East Lancashire Hospitals NHS
NHS Trust

EAST LANCASHIRE HOSPITALS NHS TRUST
COMMITTEE HANDBOOK 2015/16

Contents

Code of Conduct

1. High standards of corporate and personal conduct are an essential component of good public services. East Lancashire Hospitals NHS Trust seeks to comply with the principles of best practice applicable to governance and behaviour in the NHS and to ensure the organisation and all Directors and employees comply with any relevant code of practice.
2. The purpose of this code, based on the Nolan Principles is to provide clear guidance on the standards of conduct and behaviour expected of all directors and employees and forms part of the framework designed to promote the highest possible standards of conduct and behaviour within the trust.
3. The First Report of the Committee on Standards in Public Life (1995) described the 'Nolan Principles' which set out the ways in which holders of public office should behave in discharging their duties. The seven principles are:
    - **Selflessness** – Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.
    - **Integrity** – Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
    - **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.
    - **Accountability** – Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
    - **Openness** – Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.
    - **Honesty** – Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
    - **Leadership** – Holders of public office should promote and support these principles by leadership and example.
4. Although written primarily for the Board members this code in most parts does extend to all employees.

5. The Board has a duty to conduct business with probity, to respond to staff, and patients impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct.
6. Through leadership and personal and collective behaviour the Board sets an example in the conduct of its business and promotes the highest standards of corporate conduct that is also expected throughout the trust.
7. The Board will ensure that the provisions of the Standing Orders, Standing Financial Instructions and accompanying Scheme of Delegation conform to best practice and serve to enhance the potential for Directors and employees to meet these standards of conduct.
8. The Board expects that this code will inform and govern the decisions and conduct of all directors and also be reflected in the conduct of all employees.
9. Board members and employees will comply with the requirements of the Standing Orders and Standing Financial Instructions in relation to confidentiality and access to information, the declaration of interests and hospitality, the management of conflicts of interest and the Trust's policy on Raising Concerns (Whistle Blowing).
10. This code of conduct also applies to business transactions with suppliers and commissioners.

Personal Conduct

11. Directors and all employees will not conduct themselves in a manner that could reasonably be regarded as bringing their office or the trust into disrepute all directors and employees must, where it is applicable to their role:
    - act in the best interests of the trust and adhere to its values and this code of conduct.
    - respect others and treat them with dignity and fairness
    - seek to ensure that no one is unlawfully discriminated against and promote equal opportunities and social inclusion
    - be honest and act with integrity and probity
    - raise concerns and provide appropriate challenge regarding the running of the trust or a proposed action where appropriate
    - make every effort to attend meetings where practicable
    - achieve good practice in respect of the conduct of meetings and respect the views of others.
    - take and consider advice on issues where appropriate

- not use their position for personal advantage or seek to gain preferential treatment; nor seek improperly to confer an advantage or disadvantage on any other person.
- accept responsibility for their performance, learning and development

12. In addition to the codes of conduct that apply, in a greater or lesser degree to all staff, Directors must also :
    - contribute to the workings of the Board in order for it to fulfil its role and functions.
    - recognise that the Board is collectively responsible for the exercise of its powers and the performance of the trust.
    - recognise the differing roles of the chair, senior independent director, chief executive, executive directors and Non-Executive directors.

Trust Board Terms of Reference

Board Accountability

The Trust will demonstrate its accountability to the public and the patients we serve by operating its business in as transparent a way as possible. This will be demonstrated by publishing board papers on the Trust website and holding Board meetings in public, only reserving the right to meet privately where matters are to be discussed where a patient or group of patients or a member of staff is or could be identifiable, or where the business is of a confidential commercial nature.

The Trust board will, on behalf of the Trust, approve an annual report in accordance with Trust policy and to the nationally set timescale. It will summarise the financial position of the trust and the key activities carried out throughout the year. The Trust Board will also approve the Trust's Annual Quality Account and such other annual or other reports as required by legislation or other requirements.

Role of the Board

- The Board led by the Chair, is responsible for listening to staff and patients and through engagement establishing the vision and strategic direction of the Trust.
- It is also responsible for setting the annual and longer terms objectives for the Trust.
- It sets the strategic and operational quality outcomes it expects the organisation to achieve and is responsible for driving the Trust forward to achieve them.
- The objectives will take into account the trust's business plans, national and local clinical guidance, the requirements of NHS England and the Regulators, and the Trust's statutory obligations.
- The Board oversees the delivery of its planned results by monitoring performance against objectives and assuring itself that corrective action is taken when necessary.
- The Board also ensures that it has an Integrated Business Plan underpinned by a range of supporting strategies.
- The Board will assure itself that there is a Financial Strategy that describes effective financial stewardship throughout the trust and demonstrates how the trust derives value for money for the resources it has. It will also describe financial control and robust financial planning arrangements.
- The Board will ensure there is a Quality Improvement Strategy underpinned by a Workforce and Organisational Development Plan that enables the trust to develop and sustain a culture of continuous Quality Improvement, ensuring that the trust can deliver safe, personal and effective care every time.

- The Board, through the Remuneration Committee will appoint and remunerate senior executives and ensure there are robust arrangements for their appraisal.
- The Board will seek assurance that there is effective dialogue between the organisation and the local community on its plans and performance and that these plans are responsive to the community's needs.
- The Board will transact its business in an open and transparent manner and ensure that the duty of candour is met at all times
- Board members will ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation.
- The Board will ensure there is a Governance and Risk Management Strategy that delivers high standards of corporate and clinical governance and risk management.
- The Chief Executive will sign a Governance Statement on behalf of the Board each financial year identifying how risks are identified and managed.
- The Board will ensure there is a system of internal control and stewardship which supports the delivery of safe, personal and effective patient care and the achievement of the organisation's objectives.
- The Board will through the deployment of a Board Assurance Framework assures itself that:-
    - the Trust's Key Objectives are agreed
    - the principal risks to those objectives are identified
    - controls which eliminate or reduce these risks are implemented
    - harm or the potential for harm is minimised.
    - the effectiveness of these controls are independently assured.
    - there is a strategy in place for continuous quality improvement to support risk minimisation
    - reports on unacceptable or serious risks and the effectiveness of control mechanisms are received from the Executive Directors and independent assurors.
    - action plans are agreed to improve control over serious or unacceptable risks.
    - policies are in place to determine levels of acceptable risk and thus informing what level of risks should be accepted / retained (Risk Appetite) .
    - the trust complies with all standards and guidelines issued by the regulators, NHS England, the NHS Litigation Authority, the Royal Colleges and other professional and national bodies.

Board Membership

- Chairman
- Chief Executive
- Non-Executive Directors
- Executive Directors

Quorum

One third of whole number of Directors, including two Executive and two Non-Executive Directors.

Regular Reports

A schedule of regular reports will be presented to the Board by the Executive Directors, including reports and/or minutes from the Board Committees and sub-committees. The schedule may be subject to alteration and will be regularly reviewed and updated.

In addition to the scheduled reports other reports will be required as issues arise and these will be prioritised according to their subject/content. The prioritisation will take into account the need for rapid transmission of issues to the Board and the need for "no surprises".

All reports will take the same format and will have the key points summarised on the front sheet. The front sheet(s) will be completed fully for all papers.

As well as comprehensive minutes an action log will be kept of all actions directed to be completed by the Board and will be updated at every meeting.

All business will be transacted in Part I of the meeting, unless due to the confidential nature of the business, publicity would be prejudicial to the public interest.

Frequency & Format of Meetings

Formal Trust Board meetings will be held monthly at least 10 times a year. Members, or by exception the nominated representative, are expected to attend each meeting during the course of the year. There is an Annual General Meeting in accordance with the NHS Trust (Public Meetings) Regulations 1991. Extraordinary Trust Board meetings may be called in accordance with the Trust's Standing Orders outside the regular schedule of meetings where business of an urgent nature must be conducted.

Recognised Committees of the Board

The Board is supported in meeting its duties by a number of Committees and sub committees. The committees have delegated duties and responsibilities that they carry out on behalf of the Board.

Along with Executive Director reports, the Committees are responsible for elements of the governance assurance arrangements for the Board. The Trust has five recognised Committees. Each committee operates to its agreed Terms of Reference and may have delegated powers as agreed by the Trust Board and described in their Terms of Reference. The committee structure and the wider governance arrangements are outlined in the appendices to the Committee Handbook.

The recognised Committees of the Board are:

- The Audit Committee
- The Remuneration Committee
- The Charitable Funds Committee
- The Patient Safety and Governance Committee
- The Finance and Performance Committee

Constitution

The Board has resolved to establish a Committee of the Board to be known as the Audit Committee. 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. The Audit Committee is the high level risk committee operating on behalf of the Board and concerns itself with the function and effectiveness of all committees. It is the committee that brings all aspects of governance and risk management together.

Purpose of the Committee

The Audit Committee is charged with ensuring that the Board and Accounting Officer of the organisation gain the assurance they need on governance, risk management, the control environment and on the integrity of the financial statements, as well as other elements of the Annual Report and Accounts

The role of the Audit Committee is a challenging one and needs strong, independent members with an appropriate range of skills and experience. The committee acts as the "conscience" of the organisation and demonstrates strong constructive challenge where required, for example, regarding risks arising from increasing fiscal and resource constraints, new service delivery models, information flows on risk and control, and the agility of the organisation to respond to emerging risks.

The Audit committee fulfils a major part in providing independent and objective assurance through the work of internal and external auditors and counter fraud, and reviewing reports and intelligence from external bodies including regulators.

It is essential that the Audit Committee understands how the governance arrangements support the achievement of the Trust's strategies and objectives, especially:

- The Trust's vision and purpose;
- The mechanisms in place to ensure effective organisational accountability, performance and risk management;
- The roles and responsibilities of individuals and committees and other groups to support the effective discharge of the Trust's responsibilities, decision making and reporting;

The committee must also understand the organisation's business strategy, operating environment and the associated risks. It must take into account the role and activities of the Board and other committees in relation to managing risk and should ensure the Board

discusses its policies, attitude to and appetite for risk to ensure these are appropriately defined and communicated so management operates within these parameters.

Membership

The Committee members are appointed by the Board from amongst the non –executive directors of the Trust and consist of not less than three members. A quorum shall be two members.

One of the members of the committee will have the required qualifications to be an Audit Committee Chair and will be appointed Chairman of the Audit Committee by the Board.

The Audit Committee should corporately possess knowledge / skills / experience / understanding of:

- accounting;
- risk management;
- internal / external audit; and
- technical or specialist issues pertinent to the organisation's business.
- experience of managing similar sized organisations;
- the wider relevant environments in which the organisation operates
- the accountability structures

The Chairman of the Trust shall not be a member of the Committee.

There will be three Non-Executive director members of the Committee for 2014/15 with a Non-Executive Director Chair

Quorum

The committee shall be deemed quorate if there are two members of the committee present.

Delegated Deputies

Members are expected to attend at least 75% of the meetings but in the unusual event that a member of the committee cannot attend the following are the delegated deputies.

- Chair of the Committee – A member of the Committee
- Member of the Committee – A Non-Executive Director
- Executive Directors who would normally be in attendance or in attendance because of the nature of the agenda items may be deputised by a senior manager within their corporate structure.

Attendance

The Directors of Finance, Medicine, and Chief Nurse, Associate Director of Quality and Safety and appropriate internal and external audit representatives shall normally attend meetings. At least once a year the Committee members will meet privately with the external and internal Auditors.

The Chief Executive will be invited to attend and will discuss at least annually with the Committee the process for assurance that supports the Annual Governance Statement. He/she will also attend when the Committee considers the draft internal audit plan and the annual accounts. All other Executive Directors will be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

The Company Secretary, or whoever covers these duties, shall be Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members. His/her duties will include:

- Agreement of the agenda with Chair and attendees and collation of papers
- Taking the minutes
- Keeping a record of matters arising and issues to be carried forward
- Advising the Committee on pertinent issues/areas

Frequency

A minimum of five meetings per annum will be held in accordance with the timetable agreed by the Trust Board. Members or their nominated representative are expected to attend at each meeting.

The external auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

It is good practice for the Chair of the Audit Committee to meet with the Accounting Officer, the Finance Director, the Head of Internal Audit and the external auditor's senior representative outside of the formal committee structure.

Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee or agent and all employees are directed to co-operate with any request made by the Committee.

As well as having the permanent members of the committee the committee is empowered to co-opt members for a period of time (not exceeding a year, and with the approval of the Board) to provide specialist skills, knowledge and experience which the Committee needs at a particular time and procure specialist advice at the expense of the organisation on an ad-hoc basis to support them in relation to particular pieces of committee business

Duties

The duties of the Committee are categorised as follows:

Governance, Risk Management and Internal Control

- The Committee shall 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 objectives. In particular the Committee will review the adequacy and effectiveness of:
    - All risk and control related disclosure statements (in particular the Annual Governance Statement, formally known as Statement on Internal Control) together with any accompanying Head of Internal Audit Statement, external audit opinion or other appropriate independent assurances, prior to their endorsement by the Board.
    - The underlying assurance processes that indicate the degree of achievement of the corporate objectives, the effectiveness of the management of the principal risks and the appropriateness of the above disclosure statements
    - The policies for ensuring compliance with the relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
    - The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service.
- In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of the effectiveness.
- This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

- The role of the Audit Committee in relation to internal audit should include advising the Accounting Officer and Board on the:

- Internal Audit Charter and periodic internal audit plans, forming a view on how well they reflect the organisation's risk exposure and support the Head of Internal Audit's responsibility to provide an annual opinion;
- adequacy of the resources available to internal audit;
- internal audit charter, or terms of reference, for internal audit;
- results of internal audit work, including reports on the effectiveness of systems for governance, risk management and control, and management responses to issues raised;
- annual internal audit opinion and annual report; and

- The Committee shall ensure that there is an effective internal audit function that meets mandatory *NHS Internal Audit Standards* and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:
  - Consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal
  - Review and approval of the Internal Audit Charter, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework
  - Considering the major findings of internal audit work (and management's response) and ensuring coordination between the internal and external auditors to optimise audit resources
  - Ensuring that the internal audit function is adequately resources and has appropriate standing within the organisation
  - The Annual review of the effectiveness of internal audit

External Audit

- The Committee shall review the work and findings of the external auditors and consider the implications and management's response to their work. This will be achieved by:
  - Consideration of the appointment and performance of the external auditors, as far as the rules governing the appointment permit
  - Discussion and agreement with the external auditors, before the audit commences, of the scope and nature of the audit as set out in the annual plan, and ensuring coordination, as appropriate, with other external auditors in the local health economy
  - Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee

- Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Other Assurance Functions

- The Audit Committee shall 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 and professional bodies with responsibility for the performance of staff or functions.
- To seek assurance on the implementation of guidance and recommendations from external inspection and accreditation visits from the Patient Safety and Governance Committee.
- In addition, the Committee will review the work of all other committees within the organisation whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the work and functionality of the Patient Safety and Governance Committee which reports to the Board on all aspects of clinical governance and risk management and the Operational Delivery Board that reports to the Board on all aspects of corporate governance and performance. This function will be undertaken through the review of the Annual Reports of the Board's formal subcommittees.
- The Audit Committee will receive an annual report on the review of the effectiveness of the Trust's arrangements for staff to raise concerns and whistleblowing
- The Audit Committee will review the Quality Account prior to publication.

