EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **BOARD OF DIRECTORS**

DATE: **30 OCTOBER 2014**

SUBJECT: **RISK MANAGEMENT STRATEGY – ANNUAL REVIEW**

REPORT FROM: **CHIEF NURSE AND DIRECTOR OF QUALITY**

PURPOSE: **Approval**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT
The report was last presented to the Integrated Audit and Governance Committee in October 2014 before discussion at the Board of Directors this month. This is part of the annual review.

SUMMARY
The Trust must ensure that it delivers its objectives effectively. The Trust is required to have a Board approved Risk Management Strategy, reviewed and approved annually, which ensures that there are processes in place to identify significant risks to the strategic and annual objectives, that an understanding of the nature of the risk is sought and that remedial measures are rapidly put into action.

The attached version 9 is the draft report for review by the Board of Directors. It was reviewed by the Quality Assurance Board (QAB) on 24 September and the Integrated Audit and Governance Committee (IAGC) on 09 October 2014.

Changes to the previous version are highlighted, however the key changes to the previous version are as follows:

1. updated the meeting structure to the most current version;
2. clarified the roles and responsibilities at divisional leadership and Executive level;
3. incorporated the revised ToR for all the relevant assurance committees based on the revised meeting structure;
4. removed references to the NHS Litigation Authority Risk Management Standards and incorporated other external regulatory compliance;
5. changed the job titles for members of the Executive team i.e. Chief Nurse and Director of Quality and the Director of Human Resources;
6. updated the Monitor risk ratings;
7. strengthened the role of the divisions and divisional leadership teams in the management of risk locally and their compliance with CQC and other related regulated activities.

RECOMMENDATIONS:
The QAB is asked to review the risk management strategy and comment on the amendments made to this version and highlight any areas of omission.

NEXT STEPS:
The revised strategy was presented to the IAGC at the October meeting and then to the Board of Directors in November for approval.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:
The Strategy and BAF will ultimately drive the Annual Governance Statement, which represents the Trusts' ability to identify and manage risks effectively. Failure to demonstrate a consistent approach to the mitigation and control of risks can impact considerably on the effective delivery of the Trust's strategic and annual objectives.

LINKS TO BOARD ASSURANCE FRAMEWORK:
The strategy is used to assess the risk of non-achievement of the strategic and annual objectives.

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:
The strategy supports the process and procedure of managing risk across the Trust.

FINANCIAL AND RESOURCE IMPLICATIONS:
Actions to mitigate certain risks have considerable impact on Trust expenditure; financial risks are now quantified in terms of single or cumulative costs. Failure to mitigate some risks will also result in financial loss or an inability to sustain projected income levels. The strategy supports achievement of an overall continuity of service rating of 3 or above and a green governance rating.

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:
The Trust could face litigation if risks are not addressed effectively.

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES
Not applicable

BOARD OF DIRECTORS ACTION REQUIRED:
(a) to approve the strategy

CONSEQUENCES OF NOT TAKING ACTION:
The Trust fails to meet the requirement for an annual review of the Risk Management Strategy and will continue to face unmitigated risks which may result in a worsening of the current position.

East Kent Hospitals University NHS Foundation Trust

East Kent Hospitals University NHS Foundation Trust

Risk Management Strategy - DRAFT

Version:	~~8~~9
Ratified by:	Board of Directors
Date ratified	tbc
Name of originator/author	Deputy Director of Risk, Governance and Patient Safety
Director responsible for implementation	Chief Nurse & ~~,~~Director of Quality ~~& Operations~~
Date issued:	tbc
Review date:	September 201~~3~~4 as routine annual review
Target Audience:	All staff Trust Wide

Version Control Schedule

Version	Date	Author	Status	Comment
1	04/04/08	Steve O'Neill	Agreed	
2	28/11/08	Steve O'Neill	Agreed	Updated to reflect Foundation Status
3	28/8/09	Sally Moore	Agreed	Annual review
4	27/10/10	Sally Moore	Agreed	Updated risk metrics to incorporate financial impact
5	August 2010	Helen Goodwin	Agreed	Updated reporting and risk assessment criteria. Incorporation of CQC registration Forward planning for divisional re-structuring
6	October 2011	Helen Goodwin/ Julie Pearce	Agreed	Revised structure and reporting schedules Risk and Governance responsibilities Inclusion of health and safety
7	August 2012	Helen Goodwin/ Julie Pearce	Agreed	Divisional risk and governance responsibilities and reporting structures; incorporation of risk appetite
8	July 2013	Helen Goodwin	Agreed	Revised to reflect the impact of the Francis Inquiry reports, alignment with annual objectives and clinical audit plan
9	September	Helen Goodwin		Revised to incorporate the revised meeting

	2014			structures and associated ToR. Roles and responsibilities for risk reviewed

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Appendices

Summary

Key points within this Strategy at a glance:

1. East Kent Hospitals NHS University Foundation Trust (EKHUFT) is committed to proactive management of risk and ongoing development of robust systems of governance and assurance. This document presents EKHUFT's formal Risk Management Strategy, which has been ratified by the Trust's Board of Directors.

2. The Risk Management Strategy applies to the management of all types of risk associated with the services, operations and business of the Trust including clinical, health and safety and other forms of non clinical risk. The resources for managing risk are finite and the aim of the strategy is to achieve an optimum response to risk, prioritised in accordance with a consistent evaluation of the risk identified. The amount of risk that is judged to be tolerable and justifiable to the Trust is defined as the "risk appetite".

3. There is a clear responsibility of the Trust Board in response to the second Francis Report, published in February 2013, to provide assurance that patient safety is at the top of the agenda; this is reflected in the content of the Corporate Risk Register and through the information provided to Commissioners and other external stakeholders. Patient safety and quality risk assessment follows the consistent risk stratification model outlined in the Strategy.

4. The interface with the annual Clinical Audit Plan on areas of emerging clinical risk is fundamentally linked to the Francis Reports and to the recommendations. There is a work plan through the Integrated Audit and Governance Committee (IAGC) and Quality Committee (QC) to ensure the Plan is responsive to emerging areas of clinical risk.

5. The four core components of the Quality Governance Framework also support the principles of the Risk Management Strategy.

6. The Trust is responsible for ensuring that skills, knowledge, and risk awareness become embedded into the normal running of the organisation as described in the Trust's approach to risk management training and the associated Training Needs Analysis.

7. Incidents, Near misses and Serious Incidents (SI's) are reported as detailed in the 'Trust Policy for the Management of Incidents, including Serious Incidents for Investigation and External Notification (AIR Policy).

8. Incident reporting is monitored by the Corporate Patient Safety and Risk Management Team; Divisional teams are responsible for local investigation and management of incidents with support and advice from the corporate team. Where specific areas of

concern are identified, the Patient Safety and Risk Management Team work with Divisional teams to minimise and manage the risk.

9. Risk Registers are reviewed by the Divisional Risk and Governance Groups for progress and effectiveness before submission to the Risk Management Team for review. Divisional risk registers are presented to the Quality Assurance Board~~Risk Management Governance Group~~ (QAB~~RMGG~~), a rolling programme at least twice per year.

10. The corporate risk register (CRR) is reviewed by the Quality Assurance Board~~Risk Management and Governance Group~~ (QAB~~RMGG~~) monthly before submission to the Integrated Audit and Governance Committee (IAGC) bi-monthly. The Board of Directors receive the CRR in full twice per year and a summary of the top ten risks on the CRR in accordance with the Board workplan.

11. The ~~Corporate Performance~~ Management Board~~Team~~ (MB~~CPMT~~) receives minutes of the ~~RMGG~~ QAB meetings monthly and identifies any emerging risks or any changes required to the assessment of existing risks. The Trust Secretary~~CEG~~ produces the Board Assurance Framework (BAF) from the Trust's annual objectives and the Management Board reviews the BAF on a quarterly basis to monitor progress and to identify any additional risks. The IAGC receives a report on the BAF at least twice per year.

12. The ~~RMGG~~ QAB reviews the controls and actions for Divisional Risk Registers and the Board Assurance Framework, and ensures that the recommendations are implemented as appropriate.

13. The Clinical Governance & Risk Management Strategy for Maternity Services ~~meets the requirements of the NHS Litigation Authority risk management standards and~~ is informed by the Trust's risk management strategy, policies and procedures.

14. An annual review of the duties and responsibilities of key individuals within the Trust and Committees with responsibility for risk is carried out as part of the preparation of the Annual Governance Statement and publication within the Annual Report and Accounts.

~~15.~~The Risk Management Strategy supports the key principles of the Quality Strategy and the Quality, Improvement and Innovation Hub as an enabler to share good practice and support the principles of standardisation. ~~The key performance indicators on the effectiveness of~~

~~16.~~15.

1. Introduction

1.1. East Kent Hospitals University NHS Foundation Trust recognises that healthcare provision and the activities associated with caring for patients, employing staff, providing premises and managing finances are all, by their very nature, risk activities and will therefore carry an inherent degree of risk. These risks are present on a day to day basis throughout the Trust.

1.2. The continued delivery of high quality healthcare requires the identification, management and minimisation of events or activities which could result in unnecessary risks to patients, staff and visitors or members of the public. The management of risk is therefore a key organisational responsibility and is the responsibility of all staff employed by the Trust. See Appendix 3

1.3. The Trust is committed to ensuring the Health and Safety of patients, staff and the public through the integrated management of all aspects of governance and risk. Good governance, i.e. the way that the organisation is directed, controlled and held to account, is at the heart of controlling risk in any organisation. The Trust has adopted an integrated approach to the overall management of risk irrespective of whether risks are clinical, non-clinical, organisational or financial. Risk management is embedded within the Trust's overall performance management framework and informs business planning and investment decisions.

1.4. The Trust's organisational arrangements for addressing risk management are in keeping with best practice guidance and it is recognised that a systematic approach to assessing and managing risk is essential in order to deliver high quality patient care and the Health & Safety of staff and the public.

1.5. This strategy is an "umbrella" document covering all aspects of risk management within the Trust. The Trust already has a number of policies and procedures related to risk management which should be read in conjunction with this strategy, specifically the Trust's Quality Strategy, the Patient Safety ~~Strategy~~Plan, the Clinical Governance and Risk Management Strategy for Maternity Services and the over arching Health and Safety Policy (See Appendix 2).

1.6. The Trust is committed to defining and documenting a formal statement on risk appetite in line with British Standard (BS31100). Risk appetite is defined as "

> *"the amount of risk that an organisation is prepared to accept, tolerate or be exposed to at any point in time."* HMT – Orange Book (2005).

2. Purpose of Risk Management

2.1. East Kent Hospitals NHS University Foundation Trust (EKHUFT) is committed to managing actively all aspects of risk inherent in the organisation.

2.2. Risk is defined by the Department of Health in 'Organisation with a Memory' (2000) as "the likelihood, high or low, that somebody or something will be harmed by a hazard, multiplied by the severity of the potential harm." (See Appendix 1). Risk Management is the identification, assessment and control of the impact of events to which EKUHFT is exposed. This process is carried out in order to minimise the likelihood and impact

of adverse events. It covers the full range of risk exposure and therefore includes economic, reputation and clinical and non clinical risk as well as any risk to the achievement of the Trust's annual and strategic objectives. The strategy demonstrates a system of internal control and supports an assurance framework to enable the Chief Executive to sign the annual Governance Statement. The strategy provides the assurance that the Board has been properly informed about the totality of the risks, and has arrived at their conclusions based on all the evidence presented to them. A copy of the Governance Statement is available in the document library after it has been submitted with the annual accounts and annual report.

2.3. The Board of Directors recognises that Risk Management is an integral part of good management practice and to be most effective should be part of the Trust's culture. The Board is, therefore, committed to ensuring that Risk Management forms an integral part of its philosophy, practices and business plans rather than viewed or practiced as a separate programme and that responsibility for implementation is accepted at all levels of the organisation.

2.4. Risk falls into three components:

2.4.1. the inherent risk status – i.e. that before any controls are put in place;
2.4.2. risk mitigation – i.e. management actions;
2.4.3. residual risk after actions have been implemented.

2.5. The key objectives of this strategy are to provide the framework for:

2.5.1. the assessment of clinical risk and evidence of action taken;
maintaining full registration without conditions with the Care Quality Commission (CQC) and fulfilling the requirement of other Regulators to maintain compliance~~; this is contingent upon the on-going consultation with the CQC on the future inspection programme~~;
~~2.5.3.~~2.5.2. ~~achieving and sustaining level 3 accreditation with the NHS Litigation Authority (NHSLA) Risk Management Standards; this is also contingent upon the inspection programme currently under review;~~
2.5.3. production of the Board Assurance Framework to enable the annual Governance Statement;
2.5.4. assessing the risks associated with achievement of the annual and strategic objectives;~~.~~
2.5.5. a clear alignment to the quality strategy ensuring that the principles of standardisation are embedded across the Trust and staff are enabled to adopt these models;
2.5.6. the integration of Risk Management and Health and Safety within the Trust's strategic aims and objectives. The Governance and Risk Management structure is identified in Appendix 5;
2.5.7. integration of governance encompassing financial, clinical, corporate, information, performance and research governance;
2.5.8. achieving compliance with the Health and Safety at Work Act 1974
2.5.9. ensuring that the Trust remains within its licensing authorisation as defined by Monitor and to deliver a risk management framework which highlights to the Executive Team and Trust Board any risks which may prevent the Trust from complying with its licensing authorisation;

2.5.10. achieve an overall ~~financial~~ continuity of service~~risk~~ rating of 3 or above and a green governance rating.

2.6. The changing national climate around the quality of service provision and ensuring that patients are the priority for all healthcare related activities has been clarified following the publication of the second Francis Report. This Strategy links directly to the Trust action plan in response to this Report, to the Quality Strategy and to the Quality Governance Framework.

2.7. Lessons learned from the Francis Inquiry into Mid-Staffordshire NHS Foundation Trust demonstrate the importance of an overarching assessment of risk to the Trust. The degree to which risks are interconnected and sometime sequential and of the cumulative impact and disruptive effect on a number of risks occurring at the same time are considered within the risk assessment form in Appendix 6.

3. Risk Appetite

3.1. Communication and application of the Board of Directors attitude to risk is essential if decision-making is to be successful. This must be clear and be consistent with the strategic objectives for the Trust. Risk appetite is a series of boundaries, which are authorised by the Board and by delegated authority, which guide all staff on the limits of risk they can take.

3.2. In line with British Standard BS31100, the Trust is committed to not taking risks that affect the quality of care and the experience of every person accessing our services.

4. Authority of all managers with regard to managing risk

4.1. Managers are responsible for implementing and monitoring any identified risk management control or assurance measures within their designated area/and scope of responsibility. Departmental managers are expected to address low level risk issues as they arise.

4.2. In situations where significant risks have been identified and where local control measures are considered to be potentially inadequate and where local resolution has not been satisfactorily achieved, managers are responsible for and have the authority to:

- 4.2.1. Add risks to the local and divisional risk register
- 4.2.2. Bring these risks to the attention of the Divisional Management Team which in turn raise them for discussion at Quality Assurance Board~~Risk Management and Governance Group~~ (QAB~~RMGG~~), or Strategic Health and Safety Committee.(SH&SC) or the Management Board
- 4.2.3. Escalate serious risk with the appropriate Director and manage in accordance with policy (See Appendix 7)
- 4.2.4. Request that ~~RMGG~~ QAB or SH&SC consider significant risks for addition to the Corporate Risk Register.
- 4.2.5. Develop and submit business cases where appropriate to support mitigation and improvements.

