Executive.
- The receipt of assurance, through the appraisal system, on the delivery of the objectives and the personal development plans of the Chief Executive and other Directors reporting directly to the Chief Executive.

Commercial Oversight Committee

- The provision of assurance to the Board on the operation and performance of the Trust's subsidiaries and other trading ventures.

(*The Terms of Reference and Membership of each of the above Committees are set out in Appendix 11)*

3.7 The Quality Governance Structure



The Trust's Quality Governance Arrangements have been designed to ensure:

(a) The continual provision of assurance on the quality of services to the Board of Directors through its Quality Assurance Committee.

(b) Consistency and the implementation of best practice across each Clinical Specialty.

These arrangements enable the Trust to achieve the benefits which come from being large and diverse (learning, resilience and consistency) whilst providing robust building blocks for our clinical governance systems.

In summary the roles of these Committees and groups are as follows:

Quality Assurance Committee (QuAC) – *See section 3.6 above*

Executive Management Team (EMT) – *See section 3.8 below*

Locality Management and Governance Boards (LMGBs):

- One LMGB for each of the Trust's Localities: County Durham and Darlington, Forensic, North Yorkshire, Teesside and York and Selby.
- Chaired by the Director of Operations.
- Provide assurance on the quality and safety of the operational clinical services to the Quality Assurance Committee.
- Accountable for the delivery of relevant elements of the Business Plan, contractual requirements, and compliance with CQC and other legislative and regulatory frameworks within the Localities.

Clinical Directorate Quality and Assurance Groups (QuAGs):

- One per Locality for each Clinical Directorate:
  - Geographically based localities - Adult Services, Mental Health Services for Older People, Learning Disability Services and Children and Young People Services.
  - Forensic Services Locality – Forensic Mental Health Services, Forensic Learning Disability Services, Offender Healthcare Services.
- Chaired by the relevant Clinical Director working alongside the Head of Service.
- Provide assurance to their respective LMGBs through monitoring inspection reports, user feedback, performance data, audit outcomes, untoward incidents, complaints, CQC reports, etc.
- Oversight of governance systems, including risk management, and the appropriate delivery of action plans in their Directorate to ensure compliance with all relevant standards (in liaison with other QuAGs and the Speciality Development Groups).

Thematic Quality Assurance Committees/Groups:

- Oversight of, and the provision of assurance on, the delivery of the frameworks (patient experience, patient safety, clinical effectiveness and clinical assurance) supporting the Quality Strategy.
- Oversight of, and the provision of assurance on, key quality governance systems and processes.

The Clinical Leaders Board:

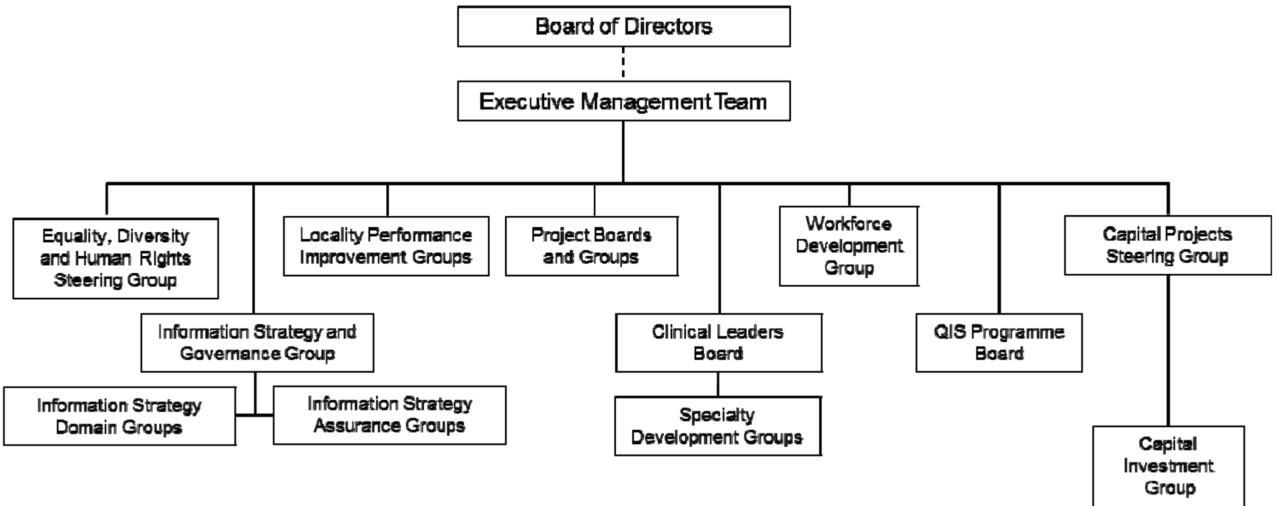
- A forum for the most senior clinicians in the Trust to provide collective advice to the Executive Management Team (EMT) and, in turn, the Board.

Specialty Development Groups:

- The development of quality, including standards of best practice based on lessons learnt from SUIs, patient outcome and experience data, NICE guidelines, benchmarking, new national policies and strategies etc, and the provision of "thought leadership" to promote a positive patient focussed culture within their respective specialties (Adult Mental Health, Children and Young People, Forensic, Learning Disability, Mental Health Services for Older People).

- Leadership of the clinical audit programme and implementation of NICE guidelines ensuring consistency in each of the Localities.

3.8 The Executive Management Team



Collectively, the Executive Management Team (EMT) is responsible for providing the systems, processes and evidence of governance.

The EMT is also responsible for:

- Ensuring that the Board, as a whole, is kept appraised of progress, changes and any other issues affecting integrated governance.
- Identifying risks which impact across Directorates and Portfolios; receiving assurance that these are being managed effectively; and escalating any significant risks for consideration by the Board.
- Ensuring supporting strategies and policies are regularly reviewed and comply with the Licence, the Constitution and statutory and regulatory requirements.

(*The Membership of the Executive Management Team, including the individual portfolios of its members are provided in Appendix 12. Its Terms of Reference are provided in Appendix 13).*

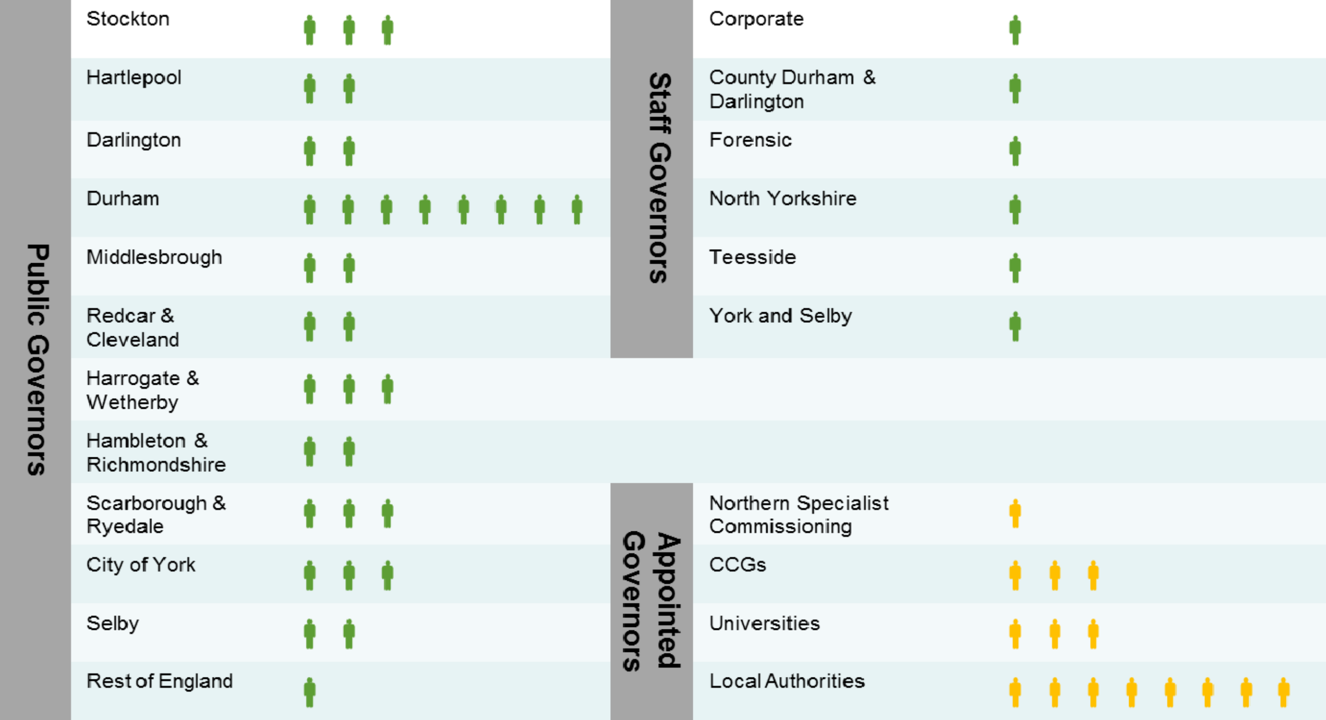
The EMT is supported by a number of groups and working parties including the Clinical Leaders Board and Specialty Development Groups (see section 3.7 above).

