POLICY TITLE:	**GOVERNANCE (CLINICAL AND INFORMATION) POLICY**
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POLICY OWNER:	Dr Clare Fenton Mr Peter Fenton
RESPONSIBLE SIGNATORY:	Dr Clare Fenton – Medical Director Mr Peter Fenton – Administrative Manager

EQUALITY AND DIVERSITY STATEMENT

The Amber Tree Clinic LTD is committed to the fair treatment of all in line with the Equality Act 2010. An equality impact assessment has been completed on this policy to ensure that it can be implemented consistently regardless of any protected characteristics, and all will be treated with dignity and respect.

To ensure that this policy is relevant and up to date, comments and suggestions for additions or amendments are sought from users of this document. To contribute towards the process of review, email admin@theambertree.co.uk

Amendment Record

Version	Amendment	Reason

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1. POLICY STATEMENT.

The Amber Tree is committed to maintaining effective governance structures and processes to ensure the delivery of high-quality psychiatric services, in accordance with the Care Quality Commission (CQC) guidelines and relevant UK legislation. This policy outlines the procedures and responsibilities for governance within the practice.

2. POLICY AIM.

2.1. Establish clear governance structures and processes that promote clinical excellence through improvement, accountability, transparency, and compliance.

2.2. Ensure that The Amber Tree complies with all relevant UK legislation and guidance, including the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Care Quality Commission (CQC) Regulations and Standards, National Institute for Health and Care Excellence (NICE) Guidelines.

2.3. Continuously monitor and improve the quality and safety of its services.

2.4. Consider the feedback, concerns, complaints and needs of all patients and staff.

2.5. Manage budgets with fiscal responsibility and in line with CQC and Legal requirements.

2.6. Manage contracts with other agencies or professionals in a professional, transparent and legal way.

2.7. Assure regulators that The Amber Tree is adhering to all regulations and legal frameworks.

3. GOVERNANCE STRUCTURES.

3.1. For the clarity of this policy, 'Governance' is defined as the system by which an organization manages the quality of the service it provides. This is done via 8 key elements:-

- Clinical Effectiveness.
- Clinical Audit.
- Transparency and openness.
- Risk management and safeguarding.
- Research and service development.
- Education and training.
- Information management.
- Fit and proper persons.

3.2. The Amber Tree has established clear governance structures, including a named Responsible Individuals (RI) and Registered Manager, with defined roles and responsibilities.

3.3. The practice has a robust governance process, including annual reviews of policies, procedures, and quality assurance measures.

4. CLINICAL EFFECTIVENESS AND PATIENT EXPERIENCE.

4.1. Clinical Effectiveness.

4.1.1. At all times The Amber Tree is committed to using research, guidelines, and resources to provide the best possible patient care and experience.

4.1.2. Pertinent national guidelines will be reviewed annually to assess for any changes, or at an earlier date if any changes are announced.
4.1.3. Local protocols will be reviewed at least annually to assess for any improvements that need to be made to enhance the patient experience.
4.1.4. A concern, risk event, research or audit result can if required, trigger a review of the processes The Amber Tree uses.
4.1.5. The Amber Tree recognises that guidelines have limitations and supports clinicians to individualise assessments and treatment plans if it is required, however, the rationale should be documented along with the outcome of peer review discussion and patient/ parent consent.

4.2. Patient Experience.

4.2.1. Feedback will be invited at every appointment and both patients and parents will be invited by email to provide feedback every 6 months.
4.2.2. This feedback will be reviewed in the next available governance meeting. If the feedback contains a concern or complaint this will be investigated immediately using the complaints policy.

5. CLINICAL AUDIT.

5.1. A Clinical Audit reviews the service against set guidelines and helps the service by identifying areas for improvement.
5.1.1. Guidelines include the Amber Tree policies, national or international guidelines such as NICE, and regional or local guidelines such as those created by commissioners or local expert groups.

5.2. Audits will generally examine the Amber Tree's compliance with these guidelines, however, The Amber Tree is also committed to contributing to national audits; the results of which can aid The Amber Tree patients by highlighting needs or identifying improvements the service can make.