5. Risk Management Process

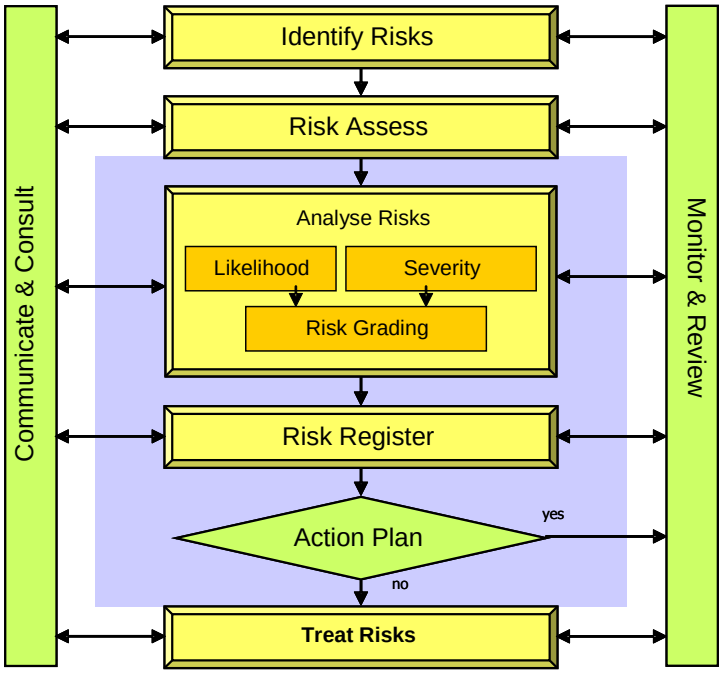
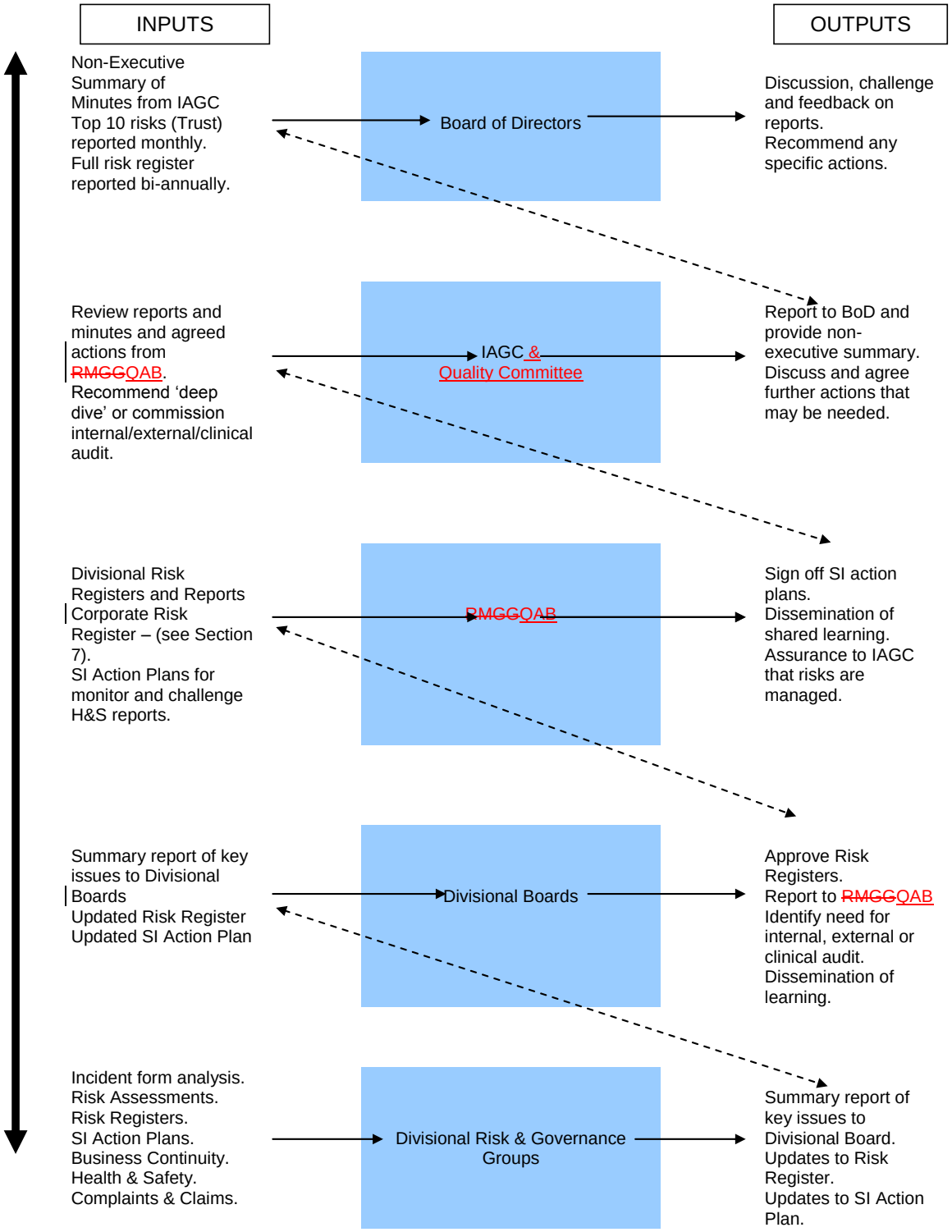


Figure 1 Risk Management Flow Chart

5.1. The Trust's approach to identifying, analysing, evaluating and treating risks follows best practice guidance. All or some of the stages above may be employed dependant upon the hazard, risk or incident (Refer to Appendix 6 and 8).

5.2. The process of risk management is dynamic. Risk likelihood and severity, as well as risk appetite can change over time through circumstances and experience. The perception of the public to risk and confidence in the Trust's ability to identify and mitigate risk successfully can also shift in light of adverse publicity and risk failures outside the direct control of the Trust. Risk awareness and communications play an important part in protecting the Trust's reputation.

Inputs and Outputs from the Risk Pathways



6. Risk Management Strategy

6.1. This Risk Management Strategy applies to the management of all risk within the Trust associated with the services, operations and business of the Trust. These include:

6.1.1. **Corporate risk**: threats to the key aims of the Trust both strategic and operational (e.g. service developments, performance targets), financial risks, IT risk (e.g. computer system failures) and risks to the Trust reputation.

6.1.2. **Clinical risk**: risk of harm to patients, staff and relatives, in carrying out clinical activities.

6.1.3. **Non-clinical risk**: includes health and safety - the range of risks associated with personal health and safety of staff, patients and visitors.

7. Risk Management and Review (including Assurance)

7.1. Divisional Risk Registers, the Trust Corporate Risk Register and the Board Assurance Framework, provide the means for risk monitoring. To assist in the monitoring and review of risks and their management the following systems and processes take place:

7.1.1. Incidents, Near misses and SI's are reported and analysed as detailed in the 'Trust Policy for the Management of Incidents, including Serious Incidents for Investigation and External Notification (AIR Policy)

7.1.2. Local risk assessment is completed at source with each reported risk or incident being graded using the Trust Risk Grading Matrix. The local systems mirror the Trust Strategy; risk assessments, risk registers, incident analysis and SI's are discussed at Divisional Governance Groups.

7.1.3. Risk Assessment of incidents are completed at several levels; some as formal risk assessments, others as incident reports, care plans, SI reports, etc, as detailed in the Trust Policy for the Management of Incidents, including Serious Incidents for Investigation and External Notification (AIR Policy) and Health and Safety policy.

7.1.4. Each Division completes a Risk Register based on their assessment of current or future risks that contain controls, assurances and actions as detailed in the Trust Policy for the Management of Incidents, including Serious Incidents for Investigation and External Notification (AIR Policy) and Health and Safety Policy.

7.1.5. Divisional Risk Registers are presented and collated at least quarterly into the Trust Corporate Risk Register to be reviewed by ~~RMGG~~ QAB and Board of Directors.

7.1.6. For each risk, the controls assurances and actions will be allocated a responsible manager or lead director to ensure risk management actions are delivered as planned.

7.1.7. Where a risk control, assurance or action is assessed to be critical (i.e. were it not present the level of the risk would be “High”) the means of assuring that controls are in place will be defined and recorded in the appropriate risk register(s) and / or assurance framework.

7.1.8. As part of the divisional performance review, quarterly reviews of the top five risks will take place including progress of control measures, assurances and action plans.

7.1.9. The Corporate Risk Register and Assurance Framework will be reviewed quarterly by the Corporate Performance Management Team as a mechanism for monitoring the effective management of principal risks and as a basis for considering the public declarations required in the annual Governance Statement and inclusion in the Business Planning processes of the Trust.

7.1.10. The top ten risks are reviewed by the Board of Directors on a monthly basis, with the full risk register reviewed bi-annually.

7.1.11. The Integrated Audit and Governance Committee and the Quality Committee (QC) receive reports and the minutes from the ~~Risk Management and Governance Group~~Quality Assurance Board and provide a report to the Board of Directors on a two monthly basis.

8. Process for the Management of Risk locally, which reflects organisation-wide risk management strategy

8.1. It is the responsibility of the Divisions/Corporate Departments to undertake risk assessments/identify risk as part of routine management practice.

8.2. Divisions/Corporate Departments are responsible for validating, prioritising and identifying solutions to their risks. These are then entered onto their local risk register.

8.3. Divisions/Corporate Departments are responsible for having a nominated person who will update their risk register.

8.4. Divisions/Corporate Departments are responsible for ensuring that action plans are effectively implemented and monitored to mitigate risks.

8.5. Divisions/Corporate Departments should only escalate risks if, after local management action, a residual level of risk remains which should then be discussed with the Deputy Director of Risk, Governance and Patient Safety for agreement to escalate to QAB and the Management Board.~~RMGG~~.

8.6. Division/Corporate Governance Groups should review their Risk Registers regularly (at least quarterly). The top five risks are reviewed at the Divisional Performance Reviews. ~~(Check with David Baines)~~

8.7. Divisional Boards should scrutinise and validate their risks;

8.7.1. before submission of reports to ~~RMGG~~QAB

8.7.2. at regular intervals to ensure that action plans are being implemented and risks mitigated; this process normally occurs at the Divisional governance meetings held on a monthly basis.

8.8. All senior managers should use their local Risk Registers as a management tool and ensure that the risk registers are used to inform the annual business planning process.

9. Training

9.1. The Trust has a responsibility to ensure that its employees are safe and competent with the appropriate knowledge and skills to deliver high quality care to its service users. Risk Management training, for all staff groups, is described in the Trust's Training Needs Analysis and the expectation is that all staff will comply and undertake the appropriate training programme.

9.2. Training will be appropriate to the staff groups receiving it and commensurate with their risk management responsibilities. The Trust reserves the right to identify how, where and when risk training will take place.

9.3. Trust Board & Directors and Very Senior Managers:

9.3.1. Risk management awareness training will be delivered to all board members, (including Executive and Non Executive Directors) executives and senior managers (Divisional Leadership Team) on an annual basis. Record of attendance will be audited via ESR and noted at IAGC. Non attendees will be brought to the attention of the chair of the Committee and relevant training arranged

9.4. The aim of all risk training is:

9.4.1. To develop a more risk-aware mindset within the Trust.

9.4.2. To shift the culture from one of reactive to proactive prevention.

9.4.3. To ensure that all those who have general responsibility for managing and preventing risks are aware of their roles.

9.4.4. To ensure those who have specific responsibility for managing and preventing risks have the necessary skills to be able to do this.

10. Monitoring and Review of the Effectiveness of this Strategy

10.1. The effectiveness of this Strategy will be monitored as follows:

1. Key process/part of this policy for which compliance or effectiveness is being monitored	2. Monitoring method (i.e. audit, report, on-going committee review, survey etc.)	3. Job title and department of person responsible for leading the monitoring	4. Frequency of the monitoring activity	5. Monitoring Committee responsible for receiving the monitoring report/audit results etc.	6. Committee responsible for ensuring that action plans are completed
Compliance with the Trust Risk Strategy at Divisional level~~, and process for managing risk locally.~~	Review Terms of Reference, Minutes of meeting. Presentation of risk registers to ~~RMGG~~QAB	Divisional Directors	At least quarterly	~~RMGG~~QAB	QAB ~~RMGG~~
	Locality risk registers reviewed	Divisional risk and governance leads	Six monthly	Divisional governance meetings	Divisional governance meetings
The process for managing risk locally is aligned with the overarching strategy.					
Reporting arrangements in to the high level Committees and the Board.	Review Terms of Reference and minutes of meetings/reports to IAGC and BoD.	~~Board~~ Trust Secretary	Annually	QAB ~~RMGG~~	QAB ~~RMGG~~
Committee effectiveness.	Review actions plans/trends and learning Development of change registers	Divisional Directors	At least quarterly	QAB ~~RMGG~~	QAB ~~RMGG~~
Compliance with the process for Risk Registers.	Review of Divisional and Trust Risk Registers.	Divisional Directors	At least Annually	QAB ~~RMGG~~	QAB ~~RMGG~~
Ensuing that strategic risks are assessed and reviewed and aligned with the top annual objectives via the Assurance Framework.	Review of the Assurance Framework content and process – annual audit of process by internal audit.	~~Board~~ Trust Secretary	Annually	QAB ~~RMGG~~	QAB ~~RMGG~~
Risk management training for Board members and very senior managers, including divisional leadership teams	Review of compliance, attendance and the process of following up non attendance as described in TNA	Director of HR ~~and Corporate Services~~	Annual	QAB ~~RMGG~~	QAB ~~RMGG~~

~~o~~10.2. The Trust reserves the right to change reporting and monitoring processes as required.

~~10.2.~~10.3. Links to relevant policies are outlined in Appendix 2.

Appendix 1

Definitions used within risk management

Untoward incident	Any event/incident or circumstance leading to unintentional harm or suffering
Serious Incident (SI's)	May require reporting externally to Serious Incidents for Investigation and External Notification (STEIS). Investigated using root cause analysis approach.
Board Assurance Framework (BAF)	A tool for the Board corporately to assure itself (gain confidence, based on evidence) about successful delivery of the organisation's principal objectives.
Hazard	Situations with the potential to cause harm
Inherent Risk	The risk that an activity would pose if no controls or other mitigating factors were in place
External Audit	External Audit is an essential element of corporate governance, contributing to the stewardship and process of accountability for use of resources. The scope of audits is extended to cover not just financial statements but the arrangements to secure value for money.
Internal Audit	The Trust currently engages ~~RSM Tenon~~TIAA as its Internal Auditors. They primarily provide an independent and objective opinion to the Trust on the degree to which risk management, control and governance processes support the achievement of the Trust's objectives
~~NHS Litigation Authority Risk Management Standards~~	~~The NHSLA risk management assessment has been specifically developed to reflect issues which arise in the negligence claims made against NHS bodies. There are five sets of standards, reflecting the different organisational, clinical and non-clinical risks.~~
Near Miss	Any event/incident which could have caused harm to patients, staff or reputation of the Trust, had it been allowed to reach it's natural conclusion
Residual Risk	The risk that remains after controls are taken into account
Risk Assessment	Consists of a combination of the probability of a perceived threat and the magnitude of its impact upon objectives
Risk Management	Systematic application of management policies, procedures and practices to the tasks of identifying, analysing, assessing, treating and monitoring risk. Includes the application of Health and Safety Regulations in every day working practice.
Risk Registers	A log of risks of all kinds that threaten an organisations success in achieving its declared aims and objectives. It is a dynamic living document, which is populated through the organisations risk assessment and evaluation processes.
Acceptable Risk	Is one which has been accepted after proper evaluation and is one where proper controls have been implemented? The acceptance of a risk should represent an informed decision to accept the likelihood of that risk. • Identified and entered on the Risk Register • Quantified (Consequences and Likelihood) • Reviewed and have been deemed acceptable by the Board of Directors • Controlled and kept under review.
Risk Tolerance	The amount of risk exposure, or potential adverse impact from an event that the organisation is willing to accept or retain
Risk Treatment	Selection and implementation of appropriate options for dealing with risk
Annual Governance Statement	An annual statement signed by the Chief Executive declaring the approach and responsibility for, risk management, internal control and corporate governance. Forms part of the Annual Report and Accounts.

