AGENDA FOR THE SPECIAL MEETING OF THE BOARD OF DIRECTORS
TUESDAY 20TH DECEMBER 2016
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 (9.35 am)

Item 4	To consider the report of the Quality Assurance Committee including the approval of the Quality Strategy 2017 – 2020.	**HG/EM**	**Attached**
Item 5	To receive and note a report on actions taken to mitigate staffing risks in Forensic Services.	**BK**	**Attached**

Governance (10.00 am)

Item 6	To approve the revised Integrated Governance Framework. (The views of the Audit Committee on the above matter will be reported verbally to the meeting).	**CM**	**Attached**

Items for Information (10.05 am)

Item 7 To note that the next meeting of the Board of Directors will be held, in public, on **Tuesday 31st January 2017** in The Durham Centre, Belmont Industrial Estate, Durham, DH1 1TN.

Confidential Motion (10.10 am)

Item 8 **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.

The amount of any expenditure proposed to be incurred by the Trust under any particular contract for the acquisition of property or the supply of goods or services.

Any terms proposed or to be proposed by or to the Trust in the course of negotiations for a contract for the acquisition or disposal of property or the supply of goods or services.

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

Any documents relating to the Trust's forward plans prepared in accordance with paragraph 27 of schedule 7 of the National Health Service Act 2006.

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.

Any advice received or information obtained from legal or financial advisers appointed by the Trust or action to be taken in connection with that advice or information.

Mrs. Lesley Bessant
Chairman
14th December 2016

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

Item 4

FOR GENERAL RELEASE

Board of Directors

DATE:	**Tuesday, 20 December 2016**
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 any current areas of concern in relation to quality and to provide assurance on the systems and processes in place.

Assurance statement pertaining to QuAC meeting held 01 December 2016:

The Quality Assurance Committee has consistently reviewed all relevant Trust quality related processes, in line with the Committee's Terms of Reference. Issues to be addressed have been documented, are being progressed via appropriate leads and monitored via the appropriate sub-groups of QuAC.

Key matters considered by the Committee are summarised as follows:

1. The Locality areas of Forensics and York & Selby, where key concerns were around recruitment, estate and environment issues and lack of clear agreement with CCGs and NHS England around the Transforming Care work stream, regarding service models and investment into community services.
- Updates from the Patient Safety Group, Patient Experience Group and Infection, Prevention & Control Assurance Report
- The Draft Quality Strategy Review – strategy attached at Appendix 2
- CQC compliance and Safeguarding and Public Protection assurance updates
- Governance matters were considered and noted through assurance, with reports on Health, Safety, Security and Fire and the Force Reduction Quarterly report

Recommendations:

That the Board of Directors:

- Receive and note the report of the Quality Assurance Committee from its meeting held on 01 December 2016.
- Approve the revised Quality Strategy (appendix 1).
- Note the confirmed minutes of the meeting held on 03 November 2016 (appendix 2).

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 20 December 2016**
TITLE:	**To receive the assurance 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 December 2016.

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 copies of assurance reports to support the regulatory standards, were also considered.

3. KEY ISSUES

The Committee received updates from the Locality Directors of Operations around the principle risks and concerns, together with assurances and progress from Forensics and York & Selby localities.

4. 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. Key issues raised were:

4.1 FORENSIC LMGB – where key issues raised were:

2. The ongoing pressure of vacancies for Registered Nurses and vacancies filled with perceptees. The overall vacancy position had been improved within IP services from 42.0 WTE to 9.0 WTE vacancies and steps had been taken to manage pressure across the wards, with discussions ongoing around medium and longer term recruitment strategies. Psychology posts were also proving difficult to recruit to.
3. There was a continued lack of clear agreement with CCGs and NHS England around the Transforming Care work stream, regarding service models and investment into community services.
4. The quality of estate and in particular fire safety issues. The service was working closely with EFM around remedial actions and robust alternative measures were in place.
5. Following a recent Kaizen event to increase patient movement/exercise the internal gates within the perimeter of Ridgeway had been opened.

6. There had been very positive feedback following a recent CQC visit to the team at HMP Durham.
7. There had been 2 Regulation 28 letters as a result of an inquest following a death at HMP Low Newton with regards to the same incident.
8. There were continued problems with AMH patients accessing cigarettes from the local shops whilst they were on leave.
9. There had been an increase in missed signatures regarding medication administration, however this amounted to 21 signatures omitted out of a possible 9122 administrations during the 7 day audit period giving an omission rate of 0.23%, within the threshold of 0.5% or less stipulated for the audit.

4.2 YORK & SELBY LMGB - where key issues raised were:

1. The beds at Peppermill Court had been reopened with minor environmental problems being worked through.
2. There continued to be key concerns in the locality around estate issues and ongoing concerns around timeliness of response, quality of work and backlog of work with NHS PS.
3. Staffing, with particular issues in MHSOP services linked to recruitment, sickness and the use of bank and agency staff.
4. Delayed discharges remained an issue, with weekly huddles to monitor the position.
5. Data quality and staff using PARIS - due to the move on to TEWV PARIS there are still some training issues to be resolved.
6. Compliance with appraisal, statutory and mandatory training remained below target.

4.3 Patient Safety Group Assurance Report

1. The key messages from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness - benchmarking would now take place with locality data to compare with the national picture and the key clinical lessons from this would be shared with LMGBs.
2. There had been some data analysis using the Mazars tool for death categorisation from 01 October to 15 November 2016, where 145 deaths had been reported through Datix, 26 of which the service users had been on CPA. It was agreed the 26 would form the first pilot of a mortality review in December 2016.
3. An internal audit would be undertaken around the reporting of seclusion.

4.4 Safeguarding & Public Protection Exception Report

1. The MAPPA serious case review would conclude by December 2016.
2. The 3 serious case reviews in Hartlepool were expected to complete in early 2017.
3. Staff from CAMHS and the safeguarding children team would attend a practitioner event in Durham regarding the long term neglect of 2 children.
4. Feedback from a CQC inspection in Durham for Safeguarding and Looked after Children had outlined improvements around recording safeguarding issues.
5. The Trust would support a single inspection from OFSTED of York Children's Social Care.

4.5 Patient Experience Group Assurance Report

1. The assurance statement followed the Patient Experience Group meeting held on 12 October 2016, the November meeting had been cancelled due to the unannounced CQC inspection.

2. There had been 11 complaints in September 2016, a reduction of 3 from August 2016. PALS overall had continued to increase, with 164 in September 2016 compared to 150 in August 2016, however there were no particular trends or themes to note.

4.6 Infection, Prevention & Control Assurance Report

1. There had been a significant improvement regarding the Essential Steps monitoring data following the introduction of the escalation process which was agreed by the Director of Infection, Prevention and Control.
2. Agreement had been reached that IPC Nurses wold undertake unannounced IPC audits of any new premises, new builds and clinical areas where audits had scored less than 85%. The IPC audit tool had been amended to include information on medical devices and distributed to Modern Matrons for completion

4.7 Draft Quality Strategy Review

1. The Draft Quality Strategy had gone through a lengthy and thorough consultation period, with staff, service users, carers and Governors since February 2016 when the new process had first been approved at QuAC. The strategy is attached for approval at Appendix 1.
2. Two preferences had been identified for target setting, one for a Trust target for each measure and secondly a variant target according to different service areas.
3. The Draft Quality Strategy had been benchmarked against other Organisations and final re-formatting would be supported by the Communications Team.

5. COMPLIANCE/PERFORMANCE – EXCEPTION/ASSURANCE REPORTS

5.1 Compliance with CQC Registration Requirements

1. The CQC had published their Annual Review of the Mental Health Act.
2. The Compliance Team had been notified of 2 joint Ofsted and CQC inspections in York and Durham in respect of Safeguarding.
3. Following the recent unannounced inspection a Regulation 17 letter was received in relation to to Cherry Tree House and Worsley Court. An action plan of remedial measures to address the issues raised would be submitted to the CQC within 7 days as required. Due to the concerns raised by CQC in relation to patient safety because of staff training deficits, a plan was now in place for the patients in Worsley Court to be discharged to appropriate residential care or transferred to Springwood, North Yorkshire until Acomb Gables opens in February 2017. The other environmental issues such as cleaning and privacy and dignity had been addressed at the time of the inspection in November 2016.

5.2 Health, Safety, Security and Fire

1. A rectification plan had been agreed with PFI partners around the fire defects at Roseberry Park.
2. There had been a reduction of 59% in lone working incidents, which were mainly related to home visits by community staff.
3. There had been a 25% increase between 2015/16 and 2016/17 in Violence and Aggression incidents that fell under the NHS Protect Criteria and a 16% increase in incidents reported to the Police.

4. Audits had revealed there were 45 complete workbooks out of a total of 107 during Quarter 1 & 2 and the H&S team continued to chase outstanding actions.
5. EMT was considering the results of a task and finish group to look at assurances around the management arrangements for compliance with the working time regulations.
6. There had been incidents of staff not adhering to risk assessments for staff/patient ratio in isolated areas.

5.3 Force Reduction Quarterly Report

1. The Force Reduction project remained on track to fully implement the core interventions, set out in the Trust wide force reduction plan.
2. The team are working in collaboration with the Paris and Datix teams to make further enhancements to qualitative information.
3. There had been a significant reduction in the use of the most restrictive types of physical interventions and there would continue to be support and clinical leadership to maintain this.
4. Behaviour Support Plans were embedding in Adult Mental Health and Tier 4 CAMHS services and would be audited on an annual basis going forward.
5. The Behaviour that Challenges policy was out for consultation and a new clinical procedure was in development on the safe use of physical holds.
6. The overall number of incidents and restrictive interventions had increased during the quarter; however the use of the most severe restrictive practices remained at 40%.
7. There had been one patient on Evergreen Ward that had received 40 incidents of rapid tranquilisation due to the complexities of their mental health needs.

6. GOVERNANCE

6.1 Assurance Report of the Research Governance Group

1. The Research Governance Group had met on 16 June and 15 September 2016.
2. There had been developments around leadership, the Research & Development Strategy implementation plan and a review of collaborations with Universities.
3. Good progress was being made against the key performance indicators, both on the recruitment to National Institute of Health Research portfolio studies and the annual external R&D income.
4. Following the Research Governance exception report to QuAC in October 2016, local Caldicott approval at Trust level wold still be sought if patient identifiable information was leaving the Trust for the purpose of research. Further guidance from the Health Research Authority was awaited.

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 considered and noted the corporate assurance and performance reports that were received. The Committee were assured that all risks highlighted were being either managed or addressed with proposed mitigation plans.

9. RECOMMENDATIONS

That the Board of Directors:

- Receive and note the report of the Quality Assurance Committee from its meeting held on 01 December 2016.
- Approve the revised Quality Strategy (appendix 1).
- Note the confirmed minutes of the meeting held on 03 November 2016 (appendix 2).

Mrs Elizabeth Moody
Director of Nursing & Governance/ Quality Governance
December 2016

APPENDIX 2

Item 1

MINUTES OF THE MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 3 NOVEMBER 2016, IN THE BOARD ROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

Present:
Dr Hugh Griffiths, Chairman of the Committee
Mrs Lesley Bessant, Chairman of the Trust
Dr Nick Land, Medical Director
Mrs Elizabeth Moody, Director of Nursing & Governance
Mrs Shirley-Anne Richardson, Non-Executive Director
Mr Jim Tucker, Non-Executive Director, (Deputy Chairman of the Trust)
Mr Richard Simpson, Non-Executive Director

In attendance:
Mrs Karen Atkinson, Head of Nursing, Adult MH & Substance Misuse
Mrs Karen Agar, Associate Director of Nursing and Governance (for minute 16/155)
Mr David Brown, Director of Operations, Teesside (for minute 16/152)
Mrs Adele Coulthard, Director of Operations for North Yorkshire (for minute 16/153)
Mr Chris Lanigan, Head of Planning & Business Development (for minute 16/156)
Mr David Levy, Director of Human Resources & Organisational Development (for minute 16/158)
Mrs Donna Oliver, Deputy Trust Secretary
Mr Chris Williams, Chief Pharmacist, (for minute 16/159)

Students: Scott Millington, Charlene Lynn, Chelsea McCabe, Kayleigh McIver, Kathryn McElvenny

16/149 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr Colin Martin, Chief Executive, Mr Brent Kilmurray, Chief Operating Officer, Dr Lenny Cornwall, Medical Director for North Yorkshire, Mrs Jennifer Illingworth, Director of Quality Governance, Mrs Sarah Jay, Equality & Diversity Lead.

16/150 MINUTES OF PREVIOUS MEETING

Agreed – that the minutes of the meeting held on 6 October 2016 be approved as a correct record and signed by the Chairman of the Committee.

16/151 ACTION LOG

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

The following updates were noted:

15/137 "Review of scorecard metrics with Dept. Heads in October then bring back to QuAC".
This action would be brought back to the QuAC meeting on 1 December 2016.

16/48 "Analysis of dashboard indicators: to discuss with OMT how to ensure that in investigating any breaches we can gain assurance that the care was appropriate".
This action would be brought back to the QuAC meeting on 1 December 2016.

16/117 "Report to QuAC around compliance with Trust Policy".
Completed

16/137 "Look into the compliance rate of audit 4391 at 50-79% to establish the actual rate".
The rate of compliance was reported for this audit as most criteria had scored either green (>80%) or higher amber (>65%).
Completed

16/143 "That the Physical Health Group would report through to LMGBs and this change would be communicated to the Directors of Operations".
Completed

16/152 TEES LMGB ASSURANCE/EXCEPTION REPORT

The Committee received and noted the Tees LMGB Assurance/Exception Report.

Mr Brown highlighted the main concerns at present, which were:

1. Recruitment and retention, with the appointment of 18 staff due to start employment between September 2016 and January 2017.
   On this matter it was noted that:
   i) Looking to recruit abroad had been thought an option; however this would not be suitable for the Trust.
   ii) There had been significant turnover of nursing staff as well as newly qualified nursing staff currently on Wards requiring appropriate mentorship and support.
   iii) Recruitment of medical staff, with difficulty replacing some Consultants. There were currently 41 vacancies in the North East region for MHSOP Consultants.
2. Acuity on the Wards continued to be a growing problem, particularly the children's Ward at West Lane. The expected re-opening of Peppermill court had not alleviated the pressures on beds, with the numbers of out of area patients as high as 20 in the last 2 weeks.
3. Patient falls, despite lots of interventions to prevent patients from falling. It was acknowledged that Westerdale South, which had been designed some time ago for a different cohort of patient needs did not provide the close observation required to prevent falls. Discussions were underway around the potential to swap Westerdale North and South Wards.
4. An increase in out of area admissions in MHSOP, as a result of clusters of organic admissions, which were difficult to manage due to relatively small number of beds.
5. Delayed discharges due to the lack of external nursing home places.

In the North Tees patch a group would be set up to look at this matter, which had been recognised as a growing National picture.

Agreed: That the bed pressures, including occupancy, and out of area placements, as well as future bed provision and staffing would be escalated to the Board of Directors.

Action: Mrs E Moody

Following discussion it was noted that:

i) The culture of night duty staff on Westerdale South had been addressed following CCTV footage which had revealed a lack of effort at night times. The Committee was assured that since 5 new members of staff had been installed on the Ward the work ethic had subsequently improved.
ii) The Police had released some guidance, which would impact on the Trust since there would no longer be support from the Police for transferring patients.

16/153 NORTH YORKSHIRE LMGB ASSURANCE/EXCEPTION REPORT

The Committee received and noted the North Yorkshire LMGB Assurance/Exception Report.

Mrs Coulthard highlighted the main concerns at present, which were:

1. High levels of activity, sickness and difficulties with recruitment, which continued to add extra pressures on staff, in particular affecting Ayckbourn Adult Mental Health services.
   On this matter it was noted that a stop the line action plan, with weekly calls had been implemented to proactively manage staffing shortages on the inpatient rota. The Committee was assured that there was a dedicated Consultant for each Ward.