Counter Fraud

- The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

Management

- The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
- The Committee may also request specific reports from individual functions within the organisation as they may be appropriate to the overall arrangements.

Financial Reporting

- The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance. The Committee will ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.
- The Audit Committee will review the annual report and financial statements before submission to the Board, focussing particularly on:
    - The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
    - Changes in and compliance with accounting policies, practices and estimation techniques
    - Unadjusted mis-statements in the financial statements
    - Significant judgements in preparation of the financial statements
    - Significant adjustments resulting from the audit
    - Letter of Representation
    - Qualitative aspects of financial reporting
- In reaching a view on the accounts, the Committee will consider:
    - key accounting policies and disclosures;
    - assurances about the financial systems which provide the figures for the accounts;
    - the quality of the control arrangements over the preparation of the accounts;
    - key judgements made in preparing the accounts;
    - any disputes arising between those preparing the accounts and the auditors; and
    - reports, advice and findings from external audit (especially the Audit Completion Report – ISA 260 Report)

Other Matters

- The minutes of the Audit Committee meetings shall be formally recorded by the Company Secretary and a report submitted into the Board. From each meeting the Chair of the

Committee shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

- For monitoring compliance purposes the Committee will report to the Board at least once each calendar year on its work in support of the Annual Governance Statement for the previous financial year. Its report will specifically cover the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements, the appropriateness of the evidence compiled to demonstrate fitness to register with the Care Quality Commission and the robustness of the processes behind the quality accounts.

Committee Support

The Company Secretary

The Director of Finance

Review

The committee will review its own effectiveness at least once a year taking into account the views of internal and external audit as well as other external bodies including regulators

Constitution

The Trust Board has established this Committee to be known as the Charitable Funds Committee. The Committee will report its actions and decisions to the Trust Board.

The Committee has overarching responsibility for the monitoring and approval of activities relating to charitable fund raising and the uses to which charitable funds are applied providing assurance to Trust Board members in their role of Trustees of the organisation's Charitable Funds.

The Committee has the authority to appoint short term, outcome focused subcommittees but does not routinely receive reports from other subcommittees.

Purpose and Delegated Responsibilities

The Trust receives funds for charitable purposes from a number of sources. The Trust as a corporate body is the Trustee of these funds. The Trust Board must therefore ensure that its duties as a Trustee are discharged correctly taking advice as necessary.

The Board when acting as Trustees of the charitable funds will act in accordance with guidance from the Charities Commission, and will discharge its function as Trustee as far as possible, separately from its duty as a Trust Board. The Trust Board appoints this Committee to discharge this function. In addition the Trust Board delegates to this Committee the authority to examine and approve the annual accounts of funds held on trust.

The Committee will oversee the management of funds held on trust and charitable funds. In particular the Committee will:

(a) Set a corporate strategy for the management of funds

(b) Assure the Trust Board that the policies and procedures for the management and administration of Trust funds are adequate, effective and observed

I Review the investments held by the Trust at regular intervals

(d) Review the performance of funds on a regular basis

I Approve and review the application of funds

(f) Approve, accredit and support fundraising activities in accordance with the Trust's Guidelines for Fund Raising Activities

(g) Approve and review the appointment of those managing investments on behalf of the Trustees

(h) Make recommendations to the Trust Board regarding the management and performance of funds

(i) Provide an annual report to the Trust Board on the Committee's activities

Membership

Two Non-Executive Directors, Director of Finance, Director of Operations and Deputy Chief Nurse

Quorum

A quorum (1 Non-Executive Director and 1 Executive Director) must be maintained at all meetings. Each member will attend a minimum of 75% of the meetings throughout the year. Members who are unable to attend will arrange for their nominated deputy to attend, their attendance will be recorded in the minutes, making clear on whose behalf they attend.

Nominated Deputy Arrangements

Chair	A Non-Executive Director
Non-Executive Director	Non-Executive Director
Executive Director	Senior Manager within the Executive Director's reporting structure
Deputy Chief Nurse	A Governance or Senior Nursing Representative

In Attendance

Any other Executive or Non-Executive Director may be in attendance at meetings in their role as Trustee of the Charitable Funds.

Divisional General Managers will attend meetings where requests for funds from their Division appear as an agenda item.

The Company Secretary, the Charitable Funds Accountant and a Staff Side Representative will normally be in attendance.

Frequency of Meetings

The committee will meet for a minimum of three meetings per year. These will normally be held on a quarterly basis.

Reporting Arrangements

The Committee will provide a summary of its decisions and actions to the next meeting of the Trust Board. The Committee does not regularly receive reports from other subcommittees.

Regular Reports

- Funds' Performance Update Report
- Applications in the form of a business case for the use of funds

Committee Support

Lead Director	- Director of Finance
Agenda and Minute Preparation	- Company Secretary

Review

The effectiveness of the Committee will be reviewed on an annual basis as part of the Trust Board Business Cycle. The Committee will provide an annual report on its activities to the Trust Board as part of this review.

The annual report will as a minimum report on the Committee's compliance with the reporting arrangements detailed above.

The functioning of the Committee may be assessed within the normal annual cycle of reporting by the Audit Committee through the internal and external auditors and external regulatory bodies.

Constitution

The Trust Board has established this Committee to be known as the Remuneration Committee. The Committee will report to the Trust Board. The Committee has overarching responsibility for the remuneration of, arrangements for the appointment of, and agreement of termination packages for, Executive Directors and very senior management outside Agenda for Change arrangements within the Trust. The Committee has the authority to appoint short term, outcome focused sub committees but does not routinely receive reports from other sub committees

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Purpose and Delegated Authority

The Committee has authority to determine, in consultation with the Chairman and the Chief Executive of the Trust;

- the policy on the remuneration of Executive Directors
- the specific remuneration packages for each of the Executive Directors including pension rights and any compensation payments
- the remuneration of other very senior employees who are considered by the Committee to hold key positions within the Trust and whose remuneration package is, or is considered appropriate to place, outside the provisions of the Agenda for Change framework
- the remuneration of other employees who are considered by the Committee to hold key positions within the Trust who are employed to perform specific short term functions on a semi consultancy basis
- the arrangements for the appointment of individuals outlined above
- the termination packages of any individual outlined above.

In determining the remuneration and termination packages and the remuneration policy, the Committee shall keep in mind:

- firstly, the desirability of the maintenance throughout the Trust of a competitive, fair remuneration structure which operates in the interests of, and to the benefit of, the financial and commercial health of the Trust
- secondly, ensuring the members of the executive management of the Trust are provided with appropriate incentives to encourage enhanced performance and are, in a fair and responsible manner, rewarded for their individual contributions to the success of the organisation

The Committee is authorised through the Secretary to seek any information it requires from any employee in order to perform its duties.

The Committee is authorised, in consultation with the Secretary, where necessary to fulfil its duties, to obtain any outside legal or other professional advice including the advice of independent remuneration consultants, to secure the attendance of external advisors at meetings and to obtain reliable up to date information about remuneration in other Trusts.

The Committee has authority to commission reports and surveys that it considers necessary to fulfil its obligations.

Membership

Chairman and four Non-Executive Directors

No individual will be involved in any part of a meeting at which decisions as to their own remuneration will be taken

Quorum

Board Chairman and two Non-Executive Directors. A quorum must be maintained at all meetings. Each member will attend a minimum of 75% of the meetings throughout the year

In Attendance

Chief Executive

The Director of Human Resources and Organisational Development and the Company Secretary will normally be in attendance

Nominated Deputy Arrangements

Chief Executive – Deputy Chief Executive

Frequency & Format of Meetings

At least two meetings will be held annually. Additional meetings will be convened by the Secretary at the request of any member of the Committee.

Regular Reports

None.

Monitoring Arrangements

The effectiveness of the Committee will be reviewed on an annual basis as part of the Trust Board Business Cycle. The Committee will provide an annual report on its activities within the

Trust's Annual Report. The functioning of the Committee may be assessed within the normal annual cycle of reporting by the Audit Committee through the internal and external auditors and external regulatory bodies.

Committee Services

Lead Director – Chief Executive

Secretary – Company Secretary

Constitution

The Trust Board has established a Committee with delegated authority to act on its behalf in matters relating to patient safety and governance to be known as the Patient Safety and Governance Committee.

The Committee will provide assurance to the Board and to the Audit Committee which is the high level Risk Committee of the Board, on all matters that it considers and scrutinises on behalf of the Board.

Purpose

The purpose of this committee is to provide assurance to the Board that all aspects of the delivery of safe, personal and effective care are being appropriately governed and that the evidence to support that assurance is scrutinised in detail on behalf of the Board.

Membership

3 Non-Executive Directors including a Non- Executive Chair of the Committee
Director of Operations
Chief Nurse
Medical Director
Director of Finance

Quorum

Four members, one of which must be a clinician and two of which will be Non-Executive Directors.

A quorum must be maintained at all meetings. Members are expected to attend all meetings but will attend at least 75% of meetings. Members who are unable to attend will arrange for the attendance of a nominated deputy, whose attendance will be recorded in the minutes, making clear on whose behalf they attend.

Nominated Deputies

Chair	- a Non-Executive member of the Committee
Non-Executives	- a Non-Executive
Director of Operations	- a Director
Chief Nurse	- Deputy Chief Nurse
Medical Director	- Chief Medical Officer

Director of Finance - Deputy Director of Finance

Attendance

The Associate Director of Patient Safety and Governance and the Company Secretary will normally be in attendance at meetings. The Committee may direct the attendance of others at meetings as the Chair of the Committee deems appropriate

Frequency

The Committee will meet at least 8 times a year, the dates of which are detailed in the schedule attached to the Handbook. Additional meetings may be called at the discretion of the Chair of the Committee as provided for in the Trust Standing Orders and Standing Financial Instructions.

Authority

The Committee has no executive powers other than those specified in these Terms of Reference and by the Trust Board in its Scheme of Delegation.

The Committee forms the high level Committee for Quality and Safety reporting.

The Committee is authorised to investigate any issue within the scope of 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, with the support of the Board Secretary, to obtain any independent professional advice it considers necessary in accordance with these Terms of Reference.

Duties and Responsibilities

The Committee will review and approve the Trust's Risk Management Strategy (and supporting documents) assuring the Board that it contains the information necessary to support good governance and risk management throughout the Trust, assuring itself that the Trust meets the requirements of all mandatory and best practice guidance issued in relation to clinical and corporate governance

The Committee will assure itself that adequate and appropriate integrated governance structures, processes and controls (including Risk Assurance Frameworks at all levels) are in place across the Trust. In particular this committee is responsible for the detailed scrutiny of the safety, personalisation and effectiveness of care and will establish Trust wide governance priorities.

The Trust Governance and Risk Management Strategy allows for the establishment of Divisional governance arrangements within a strong accountability framework. The committee will approve the governance arrangements proposed by the divisions and will have oversight of the establishment and function of any boards or committees established within those arrangements.

It will approve the Terms of Reference and membership of its reporting committees and oversee the work of its sub-committees receiving reports from them for consideration and action as necessary.

The Committee will receive reports from its sub-committees at which the patient safety and quality issues and risk management processes in the Divisions are debated and monitored collectively.

The Committee will provide the Board, through the Audit Committee, with the assurance that the divisional committees are functioning appropriately in terms of governance and risk management and contribute positively to ensuring the delivery of safe, personal and effective care.

It will satisfy itself that at every level of the trust staff identify, prioritise and manage risk arising from corporate and clinical issues on a continuing basis.

It has responsibility for scrutinising the Trust's (Corporate) Risk Assurance Framework on a monthly or near monthly basis and satisfying itself that the identified risks are being managed appropriately within the divisions and departments and at executive level.

It is responsible for ensuring that those risks escalated to the Board Strategic Risk Assurance Framework are appropriate and proportionate, seeking further assurance from the executive team and escalating to the Board, concerns relating to unresolved risks that may require executive action or pose significant threats to the operation, resources or reputation of the Trust.

The Committee will scrutinise the effective and efficient use of resources through evidence based clinical practice and assure itself that there is an appropriate process in place to monitor and promote compliance across the Trust with all standards and guidelines issued by the regulators, NHS England, the NHS Litigation Authority, the Royal Colleges and other professional and national bodies

It will promote a culture of open and honest reporting of any situation that may threaten the quality of patient care, and oversee the process within the Trust to ensure that appropriate action is taken in response to adverse clinical incidents, complaints and litigation

The committee will satisfy itself that examples of good practice are disseminated within the Trust, ensuring that its sub-committees have adequately scrutinised the investigation of

incidents and that there is evidence that learning is identified and disseminated across the Trust.

The committee will satisfy itself that those elements of business relating to Patient Safety and Governance that are contained in the Terms of Reference of other committees are carried out effectively for example ensuring that there is an appropriate mechanism in place for action to be taken in response to the results of clinical audit; that guidelines and standards are introduced consistently across the trust and poor practice is challenged.