Appendix 2

Links to Relevant Policies

This Strategy is linked to the following policy/strategy documentation:

Policy name	Approval	Owner
Quality Strategy	Board of Directors	Deputy Chief Nurse and Deputy Director ~~Head~~ of Quality
Claims Handling Policy and Procedures	~~RMGG~~QAB	Legal Services
Health and Safety Policy	QAB~~RMGG~~/Strategic Health and Safety Committee	Senior Health and Safety Advisor
~~Quality Strategy~~	~~RMGG~~	~~Deputy Chief Nurse~~
COSHH Policy	H&S Committee	Senior H&S Advisor
Policy for the Management of Incidents, including Serious Incidents for Investigation and External Notification (AIR)	QAB~~RMGG~~	Head of Patient Safety
Compliments and Complaints Policy	QAB~~RMGG~~	Senior Complaints Manager
Management of Violence and Aggression Policy	QAB~~RMGG~~	Senior Health and Safety Advisor
CAS Policy	QAB~~RMGG~~	Deputy Director of Risk and governance
Infection Control Policy	CA~~M~~B	Director of Infection Prevention and Control
Management of Stress Policy	QAB~~RMGG~~	Health and Safety Lead
Slips, Trips and Falls Policy – Patients	QAB~~RMGG~~	Lead for falls prevention
Slips, Trips and Falls Policy – Staff, visitors etc	QAB~~RMGG~~	Health and Safety Lead
Transfer of Patients Policy	QAB~~RMGG~~	
Security Policy	QAB~~RMGG~~	Lead Local Security Management Specialist
Harassment and Bullying Policy	CA~~M~~B	Head of ~~Corporate~~ HR
Raising a Matter of Concern Policy	~~CPMT~~Management Board	Head of ~~Corporate~~ HR
Policy for the Development and Management of Organisation Wide Policies and Other Procedural Documents	QAB~~RMGG~~	Trust Secretary
Training Needs Analysis	QAB~~RMGG~~	~~Associate Chief Nurse and~~ Head of Learning and HR Business Partner~~ing~~

Approach to Risk Management Training	QAB~~RMGC~~	Head of ~~Corporate~~ HR
Clinical Governance & Risk Management Strategy for maternity services	QAB~~RMGC~~	Head of Midwifery

Appendix 3

Duties of key individuals

Risk and Risk Management Responsibilities

The responsibilities for risk and risk management lie at the levels of the organisation to which the risks belong. As such it is the responsibility of the Board and Management Team to undertake the strategic risk management activities and for the Clinical/Corporate Boards and Divisions to undertake the tactical, operational and project risk management activities. These responsibilities and EKHUFT's risk management goals are built into individuals' objectives and personal development goals.

All staff

All staff have individual responsibility for engaging in risk management activities at EKHUFT. Staff are made aware of this Strategy by publication on SharePoint, through the published minutes of corporate, divisional and local governance meetings and through its implementation. Using this mechanism staff are supported and committed to the identification and minimisation of risk.

Key responsibilities of staff are to:

- Maintain general risk awareness and accept personal responsibility for maintaining a safe environment, notifying line managers of any identified risks.
- Report incidents in accordance with the Trust's Incident Reporting Procedure (detailed in the Policy for the Management of Incidents, including Serious Incidents for Investigation and External Notification).
- Resolve risks or bring immediate risk issues to the attention of their line manager.
- Act safely at all times.
- Comply with the Trust's policies, procedures and guidelines that are in place to protect the health, safety and welfare of anyone affected by the Trust's activities.
- Be familiar with and comply with the Trust's risk management and Health & Safety procedures.
- Where staff feel that raising issues may compromise them or may not be effective they should be aware of and encouraged to follow the Trust's Raising Concerns Policy.
- Neither intentionally, nor recklessly interferes with, nor misuse any work equipment, nor with the equipment provided for the protection of health and safety.
- Undertake training and any other risk training deemed necessary for their role as described in the Trust Risk Management Training Needs Analysis.

- Comply with professional guidelines (as applicable to their role and profession) and act in accordance with such guidelines and codes of practice.
- Maintain confidentiality of patient and Trust information.

All managers

Managers working throughout the Trust are responsible for the local implementation of this Strategy in their departments, wards and/or other clinical and non-clinical areas; this includes acting to resolve local risks, or escalating appropriately through a defined process. They are responsible for promoting an open and just culture amongst their staff and for engendering the importance of risk awareness at a local level amongst their staff. Furthermore they are responsible for ensuring that local risk management activities (for example, risk assessments, incident reporting etc.) are carried out to support Trust-wide learning from risk issues. These include:

- Reviewing clinical and non-clinical incidents, accidents, mistakes and 'near misses' reported to their department.
- Undertaking initial categorisation of the type of event and seriousness on the incident report form.
- Fostering an environment in which staff are encouraged to report incidents and discuss the implications constructively and openly.
- Maintaining departmental policies and procedures and ensuring staff are made aware of them and are trained to follow them.
- Ensuring that there is a regular multidisciplinary governance meeting which reviews serious incidents and actions arising and all relevant policies and procedures.
- Deciding who should lead the review of incidents and investigations and when this should be escalated beyond the departmental level.
- Aligning the clinical audit programmes with actual and emerging clinical risks.
- Ensuring that full disclosure, where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff – whether or not the patient asks.
- Ensuring that the required actions have been taken and are followed through and evidence of change is recorded.

Risk Leads

Designated 'Risk Leads' covering Division's have specific roles as the focal point and local champion for risk management development. They will nurture an increasing awareness of risk management requirements in their colleagues and foster an open culture where adverse incident, near misses and concerns can be freely discussed and where lessons are learned and change is embedded.

Risk Leads are responsible for:

- Implementing this Strategy at a local level by ensuring risk assessments are carried out, risk registers are updated and reviewed through clear internal governance processes and incidents are reported in a timely manner by staff.
- Raising awareness of risk management systems and processes locally, and taking local action to reduce risks where appropriate.
- Working collaboratively with the corporate Risk Management Team to ensure that local intelligence on risk is communicated appropriately throughout the organisation, incidents are reported and analysed and the corporate risk register is updated with information from departmental risk registers.

Divisional Directors and Divisional Medical Directors

Divisional Directors and Divisional Medical Directors have the following responsibilities:

- Leading risk management strategies within their divisions and ensuring appropriate risk structures and processes are maintained and delivered.
- Monitoring incident trends and outcomes and ensuring comprehensive investigation and action for incidents of a serious nature.
- Leading and collating risk assessments and reviewing and updating risk registers across their division.
- Ensuring that controls and assurances are in place and working for areas of substantial risk.
- Ensure staff understand and contribute to the compliance requirements for ~~both~~ the Care Quality Commission (CQC) and ~~NHS Litigation Risk Management Standards (NHSLA)~~other compliance requirements pertinent to divisional activity and implement as part of their governance agenda.
- Promoting an open culture within the division and facilitating/supporting Trust wide learning from risk issues.
- Ensuring there are robust internal systems to ensure that the duty of openness, transparency and candour is embedded within the Division.
- Ensuring the risks associated with the achievement of the Divisional Quality Governance Framework are assessed and reported.

The Head of Patient Experience Team is responsible for:

- Ensuring complaints and concerns are responded to quickly, openly and efficiently
- Providing analyses of complaints, resolving complex and difficult complaints to avoid unnecessary litigation.
- Ensuring that lessons are learnt from complaints to minimise the chances of a recurrence.
- Working collaboratively with the Risk Team and Claims Manager to promote aggregated learning from complaints, claims, incidents and risk assessments.

The Legal Services/Claims Managers

The Legal Services/Claims Managers are responsible for:

- Ensuring equitable and cost effective resolution of claims.
- Liaising with the Trust's legal advisors on claims efficiently and effectively.
- Ensuring that lessons are learnt from claims to minimise the chances of a recurrence; this is in collaboration with the divisions, individuals and teams involved in claims to prevent recurrence.
- Working collaboratively with the Risk Team and Patient Experience Team Manager to promote aggregated learning from complaints, claims, incidents, and risk assessments.
- Providing advice and support staff involved in claims and Coroners' inquests.
- Providing up to date intelligence from the Trust's legal advisors on open and closed claims for the purposes of education and facilitation of training.

Senior Health and Safety Advisor

The Senior Health and Safety Advisor is responsible for:

- Leading the Health and Safety at Work (1974) compliance and supporting the site-based Health and Safety Advisors to the Trust.
- Ensuring that managers and staff are provided with non-clinical risk management information and support.
- Promoting the use and understanding of risk assessment and audit processes throughout the Trust.
- Investigating and reporting on all non-clinical accidents and incidents.
- Providing an input into the aggregated quarterly and annual reports on incidents, claims and complaints.

Information Governance Manager

The Information Governance (IG) Manager is accountable to the Chief Nurse and Director of Quality ~~and Operations~~ and is responsible for the production and implementation of the Information Governance policies and procedures and ensuring that Caldicott principles are embedded. The IG Manager is also responsible for submitting the NHS annual Information Governance Toolkit and ensuring the implementation and management of the initiatives detailed therein.

Deputy Director of Risk, Governance and Patient Safety

The Deputy Director of Risk, Governance and Patient Safety is responsible for the strategic development of risk management across the Trust. This involves developing and leading on a risk management programme which systematically recognises, reports, analyses and evaluates all types of risk, with a view to promoting processes to control and/or minimise risk throughout the organisation.

Responsibility for the management of the corporate Risk Team including the following:

- Maintaining the Trust Corporate Risk Register.
- Advising on external reporting requirements.
- Maintaining and monitoring the reporting system of incidents within the Trust.
- Analysing trends to inform clinical divisional decisions and corporate management decisions.

- Supporting reviews of serious incidents.
- Reviewing samples of incidents for consistency and identifying lessons to be learned.
- Advising on the need for independent investigations by external agencies or individuals.

The Patient Safety and Risk Management Team are responsible for monitoring all incidents on the Trust's incident, claims and complaints system (Datix). Analysis and trends are regularly fed back to Divisions and Departments, and, in anonymised form, to the central national team within NHS England. The data is used, both in the Trust and by the National Reporting and Learning System, to target risk reduction programmes. Data is also used to assist in compliance with Health and Safety legislation. The responsibilities of the Patient Safety and Risk Management Team also cover the following:

- To ensure that systems and processes are in place across the Trust so that risks are identified, assessed, recorded, reported and managed in a way that minimises the risk of injury, damage or financial loss to the Trust, its staff, patients and visitors.
- To line manage staff working on key risk management processes including the trust-wide incident reporting system, incident investigations and risk registers.
- To promote an open and just culture throughout the Trust, where the focus of risk management activities is on learning lessons and improving services which are sustained.
- ~~To ensure that the Trust's risk management activities are compliant with the requirements of the NHS Litigation Authority Risk Management Standards for Acute Trusts.~~
- To advise the Risk Management Governance Group and Board of Directors on trends and statistical analyses of incidents, near misses, complaints, claims and risks.

Chief Nurse and Director of Quality ~~and Operations~~

The Chief Nurse and Director of Quality ~~& Operations~~ provides the leadership on risk management activities across the Trust, ensuring that the Trust's key risk management objectives are met. This role has the executive responsibility for ensuring that risk management processes are reviewed, updated and driven forward by the Trust.

The Chief Nurse and Director of Quality ~~& Operations~~ is accountable to the Chief Executive and the Board for ensuring that this Strategy is implemented effectively and evaluated consistently. The Chief Nurse and Director of Quality ~~& Operations~~ and the Executive Medical Director are both responsible for assessing potential Serious Incidents and deciding which incidents will be analysed/investigated and notified externally (This is further described within the AIR policy).

The Executive Medical Director

The Executive Medical Director's responsibilities are to provide a leadership focus for clinical risk management activities throughout the Trust and to ensure that training and resources are available to support risk management activities.

Where an incident is serious and involves a research subject or a research study then the decision about which incidents to investigate, how the investigation should be organised and

the terms of reference for any investigation should be taken in conjunction with the Director of Research and Development.

Executive Directors

Executive Directors have overall responsibility for the implementation of the risk management strategy. They are responsible for the oversight of the processes for identifying and assessing risk, and for advising the Chief Executive as required. They must ensure that, so far as it is reasonably practical, resources are available in order to manage risk. The Trust Functional Structure describes the core business areas and key business output for each Executive lead.

The Chief Executive

The Chief Executive has overall responsibility for risk management at East Kent Hospitals University NHS Foundation Trust as the Accountable Officer. The Chief Executive is responsible for ensuring that a risk management system is established, implemented and maintained in accordance with this strategy.

There will be cases when risks identified at the tactical, operational or project level will be significant to EKHUFT. Such risk will be escalated to the appropriate level through the Trust's line management processes. The Management Team and Board will set the risk appetite of EKHUFT and the system for enabling risk control and contingency decisions.

Board of Directors

The Trust Board is accountable to Monitor in ensuring that sound governance systems are in place and that risks associated with any of its functions are managed within a robust compliance framework.

The Board of Directors is responsible for reviewing the effectiveness of all Internal Controls (financial, organisational, clinical and health and safety). The Board is required to produce statements of assurance, which demonstrate that it is doing its 'reasonable best' to ensure that the Trust meets the approved Strategic and Annual objectives and protects patients, staff, the public and stakeholders against risk of all kinds.

The Board of Directors inform the annual Governance Statement made by the Chief Executive in the Annual Report and Accounts. The Board of Directors must be able to demonstrate that they have been informed, through the Board Assurance Framework, about all significant risks affecting the achievement of these objectives and of the significant risks are controlled within defined tolerance limits. Conclusions on the totality of risk, risk appetite and the management of risks identified must be based on the evidence presented to them.

Other responsibilities with regard to risk include:

- delegation to Executive and Divisional managers the responsibility to design, implement and monitor the Risk Management Strategy;
- ensuring risk assessment are performed on a continual basis;
- ensuring that the frameworks and methodologies that are implemented increase the probability of anticipating unpredictable risks;

- ensuring Executive and Divisional managers consider and implement responses appropriate to the level of risk;
- ensuring Executive and Divisional managers undertake a continual risk monitoring process;
- receiving assurance regarding the effectiveness of the risk management process;
- aligning the Quality Strategy and the Quality Governance Framework to the Risk Management Strategy in order to ensure standardisation and consistency of the assessment and management of risk.
- ensuring there are processes in place to enable complete, timely, relevant accurate and accessible risk disclosure to stakeholders.

Appendix 4

Relevant Committees with Responsibilities for Risk Management

The following describes how responsibilities of different Trust committees for risk management are executed.

It may be necessary for the structure to change during the year. Updates will be added to this strategy without the need for re-approval. All committees/groups within the structure have a responsibility for escalating risk issues discussed at the committee in line with the Trust escalation process; however the following groups have specific functions pertaining to risk management.

Board of Directors Committees and Executive Groups reporting structure is at Appendix 5.

Integrated Audit Governance Committee (IAGC)

Reporting to the Board, the Integrated Audit and Governance Committee (IAGC) has responsibility for monitoring and review of the risk, control and governance processes which have been established in the organisation, and the associated assurance processes. This is in order to help the Board of Directors be fully assured that the most efficient, effective and economic risk, control and governance processes are in place and the associated assurance processes are optimal. The IAGC also receive reports from the Trust Quality Assurance Board (QAB)~~Risk Management and Governance Group~~, the Information Governance Steering Group and from the Health and Safety Strategic Committee (See Terms of Reference Appendix 9).

Finance and Investment Committee (FIC)

Reporting to the Board, the Finance and Investment committee (FIC) has responsibility for reviewing the financial strategy and for monitoring and review of the risk, control and governance processes associated with financial management of the Trust. The outcomes of discussion on any additions to or changes in the evaluation of financial risks are noted by ~~RMGG~~ QAB and incorporated into the Corporate Risk Register. (See Terms of Reference Appendix 9).

~~Risk Management and Governance Group~~Quality Assurance Board (QAB~~RMGG~~)

This committee reports to the Chief Executive's Group and is responsible for the development of the Risk Management Strategy and associated policies and procedures. It is responsible for monitoring the effectiveness of the strategy and policy, and ensuring that actions to mitigate and manage risk are taken in a timely manner. It provides the IAGC and the QC with regular reports and will work with ~~IAGC~~ both committees to ~~continually~~ strengthen the systems of control, governance and assurance. (See Terms of Reference Appendix 9).