2. In MHSOP services there were high levels of enhanced observation on Rowan Lea in Scarborough and Rowan Ward in Harrogate, with the service following their business continuity plan and diverting community staff to support safe staffing levels.
   On this matter it was noted that:

   a) There had been 4 individual patients on Rowan Lea since June 2016 requiring high level observations, which had added to the pressures.

   b) The bed numbers in Scarborough had been reduced from 13 to 11 and nurse leadership had been reviewed, with 2 Ward Managers stepping up to the challenge, with some good feedback received from the CQC.

3. In Tier 3 CAMHS services maintaining standards of service had been affected by highly complex cases, particularly in the Northallerton team.

Following discussion it was noted that:

i) PIPs, the arm's length subsidiary Company of the Trust, was currently looking to identify any solutions to providing housing for patients with complex learning disabilities and behaviour that challenges in the community.
ii) The female patient that had jumped out of a bedroom window had been at their home and not on Trust premises.

iii) Access to PICU continued to be challenging and the Committee acknowledged that this matter had been raised with the Director of Operations and would be discussed further at a forthcoming EMT meeting.
On this matter it was noted that the escalation process did work, however there were communication problems in sourcing PICU beds on Wards.

iv) Concerns had been raised around SI reports being changed after being agreed at the service panel, before going to the Directors panel, with the clinical team being unaware of the changes.
On this matter it was noted that there would be a meeting with the Heads of Service and Director of Quality Governance around patient safety processes, reports and ownership of action plans.

Agreed: that further investigation should be undertaken to look at Sis that had been changed.

Action: Mrs J Illingworth

16/154 PATIENT SAFETY GROUP REPORT

The Committee received and noted the Patient Safety Group report for September 2016 and the Patient Safety Group Quality Report for August 2016.

Arising from the report it was noted that:

1. The summary following publication of the national confidential enquiry into suicide and homicide by people with mental illness had been included in the month's Lessons Learned Bulletin and circulated to staff.
2. Monitoring the fluctuating numbers of control and restraint in Tier 4 CAMHS would continue, with a further report at the end of Q3.
3. Some data had been received about the actual numbers of service user deaths being reported through Datix and it had been agreed to look at those on CPA only in the first instance.

Following discussion it was noted that:

i) The data presented in the Patient Safety Group Quality Report around Trust wide level 3 incidents, including CAMHS Tier 4 would show any Wards that were outliers and how frequently teams were an outlier. This information would be more useful shown over a period of time, rather than monthly.

ii) The Trust had adopted the Mazars principle for mortality reviews and all unexpected deaths and some expected deaths were being analysed, including the demographics.
Further work would be required to identify the approach for mortality reviews with services in liaison with the Patient Safety Team.
Mrs Moody would circulate to QuAC the CQC thematic review, which had been agreed across 9 Trusts and have a further discussion around this matter at the December QuAC meeting.

Action: Mrs E Moody

16/155 SAFEGUARDING & PUBLIC PROTECTION 6 MONTHLY REPORT

The Committee received and noted the Safeguarding & Public Protection 6 monthly Report.

Arising from the report it was highlighted that:

1. There had been an increase in the number of alert contacts made to the safeguarding team in Quarter 1 and 2 with a 17% increase in the first 6 months. A review was underway of the current capacity of the safeguarding teams.
2. There had been 6 allegations of abuse against Trust staff in Q1 and 11 in Q2. These had been dealt with through disciplinary investigations, 6 of the cases were found to have no case to answer, however due to the nature of one concern raised a referral had been made to the DBS. An update on this matter would be brought back to the next QuAC meeting.
3. Updates were heard around the serious case reviews ongoing in Hartlepool, Redcar & Cleveland, Durham, Darlington and Tees.
4. There had been a 6% increase in compliance against level 2 Safeguarding Adults training.

Following discussion it was noted that future attendance at multi-agency meetings would be reviewed in light of resources within the Safeguarding Team.

16/156 QUALITY ACCOUNT QUARTER 2 2016/17 PERFORMANCE REPORT

The Committee noted and received an update on progress with the 4 key Quality priorities for 2016/17, identified in the Quality Account, as well as performance against the agreed quality metrics.

Arising from the report it was noted that:

1. All Quality Account priorities were reported as being on track to be completed as planned, with 1 exception around the milestone within the harm minimisation project.
2. There were 3 areas reported as red in the metrics around patient falls, length of stay in Adult & Older People Mental Health and percentage of complaints resolved satisfactorily.

Following discussion it was noted that:

i) The length of stay for older people was becoming an increased pressure for the Trust due to a reduction in beds and the complexity of patient needs, including physical health care.
ii) The Trust provided a substantial variation in beds across the localities, with a population of 600,000 in Teesside, compared to 325,000 in York.
iii) Further work would be undertaken around patient falls to understand the significant deterioration in Quarter 2 with 113 falls.
Mrs Moody assured the QuAC that a much deeper analysis of the information would be required to ensure that all lessons were being learned and this was underway.

16/157 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS

The Committee received and noted the Compliance with CQC Registration Requirements Report.

Arising from the report it was noted that:

1. Since the opening of Peppermill Court in York there had been a CQC visit where concerns had been raised about the suitability of the 136 suite and soundproofing. This would be rectified imminently.

2. There had been some positive feedback for the community Mental Health Team based at Durham HMP, following a HMCIP inspection.
3. An anonymous concern had been raised about Cherry Trees House in York in respect of staffing and medication and the relevant information had been sent to the CQC.
4. Mental Health Act inspections had taken place at Ramsey LD and Kestrel/Kite FLD with minor issues identified and a further 7 reports were awaited from the CQC.
5. The unannounced CQC inspection had begun on 1 November 2016 across all core services for adult inpatients.
   On this matter it was noted that there had been some very positive comments about the level of care seen on the wards and staff attitude.

16/158 EQUALITY, DIVERSITY & HUMAN RIGHTS REPORT

The Committee received and noted the Equality, Diversity & Human Rights Report.

It was highlighted from the report that:

1. The Equality, Diversity and Human Rights Steering Group had met on 12 October 2016.
2. Key Performance Indicators and other data had been monitored by the Group and data broken down into localities and specialisms in order to highlight EDHR issues of concern. The Group would in future, provide exception reports by locality and specialism with explanatory narrative.
3. The Group had looked at the 2012/2016 equality objectives with some requiring further work around cultural competency training, (to train 55 clinical staff to act as 'equality experts'), to decrease by 50% the number of indicators where staff who have long term health conditions have significantly less favourable scores and to develop actions where staff share protected characteristics, however score worse than staff in general.
4. There had been a briefing from the Health & Safety Manager on Disability Access audits following an audit of all inpatient premises in Durham and Darlington
5. The Group had received an update on locality equality objectives.

Following discussion it was noted that there would be a Board Seminar in March 2017 on the issue of human rights.

16/159 DRUG & THERAPEUTICS REPORT

The Committee received and noted the Drug & Therapeutics Report.

It was highlighted from the report that:

1. The Safer Transfer of Prescribing Guidance had now been approved and was available on the Trust website and intranet.
2. There continued to be a risk around TEWV clinical staff accessing blood results. Licences for WebICE, the current solution was extremely limited in each locality. This would be resolved by a Paris solution by April 2017.
3. The Drug & Therapeutics Committee had recommended to Clinicians the Surescreen diagnostic brand of urine strips to be used Trust wide.
   On this matter it was noted that some further work would be undertaken to restrict the purchase of varied urine strips on Cardea.

4. A comprehensive guide regarding monitoring for all psychotropic medications would be completed for the D&T meeting in November 2016.
   On this matter it was noted that a register would record that patients were being monitored at 3 and 12 months.
5. There was further work to be undertaken around POMH 14b alcohol detoxification audit, since the report had shown poor compliance with blood tests on admission and the use of parenteral thiamine.

Following discussion it was noted that there was uncertainty around screening provisions and practice on different Wards.

Agreed: that a short report explaining the screening provision and tests available to Wards would be included in the next D&T report to the Quality Assurance Committee in February 2017.

Following discussion it was noted that the Trust would respond to the NHS Improvement Patient Safety alert "Think Kidneys", which set out steps for implementation across Trusts nationally by April 2017.

16/160 ANY MATTERS ARISING TO BE ESCALATED TO THE TRUST BOARD OR PROPOSED FOR ADDITION TO THE TRUST RISK REGISTER, AUDIT COMMITTEE, INVESTMENT COMMITTEE OR CLINICAL LEADERSHIP BOARD.

The QuAC escalated to the Board of Directors the matter of bed provision in York and the total bed provision for the Trust.

16/161 ANY OTHER BUSINESS

There was no other business to note.

16/162 COMMITTEE MEETING

There was nothing to note.

16/163 DATE AND TIME OF NEXT MEETING:

The next meeting of the Quality Assurance Committee will be held on Thursday 1 December 2016,
2.00pm – 5.00pm in the Board Room, West Park Hospital.
Email papers/reports to Donna Oliver donnaoliver1@nhs.net

The meeting concluded at 4.20pm

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Dr Hugh Griffiths
CHAIRMAN
1 December 2016

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

APPENDIX 1:

Quality Strategy

2017-2020

Version: **Draft v6**	**Date Completed:** **Dec 2016** **Date of Next Review:** **March 2020**
Lead Director: **Jennifer Illingworth**	**Author:** **Michael Sykes**

The Aims of the Strategy

- To ensure quality of care underpins every decision taken by every member of staff every day.
- To set the vision and direction for the further development and improvement of the quality of care delivered by the Trust over the next three years.
- To communicate to staff the Trust's expectations in terms of their delivery of excellent patient experience and services.
- To provide the safest care.
- To provide a framework for the development and monitoring of work to improve care.
- To ensure there are clear processes for the assurance of care quality.
- To realise our vision to deliver high quality services that exceed people's expectations.

Our ambition is:

To ensure safe, patient centred and effective high quality care and treatment.

The Case for Change

Why do we need a Quality Strategy?

- To be clear on our ambitions for quality
- To describe the components of 'quality'
- To demonstrate how we will monitor and improve quality
- To be clear on how we will exceed patients' and carers' expectations

What have we achieved so far?

The Trust's 2015 Community Mental Health Survey results led to the Care Quality Commission highlighting the Trust as one of five best performing Trusts. There were 4 areas where the Trust was significantly better than most other Trusts, these were: Organising Care; Planning Care; Reviewing Care and Crisis Care. In the last national NHS Staff Survey, the Trust remained the top Mental Health and Learning Disability provider.

The Trust has also been successful at a team level, for example, one team was awarded Team of the Year from the Royal College of Psychiatrists. The judges commented that the team had led projects regionally that improve service users' experiences, such as reducing physical intervention, promoting positive behavioural support and encouraging carer engagement.

In 2016, we were successful in three categories in the prestigious Positive Practice in Mental Health Awards and shortlisted in in the provider trust of the year category of the HSJ Awards 2016.

However, there remain further opportunities to improve. The recruitment and deployment of the right staff with the right skills in the right place at the right time is a strategic priority for the Trust as it underpins our achievement of most of our other priorities. The Trust plans to undertake an annual staffing review using evidence based safe staffing tools. The Trust seeks continual improvement in all its services, but will put particular emphasis on embedding recovery, reducing preventable deaths, improving transitions and reducing harm from falls.

How was this Strategy developed?

Twenty-two engagement workshops were held across the Trust to seek the views of service users, carers, staff, governors and members. These workshops asked attendees to define 'quality', to develop objectives to be delivered through the strategy, to consider how these could be measured and what steps should be taken to deliver it. Each workshop built upon the outputs of previous workshops. This was added to by targeted input through attendance at specific groups of patients and carers under-represented in the workshops.

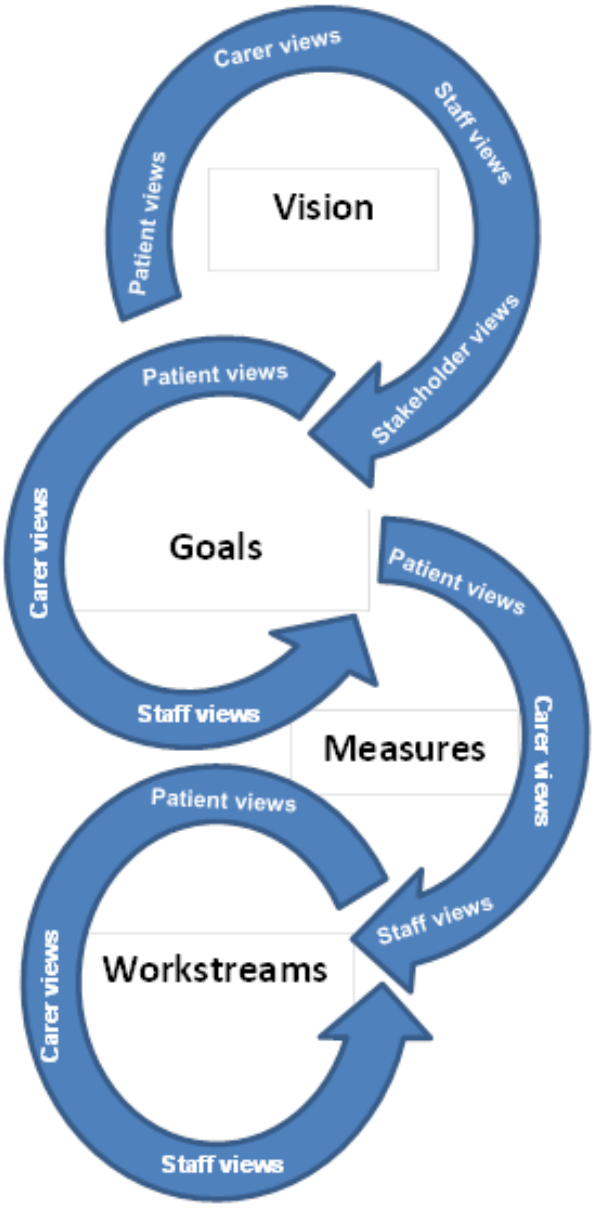
This input was collated into a draft Strategy which was consulted upon, prior to approval by the senior leaders within the Trust.

Our five **values** are:

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

Behaviours to demonstrate our commitment to quality:

- Put service users first.
- Clarify people's needs and expectations and work together and with kindness to meet them.
- Seek and act on feedback from service users, carers and staff.
- Learn from and be open about mistakes if things go wrong, whilst also building upon successes.
- Produce and share information that meets the needs of all individuals.
- Do what we say we are going to do.
- Strive to eliminate waste and minimise non-value adding activities.



Our quality vision for the future

We will provide care which is patient, carer and staff co-produced, recovery-focussed and meets agreed expectations.

We will provide care which is sensitive to the distress and needs of patients, carers and staff. Staff will respond with kind, intelligent and wise action to enable the person to flourish.

Care will be flexible and proactive to clinical need and provided by skilled and compassionate staff with the time to care.

Care will be consistent with best practice, delivered efficiently and where possible, integrated with the other agencies with whom we work.

The Trust will support staff to deliver high-quality care and will provide therapeutic environments which maintain safety and dignity.

Background

Delivery of this strategy will realise our Trust vision to deliver high quality services that exceed people's expectations.

'Quality' is seen differently by different people, and to reflect this the current strategy sought to reflect the views of a wide range of people. Historically, 'High Quality Care for All' (2008) defined quality as care that is *safe, clinically effective and providing the best possible experience*. In 2015, the Care Quality Commission added to this, saying services should also be *responsive* and *well-led*. The above box describes the quality vision as determined through the extensive engagement in the development of this strategy.

Contractually, the NHS Quality Outcomes Framework provides a focus for driving quality improvement and outcome measurement for the contracts we deliver. This work is supported by a number of quality initiatives, including those as part of national campaigns, such as *Sign up to safety*, those delivered as part of Commissioning for Quality and Innovation (CQuIN) arrangements and those described within our Quality Account each year. In addition, the care we deliver is subject to a quality regulatory framework overseen by the Care Quality Commission and NHS Improvement. It is anticipated that delivery of this strategy will support the Trust to meet the requirements of each of these mechanisms, as well as deliver the Trust's own vision for the future.