3.9 Other Groups

The following Groups, whilst not being part of the formal governance structure, provide forums for discussion of emerging and ongoing matters:

- Operational Management Team and Clinical Leaders and Operational Directors Group (CLODS):
- Joint Consultative Committee.

3.10 The Council of Governors



The Council of Governors comprises:

- Public Governors (elected by the Public Members of the Trust).
- Staff Governors (elected by the Staff Members of the Trust).
- Appointed Governors representing those stakeholder organisations set out in the Constitution.

It appoints a Lead Governor whose role is to provide a point of contact for Monitor and the CQC.

The Council of Governors has general duties:

- To hold the Non-Executive Directors, both individually and collectively, to account for the performance of the Board.
- To represent the members of Trust and the public.

It has the following role and responsibilities:

- To develop the membership of the Trust and represent its interests.

- To present its views to the Board of Directors for the purposes of the preparation (by the Directors) of the document containing information on the Trust's forward Plan in respect of each financial year to be given to Monitor.
- To determine whether it is satisfied that any proposed activities, other than those for the provision of goods and services for the purposes of the health service in England, will not, to any significant extent, interfere with the fulfilment of the Trust's principal purpose and to notify the Board accordingly.
- To determine any proposals by the Board of Directors to increase by 5% or more the proportion of the Trust's total income, in any financial year, attributable to activities other than for the provision of goods and services for the purposes of the health service in England.
- To respond to any matter as appropriate when consulted by the Board of Directors.
- To appoint or remove the Chairman and the other Non-Executive Directors and to determine their remuneration and other terms and conditions of service.
- To approve the appointment of the Chief Executive.
- To consider the Annual Accounts, any reports of the Auditor on them, and the Annual Report.
- To appoint or remove the Trust's External Auditor.
- To determine (in conjunction with the Board of Directors) any questions on mergers, acquisitions or separation of the Trust or whether the Trust should be dissolved.
- To determine any significant transactions proposed by the Board of Directors.
- To consider any matters raised by Monitor or the Care Quality Commission which could have or lead to a substantial change to the Trust's financial wellbeing, healthcare delivery performance, or reputation and standing or which might otherwise affect the Trust's compliance with the terms of its Licence or its registration of services.
- To determine (in conjunction with the Board of Directors) any proposed changes to the Trust's Constitution.
- To decide whether to refer matters relating to the Trust application of the Constitution to a special panel created by Monitor.

The Council of Governors has established a number of Committees and groups including:

- The Nomination and Remuneration Committee.
- The Making the Most of Membership Committee.
- The Task and Finish Group Oversight Committee.
- Task and Finish Groups.
- The Quality Account Task Group.
- Business Planning Workshops.

3.11 **Membership**

Membership is important in ensuring the accountability of the Trust to the local populations it serves.

It also provides:
- The foundation for engagement and involvement in the development of the Trust's services.
- Opportunities to raise awareness of mental health and learning disability issues and to promote social inclusion.

The Membership must be reasonably representative of the Trust's population.

Membership is divided into 2 categories:

- **Public membership**
  Public Members must be at least 14 years of age and live in one of the Trust's Constituencies:
  - Darlington
  - Durham
  - Hambleton and Richmondshire
  - Harrogate and Wetherby
  - Hartlepool
  - Middlesbrough
  - Scarborough and Ryedale
  - Redcar and Cleveland
  - Stockton on Tees
  - City of York
  - Selby
  - Rest of England

- **Staff membership**
  Staff who work for the Foundation Trust automatically become a member in the relevant Staff Class if they hold a contract of 12 months or more; however, they may opt out.

  Staff members are divided into categories based on their geographic location:
  - Corporate
  - Forensic
  - Co Durham and Darlington
  - Teesside
  - North Yorkshire
  - York and Selby

The Trust must in accordance with statutory requirements:
- Present the Trust's Annual Report and Accounts to an Annual Members' Meeting (combined with the Annual General Meeting).
- Put in place arrangements for election of Governors by the Members.

- Provide the Members with opportunities to consider and veto any changes to the Constitution which affect the powers and duties of the Council of Governors.

However, the Trust also recognises the benefits which come from having an engaged membership and actively encourages involvement in a wide range of activities.

To support this approach the Trust has put in place levels of membership to ensure communication and involvement are tailored to individual requirements.

Level	Membership
Level 1	Support Member Receives • Annual General Meeting Notification • Governor Election material
Level 2	Informed Member Receives • Annual General Meeting Notification • Governor Election material • Insight Magazine
Level 3 (Default)	Active Member Receives • Annual General Meeting Notification • Governor Election material • Insight Magazine • Event notification • Consultations • Surveys
Level 4	Involved Member Receives • Annual General Meeting Notification • Governor Election material • Insight Magazine • Event notification • Consultations • Surveys • Active member of Patient and Public Involvement participating in service user and carer groups, reference groups etc which often attract honorarium payments and expense reimbursement

Those Members choosing level 4 have a wide range of options to be involved and engaged in the Trust's activities including:

- Becoming experts by experience.
- Becoming Governors.
- Volunteering.
- Involvement in research and development.
- Undertaking assessment of the care environment.
- Participating in service user and carer involvement groups.
- Involvement in the work of the quality assurance groups (see section 3.7).

The Trust has also developed a Member Charter (Appendix 14) which is provided to all Members and which clearly identities what they can expect in relation to communication and engagement activities with the Trust.

PART 4 – KEY SYSTEMS AND PROCESSES

4.1 **Introduction**

The Trust has established a number of key systems and processes to support its Integrated Governance arrangements.

4.2. **The Integrated Assurance and Risk Management Framework**

The Integrated Assurance and Risk Management Framework provides:

- A simple but comprehensive method for the effective and focussed management of the principal risks to the achievement of the Trust's Strategic Goals.
- A structure for evidence supporting the Annual Governance Statement.
- Effective reporting to the Board enabling the prioritisation of actions and effective performance management.

The Framework is based on:

- Establishing the Trust's Strategic Objectives (See section 4.3).
- Identifying, evaluating and managing the risks to the achievement of these objectives.
- Establishing controls to manage the risks.
- Putting in place systems to provide assurance on those controls.
- Identifying and addressing any gaps in controls and assurance.
- Undertaking mitigating actions to reduce exposure to risk.
- Ensuring that there are robust arrangements for monitoring and reporting of risks.