Strategic Health and Safety Committee

This committee is supported by Site based Health and Safety Committees to meet the requirements of section 2 (7) of the Health and Safety at Work Act 1974 and reports to the Risk Management and Governance Group. (See Terms of Reference Appendix 9)

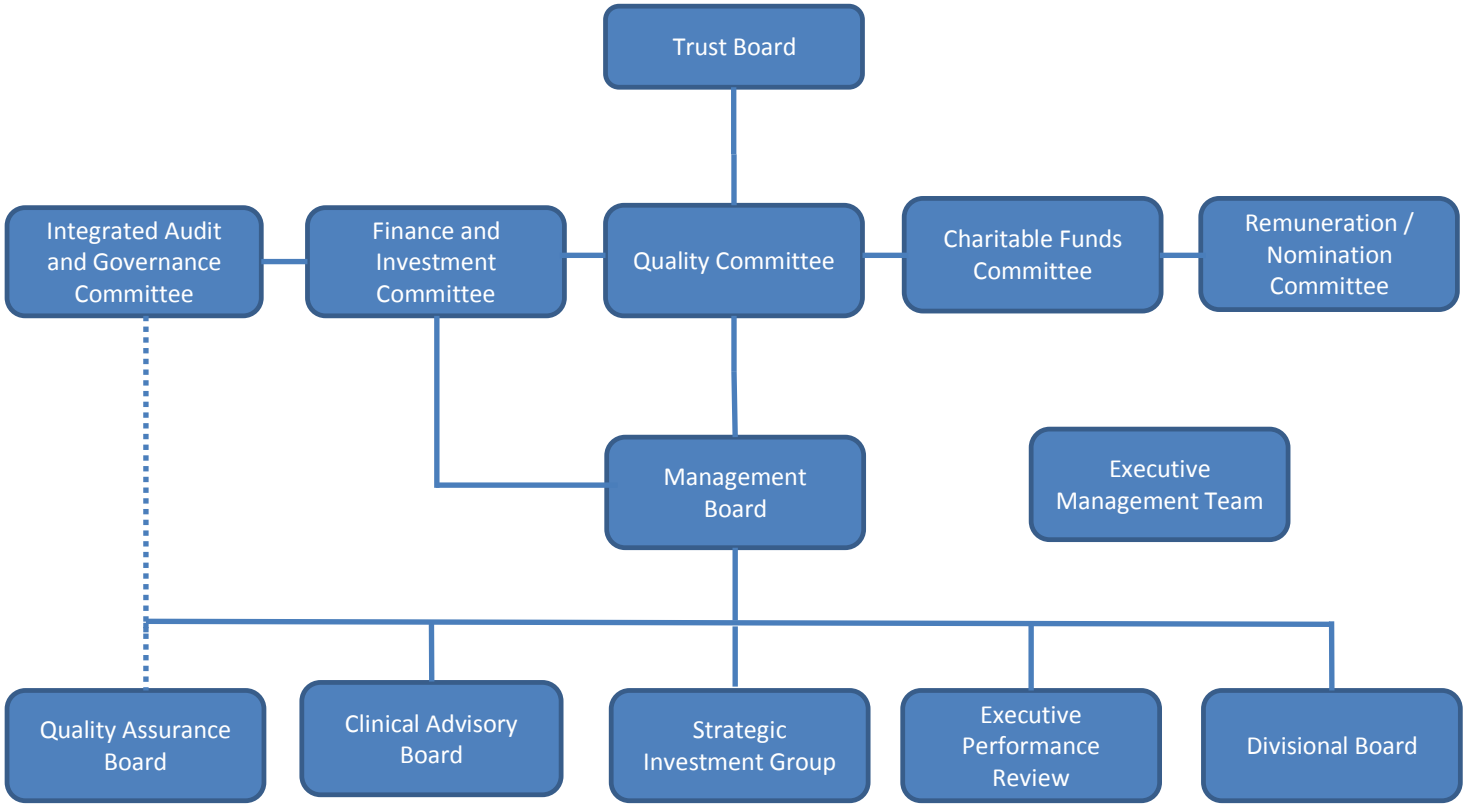
Board of Directors

The Board of Directors is ultimately accountable for ensuring that the Trust is complying with its Terms of Authorisation, which includes its arrangements for integrated governance and effective risk management. The Board of Directors and the Chief Executive are also responsible for ensuring that an open and just culture is developed and sustained throughout the Trust; this is an essential foundation for effective risk management.

The Director of Human Resources ~~and Corporate Services~~ ensures that papers received to be discussed at Management Board~~Corporate Management Performance Team~~ and Board of Directors address the issue of risk in line with this strategy.

Appendix 5

Organisational Chart for Committee Structure Responsible for Management of Risk



Appendix 6

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

RISK ASSESSMENT FORM

Impact x 5:	Likelihood of recurrence x 5:	Overall Risk Rating (E.H.M.L) 5x5:	Active (A), Emerging (E) or Maintenance (M)?

DIVISION: **SPECIALITY/DEPT:** **ASSESSED BY:**
DATE OF ASSESSMENT:

SOURCE OF RISK: **RISK DESCRIPTION:**
Existing Controls & adequacy:

LEVEL	IMPACT OF RISK
1	Negligible - no obvious harm, disruption to service delivery or financial impact. Reputation is unaffected.
2	Low - The Trust will face some issues but which will not lower its ability to deliver quality services. Minimal harm to patients; local adverse publicity unlikely; minimal impact on service delivery. Financial impact up to £1 million non recurrent/one off or up to £2 million over 3 years.
3	Moderate – The Trust will face some difficulties which may have a small impact on its ability to deliver quality services and require some elements of its long term strategy to be revised. Level of harm caused requires medical intervention resulting in an increased length of stay. Local adverse publicity possible. Financial impact between £1 million and £3 million non recurrent/one off, or between £2million and £ 6million over 3 years.
4	Significant – The Trust will face some major difficulties which are likely to undermine its ability to deliver quality services on a daily basis and / or its long terms strategy. Major injuries / harm to patients resulting in prolonged length of stay. External reporting of consequences required. Local adverse publicity certain, national adverse publicity expected. Likelihood of litigation action. Temporary service closure. Financial impact between £3million and £5million non recurrent/one off or between £6 million and £10million over 3 years.
5	Extreme – The Trust will face serious difficulties and will be unable to deliver services on a daily basis. Its long term strategy will be in jeopardy. Serious harm may be caused to patients resulting in death or significant multiple injuries. Extended service closure inevitable. Protracted national adverse publicity. Financial impact at least £5 million non recurrent/one off, or at least £10 million over 3 years.

LEVEL	LIKELIHOOD OF RISK CRYSTALLISING\RECURRENCE
1	Rare - may occur only in exceptional circumstances. So unlikely probability is close to zero.
2	Unlikely - could occur at some time although unlikely. Probability is 1 - 25%.
3	Possible – reasonable chance of occurring. Probability is 25 – 50%.
4	Likely – likely to occur. Probability is 50 – 75%.
5	Almost Certain – Most likely to occur than not. Probability is 75 -100%.

Likelihood \ Impact	1	2	3	4	5
1	L	L	M	H	H
2	L	L	M	H	E
3	L	M	H	E	E
4	M	M	H	E	E
5	M	H	E	E	E

E	Extreme Risk - immediate action required
H	High Risk - senior management attention required
M	Moderate Risk - management responsibility must be specified
L	Low Risk - manage by routine procedures

ACTION REQUIRED

To be completed at the time of the assessment; include clear actions to address weaknesses in the control measures and likelihood of events occurring.
Action points to be agreed with the identified person responsible and the overall plan approved by the line manager of the risk assessor and included on the local risk register.
Significant risks to be brought to the immediate attention of the Department Manager and appropriate risk specialists (e.g. Tissue Viability, Health & Safety, and Infection Control)

ACTION POINT(S)	RESOURCES REQUIRED	LEAD	TARGET DATE	REVIEWDATE/ PROGRESS

RISK RATING FOLLOWING AGREED ACTION: what score you think the risk will be if the actions are completed (impact + likelihood = risk score)

ACTION APPROVED BY:
(e.g. General Manager, Risk Lead, H&S Manager, Divisional Manager, Site Manager, Lead Clinician)

Review Date:
It is a requirement for risk assessments to be reviewed on, at least, an annual basis or in the event that there are any changes to the task / activity being assessed

Appendix 7

RISK ESCALATION FORM

Corporate/Divisional Risk Register			**Ref #**
Form for the Aggregation and Escalation of Risk			
Originating Specialty	**Date first put on risk register**	**Lead**	**Current score**
Risk(s) in brief			
Mitigation in place		**Timetable**	**Post mitigation score**
Reason for aggregation/escalation		**New Lead**	**Recommended aggregate score**
Recommended new mitigation		**Timetable**	**New post mitigation score**
Comments		**Approved Y/N?**	**Date**

Appendix 8

Qualitative Measures of Consequences (Actual/Potential)

Descriptor	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Injury (Physical/ Psychological)	►Adverse event requiring no/minimal intervention or treatment.	►Minor injury or illness – first aid treatment needed ►Health associated infection which may/did result in semi permanent harm ►Affects 1-2 people	►Moderate injury or illness requiring professional intervention ►No staff attending mandatory / key training ►RIDDOR / Agency reportable incident (4-14 days lost) ►Adverse event which impacts on a small number of patients ►Affects 3-15 people	►Major injury / long term incapacity / disability (e.g. loss of limb) ►>14 days off work ►Affects 16 – 50 people	►Fatalities ►Multiple permanent injuries or irreversible health effects ►An event affecting >50 people
Patient Experience	►Reduced level of patient experience which is not due to delivery of clinical care	►Unsatisfactory patient experience directly due to clinical care – readily resolvable ►Increase in length of hospital stay by 1-3 days	►Unsatisfactory management of patient care – local resolution (with potential to go to independent review) ►Increased length of hospital stay by 4 – 15 days	►Unsatisfactory management of patient care with long term effects ►increased length of hospital stay >15 days ►Misdiagnosis	►Incident leading to death ►Totally unsatisfactory level or quality of treatment / service
Environmental Impact	►Onsite release of substance averted	►Onsite release of substance contained ►Minor damage to Trust property – easily remedied <£10K	►On site release no detrimental effect ►Moderate damage to Trust property – remedied by Trust staff / replacement of items required £10K – £50K	►Offsite release with no detrimental effect / on-site release with potential for detrimental effect ►Major damage to Trust property – external organisations required to remedy - associated costs >£50K	►Onsite /offsite release with realised detrimental / catastrophic effects ►Loss of building / major piece of equipment vital to the Trusts business continuity
Staffing & Competence	►Short term low staffing level (<1 day) – temporary disruption to patient care ►Minor competency related failure reduces service quality <1 day ►Low staff morale affecting one person	►On-going low staffing level – minor reduction in quality of patient care ►Unresolved trend relating to competency reducing service quality ►75% - 95% staff attendance at mandatory / key training ►Low staff morale (1% - 25% of staff)	►Late delivery of key objective / service due to lack of staff ►50% - 75% staff attendance at mandatory / key training ►Unsafe staffing level ►Error due to ineffective training / competency we removed ►Low staff morale (25% - 50% of staff)	►Uncertain delivery of key objective / service due to lack of staff ►25%-50% staff attendance at mandatory / key training ►Unsafe staffing level >5days ►Serious error due to ineffective training and / or competency ►Very low staff morale (50% – 75% of staff)	►Non-delivery of key objective / service due to lack of staff ►Ongoing unsafe staffing levels ►Loss of several key staff ►Critical error due to lack of staff or insufficient training and / or competency ►Less than 25% attendance at mandatory / key training on an ongoing basis ►Very low staff morale (>75%)
Complaints/ Claims	►Informal / locally resolved complaint ►Potential for settlement / litigation <£500	►Overall treatment / service substandard ►Formal justified complaint (Stage 1) ►Minor implications for patient safety if unresolved ►Claim <£10K	►Justified complaint (Stage 2) involving lack of appropriate care ►Claim(s) between £10K - £100K ►Major implications for patient safety if unresolved	►Multiple justified complaints ►Independent review ►Claim(s) between £100K - £1M ►Non-compliance with national standards with significant risk to patients if unresolved	►Multiple justified complaints ►Single major claim ►Inquest / ombudsman inquiry ►Claims >£1M
Financial	►Negligible – no obvious harm, disruption to service delivery or financial impact.	►Financial impact up to £1 million non recurrent/one off or up to £2 million over 3 years.	►Financial impact between £1 million and £3 million non recurrent/one off, or between £2million and £ 6million over 3 years.	►Financial impact between £3million and £5million non recurrent/one off or between £6 million and £1 0million over 3 years.	►Financial impact at least £5 million non recurrent/one off, or at least £10 million over 3 years.

Objectives/ Projects	►Interruption does not impact on delivery of patient care / ability to provide service ►Insignificant cost increase / schedule slippage	►<5% over project budget / schedule slippage	►5 – 10% over project budget / schedule slippage	►10 – 25% over project budget / schedule slippage	►>25% over project budget / schedule slippage
Business/ Service Interruption	►Loss/Interruption of >1 hour; no impact on delivery of patient care / ability to provide services	►Short term disruption, of >8 hours, with minor impact	►Loss / interruption of >1 day ►Disruption causes unacceptable impact on patient care ►Non-permanent loss of ability to provide service	►Loss / interruption of > 1 week. ►Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked ►Temporary service closure	►Permanent loss of core service / facility ►Disruption to facility leading to significant 'knock-on' effect across local health economy ►Extended service closure
Inspection/ Statutory Duty	►Small number of recommendations which focus on minor quality improvement issues ►No or minimal impact or breach of guidance / statutory duty ►Minor non-compliance with standards	►Minor recommendations which can be implemented by low level of management action ►Breach of Statutory legislation ►No audit trial to demonstrate that objectives are being met (NICE; HSE; NSF etc.)	►Challenging Recommendations which can be addressed with appropriate action plans ►Single breach of statutory duty ►Non-compliance with core standards <50% of objectives within standards met	►Enforcement action ►Multiple breaches of statutory duty ►Improvement Notice ►Critical Report ►Low performance rating ►Major non-compliance with core standards	►Multiple breaches of statutory duty ►Prosecution ►Severely critical report ►Zero performance rating ►Complete systems change required ►No objectives / standards being met
Adverse Publicity / Reputation	►Rumours ►Potential for public concern	►Local Media – short term – minor effect on public attitudes / staff morale ►Elements of public expectation not being met	►Local media – long term – moderate effect – impact on public perception of Trust & staff morale	►National media <3 days – public confidence in organisation undermined – use of services affected	►National / International adverse publicity >3 days. ►MP concerned (questions in the House) ►Total loss of public confidence
Fire Safety/ General Security	►Minor short term (<1day) shortfall in fire safety system. ►Security incident with no adverse outcome	►Temporary (<1 month) shortfall in fire safety system / single detector etc (non-patient area) ►Security incident managed locally ►Controlled drug discrepancy – accounted for	►Fire code non-compliance / lack of single detector – patient area etc. ►Security incident leading to compromised staff / patient safety. ►Controlled drug discrepancy – not accounted for	►Significant failure of critical component of fire safety system (patient area) ►Serious compromise of staff / patient safety	►Failure of multiple critical components of fire safety system (high risk patient area) ►Infant / young person abduction
Information Governance/ IT	►Breach of confidentiality – no adverse outcome. ►Unplanned loss of IT facilities < half a day ►Health records / documentation incident – no adverse outcome	►Minor breach of confidentiality – readily resolvable ►Unplanned loss of IT facilities < 1 day ►Health records incident / documentation incident – readily resolvable	►Moderate breach of confidentiality – complaint initiated ►Health records documentation incident – patient care affected with short term consequence	►Serious breach of confidentiality – more than one person ►Unplanned loss of IT facilities >1 day but less than one week ►Health records / documentation incident – patient care affected with major consequence	►Serious breach of confidentiality – large numbers ►Unplanned loss of IT facilities >1 week ►Health records / documentation incident – catastrophic consequence

Appendix 9

TERMS OF REFERENCE
MANAGEMENT BOARD

1. CONSTITUTION

1.1. The Management Board (MB) has been constituted by the Chief Executive and is the executive decision making committee of the Trust, chaired by the Chief Executive

2. PURPOSE

2.1. The Management 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 person centred care and to support the Trust Board in setting and delivering the Trust's strategic direction and priorities.

2.2. It is also the formal route to support the Chief Executive in effectively discharging his responsibility as Accounting Officer.

3. OBJECTIVES

Strategy and Objectives

3.1. Shape and develop proposals on the Trust's vision and values, purpose and strategic direction.

3.2. Develop and recommend for submission to the Trust Board, the Trust's annual objectives and Annual Plan, including the revenue and capital budgets to support delivery of the Annual Plan

3.3. Monitor the implementation of the Annual Plan and delivery of the Trust's objectives and report on this to the Trust Board on a quarterly basis.

3.4. Review strategies, strategic development proposals and proposals for major service change ahead of submission for Chief Executive or Trust Board approval as appropriate.

Clinical Quality & Safety

3.5. Identify at each meeting any immediate quality and safety concerns and agree on the action to be taken to review and address these.