The Committee will satisfy itself that Safeguarding Children and Vulnerable Adults is at the heart of everything we do, ensuring that the Trust meets all of its obligations in respect of safeguarding at all times. This includes satisfying itself that all staff have training to the standard and frequency required. It will also satisfy itself that the Trust captures the learning from nationally published reports and that the learning is embedded in the practices, policies and procedures of the Trust.

It will also satisfy itself that the appropriate actions in respect of Patient Safety and Governance have been taken following recommendations by any relevant external body. This includes monitoring the Trust's compliance with the Care Quality Commission registration requirements and any reports resulting from visits.

The committee will receive a detailed report on the activity of the PALs service and Complaints and Litigation.

The Committee will approve all new policies and procedures (and amendments to existing policies) in the Trust once they have been through the Policy Council and its supporting processes and endorsed by the Patient Safety and Risk Assurance Committee, ensuring that they are in accordance with all relevant legislation and guidance.

The Committee will seek assurances that as well as delivering safe, personal and effective care to patients the health and welfare of staff and others for whom the Trust owes a duty of care is protected.

The Committee will also consider matters referred to it by other committees and groups across the Trust.

Reporting

Following each committee meeting the Chair of the committee, supported by the Associate Director of Patient Safety and Governance, will provide the next meeting of the Board with a written report. The report will contain the issues discussed including key issues raised by committee members and the decision or recommendation made on behalf of the Board. The papers from the meeting and the full minutes of the Committee will be available to all Board members.

Four subcommittees, the Serious Incident Review and Investigation Panel, the Patient Safety and Risk Assurance Committee, the Patient Experience Group and the Clinical Effectiveness Committee will report to each meeting of the Patient Safety and Governance Committee. The reports will include any issues to be escalated from the divisions and reporting subgroups and a summary of the key issues raised and the decisions or recommendations made.

The Committee will also receive a report from the Internal Safeguarding Board for children and for adults and will receive reports from the local safeguarding boards established by the local authorities. It will also receive reports on any nationally published reports.

Review

The effectiveness of the Committee will be reviewed on an annual basis as part of the Trust Board business cycle. The Committee will provide an annual report on its activities the Trust Board as part of this review. The functioning of the Committee may be assessed within the normal annual cycle of reporting by the Audit Committee through the internal and external auditors and external regulatory bodies.

Committee Support

Lead Director –Medical Director and Chief Nurse

Secretary – Company Secretary

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Finance and Performance Committee Terms of Reference

Constitution

The Board has established the Finance and Performance Committee to provide assurance on the delivery of the financial plans approved by the Board for the current year, develop forward plans for subsequent financial years for consideration by the Board and examine in detail risks to the achievement of national and local performance and activity standards.

Purpose

To support the Trust Board in the analysis and review of Trust financial and performance plans, providing advice and assurance to the Board on financial and performance issues.
It will:

- look in detail at Cost Improvement Programmes and their delivery
- consider the financial performance in the current year and look ahead to expected performance for the subsequent 2-5 years.
- provide the board with a forum for detailed discussions of progress against the Integrated Business Plan including the delivery of Cost Improvement Programmes.
- Assess the performance of the organisation against all national and local performance standards

Membership

Chairman (Chair)
Chief Executive
Non Executive Directors
Director of Finance
Medical Director
Chief Nurse
Director of Operations
Director of HR and OD
Director of Service Development
Chief Medical Officer

In attendance

Company Secretary

Frequency

The Committee will meet at least 10 times a year the dates of which are detailed in the schedule attached to the Handbook. Additional meetings may be called at the discretion of the Chair of the Committee as provided for in the Trust Standing Orders and Standing Financial Instructions or at the request of the Patient Safety and Governance Committee

Quorum

One third of the membership to include two Non-Executive Directors and two Executive Directors

Regular Reports

Integrated Performance Report

Finance Report

Authority

To summon reports (and individuals) to enable the committee to discharge its duties

Reporting

The Committee will report to the Trust Board

Review

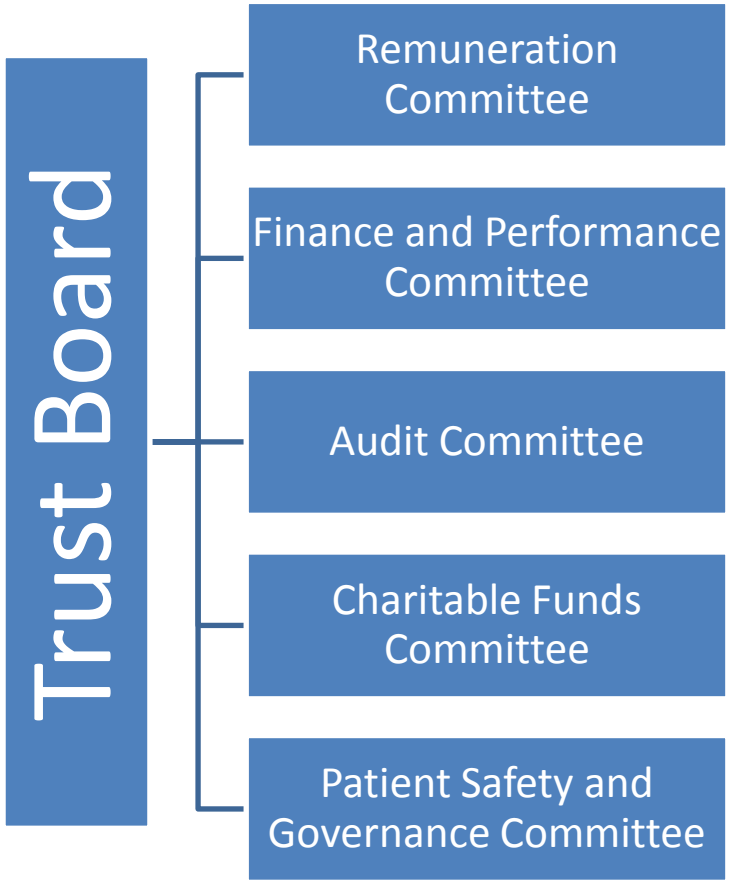
The effectiveness of the Committee will be reviewed on an annual basis as part of the Trust Board Business Cycle. The Committee will provide an annual report on its activities to the Trust Board as part of this review. The functioning of the Committee may be assessed within the normal annual cycle of reporting by the Audit Committee through the internal and external auditors and external regulatory bodies.

Board Services

Chair	– Non Executive Director
Secretary	– Company Secretary
Lead Director	– Director of Finance

Committees reporting

None


Trust Board
Remuneration Committee
Finance and Performance Committee
Audit Committee
Charitable Funds Committee
Patient Safety and Governance Committee

	Trust Board Part 1	Trust Board Part 2	Finance and Performance	Patient Safety & Governance	Audit Committee	Charitable Funds	Board Development	Remuneration
JANUARY	28 @14:00	28 @ 12:00	19 @ 12:30	7 @10:00				28 @ 16:30
FEBRUARY	25 @14:00	25 @ 12:00	23 @ 12:30	- -	18 @14:00		- -	25 @ 16:30
MARCH	25 @14:00	25 @ 12:00	23 @ 12:30	18 @ 14:00		4 @14:00	11 @ 14:00	25 @ 16:30
APRIL	29 @14:00	29 @ 12:00	27 @ 12:30	15 @10:00	1 @14:00		- -	29 @ 16:30
MAY	27 @14:00	27 @ 12:00	25 @ 12:30	13 @10:00	14 @14:00		13 @14:00	27 @ 16:30
JUNE	24 @14:00	24 @ 12:00	22 @ 12:30		3 @14:00	10 @ 10:00	- -	24 @ 16:30
JULY	29 @14:00	29 @ 12:00	27 @ 12:30	1 @10:00	15 @14:00		8 @ 14:00	29 @ 16:30
AUGUST				- -			- -	
SEPTEMBER	30 @14:00	30 @ 12:00	28 @ 12:30	16 @10:00	2 @14:00	16 @14:00	9 @ 14:00	30 @ 16:30
OCTOBER	28 @14:00	28 @ 12:00	26 @ 12:30		14 @10:00		- -	28 @ 16:30
NOVEMBER	25 @14:00	25 @ 12:00	23 @ 12:30	4 @10:00			11 @ 14:00	25 @ 16:30
DECEMBER				16 @10:00	2 @14:00	16 @14:00	- -	

Summary Of Board To Ward Responsibilities For Governance and Risk Management

Board/Committee/Individual	Responsibilities That Impact On Risk Management
Board	**Accountable to the people it serves** **The Board led by the Chairman:** • is responsible for establishing the vision and strategic direction of the Trust. • is also responsible setting the annual and longer terms objectives for the Trust. • sets the strategic and operational quality outcomes it expects the organisation to achieve • is responsible for driving the Trust forward to achieve them. • oversees the delivery of its planned results by monitoring performance assuring itself that corrective action is taken when necessary. • ensures there is a Quality Improvement Strategy underpinned by a Workforce and Organisational Development Plan that enables the trust to develop and sustain a culture of continuous Quality Improvement, ensuring that the trust can deliver safe, personal and effective care every time. • assure themselves that there is effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs. • will transact its business in an open and transparent manner and ensure that the duty of candour is met at all times • ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation. • will ensure there is a Governance and Risk Management Strategy that ensures that high standards of corporate and clinical governance and risk management. **The Chief Executive** • is required to sign a Governance Statement on behalf of the Board each financial year. This includes how risks are identified and managed, the Trust Board is accountable for ensuring a system of internal control and stewardship which supports the delivery of safe, personal and effective patient care and the achievement of the organisation's objectives. **The Board assures itself that:-** • the Trust's Key Objectives are agreed .

Board/Committee/Individual	Responsibilities That Impact On Risk Management
	• the principal risks to those objectives are identified • controls which eliminate or reduce these risks are implemented • harm or the potential for harm is minimised. • the effectiveness of these controls are independently assured. • There is a strategy in place for continuous quality Improvement to support risk minimisation • reports on unacceptable or serious risks and the effectiveness of control mechanisms are received from the Executive Directors and independent assurors. • action plans are agreed to improve control over serious or unacceptable risks. • policies are in place to determine levels of acceptable risk and thus informing what level of risks should be accepted / retained (Risk Appetite) . • the trust complies with all standards and guidelines issued by the regulators, NHS England, the NHS Litigation Authority, the Royal Colleges and other professional and national bodies.
Audit Committee	**Accountable to the Board** **The Audit Committee** • is charged with ensuring that the Board and Accounting Officer of the organisation gain the assurance they need on governance, risk management, the control environment and on the integrity of the financial statements, as well as other elements of the Annual Report and Accounts • acts as the "conscience" of the organisation and strong constructive challenge where required, for example, regarding risks arising from increasing fiscal and resource constraints, new service delivery models, information flows on risk and control, and the agility of the organisation to respond to emerging risks. • is a major part of the corporate layer of accountability, overseeing the function of all committees; • is the independent and more objective assurance, and includes internal audit and receiving intelligence from external bodies including regulators and the external auditor. • fully understands how the governance arrangements support the achievement of the Trust's strategies and objectives, especially: ◦ The Trust's vision and purpose; ◦ The mechanisms in place to ensure effective organisational accountability, performance and risk management; ◦ Roles and responsibilities of individuals and committees and other groups to support the effective discharge of the Trust's responsibilities, decision making and reporting; • understands the organisation's business strategy, operating environment and the associated risks.

Board/Committee/Individual	Responsibilities That Impact On Risk Management
	• takes into account the role and activities of the Board and other committees in relation to managing risk and should ensure the Board discusses its policies, attitude to and appetite for risk to ensure these are appropriately defined and communicated so management operates within these parameters. • reviews 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 objectives. In particular the Committee will review the adequacy and effectiveness of: ◦ All risk and control related disclosure statements (in particular the Annual Governance Statement, formally known as Statement on Internal Control) together with any accompanying Head of Internal Audit Statement, external audit opinion or other appropriate independent assurances, prior to their endorsement by the Board. ◦ The underlying assurance processes that indicate the degree of achievement of the corporate objectives, the effectiveness of the management of the principal risks and the appropriateness of the above disclosure statements ◦ The policies for ensuring compliance with the relevant regulatory, legal and code of conduct requirements and related reporting and self-certification ◦ The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service. • utilises the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of the effectiveness. • oversees the production of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it. • ensures that there is an effective internal audit function that meets mandatory *NHS Internal Audit Standards* or (*Government Internal Audit Standards* in an NHS Foundation Trust) and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by: ◦ Consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal ◦ Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework ◦ Considering the major findings of internal audit work (and management's response) and ensuring coordination between the internal and external auditors to optimise audit resources ◦ Ensuring that the internal audit function is adequately resources and has appropriate standing within the organisation ◦ The Annual review of the effectiveness of internal audit ◦ with Internal Audit input advises the Accounting Officer and Board on the:

Board/Committee/Individual	Responsibilities That Impact On Risk Management
	◦ internal audit strategy and periodic internal audit plans, forming a view on how well they reflect the organisation's risk exposure and support the Head of Internal Audit's responsibility to provide an annual opinion; ◦ adequacy of the resources available to internal audit; ◦ internal audit charter, or terms of reference, for internal audit; ◦ results of internal audit work, including reports on the effectiveness of systems for governance, risk management and control, and management responses to issues raised; ◦ annual internal audit opinion and annual report; and • reviews the work and findings of the external auditors and consider the implications and management's response to their work. This will be achieved by: ◦ Consideration of the appointment and performance of the external auditors, as far as the rules governing the appointment permit ◦ Discussion and agreement with the external auditors, before the audit commences, of the scope and nature of the audit as set out in the annual plan, and ensuring coordination, as appropriate, with other external auditors in the local health economy ◦ Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee ◦ Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses. • reviews 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 and professional bodies with responsibility for the performance of staff or functions. • will review the work of all other committees within the organisation whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the work and functionality of the Patient Safety and Governance Committee which reports to the Board on all aspects of clinical governance and risk management • will satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. • will request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. • may also request specific reports from individual functions within the organisation as they may be appropriate to the overall arrangements.