The Trust's Risk Management Policy is available at Appendix 15.

4.3 **The Planning and Performance Management Framework**

- **The Planning Cycle**

  The Business Plan is a key element of the Trust's governance arrangements. Its enables to the Trust to:

  - Identify actions to be taken in the relevant years to move the organisation towards achievement of its Strategic Goals.
  - Identify how resources will be deployed.
  - Communicate its intentions to internal and external stakeholders.

  The submission of a Plan to Monitor is also a requirement of the Foundation Trust Risk Assessment Framework.

  The development of the Business Plan is based on an annual cycle which is closely aligned to that of the Quality Account and includes:

  - The identification of key issues and implications of changes to the environment enabling priorities and key objectives to be developed (the "what").

- The development of Service Plans to deliver the priorities/key objectives (i.e. the "how") including discussions and the provisional agreements of budgets.
- Consultation with the Council of Governors.

- **Performance Management**

The Trust's robust performance management processes provide a key control within the Integrated Assurance and Risk Management Framework.

The Trust's performance management arrangements include:

- The production of a suite of reports at various levels throughout the organisation which highlight variances in performance against a set of agreed performance indicators, standards and targets.
- A range of forums where performance is reported and discussed resulting in appropriate corrective action being agreed as necessary.

The Performance Management framework provides assurance to the Board, the Council of Governors, Commissioners and Regulators on:

- The delivery of national targets.
- Compliance with the requirements of contracts.
- Progress towards the delivery of the Business Plan and our Strategic Goals.
- On the achievement of quality and innovation under the CQUIN payment scheme; potentially providing additional funding.

The Trust has developed an Integrated Information Centre that electronically downloads data from all our major information systems such as PARIS (our fully electronic patient record), ESR (staff system) and the finance system. This enables interactive reporting and the interrogation of the most up to date performance information at all times.

- **The Project Management Framework**

The Project Management Framework enables the effective planning and management of the priorities identified in the Business Plan (see above).

The Framework provides clear guidance and templates for scoping, developing business cases and project plans, monitoring and evaluating service change projects.

Reporting arrangements are determined by the relative strategic importance and level of risk associated with each individual project.

4.4 Audit

- **External Audit**

The role of External Audit, which includes auditing the Annual Report, Annual Accounts and Quality Report, is governed by Monitor's "Audit Code for NHS Foundation Trusts".

In order to maintain the independence of the External Auditors, the Trust has agreed a protocol under which the Chairman of the Audit Committee must agree the commissioning of any work outside the Audit Code from the Auditors' parent firm.

The External Auditors' primary responsibility is to the Council of Governors, which has the powers of appointment and dismissal.

- **Internal Audit**

Through a programme of internal reviews and testing the Head of Internal Audit:

- Provides an independent opinion on the operation and effectiveness of controls.
- Verifies the accuracy of the Annual Governance Statement and processes that have informed the preparation of the Statement.

The internal audit programme is based on risk assessments on the achievement of the Trust's objectives and is agreed and monitored by the Audit Committee.

- **Clinical Audit**

The Trust undertakes clinical audits to provide assurance that it is meeting its obligations to:

- Improve health and reduce inequalities.
- Conform with nationally agreed best practice.
- Ensure clinical risks are assessed, actions are taken to mitigate these risks and lessons are learnt from practice incidents.

A programme of clinical audits to meet the above requirements is agreed annually by the Quality Assurance Committee.

Assurance on the coverage of, and progress against, the programme is provided to the Board by the Audit Committee.

- **Other Audits and Reviews**

The Board, Audit Committee or Executive Management Team may commission any audits or reviews which they consider appropriate to provide assurance on compliance, the robustness of internal controls or

any matters which could affect the achievement of the Strategic Goals e.g. mock CQC inspections.

4.5 The Assurance and Escalation Framework

The Assurance and Escalation Framework (AEF) sets out the arrangements and the triggers for the escalation of issues that could indicate quality, governance or other substantial risks in the context of the Trust's management and quality governance arrangements.

It is inherently linked to the Risk Management Policy and the Performance Management Framework.

A copy of the AEF is attached as Appendix 16.

4.6 Performance Evaluation Schemes

In accordance with the Code of Governance:

- The Board undertakes an evaluation of its own performance and that of its Committees and individual Directors based on a scheme developed by Deloitte LLP.

  Details of the scheme are provided in the Annual Report.

  The outcomes of the evaluations are:
  - Reviewed by the Board and form the basis of an annual development plan.
  - Fed into the appraisals of the Chairman, Chief Executive and Directors. The findings for the Chairman and Non-Executive Directors are also reported to the Council of Governors.

- The Council of Governors undertakes a performance evaluation by self-assessment which it uses as the basis of its development plan and training and development scheme.

4.7 The Policy Framework

The Executive Management Team has developed a comprehensive portfolio of policies and procedures which act as internal controls for the management of risk. These are available on the Trust's website.

PART 5 – COMPLIANCE AND MONITORING

5.1 Compliance

The Board of Directors is responsible for monitoring compliance with this Framework.

In order to ensure compliance the Board of Directors will:

- Review this Framework annually to ensure it is fit for purpose.
- Review and revise the Strategic Goals and organisational objectives identified within the Strategic Direction.
- Review the internal and independent assurances on which it relies and make adequate arrangements to address any gaps.
- Require regular reviews of the Policy Framework.
- Implement and maintain an adequate performance review framework.
- Receive information / annual reports in accordance with the Board's annual programme.
- Consider the internal auditor's opinion statement to improve the robustness of the Assurance Framework.
- Receive reports and other assurances from core committees, particularly the Audit Committee.
- Receive reports and communication from Executive Directors, Corporate Directors, Operational Directors, Clinical Directors, managers and staff.
- Review the effectiveness of its Committees annually as part of the Board Performance Evaluation Scheme.

5.2 Monitoring

The operation of this Framework will be monitored by the Audit Committee supported by reviews undertaken by Internal and External Audit.

At least annually the Audit Committee will report to the Board on its work in support of the Annual Governance Statement specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation and the integration of governance arrangements.

In accordance with Monitor's Risk Assessment Framework, the Board will commission an independent external assessment of its governance arrangements (a ""well-led" review) at least once every three years.

DUTY OF CANDOUR STAFF BRIEFING

This briefing note is to build on your understanding of the Duty of Candour.

The Duty of Candour is a legal requirement under **Regulation 20** of the Fundamental Standards that was introduced in October 2014. It is part of the response to the Mid Staffordshire Francis Inquiry into failings of care.

In this regulation:

- ‘An apology’ means an expression of sorrow or regret in respect of a notifiable safety incident.

It means that Acute Trusts, Community and Mental Health Trusts have a legal duty to inform and apologise to patients if something goes wrong with their treatment or care. The Department of Health requires all staff to be open about mistakes and always tell patients and carers where applicable, if something has gone wrong.

The Professional Duty of Candour
The NMC and GMC have developed joint guidance (Openness and honesty when things go wrong: The Professional Duty of Candour, June 2015) to help nurses and doctors better understand their role and responsibility in situations involving Duty of Candour.

It is important all TEWV healthcare professionals have a copy of or access to this guidance. To further support staff the Trust has a Duty of Candour Policy based on the NMC and GMC guidance and Regulation 20 (Health and Social Care Act), which is a statutory requirement for registration with the CQC.

In TEWV we have always aimed to be open with patients (and their families when appropriate) and record such conversations on PARIS. The new joint guidance gives clear information on what we must do when something that goes wrong with a patient’s treatment or care that causes or has the potential to cause harm or distress to them. It isn’t expected that every team member takes responsibility for reporting adverse incidents and speaking to patients if something goes wrong. However, it is expected that someone in the team takes responsibility for each of the steps and that the team support the process.