Goals

Each Goal has high-level measures which seek to enable the Trust to monitor assurance that the Trust's Quality Vision is being delivered. These measures will be scrutinised by the Quality Assurance Committee. In addition, the engagement workshops identified a number of actions, established and new, which will each be monitored. These actions are summarized in the Driver Diagram on page 12.

Goal 1: "Patients, carers and staff will feel listened to and heard, engaged and empowered and treated with kindness, respect and dignity."

Objectives – By 2020:

- 94% of patients will report their overall experience as excellent or good
- 94% of patients will report that staff treated them with dignity and respect
- 94% of patients would recommend our service to friends and family if they needed similar care or treatment
- A 7% increase in staff who state they agree or strongly agree that their job gives them satisfaction
- A 7% increase in staff who report that they can contribute towards improvements at work

In addition, we will deliver year-on-year improvements in the:

- Percentage of patients who state they have been involved as much as they wanted to be in the planning of their care
- Percentage of carers who report their overall experience as excellent or good
- Percentage of carers who report feeling listened to and heard

To achieve this:

We will ensure each patient is involved in developing their care, and that they are given a copy of their care plan.
Assurance: *Annual clinical audits of co-production in care planning monitored by the Clinical Effectiveness Group. Patient survey responses regarding involvement in care planning monitored by the Patient Experience Group.*

We will ensure aspirations for care are discussed with patients and carers. From this, goals and the steps towards these goals will be agreed. We will use supervision as a driver to delivering this.
Assurance: P*atient survey responses regarding involvement in care planning will be monitored by the Patient Experience Group. Annual clinical audits of co-production in care planning and of supervision will be monitored by the Clinical Effectiveness Group.*

We will manage comments, concerns and complaints through an effective, timely and improvement-focussed process.
Assurance: *Quarterly Trust-level report and Locality reports to the Quality Assurance Committee. In addition, themes will be reviewed by the Patient Experience Group.*

We will ensure that improvements are made as a result of patient-led assessments of the care environment (PLACE).
Assurance: *PLACE reports to the Quality Assurance Committee*
We will publish information about the experience our patients have of using our services.

Assurance: *Bi-monthly Patient and carer experience report to the Quality Assurance Committee*

We will support the Triangle of Care as a therapeutic alliance between service users, staff members and carers that promotes safety, supports recovery and sustains wellbeing.
Assurance: *Report to the Triangle of Care Steering Group*

We will ensure carers receive timely and appropriate information to support them and the person they care for. We will treat carers as individuals and with dignity and respect for their cultural, communication, physical and mental health needs.
Assurance: *Bi-monthly Patient and carer experience report to the Quality Assurance Committee*

We will involve carers in decisions about the care and treatment of the person they care for, wherever possible.
Assurance: *Bi-monthly Patient and carer experience report to the Quality Assurance Committee*

We will consult with and seek views from patients and carers when planning, developing, delivering and improving services.
Assurance: *Monitored by the Involvement Team and through quarterly reports to the Involvement and Engagement Committee of the Council of Governors. The involvement of Experts By Experience is monitored through the Recovery Programme Board.*

We will involve patients and carers in staff recruitment and training.
Assurance: *Monitored by the Involvement Team and through quarterly reports to the Involvement and Engagement Committee of the Council of Governors*

We will develop and implement carer awareness training for staff to ensure carers needs are recognized.
Assurance: *Report to the Triangle of Care Steering Group*

We will use the quality improvement system philosophy and tools to maximise the time staff have available to work with patients, their families and carers. As a result, patients will receive personalised care at a pace and level that is suitable to them to enable a journey from first contact with our service to a meaningful recovery.
Assurance: *Delivery will be assessed through reports to EMT and through the Goal 1 assurance measures.*

We will ensure that staff have the support they need to do a good job, have a worthwhile job with the chance to develop and have the opportunity to improve the way they work.
Assurance: EMT and *Board reviews of staff survey reports*

We will create the conditions under which staff feel socially safe in order to nurture compassion and so that staff are committed to undertaking intelligent actions in response to distress.
Assurance: *EMT and Board reviews of staff survey reports and Compassion project report to EMT.*

We will develop an implementation plan describing specific work to deliver these objectives. This implementation plan will be monitored through the Patient Experience Group reporting to the Quality Assurance Committee.

Goal 2: "We will enhance safety and minimise harm*"

Objectives – By 2020:

- 88% of patients will respond 'yes always' to the question, 'do you feel safe on the ward'?
- A reduction in the rate of level 3 or above medication incidents reported by 21% for community patients and by 80% for in-patients.
- A reduction in the rate of level 3 or above incidents of self-harm by 24% for community patients and by 17% for in-patients. This excludes those in adult mental health, where work to understand the impact of safe cutting as part of a harm minimization approach will be undertaken prior to target setting.
- A reduction in the rate of level 3 or above incidents of falls by 26% for community patients and by 67% for in-patients.
- A reduction in the rate of physical intervention by 40% (community) and 21% (in-patients).
  Rates are by caseload for community patients and by occupied bed days for in-patients.

In addition, we will deliver a year-on-year improvement in the percentage of patients who report feeling supported by staff to feel safe and in the use of seclusion.

To achieve this:

We will communicate that we define harm as, 'a multifaceted concept which is best informed by the patient themselves, their family and carers and our clinicians'. As such it will evolve over time and may include:

- Tangible harm – such as suicide, self-harm, falls, physical health deterioration, medication adverse reactions, neglect and vulnerability;
- Harder to define harm may include safeguarding, exploitation, or loss of: freedom, humanity, privacy, control, liberty, self-determination, hopefulness, self-esteem, dignity, optimism (This list is not exhaustive);
- Short term harm (that might require physical healthcare or lead to an inability to pursue one's interests) and long term harm, such as loss of confidence, independence or inspiration;
- Harm as a result of an act and/or of omission;
- Harm to self and others;
- Iatrogenic harm.

We will further develop our approach to risk management ensuring a focus on the minimization of harm, in all its forms.
Assurance: *Harm minimization report monthly to Patient Safety Group.*

We will provide suicide prevention training as part of a range of interventions to reduce harm.
Assurance: *Harm minimization report monthly to Patient Safety Group.*

We will manage local and national incident reporting and investigation by an effective, open and timely process.
Assurance: *Report to the Quality Assurance Committee*

We will use workshops to ensure an open culture with patients and carers and a just culture for staff.
Assurance: *Report to the Patient Safety Group*

We will use national patient safety information for benchmarking the performance and position of the Trust
Assurance: *Report to the Quality Assurance Committee*

We will seek to reduce harm from medications, including reducing medication errors.
Assurance: Safer Medication Practice Group report to the Drugs and therapeutics Committee

We will ensure the physical health needs of patients are assessed, regularly monitored and appropriately managed in line with agreed Trust standards.
Assurance: *Report to Physical Health and Wellbeing Group*

We will seek to reduce the use of physical restraint in order to:

- enhance patients' experience and safety,
- support patients' journey towards recovery;
- provide a safer working environment;
- improve staff morale.

Assurance: *Report to Patient Safety Group*

We will maintain openness and transparency by publishing patient safety information.
Assurance: *Annual Patient Safety Group report to the Quality Assurance Committee*

By 2017/18 all our acute assessment and treatment beds will be in single en-suite bedrooms.
Assurance: *Annual Patient Safety Group report to the Quality Assurance Committee*

We will develop an implementation plan describing specific work to deliver these objectives. This implementation plan will be monitored through the Executive Management Team or the Clinical Effectiveness Group reporting to the Quality Assurance Committee.

**** We believe that the above measurable objectives are the best available, but that further work to develop, test and implement measures of harm to recovery would lead to a focus on long-term patient-focused harm minimisation.***

Goal 3: "We will support people to achieve personal recovery as reported by patients, carers and clinicians."

Objectives
We will deliver year-on-year improvement in outcome measures (as determined by the current development plan)

To achieve this:
We will deliver the recovery strategy Goals to:

- transform the culture of the Trust to be more recovery orientated
- increase opportunities for people with lived experience of mental health to be involved and work within the Trust at all levels of the organisation
- develop Recovery Colleges
- ensure Trust risk procedures are in line with recovery values and do not harm recovery.

Assurance: *Recovery project report to the Executive Management Team*

will implement, monitor and seek continual improvement in outcome measures within each of our services.
Assurance: *Outcome measures report to Executive Management Team*

Nationally and locally there are challenges recruiting and retaining key staff. In spite of this, we will continue to take effective action to ensure that we have the right number of appropriately skilled staff to support the delivery of the improved outcomes.
Assurance: *Quarterly workforce report to Board*

We will deliver 'best practice', in line with NICE guidance where appropriate.
Assurance: *Annual Clinical Effectiveness Report to the Quality Assurance Committee*

We will use national and local benchmarking and assurance exercises to evaluate services, to highlight and share good practice and reduce any poor performance or out of date practices.
Assurance: *Quarterly Clinical Effectiveness Report to the Quality Assurance Committee*

To improve our services, we will collect and respond to information about care, collecting data using a range of methodologies, for example inspection and audit findings using real-time and periodic information.
Assurance: *Quarterly Clinical Effectiveness Report to the Quality Assurance Committee*

We will involve people who use services in the monitoring of clinical effectiveness.
Assurance: *Annual Clinical Effectiveness Report to the Quality Assurance Committee*

We will develop an implementation plan describing specific work to deliver these objectives. This implementation plan will be monitored through the Executive Management Team or the Clinical Effectiveness Group reporting to the Quality Assurance Committee.

The TEWV way

In 2007, we committed, as part of a ten year strategy, to drive up quality and patient safety. Since then, we have consistently strived to embed a culture of quality improvement in our Trust, in order to continuously improve the quality of care we provide to our patients. This has since become the 'TEWV way'.

The 'TEWV way' involves a simple philosophy incorporating vision, compact and method to ensure we put the patient at the heart of everything we do; working together to prevent and address issues as they arise.

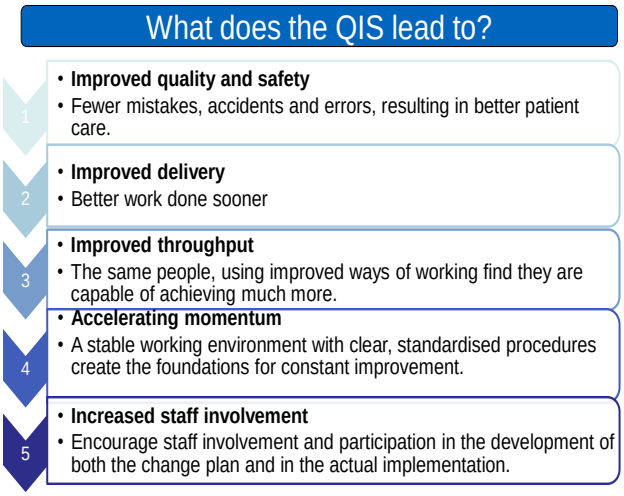
Vision	Compact	Method
• To deliver high quality services that exceed people's expectations.	• A behavioural contract between the Trust and it's staff • Developed in 2009 in consultation with 300 staff	• The TEWV Quality Improvement System • Based on Lean methodology from Toyota Production Systems and Virginia Mason

Over the next two years, we will review and refresh the Trust values, behaviours and compact. We will embed the revised values and behaviours into key management and supervision processes to ensure that they are lived by staff and experienced by patients, carers and staff.

What is the method?

In 2007 we created the Kaizen Promotion Office (KPO) and worked closely with a United States healthcare provider, who had successfully translated methodologies derived from Toyota, to improve the quality of care provided to patients. This became our Quality Improvement System (QIS).

TEWV QIS is about improving the ways we do things within the Trust by identifying and removing wasteful activities and focusing on those that add value to our 'customers'.



A significant number of TEVW staff are trained as leaders in the methodology and over two thousand have taken part in improvement activities and events

It is based on the belief that the staff know what to improve, how to eliminate waste and reduce non value adding activity.

We believe it is the job of management to make the time and improvement methods available to staff to enable them to make those improvements.

An annual programme of quality improvement activity, that is supported by the KPO is developed each year based on the key priorities of the Board of Directors in the business planning. In addition, Directorates identify and carry out their own improvement events to address areas of quality and performance.

In addition:

We will use the information in the below scorecard, supported with additional feedback mechanisms, to assess success in meeting the above Goals and determining further opportunities to improve.

We will learn from gaps in quality and be open and fair with those affected.
Assurance: *Annual staff survey and monthly learning lessons report to the Patient Safety Group*

We will publish additional steps to improve quality in the Quality Account.

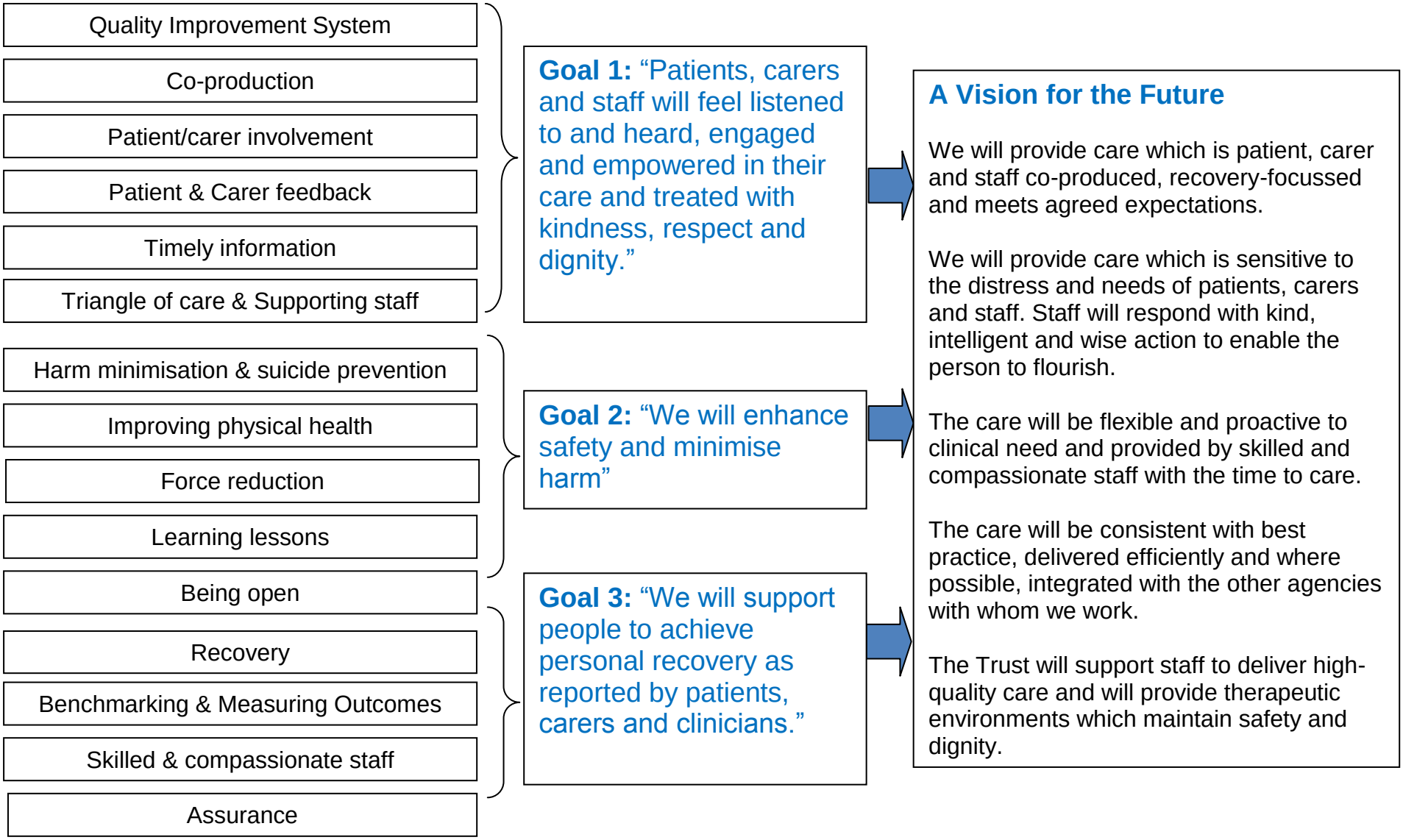
We will deliver on other objectives which underpin quality, including those described in the Recovery, Workforce Development and the Research and Development Strategies, the Estates and Facilities Management Framework and the Integrated Governance Framework.