Board/Committee/Individual	Responsibilities That Impact On Risk Management
	• monitors the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance. The Committee will ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board. • reviews he annual report and financial statements before submission to the Board, focussing particularly on: ◦ The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee ◦ Changes in and compliance with accounting policies, practices and estimation techniques ◦ Unadjusted mis-statements in the financial statements ◦ Significant judgements in preparation of the financial statements ◦ Significant adjustments resulting from the audit ◦ Letter of Representation ◦ Qualitative aspects of financial reporting
Charitable Funds Committee	The Trust receives funds for charitable purposes from a number of sources. The Trust as a corporate body is the Trustee of these funds. The Trust Board • must ensure that its duties as a Trustee are discharged correctly taking advice as necessary. • when acting as Trustees of the charitable funds should function in line with guidance from the Charities Commission, and should as far as it is feasible to do, be completely separated from the business of the Board. • appoints this Committee to discharge this function. In addition the Trust Board delegates to this Committee the authority to examine and approve the annual accounts of funds held on trust. **Reporting to the Board in its capacity as the Board of Trustees** **The Charitable Funds Committee** • oversees the management of funds held on trust and charitable funds. In particular the Committee will: ◦ Set a corporate strategy for the management of funds ◦ Assure the Trust Board that the policies and procedures for the management and administration of Trust funds are adequate, effective and observed ◦ Review the investments held by the Trust at regular intervals ◦ Review the performance of funds on a regular basis ◦ Approve and review the application of funds ◦ Approve, accredit and support fundraising activities in accordance with the Trust's Guidelines for Fund Raising Activities

Board/Committee/Individual	Responsibilities That Impact On Risk Management
	◦ Approve and review the appointment of those managing investments on behalf of the Trustees ◦ Make recommendations to the Trust Board regarding the management and performance of funds ◦ Provide an annual report to the Trust Board on the Committee's activities
Remuneration Committee	**Accountable to the Board** The Committee has authority to determine, in consultation with the Chairman and the Chief Executive of the Trust; • the policy on the remuneration of Executive Directors • the specific remuneration packages for each of the Executive Directors including pension rights and any compensation payments • the remuneration of other very senior employees who are considered by the Committee to hold key positions within the Trust and whose remuneration package is, or is considered appropriate to place, outside the provisions of the Agenda for Change framework • the remuneration of other employees who are considered by the Committee to hold key positions within the Trust who are employed to perform specific short term functions on a semi consultancy basis • the arrangements for the appointment of individuals outlined above • the termination packages of any individual outlined above. • In determining the remuneration and termination packages and the remuneration policy, the Committee shall keep in mind: ◦ firstly, the desirability of the maintenance throughout the Trust of a competitive, fair remuneration structure which operates in the interests of, and to the benefit of, the financial and commercial health of the Trust ◦ secondly, ensuring the members of the executive management of the Trust are provided with appropriate incentives to encourage enhanced performance and are, in a fair and responsible manner, rewarded for their individual contributions to the success of the organisation
Patient Safety and Governance Committee	**Accountable to the Board** **The Patient Safety and Governance Committee** This is the Key Committee in the Risk Management reporting. The committee: • provides assurance to the Board that all aspects of the delivery of safe, personal and effective care are being appropriately governed and that the evidence to support that assurance is scrutinised in detail on behalf of the Board. • reviews and approves the Trust's Risk Management Strategy (and supporting documents) assuring the Board that it contains the information necessary to support good governance and risk management throughout the Trust, assuring itself that the Trust meets the requirements of all mandatory and best practice guidance issued on governance. • assures itself that adequate and appropriate integrated governance structures, processes and controls (including Risk Assurance

Board/Committee/Individual	Responsibilities That Impact On Risk Management
	Frameworks at all levels) are in place across the Trust. In particular this committee is responsible for the detailed scrutiny of the safety, personalisation and effectiveness of care and will establish Trust wide governance priorities. • approves the governance arrangements proposed by the divisions and will have oversight of the establishment and function of any boards or committees established within those arrangements. • approves the Terms of Reference and membership of its reporting committees and oversee the work of its sub-committees receiving reports from them for consideration and action as necessary. • receives reports from its sub-committees at which the patient safety and quality issues and risk management processes in the Divisions are debated and monitored collectively • provides the Board, with the audit committee, with the assurance that the divisional committees are functioning appropriately in terms of governance and risk management and contribute positively to ensuring the delivery of safe, personal and effective care. • satisfies itself that at every level of the trust staff Identify, prioritise and manage risk arising from corporate and clinical issues on a continuing basis. • has responsibility for scrutinising the Trust's (Corporate) Risk Assurance Framework on a monthly or near monthly basis and satisfying itself that the identified risks are being managed appropriately within the divisions and departments and at executive level. • is responsible for ensuring that those risks escalated to the Board Strategic Risk Assurance Framework are appropriate and proportionate, seeking further assurance from the executive team and escalating to the Board, concerns relating to unresolved risks that may require executive action or pose significant threats to the operation, resources or reputation of the Trust. • scrutinises the effective and efficient use of resources through evidence based clinical practice and assure itself that there is an appropriate process in place to monitor and promote compliance across the Trust with all standards and guidelines issued by the regulators, NHS England, the NHS Litigation Authority, the Royal Colleges and other professional and national bodies • promotes a culture of open and honest reporting of a situation that may threaten the quality of patient care, and oversee the process to ensure that appropriate action is taken in response to adverse clinical incidents, complaints and litigation • satisfies itself that examples of good practice are disseminated within the Trust, ensuring that its sub-committees have adequately scrutinised the investigation of incidents and that there is evidence that learning is identified and disseminated across the Trust. • assures itself that those elements of business relating to Patient Safety and Governance that are contained in the Terms of Reference of other committees are carried out effectively for example ensuring that there is an appropriate mechanism in place for action to be taken in response to the results of clinical audit; that guidelines and standards are introduced consistently across the trust and poor practice is challenge • satisfies itself that Safeguarding Children and Vulnerable Adults is at the heart of everything we do, ensuring that the Trust meets all of its obligations in respect of safeguarding at all times. This includes satisfying itself that all staff have training to the standard

Board/Committee/Individual	Responsibilities That Impact On Risk Management
	and frequency required. It will also satisfy itself that the Trust captures the learning from nationally published reports and that the learning is embedded in the practices, policies and procedures of the Trust. • assures itself that the appropriate actions in respect of Patient Safety and Governance have been taken following recommendations by any relevant external body. This includes monitoring the Trust's compliance with the Care Quality Commission registration requirements and any reports resulting from visits. • receives a detailed report on the activity of the PALs service and Complaints and Litigation. • seeks assurances that as well as delivering safe, personal and effective care to patients the health and welfare of staff and others for whom the Trust owes a duty of care is protected. • considers matters referred to it by other committees and groups across the Trust.
Finance and Performance Committee	**Accountable to the Board** The Finance and Performance Committee is established to provide a forum in which the Board can consider in more detail progress against the Trusts objectives and Integrated Business Plan and consider the mitigating strategies and actions being devised and implemented to ensure the delivery of the Plan. It will: • look in detail at Cost Improvement Programmes and their delivery • consider the financial performance in the current year and look ahead to expected performance for the subsequent 2-5 years. • provide the board with a forum for detailed discussions of progress against the Integrated Business Plan including the delivery of Cost Improvement Programmes. • Assess the performance of the organisation against all national and local performance standards
Operational Delivery Board	**Accountable to the Chief Executive** The Operational Delivery Board is the senior management committee within the Trust. Its purpose is to oversee the effective operational management of the Trust (including achievement of statutory duties, standards, targets and other obligations) and the delivery of safe, personal and effective care, and to support the Trust Board in setting and delivering the organisation's strategic direction and priorities. It is the major scrutiny committee for holding the Divisions to account for their performance and forms the high level Committee for executive decision making, communication with the Divisional teams and reporting arrangements set out in the Trust Governance and Risk Management Strategy

Board/Committee/Individual	Responsibilities That Impact On Risk Management
	The Committee will: • develop and agree proposals for submission to the Trust Board on the organisation's Vision and Values, Purpose and Strategic Direction . • develop and agree proposals for submission to the Trust Board on the Trust's annual objectives and Integrated Business Plan, including the revenue and capital budgets to support delivery of the Plan • review the Trust's overall performance on a monthly basis to inform monthly performance reporting to the Trust Board, including review of the performance dashboard to be presented to the Trust Board. • monitor ongoing compliance with statutory duties, standards, targets and other obligations, and agree actions and responsibilities to address shortcomings or development requirements identified. • agree actions and responsibilities in relation to key performance issues escalated from the monthly Performance Review meetings with Clinical Divisions. • challenge progress against key Performance Indicators, approve requests for resourcing changes and assess and manage risks in accordance with the Trust's Standing Orders and Standing Financial Instructions. • review and approve for submission to the Audit Committee and the Trust Board the Trust's Annual Statement of Governance. • review all draft declarations of compliance with standards against which the Trust is monitored. • consider the quality of mitigations, controls and action plans in place in the Divisions to bring performance to an acceptable level • oversee the effective delivery of safe, high quality, patient-centred care through exception reporting from the Divisions across the Trust. • receive feedback from committees and sub-groups attended by members of the committee or others to gain assurance that the committees of the trust are functioning appropriately • review progress against selected Patient Safety Indicators as outlined in the Quality Account • receive an update on the bi-annual claims report • review business cases for major service and strategic developments, making recommendations for approval to the Trust Board as required under the Trust's Standing Orders and Standing Financial Instruct • assess and seek assurance about risk controls • ensure the development and recommendation to the trust board, of an effective system of risk management. • keep under review risks to delivery of the organisation's objectives, and agree: • action necessary to mitigate or manage risk the status of risk, where appropriate reflecting changes in the strategic risk assurance framework

Board/Committee/Individual	Responsibilities That Impact On Risk Management
	• ensure that there are effective arrangements in place to protect the health and safety of staff, service users, and people working at, or visiting the trust. • propose risk management policy and agree risk thresholds for regular scrutiny by the Board or by a Committee • ensure that there are appropriate resources invested in risk management • consider and recommend strategic risks to the board via the Patient Safety and Governance Committee • as well as the other risk management arrangements, keep the risk register under review, including items removed and added to the register and recommends items to be included in the risk register • on a monthly basis review risk scores in the light of controls to mitigate risk and confirms its support [or not] for the risk score, confirming the controls or recommending additions • agree any escalation triggers with the Divisions • be responsible for ensuring appropriate communications between the Board and the Divisional structures
	•
Patient Safety and Risk Assurance Committee, Clinical Effectiveness Committee, SIRI Panel and Patient Experience Group	**Accountable to the Patient Safety and Governance Committee** These are the formal sub-committees of the Patient Safety and Governance Committee whose purpose is to: • examine the detail of the effectiveness of the divisional governance and risk management arrangements and pull together risk management for the trust as a whole and escalate as necessary issues to the Patient Safety and Governance Committee. • use its delegated responsibility for overseeing the compilation of the Trust (Corporate)Risk Assurance Framework using the agreed scoring mechanism and the Divisional Risk Registers as a basis for that framework, ensuring that risks are escalated appropriately to the Patient Safety and Governance Committee and where necessary recommending those for escalation to the Board Strategic Risk Assurance Framework • receive reports on the Divisional Risk Assurance Frameworks and examine the details of the Divisional Risk Registers and Risk Assurance Frameworks and satisfy itself that risks are being identified and reduced or eliminated. • consider all proposals for re-scoring existing risks, the addition to, or de-escalation from, the Trust (Corporate) Risk Assurance Framework and determine the recommendations to be made to the Patient Safety and Governance Committee. • discuss the mitigation plans and controls for all risks prior to inclusion on the Trust (Corporate)Risk Assurance Framework giving assurance to the Patient Safety and Governance Committee that risks are being appropriately managed. • receive reports from Divisions and the Governance Unit and identify risk mitigation plans that are not delivering, highlighting areas

Board/Committee/Individual	Responsibilities That Impact On Risk Management
	where there is limited assurance that the risk mitigation plan will deliver the required outcome. • set out the improvements expected from the divisions. It will also ensure that there is appropriate reporting within the divisions on all matters relating to risk management and assurance • seek clarity from Divisions about their own Risk Assurance Frameworks and will moderate risk ratings in the Divisional Risk Assurance Frameworks with particular emphasis on those with a score rating of 15-25 to ensure consistency of scoring across the Trust, they will agree the risk description, and amend or approve the risk rated score for inclusion in the Appropriate Framework as necessary. • approve the Trust (Corporate) Risk Assurance Framework for submission to the Patient Safety and Governance Committee • satisfy itself that the divisions are compliant with all standards and guidelines issued by the regulators, NHS England, the NHS Litigation Authority, the Royal Colleges and other professional and national bodies • seek assurance that there is a culture of openness and transparency with no blame that encourages the reporting of incidents and near misses, such that the Trust is a high reporter with a reducing level of harm associated with incidents and events. • take a view about divisional major Service Improvement Plans and all cross divisional plans before implementation so that it is satisfied that all risks are identified and mitigated before implementation and that the plans make coherent clinical sense and do not compromise the safety of care. • Satisfy itself that post change implementation audit is carried out to assure the board that the risks were controlled and that the quality of patient care has improved or remained as planned. • Ensure that lessons are learned from incidents and events, and that lessons learned during clinical and system redesign are shared across the trust • help identify, propose and monitor delivery of Quality, Safety and Governance priorities for the Trust. • co-ordinate all risk management activities across the Trust ensuring the standardisation of risk reporting tools including the use of Risk Assurance Frameworks • assure itself of the effective co-ordination of systems that manage complaints and litigation, claims management and insurance, hazard occurrence and adverse incident reporting. • seek assurance that there is robust risk awareness and risk assessment training programmes appropriate to roles and responsibilities for all staff and will monitor attendance of key personnel. • ensure that all divisions and directorates or departments are reporting appropriately on all issues relating to patient safety and governance through the reporting routes, giving assurance to the Patient Safety and Governance that the information they receive is robust. • drive the Information Governance agenda including quality assuring the Trust Statement of Compliance with the requirements set out the NHS codes of practice prior to its submission.