When we realise that something has gone wrong, the NMC and GMC guidance tells us that we must:

- Tell the patient (or, where appropriate, the patient's advocate, relevant other), making sure the someone is available to give them emotional support
- Apologise to the patient (or, where appropriate, the patient's advocate, relevant other)
- Offer an appropriate remedy or support and put the matter right (if possible)
- Explain fully to the patient (or, where appropriate, the patient's advocate, relevant other) the short and long effects of what has happened.

The clinical team will decide who will be the most appropriate person to do this; it is good practice for it to be someone senior in the team.

Additionally, healthcare professionals must also be open and honest with their colleagues, their employer and any relevant organisations as well as taking part in reviews and investigations when requested.

Saying sorry

Apologising to a patient when something has gone wrong does not mean that you are admitting liability for what has happened; you are not expected to take personal responsibility for something that wasn't your fault. The patient has the right to receive an apology from the most appropriate member of the team.

Patients expect to be told three things as part of an apology:

1. What happened
2. What can be done to deal with any harm caused
3. What will be done to prevent this happening to someone else

Patients are likely to find it more meaningful if you offer a personalised apology, for example 'I am sorry …' versus a general expression of regret about the incident.

Being open and honest with patients about near misses

A near miss is an adverse incident that had the potential to cause harm but did not do so. Professional judgment is needed when deciding whether to tell a patient about a near miss; you may need advice from the team or a senior colleague.

Encouraging a learning culture by reporting errors

If something has gone wrong with patient care it is vital that it is reported at an early stage so that lessons can be learnt. Patients must be protected from future harm and the Trust's incident reporting policy should be followed.

The Duty of Candour applies to all serious incidents (previously known as Level 5 and Level 4 Incidents) and the Patient Safety Team proposes to manage this process with the clinical team involved.

The Culture of Candour applies to all other incidents involving errors in a patient's care and or treatment and is a matter of professional judgement; it is better to be open than not. A key question to reflect upon is:

"Do I believe this harm has resulted from actions, omissions or mistakes made by the Trust staff involved in the care of this person?"

We know from recent discussions that staff can find these open conversations difficult and a Trust-wide training programme to support staff is to be made available.

In summary:

- If the situation is a serious incident which requires the Duty of Candour to be applied the MDT should decide the most appropriate person to apologise to the patient and or family. This person will then work with the Patient Safety team on implementing the formal Duty of Candour process through with the Head of Patient Safety at tewv.patientsafety@nhs.net or Tel. No. 0191 333 6522

  AND

- In developing the culture of candour it is important that all staff are open and honest with patients and their family or carers (as appropriate) and apologise if things have gone wrong with the patient's care or treatment
- A record of the culture of candour conversation must be entered onto PARIS
- Good practice is to follow up the conversation by sending a letter to the patient confirming what was said during the conversation

Please do let me or the Head of Patient Safety or Head of Compliance know if you require further advice or guidance.

Jennifer Illingworth
Director of Governance and Quality

Appendix 5

ITEM NO.

(Notes to support completion are available on the Trust's Intranet Site)

[FOR GENERAL RELEASE/CONFIDENTIAL]

[BOARD OF DIRECTORS/COUNCIL OF GOVERNORS/EXECUTIVE MANAGEMENT TEAM/LMGB/QuAG/SDG/OTHER COMMITTEE]

DATE:	
TITLE:	
REPORT OF:	
REPORT FOR:	

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing	
To continuously improve the quality and value of our work	
To recruit, develop and retain a skilled, compassionate and motivated workforce	
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve.	

Executive Summary:

Recommendations:

MEETING OF:	**[BOARD OF DIRECTORS/COUNCIL OF GOVERNORS/EXECUTIVE MANAGEMENT TEAM/LMGB/QuAG/SDG/OTHER COMMITTEE]**
DATE:	
TITLE:	

1. INTRODUCTION & PURPOSE:

1.1

1.2

2. BACKGROUND INFORMATION AND CONTEXT:

2.1

2.2

3. KEY ISSUES:

3.1

3.2

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**

4.2 **Financial/Value for Money:**

4.3 **Legal and Constitutional (including the NHS Constitution):**

4.4 **Equality and Diversity:**

4.4 **Other implications:**

5. RISKS:

6. CONCLUSIONS:

7. RECOMMENDATIONS:

Author,
Title

Background Papers:

APPENDIX 11

BOARD OF DIRECTORS - CORE COMMITTEES

Appendix 11.6

QUALITY ASSURANCE COMMITTEE

TERMS OF REFERENCE

1 PURPOSE

The Quality Assurance Committee is established under Standing Order 6 of the Board of Directors.

The Standing Orders of the Board of Directors, as far as they are applicable and with any appropriate alterations, shall apply to meetings of the Committee,

The Committee exists to provide assurance to the Board to enable it ("the Board") to fulfil its responsibilities.

2 FUNCTIONS

2.1 To provide assurance to the Board that the Trust is discharging its duty of quality and safety in compliance with the Health and Social Care Act 2008 ("the Act").

2.2 To gain and provide assurance to the Board on:

a. The Trust's compliance with regulation requirements enabling it to maintain registration with the Care Quality Commission to undertake regulated activities at each location;

b. The Trust is compliant with the Regulator's standards of quality and safety as set out in the Health and Social Care Act 2008 (Registration requirements) Regulations 2009 and the fundamental standards prescribed in the Health and Social Care Act (Regulated Activities) Regulations 2014 (from 1st April 2015);

c. The delivery of the strategic quality objectives in the Trust's Quality Strategy and its supporting Frameworks;

d. The delivery of the Quality Account priorities and escalate risks of achievement to the Board;

e. That effective processes are in place in the Trust to ensure that lessons are learned and that good practice is shared and implemented across the Trust.

And to escalate risk to the Board where assurance is lacking.

2.3 To make recommendations about priorities in the Trust's Annual Quality Account for the following year.

2.4 To commission and monitor projects/programmes of work to assist the Trust to maintain CQC registration and/or discharge its duty of quality and safety.

2.5 To co-operate fully with all Board Committees and to support those Committees achieving their objectives.

2.6 To develop an annual programme of work to ensure the functions of the Committee are achieved.

2.7 To agree in consultation with the Audit Committee, an annual Clinical Audit programme (aligned to the key clinical risks of the Trust); and to monitor that programme and liaise with the Audit Committee as appropriate.

2.8 To monitor that the risks relevant to the Committee within the Risk Register are regularly reviewed to reflect the dynamic nature of risk.

2.9 To agree the information requirements of the Committee which will assist it to fulfil its functions, identify any risk to the Trust and allow improvement to be monitored. The information will be provided to the Committee through regular reports which meet the requirements of Monitor's Quality Governance Framework.

2.10 To obtain assurance from service users and carers on the quality and safety of service provision through an Essential Standards Group.

2.11 To undertake an annual review of each working group that reports to the Committee.

2.12 To provide the Board of Directors with a monthly report on the quality, assurance and governance activities of the Committee and to escalate any risk to quality to the Board for its attention in accordance with the Trust's integrated governance arrangements.

3 MEMBERSHIP

Voting Members
Chairman of the Committee (a Non-Executive Director)
Trust Chairman
4 Non-Executive Directors / Associate Non-Executive Directors
Director of Nursing and Governance
Medical Director
Chief Operating Officer
Chief Executive
Director of Quality Governance

IN ATTENDANCE (Whole meeting)

- The 2 Deputy Medical Directors and Directors of Operations whose LMGB reports are being considered.
- Deputy Director of Nursing
- Associate Directors of Nursing

The Trust Secretary shall be the secretary of the Committee.