3.6. Review the monthly Clinical Quality and Patient Safety report to be presented to the Trust Board.

3.7. Oversee the effective delivery of safe, high quality, patient-centred care and the implementation of the Trust's Quality Strategy.

Performance and Financial Management

3.8. 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 and other performance reports (including finance and workforce) to be presented to the Trust Board.

3.9. Monitor on-going compliance with statutory duties, standards, targets and other obligations, and agree actions and responsibilities to address shortcomings or development requirements identified. To ensure, where appropriate, the alignment of the Trust's strategy with the strategy of key partners.

3.10. Agree action and responsibilities in relation to key performance issues escalated from the Executive Performance Review meetings with Divisions.

3.11. Review delivery of and agree corrective action in relation to the programmes that make up the Cost Improvement Programme.

Governance and Risk Management

3.12. On a quarterly basis review the Corporate Risk Register and Board Assurance Framework.

3.13. Discuss and agree any risks identified in reports coming to MB with a view to including them on the Corporate Risk Register.

3.14. Ensure all policies relating to Trust-wide delivery and impact comply with relevant regulatory and legal requirements as well as best practice.

3.15. Receive assurance from the Quality Assurance Board in relation to the robustness of governance and risk processes and procedures in place.

Staffing and Training

3.16. Monitor the uptake of statutory and mandatory training through quarterly reporting to ensure that effective actions are being taken to meet the agreed Trust targets.

3.17. Oversee the effective promotion and implementation of education and research programmes within the Divisions.

Business Cases

3.18. Review business cases for major service and strategic developments, making recommendations for approval to the Finance and Investment Committee and Trust Board in line with the Standing Financial Instructions.

4. MEMBERSHIP AND ATTENDANCE

Members

Chief Executive (Chair)
Chief Nurse and Director of Quality & Operations (Deputy Chair)
Director of Finance, Performance & Information
Director of Strategic Development and Capital Planning
Director of HR
Medical Director
Divisional Director – Clinical Support
Divisional Director – Specialist Services
Divisional Director – Surgical Services
Divisional Director – Urgent Care and Long-term Services
Trust Secretary

Attendees

The MB may invite any member of Trust staff to attend to present or provide specific reporting. The Internal Auditors' are regular attendees.

Quorum

4.1. The intention is to reach decisions through consensus and once decisions are taken, to sustain a 'corporate position'. However, should it be necessary to vote on issues, at least one member from each Division (or their representative) plus two Executive Directors.

4.2. If any member disagrees with the decision then their concerns should be raised at the meeting and noted within the minutes.

Attendance by Members'

4.3. The Chair or the nominated deputy of the Committee will be expected to attend 100% of the meetings. Other Committee members will be required to attend a minimum of 80% of all meetings and be allowed to send a Deputy to one meeting per annum.

Attendance by Officers'

4.4. Other staff may be co-opted to attend meetings as considered appropriate by the Committee on an ad-hoc basis.

5. FREQUENCY

5.1. The Board shall meet monthly. The Chair may call additional meetings to ensure business is undertaken in a timely way.

6. AUTHORITY

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

6.2. The Committee has decision making powers with regard to the approval of clinical policies.

6.3. The Committee is authorised to create sub-groups or working groups, as are necessary to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers (unless expressly authorised by the Board) and remains accountable for the work of any such group.

6.4. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary or advantageous to its work.

7. SERVICING ARRANGEMENTS

7.1. The Group will be serviced by the Corporate Secretariat.

7.2. Papers will be sent prior to meetings and members will be encouraged to comment via correspondence between meetings as appropriate.

8. ACCOUNTABILITY AND REPORTING

8.1. The Management Board is accountable to Chief Executive.

8.2. Minutes will be reported to the Management Board once they have been approved by the Chair along with exception reports as agreed by the membership of this Board to be escalated to either the Quality Committee or the Finance and Investment Committee.

9. MONITORING EFFECTIVENESS AND REVIEW

9.1. The Board will provide an annual report outlining the activities it has undertaken throughout the year along with a review of its Terms of Reference.

9.2. A survey will be undertaken by the members on an annual basis to ensure that the terms of reference are being met and where they are not either; consideration and agreement to change the terms of reference is made or an action plan is put in place to ensure the terms of reference are met.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC)

TERMS OF REFERENCE

1. CONSTITUTION

These Terms of Reference are based on recommendations and guidance from the Cadbury Committee, the Combined Code, the NHS Audit Committee Handbook, the NHS Integrated Governance Handbook and subsequent guidance including Monitor's Audit Code, Code of Governance and Compliance Framework. The role of the Integrated Audit and Governance Committee (referred to as the IAGC) is to scrutinise and review the Trust's systems of governance, risk management, and internal control. It reports to the Board of Directors (herein shown as the Board) on its work in support of the Annual Report, Quality Report, Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness of risk management arrangements, and the robustness of the self-assessment against CQC regulations.

The IAGC is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference. Its key responsibilities are to:

- monitor the integrity of the financial statements of the Trust, and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained in them;
- review the Trust's internal controls (clinical and financial) and risk management systems;
- review and monitor the external auditor's independence and objectivity and the effectiveness of the external audit process, including approval of annual plans, taking into consideration relevant UK professional and regulatory requirements;
- make recommendations to the Council of Governors regarding the appointment, re-appointment and removal of the external auditor, including tender procedures;
- develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm;
- monitor and review the effectiveness of the Trust's internal audit function and counter-fraud arrangements, including approval and review of related annual plans;

INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC)

TERMS OF REFERENCE

1. CONSTITUTION

These Terms of Reference are based on recommendations and guidance from the Cadbury Committee, Combined Code, the NHS Audit Committee Handbook, the NHS Integrated Governance Handbook and subsequent guidance including Monitor's Audit Code, Code of Governance and Compliance Framework. The role of the Integrated Audit and Governance Committee (referred to as the IAGC) is to scrutinise and review the Trust's systems of governance, risk management, and internal control. It reports to the Board of Directors (herein shown as the Board) on its work in support of the Annual Report, Quality Report, Annual Governance Statement , specifically commenting on the fitness for purpose of the Board Assurance Framework, completeness of risk management arrangements, and robustness of the self-assessment against CQC regulations.

The IAGC is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference. Its key responsibilities are to:

- monitor the integrity of the financial statements of the Trust, and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained in them;
- review the Trust's internal controls (clinical and financial) and risk management systems;
- review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements, including approval of annual plans;
- make recommendations to the Council of Governors regarding the appointment, re-appointment and removal of the external auditor, including tender procedures;
- develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm;
- monitor and review the effectiveness of the Trust's internal audit function and counter-fraud arrangements, including approval and review of related annual plans;
- approve the appointment and/or removal of the internal auditors
- report to the Council of Governors, identifying any matters in respect of which it considers that action or improvement is needed, making recommendations as to the steps to be taken;
- produce an annual report for the Board of Directors

- Review arrangements by which staff within Trust may raise confidentially concerns over financial control and reporting; clinical quality and patient safety; and other matters.

2. MEMBERSHIP AND ATTENDANCE

2.1 Membership

The IAGC shall be appointed by the Board from amongst the Non-Executive directors of the Trust and shall consist of not less than 4 members. A quorum shall be 2 members. There will be appropriate cross membership with other Board committees. One member of the IAGC should have significant, recent and relevant financial experience as outlined in the Combined Code and Sarbanes-Oxley Act 2002. The Chair of the Trust shall not be a member of the IAGC. Members are required to attend at least 50% of meetings and may not nominate a substitute to attend in their place.

2.2 Chairing the Committee

One of the members will be appointed Chair of the IAGC by the Board.
If the Chair is absent from the meeting, another non-executive director as the members present shall choose, shall preside.

2.3 Voting

When a vote is requested, the question shall be determined by a majority of the votes of the members present for the item. In the event of an equality of votes, the person presiding shall have a second or casting vote.

2.4 Attendance by Others at Meetings

External and Internal Auditors and the Head of Clinical Audit are required to make themselves available when required for a private meeting with the IAGC Chair immediately prior to each IAGC meeting.

The Finance Director, Chief Nurse and Director of Operations and Quality Trust Secretary and appropriate Internal and External Audit representatives shall normally attend Committee meetings.

The Chief Executive and other executive directors may be invited to attend, but particularly when the IAGC is discussing areas of risk or operation that are the responsibility of that director.

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

The Trust Secretary and/or Assistant Trust Secretary shall be Secretary to the IAGC and shall attend to take minutes of the meeting and provide appropriate support to the Chair and committee members.

3 FREQUENCY OF MEETINGS

Meetings shall be held not less than five times a year not including joint meetings with the Finance and Investment Committee (see section 11). The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

4. DELEGATED AUTHORITY

Section 5 of the Trust's Standing Financial Instructions and Section 5.9.1 of Standing Orders sets out the modus operandi of the IAGC.

4.1 As a committee of the Board of Directors, it will:
- 4.1.1 Be accountable and report to the Board of Directors.
- 4.1.2 Make recommendations to the Board.
- 4.1.3 Review and approve accounting policy where relevant.
- 4.1.4 Monitor and hold to account directors and senior managers responsible for ensuring internal controls are sufficiently robust.

4.2 The Board delegates the above functions to the IAGC. The Board also delegates decisions not of a significant nature. In practice what is significant will depend on the judgement of members but committees must refer the following types of issue to the full Board.
Any matter which will:
- 4.2.1 Change the strategic direction of the Trust.
- 4.2.2 Conflict with statutory obligations.
- 4.2.3 Contravene national policy decisions or governmental directives.
- 4.2.4 Have significant revenue implications.
- 4.2.5 Have significant governance implications.
- 4.2.6 Be likely to arouse significant public or media interest.

4.3 The IAGC is authorised to investigate any activity within the terms of reference and to seek any information it requires from any employee and all employees are directed to co-operate with any request which in the opinion of the Chair of the committee is properly made by the committee.

4.4 The IAGC is authorised to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary. Legal advice should normally be arranged through one of the Trust's claims managers.

5. DUTIES OF THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE

5.1 **The Chair**

The Chair is responsible for the following:
- Approving agendas for meetings
- Chairing pre meetings with the auditors
- Chairing meetings
- Reporting to the board (highlighting any issues requiring further disclosure or executive action);
- Reporting immediately those items of a significant nature regarding the Board Assurance Framework and the Risk Register;
- Providing an executive summary report following each committee meeting for the Board of Directors' meeting;
- Notifying the Chair(s) of any other committee(s) of specific actions arising from the IAGC that affect the other committee(s) and ensuring these actions are detailed in the IAGC minutes;
- Approving the minutes of the IAGC before they are submitted to the Board of Directors;
- Having a second or casting vote in the event of there being an equality of votes when voting;

- Ensuring there is unhindered access to the Heads of External and Internal Audit for any matters of internal control or risk requiring urgent advice or action.

5.2 The Integrated Audit and Governance Committee (IAGC)

5.2.1 Governance, Risk Management and Internal Control

The IAGC shall review the establishment and maintenance of an effective system of integrated governance, risk management, internal control (clinical and financial) across the whole of the organisation activities that supports the achievement of the Trust's objectives.

In particular, the committee will review the adequacy of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement , regular reports on the activities of the Risk Management and Governance Committee, self-certification statements to the Regulator, and Care Quality Commission declarations), together with any accompanying Head of Internal Audit statement, External Auditor opinion or other appropriate independent assurances, prior to endorsement by the Board.
- underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements. The IAGC will undertake periodic review of progress against the Board Assurance Framework and Corporate Risk Register, with significant changes highlighted. Where these items are of such a significant nature, 4.2 refers, the chair of the committee will bring them to the immediate attention of the chair of the Board of Directors. A full copy of these key documents will be made available to the IAGC in accordance with the timetable agreed by the Board and will normally be reviewed in full prior to the production of the Annual Report and Accounts and the Annual Governance Statement and as part of the Trust's mid year review process.
- policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and consider any training requirements to ensure committee members are kept up to date with emerging requirements.
- policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service.
- arrangements by which staff of the Trust may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters, with the aim of ensuring that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

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 audit functions. 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 their effectiveness.

This will be evidenced through the committee's use of an effective Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

5.2.2 External Audit

The Council of Governors will take the lead in agreeing with the IAGC the criteria for appointing, reappointing and removing auditors. The IAGC will make

recommendations to the Council of Governors on these matters, and approve the remuneration and terms of engagement of the external auditor. In accordance with its Standing Orders, the Council of Governors will appoint the external auditor following recommendation from the IAGC.

The IAGC shall develop and implement policy, in collaboration with the Finance and Performance Management Directorate, regarding the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance. All requests for the supply of non-audit services must be presented to the IAGC for noting.

The committee shall review and monitor the External Auditor's independence and objectivity, and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements.

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

- consideration of the performance of the External Auditor
- review and agree the annual external audit plan
- 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 all audit reports that are specifically drawn to the attention of the committee by the auditors which will include the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

The Head of External Audit will have unhindered and confidential access to the chair of the committee.

5.2.3 Internal Audit

The committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the IAGC, 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 Board Assurance Framework;
- where there is a requirement to undertake work outside of the approved annual work plan, all such requests must be presented to the IAGC for approval;
- consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources;
- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;
- annual review of the effectiveness of internal audit in such manner as is appropriate and agreed by the IAGC, including a review of the successful operation of the contract between the Trust and Internal Audit.

The Head of Internal Audit will have unhindered and confidential access to the chair of the IAGC.

5.2.4 **Other Assurance Functions**

The committee shall review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications for the governance of the organisation. These will include, but not be limited to, any review by Department of Health arms-length bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, Monitor etc.), and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies etc.).

In addition, the committee will review the work of other committees within the Trust, whose work can provide relevant assurance to the IAGC's own scope of work. This will particularly include the Risk Management and Governance Group. With regard to clinical risk management, the committee will wish to satisfy themselves on the assurance that can be gained from the clinical audit function and review of minutes of the Clinical Management Board.

5.2.5 **Management**

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

They may also request reports from individual functions within the Trust (e.g. clinical audit) as they may be appropriate to the overall arrangements.

5.2.6 **Financial Reporting**

The IAGC will monitor the integrity of the financial statements of the Trust, and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained in them. In doing so, the committee shall additionally utilise the findings of the Finance and Investment Committee, which is chaired by a non-executive director of the Trust Board.

The IAGC shall review the Annual Report and Accounts before submission to the Board, focusing particularly on:

- changes in, and compliance with, accounting policies and practices;
- major judgemental areas and;
- significant adjustments resulting from the audit;
- the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the committee;
- unadjusted mis-statements in the financial statements.

Providing mandatory issues (as detailed in paragraph 1) are reserved for the attention of the full committee in session, other matters including review of the Annual Report and Summary Financial Statements may be dealt with as the committee deems appropriate through a process coordinated by the committee Chair.

The Committee should also 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.

5.3 Trust Secretariat and Finance

The IAGC shall be supported administratively by the Trust Secretariat and Finance whose duties in this respect will include:

- Agreement of agenda with Chair and attendees and collation of papers
- Minute-taking & keeping a record of matters arising and issues to be carried forward
- Advising the Committee on pertinent areas, specifically in relation to Monitor's Code of Governance and the requirements of the Compliance Framework.
- Supporting any ongoing training requirements for non-executive directors as appropriate for their membership of the committee.

6. WORKING GROUPS

The IAGC may set up permanent groups or time limited working groups to deal with specific issues. Precise terms of reference for these shall be determined by the committee. However, Board committees are not entitled to further delegate their powers to other bodies, unless expressly authorised by the Board of Directors (Standing Order section 5 refers).

7.SERVICING AND REPORTING ARRANGEMENTS

The IAGC will maintain a rolling annual work plan that will inform its agendas and seek to ensure that all duties are covered over the annual cycle.

Reporting arrangements into the high level committee with overarching responsibility for risk (the IAGC) will be as described in the rolling annual work plan together with anything extra agreed for a particular meeting. Any sub-committees of the IAGC will formally update the committee following each meeting.

Agendas and papers shall be distributed one week prior to the meeting.

The minutes of IAGC meetings shall be formally recorded by the Trust Secretariat and submitted to the Board of Directors. The Chair of the committee shall provide an executive summary report for the next Board of Directors' meeting that highlights substantive issues and recommendations. Minutes of the meeting will also be reported to the Board of Directors.