5.3. Audits can be suggested by any clinician or patient and will be considered in monthly governance meetings.

5.4. There will be an annual audit for compliance with NICE guidance for relevant disorders, as well as monthly medication audits.
5.4.1. An audit may also be triggered by a risk event, concern or complaint raised.

5.5. The results of audits will be disseminated via email with the pertinent learning points identified, a time scale for reaudit established, and a link to the full audit.
5.5.1. If required or felt helpful, a presentation will also take place.

6. TRANSPARENCY AND OPENNESS.

6.1. The Amber Tree promotes a culture of transparency, openness and feedback on services provided.

6.2. Feedback in Clinical Governance.

6.2.1. The Amber Tree expects clinicians to seek feedback at the end of each assessment and disseminate this in clinical governance meetings, along with any feedback of their own.
6.2.2. At each governance meeting, there will be an assessment of this feedback.

6.2.3. If a clinician does not provide feedback without reason for more than 2 meetings, this will be discussed and a meeting requested with the clinician to understand the reasons for this, and what can be done to help resolve them.

6.3. Service User Feedback.

6.3.1. The Amber Tree recognises that children and young people, including The Amber Tree patients and their parents, are a critical part of the governance process.

6.3.2. The Amber Tree will have quarterly meetings with young people as well as separately with their parents, to discuss all aspects of governance and seek their guidance and feedback.

6.3.3. This will include meeting with local children and young people in North Yorkshire and meeting with patients and their parents.

6.4. Managing Inspections and Feedback

6.4.1. The Amber Tree recognises that clinicians can find inspections stressful and may feel unsure of how to manage this.

6.4.2. To help all Amber Tree staff to feel able to be open and comfortable during an inspection, The Amber Tree will run a short, internal "mock" inspection annually.

6.4.3. The results will be used to improve the service and empower the team to engage with inspections without fear.

6.5. The Amber Tree will review the website every 6 months or earlier if a concern or change occurs, to ensure it remains up to date. The Amber Tree will also engage with the public through social media, posting resources and updates.

7. RISK MANAGEMENT AND SAFEGUARDING.

7.1. For the clarity of this policy, 'Risks' can be to the patient, clinician, other staff or The Amber Tree organisation.

7.2. Risks are managed through the use of the risk assessments, policies, and protocols created by The Amber Tree, and informed by Government and CQC guidance.

7.3. These Risk Assessments and Protocols will be reviewed at the monthly governance meeting, alongside any immediate response or intervention that was required for any risk events that may have taken place since the previous meeting and have not already been addressed.

7.4. All the Amber Tree policies incorporate different aspects of minimising risk. Clinical governance will review these policies annually, or if a significant event requires an early policy review.

7.5. Patient Risk Assessments.

7.5.1. All patients attending The Amber Tree will have a risk assessment completed and reviewed every 6 months.

7.5.2. To mitigate any risks identified, all Amber Tree patients will have a care plan which must be reviewed at least every 6 months. However, The Amber Tree encourages clinicians to review the risk and care plan at every appointment, where appropriate.

7.5.3. The risk and care plan must be reviewed when it is identified that there has been a change in presentation, risk or in the child's environment or care.

7.6. If a 'Risk Event' or Safeguarding Issue occurs.

7.6.1. Risk events that need to be immediately reported to the Medical Director of The Amber Tree are:-

- Attempted suicide.

- Life-threatening self-harm.
- Harm to others.

7.6.2. In these situations, the care and treatment of the patients will be reviewed to assess whether any change is required and to discover any learning points to help The Amber Tree improve the service they provide.

7.6.3. This will also trigger a clinical governance meeting to review the policies, risk assessments and protocols relevant to the event, and what outcomes or revisions are required.

7.6.4. Reflection and lessons from risk events that have formed part of a team meeting will come back to clinical governance to ensure this has been conducted appropriately and upholds a culture of compassion and openness.

7.6.5. Further outcomes will be considered before the final summary report is produced. Further details on this are available in the significant events policy.

7.6.6. If the review identifies any specific learning needs or concerns about the clinician this will be discussed with them.

7.7. Mental health services will frequently encounter changes in risk and risk events which could not be foreseen or mitigated by clinicians. The Amber Tree supports clinicians to explore how and why a risk event has occurred without fear of blame or blaming others.