NB other staff will attend for the relevant specific agenda item only

4 QUORUM

4.1 A quorum should be not less than two Non-Executive Directors, one of which will chair the meeting and two Executive Directors.

5 FREQUENCY OF MEETINGS

The Committee will meet monthly, usually from 14:00 – 17.00 on the 1st Thursday of the month.

6 RELATIONSHIP WITH THE BOARD AND OTHER COMMITTEES

In the course of fulfilling its duties if the Committee becomes aware of any risk which could impact on the Trust's ability to deliver its Strategic Goals it shall seek assurances from the appropriate Director whether the risk is being managed effectively.

On considering the Director's report it shall:

- Assure itself that appropriate controls are in place to manage that risk or specify the controls it considers should be established to mitigate the risk.
- Report to the Audit Committee if the risk raises concerns regarding the effectiveness of the Trust's governance arrangements; risk management and assurance arrangements; or system of internal control.
- Make a recommendation to the Board that the risk be included in the Board's Chapter of the Integrated Assurance framework and Risk Register if it believes the risk could have significant impact on the sustainability/viability of the Trust or its ability to deliver the Strategic Direction.

7 DELEGATED AUTHORITY

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

The Committee has delegated authority, subject to consultation with the Audit Committee, to approve an annual programme of clinical audit.

8 REVIEW

The Committee will be reviewed at least annually – within 12 months following approval by the Board of Directors or earlier if required by national guidance or legislation.

Appendix 11.7

Membership of Board Committees

1 **Audit Committee**

Chairman
- Marcus Hawthorn

Committee Members
- Dr. Hugh Griffiths
- David Jennings
- Richard Simpson

2 **Commercial Oversight Committee**

Chairman
- Lesley Bessant

Committee Members
- Marcus Hawthorn
- Jim Tucker
- Dr. Nick Land

3 **Investment Committee (includes Charitable Funds)**

Chairman
- Jim Tucker

Committee Members
- Lesley Bessant
- Marcus Hawthorn
- Barbara Matthews
- Martin Barkley
- Colin Martin
- Brent Kilmurray
- Sharon Pickering

4 **Mental Health Legislation Committee**

Chairman
- Richard Simpson

Committee Members

- Lesley Bessant
- Dr. Hugh Griffiths
- Dr. Nick Land
- Brent Kilmurray

- Elizabeth Moody
- Keith Marsden - Public Governor
- Janice Clark – Public Governor

4 **Nomination and Remuneration Committee**

Chairman
- Lesley Bessant

Committee Members
- All Non-Executive Directors
- Martin Barkley (Matters pertaining to the appointment of Executive Directors (excluding to the office of Chief Executive) and other Directors who report directly to the Chief Executive only).

5 **Quality Assurance Committee**

Chairman
- Dr. Hugh Griffiths

Voting Members
- Lesley Bessant
- David Jennings
- Barbara Matthews
- Richard Simpson
- Jim Tucker
- Martin Barkley
- Dr. Nick Land
- Brent Kilmurray
- Elizabeth Moody
- Jennifer Illingworth

Tees, Esk and Wear Valleys NHS
NHS Trust

Membership of the Executive Management Team and their Portfolios

Appendix 12

Chief Executive

Trust Secretary

Director of Finance & Information (Deputy Chief Executive)

Finance & Information Directorate:
- *Information*
- *Information Strategic Projects*
- *IG & Records Mgt*
- *IT Customer Services*
- *Capital*
- *PbR*
- *Financial Control*
- *Financial Mgt*

(Internal Audit provided externally)

Director of HR and Organisational Development

HR & OD Directorate:
- Workforce Information & Assurance
- Operational Human Resources
- Workforce Development
- Organisational Development
- Health & Wellbeing
- Equality & Diversity

Medical Director

Medical Directorate:
- *Research & Development*
- *Medical Development*
- *Medical Education*
- *Deputy Medical Directors**
- *Senior Clinical Directors**

*(*Joint responsibility with the Chief Operating Officer)*

Director of Planning, Performance & Communications

Planning, Performance & Communications Directorate:
- *Communications*
- *Planning & Business Development*
- *Performance*

Director of Nursing & Governance

Director of Quality Governance

Nursing & Governance Directorate
- *Nursing Leadership & Education*
- *Clinical Audit & Effectiveness*
- *Patient Safety & Clinical Risk*
- *Suicide Prevention*
- *MH Legislation*
- *Patient & Carer Experience*
- *Safeguarding Children & Adults*
- *Complaints and PALS*
- *IPC/PHC/Back Care*
- *Suicide Prevention*
- *CQC Registration & Compliance*
- *Legal Services*

Chief Operating Officer

Senior Clinical Director for Kaizen Promotion Office

- Director of Operations (York & Selby)
- Director of Operations (Teesside)
- Director of Operations (County Durham and Darlington)
- Director of Operations (North Yorkshire)
- Director of Operations (Forensics)
- Director of Operations (Estates and Facilities Management)

APPENDIX 13

EXECUTIVE MANAGEMENT TEAM

TERMS OF REFERENCE

1 OVERALL PURPOSE

The Executive Management Team is accountable for the delivery of the operational objectives as agreed by the Board of Directors and provides leadership to the Trust along with the Board of Directors.

The Executive Management Team is accountable for ensuring that appropriate frameworks, policies and procedures are in place to support the delivery of the organisational objectives. It will also support the Chief Executive in effectively discharging his responsibilities as Accountable Officer. It will ensure that it operates within the Trust's Standing Financial Instructions, Standing Orders and regulatory and legal requirements.

2 TERMS OF REFERENCE

The Executive Management Team will:

- Track the Trust's performance against its objectives.
- Ensure systems are in place for performance reporting as required including to the Board of Directors.
- Review and manage the Trust's performance in relation to its achievement of key targets, Integrated Business Plan, Care Quality Commission Registration, Contract requirements, CQUIN and delegate and co-ordinate action where necessary.
- Ensure that structures, processes and procedures are in place for the effective and safe delivery of services and monitor the effective operation of the Trust including the establishment of working groups as required.
- Review and approve business cases for service developments that are within the delegated limits as identified within the Trust's levels of delegated authority and in line with the Trust's strategic objectives.
- Provide assurance to the Board and Audit Committee that the integrated assurance systems (incorporating the Integrated Assurance Framework and Risk Register) are operating effectively and underpin delivery of clinical and corporate services.
- Ensure the provision of appropriate and accurate information to the Board of Directors.
- Ratify Trust-wide policies for implementation.

- Receive and respond to reports from Lead Directors with regard to the work of the Workforce Group, the Service Development Group, the Information Strategy and Governance Group and the Estates, Facilities and Security Group and the TEWV Quality Improvement System Project Board.

3 EXECUTIVE MANAGEMENT TEAM MEMBERSHIP

- Chief Executive (and chairman of EMT)*
- Director of Finance*
- Chief Operating Officer*
- Medical Director*
- Director of Nursing and Governance*
- Director of Performance and Planning
- Director of Human Resources and Organisation Development
- Director of Operations: Estates and Facilities Management
- Director of Operations: County Durham and Darlington
- Director of Operations: Forensic Services
- Director of Operations: North Yorkshire
- Director of Operations: Teesside
- Director of Operations: York and Selby
- Senior Clinical Director for the Kaizen Promotion Office
- Director of Quality Governance
- Trust Company Secretary

(* Executive Directors)

Members of the Executive Management Team are expected to attend every meeting unless their absence is due to a reasonable cause agreed with the Chief Executive. Nominated deputies may be appointed when appropriate.

The quorum for meetings of EMT shall be one-third of its membership (including nominated deputies).

4 REPORTING ARRANGEMENTS

The Executive Team is accountable to the Board of Directors in respect of executive delegated authority re policies and procedures. A monthly report listing policies and procedures ratified by the EMT will be reported to the Board at each monthly meeting.