The Chair of the committee shall draw to the attention of the Board of Directors any issues that require disclosure to the full Board, or require executive action. Specific actions arising from one committee affecting the work of another committee will be detailed in the minutes and notified to the Chair of the other Committee.

The Committee will report to the Board of Directors annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the extent to which risk management is fully embedded in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against the Care Quality Commission regulations.

8.MONITORING COMPLIANCE

The IAGC will review the year's activities and produce a Chair's annual report for submission to the Board of Directors on compliance with the committee's terms of reference, and best practice guidance. This will cover the following:

- Duties
- Accountability including reporting arrangements to the board
- Membership, including nominated deputy where appropriate
- Frequency of meetings

- Requirements for a quorum
- Required frequency of attendance by members
- Reporting arrangements into the high level committee with overarching responsibility for risk (the IAGC)
- Process for monitoring compliance with all of the above
- The work and achievements of the committee
- Outcome of the committee's annual self-assessment
- An action plan, if appropriate, to rectify any deficiencies (to be monitored by the Board).

The IAGC shall report to the Council of Governors, identifying any matters within the Council's remit in respect of which it considers that action or improvement is needed, and making recommendations as to the steps to be taken.

9.CONFIDENTIALITY

All minutes of the Committee are deemed confidential, and not for publication. Confidential minutes shall be maintained, where necessary, for considerations of confidentiality, including commercial confidentiality. Matters specifically agreed to be confidential by the committee must be treated as entirely confidential. They must be minuted and reported to the Board separately. In addition, all committee business must be kept confidential until reported to the Board or otherwise concluded, unless the committee agrees otherwise.

Summary minutes *will/will not* be produced for public Board meetings. [to be confirmed]

10.GENERAL MATTERS

10.1 Reference should be made, as appropriate to the Standing Orders and Standing Financial Instructions and Scheme of Delegation of the Trust.

10.2 These terms of reference will be reviewed by the Board of Directors annually. Any proposed changes to these terms of reference will be approved by the Board of Directors.

11. JOINT COMMITTEES

11.1 The Committee shall meet annually in May, jointly with the Finance and Investment Committee (FIC) for the purpose of reviewing the annual report and accounts, and annual plan, prior to formal approval by the Board of Directors.

11.2 Other joint meetings with the FIC shall be held from time to time as agreed between the Chair of the FIC, the Chair of the IAGC, Trust Chairman, Trust Chief Executive and Executive Directors, for the purpose of reviewing Divisional performance and for such other matters as may be agreed by both Committees within their respective Terms of Reference.

11.3 Meetings shall be chaired jointly unless otherwise agreed by the Chairs of both committees.

11.4 All members of the IAGC and FIC shall be members of the Joint Committee. Attendance by others will be by invitation but will normally include the Deputy Finance Director and Deputy Director of Risk and Governance.

11.5 A quorum shall comprise Chairs of IAGC and FIC, the Director of Finance and Performance Management and the Chief Nurse/Director of Quality and Operations.

~~11.6 In all other regards the Joint Committee will operate and be administered in the same manner as set out in each Committee's individual Terms of Reference.~~

~~End~~

~~Change Control – Terms of Reference approved by the Trust Board~~

~~2012 Terms of Reference review~~
~~IAGC 14-06-12~~

~~2011 Terms of Reference Review:~~
~~IAGC August 2011~~
~~Board of Directors August 2011~~

~~2010 Terms of Reference Review:~~
~~Audit Committee: 24 May 2010~~
~~**Board of Directors: 26 May 2010**~~
~~Next update due: May 2011~~

~~Last approved by: Board of Directors June 2009~~
~~Reconfirmed at Audit Committee 13 August 2009~~

~~CC Version date: 01-06-12~~

- approve the appointment and/or removal of the internal auditors;
- report to the Council of Governors, identifying any matters in respect of which it considers that action or improvement is needed, making recommendations as to the steps to be taken;
- produce an annual report for the Board of Directors
- review arrangements by which staff within the Trust may raise confidentially concerns over financial control and reporting, clinical quality and patient safety and other matters.

2. MEMBERSHIP AND ATTENDANCE

2.1 Membership

The IAGC shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than 4 members. A quorum shall be 2 members. There will be appropriate cross-membership with other Board committees. One member of the IAGC should have significant, recent and relevant financial experience as outlined in the Combined Code and Sarbanes-Oxley Act 2002. The Chair of the Trust shall not be a member of the IAGC. Members are required to attend at least 50% of meetings and may not nominate a substitute to attend in their place.

2.2 Chairing the Committee

One of the members will be appointed Chair of the IAGC by the Board.
If the Chair is absent from the meeting, another Non-Executive Director, as the members present shall choose, shall preside.

2.3 Voting

When a vote is requested, the question shall be determined by a majority of the votes of the members present for the item. In the event of an equality of votes, the person presiding shall have a second or casting vote.

2.4 Attendance by Others at Meetings

External and Internal Auditors the Head of Clinical Audit and a representative of the counter-fraud specialists are required to make themselves available when required for a private meeting with the IAGC Chair immediately prior to each IAGC meeting.

The Finance Director, Chief Nurse and Director of Operations and Quality Trust Secretary and appropriate Internal and External Audit and counter-fraud representatives shall normally attend IAGC meetings.

The Chief Executive and other executive directors may be invited to attend, particularly when the IAGC is discussing areas of risk or operation that are the responsibility of that director.

The Chief Executive should be invited to attend, at least annually, to discuss with the IAGC the process for assurance that supports the Annual Governance Statement. He or she should also attend when the Committee considers the draft Annual Governance Statement and the Annual Report and Accounts.

The Trust Secretary and/or Assistant Trust Secretary shall be Secretary to the IAGC and shall attend to take minutes of the meeting and provide appropriate support to the Chair and committee members.

Representatives from other organisations (for example, NHS Protect) and other individuals may be invited to attend on occasion.

3 FREQUENCY OF MEETINGS

Meetings shall be held quarterly, not including joint meetings with the Finance and Investment Committee (see section 12). The Board, Chief Executive, External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

4. DELEGATED AUTHORITY

Section 5 of the Trust's Standing Financial Instructions and Section 5.9.1 of the Trust's Standing Orders sets out the modus operandi of the IAGC.

4.1 As a committee of the Board of Directors, it will:

- 4.1.1 Be accountable and report to the Board of Directors.
- 4.1.2 Make recommendations to the Board.
- 4.1.3 Review and approve accounting policy where relevant.
- 4.1.4 Monitor and hold to account directors and senior managers responsible for ensuring internal controls are sufficiently robust.

4.2 The Board delegates the above functions to the IAGC. The Board also delegates decisions not of a significant nature. In practice what is significant will depend on the judgement of members but committees must refer the following types of issue to the full Board.

Any matter which will:

- 4.2.1 Change the strategic direction of the Trust.
- 4.2.2 Conflict with statutory obligations.
- 4.2.3 Contravene national policy decisions or governmental directives.
- 4.2.4 Have significant revenue implications.
- 4.2.5 Have significant governance implications.
- 4.2.6 Be likely to arouse significant public or media interest.

4.3 The IAGC is authorised to investigate any activity within the terms of reference and to seek any information it requires from any employee and all employees are directed to co-operate with any request, which in the opinion of the Chair of the IAGC is properly made by the Committee.

4.4 The IAGC is authorised to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it

considers this necessary. Legal advice should normally be arranged through one of the Trust's claims managers.

5. DUTIES OF THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE

5.1 The Chair

The Chair is responsible for the following:

- Approving agendas for meetings
- Chairing pre meetings with the auditors and counter-fraud specialists
- Chairing meetings
- Reporting to the board (highlighting any issues requiring further disclosure or executive action);
- Reporting immediately those items of a significant nature regarding the Board Assurance Framework and the Risk Register;
- Providing an executive summary report following each committee meeting for the Board of Directors' meeting;
- Notifying the Chair(s) of any other committee(s) of specific actions arising from the IAGC that affect the other committee(s) and ensuring these actions are detailed in the IAGC minutes;
- Approving the minutes of the IAGC before they are submitted to the Board of Directors;
- Having a second or casting vote in the event of there being an equality of votes when voting;
- Ensuring there is unhindered access to the Heads of External and Internal Audit for any matters of internal control or risk requiring urgent advice or action.

5.2 The Integrated Audit and Governance Committee (IAGC)

5.2.1 Governance, Risk Management and Internal Control

The IAGC shall review the establishment and maintenance of an effective system of integrated governance, risk management, internal control (clinical and non-clinical) across the whole of the organisation activities,that supports the achievement of the Trust's objectives.

In particular, the committee will review the adequacy of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement, regular reports on the activities of the Risk Management and Governance Committee, self-certification statements to the Regulator, and Care Quality Commission declarations), together with any accompanying Head of Internal Audit statement, External Auditor opinion or other appropriate independent assurances, prior to endorsement by the Board.
- underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements. The IAGC will undertake periodic review of progress against the Board Assurance Framework and Corporate Risk Register, with significant changes highlighted. Where these items are of such a significant nature, 4.2 refers, the Chair of the IAGC will bring them to the immediate attention of the chair of the Board of Directors. A full

copy of these key documents will be made available to the IAGC in accordance with the timetable agreed by the Board and will normally be reviewed in full prior to the production of the Annual Report and Accounts and the Annual Governance Statement and as part of the Trust's mid year review process.

- policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications, and consider any training requirements to ensure committee members are kept up to date with emerging requirements.
- policies and procedures for all work related tocounter fraud and security as required by NHS Protect..
- arrangements by which staff of the Trust may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters, with the aim of ensuring that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

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 audit functions. 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 their effectiveness.

This will be evidenced through the committee's use of an effective Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key committees so that it understands processes and linkages. However, these other committee's must not usurp the Committee's role.

5.2.2 **External Audit**

The Council of Governors will take the lead in agreeing with the IAGC the criteria for appointing, reappointing and removing auditors. The IAGC will make recommendations to the Council of Governors on these matters, and approve the remuneration and terms of engagement of the External Auditor. In accordance with its Standing Orders, the Council of Governors will appoint the external auditor following recommendation from the IAGC.

The IAGC shall develop and implement policy, in collaboration with the Finance and Performance Management Directorate, regarding the engagement of the External Auditor to supply non-audit services, taking into account relevant ethical guidance. All requests for the supply of non-audit services must be presented to the IAGC for noting.

The IAGC shall review and monitor the External Auditor's independence and objectivity, and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements.

The IAGC shall review the work and findings of the External Auditor and consider the implications and management's responses to their work.

This will be achieved by:

- consideration of the appointment and performance of the External Auditor, as far as the rules governing the appointment permit.
- review and agreement, before the audit commences, the nature and scope of the audit as set out in the annual external audit plan
- 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 audit reports that are specifically drawn to the attention of the IAGC by the auditors which will include the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.
- Ensuring that there is in place a clear policy for the engagement of external auditors to supply non audit services.

The Head of External Audit will have unhindered and confidential access to the Chair of the IAGC.

5.2.3 Internal Audit

The IAGC shall ensure that there is an effective Internal Audit function established by management that meets the Public Sector Internal Audit Standards, 2013 and provides appropriate independent assurance to the IAGC, 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 Board Assurance Framework;
- where there is a requirement to undertake work outside of the approved annual work plan, all such requests must be presented to the IAGC for approval;
- consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources;
- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;
- annual review of the effectiveness of internal audit in such manner as is appropriate and agreed by the IAGC, including a review of the successful operation of the contract between the Trust and Internal Audit.

The Head of Internal Audit will have unhindered and confidential access to the Chair of the IAGC.

5.2.4 Other Assurance Functions

The IAGC shall review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications for the governance of the organisation. These will include, but not be limited to, any review by Department of Health arms-length bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, Monitor etc.), and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies etc.).

In addition, the IAGC will review the work of other committees within the Trust, whose work can provide relevant assurance to the IAGC's own scope of work. This will particularly include the Risk Management and Governance Group. With regard to clinical risk management, the IAGC will wish to satisfy themselves on the assurance that can be gained from the clinical audit function and review of minutes of the Clinical Management Board.

5.2.5 Counter Fraud

The IAGC shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Protect's standards and shall review the outcomes of work in these areas.

5.2.6 **Management**

The IAGC shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

They may also request reports from individual functions within the Trust (e.g. clinical audit) as they may be appropriate to the overall arrangements.

5.2.7 **Financial Reporting**

The IAGC will monitor the integrity of the financial statements of the Trust, and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained in them. In doing so, the IAGC shall additionally utilise the findings of the Finance and Investment Committee, which is chaired by a Non-Executive Director of the Trust Board.

The IAGC shall review the Annual Report and Accounts before submission to the Board, focusing particularly on:

- changes in, and compliance with, accounting policies and practices and estimation techniques;
- major judgemental areas;
- significant judgements in the preparation of the financial statements;
- significant adjustments resulting from the audit;

- the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the IAGC;
- letters of representation;
- explanations for significant variances;
- unadjusted mis-statements in the financial statements.

Providing mandatory issues (as detailed in paragraph 1) are reserved for the attention of the full committee in session, other matters including review of the Annual Report and Summary Financial Statements may be dealt with as the IAGC deems appropriate through a process coordinated by the IAGC Chair.

The IAGC should also 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.

5.3 Trust Secretariat

The IAGC shall be supported administratively by the Trust Secretariat whose duties in this respect will include:

- agreement of the agenda with the Chair and attendees and collation and circulation of papers in good time
- ensuring that those invited to each meeting attend
- minute-taking and keeping a record of matters arising and issues to be carried forward
- helping the Chair to prepare reports to the Board
- arranging meetings for the Chair – for example , with the internal/external auditors or local counter fraud specialists
- maintaining records of members' appointments and renewal dates etc
- advising the IAGC on pertinent issues/areas of interest/policy developments
- ensuring that action points are taken forward between meetings

supporting any ongoing training requirements for Non-Executive Directors as appropriate for their membership of the IAGC.

6. WORKING GROUPS

The IAGC may set up permanent groups or time limited working groups to deal with specific issues. Precise terms of reference for these shall be determined by the IAGC. However, Board committees are not entitled to further delegate their powers to other bodies, unless expressly authorised by the Board of Directors (Standing Order section 5 refers).

7. SERVICING AND REPORTING ARRANGEMENTS

The IAGC will maintain a rolling annual work plan that will inform its agendas and seek to ensure that all duties are covered over the annual cycle.

Reporting arrangements into the high level committee with overarching responsibility for risk (the IAGC) will be as described in the rolling annual work plan together with anything extra agreed for a particular meeting. Any sub committees of the IAGC will formally update the committee following each meeting.

Agendas and papers shall be distributed one week prior to the meeting.

The minutes of IAGC meetings shall be formally recorded by the Trust Secretariat and submitted to the members of the IAGC. The Chair of the IAGC shall provide an executive summary report for the next Board of Directors' meeting that highlights substantive issues and recommendations. Minutes of the meeting will also be reported to the Board of Directors in closed session.

The IAGC Chair shall draw to the attention of the Board of Directors any issues that require disclosure to the full Board, or require executive action. Specific actions arising from one committee affecting the work of another committee will be detailed in the minutes and notified to the chair of the other committee.

The IAGC will report to the Board of Directors annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the extent to which risk management is fully embedded in the organisation, the integration of governance arrangements and the appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business and the robustness of the processes behind the quality accounts.

The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

8. MONITORING COMPLIANCE

The IAGC will review the year's activities and produce a Chair's annual report for submission to the Board of Directors on compliance with the committee's terms of reference, and best practice guidance. This will cover the following:

- Duties
- Accountability including reporting arrangements to the board
- Membership, including nominated deputy where appropriate
- Frequency of meetings
- Requirements for a quorum
- Required frequency of attendance by members
- Reporting arrangements into the high level committee with overarching responsibility for risk (the IAGC)
- Process for monitoring compliance with all of the above
- The work and achievements of the IAGC
- Outcome of the IAGC's annual self-assessment
- An action plan, if appropriate, to rectify any deficiencies (to be monitored by the Board).

The IAGC shall report to the Council of Governors, identifying any matters within the Council's remit in respect of which it considers that action or improvement is needed, and making recommendations as to the steps to be taken.