7.8. Joined-up working is essential when other agencies are involved in treatment or care, therefore The Amber Tree seeks consent to communicate with other agencies and will review whether it is appropriate to continue treatment if consent is not given or is withdrawn.

7.8.1. For example, The Amber Tree has a policy of requiring patients to consent to communication with their GP if any medication is to be prescribed.

8. RESEARCH AND SERVICE DEVELOPMENT.

8.1. The Amber Tree recognises that using the outcomes of research on adults does not necessarily create the best clinical tools for children.

8.2. The Amber Tree actively encourages research to help develop the best patient experience using child or young-person-orientated clinical tools for our patients.

8.3. The proposed research will be reviewed in clinical governance to ensure patient involvement is consensual, the correct ethical approvals are in place and that this research will benefit our patients and clinicians.

9. EDUCATION AND TRAINING.

9.1. Continued Professional Development.

9.1.1. It is the professional duty of all Amber Tree clinicians to keep their knowledge and skills up to date in line with the recommendations from their registered professional body often termed continuing professional development (CPD).

9.1.2. The Amber Tree will require evidence from clinicians that they remain registered with their professional body, attend regular supervision sessions as required, and engage annually in appraisals.

9.1.3. The Amber Tree can provide information and recommendations for companies that conduct appraisals if the clinician requires this.

9.1.4. The Amber Tree will provide dedicated paid time for clinicians to attend any training approved by the Amber Tree for the clinician's appraisal.

9.2. Disseminating Training Outcomes.

9.2.1. Knowledge sharing is an important aspect of clinician development and service improvement therefore clinicians who are supported to attend training by The Amber Tree are asked to prepare a presentation or other resource on the pertinent learning points for others who may benefit from the learning.
9.2.2. Clinicians are experts in their field and The Amber Tree recognises that they may receive training that they feel requires an urgent change of practice or update for the team. In this situation, the clinician is asked to email the information to the Medical Director to allow a timely review and dissemination to the team.
9.2.3. The details of training and knowledge sharing are discussed further in the education and training policy.

9.3. Training and Governance.

9.3.1. Staff members involved in governance processes will receive training as needed to fulfil their roles effectively. The training policy will be reviewed in governance meetings annually.
9.3.2. Training needs out-with those covered in the training policy will be considered in monthly governance meetings.
9.3.3. Compulsory training rates will be monitored in monthly governance meetings and actions taken in line with the training policy if these rates fall below an acceptable level.
9.3.4. The rates of compliance for supervision and appraisal will be discussed in monthly governance meetings to ensure target rates are achieved.
9.3.5. Alongside this, there will be a review of wider learning from which The Amber Tree team will be able to make suggestions for future training.
9.3.6. Any concerns about difficulties related to training, supervision and appraisal will be discussed in monthly governance meetings to ensure timely solutions are found.
9.3.7. The Amber Tree recognises that it is extremely rare for a clinician to disengage with training, supervision, or appraisal without good reason therefore a zero-blame ethos will be adopted in governance meetings.

10. INFORMATION MANAGEMENT.

10.1. The Amber Tree does not currently have a Caldicott Guardian, however, The Amber Tree will appoint one as soon as possible as the service grows. This situation will be reviewed in the monthly governance meetings.

10.2. Quality of Patient Notes.

10.2.1. Patient records held by the Amber Tree should be comprehensive and of a high quality.
10.2.2. Clinicians should copy email correspondence, minutes of meetings and other pertinent information into the patient record to ensure all relevant information is captured.
10.2.3. The quality of patient notes will be audited annually to ensure that assessment and treatment notes:
1. Are recorded in a timely fashion and easily understood.
2. Reflect the content of the appointment, including a summary of any treatment and next steps.
3. Identify the rationale and/or information sources used to create the care plan.
4. Identify consent and the appropriate assessment of consent.
5. Include all liaison with other professionals, in particular timely letters sent to the GP or other NHS services, or the rationale for not sending them.

10.3. Information Governance.

10.3.1. Details of Patient privacy and information governance is discussed in a separate policy.
10.3.2. Annual governance meetings will assess compliance with data protection legislation, along with the associated policy, auditing a subset of clinician notes.