Scorecard (To be collated quarterly at QuAG, LMGB and Trust levels)

GOAL	Strategic Metrics	Mar 2020 TARGET	Current
1	Percentage of patients who state they have been involved as much as they wanted to be in the planning of their care?	To be determined Apr 2018	Not available
1	Percentage of patients who reported their overall experience as excellent or good	94%	92%
1	Percentage of carers who reported their overall experience as excellent or good	To be determined Apr 2018	Not available
1	Percentage of patients that report that staff treated them with dignity and respect	94%	87%
1	Percentage of carers that report feeling listened to and heard	To be determined Apr 2018	Not available
1	Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment	94%	86%
1	Percentage of staff reporting they can contribute towards improvements at work	87%	80%
1	Percentage of staff who state they agree or strongly agree that their job gives them satisfaction	85%	78%
2	Percentage of patients reported 'yes always' to the question, 'do you feel safe on the ward'?	88%	82%
2	Percentage of patients who report feeling supported by staff to feel safe	To be determined Apr 2018	Not available
2	Medication incidents reported (level 3 and above) per 1000 occupied bed days / 1000 patients (for in-patient and community patients respectively)	Community: 0.0086 In-patient: 0.022	Community: 0.011 In-patient: 0.11
2	Number of incidents of self-harm (level 3 and above) per 1000 occupied bed days / 1000 patients (for in-patient and community patients respectively)	Community: 0.77 In-patient: 0.49	Community:1.016 In-patient: 0.594
2	Number of incidents of falls (level 3 and above) per 1000 occupied bed days / 1000 patients (for in-patient and community patients respectively)	Community: 0.014 In-patient: 0.11	Community: 0.019 In-patient: 0.33
2	Number of incidents of physical intervention / restraint per 1000 occupied bed days	Community: 0.072 In-patient: 12.8	Community: 0.12 In-patient: 16.36
2	Number of episodes of seclusion per 1000 occupied bed days	To be determined Apr 2018	0.66
3	Outcome measures (as determined by the current development plan)	To be determined Apr 2018	Not available

Strategy Driver Diagram

The following Driver Diagram summarises the key areas of work which will help us deliver our vision for every person, every time:



ITEM NO. 5

FOR GENERAL RELEASE

Trust Board

DATE:	**20 December 2016**
TITLE:	**Staffing pressures and mitigations within the Forensic Service**
REPORT OF:	**Brent Kilmurray**
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:

The Forensic Service has been dealing with a significant and prolonged staffing pressure, particularly amongst qualified nursing staff, for well over a year. Although this has been across both in-patient settings, it has been particularly acute in the Forensic Learning Disability Service.

Staffing pressures within the service have been escalated and regularly reported to the Executive Management Team and the Quality Assurance Committee.

In response to the pressures, a plan was developed in March 2016 to mitigate the immediate effects. In the longer term the intention is to reduce the possibility of pressures in the future developing to the same extent. Daily lean management is being introduced into the forensic service in early 2017 as part of the Model Wards programme, which should support staff in managing day-to-day pressures, as well as flagging up imminent problems that need addressing.

Recommendations:

To note the contents of this report, and to provide comment and any recommendations as to progress to date.

MEETING OF:	**Trust Board**
DATE:	**20th December 2016**
TITLE:	**Staffing pressures and mitigations within the Forensic Service**

1. INTRODUCTION & PURPOSE:

1.1 This report is provided to the Trust Board to detail the nature and degree of staffing pressures within the Forensic In-patient Wards, and provide assurance as to both the mitigations in place to manage the pressure and the steps undertaken to reduce the long-term impact.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The Forensic Service has over the years gone through periods when there have been particular staffing pressures within certain professional groups. However by the beginning of 2016 there was a sense that we had hit a 'perfect storm', with their being a prolonged and significant deficit in our qualified nursing establishment across both FLD and FMH. This sense was further compounded in the finding that there was a ward night shift that failed to be covered by a qualified nurse. Contributory factors included the impact of Transforming Care on staff morale / retention, and recent establishment reductions, particularly at night.

2.2 In March 2016 a service-wide meeting took place with the Director of Operations, Head of Nursing, Deputy Medical Director, Heads of Service, Modern Matrons and Clinical Directors to understand and begin to consider options related to nursing staff pressures within the inpatient wards.

2.3 From this a plan was developed that examined the main issues/impact, possible causes and mitigating actions. This has been kept under regular review, and was last updated by the Head of Nursing 12.12.16.

3. KEY ISSUES:

3.1 Appendix 1 details the issues, impact, and mitigating actions by the service. However in summary, it covered the following areas:

- Insufficient staffing levels, especially at night, impacting on ability of staff to respond to incidents and to take staff breaks.
- Insufficient daytime capacity to guarantee expected standards, fulfil patient leave requirements, meet policy requirements and deliver planned activities.
- Registered nurse vacancies despite staffing pressures.
- Staff on restricted duties limiting flexibility in providing staffing solutions.
- Training attendance (particularly for non-mandatory / service specific training).
- Long-term recruitment and retention

3.2 The main actions put in to place to address these issues are as follows:

3.3 The role of night coordinators (band 6) was developed and recruited in to. The night co-ordinators act across the site to respond to incidents, support staff breaks, support seclusion reviews etc. This has been extremely successful. The role is being further developed e.g.to act as fire wardens.

3.4 The service has realigned registered staff between wards to maximise the numbers on each ward.

3.5 The service undertook multiple recruitment drives, and recruited at risk to ensure vacancies were filled.

3.6 As a short term measure, FLD employed six agency staff. This allowed time for new recruits / preceptees to start in post from October 2016. A limited number of agency staff have been retained to ensure preceptees (as they constitute the majority of the new recruits) receive the right level of support and training as they commence their new roles.

3.7 Three additional Band 6 posts are currently being recruited to FMH from existing monies.

3.8 Shifts are being taken to nurse bank as soon as completed.

3.9 An escalation protocol has been agreed to ensure that all wards have a qualified member of staff on duty.

3.10 Following a QIS for leaders project by one of the modern matrons, a new way of completing Health Roster is being piloted; ward mangers within a cluster complete it together. This appears to be more efficient and lead to better outcomes through sharing knowledge of staff, experience and resources.

3.11 The service has worked closely with Human Resources and Modern Matrons to review all cases of staff who are on restricted duties to ensure that they remain appropriate and proportionate.

3.12 Alarm calls have been altered so they are now site-wide, ensuring a better and more consistent response to incidents.

3.13 Wherever possible, we have moved training venues to be delivered locally, to maximise release / minimise pulling of staff back to the wards.

3.14 Training is now better planned, in advance of Health Roster, to ensure attendance.

3.15 Areas of particular training need being prioritised and delivered locally e.g. the Ridgeway physical healthcare team has delivered a two day course for registered nurses in house.

3.16 Future activity includes the following:

- An establishment review tool is planned to be rolled out across the service.
- We are further investing in our dedicated healthcare team to provide the right training and support to staff over longer periods.
- Trust wide the longer term options for opportunities to undertake nurse training are being explored, and forensic services are part of that review.

3.17 The Model Ward Programme is examining how staff resources can be better deployed. IN addition an RPIW on Daily Lean Management is scheduled for January 2017, which is anticipated to examine and address how best to escalate issues and find solutions before they become a crisis.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
Safe staffing is a fundamental standard, and must be assured.

4.2 **Financial/Value for Money:**
Staffing pressures have led to an increase in use of bank staff and the introduction of agency staff for the first time, whose costs have had to be absorbed by the service.

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

4.4 **Equality and Diversity:**
None identified.

4.4 **Other implications:**
None.

5. RISKS:

Safe staffing levels are on the risk registers of the Forensic LMGB as well as the FLD QUAG and FMH QUAG risk registers.

6. CONCLUSIONS:

The service has responded to a sustained and prolonged staffing pressure through a series of short and medium term actions to ensure safe staffing and good patient outcomes and experience.

7. RECOMMENDATIONS:

For Trust Board to review and comment on the progress to date within the Forensic Service in response to staffing pressures.

Author	**Dr Ahmad Khouja**	**Rachel Weddle**
Title	**Deputy Medical Director**	**Head of Nursing**

Background Papers:

None

Appendix 1

Issue and impact	Possible causes	Mitigating actions	Progress / update (12/12/16)	Further actions / questions (March 16)
Overall staffing levels especially at night. Can impact on response between wards. Impacts upon staff taking breaks off site.	Reduction in overall night shift establishment (FLD) Increase in acuity resulting in higher enhanced observations Fill rates from nurse bank Timeliness of shifts going to bank Changes in restrictive practice may have increased staff support / supervision required for some activities Overall reduced establishment / buffer at night.	6-12 shifts – now recruited into Support / oversight from night coordinator role re pro-active management of clinical pressures Control rooms ability to extend response calls	Night coordinator role in place supporting response to incidents, consideration of clinical activity / break support Resource pool now in place and reported to be making a positive difference. Alarm calls now site wide and process in place to support full site response as needed. Breaks audit suggest majority of night staff are getting breaks. Shifts are going as soon as roster is completed to nurse bank. Acuity remains high and is unlikely to reduce especially as bed numbers decrease across the whole system. This reduces options for transfer to high secure, creates delays in those accepted for transfer and concentrates acuity in a smaller number of beds. Roll out of establishment review tool	Consider whole site response system based on blocks. Seek update from HR re breaks audit Are we putting requests to nurse bank early enough? Are we reliant upon moving staff each day? Are business continuity plans effective? Is there a difference in / out of hours? Potential impact of gender / diagnosis / acuity / bed numbers reflected in bed price / future bids? How are we measuring acuity?

Issue and impact	Possible causes	Mitigating actions	Progress / update (12/12/16)	Further actions / questions (March 16)
			planned	
Registered nurse vacancies Difficulty covering shifts with <u>any</u> registered nurse cover. Registered nurses (that can) are often working alone. Reduction in perceived support and supervision. Ward managers dropping into increasing number of shifts	Lack of registered nurses available through completion of nurse training Financial incentives at band 6 in community resulting in retention issues Lack of sense of value if not invested in through development Skills (when developed) sought from other services Shift pattern (12 hour shifts) Sense of isolation when only Q on shift Fill rates of nurse bank	Multiple recruitment drives and ongoing continual adverts and interviews Use of agency registered staff (FLD) Rotation of existing staff between wards to share 'load' Preceptorship programme	New starters now in post from October 16 although majority are preceptees so need to work alongside another registered nurse Concerns regarding further recruitment by community teams remain as new services develop Limited numbers of agency registered staff remain in use in FLD Escalation protocol circulated but anecdotally unclear if always followed Roster Reviews have taken place	Model wards as a project but are there short term solutions before it commences to streamline workload to nursing priorities to support staff and potentially increase retention?

Issue and impact	Possible causes	Mitigating actions	Progress / update (12/12/16)	Further actions / questions (March 16)
	No buffer from current establishment			
Staff on restricted duties. Reduces ability to respond to incidents / move staff based on clinical need. Increases management time spent by ward managers Restrictions limit flexibility of rostering e.g. pregnant staff need to be based on day shift	Demographic of staff group means will always be likely to have staff with restrictions Underlying Health issues in some staff lead to restrictions Occupational health advice appears standard e.g. advises modification / restriction. Some concerns that occupational health report 'what staff tell them'? Threshold limit lower for moving non clinically	Current reviews of restriction	Heads of Service working closely with HR and Matrons to review cases of restricted duties	Understand scale of issue. Discuss with HR if unfit for MOVA are they fit for other requirements e.g. CPR? Consider if some cases need review and where appropriate to be supported into other posts Are we asking occupational health the right questions? (e.g. currently we seem to be asking if they can do aspects / all of role – should we instead be asking what needs to be in place to enable them to fulfil their role?). Puts emphasis on them stating in post as opposed to 'temporary' moves

Issue and impact	Possible causes	Mitigating actions	Progress / update (12/12/16)	Further actions / questions (March 16)
Inability to achieve expected standards (appraisal / supervision) / fulfil patient leave requirements and meet policy requirements (seclusion) and deliver planned activities At times patient leaves are cancelled due to overall staffing Nurses feeling role is diluted and they are doing components that others do not see as their role. Staff missing breaks / working short staffed / leaves getting cancelled Not achieving development activities with nursing staff	Lack of 2nd registered nurse on shift. Wards running short staffed Role clarity for nursing – what are they doing out with their core function / administrative duties on behalf of MDT. Multiple 'priorities' delegated centrally Lack of advanced planning / coordination. Reflects empowerment / 'ownership' of shifts and MDT decision making by nursing staff Vacancy factor increases proportion of workload between staff in post	Ensure timely recruitment into maternity posts where can. Safe wards where embedded. FMH reviewed resource capacity to deliver leave prescriptions to try and match planning to resources.	Night coordinator role now in place supporting seclusion reviews and supervision as needed Model Ward Project commenced including a number of staff training as QIS leaders with ward based projects RPIW planned for early 2017 re role of B5/6. This will be focussed on handovers and coordination	Through model wards review quality of coordination and forward planning. Explore ownership and empowerment of front line nurses. Review 'scene setting' for the shift – quality of handovers in terms of communication of pertinent issues / tone / efficiency and frequency. Short term actions for all wards?
Unpredictable activity impacts upon planning	Leave prescriptions exceeding nurse resource capacity			

Issue and impact	Possible causes	Mitigating actions	Progress / update (12/12/16)	Further actions / questions (March 16)
Training attendance (particularly non mandatory / service specific training) Potential risk to patient safety if staff not appropriately trained to meet individual needs. Risk of increased staffing pressures as staff not able to resolve issues locally e.g. physical health complications Potential impact onlength of stay if staff not suitably skilled to manage specific conditions Potential increase in staff burnout / retention if staff feeling under invested in / under skilled for role	Only mandatory training is included in the establishment 'head room' Loss of staff who feel undervalued due to lack of development Difficulty in release of staff from the wards / cancellation of staff attending training due to short term staffing pressures. Training is sometimes planned after roster is produced making release harder. Multiple competing training priorities meaning that we are not achieving high	Training is locally delivered to maximize release / minimize the 'pulling' of staff back to the wards. Ensure training planned in advance of Health Roster to aid planning. Investment in physical healthcare team to support physical healthcare.	Pro-active completion of the Forensic Training Needs Analysis to ensure that the priorities are right for the specific service need Physical Healthcare team delivering full 2 day course for registered nurses in house Forensics well engaged in the Trust wide TNA planning - post RPIW from July Reviews of Health Roster undertaken including a project piloting shared completion through a cluster to try and maximise use of resources. Resource implications currently mean front loading training whilst preferable has not been practical to date.	Is there further support that can be offered by in house training team? Are we utilising registered staff that are not ward based to support training cascade? Is cancelling training and pulling staff back always a last resort? Should we front load training for new starter's pre allocation to roster?