9. CONFIDENTIALITY

All minutes of the IAGC are deemed confidential, and not for publication. Confidential minutes shall be maintained, where necessary, for considerations of confidentiality, including commercial confidentiality. Matters specifically agreed to be confidential by the IAGC must be treated as entirely confidential. They must be minuted and reported to the Board separately. In addition, all committee business must be kept confidential until reported to the Board or otherwise concluded, unless the IAGC agrees otherwise.

Summary minutes will not be produced for Public Board meetings. A Committee Chair's report is produced for Public Board meetings.

10. GENERAL MATTERS

10.1 Reference should be made, as appropriate to the Standing Orders and Standing Financial Instructions and Scheme of Delegation of the Trust.

10.2 These terms of reference will be reviewed by the Board of Directors annually. Any proposed changes to these terms of reference will be approved by the Board of Directors.

11. JOINT COMMITTEES

11.1 The IAGC shall meet annually in May, jointly with the Finance and Investment Committee (FIC) for the purpose of reviewing the annual report and accounts, and annual plan, prior to formal approval by the Board of Directors.

11.2 Other joint meetings with the FIC shall be held from time to time as agreed between the Chair of the FIC, the Chair of the IAGC, Trust Chairman, Trust Chief Executive and Executive Directors, for the purpose of reviewing Divisional performance and for such other matters as may be agreed by both Committees within their respective Terms of Reference.

11.3 Meetings shall be chaired jointly unless otherwise agreed by the Chairs of both committees.

11.4 All members of the IAGC and FIC shall be members of the Joint Committee. Attendance by others will be by invitation but will normally include the Deputy Finance Director and Deputy Director of Risk and Governance.

11.5 A quorum shall comprise Chairs of both the IAGC and FIC, the Director of Finance and Performance Management and the Chief Nurse/Director of Quality and Operations.

11.6 In all other regards the Joint Committee will operate and be administered in the same manner as set out in each Committee's individual Terms of Reference.

End

Version approved by IAGC 14/08/14 and Board on 29/8/14

TERMS OF REFERENCE
QUALITY COMMITTEE

1. Constitution

1.1. The Board of Directors ("the Board") has established a Committee to the Board to be known as the Quality Committee. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

2. Purpose

2.1. The Committee is responsible for providing the Board with assurance on all aspects of quality, including strategy, delivery, governance, clinical risk management, workforce and information governance, clinical audit; and the regulatory standards relevant to quality and safety.

3. Responsibilities

Strategy and Performance

3.1. Oversee the development and implementation of the Quality Strategy with a clear focus on improvement, drawing on and benchmarking against ideas and best practice from external organisations.

3.2. Ensure that the Trust's Quality Strategy and performance are consistent with the goals of the NHS Outcomes Framework.

3.3. Review trends in patient safety, experience and outcomes (effectiveness) to provide assurance to the Board on performance and undertake 'deep dives' as appropriate.

3.4. Oversee the development and implementation of action plans arising from both in-patient and other care related surveys with recommendations to the Board as appropriate.

3.5. Oversee the implementation of the Trust's Francis Report Action Plan and provide assurance to the Board on its delivery

3.6. Oversee the continuing evolution and implementation of the Trust's 'We Care' programme

Governance

3.7. Oversee the effectiveness of the clinical systems developed and implemented by the Quality and Assurance Board to ensure they maintain compliance with the Care Quality Commission's Essential Standards of Quality and Safety.

3.8 Monitor the progress against actions to mitigate the quality risks on the corporate risk register and provide assurance to the Board that adequate steps are taken to reduce the risks in line with the Board's risk appetite.

3.9 Review the controls and assurance against relevant quality risks on the Board Assurance Framework and provide assurance to the Board that risks to the annual objectives are being managed and facilitate the completion of the Annual Governance Statement at year end.

3.10 Obtain assurance that the Trust is compliant with guidance from NICE and other related bodies.

3.11 Obtain assurance of the Trust's ongoing compliance with the Care Quality Commission registration through appropriate systems of control.

3.12 Consider external and internal assurance reports and monitor action plans in relation to clinical governance resulting from improvement reviews / notices from Monitor, the Care Quality Commission, the Health and Safety Executive and other external assessors.

Clinical Audit

3.13 Receive the annual clinical audit programme and provide assurance to the Board that clinical audit supports the divisions to provide safe and clinically effective patient care.

3.14. Obtain assurance that the clinical divisions deliver against their agreed annual clinical audit programme.

Communication

3.15. Oversee the communication of the trust's quality aspirations and objectives throughout the organisation.

Other possible responsibilities:

- Quality assurance of CIPs
- NED governance group remit regarding access targets
- Staffing ratios
- Annual Quality Report

4. Membership

4.1. The Committee shall be appointed by the Board with a membership of both Non-Executive and Executive Directors as well as representation of the views of users, carers and other relevant interests, as appropriate.

Members
Chairman (Chair)
Non-Executive Directors who are members of the Integrated Audit Committee + Professor Chris Corrigan, NED
Chief Executive Officer
Chief Nursing Officer and Director of Quality and Operations (Lead Executive)

Medical Director
Director of Human Resources

Attendees
Deputy Director of Risk, Governance and Patient Safety
Deputy Director of Nursing and Quality
Clinical Audit Manager

5. Quorum

5.1. Business will only be conducted if the meeting is quorate. The committee will be quorate with four members, including at least two Non-Executive Directors, the Chief Nurse and/or one other Executive Director.

6. Attendance

6.1. Members and Attendees

The Chair and Lead Executive, or their nominated deputy, of the Committee will be expected to attend 100% of the meetings. Other Committee members will be required to attend a minimum of 80% of all meetings and be allowed to send a Deputy to one meeting per annum.

6.2. Others

The Non-Executive Directors, Executive Directors and Trust Secretary have an open invitation to attend any meeting.

The Committee can co-opt as necessary the Heads of Department when the Committee is discussing areas of the operation that are the responsibility of those Heads.

7. Accountability and Reporting Arrangements

7.1. The Committee will be accountable to the Board. A report of the meeting will be submitted and presented to the Board by the Chair who shall draw to the attention of the Board issues that require disclosure to the full Board, or require executive action.

7.2. The Committee shall refer to the other Board Assurance Committees (the Integrated Audit Committee and the Finance and Investment Committee) matters considered by the Committee deemed relevant to their attention. The Committee, in turn, will consider matters referred to it by those two Assurance Committees.

7.3. The annual work plan of the Committee may be reviewed by the Integrated Audit Committee at any given time.

8. Frequency

8.1. The Committee will meet quarterly. Additional meetings may be arranged when required to support the effective functioning of the Trust.

9. Authority

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

9.2. The Committee is authorised by the Board to request the attendance of individuals and authorities from outside the trust with relevant experience and expertise if it considers this necessary or advantageous to its work.

9.3. The Committee has decision making powers with regard to the approval of clinical procedural documents.

9.4. The Committee is authorised to create sub-groups or working groups, as are necessary to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers (unless expressly authorised by the Board) and remains accountable for the work of any such group.

9.5. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary or advantageous to its work.

10. Monitoring Effectiveness

10.1. The Committee will undertake an annual review of its performance against its work plan in order to evaluate the achievement of its duties. This review will inform the Committee's annual report to the Board.

11. Administration

11.1. The servicing, administrative and appropriate support to the Chair and Committee will be undertaken by the Trust Secretariat, who will record minutes of the meetings. The planning of the meetings is the responsibility of the Chair.

12. Review

12.1. The Committee will review its Terms of Reference and work programme on an annual basis, as a minimum

VERSION
Approved by Board 29 August 2014

EAST KENT HOSPTIALS UNIVERSITY NHS FOUNDATION TRUST

FINANCE AND INVESTMENT COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Board of Directors has established a committee of the Board known as the Finance and Investment Committee.

2. PURPOSE OF THE COMMITTEE

2.1 The purpose of the Committee is to maintain a detailed overview of the Trust's assets and resources in relation to the achievement of financial targets and business objectives and the financial stability of the Trust. This will include:-

- overseeing the development and maintenance of the Trust's medium and long term financial strategy
- reviewing and monitoring financial plans and their link to operational performance
- overseeing financial risk evaluation, measurement and management
- scrutiny and approval of business cases and oversight of the capital programme
- maintaining oversight of the finance function, key financial policies and other financial issues that may arise

2.2 As a committee of the Board of Directors, it will:

- Make recommendations to the Board.
- Develop policy.
- Monitor and hold to account.

2.3 The Committee is authorised to investigate any activity within the terms of reference and to seek any information it requires from any employee and all employees are directed to co-operate with any request which in the opinion of the Chair of the Committee is properly made by the Committee.

3. MEMBERSHIP AND ATTENDANCE

3.1 The membership of the Committee shall consist of the Chair of the Trust and at least two Non-Executive Directors, together with the Chief Executive and Finance Director.

3.2 **Chairing the Committee -** The Chair of the Committee shall be a Non-Executive Director appointed by the Trust Chairman in discussion with the Board of Directors.

If the Committee Chair is absent from the meeting, another Non-Executive Director as the directors present shall choose, shall preside.

3.3 **Quorum -** At any meeting of the Committee, at least two Non-Executive Directors and one Executive Director must be present.

3.4 **Voting -** When a vote is requested, the question shall be determined by a majority of the votes of the members present for the item. In the event of an equality of votes, the person presiding shall have a second or casting vote.

3.5 **Attendance by Others at Meetings -** The Chief Nurse/Director of Quality and Operations, Medical Director, Director of Strategic Development and Capital Planning and Deputy Finance Director shall normally attend. Others may be invited to attend meetings or parts of meetings, as deemed appropriate by the Chair.

4. OBJECTIVES

4.1 The Committee has the following specific duties and functions which are set out in a rolling annual work plan.

4.2 **Financial Strategy**

- To consider the Financial Strategy, ensuring that the financial objectives are consistent with the strategic direction and quality priorities.
- To review the Monitor long term financial model
- To review key medium term planning assumptions
- To review Monitor/LAT /CCG/NHS England, etc publications around financial and operating environment and their link to planning assumptions and models

4.3 **Monitoring Performance**

- Monitor the achievement of the financial strategy, and financial targets,associated activity targets and how these relate to the performance of the trust in non-financial domains such as patient safety and effectiveness.
- Monitor balanced scorecard, and activity and financial performance.
- To scrutinise financial and non-financial performance, trends, projections and underlying data on a monthly basis so that assurance can be sought around any action plans that address emerging patterns in finance or activity.
    - To oversee the development of financial and non-financial performance reporting, to include:
    - Greater emphasis on interpretation of the financial position and development of corrective plans where necessary.
    - Structuring monitoring reports around the key performance statements.

- Developing high level metrics to focus the Committee on areas where corrective action may need to be developed
- Linking the narrative to implications of compliance with the FT licence, in particular the financial risk rating and other licence conditions
- Monitoring agreed actions
- To consider the annual reference costs and review profitability analyses.
- To review the annual accounts prior to IAGC and Board approval (see section 12)

4.4 Financial Risk Management

To review financial risk and advise the IAGC and Board accordingly:

- Review and evaluation of key financial risks e.g. tariff changes, contract penalty considerations, CCG/SCG Commissioning intentions, achievement of savings, control of recruitment (and hence pay bill), costs and benefits of underlying additional activity
- Development of risk management process around the evaluated risks linking to Assurance Framework providing assurance around active financial risk management [Note: the formal link between the finance risk register and Corporate Risk Register will be through the Risk Management and Governance Group)

4.5 Business Case consideration and Capital Programme management

- To perform a preliminary review of proposed major investments.
- To establish the overall controls which govern business case investments, using Monitor's guidance on Risk Evaluation for Investment Decisions, and to approve the Trust's Business Case Procedure. In accordance with the Business Case Procedure (ref FPP/B1) and Scheme of Delegation rigorously review and approve business cases. (see section 5.2 below)
- To ensure that robust processes are followed, evaluating, scrutinising and monitoring investments so that benefits realisation can be confirmed.
- To ensure testing of all relevant options for larger business cases prior to detailed workup
- To focus on financial metrics within cases e.g. payback periods, rate of return etc.
- To oversee the development and management of the rolling capital programme including scrutiny of the prioritisation process, forecasting and remedial action, and report to the Board accordingly.

4.7 **Other Matters**

- To provide an opportunity for examination of fitness for purpose of the finance function compared to the scale of the financial challenge
- To consider ad hoc financial issues that arise (e.g. Private Patient Cap, estate revaluation etc.)
- To develop the Trust's Treasury Policy in line with Monitor's guidance on Managing Operating Cash. To scrutinise arrangements for a working capital facility and other long terms loans if required, and investment of surplus cash.
- To periodically consider changes required to Trust Standing Financial Instructions due to structural change within the Trust, developments in the Monitor regime and the wider statutory/regulatory framework.
- To oversee arrangements for outsourced financial functions and shared financial services.
- To consider such other matters and take such other decisions of a generally financial nature as the Board shall delegate to it.

5. DELEGATED AUTHORITY

5.1 The Board delegates the above functions to the committee. The Board also delegates decisions not of a significant nature. In practice what is significant will depend on the judgement of members but committees must refer the following types of issue to the full Board.
Any matter which will:

- Change the strategic direction of the Trust.
- Conflict with statutory obligations.
- Contravene national policy decisions or governmental directives.
- Have significant revenue, capital or cash implications.
- Have significant governance implications.
- Be likely to arouse significant public or media interest.

The Committee will be expected to take decisions in its areas of expertise unless there are wider implications for the Trust, requiring the matter to be referred to the full Board.

5.2 The Board delegates to the Committee the specific function of reviewing and approving business cases for capital and revenue investment falling within the following three categories:

- Self-funding business cases with a cost impact over 5 years of more than £2.5m and less than £5m.
- Non-self-funding business cases requiring up to £2.5m revenue funding over a five year period
- Business cases requiring capital investment of more than £1m and less than £2.5m

Under the Trust's Reservation of Powers section 17.1, the Board of Directors must ratify proposals involving the acquisition, disposal, or change of use of land and buildings. Disposal of protected property requires Monitor approval.

Where the disposal of land or buildings has been approved in principle by the Board (and by Monitor if protected property in involved) and a market value has been obtained, the Committee is required, under section 10 of the Trust's Scheme of Delegation, to provide to the executive members of the Committee a permitted range and/or percentage deviation from market value that may be accepted from a prospective purchaser without further recourse to the Committee.

5.3 The Committee is authorised to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary. Legal advice should normally be arranged through the Trust Secretary.

6. WORKING GROUPS

6.1 A committee may set up permanent groups or time limited working groups to deal with specific issues. Precise terms of reference for these shall be determined by the committee. However, Board committees are not entitled to further delegate their powers to other bodies, unless expressly authorised by the Board (Standing Order 5.5 refers).

7. FREQUENCY OF MEETINGS

7.1 Meetings of the Committee shall generally be held monthly in advance of the main Board meeting. At the discretion of the Chair, other meetings may be held to fulfil its main functions.

8. SERVICING ARRANGEMENTS

8.1 A member of the Board Secretariat shall attend meetings and take minutes. Agendas and papers shall be distributed in accordance with deadlines agreed with the Committee Chair. Minutes shall normally be made available at the following month's Board meeting.

9. REPORTING ARRANGEMENTS

9.1 The Committee shall report in writing to the Board the basis for its recommendations, if required, in addition to submitting its minutes. Owing to the proximity of meetings, the Committee Chair will also provide a verbal update to the Board at each meeting.

10. CONFIDENTIALITY

10.1 All minutes of the Committee are deemed confidential, and not for publication. Confidential minutes shall be maintained, where necessary, for considerations of confidentiality, including commercial confidentiality. Matters specifically agreed to be confidential by the committee must be treated as entirely confidential. They must be minuted and reported to the Board separately. In addition, all committee business must be kept confidential until reported to the Board or otherwise concluded, unless the committee agrees otherwise.

10.2 Summary notes will be produced for public Board meetings.

11. GENERAL MATTERS

11.1 Reference should be made, as appropriate to the Standing Orders and Standing Financial Instructions and Scheme of Delegation of the Trust.

11.2 Terms of Reference shall be reviewed at least annually. Any proposed changes to these terms of reference will need to be approved by the Board.

12. JOINT COMMITTEES

12.1 The Committee shall meet annually in May, jointly with the Integrated Audit and Governance Committee (IAGC) for the purpose of reviewing the annual report and accounts, and annual plan, prior to formal approval by the Board of Directors.