In the course of fulfilling its terms of reference if the EMT becomes aware of any risk which could impact on the Trust's ability to deliver its Strategic Goals it shall seek assurances from the appropriate Director that the risk is being managed effectively. On considering the Director's report EMT shall:

- Assure itself that appropriate controls are in place to manage the risk or specify the controls it considers should be established to mitigate the risk.

- Report to the Audit Committee if the risk raises concerns regarding the effectiveness of the Trust's governance arrangements; risk management and assurance arrangements or system of internal control.
- Make a recommendation to the Board that the risk be included in the Board's Chapter of the Integrated Assurance Framework and Risk Register if it believes the risk could have a significant impact on the sustainability/viability of the Trust or on its ability to deliver the Strategic Direction.

The Executive Management Team will meet on a weekly basis.

APPENDIX 15

RISK MANAGEMENT POLICY

1 WHAT IS RISK?

Risk is an uncertain event or set of events which, should it/they occur, will have an effect on the achievement of objectives.

Understanding and responding to risk, both clinical and non-clinical, is vital in making Tees, Esk and Wear Valleys NHS Foundation Trust a safe and successful organisation.

Risk management is the process by which risks are identified, assessed, evaluated, controlled or accepted and is a key element of our Integrated Governance arrangements.

A glossary of terms used in this policy is attached as Annex 1.

2 RESPONSIBILITIES FOR GOVERNANCE AND OVERSIGHT OF RISK

The Board of Directors is responsible for determining the Trust's approach to risk, including its risk appetite, and approving the risk management policy.

The Chief Executive, in his capacity as the Accounting Officer, is responsible for ensuring the effective implementation of risk management in the Trust.

The Audit Committee has responsibilities for providing assurance to the Board, through its oversight of governance, risk management and internal control, on the effectiveness and robustness of the Trust's risk management arrangements.

The Quality Assurance Committee is the principal provider of assurance to the Board on the quality and safety of the operational clinical services and has a key role in escalating risks to the Board where this is lacking.

3 THE TRUST'S APPROACH TO RISK MANAGEMENT

The Trust's approach to risk management is aligned to its governance structures and assurance and escalation arrangements.

3.1 Risk Registers and Risk Logs:

Risk registers will be maintained for:

- The Board of Directors
- Corporate Directorates
- Locality Management and Governance Boards (LMGBs)
- Directorate Quality Assurance Groups (QuAGs)

These risk registers are called “Chapters of the Integrated Assurance Framework and Risk Register” and contain information to support the Board Assurance Framework.

It is planned to introduce “risk logs” for wards and community teams. Guidance on the preparation, maintenance and reporting of these will be issued separately.

3.2 Risk Register Ownership and Risk Managers

Each Risk Register will have an owner who is responsible for: ensuring risk management policies are followed; supporting the identification of risks; updating and reporting on relevant risks; appointing risk managers; and for escalating risks, as appropriate, within the Trust’s governance structure.

Each individual risk will have a risk manager, appointed by the risk owner whose role includes:

- Understanding, monitoring and reviewing the risk.
- Being able to report on its status (e.g. its risk score).
- Ensuring appropriate controls are enacted.
- Ensuring that mitigating actions, if appropriate, are completed within agreed timescales.

Further information on risk registers and risk register owners is set out in Annex 2 to this policy.

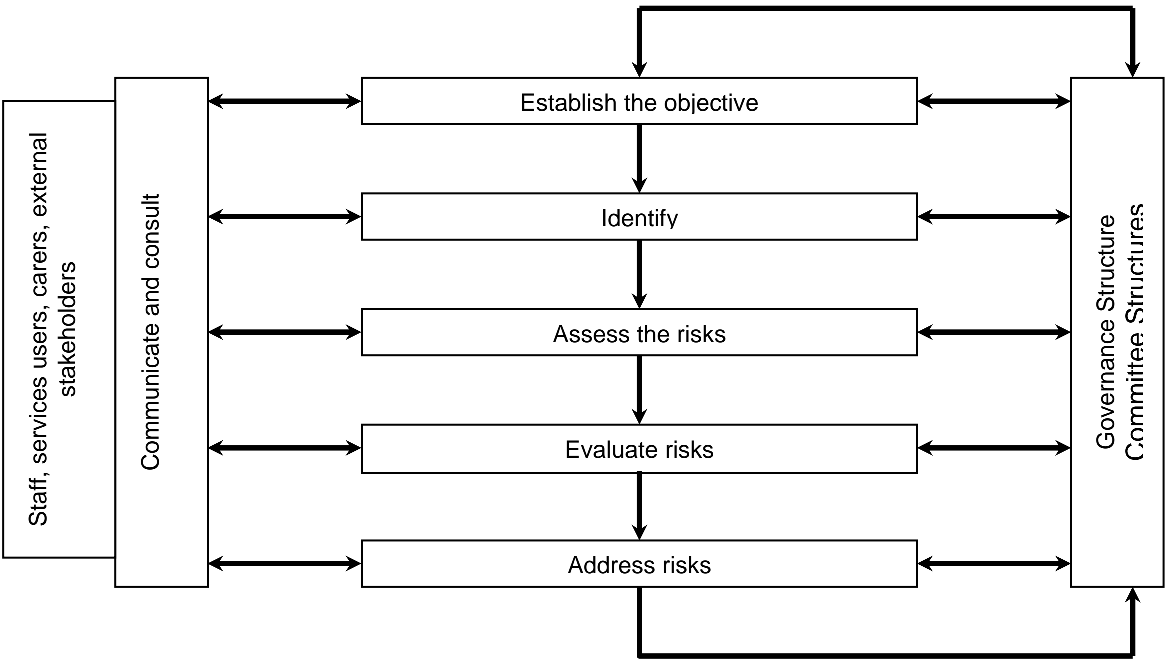
3.3 Recording Risks

The profiles for all risks included on a risk register will be held on the DATIX system.

4 THE RISK MANAGEMENT MODEL

The Trust’s model for risk management has five stages: **Establishing** the objective, **Identifying** the risk, **Assessing** the risk, **Evaluating** the acceptability of the risk and finally **Addressing** the risk.

Model for Risk Management



The principles of the risk management model will be employed to assess all risks in the organisation.

A “one page” overview of the risk management model is set out in Annex 3.

4.1 Establishing the objective

The Trust’s objectives (its Strategic Goals and Priorities) are set out in the Business Plan and supporting Service Plans.