Issue and impact	Possible causes	Mitigating actions	Progress / update (12/12/16)	Further actions / questions (March 16)
Inability to deliver nursing component of treatment plans e.g. DBT	numbers in any of them Training priorities set centrally (stat and mand) without service view			
Recruitment and retention remains an ongoing issue and pressure Does the ability to only advertise vacancy for HCA at reduced band impede internal movement between services? Final placement student opportunities are limited which may reduce pool of interested staff Ongoing expansion of services which are community based,	Restricted internal movement e.g. adult services of experienced HCA into Forensics. Unable to recruit suitably skilled and experienced staff to certain posts Current model is final placement is a return to year 1 placement and forensics do not offer placement in year 1.	Skill mix review to increase B6 posts in FMH. Development opportunities for HCA to undertake training	Trust wide issue and longer term options for opportunities to undertake nurse training being explored. 3 x additional Band 6 posts currently being recruited to in FMH from existing monies No short term solutions regarding increased nurses coming through training however more proactively involved in recruitment drives Trust wide. Service has realigned registered staff between the respective wards to maximise the numbers on each ward. Discussions regarding taking 3rd year students to increase possibility of recruiting these staff into posts are	

Issue and impact	Possible causes	Mitigating actions	Progress / update (12/12/16)	Further actions / questions (March 16)
predominantly offering posts at Band 6 Transforming Care leading to uncertainty / consultations / impact on ability to recruit substantively	Loss of post preceptee Band 5 staff to Band 6 posts elsewhere Increased loss of staff from service and increased challenges recruiting staff in. Impact of staffing pressures creates an revolving staffing cycle		ongoing	

ITEM NO. 6

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**20th December 2016**
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 Integrated Governance Framework (IGF) describes the governance arrangements of the Trust, providing a comprehensive and cohesive framework with regard to behaviours, structures and systems and processes.

This report sets out the proposed changes to the document following its annual review.

The Audit Committee has reviewed the proposed changes and has recommended the revised IGF to the Board for approval subject to discussions on the rationale for the establishment of a Resources Committee.

Recommendations:

The Board of Directors is asked to:

(1) Approve the revised Integrated Governance Framework.

(2) Establish the Resources Committee as a formal committee of the Board in place of the Investment Committee.

(3) Appoint the Chairman and Non-Executive Director Members of the proposed Resources Committee.

MEETING OF:	**Board of Directors**
DATE:	**20th December 2016**
TITLE:	**Integrated Governance Framework**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to seek the Board of Directors approval of the revised Integrated Governance Framework (IGF) including the establishment of a Resources Committee.

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 IGF is reviewed annually to take into account changes to the Trust's governance arrangements and the regulatory environment. The present version of the document was approved by the Board on 15th December 2015 (minute 15/348 refers).

3. KEY ISSUES:

3.1 Those parts of the IGF, which are proposed for amendment, are attached as Annex 1 to this report. The key changes have been highlighted for ease of reference.

(Note: A full version of the IGF has also been placed in the Board's reading room on the Boardpad system for information with copies provided to the Executive Directors).

3.2 The key changes to the document are as follows:

(a) Section 1.1 – Introduction

Proposed changes to the wording and formatting to draw out and emphasise the role of the Trust's integrated governance arrangements in providing assurance to the Board.

(b) Section 1.5 – The Statutory and Regulatory Framework

Proposed amendments to reflect:

- The establishment of NHS Improvement (NHSI) replacing Monitor (throughout the document).
- The introduction of the Single Oversight Framework (in place of the Risk Assessment Framework) and consequential changes to the narrative on triennial external governance reviews and CQC "well-led" inspections.
- The introduction of the "Freedom to Speak Up Guardian".

(c) Section 3.6 – The Board of Directors, its Committees and the Executive Management Team

Changes to reflect the proposal to replace the Investment Committee with a Resources Committee.

(d) Part 4 – Key Systems and Processes

Proposed changes to:

- Include "organisational" in the title of the Risk Management Policy to differentiate it from clinical risk management arrangements relating to individual patients.
- Include information on the Involvement and Engagement Framework (approved by the Council of Governors in November 2015) and the TEWV Quality Improvement System for completeness.
- Amend the text on the External Auditors to provide a fuller description of their role and to reflect the requirement for them to follow the Audit Code issued by the National Audit Office in place of the Audit Code for NHS Foundation Trusts.

(e) Appendix 10 – Core Committees

- Amendments to reflect the changes to the terms of reference and membership of the Committees as agreed by the Board at its meetings held on 29th September and the change to one of the Governor Members of the Mental Health Legislation Committee (as agreed by the Council of Governors).
- Further suggested changes to the terms of reference:
  - To include those of the proposed Resources Committee.
  - To reflect the invitation for a Governor to attend the special meeting of the Audit Committee to consider the Annual Report and Accounts.
  - To standardise, where appropriate, reporting arrangements from the Committees to the Board.

(f) Appendix 14 – Operational Risk Management Policy

Changes to reflect the decisions of the Executive Management Team on:

- The introduction of issues logs at ward/team level.
- Reporting, escalation and step-down arrangements between wards/teams and Quality Assurance Groups recognising the variations in structures across the Trust.

3.3 The Audit Committee has reviewed the proposed changes to the document and has recommended them to the Board for approval subject to discussions on the rationale for the establishment of the proposed Resources Committee.

3.4 If the Resources Committee is established the Board is asked to appoint its Chairman and Non-Executive Director Members. It is suggested that these should be the same as those currently serving on the Investment Committee.

3.5 Board Members will be aware that, following discussions at the Seminar held on 8th November 2016, a focussed piece of work is being undertaken to review and strengthen the Trust's governance arrangements particularly in relation to assurance and risk management processes. Any changes arising from this initiative are likely to result in amendments to the IGF.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** The IGF supports compliance with the "well-led" domain of the CQC's Fundamental Standards.

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

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

4.4 **Equality and Diversity:** No implications have identified from the equality analysis screening of the IGF.

4.5 **Other implications:** There are no other implications.

5. RISKS:

5.1 There are risks of organisational failure if the Trust's governance arrangements are not comprehensive, robust and understood.

6. CONCLUSIONS:

6.1 The IGF has been updated to reflect changes to the internal and external regulatory environment.

7. RECOMMENDATIONS:

7.1 The Board is asked to:

(a) Approve the proposed amendments to the Integrated Governance Framework.

(b) Establish a Resources Committee in place of the Investment Committee.

(b) Approve the appointment of the Chairman and Non-Executive Members of the Resources Committee as follows:

- Chairman – Jim Tucker
- Non-Executive Members – Marcus Hawthorn, David Jennings and Paul Murphy.

(c) Note the focussed work being undertaken to strengthen assurance and risk management processes following the Board Seminar held on 8th

November 2016 and that the outcome of this initiative will need to be reflected in the next iteration of the IGF.

Phil Bellas, Trust Secretary

Background Papers:
Full version of the Integrated Governance Framework
Single Oversight Framework
Notes of the Board Seminar held on 8th November 2016

Tees, Esk and Wear Valleys NHS
NHS Trust

Integrated Governance Framework

(including the Organisational 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	~~15~~th December 201~~5~~6
Date of Review	December 201~~6~~7
Replacing	Integrated Governance Framework (December ~~February~~ 2015 Edition)
Lead	~~Martin Barkley~~ Colin Martin
Members of working party	

This policy has been agreed and accepted by: (Director)

Name	Designation	Signature	Date
Colin Martin~~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	**~~15~~20th December 201~~5~~6**
This policy has gone through an equality impact assessment (EqIA)	Date of EqIA **December 2016~~1 April 2008~~ (remains relevant)**

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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 support:

- The provision of assurance (confidence/ evidence /certainty) to the Board of Directors, the Council of Governors, Members and other stakeholders that the organisation is meeting its statutory and regulatory duties, achieving its strategic objectives and fulfilling its obligations to patients, carers, staff and local communities.
- The identification and management of 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.

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 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 NHS Improvement (NHSI).[1]

[1] NHS Improvement is the operational name for an organisation which brings together the functions of Monitor, the health sector regulator, and the Trust Development Agency.

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 NHSI.
- **Pricing** – These conditions oblige providers, for example, to record information that NHSI needs to set prices, to check that data is accurate, and where required, charge commissioners in accordance with the national tariff documents.
- **Choice and Competition** – These conditions oblige providers to help patients 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.

NHSI's approach to overseeing NHS Foundation Trusts and NHS Trusts is set out in its Single Oversight Framework (SOF).

The purpose of the framework is to identify where providers may benefit from, or require, improvement support from the regulator across five themes:

- Quality of care (safe, effective, caring, responsive)
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability ("well-led")

Under the SOF providers are placed in "segments", from segment 1 (maximum autonomy) to 4 (special measures), depending on the amount of support each needs.

Segmentation is determined by a number of factors including the findings of CQC inspections.

Foundation Trusts will be placed in segments 3 and 4 where NHSI considers that they are in breach or suspected breach of their Licence conditions. Enforcement action by the regulator is likely in these circumstances.

NHSI expects Foundation Trusts to undertake independent external reviews of their governance arrangements every three years.

The framework for these "well-led" reviews 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 NHSI together with the Foundation Trust's plans to address them.

The characteristics of a well-led organisation, as defined by NHSI, are aligned to those of the CQC. This enables information to be shared between the regulators and for the outcomes of the external governance reviews to be used in the CQC's inspections (see below).

At present work is being undertaken by NHSI and the CQC to align their approaches more fully with the intention of moving towards a single combined assessment of quality and use of resources.

- **The Foundation Trust Code of Governance**

  The Foundation Trust Code of Governance, published by NHSI, 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 five key questions:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

These will be supplemented by an assessment of use of resources which is being jointly developed by the CQC and NHS Improvement.

Whilst NHSI's "well-led" assessments focus primarily at Board and Committee level, the CQC's inspection framework in this area 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. In doing so it has learnt from best practice e.g. external independent evaluations.

However, the arrangements are under continual review and development reflecting 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.

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

The roles and responsibilities of staff are set out in the Duty of Candour Policy.

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.

In accordance with national guidance the Trust has a "Freedom to Speak Up Guardian" whose purpose is to work alongside leadership teams to support the organisation in becoming a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.

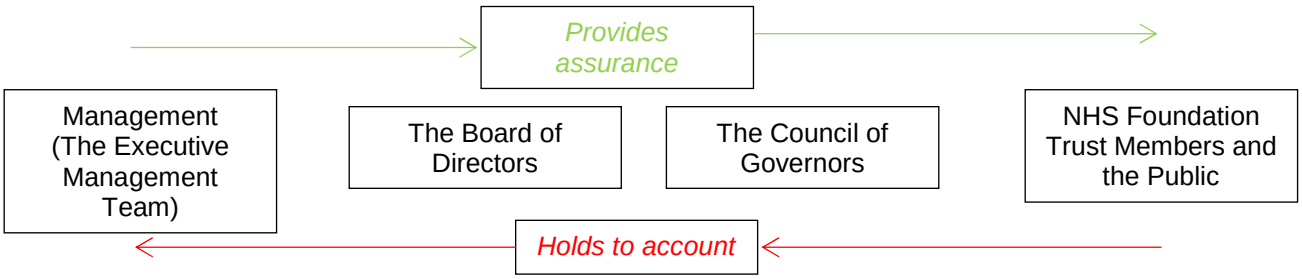
PART 3 – GOVERNANCE STRUCTURES AND ROLES

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 NHSI 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 3.

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.

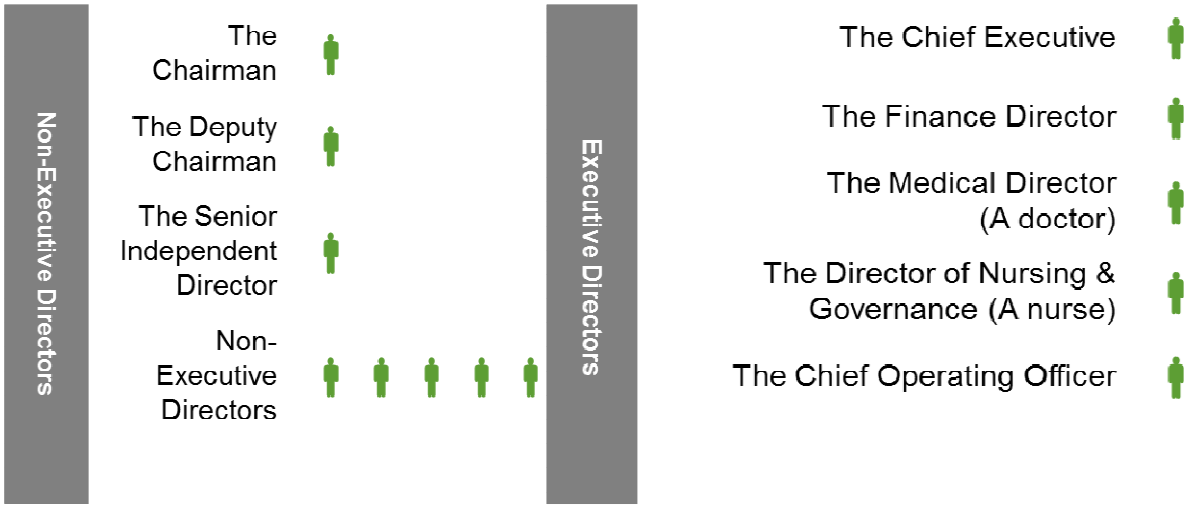
On behalf of the Chief Executive, the Trust Secretary also has responsibility for overseeing the governance and assurance arrangements of the Trust.

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 4).
- The sequence of meetings to support its quality governance arrangements (Appendix 5).
- Standard Action Plan (Appendix 6).
- Standards for agendas and minutes of meetings (Appendix 7).
- Standard agenda templates for the Quality Assurance Groups and Specialty Development Groups (Appendices 8 and 9).

3.5 The Board of Directors



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]

As a unitary Board, both Executive and Non-Executive Directors have collective responsibility and liability for all aspects of the performance of the Foundation

[2] Health and Social Care Act 2012

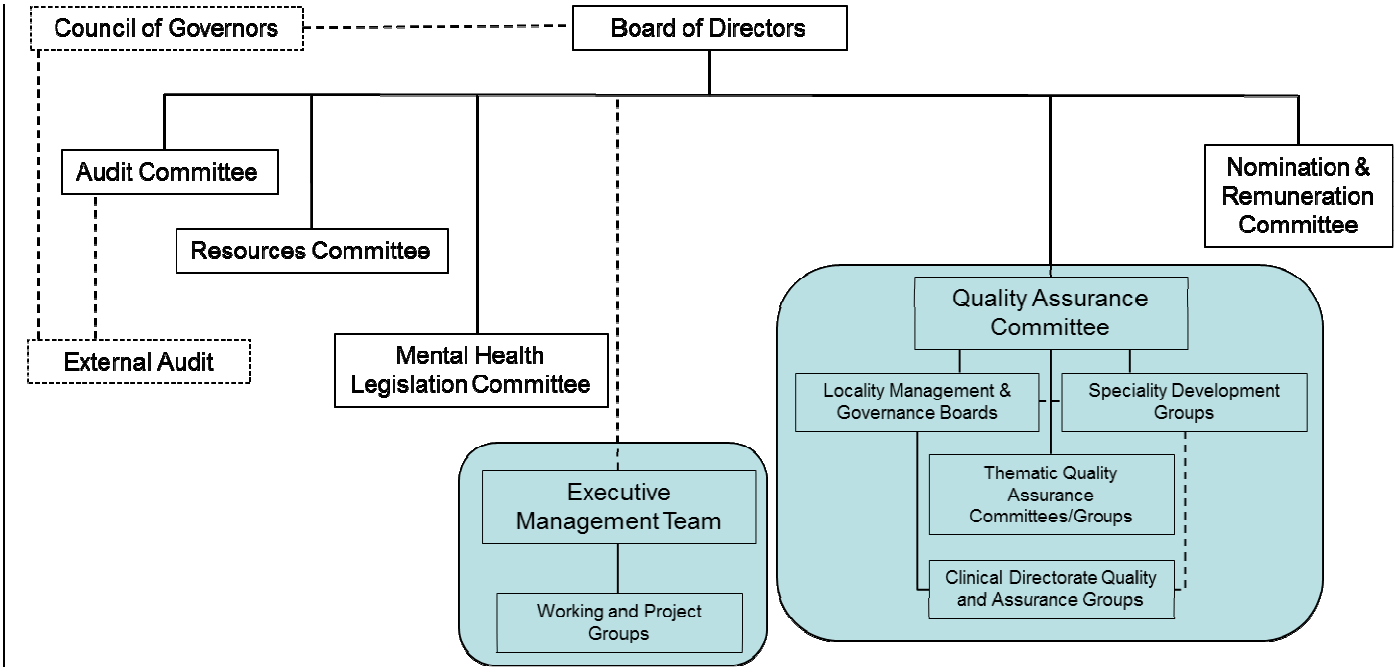
Trust, including financial performance, clinical and service quality, management and governance.