Board/Committee/Individual	Responsibilities That Impact On Risk Management
	• oversee any action plans that derive from a gap analysis against the Information Governance Toolkit for the NHS and its Partners which forms the basis for the Trust Statement. • to oversee the delivery of safe, personal and effective care. To support this element of their business the Committees will receive reports on a range of matters as they pertain to the safety, the personalisation and the effectiveness of care and will request actions to mitigate any risks or to meet any gaps in the quality of service they provide. The Committees will link to the Quality Improvement agenda to ensure that improvement activities are focussed on identified areas
Other corporate functions with identified responsibilities	**Accountable to Line Managers and Reporting to the Appropriate Committees as set out in the Committee Handbook** As well as the responsibilities of the Executive Team and the Board and its Committees there are a number of roles across the Trust that contribute to the Governance and Risk Management. Along with the Quality and Safety Unit these corporate or trust wide functions make a significant contribution to robust governance arrangements and the management of risks across the trust. The roles set out below are not exhaustive and other roles and responsibilities are set out in other Policies and Procedures of the Trust The Governance and Risk Management Strategy identifies these roles in detail. The list includes: • The Company Secretary • Head of Internal Audit • Head of Patient Administration • Occupational Health and Wellbeing Services • The Associate Director of IM&T • Counter Fraud and Security Management Officers • The Fire Officer • The Health & Safety Assurance Coordinator (Health & Safety Officer) • The Associate Director of Estates and Facilities • Heads of Learning and Organisational Development and Human Resource • Director of Infection Prevention and Control and Team • Controlled Drugs Accountable Officer
Quality and Safety Unit	**Accountable to the Medical Director**

Board/Committee/Individual	Responsibilities That Impact On Risk Management
	The purpose of the Quality and Safety Unit As well as describing executive and specific responsibilities this document also sets out the roles and responsibilities of a range of clinical leaders and governance and risk management "subject matter experts" whose role it is to oversee and support good governance and the management of risks across the trust on behalf of the executive team to ensure the delivery of safe, personal and effective care. This is the Quality and Safety Unit, led by the Associate Director of Patient Safety and Governance The list of responsibilities held by the members of the Quality and Safety Unit is not exhaustive and there are Trust Policies which also describe responsibilities for risk management for individuals not listed below. The Policies identify the individuals or groups of individuals responsible for their management and they include individuals within Divisions and Corporate Directorates who have specific roles as defined in that specific Trust Policy or procedures The Quality and Safety Unit has a number of core staff and a range of clinicians who also provide cross trust advice and challenge. • The Associate Director of Patient Safety and Governance • The Deputy Director of Nursing (Corporate) • The Deputy Medical Director • The Associate Director of Medicine (Service Integration/Improvement) • The Clinical Director for the Medical Directors Office • The Risk and Assurance Development Manager • Head of Complaints and Litigation • The Clinical Audit Manager • Incident and Risk Coordinator • Administrative support **The Quality and Safety Unit will** • support the key Governance and Risk Management Committees • support the Policy Council • oversee the development of the governance arrangements in the Divisions providing advice and support as necessary • ensure that the Quality of Risk Assurance Frameworks meets the required standard and leading in the production of the Trust (Corporate) and Board Strategic Frameworks • oversee the management of complaints across the Trust, taking responsibility for directly managing the more complex complaints • manage the process of litigation

Board/Committee/Individual	Responsibilities That Impact On Risk Management
	• oversee and quality assure the reporting of incidents ensuring the trust meets its obligations for reporting upwards • arrange and support any internal or external reviews into serious incidents • provide reports as required for the committees at all corporate levels • provide assurance to the Quality and Patient Safety Committee about the quality of the Divisional Management reports in relation to governance and risk management • oversee the production and monitoring of any clinical action plans that derive from visits or reports from the regulators or any other national body.
Divisional Arrangements	**Accountable to the Operational Delivery Board** **T**he Trust has established robust governance and risk management arrangements to demonstrate accountability throughout the Trust and provide the Board with assurance that the Trust is meeting its key objectives and delivering safe, personal and effective care to patients. At a corporate level these are illustrated in the Committee Handbook. As part of the delegation to divisions the responsibility for determining governance and risk management arrangements at Divisional level is delegated to the Divisional Director supported by the Divisional General Manager, the Divisional Chief Nurse and the Divisional Governance lead. The arrangements will be quality assured by the Quality and Safety Unit The divisions will be required to meet the standards set out in the Committee Handbook and will: • provide the Board with evidence of accountability and assurance that the division is delivering their responsibilities and contributing positively to the objectives of the trust. The assurance will be given through a number of reporting routes also illustrated and described in the Committee Handbook • ensure they meet the reporting requirements of the Board and it's committees and sub-committees. • have clear escalation policies in place that meet the requirements of the Trust Incident Reporting to ensure that there is a rapid upward reporting of significant and serious events. As a supplementary route for reporting, as well as the normal incident reporting process this should include a phone call to the Chief Nurse or the Medical Director or the On Call Executive, and as soon as is feasible to the Quality and Safety Unit. This will enable the Board to be made aware of serious issues in advance of the normal process ensuring "no surprises". • meet the requirements of the Performance and Accountability meetings chaired by the Director of Operations which is the main formal route of accountability for all areas of responsibility and will cover the delivery of safe, personal and effective care and will normally take place on a monthly basis but can be more frequent if there are particular performance issues. • report through the attendance of the Divisional Director to the Operational Delivery Board which acts on behalf of the Board and is the key Committee for the performance and accountability route as set out in the Governance and Risk Management Strategy and

Board/Committee/Individual	Responsibilities That Impact On Risk Management
	the Committee Handbook • report as required to the Patient Safety and Risk Assurance Committee, Clinical Effectiveness Committee, SIRI Panel and Patient Experience Group, which in turn report to the Patient Safety and Governance Committee as set out in the Governance and Risk Management Strategy and the Committee. • Submit any major Cost Improvement Programmes to the Operational Delivery Board who will scrutinise the proposals referred to them by the Medical Director or Chief Nurse before they are signed off from a patient safety perspective. • Through the Divisional Director speak to their performance on sharing learning across the trust following incidents and complaints. • will describe the responsibilities and accountabilities they have delegated to Directorate and function specific Clinical leads such as, Matrons, Service Quality Lead, Directorate Managers, Business Managers, and Departmental Heads. • Agree any escalation triggers with the Operational Delivery Board
Departmental and Directorate Arrangements	**Accountable through the Divisional Management Arrangements** The Directorates or Departments will • operate within the governance and risk management arrangements established by the division when discharging their responsibilities and will systematically identify, evaluate, eliminate or reduce and manage risks. • on behalf of their services or sphere of responsibility, will provide reports on the quality of care including highlighting risks, and demonstrating with evidence the effectiveness of the controls they have put in place to reduce or eliminate these. • ensure that they report any significant risks of incidents to the Divisional Director or the Divisional General Manger or the Chief Nurse depending on their line management arrangements. • also ensure they report this up to the executive team as described in the Divisional responsibilities above. Out of hours they will report to the on-call manager. As soon as possible they will ensure that the Quality and Safety Unit has been informed by the route set out in the Reporting of Incidents policy. • be held to account through governance, and reporting arrangements for delivering their agreed objectives and operating effectively within the governance arrangements. • meet their own identified training needs , participate in risk awareness training through Mandatory Training and also identify and meet the education and training needs of their staff so that they are aware of and understand risk management and ensure risks are reduced. • ensure that care delivered in the directorate or department is safe, personal and effective and that they have evidence to support that
Ward/team	**Accountable through line management and professional accountability arrangements**

Board/Committee/Individual	Responsibilities That Impact On Risk Management
arrangements	As in the directorate responsibilities of individuals at ward or team levels will include • operate within the governance and risk management arrangements established by the division when discharging their responsibilities and will systematically identify, evaluate, eliminate or reduce and manage risks. • on behalf of their services or sphere of responsibility, will provide reports on the quality of care including highlighting risks, and demonstrating with evidence the effectiveness of the controls they have put in place to reduce or eliminate these • ensure that they report any significant risks of incidents to the Divisional Director or the Divisional General Manger or the Chief Nurse depending on their line management arrangements. They will in turn ensure they report this up to the executive team as described above. Out of hours they will report to the on-call manager. As soon as possible they will ensure that the Quality and Safety Unit has been informed by the route set out in the Reporting of incidents policy. • be held to account through governance, and reporting arrangements for delivering their agreed objectives and operating effectively within the governance arrangements. • will meet they own identified training needs , participate in risk awareness training through Mandatory Training and also identify and meet the education and training needs of their staff so that they are aware of and understand risk management and ensure risks are reduced. • ensure that care delivered in the directorate or department is safe, personal and effective and that they have evidence to support that • ensure that all staff from all disciplines attend the Share to Care meetings
Individual Staff duties	**Accountable through line management and professional accountability arrangements** In addition to the requirement to fulfil the duties of any employee – All clinicians employed by the Trust have a responsibility to ensuring the delivery of safe personal and effective care to their patients and they are personally responsible for : • ensuring they maintain their professional registration and practice within the standards of their professional bodies, any other national standards or guidelines and any locally determined clinical policies and guidelines to ensure their practice is as risk free as possible; • identifying through their own department's risk assessment process and line management arrangements, any risks they feel exist within the service and their practice reporting those risks and taking action to minimise identified risks: • providing incident reports and supporting documentation for any unexpected event or incident arising from clinical care or treatment provided; • satisfying themselves that action has been taken when they have reported a risk or incident

Board/Committee/Individual	Responsibilities That Impact On Risk Management
	• ensuring they handle informal concerns and complaints in accordance with Trust Policy and procedure and participate in the investigation of any such complaints. • providing statements and reports for HM Coroner as requested. • handling claims in accordance with Trust Claims procedures and participate in the investigation of any such claims. • undertaking corporate and local induction and all mandatory update training but specifically that which relates to the risk management policy and procedures as determined in the Trust Policy. • Participating in performance review processes and professional revalidation requirements and actively participating in objective/setting and job planning • Attend share to care meetings ensuring that they introduce best practice identified and agreed into their own work Other staff are responsible for fulfilling their role to the best of their ability to support the delivery of care and to report any concerns they have about the quality of that care.
Special Responsibilities	**Safeguarding Children and Vulnerable Adults** The Trust Safeguarding Children and Vulnerable Adults Policies outline the arrangements for Child Protection and the protection of Vulnerable Adults in the Trust. The Division of Family Care has the designated lead on Safeguarding both Children and Vulnerable Adults reporting to the Chief Nurse through the structure defined in the Safeguarding Children Policy. The Family Care Division administers the Trust Safeguarding Board which reports directly through to the Patient Safety and Governance Committee and ultimately to the board through the committee arrangements. It is important that • The Division satisfies itself that all of the requirements in relation to named and designated professionals is met and that they oversee all issues in relation to Safeguarding Children and Adults across the trust, and that all risks are identified, reported and reduced or eliminated. • in line with the Trust Policies the division ensures that the trust meets all of its obligations in relation to working in partnership with all agencies concerned with the protection of children and adults and ensures that we share information about children and adults at risk as necessary • the Safeguarding Board reports at least quarterly to the Trust Board and produces a Safeguarding Annual Report for the Board. As well as using the reporting routes for incidents as laid down in the Policy any issues relating to safeguarding are escalated immediately to the responsible Executive Director or another Executive in their absence

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External Review Outcomes	18 March 2015
Policies Approved	18 March 2015
Regulation 28 notices	18 March 2015
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Clinical Coding Audit	18 March 2015
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Claims Report	18 March 2015
Complaints Report	18 March 2015
Falls Collaborative Update	18 March 2015
Staff Survey Update	18 March 2015
Attendance Report	18 March 2015
Cancer Patient Experience Survey Update	18 March 2015
Annual Research and Development Report and Plan	18 March 2015
Annual Francis Report	18 March 2015
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SIRI Panel Annual Report	18 March 2015
Clinical Effectiveness Committee Annual Report	18 March 2015
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Divisional Governance Arrangements Review	15 April 2015
Committee Annual Report	15 April 2015
CQUIN Update	15 April 2015
IR1 Report Review	15 April 2015
DOLS Report	15 April 2015
PALS Report	15 April 2015
Mortality Alerts	15 April 2015
PROMS Update	15 April 2015
Patient Survey Update	15 April 2015
Staff Survey Update	15 April 2015
Patient Safety Walkround Annual Report	15 April 2015
Attendance Report	15 April 2015
Committee Annual Report	15 April 2015
Draft Quality Account	15 April 2015
Annual Governance Statement	15 April 2015
Internal Safeguarding Board Report	13 May 2015
Clinical Coding Audit	13 May 2015
Quality Account Deep Dive	13 May 2015
Claims Report	13 May 2015
Complaints Report	13 May 2015
Early Warning Score Implementation	13 May 2015
Quality Strategy Review	13 May 2015
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Attendance Report	13 May 2015
Quality Impact Assessment Review	13 May 2015
Draft Quality Account	13 May 2015
Membership Strategy Review	13 May 2015
Medicines Management Annual Report	13 May 2015
Clinical Strategy Review	13 May 2015
Breast Screening Annual Report	13 May 2015
Divisional Governance Arrangements Review	01 July 2015
CQUIN Update	01 July 2015
IR1 Report Review	01 July 2015
PALS Report	01 July 2015
Mortality Alerts	01 July 2015
Clinical Audit Annual Report and Plan	01 July 2015
PLACE Annual Report	01 July 2015
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Attendance Report	01 July 2015
NLRS Benchmarking Report	01 July 2015
Duty of Candour Annual Report	01 July 2015
Patient Safety Walkround Annual Report	01 July 2015
Organ Donation Annual Report	01 July 2015
Safeguarding Annual Report	01 July 2015
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Quality Account Deep Dive	16 September 2015
Claims Report	16 September 2015
Complaints Report	16 September 2015
Patient Survey Update	16 September 2015
Pressure Ulcer Collaborative Update	16 September 2015
Whistleblowing Update	16 September 2015
Annual DIPC Report	16 September 2015
Engagement Update	16 September 2015
Divisional Governance Arrangements Review	16 September 2015
CQUIN Update	16 September 2015
IR1 Report Review	16 September 2015
DOLS Report	16 September 2015
PALS Report	16 September 2015
Mortality Alerts	16 September 2015
Early Warning Score Implementation	16 September 2015
Falls Collaborative Update	16 September 2015
Risk Management Strategy, Policy and Plan	16 September 2015
Staff Survey Update	16 September 2015
Patient Safety Walkround Report	16 September 2015
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End of Life Care Annual Report	16 September 2015
Nursing & Midwifery Strategy Review	16 September 2015
Whistleblowing Update	04 November 2015
Emergency Planning Report	04 November 2015
Francis Annual Report	04 November 2015
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Quality Impact Assessment Review	04 November 2015
Cancer Patient Experience Survey Update	04 November 2015
Subcommittee Handbooks	04 November 2015
Policy Review Process	04 November 2015
Patient Survey Update	16 December 2015
PROMS Update	16 December 2015
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Guidelines for Establishing Governance Arrangements and Managing Risk

Introduction

This guidance is intended for all levels within the trust but is predominantly written for the Divisions to use when establishing their own governance arrangements.