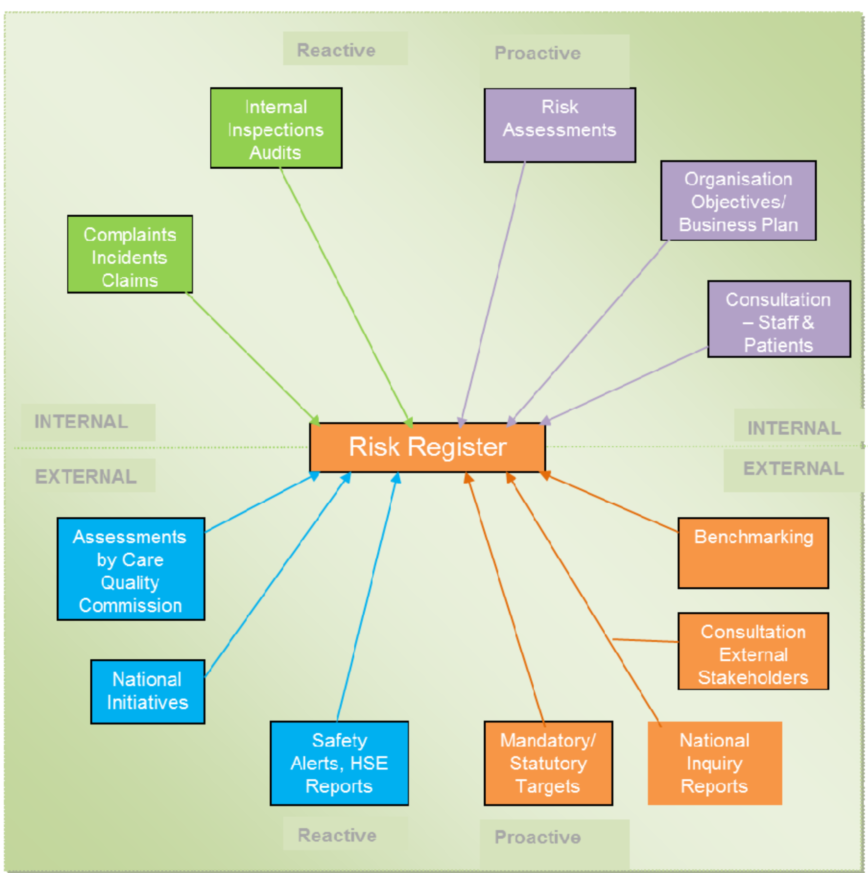
4.2 Identifying the Risk

Following the approval of the Business Plan the Board, on the advice of the Executive Management Team, will review the principal risks to the achievement of the Trust’s priorities for inclusion in its Chapter of the IAF&RR.

Each Corporate Directorate, LMGB and QuAG will also review the risks arising from the Business Plan (and their Service Plans). In doing so they will be mindful of:

- Any directions given by the Board, the Executive Management Team or, in the case of QuAGs, their LMGB.
- The views of the Clinical Specialties.
- Risks arising from third parties.

However, the identification of risk is not limited to an annual review but is also dynamic. During the year risks will also be identified through both internal and external sources.



4.3 **Describing the Risk**

The description of all risks should commence *"It is a risk that …"*

4.4 **Assessing the Risk**

The assessment of risk will tell us how significant the risk is, how well we control the risk and areas where improved control is required. This will enable us to ensure appropriate oversight of the risk within the Trust's governance arrangements.

It is critical that all available information is gathered at the risk identification stage.

Risk assessments will be undertaken by the Risk Manager and reported to the next meeting of the Board, LMGB or QuAG, as appropriate.

However, where a risk is assessed as very high (risk score 27+) or high (risk score 18-25) the Chief Executive or the relevant Director, respectively, should also be notified under the Assurance and Escalation Framework (see Appendix 16 of the Integrated Governance Framework).

When considering the chances of a risk occurring it is essential to consider the controls and assurances that are currently in place as these will assist in reducing that likelihood. A risk with well established controls is less likely to occur than a risk with gaps in control. Evidence that the controls are in place and effective also enables more accurate assessment of risk scoring and information about what could be done to reduce the risk.

The Trust uses the following approach to ensure risks are assessed consistently:

- The risk will be rated in terms of consequence and likelihood.
- The ratings are used to determine the Risk Score.
- The risk level is identified from the Risk Score.

4.4.1 Rating Consequence and Likelihood

Ratings for a risk's consequence and likelihood are as follows:

Categories for Consequence	Rating	Categories of Likelihood	Rating
Negligible	1	Rare	1
Minor	3	Unlikely	2
Moderate	5	Possible	3
Major	7	Likely	4
Catastrophic	9	Almost Certain	5

Descriptions of the above ratings are provided in Annex 4.

4.4.2 Risk Scores

Risk scores are calculated with reference to the following table:

Likelihood Rating							
	Almost Certain	5	5	15	25	35	45
	Likely	4	4	12	20	28	36
	Possible	3	3	9	15	21	27
	Unlikely	2	2	6	10	14	18
	Rare	1	1	3	5	7	9
			1	3	5	7	9
			Negligible	Minor	Moderate	Major	Catastrophic
			Consequence rating				

4.4.3 Risk Levels

The Trust has identified four risk levels based on the following risk scores:

Risk Levels	Risk scores	
	From	To
Very High	27	45
High	18	25
Medium	9	15
Low	1	6

4.5 Addressing the risk

The objective in addressing a risk it to ensure that it does not develop into an issue where its potential is realised. It is important at this stage to consider the arrangements (controls) that already exist to manage the risk and whether these are sufficient and are operating effectively (assurance). Having properly identified, then assessed the risk and reviewed current control measures one of the following general approaches (the four Ts') can be selected:

- ***Transfer the risk*** - this might be undertaken through contracting out, service level agreements etc and conventional insurance. These arrangements might transfer some of the risk, but may also give rise to some new ones to manage, e.g. the management of contracts.

- ***Tolerate the risk*** – our ability to take effective action against some risks may be limited, or the cost of taking action may be disproportionate to the benefit gained. If the risk is tolerated a 'watching brief' is required by the risk manager and contingency plans should be developed to address any impact.

  Risks are also tolerated when all of the mitigating actions have been implemented and are shown to be working and there are no further actions that would reduce the risk score.

- ***Treat (control) the risk*** – the majority of risks will be in this category. This will require the implementation of remedial action, setting up of systems, infrastructure, assigning management responsibility, processes, equipment, staffing, training and development, etc. The introduction of new technology or processes of care or service may eliminate the identified risk; however, they could also lead to new risks.

  Advice should be taken, where appropriate on the development of mitigating actions e.g. from a Specialty Development Group or experts in corporate services.

  Care should be taken to frame the mitigating actions so they are outcome focussed. For example a consequence or likelihood score

should not be changed as the result of the development or completion of an action plan but on there being assurance that the actions have had their intended effect.

- ***Terminate the risk*** – this is a variation on the 'treat' approach and involves taking quick decisive action to eliminate the risk altogether. This could include restricting or suspending a service until adequate controls are put in place.

To assist in determining the appropriate approach, the risk manager will calculate the target risk score (the risk score if all appropriate and proportionate controls were in place and working effectively).

- If the difference between the assessed (*current* risk score) and target risk score is insignificant it might be appropriate to tolerate the risk depending on its nature.
- If there is a significant difference between the assessed risk score and the target risk score it might be appropriate to treat, transfer or terminate the risk.

5 REPORTING, MONITORING AND REVIEWING RISKS

5.1 Reporting Arrangements for Risk Registers

The **minimum** reporting arrangements for risk registers are set out in Annex 2.

5.2 Amending Risk Registers

Changes to a risk register must be approved by the relevant body (e.g the Board, LMGB or QuAG).

A formal note must be made of all significant changes in the minutes of the meeting.

Nothing in the above requirements shall prevent a risk owner from escalating a risk in an emergency but the matter should be formally reported to the next meeting of the relevant body.

5.3 Risk Escalation

The escalation of risks within the governance structure shall be undertaken in accordance with the Assurance and Escalation Framework based on the risk score.

6 IMPLEMENTATION OF THE POLICY

Risk owners will receive standard work as part of the introduction of the DATIX system. Guidance will also be embedded within the system.

Training will be provided as detailed below.

7 TRAINING

Risk management training (based on a one hour session every three years with competency assessment) is mandatory for all Directors of Operations, Clinical Directors, Corporate Directors, Heads of Service and relevant Ward/Community Team Managers.

8 MONITORING THE TRUST'S INTEGRATED ASSURANCE FRAMEWORK AND RISK MANAGEMENT ARRANGEMENTS

In accordance with the Integrated Governance Framework the Audit Committee has responsibility for providing assurance to the Board on the operation of the Trust's Integrated Assurance and Risk Management arrangements based on reviews conducted by the Internal Auditors.