10.3.3. Any learning from this will be disseminated to the team or form part of a service improvement project.

10.3.4. Breaches in GDPR of patient confidentiality are considered significant events and are to be reported immediately to the Medical Director and Administrative Manager.

10.4. Procedure for Managing a Breach of GDPR.

10.4.1. When a member of staff identifies a data breach, the person should email the Medical Director with the following information:-

- Patient reference number.
- The date on which the breach occurred.
- List the Clinician(s), staff, or other professionals/agencies involved.
- Specifically, what has happened, using initials or anonymising with letters of the alphabet. (eg clinician A spoke to clinician B about Patient X)
- What have they done already to address the situation. (e.g. spoken to the patient).
- What do they feel need to be the next steps taken.

10.4.2. If at all possible, the breached information should be recalled immediately, and the owner of the data informed.

10.4.3. All effort needs to be made to restore data privacy, including changing passwords, re-anonymising patient data, and re-securing the central database.

10.5. Duty of Candour.

10.5.1. The Amber Tree has a duty of candour to describe and apologise when a mistake has been made that has resulted in a data breach.

10.5.2. In this situation, The Amber Tree will:-

- Inform the patient and/or their parent/carer of the data breach.
- Apologise for the data breach.
- Provide a true account of what happened, explaining whatever is known and still being investigated at that point.
- Explain to the patient and/or parent/carer what further enquiries or investigations will be undertaken.
- Offer compassion, support and signposting to support, as well as providing further meetings if felt helpful.
- Follow up by providing this information and the apology in writing.
- Provide an update on any ongoing enquiries.
- Keep a written record of all meetings and communications with the patient and/or parent/carer in the patient notes.
- Notify CQC and ICO of the data breach if required.
- Invite the patient, parent/carer to provide feedback on the Amber Tree's response to the data breach and to contribute to the training of clinicians if they feel this would be helpful.

11. FIT AND PROPER PERSONS.

11.1. Recruitment of staff is discussed in detail in the recruitment and fit and proper persons policy.

11.2. The Amber Tree is committed to providing high-quality care with suitably experienced and qualified clinicians and administrators.

11.3. Monthly governance meetings will discuss staffing needs and training needs to ensure all members of the team maintain a high-quality skill set pertinent to their role and that any additional staffing needs are identified.

11.4. Equality and diversity are assessed against every policy and any needs or concerns identified will be reviewed at the monthly governance meetings.

12. LEADERSHIP AND ACCOUNTABILITY.

12.1. The Medical Director is accountable for the overall governance of the Amber Tree and for ensuring that governance processes are effectively implemented.

12.2. The Medical Director will ensure that all aspects of this policy are implemented effectively.

13. MONITORING AND REVIEW.

13.1. This policy will be reviewed annually or sooner if there are changes in legislation or best practices.

13.2. The Medical Director and Administrative Manager will be responsible for reviewing and assessing any changes required.

14. CONTACT DETAILS.

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15. EQUALITY IMPACT ASSESSMENT.

How is the policy likely to affect the promotion of equality and the elimination of discrimination in each of the groups?			
Protected Characteristic (Equality Act 2021)	**Impact** Positive / Negative / None	**Reason / Evidence of Impact**	**Actions Taken** (if impact assessed as Negative)
Age	Positive	The main thrust of this policy is to Manage and oversee all other Policies. All the areas of EDHR that have been identified on the other The Amber Tree Policies are managed and overseen with this policy. Due to this, Governance is Probably the most important policy for EDHR, and through monitoring and always looking to improve, this ensures EDHR across all the dealings of The Amber Tree.	N/A
Disability	Positive		N/A
Gender reassignment	Positive		N/A
Marriage or civil partnership	Positive		N/A
Pregnancy or maternity	Positive		N/A
Race	Positive		N/A
Religion or beliefs	Positive		N/A
Sex	Positive		N/A
Sexual orientation	Positive		N/A
Other, please state:			
EIA completed by:			
Name: **Role/Job Title:**	Dr Clare Fenton & Mr Peter Fenton Medical Director & Administrative Manager		
Date completed:	16/01/2024		