East Lancashire Hospitals NHS Trust has established robust Corporate Governance and Risk Management arrangements to support the delivery of safe, personal and effective care for the patients we serve.

Good Governance with robust risk management arrangements through which all risks to the successful delivery of that aim are identified, reported and managed will ensure that the trust operates effectively to deliver that objective.

Governance and risk management is the combination of people, structures and processes that help ensure that patients get safe, personal and effective care when they are being cared for by the Trust

The corporate system needs to be supported by robust arrangements at a divisional level. The Trust wishes each Division to establish its own arrangements that are capable of assuring the Board and its Committees that the arrangements are capable of ensuring the division meets its delegated responsibilities and delivers that safe, personal and effective care within the agreed budget.

The Board wishes to operate in a safe “no surprises” environment in which issues are reported and actions are taken as a result of lessons learned, and where the adoption of best practice and meeting standards and delivering to performance targets is the norm.

The trust will not dictate the systems the divisions put in place but will monitor the effectiveness of the systems, through the Quality and Safety Unit and the reporting mechanisms.

The divisions are being given responsibility for their own governance arrangements, and are accountable to the Trust Board via the Governance arrangements.

In this context responsibility is taken to mean those things that the division/directorate/team/individual is required to do (actions) on behalf of the trust and accountability is how they will explain and justify their actions to the Board and other stakeholders.

Divisional Arrangements

Risks are managed by all staff to their reasonable best for the benefit of patients, staff, visitors and other stakeholders. The governance arrangements are important to the safe functioning

of the trust but also support the mandatory and contractual requirements in regard to reporting to stakeholders. They also enable the trust to demonstrate openness and transparency about the way we do our business and support the duty of candour when things do not go as well as we would like.

Our stakeholders include:

- Patients, visitors and staff
- NHS England
- Care Quality Commission
- NHS Trust Development Authority and ultimately Monitor
- Clinical Commissioning Groups
- Other NHS & Non NHS Providers
- Health and Safety Executive
- Medicines Control/Medical Devices Agency
- Serous Hazards of Transfusion (SHOT)
- Environmental Health
- Food Standards Agency
- NHS Litigation Authority
- Police
- Professional Regulatory Bodies

To support the divisions to achieve good governance there are a number of individuals and functions within the trust that will operate as internal consultants and advisors as well as carry out a performance management function.

The support functions include (but not exclusively) , Human Resources and Organisational Development , Finance, Estates and facilities, health and safety, Quality and Safety (including, patient complaints and PALs), Information and Analysis (intelligence), and Risk Management. The Committee Handbook sets out diagrammatically the structure and reporting routes to support the governance arrangements and risk management system.

It is important however that within the accountability arrangements that there is a range of less formal and supplementary reporting routes that will make the connections across the governance arrangements. These occur when a committee or group asks another committee or group to review a particular issue or plan, or will happen organically as individual members of a committee or group bring a particular perspective to the discussions and debates, either from their own personal area or responsibility or from their membership of another committee or group.

Members of staff from the divisions will play an important part of the informal reporting routes when they represent the division on committees or groups as well as using the escalation route for issues to be reported immediately to the Executive Team or the Board

The terms of reference for the committees and groups that give assurance to the Board, and the roles and responsibilities set out below, describe how the structures and supporting systems and processes will provide the Board with the assurance they need that the trust is delivering safe, personal and effective care.

The divisions will need to describe their structures and processes and how they fit into the model adopted by the Trust.

Their Terms of Reference will need to follow the format set out in the Committee Handbook.

The division will ensure that a culture of openness and transparency with a willingness to admit mistakes or identify issues that might mean things could go wrong and encourage all staff to report any situation where things have, or could have gone wrong.

The Quality and Safety Unit will provide information and support, and commission training for staff to use the reporting system effectively and to ensure they respond appropriately in any situation. The governance systems put in place by the divisions will help staff to operate safely, not hinder them.

At the heart of governance is the desire to manage risks and learn from events and situations in order to continuously improve the quality of patient care and the processes that supports that care. When something does or may go wrong, it is important to recognise that, report it and do something about it.

In the interest of openness and to support learning from mistakes, although formal disciplinary action will not automatically be taken as a result of an incident, the Trusts Disciplinary Policy outlines the circumstances in which disciplinary action will be taken. The divisions will be responsible for taking that action. Situations that may result in disciplinary action include where it is found that there is :-

- a Criminal act or a gross/repeated professional misconduct, including fraud
- abuse of clients/patients
- a failure to report an incident in which a member of staff was either involved or about which they were aware
- a breach of statutory duties

Should disciplinary action be appropriate, this will be notified to the executive team and carried out with the support of Human Resources and Organisational Development and it will be made clear as soon as the possibility emerges. The incident investigation will then be modified to take account of personnel policies.

In order that progress in managing all risks can be monitored, the Trust has process for managing Risk Assurance Frameworks (see Risk Assurance Framework models) proportionate to the level of risk. This ensures the provision of a record of all risks to the organisation and the actions being taken to minimise them. Where necessary, and where appropriate changes will be made to the Trust's systems to support the management of a single risk or group of risks.

Divisional Assurance

The Divisional system must be capable of providing the appropriate reports through the formal reporting routes and have systems in place to trigger ad hoc escalation of issues to the Executive team and the Board.

The Divisions will need to establish the systems and processes and the structure within the division to support their functions. They will need to ensure that these arrangements are built from the Wards and departments upwards and that they are capable of capturing, analysing and reporting all issues in respect of good governance and risk management. The system will adhere to Essential Standards of Quality and Safety as required by the regulators and the Board through the reporting processes will seek assurance from the divisions that

- the required standards of care is being met
- substandard performance is identified and action is taken to remedy this
- there are systems in place to continuously drive up the quality of care
- clinicians and managers identify and share best practice
- risks to the quality of care are identified and managed
- there is good stewardship of the trusts resources (financial, workforce, and estates)

The divisional processes will need to take into account the requirements of the stakeholders and any relevant monitoring and reporting required.

Risks fall into a number of categories strategic, clinical, operational, corporate and financial, the risk management systems and processes will need to be fully embedded at every level of the division and as well as their significant contribution to the safety of patients, staff and visitors these will ensure compliance with current and future risk management related standards and legislation.

Assurance will be provided to the Trust Board through the scheme of delegation and reporting mechanisms. This will enable the Board to make accurate judgements as to the

degree to which risks to patient safety and delivery of its objectives are being managed effectively and efficiently.

The levels of Assurance Framework provide evidence and enable the Trust to sign the Annual Governance Statement, Annual Accounts and Annual Quality Account. The Divisional Risk Assurance Framework is the building block of this assurance.

Everything we do contains inherent risks. Risk management and internal control is central to the effective running of any organisation. At its simplest, risk management is good management practice. It should not be seen as an end in itself, but as part of an overall management approach. The divisions will ensure that all decisions and actions carried out on behalf of the organisation are taken with consideration to the effective management of risks.

The purpose of the Governance and Risk Management Strategy that supports the delegation of responsibility to the Divisions is to create a culture that supports and encourages staff to:

- identify and control risks within their sphere of authority which may impact on patient safety and adversely affect the Trust's operational and strategic ability;
- analyse risks using an agreed grading system as explained in the risk management system section of this document;
- where possible by identifying and introducing controls and mitigating actions, eliminate risks or at least reduce them to an acceptable level;
- ensure the organisation understands and openly accepts the remaining risks.
- be open and transparent when things go wrong or there are risks to the service

To support good governance across the division the Division should set a clear steer on the strategic and operational quality outcomes it is to achieve, these should reflect the Trusts Vision and objectives and should demonstrate the part the division will play in delivering the Trust objectives.

The division should also ensure that the objectives of the directorates and all staff working in the division reflect that vision and organisational objectives so that everyone understands the part they play in the success of the Trust.

Risk Management

The Board needs to be assured that systems are fit for purpose. Divisional Systems will:

- adhere to the Trust's Policies and Procedures that systematically outline the Trust's expectations in relation to identified risk areas, statutory responsibility and

regulatory requirement - demonstrate that these policies and procedures are systematically managed, reviewed, updated and archived

- meet the requirements of the incident reporting and management system, ensuring accidents, incidents and near misses (no harm incidents) are recorded on the Trust Incident System and assessed for the likelihood and impact and that these are reported in accordance with statutory and regulatory requirements.
- maintain and monitor the Divisional Risk Assurance Framework, ensuring that the Framework identifies the Principal Risks to all strategic, corporate and divisional objectives.
- ensure that the framework continually meet the requirements of the Trust and that it is monitored on a monthly basis
- identify and record risks according to impact and likelihood and collate a record of these risks on ward/department and Divisional risk registers dependent upon the risk score and in accordance with risk escalation mechanisms are escalated to the Trust (Corporate) Risk Assurance Framework
- have in place a complaints and claims management system that meets the requirements of the Trust Policy.
- ensure that staff take action to control or mitigate risks, prevent recurrence of adverse incidents, complaints and claims and share learning with others
- produce a monthly aggregated learning report from Incidents, Complaints , PALS contacts and Claims which identifies risk themes and areas for improvement.
- enable the division to measure the impact of incidents by aiming to systematically reduce the level of harm caused by these events
- further develop the organisational risk management culture - Make risk management a natural part of day-to-day activity. This will be measurable through the extent and degree to which risks are being assessed, treated and monitored across the division.
- maintain and use the Trust Integrated Performance Framework to monitor and benchmark key performance indicators relating to Quality outcomes, Targets and Resources.
- Have a focus on the safety, personalisation and effectiveness of care
- increase knowledge and understanding of risk management by ensuring that the division has a programme of risk management training based on a training needs analysis. This will be measured through systematic monitoring and audit.

- provide assurance for the Board that its key priorities are embedded throughout the division and that risks are being positively addressed, this allows the Chief Executive to make the Annual Governance Statement.
- support the systematic progress of the Audit committee work
- drive forward the achievement of the National Health Service Litigation Authority Standards and Clinical Negligence System for Trusts and achieve higher levels of attainment – implementing relevant standards as they are required.
- ensure that the Trust Risk Management systems maintain fitness for purpose for Foundation Trust status

Central to the Trust Risk Management Process is the concept of a risk register and Risk Assurance Framework. This is a repository for information on the management of identified significant risks.

The risk register sits at the front of the Risk Assurance Framework document along with the scoring methodology and the reporting framework. Divisions are responsible for keeping this document up to date in all sections.

The Risk Assurance Framework allows the division to :

- Store information on significant risks in a meaningful way that can be distributed to key stakeholders and including risk reports for the Trust Board and its committees
- Rank risks by severity in order that they may be prioritised for action.
- Group risks by meaningful categories that permit more detailed analysis.

A Risk Assurance Framework should be maintained as a minimum for individual management units or locations, any risks with a score above an agreed level would escalate to the Divisional Risk Assurance Framework and if scoring more than 9 on the Divisional Risk Assurance Framework would escalate again (via the Quality and Patient Safety Committee) to the Trust (Corporate) Risk Assurance Framework. Any operational risks scoring above 15 in the Trust (Corporate) Risk Assurance Framework would be considered significant and will automatically be added to the Board Strategic Risk Register.

Risks which should be considered include financial, clinical, operational and / or those with regulatory impact.

Risk management is a multifaceted process, appropriate aspects of which are often best carried out by a multi-disciplinary team. It is an iterative process that can contribute to organisational improvement.

The divisional system must use the format set down by the trust as this allows risks to be comprehensively recorded and escalated and the Risk Assurance Framework contains all

the necessary guidance to scoring and recording the risk. It requires the individual or team identifying or assessing the risk to work with the Divisional Governance lead and

- Identify the risk, carry out an initial scoring (grade or quantify the frequency, likelihood or probability of harm from that activity or service) and number the Risk. (Risks will be identified from a number of sources including: Clinical practice, Health & Safety assessment process, External assessments, Incidents, Medicines and Health Care Products Regulatory Agency notices, NHS England or its agencies, Complaints, Claims, Business Plans, Major Projects, Financial planning, External Audits, Internal Audits, Performance Management, Care Quality Commission, Peat Reports and others).
- Describe the Risk including the actual risk of harm to patient, staff, visitors or the Trust.
- Record their name as the individual/team identifying and recording the risk
- Identify the lead manager responsible for mitigating and monitoring the risk
- Identify the divisional governance arrangements (Committee) to whom the risk will be reported
- Identify the strategic objectives (set out on the cover of the Risk Assurance Framework) that the risk will impact upon
- Identify the strategic risk that the risk links to
- Identify the Care Quality Commission outcomes it may impact upon
- Describe up to 4 Consequences of the risk
- What can happen?
- How can it happen?
- Identify the origins that have led to the risk (the context) and score their impact
- Determine actions in respect of the risk
- Avoid: not proceeding with activity likely to generate the risk
- Reduce: reducing or controlling the likelihood and consequences of the
- occurrence
- Transfer: arranging for another party to bear or share some part of the risk, through contracts, partnerships, joint ventures, etc. The remaining (shared) risk should still be in the Risk Assurance Framework with the sharing appearing as the control
- Accept: some risks may be minimal and retention acceptable. (This is determined by the Trusts risk appetite which is defined at the front of the Risk Assurance Frameworks). This will be reflected in the target score which will remain the same as the initial score.