Annex 1

Glossary of Risk Management Terms

Assurance	Confidence, based on sufficient evidence, that internal controls are in place, operating effectively and objectives are being achieved.
Board Assurance framework	A mechanism to identify potential risks (that may prevent the organisation achieving a stated objective), identify the controls that are in place to manage the risk, the assurances that are available to demonstrate the control is effective and any gaps in control or assurance.
Business (Annual) Plan	The document which sets out the Trust's priorities (objectives) for the forthcoming years.
Control	A process, policy or procedure which is being used to manage the risk e.g. the Performance Management Framework, the Project Management Framework, the Policy Framework, etc.
Consequence	The effect a risk would have if it happens.
External Assurance	Assurances provided by an external agency e.g. the Care Quality Commission, the External Auditors, the Royal Colleges etc.
Gap in assurance	An area where there is insufficient evidence that policies, procedures, practices or organisational structures on which reliance is placed are operating effectively.
Gap in control	Failure to put in place sufficient effective policies, procedures, practices or organisational structures to manage risks and achieve objectives.
Internal Assurance	Assurances provided by reviewers, auditors and inspectors who are part of the organisation, such as Clinical Audit or management peer review.
Mitigation/Mitigating Action	An action to manage or contain a risk to an acceptable level or to reduce the threat of the risk occurring.
Positive Assurance	Actual evidence that shows that a risk is being reasonably managed and objectives are being achieved e.g. an External Audit Report, an Inspection Report etc.
Risk	Something happening that may have an impact on the achievement of our objectives. It includes risk as an opportunity as well as a threat.
Risk assessment	The approach and processes used to prioritise and determine the likelihood of risks occurring and their potential impact on the achievement of our objectives. .
Risk Management	The process by which risk is understood, analysed, addressed and monitored to make sure organisations achieve their objectives.
Target Risk Score	The score for a risk if all reasonable controls were in place and operating effectively.

Risk Management Arrangements **Annex 2**

Risk Register	Risk Register Owner	Monitored & reviewed by -	Examples of types of risks:	Minimum Reporting Arrangements:

The Board Chapter of the IAF&RR	The Chief Executive	The Board of Directors	• Strategic risks to the achievement of the Business Plan
			• Cross Locality operational risks
			▪ "Very high" scoring risks (i.e. those with a score of => 27)
			• Significant risks to Level 1 projects
				• Half yearly reports on the whole Chapter of the IAF&RR (this will include the annual review following approval of the Business Plan).
				• Monthly summary reports highlighting:
				  • Proposed new risks or deletions
				  • Proposed changes to risk scores
				  • Outstanding mitigating actions (i.e. those past their due date)
				  • Significant changes to controls, assurances or mitigating actions.

Locality Chapters of the IAF&RR	The Director of Operations	Locality Management and Governance Boards	• Risks to the achievement of the Service Plan • Cross Directorate risks • "High" scoring business, operational and clinical risks including those arising	As above. New risks and significant changes to existing risks will also be reported to the Quality Assurance Committee in the LMGB

			from third parties (i.e. those with a risk score of 18 – 25) • Significant risks to Level 2 projects	Assurance/Exception Reports.
Corporate Directorate Chapters of the IAF&RR (inc, the Chief Operating Officer)	The Executive or Corporate Director	Executive or Corporate Director (This may include review by the Directorate Management Team)	• Risks to the achievement of the Service Plan • High scoring business and operational risks • Significant risks to projects	• Monthly reviews
Quality Assurance Group Chapters of the IAF&RR	The Head of Service	Directorate QuAGs	• Risks to the achievement of the Directorate's priorities in the Service Plan • Risks to quality identified by wards/teams • Risks re: o New national requirements from Specialties o Quality governance findings (e.g from Clinical Audits) o Staffing o External regulation o Reputation o Contractual issues • Significant risks to Level 3 projects	• As per the Board Chapter of the IAF&RR

Wards/ Community Teams (to be introduced as part of the DATIX Expansion Project)	The Ward/Community Team Manager	Local Meetings	Risks re: • Health and safety risks • Localised quality governance findings • Environmental risks • Risks to safe staffing levels • Risks from incidents	To be determined

Risk 'One Pager'

Annex 3

<table>
<tr><th colspan="4">Principles: Transparent, Co-ordinated, Knowledge and Learning and Effective</th></tr>
<tr><th>Identify the Risks</th><th>Assess the Risks</th><th>Address the Risks</th><th>Report, Monitor and Review on the Risks</th></tr>
<tr>
<td>• Objective driven: Relate risks to the impact they will have on Trust/service objectives, standards, patient care or mandatory requirements.
• Hazards, threats and risk: something that may have an impact on the achievement of objectives, the organisation, staff or patients.
• Hazard/risk types: Clinical, service objectives/standards, project, reputation, strategic partner, strategic, staff, patient safety, compliance/targets, integrated working, property
• Gathering intelligence: Through horizon scanning (forward-looking research identifying tomorrows risks and getting better prepared, patient information, incident information, near-miss reporting, incidents and events in the NHS</td>
<td>• Impact/consequences: Quality/objectives and targets, injury and ill health, finance and resources, reputation/publicity, litigation
• Risk rating: the classification of each risk based on multiplying the potential impact/consequences by the likelihood of it occurring. Based on a 5 x 5 matrix.
• Uncertainty: some risks will have uncertain impact/consequence and likelihood. Seek help with these and remember our key principles and desire to be transparent.</td>
<td>The four 'Ts"
• Transfer: Passing the risk on to someone outside the Trust.
• Tolerate: Watch the risk to ensure that its likelihood or impact doesn't change and that existing controls are effective.
• Treat: (controls): Plan and implement a series of actions to bring the risk down to an acceptable level, e.g. care plan, procedures, policy, standards, training, education, revised working arrangements.
• Terminate: Take quick decisive action to remove the risk, e.g. case review, crisis meeting.
• Existing Control Measures: The measures already in place to mange the risk. Make sure these are effective and monitor.
• Contingency: An action or arrangement that can be put into place to minimise the impact of a risk when is has gone wrong or is about to.</td>
<td>• Risk Register: Information about the risks at strategic level and service level. Has to be prepared and monitored regularly. The register indicates the risk, existing control measure, risk owner, impact and likelihood, action to be taken, and contingencies.
• Key risks to the delivery of the Trusts Strategic Direction are kept under regular review by the Board of Directors
• Reporting: Informing key stakeholders internal and external about the risk we have identified, our arrangements that exist to manage these and any action to improve control.</td>
</tr>
<tr><th colspan="4">Know your Role and Responsibility</th></tr>
</table>

Annex 4

Risk Ratings

Descriptions of Consequence Ratings:

Assessments should be made against all relevant domains. The score for the domain with the highest consequence should be used to calculate the risk score.

	Consequence ratings (severity levels) and examples of descriptors				
	1	**3**	**5**	7	**9**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Formal complaint (stage 1) Local resolution Single failure to meet internal standards Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

	Consequence ratings (severity levels) and examples of descriptors				
	1	3	5	7	9
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no	Loss/interruption of >8 hours Minor impact on	Loss/interruption of >1 day Moderate impact	Loss/interruption of >1 week Major impact on	Permanent loss of service or facility Catastrophic impact

	Consequence ratings (severity levels) and examples of descriptors				
	1	**3**	**5**	7	**9**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
	impact on the environment	environment	on environment	environment	on environment
Personal Data Security	-	Potentially serious breach but risk assessed as low e.g. files were encrypted	Serious breach and risk assessed as high (e.g unencrypted data). Non-clinical data	Serious breach and risk assessed as high (e.g unencrypted data) Clinical Data	Serious breach with likelihood that the ICO will take formal action against the Trust.

Descriptions of Likelihood Ratings:

Likelihood ratings can be determined using either the potential frequency or probability of the risk occurring.

Likelihood rating	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Probability Chance of the risk happening	<5%	5% - 20%	20% - 50%	50-80%	.>80%