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 NHSI, 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 exercises its functions effectively, efficiently and economically.

3.6 The Board of Directors, its Committees and the Executive Management Team



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.

Resources Committee:

- The oversight and provision of assurance to the Board of Directors on resource planning and deployment (including the financial strategy, capital plan, the workforce strategy and the information strategy) to support the delivery of the Operational/Business Plan.
- The scrutiny of significant business cases (e.g. major capital developments).
- Oversight of the Trust's Charitable Trust Funds.

(Note: The delivery of the Operational Plan is overseen by the Board).

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:

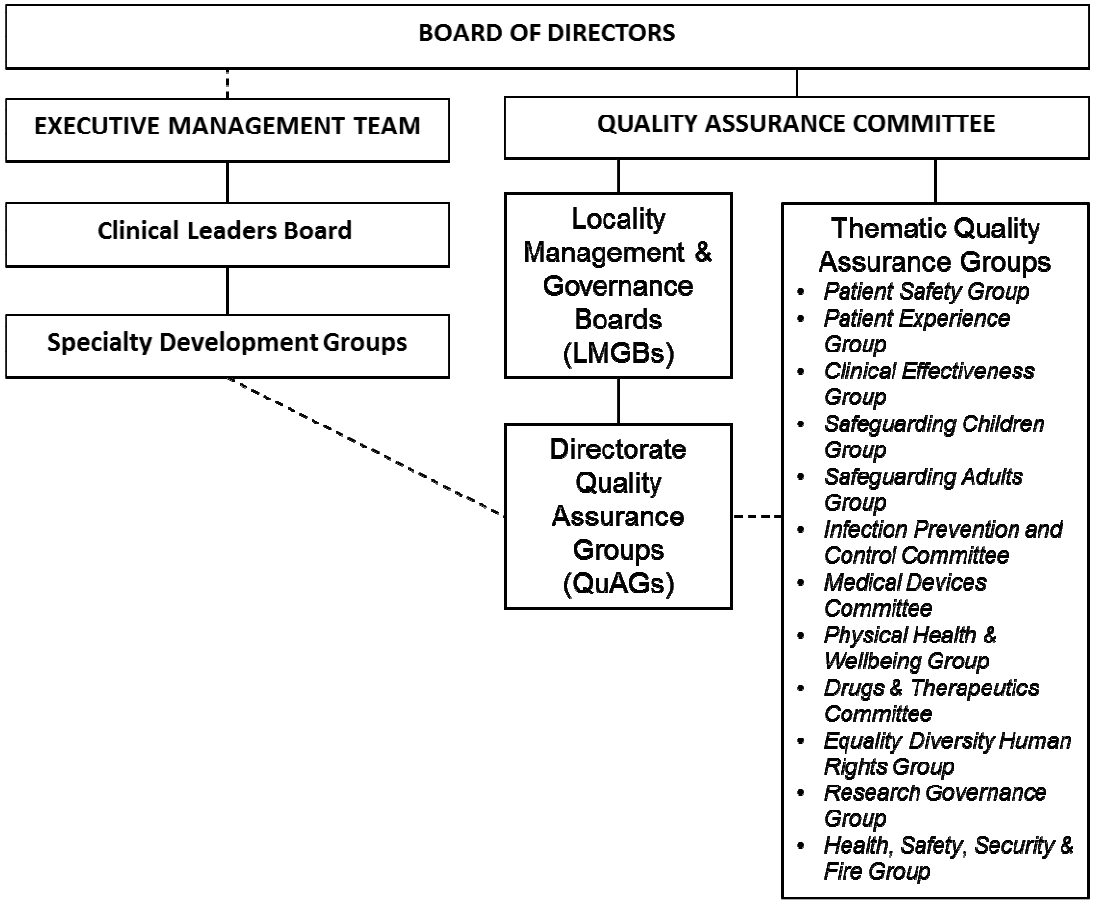
- The appointment and agreement of the terms and conditions of service of the Chief Executive and Directors reporting directly to the Chief Executive.
- The receipt of assurance, through the appraisal system, on the delivery of the objectives and the personal development plans of the Chief Executive 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 10)*

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:

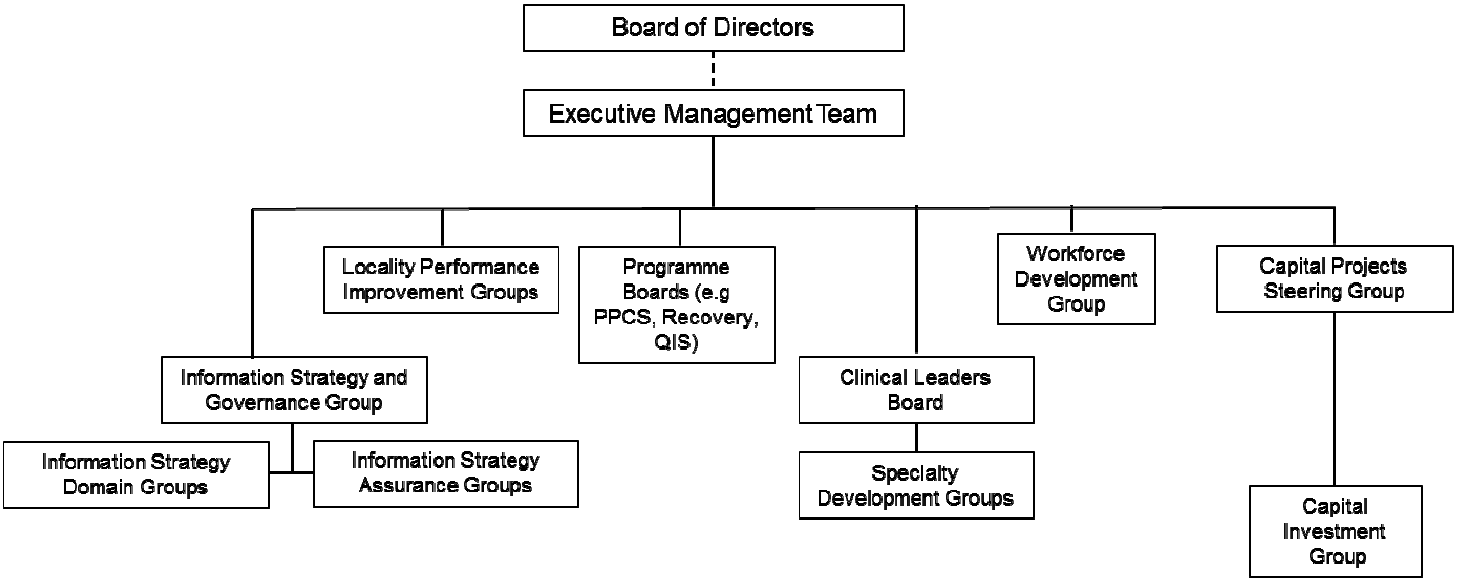
- A forum for the most senior clinicians in the Trust to provide collective advice to the Executive Management Team (EMT) and, in turn, the Board.

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 11. Its Terms of Reference are provided in Appendix 12).*

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).

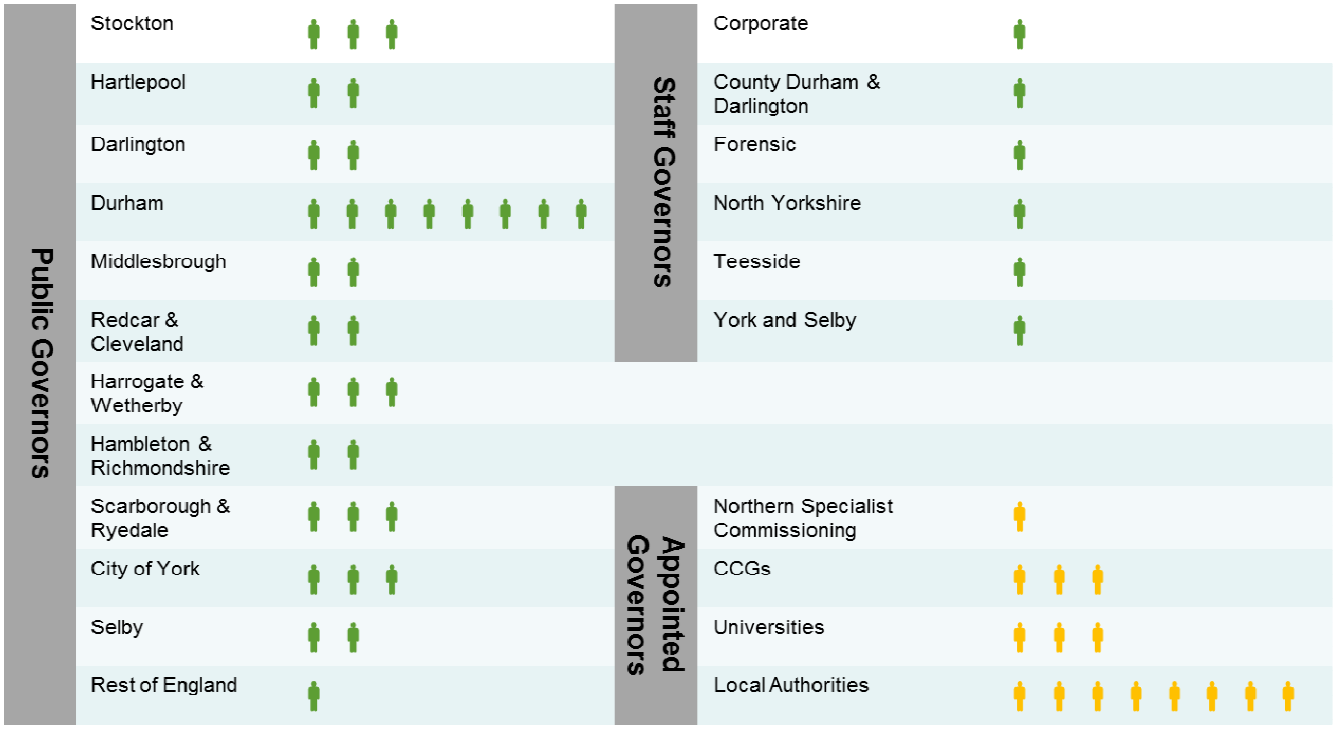
3.9 Other Groups

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

"NHS foundation trust governors are the individuals that bind a Trust to its patients, staff, and local stakeholders. They are direct representatives of local interests within the governance structure of the Trust."[3]



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 NHSI and the CQC.

The Council of Governors has general duties:[4]

- 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.

[3] NHSI
[4] The Council of Governors has reviewed the meaning of these duties and how they are undertaken. Copies of the reports on these reviews are available on the Trust's website.

- 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 NHSI.
- 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 NHSI 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 NHSI.

The following committees and groups have been established to support the Council of Governors fulfil its responsibilities:

- The Nomination and Remuneration Committee.
- The Involvement and Engagement Committee (formerly the "Making the Most of Membership Committee").
- The Task and Finish Group Oversight Committee.
- Task and Finish Groups (there are time limited groups to review and make recommendations to the Council of Governors on topics is considers important).
- 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 1	<u>Support Member</u> Receives • Annual General Meeting Notification • Governor Election material
Level 2	<u>Informed Member</u> Receives • Annual General Meeting Notification • Governor Election material • Insight Magazine
Level 3 (Default)	<u>Active Member</u> Receives • Annual General Meeting Notification • Governor Election material • Insight Magazine • Event notification • Consultations • Surveys
Level 4	<u>Involved Member</u> 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

The Trust has also developed a Member Charter (Appendix 13) 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 Organisational Risk Management Policy is available at Appendix 14.

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.
  - Provide assurance to its regulators that it is meeting its obligations and is financially sustainable.

  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 and other stakeholders.

- **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 **Involvement and Engagement Framework**

The Involvement and Engagement Framework recognises the critical importance of working in partnership with service users and carers to design and deliver high quality person centred services which promote recovery.

The concept underpinning the Framework is that of a "journey" whereby people are supported in achieving their aspirations to be involved in a range of roles and activities.

Delivery of the Framework is monitored by the Involvement and Engagement Committee of the Council of Governors.

4.5 **The TEWV Quality Improvement System**

The TEWV Quality Improvement System (QIS) aims to maximise quality and eliminate waste by a cycle of continuous improvement.

The QIS is used to help improve the quality and value of services by looking at existing ways of operating, removing waste from processes and maximising activities that add value. Processes are observed, analysed and rebuilt using the best elements to ensure high quality service delivery.

A key element of the QIS is to utilise the expertise, knowledge and experience of staff, service users and carers through their direct involvement in improvement events.

The origins of TEWV QIS lie in the world class approach to quality improvement systems delivered by Toyota - an approach subsequently translated into healthcare by the Seattle-based Virginia Mason Medical Centre.

4.6 **Audit**

- **External Audit**

The main responsibility of external audit is to perform the annual statutory audit of the financial accounts and annual report providing an independent opinion on whether they are a true and fair reflection of the Trust's position.

The External Auditors also review and provide reports on:
- The financial accounts of the Trust's Charitable Funds.
- The Trust's Quality Account.

The work of the External Auditors is governed by the Code of Audit Practice, published by the National Audit Office, guidance published by NHSI and other statutory and regulatory requirements.

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.

4.7 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 15.

4.8 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.

4.9 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 NHSI requirements, the Board will commission an independent external assessment of its governance arrangements (a ""well-led" review) at least once every three years.

APPENDIX 10

BOARD OF DIRECTORS - CORE COMMITTEES

AUDIT COMMITTEE

TERMS OF REFERENCE

1 CONSTITUTION AND PURPOSE

1.1 The Audit Committee is established under Standing Order 6 of the Board of Directors.

1.2 The Committee exists to provide the Board of Directors with a means of independent and objective review of financial and corporate governance and assurance and risk management processes across the whole of the Trust's activities (both clinical and non-clinical) both generally and in support of the achievement of the Trust's Strategic Direction.

1.3 The Committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.

1.4 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.

2 FUNCTIONS

Governance, Risk Management and Internal Control

2.1 To review 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 Goals.

In particular, the Committee will review the adequacy of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with national standards/regulatory requirements), together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board;

- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements; and

- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect.

Internal Audit

2.2 To consider the Internal Audit Strategy and Operational Plan ensuring it is consistent with the needs of the organisation as identified in the Assurance Framework.

2.3 To oversee, on an ongoing basis, the effective operation of Internal Audit in respect of:

- Adequate resourcing
- Its co-ordination with External Audit
- Meeting mandatory NHS Internal Audit Standards
- Providing adequate and appropriate independent assurances
- Having appropriate standing within the organisation
- Meeting the internal audit needs of the Trust

2.4 To consider the major findings of Internal Audit investigations and management's responses and their implications and monitor progress on the implementation of agreed recommendations.

2.5 To consider the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.

2.6 To conduct an annual review of the effectiveness of the Internal Audit function.

External Audit

2.7 To make recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the External Auditor.

(Note: Where the Council of Governors does not approve the recommendation, the Audit Committee shall prepare a statement for consideration by the Board of Directors explaining its recommendation, for inclusion in the Annual Report.)

2.8 To oversee the conduct of a market testing exercise for the appointment of an External Auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors in respect to the appointment of the External Auditor.

2.9 To discuss with the External Auditor, before the audit commences, the nature and scope of the audit and to ensure coordination, as appropriate, with other External Auditors in the local health economy.