- Where the risk is to be mitigated (reduced) identify the Controls (up to10) to be put in place and quantify costs of actions to reduce risks and compare costs against benefits. Also score the strength of the controls identified
- Set the target scores for the risk using the scoring matrix in the Risk Assurance Framework
- Establish an action plan if necessary to deliver the controls
- Identify how risks will be monitored, defining the reporting and communication mechanisms (including scoring their strength) and recording all positive and negative assurance that is received. As a result of each review the scores of the risks will be amended as necessary
- Enable the division to examine any tends in risks identified

Part of risk management is communication and as well as adding (or ensuring it is added) to the risk to the Risk Assurance Framework the person identifying the risk (or a manager) should ensure that they communicate with anyone who needs to know, in particularly those that may be affected by the risk or the controls to be put in place. It is also important that the individual or team identifying the risk has feedback about the actions taken and the outcome of the controls. It is especially important where they are not directly involved in managing the controls or monitoring the risk.

It is not possible to address all the required actions immediately there is therefore a need to set priorities for action. The priorities may be influenced by the urgency of the mitigation, the time and resources required to implement the action and other factors relating to the risk.

Whenever possible risk management should be aligned to existing work streams and plans rather than standalone plans.

The responsibilities for managing risk are identified in the governance and Risk Management Strategy. The divisional systems should meet the requirements in the strategy and include the following levels of responsibility (these are also reflected in the Risk Appetite statement in the Risk Assurance Frameworks)

- risk rating 1-3 - managed at a local level by ward / teams and department manager using controls as appropriate
- risk rating 4-8 - managed at a local level by ward / teams and department manager will have controls in place
- risk rating 9-14 - managed at divisional level by taking through divisional management committee or board and will have controls in place
- risk rating 15-25 - will be notified to the Quality and Safety Unit and discussed / challenged / moderated at divisional management committee or board and

escalated to the Quality and Patient Safety Committee via the Divisional Governance report. If necessary it will also be escalated to the Trust (Corporate) Risk Assurance Framework and where it is a significant risk, it will be escalated via the Governance and Patient Safety Committee to the Board Strategic Risk Assurance Framework

All risks will be recorded in the appropriate Risk Assurance Framework as described above and all risks will be reviewed on a monthly basis.

Once the risk score is at an acceptable level (meets the target score) it will be monitored for a further 3 months before it is "archived" in the Risk Assurance Framework. The framework allows the tabs for the worksheet to reflect the risk score and to easily move risks of a similar score together, archived risks will remain within the Risk Assurance Framework at the end of the workbook with a white tab until the risk has remained dormant for a year

Completing A Risk Excel Worksheet (Assessment and Scoring)

The Risk Assurance Frameworks are set out in excel workbooks they contain the Template for assessing risks which is the worksheet that forms the actual record of the risk. The risk register is also in the Risk Assurance Framework.

The scoring mechanism for the risks, the impact of the risk and the strength of controls and reporting is also described in the Risk Assurance Framework and should be applied to all risks. The table on the following page will help to determine which category the risk falls into when you are using the Risk Assurance Framework scoring methodology.

Divisions will normally have to identify the funding for risk control measures from their budgets although in exceptional circumstances the division may negotiate additional resources from the Director of Finance. This would require a detailed business case and would be discussed at the Divisional Performance and Accountability meetings.

Divisional Financial and Business plans must include the costs associated with known risks

Even when the Division has taken reasonable measures, approved by the Board or its committees, to eliminate or reduce risks, some risks will always remain.

There are three forms of financial risk involved in the transfer or reduction of risk, all are carefully controlled so to minimise the amount of funds that are diverted away from direct patient care.

Cost of Clinical Negligence / Indemnity

The Trust is currently covered for the cost of clinical negligence through the NHS Litigation Authority's Scheme for Trusts this covers claims arising from clinical incidents on or after 1 April 1995.

A separate scheme, Existing Liabilities Scheme, also administered by the NHS Litigation Authority, funds clinical negligence claims arising from incidents occurring before 1 April 1995.

The NHS Litigation Authority has developed risk management standards with three levels of accreditation, Divisions are required to meet the standards required by the Board.

Cost of Non-Clinical Claims/negligence

The NHS Litigation Authority administers an overarching Risk Management Scheme to fund claims on behalf of the Trust. This is called the Risk Pooling Scheme for Trusts It funds non-clinical claims made against the Trust. There is an excess on the policies which the Trust must pay in each individual case.

There is commercial insurance on Trust vehicles and leased vehicles. In addition, the Trust has commercial insurance for income generation activities and the activities of the Transfer/Transport Teams when staff are carrying out the duties associated with those teams.

The Trust will be externally assessed for accreditation against the NHS Litigation Authority risk management standards.

Funding for High Cost Implications of Serious Untoward Incidents

The funding of Serious Untoward Incident/ Major Incident Management will be met centrally where significant cost issues are identified (e.g. excessive laboratory costs following an unexpected serious outbreak of a particular disease).

The costs associated with obtaining the resource for an investigation that are not available from internal resources will be met by the Division.

Additional monies will be sought from commissioners, the Department of Health or other relevant source as necessary.

Incident Reporting and Investigation Processes

Divisions are required to adhere to the Trust Incident Reporting, Management and Investigation Policies that require that all clinical and non-clinical incidents, accidents or near miss (no harm) occurrences are reported and investigated, and that lessons are appropriately shared across the organisation, within the local health economy and within the wider NHS.

The Trust has in places processes comparable to this for Complaints, Informal Concerns and Claims and these are outlined in the respective policies for these areas, Divisions are expected to adhere to these policies also.

The Trust maintains a computerised reporting system (DATIX) for recording all incidents, complaints, PALS contacts and claims.

The incident reporting process in the Trust is outlined within the Incident Reporting and Investigation Procedures and provides the Trust with the ability to follow the course of an incident from occurrence, to monitor completion of investigations, identify remedial actions and to ensure lessons are learned to avoid future occurrence.

It provides early details of an incident that has the potential to lead to a complaint or claim and can identify multiple incidents involving the same people together with a grading of the incident's seriousness. This is essential to ensure future claims are handled within the legal pre-action protocol timescales.

The reporting system assists with the identification of departmental and corporate trends, drawing the attention of managers to areas that may require further analysis and exploration. The Trust believes that all incidents should be openly, consistently and fairly investigated so that lessons are learned and improvements are made in the quality and standard of care we deliver.

It is essential for the delivery of the governance agenda that this system is fully utilised and policies adhered to.

Responding to external recommendations specific to the organisation

Divisions are operationally responsible for delivering the Trust's systematic approach to responding to external recommendations specific to the organisation, is a key aspect of the Risk Management Strategy. The Trust expectations and processes in relation to this are outlined below.

Responding to the requirements of NICE, National Confidential Enquiries, National; Guidance, National Service Frameworks and High Level Enquiries

Divisions are also operationally responsible for the Trust's systematic approach to responding to the general requirements of NICE, National Confidential Enquiries , National Guidance, National Service Frameworks and High Level Enquiries , is a key aspect of the Risk Management Strategy. The Trust expectations and processes in relation to this are also outlined below,

Risk Management Training and Training Needs Analysis

The Division will need to input to the Trusts annual raining needs analysis to identify the risk management needs for all staff groups. The training needs analysis will be progressed via the Trust Learning and Development team and will include:

- What training needs to be provided
- Whether the Trust considers the training to be mandatory or desirable
- The staff groups which are required to undertake each type of training
- The timing of initial training and frequency of updates

The Division will ensure there are systems in place to ensure staff are able to participate in Risk Management training and/or a Trust Mandatory Training Programmes and will monitor that risk management training needs, identified within the training needs analysis, are addressed effectively, in relation to:

- What training is provided for staff and volunteers
- The staff and volunteer groups which are required to attend each type of training

The Trust will provide a Training Prospectus which will be published on the Trust intranet. The Quality and Patient Safety Committee and the Performance and Accountability meetings will monitor compliance with the training programme. The Division will receive reports regarding attendance of staff at such training and are required to ensure all staff do attend.

Training programmes for f risk management training will be evaluated and improvements will implemented accordingly by the Learning and Development Team

The Trust will maintain contemporaneous records of all staff in permanent employment. These records directly populate the Learning Management System and ensure the training needs of all staff and volunteers are considered. The Learning Management System receives a update of starters and leavers from the Human Resources Database.

Effective delivery of risk management awareness training for Board members and senior managers (Senior Management)

Risk management awareness training is provided for Board members and senior managers with updates provided at least once every calendar year. Senior staff requiring this have been identified as Trust Board members, Divisional Directors, Clinical Directors, Divisional General Managers, Associate and Deputy Medical Director and Service Quality Leads As a minimum this will be through completion of the Trust Mandatory training pack or bespoke training programme/sessions for the subject in question, authorised by the Trust Governance Unit. Divisions are required to ensure senior staff are available to undergo this training.

Attendance / participation records are co-ordinated centrally on the Trust's Learning Management System. A report will be provided quarterly to the Patient Safety and Governance Committee. The report will identify and contain a schedule of all relevant staff and dates of the Risk Management training that has been provided or is due to be undertaken.

In the event a member of staff does not attend the training within the required timeframe remedial action and follow-up is through the Company Secretary directly with the senior manager in partnership with the Associate Director of Patient Safety and Governance. The Divisional Director is responsible for leading by example and ensuring all staff attend.

Monitoring compliance against the Risk Management Strategy

Once every calendar year Internal Audit will undertake an audit of compliance with the risk management policy and process. This review will monitor the arrangements for managing and capturing risk and maintaining and updating risk registers at both local and Trust level and whether this provides a clear audit trail and a continuous system for risk management. This will ensure that the functionality of the organisational risk management structure is monitored and will ensure that monitoring the risk register and risk management process is reported on.

The audit will take a view about the Divisional arrangements and give assurance or otherwise to the Board, specifically about how risk is managed locally ensuring that there is a continual and systematic approach to risk assessment across the organisation.

In addition, at least once every calendar year, the Quality and Safety Unit will undertake an audit that will ensure that the organisational risk management structure and process is operating effectively, recommending changes as necessary to maintain robust governance and risk management. They will look specifically at

- How risk is managed locally
- How risks are assessed
- How risk assessments are conducted consistently
- How risks are managed within delegated authority
- How risks are escalated through the organisation
- How risks assessment informs risk register and whether risk registers meet required format

All Clinical Divisions and Corporate Divisions will be included in the review and at least 3 directorate/business units in each Divisions. Findings will be reported back to Quality and Patient Safety Committee, and ultimately reported through to Patient Safety and Governance Committee.

Once every calendar year Internal Audit will undertake an audit of Board Strategic Risk Assurance Framework and the Trust (Corporate) Risk Assurance Framework. The overall objectives of the review will be to ensure that the assurance frameworks are operating to meet the requirements of the Governance Statement and provide assurance that there is an effective system of internal control to manage the principle risk identified by the organisation.

Specifically the review will be used to monitor compliance with the objectives set in relation to assessing strategic risk and the systematic approach to risk assessment and management process. The report will be submitted formally by Internal Audit to the Trust Audit committee. A remedial plan will be submitted by the Director of Governance and Chief Nurse if the assurance is any less than significant.

Internal Audit will also include an evaluation of Board reporting arrangements for at least 2 Board Committees and at least one from each Division and will offer comment on their effectiveness. The report will be submitted formally by Internal Audit to the Trust Audit committee If there is anything less than significant assurance a remedial plan will be submitted to the Audit Committee by the Medical Director.

As a minimum the Company Secretary with the Associate Director of Patient Safety & Governance will ensure that the Trust Board receive an aggregated annual report from the Trust Committees in relation to Risk Management. This will give further assurance to the Board that risks are being robustly managed throughout the Trust. The Audit Committee will receive the report initially before presenting it to the Board.

As a minimum the report will outline the details of the constitution, delegated duties, reporting arrangements work plan and attendance at the committees and in the case of the Patient Safety and Governance Committee the sub-committee. Details of reports provided to the Committees and reporting arrangements into subcommittees will be included in this report.

The Annual Report and Accounts will include a statement of the Trust Board assurance in accordance process and monitoring with our Risk Management Strategy.

Every financial year the Governance Statement will be prepared and identify whether or not the internal control processes have been managed effectively and a signed statement by the Chief Executive will be used as evidence of this. The effective implementation of the Governance and Risk Management Strategy supported by this Committee Handbook along with the reports and minutes of high level committees and other committees including those established by the Divisions will be used to demonstrate effective governance and risk management. Demonstrable evidence that the Risk Assurance Frameworks are used to inform the Board and manage the operational activities of the

Trust will be achieved by the reports received at every meeting of the Board and its committees and subcommittees as well as at all levels within the divisions.

This is an aid-memoire to help with the scoring system outlined in the Risk Assurance Frameworks

Level	Descriptor	Actual/ Potential Impact on individuals	Actual /potential Impact on the organisation	Number of Persons Affected	Potential for Complaint/ Litigation	Impact on Trust Image	Financial Impact
1	Insignificant	Little or no injury or adverse outcome. Little or no treatment or intervention required	Little or no risk at all to the organisation. Little or no reduction or loss of capacity to deliver care or services	One – none	Unlikely to cause complaint. Litigation risk remote	Awareness limited to individuals within the organisation Unlikely to give rise to publicity	Less than £1K
2	Minor	Short Term Injury< 3 days absence /First Aid given. Increased Length of Stay 1-7 days Irritation/Discomfort to a number	Minimal risk to the organisation Reduced capacity to deliver	One - two people	Complaint possible. Litigation unlikely.	Coverage limited to elements within the organisation	£1 - £25K
3	Moderate	Semi-permanent injury/damage to one person. Moderate increase in treatment Medical treatment required >3days absence Increased Length of Stay 7-14days Multiple Minor injuries	RIDDOR reportable / MHRA reportable Assistance required to deal with reduced capacity to deliver case or services	Small number 3-15	Litigation possible but not certain. High potential for complaint	Coverage throughout the organisation and/or some local /external public coverage.	£25-100K
4	Major	Permanent injury Loss of body part,	Service closure or suspension of	Moderate number e.g. loss of	Litigation expected or almost certain	Extensive local coverage and	£100-£500K

		Mis-diagnosis with poor prognosis. Injury to individual not life threatening but will jeopardise the well being of the patient. Allegations of abuse, Serious medication errors Increased Length of Stay > 15 days	operational activities for a sustained period	specimens16 - 50 e.g. outbreak of infection		widespread NHS coverage	
5	Catastrophic	Death or cause serious harm that may place an individual or group of individuals life in jeopardy	Interruption to all operational activities Severe loss of confidence in the organisation Sustained failure to meet national professional standard and/or statutory requirements. >10% off planned activity target	Many Over 50 Evacuations etc e.g. part of hospital collapses or significant operational failure ie waiting times	Litigation expected & almost certain NHSE investigation Care Quality Commission , Investigation, Criminal Prosecution potential	Nationwide multimedia coverage	£500K +

Roles and Competencies For Chairs And Committee Members

The Chair of a Committee

As Chair your job is to make sure you get to the end of the meeting on time, that as many people as possible have actively participated in the meeting, and having made a decision about whatever it is you need to decide about.