2.10 To review the work and findings of the External Auditor and to consider implications and management's responses to their work. This will be achieved by:

- consideration of the appointment and performance of the External Auditor ;

- discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee; and

- reviewing all External Audit reports, including agreement of the annual audit letter (if required) before submission to the Board and any work carried out outside the annual audit plan, together with the appropriateness of management responses.

2.11 To review and monitor the External Auditor's independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements and compliance with the Audit Code for NHS Foundation Trusts.

2.12 To develop and implement a policy on the engagement of the External Auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the External Audit firm.

Annual Accounts Review

2.13 To review whether the Trust remains a "going concern" and to assure the Board accordingly.

2.14 To review the annual statutory accounts, before they are presented to the Board of Directors, to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- The meaning and significance of the figures, notes and significant changes.
- Areas where judgment has been exercised.
- Adherence to accounting policies and practices
- Explanation of estimates or provisions having a material effect
- The schedule of losses and special payments
- Any adjusted misstatements
- Any reservations and disagreements between the External Auditors and management which have not been satisfactorily resolved

2.15 To review the Annual Report and Annual Governance Statement prior to submission to the Board of Directors to determine their completeness, objectivity, integrity, accuracy and compliance with directions received from NHS Improvement.

2.16 To review the Trust's Quality Account/Report prior to inclusion in the Annual Report and submission to the Board of Directors to determine its completeness, integrity and accuracy. This review will include but is not limited to:

- Compliance with directions received from the Department of Health and NHS Improvement.
- The accuracy of mandatory and local performance indicators
- Any issues raised by stakeholders

2.17 To review all systems of accounting and financial reporting, including those of budgetary control, in order to provide assurance on the completeness and accuracy of information provided to the Board.

Other

2.18 To review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. NHS Improvement , the Care Quality Commission, NHS Litigation Authority, etc.) and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

2.19 To review the work of other committees within the organisation and the Executive Management Team (*including recommendations from EMT and the other Committees)* whose work can provide relevant assurance to the Committee's own scope of work on the appropriateness, robustness and operation of the Trust's governance arrangements. This will particularly include the Quality Assurance Committee.

In reviewing the work of the Quality Assurance Committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

2.20 To review arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters ("The Whistle Blowing Policy").

In undertaking the review the Committee's objective will be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

2.21 To review the Trust's systems and processes for the prevention of bribery and receive reports on non-compliance.

2.22 To request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

2.23 To request and review specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

2.24 To commission and review value for money studies of the Trust's services and functions and to make recommendations to the Board accordingly.

3 MEMBERSHIP

3.1 The Committee shall be appointed by the Board from amongst the Non - Executive Directors/ Associate Non-Executive Directors of the Trust and shall

consist of not less than four members. At least one Member of the Committee shall have recent and relevant financial experience.

3.2 The Chairman of the Committee shall be appointed by the Board of Directors.

3.3 Members of the Committee are expected to attend every meeting unless their absence is due to a reasonable cause agreed with the Chairman. Nominated deputies may be appointed when appropriate.

4 ATTENDANCE

4.1. The Director of Finance and appropriate Internal and External Audit representatives shall normally attend meetings. .

4.2 The Chairman of the Trust shall not be a member of the Committee but may attend as an observer at the invitation of the Committee.

4.3 Any Non-Executive Director of the Trust may attend meetings should they wish and participate in discussions on all matters before the Committee. All Non-Executive Directors will receive Audit Committee agendas and papers.

4.4. The Chief Executive and other Executive Directors **may** be invited to attend, but particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

4.5 The Chief Executive should be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

4.6 A Governor, nominated by the Council of Governors, shall be invited to attend the special meeting of the Committee to consider the draft Annual Report and Accounts, and the External Auditors' reports relating to them in an observer capacity.

4.7 The Trust Secretary, or an officer appointed by him/her, shall be the Secretary of the Committee.

5 QUORUM

5.1 A quorum shall not be less than three members of the Committee.

6 FREQUENCY

6.1. Meetings shall be held not less than three times a year.

6.2 The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

6.3 The Committee shall meet privately at least once a year with the Internal and External Auditors.

7 DELEGATED AUTHORITY

7.1 Authority to investigate any activity within its terms of reference.

7.2 Authority to seek any information it requires from any employee. All employees are directed to co-operate with any request made by the Committee.

7.3 Authority to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise at its meetings if it considers this necessary.

7.4 Authority to commission value for money and other studies.

7.5 Approval of the Internal Audit Strategy and Operational Plan.

7.6 Appointment and dismissal of the Internal Audit provider.

7.7 Approval of the External Audit Strategy.

8 REPORTING

8.1 Following every meeting the Chairman of the Committee shall report to the Board of Directors:

- To provide assurance to the Board on the matters considered and to highlight any risks and mitigating actions identified by the Committee at its meeting (including any risks which the Committee considers should be escalated to the Board Chapter of the Integrated Assurance Framework and Risk Register).
- To draw to the Board's attention any issues that require disclosure to the full Board or where executive action is required.
- To seek the Board's approval of any recommendations made by the Committee.
- To present the minutes of the Committee approved at the meeting.

8.2. The Committee will report to the Board annually 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, the integration of governance arrangements and the appropriateness of the self-assessments as required by NHS Improvement and/or the Care Quality Commission.

8.3 The Audit Committee may also make recommendations directly to the Council of Governors on any matters it deems appropriate within the Council of Governors roles and responsibilities.

9 REVIEW

9.1. The terms of reference of the Committee shall be reviewed, at least, annually.

Appendix 10.2

COMMERCIAL OVERSIGHT COMMITTEE

TERMS OF REFERENCE

1 CONSTITUTION

1.1 The Commercial Oversight Committee is established under Standing Order 6 of the Board of Directors.

1.2 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.

1.3 For the purposes of these Terms of Reference the term “Subsidiary” shall include any company, limited liability partnership, joint venture or other trading initiative which the Committee is designated as overseeing.

2 FUNCTIONS

2.1 To oversee and provide assurance to the Board on the performance of the Trust’s Subsidiaries.

2.2 To ensure that all the Trust’s Subsidiaries:

(a) Are and remain established in accordance with the Companies Act 2006 and / or other relevant legislative requirements;

(b) Have no functions other than those agreed by the Board of Directors of the Trust;

(c) Adhere to all applicable laws and statutory guidance;

(d) Ensure appropriate insurance is in place, in particular:

i. Employer Liability

ii. Public Liability

iii. If relevant, Directors and Officers insurance

iv. All other relevant insurance

(e) Apply the proceeds of any trading activity to the benefit of the Trust.

2.3 To provide input on any matter related to the Trust’s interest in a Subsidiary to:

(i) The nominee(s) on the board or equivalent of that Subsidiary.

(ii) If relevant, a person or persons appointed under Section 323 of the Companies Act 2006 to act as the Trust’s representative or representatives at any meeting of the Subsidiary.

2.4 To receive and review the annual reports and accounts of Trust Subsidiaries.

2.5 To notify any material risks with regard to the operation of the Trust Subsidiaries to the Board of Directors.

2.6 To investigate any concerns it may have in relation to any Subsidiary and to report the outcome of any investigations, if it considers it appropriate, together with suggested recommendations to the relevant Subsidiary and the Board.

2.7 To take appropriate steps to ensure the Subsidiaries remain financially solvent and provide a positive financial return to the Trust.

3 DELEGATED AUTHORITY

3.1 In carrying out its duties the Committee may do anything which appears to it to be reasonably necessary or expedient for the purposes of or in connection with the functions set out above. In particular it may agree its requirements as to the information it requires from Trust Subsidiaries in order to maintain proper oversight of their activities.

4 MEMBERSHIP

4.1 The Committee shall comprise:

- The Chairman of the Trust*.
- The Chairman of the Investment Committee*
- The Chairman of the Audit Committee*
- An Executive Director*

(* subject to them also not being a director or senior post holder of any Subsidiary).

4.2 The Chairman of the Committee shall be appointed by the Board from amongst the Committee's membership.

4.3 The Committee may require:

- Directors or senior post holders of Subsidiaries;
- Internal or external auditors;
- Any other relevant third parties

to attend its meetings, as it considers appropriate, for maintaining an oversight of Subsidiary business planning, performance and activities.

4.4 The Trust Secretary, or a member of his/her staff, shall be the Secretary to the Committee.

5 QUORUM

5.1 A quorum shall be not less than two members of the Committee of which one shall be a Non-Executive Director and one shall be an Executive Director.

6 FREQUENCY OF MEETINGS

6.1 The Committee shall meet at least once each quarter.

7 REPORTING ARRANGEMENTS

7.1 Following every meeting the Chairman of the Committee shall report to the Board of Directors:

- To provide assurance to the Board on the matters considered and to highlight any risks and mitigating actions identified by the Committee at its meeting (including any risks which the Committee considers should be escalated to the Board Chapter of the Integrated Assurance Framework and Risk Register).
- To seek the Board's approval of any recommendations made by the Committee.
- To present the minutes of the Committee approved at the meeting.

8 REVIEW

8.1 The terms of reference of the Commercial Oversight Committee shall be reviewed at least annually.

MENTAL HEALTH LEGISLATION COMMITTEE

TERMS OF REFERENCE

1 CONSTITUTION

1.1 The Mental Health Legislation Committee is established under Standing Order 6 of the Board of Directors

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

1.3 All meetings of the Committee will be held in public.

2 FUNCTIONS

2.1 To provide assurance to the Board on the Trust's compliance with the Mental Health Act 1983 and the Mental Capacity Act 2005, including any statutory Codes of Practice relating thereto, by:

(a) reviewing activity and performance with appropriate comparisons and trends; and

(b) identifying common themes arising from the findings of the Care Quality Commission following visits to the Trust's services

and to escalate risk and propose mitigating actions to the Board where assurance is lacking.

(NOTE: Oversight and monitoring of actions in response to recommendations received from the Care Quality Commission falls within the remit of the Quality Assurance Committee).

2.2 To consider the implications of any changes to statute, including statutory Codes of Practice, or case law relating to the Trust's responsibilities as a provider of mental health services and to make recommendations, as required, for changes to the Trust's policies, procedures and practice.

2.3 To ensure appropriate arrangements are in place for the appointment and appraisal of associate managers and oversee managers' hearings.

2.4 To consider other matters at the request of the Board of Directors.

3 MEMBERSHIP

3.1 The Committee will comprise:

- A Non-Executive Director as the Chairman of the Committee
- Two other Non-Executive Directors/ Associate Non-Executive Directors
- The Chairman of the Trust
- The Director of Nursing and Governance
- The Medical Director

- The Chief Operating Officer and Deputy Chief Executive
- Two Public Governors (as representatives of service user/carers)

3.2 The Chairman of the Committee shall be appointed by the Board.

3.3 The Executive Director Members of the Committee may nominate deputies (with voting rights) to attend meetings on their behalf.

3.4 Members of the Committee are expected to attend every meeting unless their absence is due to a reasonable cause agreed with the Chairman.

3.5 Any Non-Executive Director of the Trust may attend meetings should they wish and all Non-Executive Directors will receive agendas and papers.

3.6 The Trust Secretary, or an officer appointed by him/her, shall be the Secretary to the Committee.

3.7 Other officers of the Trust may attend meetings on the invitation of the Committee.

4 QUORUM

4.1 A quorum shall be three members of whom at least one must be a Non-Executive Director and one must be an Executive Director (or nominated Deputy).

5 FREQUENCY OF MEETINGS

5.1 Meetings will be held at least every quarter.

6 RELATIONSHIP WITH THE BOARD AND OTHER COMMITTEES

6.1 In the course of fulfilling its functions and 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 that the risk is being managed effectively. On considering the Director's report it shall:

- When necessary (in conjunction with the Quality Assurance Committee) 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.

7 DELEGATED AUTHORITY

7.1 The Committee is authorised to seek any information it requires through the Executive Directors and Chief Executive.

7.2 All executive action arising from the work of the Committee shall be taken forward either by way of a recommendation to the Board of Directors or by agreement of the relevant Executive Director under their delegated powers.

8 REPORTING ARRANGEMENTS

8.1 Following every meeting the Chairman of the Committee shall report to the Board of Directors:

- To provide assurance to the Board on the matters considered and to highlight any risks and mitigating actions identified by the Committee at its meeting (including any risks which the Committee considers should be escalated to the Board Chapter of the Integrated Assurance Framework and Risk Register).
- To seek the Board's approval of any recommendations made by the Committee.
- To present the minutes of the Committee approved at the meeting.

9 REVIEW

9.1 The terms of reference of the Committee will be reviewed, at least, annually.

NOMINATION AND REMUNERATION COMMITTEE OF THE BOARD OF DIRECTORS

TERMS OF REFERENCE

1 CONSTITUTION

1.1 The Nomination and Remuneration Committee is established under Standing Order 6 of the Board of Directors.

1.2 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.

2 FUNCTIONS

Nominations

2.1 To regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Board and to make recommendations to the Board with regard to any changes.

2.2 To be assured that arrangements are in place to support succession planning for Executive Director roles.

2.3 To be responsible for appointing Executive Directors and other Directors reporting directly to the Chief Executive.

2.4 To be responsible for appointing the Chief Executive subject to the approval of the Council of Governors.

2.5 To confirm any matter relating to the continuation in office of any Executive Director (including the Chief Executive) or other Director reporting directly to the Chief Executive at any time including suspension or termination of an individual as an employee of the Trust.

Remuneration

2.6 To be responsible for reviewing and deciding the terms and conditions of office of the Trust's Executive Directors and other Directors (where these are not determined nationally) including:

- Salary including any performance related pay or bonus
- Provisions for other benefits including pensions
- Allowances

2.7 To be assured, through the consideration of benchmarking information, that the terms and conditions of employment, including levels of remuneration are sufficient to attract, retain and motivate the Executive Directors and other Directors (where these are not determined nationally).

2.8 To receive reports on the performance of the Chief Executive and individual Directors who report to the Chief Executive (and other Directors if relevant), as required, to support the consideration of any decisions affecting their remuneration.

2.9 To advise upon and oversee contractual arrangements for Executive Directors and other Directors (where these are not determined nationally) including but not limited to termination payments.

Miscellaneous

2.10 To be responsible for authorising applications to NHS Improvement and HM Treasury for permission to make a special severance payment to an employee or former employee.

2.11 To consider the engagement or involvement or any suitably qualified adviser to assist with any aspect of its responsibilities.

3 DELEGATED AUTHORITY

3.1 The agreement of all matters relating to the appointment of Executive Directors and other Directors (who report directly to the Chief Executive) including the role description and person specification for the position subject to:

- All appointments being advertised externally to the Trust.
- Suitable controls being established to ensure all candidates are considered on merit against objective criteria.
- Suitable controls being established to ensure candidates meet all statutory and regulatory requirements for appointment as directors of the Trust.
- Due regard being given to equality and diversity.

3.2 The appointment Executive Directors and other Directors (who report directly to the Chief Executive) subject to the Committee being assured that the appointee is a “fit and proper person” as defined in the Licence and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

(Note: the appointment of the Chief Executive requires the approval of the Council of Governors)

3.3 The approval of the remuneration and terms and conditions of service of the Executive Directors and other Directors (where these are not determined nationally).

3.4 The approval of any annual uplifts in Trust determined pay structures.

3.5 The approval of any termination payments to the Executive Directors and other Directors (where these are not determined nationally), ensuring they are properly calculated and are reasonable with regard to their probity and value for money.

3.6 The approval of applications to NHS Improvement and HM Treasury for permission to make a special severance payment to an employee or former employee.

4 MEMBERSHIP

4.1 The Committee shall comprise the Chairman of the Trust and all Non-Executive Directors.

4.2 The Chief Executive shall be an ex officio member of the Committee for all 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.

4.3 The Chairman of the Trust shall be the Chairman of the Committee.

4.4 A quorum shall be at least three Members of the Committee.

4.5 The number of Non-Executive Directors and their individual attendance at meetings held for the purpose of conducting interviews and appointing Executive Directors or other Directors reporting to the Chief Executive shall be determined by the Chairman in consultation with the Chief Executive.