Main Duties

- Ensure that the business of the committee conforms to the standards laid down in respect of clinical and corporate governance.
- Take responsibility for ensuring that the committee makes recommendations to the Trust that have been developed within a framework of true engagement and with due regard to recognised best practice and standards
- Agree the with the lead Manager/ director the appropriate programme of work for the committee
- Attend other meetings as necessary to ensure that the work of the committee is clinically aligned with the work of other committees or working groups within the Trust
- Ensure that any agreed changes and actions that are to be implemented are communicated to all parties and that implementation is delivered as required
- Ensure that the safety, personalisation and effectiveness of care is central to all activities of the committee
- Ensure that the actions and decisions of the meeting are clearly articulated and summarised at the conclusion of each agenda item
- Ensure that you facilitate the contribution of all members on appropriate matters without yourself or allowing any other individual to dominate a meeting or subject
- The role of the Chair is to ensure all participants in a meeting can contribute to structured discussion which leads to a clear decision at the end of the meeting

Experience Required

Chairs will need to demonstrate that they have the necessary experience and or knowledge of the business of the committee and will need to show that they have, or are prepared to develop,:

- High credibility
- High-level governance and organisational skills including a good understanding of strategic planning, risk management, organisational performance management and service development and transformation.

- Demonstrable experience of building alliances and working relationships with a range of clinical and other stakeholders

Competencies Required

Leadership

- Ability to demonstrate leadership, inspire and enthuse others and able to develop both leadership and follower-ship in others;
- Ability to work from both a strategic and a coal face view point and to find solutions that marry the two often different focuses and needs;
- To be a conduit for translation of the Trust specific government policies and the broader NHS, and between clinicians and managers. Being able to demonstrate the drivers and necessity for change;
- Being able to communicate and defend often difficult decisions and recommendations on key strategic priorities for investment and supported by evidence;
- Understanding that innovative and potentially radical solutions may need to be found – the ability to think outside the box and get others to the same;
- Enthusiasm for working with colleagues from different professional backgrounds, whether managers or clinicians, in a partnership manner, valuing each other's skills and jointly delivering objectives;
- Being able to recognise key influencers and involve them;
- To ensure ownership and understanding of the committees business and priorities by the wider community through dialogue with colleagues.
- An interest in improving patient care from a systems perspective as well as at individual patient care level, together with an ability to work in both environments and bring the learning from one into the other;
- Ability to think beyond their own professional and divisional or directorate viewpoint.
- To be ambitious on behalf of the Trust, and prepared to challenge other clinicians' or managers' practice and thinking.
- Ability to cope with the uncertainty that the developing context in which the Trust operates will bring and lead others through it;

Management competencies and personal characteristics

- A good understanding of the NHS and its policies and politics;
- Excellent communication skills;
- Negotiation skills;
- Chairing meetings;

- Willing to support and develop others;
- Ability to prioritise and blend competing interests;
- Team player – ability to listen, learn, reflect, challenge and lead others;
- Open to new challenges, innovation and learning;
- An understanding of financial issues and resource management
- To have integrity and to hold the respect of the local community;
- Willing to walk the patch.

A Member of a Committee

Committee members play an important role in the governance and risk management and service transformation across the trust. This role is discharged in a number of ways, from frontline best practice, leadership as members of working groups and or committees.

Role Summary

Members will provide expert advice and support to the committee. They will be responsible for ensuring that any recommendations of the committee are coherent and clinically safe, and that they make sense.

Main Duties

Attend the committee meetings having carried out any necessary reading and pre meeting engagement or discussion with colleagues as agreed

Ensure that the business of the committee conforms to the standards laid down in respect of clinical and corporate governance

Take responsibility for ensuring that their input to the committee has been developed within a framework of true engagement and with due regard to recognised best practice and standards

Support the committee in agreeing an appropriate programme of work to deliver the necessary management of risk or transformation of services.

With other committee members ensure that all the work programmes across the Trust are clinically aligned and deliver the Trust priorities

Ensure they contribute to communication regarding any changes and actions that the committee or Trust have determined will be delivered are communicated to all parties and that implementation is delivered as required

Provide the leadership for change within their specialty and/ or within their practice

Key Relationships

Committee Chair

Clinicians from across the Trust

Medical Director and deputies

Clinical Leads from other committees

Patient and Carer Groups

Experience Required

Committee members will need to demonstrate that they have the necessary drive, experience and/ or knowledge and show that they have:

- Credibility within their own field and their management structure
- Good governance and organisational skills including a good understanding of strategic planning, risk management, and service transformation.
- Demonstrable experience of building alliances and working relationships with a range of clinical and other stakeholders

Competencies Required

Leadership

- Ability to demonstrate leadership, inspire and enthuse others and able to develop both leadership and follower-ship in others;
- Ability to work from both a strategic and a coal face view point and to find solutions that marry the two often different focuses and needs;
- Being able to demonstrate the drivers and necessity for change;
- Being able to communicate and defend often difficult decisions and recommendations, supported by evidence
- Understanding that innovative and potentially radical solutions may need to be found – the ability to think outside the box and get others to do the same;
- Enthusiasm for working with colleagues from different professional backgrounds, whether managers or clinicians, in a partnership manner, valuing each other's skills and jointly delivering objectives;
- Being able to recognise key influencers and involve them;
- To ensure ownership and understanding of the committee's business and priorities by the wider professional community through dialogue with colleagues.
- An interest in improving patient care from a systems perspective as well as at individual patient care level, together with an ability to work in both environments and bring the learning from one into the other;
- Ability to think beyond their own professional and divisional or directorate roles
- To be ambitious on behalf of the Trust, and prepared to challenge other clinicians' or managers' practice and thinking
- Ability to cope with the uncertainty that the developing market will bring and lead others through it;

Management competencies and personal characteristics

- A good understanding of the NHS and its policies and politics;
- Excellent communication skills;

- Negotiation skills;
- Ability to prioritise and blend competing interests;
- Team player – ability to listen, learn, reflect, challenge and lead others;
- Open to new challenges, innovation and learning;
- An understanding of financial issues and resource management
- To have integrity and to hold the respect of the local community;
- Willing to walk the patch.

(COMMITTEE NAME) REPORT		**Item**	
DD Month YY		**Purpose**	Information Action Monitoring
Title			
Author			
Executive sponsor			
Summary:			
Report linkages			
Related strategic aim and corporate objective			
Related to key risks identified on assurance framework			
Impact			
Legal	Yes/No	Financial	Yes/No
Equality	Yes/No	Confidentiality	Yes/No
Previously considered by:			

CHAPTER HEADING (only use in longer documents)

Section heading (use as main heading in short documents) – please don't use capitals at the start of every word.

Sub title (use where required to split an issue down)

1. Paragraphs should be numbered consecutively through the document. Overall it is a good discipline to limit a covering report to four sides of A4 which may be expanded to include appendices. To clarify whilst a strategy document may be lengthy a covering report should be concise. Concise reports can be difficult to construct but improve decision making.

2. Ideally Board papers should start with an executive summary which summarises the paper in no more than 100 words.

3. Reports should only contain relevant information which will help with information sharing or decision making.

4. Within the body of a report the font should be Ariel with a pitch of 11and 1.5line spacing. Justified in the main body of the document. Table text should not be justified.

5. As a rule abbreviations and acronyms should be minimised to ensure clarity. Resist the use of '&', '+', 'K'.

6. Suggested structure of the report:

   Executive Summary of no more than 100 words outlining the purpose of the report, key issues and recommendation.

   Main Body of the report

   - Risks and impact of taking/ not taking action
   - Relate risks and impact to quality and safety, operational performance, compliance requirements, finance, workforce and stakeholders
   - Mitigations for risks and timelines
   - How the action/ information relates to achievement of strategic aims and objectives or improvement objectives
   - Resource implications and how they will be met
   - Benchmarking intelligence

   Conclusion of report

   - Recommendation
   - Next actions
   - How the decision will be communicated internally and externally
   - How progress will be monitored (committee and frequency)

   Appendices

- Further reading, references and supporting documentation.

AN Other, Position, DD Month YY

East Lancashire Hospitals Trust
Guidelines for Producing Board or Committee Papers

INTRODUCTION

1 The purpose of this paper is to provide guidance to those preparing reports presented to the Board and other committee meetings on the new *Report Template* that has been introduced

2 One objective of the review of governance arrangements is for the organisation to be more open and transparent. All reports written for committees are potentially subject to public disclosure, even those intended for private or internal meetings. When preparing reports you should therefore strive to avoid abbreviations and NHS jargon as much as possible.

3 Those preparing reports are responsible for ensuring compliance with this *Report Template* – it is your responsibility. Ultimate accountability for the preparation of papers in accordance with this *Report Template* rests with the Lead Director / Manager who has been identified for each committee / group. Failure to adhere to these standards – together with the requirements for the submission of papers to meetings – may result in papers being pulled from meeting agendas by the Chair of the meeting.

4 It is preferable that all papers are distributed and used in electronic form however, if paper copies are to be used, staff preparing papers are responsible for copying / printing sufficient copies of their papers to be sent those attending the meeting. This is your <u>not</u> the role of the Secretary supporting the meeting, however the Secretary will be responsible for collating all the papers that have been photocopied / printed and distributing them to attendees with the agenda.

5 Electronic copies of all papers, including appendices, must be sent to the Secretary of the meeting as they are responsible for filing meeting papers.

BASIC COMPOSITION

6 All papers consist of three main components:
a) Report Header (the first 2 pages
b) Main Body of the Report
c) Appendices (if applicable)

USE OF ACRONYMS, ABBREVIATIONS AND NHS TERMINOLOGY

7 When preparing papers – irrespective of whether they are for public, private or internal meetings – staff are asked to:
- use plain English and not ‘NHS speak’,
- avoid the use of NHS acronyms and abbreviations.

8 The rational for this is as follows:

a) the Trust is committed to be more open and transparent, which means it intends to routinely publish more information about the way decisions are made;

b) the Trust is a public body and as such all papers prepared by the organisation are subject to public disclosure under the Freedom of Information Act, whether voluntarily by the Trust or as a requirement (especially during legal / investigatory processes), subject to necessary requirements to protect patient and person-identifiable information.

9 By ensuring that first time around papers are written in the expectation that they will be made public, additional work will not be required later to explain the acronyms, abbreviations and NHS terminology used. Also it is not unusual for the same abbreviation to have a different meaning in different contexts.

10 As such **only two abbreviations are now permissible in papers**, based on the assumption these will already be known by the public, these are:

- NHS,
- GP

11 In ***all other circumstances*** the full terms should be used. For those writing papers that frequently use a set of abbreviations and are concerned at additional inconvenience / time required to type in the full description, staff should be aware of their ability to add 'autocorrect' options in Word whereby when you type in the abbreviation, the full text will appear in your document.

12 Where NHS terminology has to be used to refer to a policy initiative (i.e., Payment by Results, Choose and Book), staff preparing papers are asked to explain what this means. If in doubt ….. explain. It is not just the public who may be confused, often NHS colleagues may not be sure of the meaning if it relates to activity outside their normal areas of work.

STATUS OF THIS PAPER

13 When preparing a paper you need to indicate if it is intended for distribution:

a) **to the public** – the intention is that the majority of the papers to Board meetings will be placed on the Trust's website;

b) **internally** – most of the papers sent to committees and groups will be intended for internal distribution, most often to members of the specific committee / group;

c) **private** – the nature of the issues dealt with by the organisation means that some papers going to the Board, committees or groups will need a restricted circulation. As the organisation is striving to be more open and transparent private papers should not be used for convenience or to save potential embarrassment, but usually for one of the following reasons:

- to protect patient / person identifiable data,
- it contains commercially sensitive information,
- it is a draft (the final version of which will later be published).

14 If you are requesting that a paper is a ***private paper***, you must CLEARLY INDICATE THAT IT CONSIDERED TO BE CONFIDENTIAL AND PROVIDE A REASON.

15 As has been stated above, as a public body all papers produced by the Trust may be subject to public disclosure – even if classified as internal or private.

MAIN BODY OF THE REPORT

16 This is where you need to start writing your report. Notes on the formatting are shown on the diagram

Paragraph Numbering

17 **Each paragraph** needs to be numbered. Only 'four' levels of numbering / bullets are allowed in papers as shown in the diagram. The formatting for the paragraph numbers is as follows:

Level	Shown as	Aligned at	Text indent at	Add tab stop at
1	1.	0 cm	1.27 cm	1.27 cm
2	a)	1.27 cm	1.9 cm	1.9 cm
3	i)	1.9 cm	2.54 cm	2.54 cm
4	•	2.54 cm	3.17 cm	3.17 cm

Use of Colours

18 Wherever possible when preparing papers try not use colours. If they have to be used authors need to limit the number of colours used and not use a bold colour scheme. Staff preparing papers also need to ensure that information is 'readable' if the reader is only able to access a black and white copy. For example, if using 'traffic lights' also include a text description (red, amber, green) or using R, A and G in the colour block.

19 This is for two reasons:

a) to enable colour-blind readers to be able to understand the paper;

b) to reduce costs when distributing papers.

Other Titles

20 Staff preparing papers are asked not to underline any headers / titles. If you need more than the 'Main', 'Section' or 'Sub' headers outlined in this guidance note, then use the a header in *italics* but still in Arial 11pt.