5 ATTENDANCE AT MEETINGS

5.1 With the agreement of the Chairman meetings of the Nomination and Remuneration Committee may be attended by:

- The Chief Executive
- The Director of Human Resources and Organisational Development
- any other person on the invitation of the Committee so as to assist in its deliberations

5.2 The Trust Secretary shall be the secretary of the Committee.

6 FREQUENCY OF MEETINGS

6.1 Meetings shall be held as and when required on dates and at times agreed by the Chairman.

7 MINUTES AND REPORTING PROCEDURES

7.1 The minutes of all meetings of the Nomination and Remuneration Committee shall be formerly recorded. These will be retained by the Secretary and not shared with any person who is not a member of the Committee without the permission of the Chairman.

7.2 The Nomination and Remuneration Committee will report to the Board of Directors after each meeting.

7.3 Matters pertaining to the work of the Nomination and Remuneration shall be reported, as required by NHS Improvement, in the Annual Report.

8 REVIEW

8.1 The terms of reference of the Nomination and Remuneration Committee shall be reviewed by the Board of Directors as an when it is considered necessary and expedient to do so.

Appendix 10.5

QUALITY ASSURANCE COMMITTEE

TERMS OF REFERENCE

1 CONSTITUTION

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

1.2 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,

1.3 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;

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

3.1 **Voting Members**

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

3.2 **In attendance (whole meeting)**

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

The Trust Secretary, or an officer appointed by him/her, shall be the secretary of the Committee.

3.2 **Other**

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

5.1 The Committee will meet 10 times a year usually from 14:00 – 17.00 on the 1st Thursday of the month (except in January and August).

6 RELATIONSHIP WITH THE BOARD AND OTHER COMMITTEES

6.1 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.

6.2 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

7.1 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.

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

8 REPORTING ARRANGEMENTS

8.1 Following every meeting the Chairman of the Committee shall report to the Board of Directors:

- To provide assurance to the Board on the matters considered and to highlight any risks and mitigating actions identified by the Committee at its meeting (including any risks which the Committee considers should be escalated to the Board Chapter of the Integrated Assurance Framework and Risk Register).
- To seek the Board's approval of any recommendations made by the Committee.
- To present the minutes of the Committee approved at the meeting.

9 REVIEW

9.1 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.

RESOURCES COMMITTEE (INCLUDING CHARITABLE FUNDS)

TERMS OF REFERENCE

1 CONSTITUTION

1.1 The Resources Committee is established under Standing Order 6 of the Board of Directors.

1.2 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.

2 FUNCTIONS

2.1 To provide assurance to the Board that the resources available to the Trust (both financial and non-financial) are appropriate and sufficient to deliver its Operational/Business Plan.

2.2 To provide assurance to the Board (in the context of paragraph 2.1 above) on the robustness and alignment of the following strategies and plans:

- The Financial Strategy
- The Capital Plan
- The Investment Strategy and Plan
- The Workforce Strategy and Plan
- The Information Strategy

2.3 To monitor, review progress and provide assurance to the Board on the delivery of the strategies and plans (set out in paragraph 2.2 above) particularly in relation to the achievement of commissioner investment in the service priorities.

(Note: The monitoring of progress on the delivery of the Operational/Business Plan shall be undertaken directly by the Board)

2.4 To review proposals (including evaluating risks) for major business cases and their respective funding sources and provide assurance to the Board.

2.5 To keep under review potential changes in the external environment in the medium to longer term and to draw any material risks to the sustainability of the Trust to the Board's attention.

2.6 To provide oversight of the management and administration of Charitable Funds held by the Trust.

3 DELEGATED AUTHORITY

3.1 The investigation of any activity within its terms of reference.

(Note: All employees are directed to cooperate with any request made by the Committee)

3.2 Approval of outline business cases for projects included in the Business Plan to progress to full business case stage subject to their financial consequences (both capital and revenue) remaining within estimate.

3.3 Approval of full business cases for:

- High risk investments valued under £250,000.
- Low risk investments valued between £250,000 and £1 million.

3.4 Approval of the submission of reference cost information to the Department of Health.

3.5 Approval of applications for financial assistance from the Trust's Charitable Trust Funds.

3.6 The commissioning of any outside legal or other independent professional advice and expertise if it considers this necessary.

4 MEMBERSHIP

4.1 The Committee shall comprise:

- A Non-Executive Director as the Chairman of the Committee
- Three other Non-Executive Directors / Associate Non-Executive Directors
- The Chairman of the Trust
- The Chief Executive
- The Director of Finance and Information*
- The Chief Operating Officer and Deputy Chief Executive
- The Director of Planning, Performance and Communications*
- The Director of Human Resources and Organisational Development*

(Note: Executive Members marked * are only expected to attend meetings of the Committee when matters within their portfolios are due for consideration).

4.2 The Chairman of the Committee shall be appointed by the Board of Directors.

5 ATTENDANCE AT MEETINGS

5.1 Any Non-Executive Director of the Trust may attend meetings should they wish and participate in discussions on all matters before the Committee. All Non-Executive Directors will receive agendas and papers.

5.2 The Committee may invite other directors and other Trust staff to attend its meetings as appropriate. It will also invite the attendance of independent external advisors as required subject to the size and complexity of the investment.

5.3 The Trust Secretary, or an officer appointed by him/her, shall be the Secretary of the Committee.

6 QUORUM

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

7 FREQUENCY OF MEETINGS

7.1 The Committee shall meet at least once each quarter.

8 REPORTING

8.1 Following every meeting the Chairman of the Committee shall report to the Board of Directors:

- To provide assurance to the Board on the matters considered and to highlight any risks and mitigating actions identified by the Committee at its meeting (including any risks which the Committee considers should be escalated to the Board Chapter of the Integrated Assurance Framework and Risk Register).
- To seek the Board's approval of any recommendations made by the Committee.
- To present the minutes of the Committee approved at the meeting.

9 REVIEW

9.1 The terms of reference of the Resources Committee shall be reviewed at least annually.

Appendix 10.7

Membership of Board Committees

1 **Audit Committee**

Chairman
- Marcus Hawthorn

Committee Members
- Dr. Hugh Griffiths
- David Jennings
- Paul Murphy

2 **Commercial Oversight Committee**

Chairman
- Lesley Bessant

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

3 **Mental Health Legislation Committee**

Chairman
- Richard Simpson

Committee Members

- Lesley Bessant
- Paul Murphy
- Shirley Richardson
- Dr. Nick Land
- Brent Kilmurray
- Elizabeth Moody
- Sarah Talbot Landon - Public Governor
- Janice Clark – Public Governor

4 **Nomination and Remuneration Committee**

Chairman
- Lesley Bessant

Committee Members
- All Non-Executive Directors
- Colin Martin (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
- Shirley Richardson
- Richard Simpson
- Jim Tucker
- Colin Martin
- Dr. Nick Land
- Brent Kilmurray
- Elizabeth Moody
- Jennifer Illingworth

6 **Resources Committee (includes Charitable Funds)**

Chairman

- Jim Tucker

Committee Members

- Lesley Bessant
- Marcus Hawthorn
- David Jennings
- Paul Murphy
- Colin Martin
- Drew Kendall
- Brent Kilmurray
- Sharon Pickering
- David Levy

APPENDIX 14

ORGANISATIONAL RISK MANAGEMENT POLICY

1 INTRODUCTION

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.

This policy sets out the Trust's approach to risk management - the process by which risks are identified, assessed, evaluated, controlled or accepted. It is a key element of our Integrated Governance arrangements.

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

2 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.

Risks, therefore, have three elements:

- A definite cause.
- An uncertain outcome.
- An impact/effect on objectives.

3 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 organisational risk management policy.

The Chief Executive, 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.

4 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.

4.1 **Risk Registers and Risk Logs:**

Risk registers will be maintained for:

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

(Note: Sub-QuAG risk registers may also be maintained depending on local circumstances)

These risk registers are called "Chapters of the Integrated Assurance Framework and Risk Register" (IAF&RR) and contain information required for the Board Assurance Framework.

Wards and teams will hold "issues logs", maintained by the ward/team manager, to support the identification and escalation of risks from "Ward to Board". These do not include all risks but only those they wish to, or have previously escalated, to their relevant governance group.

4.2 **Risk Register and Issue Log 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; providing supportive and constructive feedback to those escalating risks; and for escalating risks, as appropriate, within the Trust's governance structure.

Each individual risk will also 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.

Where a risk manager has not been appointed, the risk owner will undertake that role.

Issues logs will be owned by the respective ward or team manager. They are responsible for understanding, monitoring and reviewing the risk. They are also responsible for completing the log, escalating it and for documenting the outcome of this escalation.

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

4.3 Recording Risks

The profiles for all risks will be included on a risk register.

Risks included in the Chapters of the IAF&RR (see 4.1 above) will be recorded on the DATIX system. All the "required" fields of the system must be completed for each of these risks.

Only certain fields are required to be completed for issues logs. These are**:** Risk Description; Date Identified; Date Escalated; Current Risk Score (Impact x Likelihood); Contingency; Progress (capturing what is being done about the risk); Closed Date.

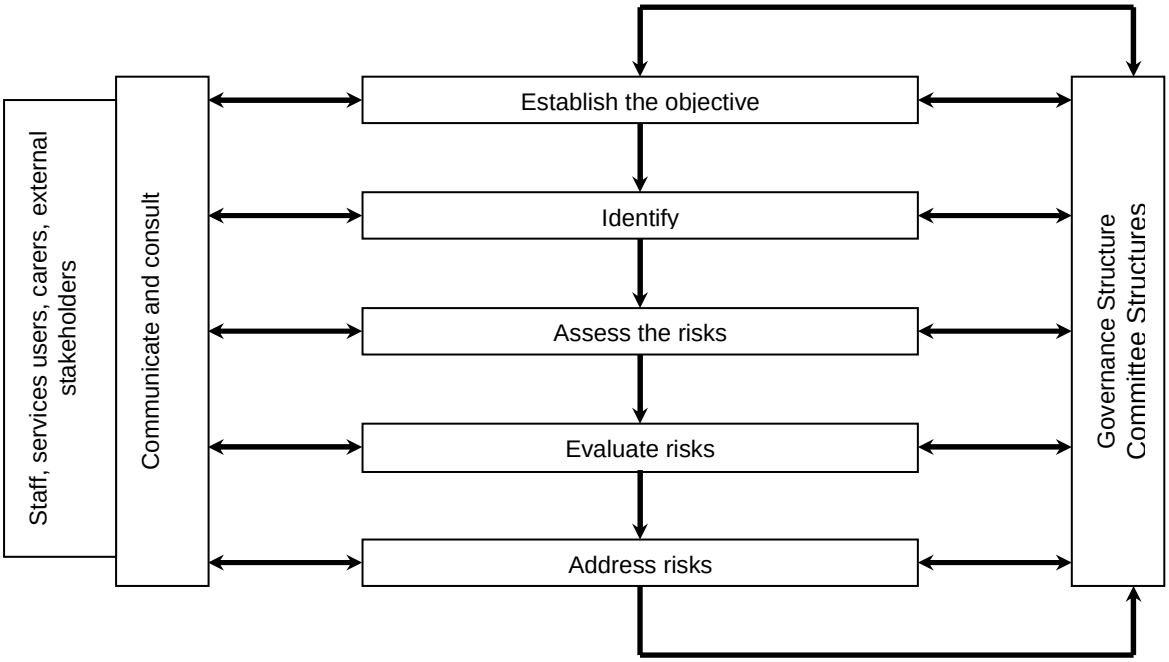
Issues logs will be held in on paper forms whilst the DATIX system is being amended to enable their capture.

(Note: it is expected that the changes to the functionality of the DATIX system to enable the recording of issues logs will be completed within two months of the approval of this policy).

5 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.

Establishing the objective

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

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.

4.1 Describing the Risk

All risks should be described as follows:

"It is a risk that [statement on the hazard – what could go wrong] due to [statement on the cause]"

Care should be taken in framing the description as it will impact on how the risk is assessed and addressed,

4.2 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 in order to assess the impact and inform the approach to managing the risk.

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

4.2.1 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	7	15
Low	1	6

4.3 Addressing the risk

The objective in addressing a risk it to ensure that it does not develop into a problem where its potential impact 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, QuAG, etc).

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 & Step Down

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

Appropriate assurance groups for escalation/step-down are identified in Appendix 2.

A flowchart for risk escalation from wards and team is attached as Appendix 5.

5.4 Risk Transfers

Where a risk is identified in one area, but the appropriate risk owner sits in another Trust area the risk should be discussed at the escalation level (i.e. the level above which it was first identified, entered and scored). The senior risk owner at that escalation level should then decide whether to discuss the management of the risk with the proposed receiving area or whether to escalate it further.

For example, *a risk identified by a Team manager within MHSOP but which was felt should be transferred to E&FM would be discussed at QuAG. The Head of Service would then decide whether to raise the risk directly with the E&FM Directorate or whether to escalate the issue to Director of Operations level.*

Where a risk is identified in one area, but the appropriate risk owner sits outside of the Trust, the risk should be discussed at the escalation level (i.e. the level above which it was first identified, entered and scored). The senior risk owner at that escalation level should then decide whether to discuss management of the risk with the proposed external risk owner or whether to escalate it further.

6 IMPLEMENTATION OF THE POLICY

A “user guide” for the DATIX system is available on “In-touch”.

Training will be provided as detailed below.

7 TRAINING

Board Members will be asked to refresh their knowledge and understanding of the Trust’s risk management processes on an annual basis (as part of the annual review of the Integrated Governance Framework).

Risk management training (based on a one hour session every three years with a competency assessment) will be offered to all Members of the Executive, Clinical Directors, Heads of Service and Ward/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.

To inform is approach the Committee will receive assurance reports following 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:	Assurance Group for Escalation	Assurance Group for Step-down

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.
					-	Local Management and Governance Boards (LMGBs)

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 from third parties (i.e. those with a risk score of 18 – 25) • Significant risks to Level 2 projects	As above. New risks and significant changes to existing risks will also be reported to the Quality Assurance Committee in the LMGB Assurance/Exception Reports.	Board of Directors (via the QuAC)	Quality Assurance Groups (QuAGs) via Head of Service
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	Board of Directors (via appropriate Committee/EMT)	DMT/SMT
Quality Assurance Group (QuAG) Chapters of the IAF&RR	The Head of Service	Directorate QuAG~~s~~	• Risks to the achievement of the Directorate's priorities in the Service Plan • Risks escalated by wards/teams • Medium Risks scored (7 to 15*) re: o New national	• As per the Board Chapter of the IAF&RR	LMGB	Relevant Governance Group/Ward or Team Manager

			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 (* Note: Risk Registers owned by Heads of Services will only include risks with scores of 11- 15 where more than one Locality Manager reports to them – see below)			
	Locality Manager (where there is more than one Locality Manager reporting to a Head of Service)	Directorate QuAG (reported for information to relevant Governance Group based on local circumstances)	As above except only for risks scoring 7 – 10	As above	LMGB (via QuAG)	Ward/Team Manager

Wards/ Community Teams (Issues Logs)	The Ward/Community Team Manager	Local Meetings	Risks with scores of 7 or above which have been or are intended to be escalated	To be determined	QuAG (or relevant governance groups as appropriate)	-

(Note: Low level risks (those with scores of 1 to 6) will be discussed in supervision).

Risk 'One Pager'

Annex 3

Principles: *Transparent, Co-ordinated, Knowledge and Learning and Effective*

Identify the Risks	Assess the Risks	Address the Risks	Report, Monitor and Review on the Risks
• 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	• 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.	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.	• 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.

Know your Role and Responsibility

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	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 impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

	Consequence ratings (severity levels) and examples of descriptors				
	1	**3**	**5**	7	**9**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
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%

Annex 5

Risk Escalation Flowchart