12.2 Other joint meetings with the IAGC shall be held from time to time (usually twice a year) as agreed between the Chair of the FIC, the Chair of the IAGC, Trust Chairman, Trust Chief Executive and Executive Directors, for the purpose of reviewing Divisional performance and for such other matters as may be agreed by both Committees within their respective Terms of Reference.

12.3 Meetings shall be chaired jointly unless otherwise agreed by the Chairs of both committees.

12.4 All members of the FIC and IAGC shall be members of the Joint Committee. Attendance by others will be by invitation but will normally include the Deputy Finance Director and Deputy Director of Risk and Governance.

12.5 A quorum shall comprise Chairs of both IAGC and FIC, the Director of Finance and Performance Management and the Chief Nurse/Director of Quality and Operations.

12.6 In all other regards the Joint Committee will operate and be administered in the same manner as set out in each Committee's individual Terms of Reference.

End

Version: reviewed May 2014 FIC
Approved at Board June 2014

~~**EAST KENT HOSPTIALS UNIVERSITY NHS FOUNDATION TRUST**~~

~~**FINANCE AND INVESTMENT COMMITTEE**~~

~~**TERMS OF REFERENCE**~~

~~**1. CONSTITUTION**~~

~~1.1 The Board of Directors has established a committee of the Board known as the Finance and Investment Committee.~~

~~**2. PURPOSE OF THE COMMITTEE**~~

2.1 The purpose of the Committee is to maintain a detailed overview of the Trust's assets and resources in relation to the achievement of financial targets and business objectives and the financial stability of the Trust. This will include:

- overseeing the development and maintenance of the Trust's medium and long term financial strategy
- reviewing and monitoring financial plans and their link to operational performance and quality
- overseeing financial risk evaluation, measurement and management
- scrutiny and approval of business cases and oversight of the capital programme
- maintaining oversight of the finance function, key financial policies and other financial issues that may arise

2.2 As a committee of the Board of Directors, it will:

- Make recommendations to the Board.
- Develop policy.
- Monitor and hold to account.

2.3 The Committee is authorised to investigate any activity within the terms of reference and to seek any information it requires from any employee and all employees are directed to co-operate with any request which in the opinion of the Chair of the Committee is properly made by the Committee.

3. MEMBERSHIP AND ATTENDANCE

3.1 The membership of the Committee shall consist of the Chair of the Trust and at least two Non-Executive Directors, together with the Chief Executive and Finance Director.

3.2 **Chairing the Committee** - The Chair of the Committee shall be a Non-Executive Director appointed by the Trust Chairman in discussion with the Board of Directors. If the Committee Chair is absent from the meeting, another Non-Executive Director as the directors present shall choose, shall preside.

3.3 **Quorum** - At any meeting of the Committee, at least two Non-Executive Directors and one Executive Director must be present.

3.4 **Voting** - When a vote is requested, the question shall be determined by a majority of the votes of the members present for the item. In the event of an equality of votes, the person presiding shall have a second or casting vote.

3.5 **Attendance by Others at Meetings** - The Chief Nurse/Director of Quality and Operations, Medical Director, Director of Strategic Development and Capital Planning and Deputy Finance Director shall normally attend. Others may be invited to attend meetings or parts of meetings, as deemed appropriate by the Chair.

4. OBJECTIVES

4.1 The Committee has the following specific duties and functions which are set out in a rolling annual work plan.

4.2 **Financial Strategy**

- To consider the Financial Strategy, ensuring that the financial objectives are consistent with the strategic direction and quality priorities.
- To review the Monitor long term financial model
- To review key medium term planning assumptions
- To review Monitor/LAT /CCG/NHS England, etc publications around financial and operating environment and their link to planning assumptions and models

4.3 **Monitoring Performance**

- Monitor the achievement of the financial strategy, and financial targets, associated activity targets and how these relate to the performance of the trust in non-financial domains such as patient safety and effectiveness.
- Monitor balanced scorecard, and activity and financial performance.
- To scrutinise financial and non-financial performance, trends, projections and underlying data on a monthly basis so that assurance can be sought around any action plans that address emerging patterns in finance or activity.
- To oversee the development of financial and non-financial performance reporting, to include:
  - Greater emphasis on interpretation of the financial position and development of corrective plans where necessary.
  - Structuring monitoring reports around the key performance statements.
  - Developing high level metrics to focus the Committee on areas where corrective action may need to be developed
  - Linking the narrative to implications of compliance with the FT licence, in particular the financial risk rating and other licence conditions
  - Monitoring agreed actions
  - To consider the annual reference costs and review profitability analyses.
  - To review the annual accounts prior to IAGC and Board approval (see section 12)

4.4 **Financial Risk Management**

To review financial risk and advise the IAGC and Board accordingly:

- Review and evaluation of key financial risks e.g. tariff changes, contract penalty considerations, CCG/SCG Commissioning intentions, achievement of savings, control of recruitment (and hence pay bill), costs and benefits of underlying additional activity

- Development of risk management process around the evaluated risks linking to Assurance Framework providing assurance around active financial risk management [Note: the formal link between the finance risk register and Corporate Risk Register will be through the Risk Management and Governance Group)

4.5 Business Case consideration and Capital Programme management

- To perform a preliminary review of proposed major investments.

- To establish the overall controls which govern business case investments, using Monitor's guidance on Risk Evaluation for Investment Decisions, and to approve the Trust's Business Case Procedure.In accordance with the Business Case Procedure (ref FPP/B1) and Scheme of Delegation rigorously review and approve business cases. (see section 5.2 below)

- To ensure that robust processes are followed, evaluating, scrutinising and monitoring investments so that benefits realisation can be confirmed.

- To ensure testing of all relevant options for larger business cases prior to detailed workup

- To focus on financial metrics within cases e.g. payback periods, rate of return etc.

- To oversee the development and management of the rolling capital programme including scrutiny of the prioritisation process, forecasting and remedial action, and report to the Board accordingly.

4.7 Other Matters

- To examine the fitness for purpose of the finance function compared to the scale of the financial challenge.

- To consider ad hoc financial issues that arise (e.g. Private Patient Cap, estate revaluation etc.)

- To develop the Trust's Treasury Policy in line with Monitor's guidance on Managing Operating Cash. To scrutinise arrangements for a working capital facility and other long terms loans if required, and investment of surplus cash.

- To periodically consider changes required to Trust Standing Financial Instructions due to structural change within the Trust, developments in the Monitor regime and the wider statutory/regulatory framework.

- To oversee arrangements for outsourced financial functions and shared financial services.

- To consider such other matters and take such other decisions of a generally financial nature as the Board shall delegate to it.

5. DELEGATED AUTHORITY

5.1 The Board delegates the above functions to the committee. The Board also delegates decisions not of a significant nature. In practice what is significant will depend on the judgement of members but committees must refer the following types of issue to the full Board.
Any matter which will:

- Change the strategic direction of the Trust.
- Conflict with statutory obligations.
- Contravene national policy decisions or governmental directives.
- Have significant revenue, capital or cash implications.
- Have significant governance implications.
- Be likely to arouse significant public or media interest.

The Committee will be expected to take decisions in its areas of expertise unless there are wider implications for the Trust, requiring the matter to be referred to the full Board.

5.2 The Board delegates to the Committee the specific function of reviewing and approving business cases for capital and revenue investment falling within the following three categories:

- Self-funding business cases with a cost impact over 5 years of more than £2.5m and less than £5m.
- Non-self-funding business cases requiring up to £2.5m revenue funding over a five year period
- Business cases requiring capital investment of more than £1m and less than £2.5m

Under the Trust's Reservation of Powers section 17.1, the Board of Directors must ratify proposals involving the acquisition, disposal, or change of use of land and buildings. Disposal of protected property requires Monitor approval.

Where the disposal of land or buildings has been approved in principle by the Board (and by Monitor if protected property in involved) and a market value has been obtained, the Committee is required, under section 10 of the Trust's Scheme of Delegation, to provide to the executive members of the Committee a permitted range and/or percentage deviation from market value that may be accepted from a prospective purchaser without further recourse to the Committee.

5.3 The Committee is authorised to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary. Legal advice should normally be arranged through the Trust Secretary.

6. WORKING GROUPS

6.1 A committee may set up permanent groups or time limited working groups to deal with specific issues. Precise terms of reference for these shall be determined by the committee. However, Board committees are not entitled to further delegate their powers to other bodies, unless expressly authorised by the Board (Standing Order 5.5 refers).

7. FREQUENCY OF MEETINGS

7.1 Meetings of the Committee shall generally be held monthly in advance of the main Board meeting. At the discretion of the Chair, other meetings may be held to fulfil its main functions.

8. SERVICING ARRANGEMENTS

8.1 A member of the Board Secretariat shall attend meetings and take minutes. Agendas and papers shall be distributed in accordance with deadlines agreed with the Committee Chair. Minutes shall normally be made available at the following month's Board meeting.

9. REPORTING ARRANGEMENTS

9.1 The Committee shall report in writing to the Board the basis for its recommendations, if required, in addition to submitting its minutes. Owing to the proximity of meetings, the Committee Chair will also provide a verbal update to the Board at each meeting.

10. CONFIDENTIALITY

10.1 All minutes of the Committee are deemed confidential, and not for publication. Confidential minutes shall be maintained, where necessary, for considerations of confidentiality, including commercial confidentiality. Matters specifically agreed to be confidential by the committee must be treated as entirely confidential. They must be minuted and reported to the Board separately. In addition, all committee business must be kept confidential until reported to the Board or otherwise concluded, unless the committee agrees otherwise.

10.2 Summary notes will be produced for public Board meetings.

11. GENERAL MATTERS

11.1 Reference should be made, as appropriate to the Standing Orders and Standing Financial Instructions and Scheme of Delegation of the Trust.

11.2 Terms of Reference shall be reviewed at least annually. Any proposed changes to these terms of reference will need to be approved by the Board.

12. JOINT COMMITTEES

12.1 The Committee shall meet annually in May, jointly with the Integrated Audit and Governance Committee (IAGC) for the purpose of reviewing the annual report and accounts, and annual plan, prior to formal approval by the Board of Directors.

12.2 Other joint meetings with the IAGC shall be held from time to time (usually twice a year) as agreed between the Chair of the FIC, the Chair of the IAGC, Trust Chairman, Trust Chief Executive and Executive Directors, for the purpose of reviewing Divisional performance and for such other matters as may be agreed by both Committees within their respective Terms of Reference.

12.3 Meetings shall be chaired jointly unless otherwise agreed by the Chairs of both committees.

12.4 All members of the FIC and IAGC shall be members of the Joint Committee. Attendance by others will be by invitation but will normally include the Deputy Finance Director and Deputy Director of Risk and Governance.

12.5 A quorum shall comprise Chairs of both IAGC and FIC, the Director of Finance and Performance Management and the Chief Nurse/Director of Quality and Operations.

12.6 In all other regards the Joint Committee will operate and be administered in the same manner as set out in each Committee's individual Terms of Reference.

End

Approved at April 2013 Board Meeting

TERMS OF REFERENCE
CLINICAL ADVISORY BOARD

1. CONSTITUTION

1.1. The Clinical Advisory Board (CAB) is constituted by the Management Board as the senior clinical effectiveness board of the Trust to improve patient safety and quality of care.

2. PURPOSE

2.1. CAB will provide clinical advice to the Management Board / Quality Committee about changes to service configuration to ensure clinical effectiveness and patient safety is maintained.

2.2. CAB will approve all Trust-wide clinical policies in line with the Policy for the Development and Management of Organisation Wide Policies and other Procedural Documents.

2.3. CAB will bring together a multi-disciplinary, senior management team of clinicians and managers to provide management oversight and support to scope, plan and deliver a transformational programme of work focused on delivering the Trust's long-term clinical strategy. The key priorities underpinning this work will include;

- improving patient safety;
- supporting care closer to home,
- where appropriate preventing admission to hospital;
- reducing length of stay and readmission rates;
- providing efficient, effective, clinically and financially sustainable services for the next 5 to 10 years, and
- where appropriate, working closely with Primary Care to improve patient pathways, particularly in long-term conditions.

3. OBJECTIVES

PART A:

3.1. Ensure the effective management and delivery of safe, efficient and timely services along with patient access and financial targets within a Clinical Governance framework that ensures safety of existing clinical services.

3.2. To ensure that planned service changes are reviewed effectively to minimise clinical risk, maximise patient benefits and work towards achieving the Trust's strategic direction for services.

3.3. Promote the improvement of quality healthcare by ensuring that National Institute and Clinical Excellence Technical Appraisals are implemented on time and that NICE guidance is considered and where appropriate implemented within the Trust.

3.4. Provide recommendations to Management Board in relation to modernising services in keeping with the Clinical Governance framework which lead to improvement of clinical systems, patient safety and experience.

3.5. Review and develop matters of clinical policy that affects the operation the Trust and to make appropriate recommendations to the Management Board.

3.6. To promote the leadership of the organisation through the Divisions and initiate the Team Briefing system within respective Divisions.

3.7. To promote an ethos of performance management throughout the Trust and work with our health care partners in the Community, other agencies and through the patient partnership forums.

PART B:

3.8. Co-ordinate the strategic direction for the clinical pathways within its scope, and will be responsible for helping reduce and alleviate any barriers across the whole health and social care system (see appendix 1 for detail).

3.9. Ensure that, at a pathway level, the impact on other pathways cross division or pan-organisation will be identified and assessed. The expectation is that this approach will facilitate the development of a fully integrated Trust-wide, longer-term clinical strategy that will be implemented over the coming 5 years.

3.10. Hold the work streams to account for delivery of their objectives but will also facilitate the required support for delivery from financial, information, prioritisation of capital and communication perspectives.

3.11. Oversee the implementation of other proposed strategic initiatives such as:

- Reduction in follow-up appointments;
- Review of non-profit making, non-mandatory services;
- Cold Orthopaedic centre;
- Location of primary care services on acute hospital sites;
- Health & Social Care Village;
- Improved internal waits and delayed transfer of care;
- Teaching Nursing homes; and
- Private patient strategic plans.

4. MEMBERSHIP AND ATTENDANCE

PART A AND B MEETING MEMBERSHIP

Members

Medical Director (Chair – Part A)
Director of Strategic Development and Capital Planning (Chair Part B)
Chief Nurse and Director of Quality
Interim Director of Operations
Director of HR and Corporate Affairs
Divisional Medical Director – Specialist Services

Divisional Medical Director – Clinical Support
Divisional Medical Director – Surgical Services
Divisional Medical Director – Urgent Care and Long-term Services
Divisional Head of Nursing – Specialist Services
Divisional Head of Nursing – Surgical Services
Divisional Head of Nursing – Urgent Care and Long-term Services
Divisional Head of Nursing – Clinical Support Services
Chief Executive
Divisional Director – Clinical Support
Divisional Director – Specialist Services
Divisional Director – Surgical Services
Divisional Director – Urgent Care and Long-term Services
Director of Finance, Performance & Information
Director of Strategy and Business Development
Associate Medical Director – Patient Safety
Associate Medical Director – Primary Care
Director of Pharmacy
Director of Laboratory Medicine
Head of Therapies
Director of Infection Prevention and Control
Director of Medical Education
Clinical Director of Information Technology

PART A ADDITIONAL MEMBERSHIP

Members

Deputy Chief Nurse
Associate Medical Director – IT
Director of Research and Development
Chair of Medical Staff Committee or deputy
Deputy Director of Risk, Governance and Patient Safety
Trust Secretary

PART B ADDITIONAL MEMBERSHIP

Members

Director of Information
Director of Communications;
Senior Strategic Development Programme Manager
Director of Estates and Facilities

Attendees

CCG / GP Representative

Quorum

4.1. The intention is to reach decisions through consensus and once decisions are taken, to sustain a 'corporate position'. However, should it be necessary to vote on issues, at least 6 clinical members which must include two Divisional Medical Directors (or their deputies), two Divisional Directors' plus the Chair or Chief Executive.

4.2. If any member disagrees with the decision then their concerns should be raised at the meeting and noted within the minutes.

Attendance by Members'

4.3. The Chair or the nominated deputy of the Committee will be expected to attend 100% of the meetings. Other Committee members will be required to attend a minimum of 75% of all meetings and be allowed to send a Deputy to one meeting per annum.

Attendance by Officers'

4.4. Other staff may be co-opted to attend meetings as considered appropriate by the Committee on an ad-hoc basis.

5. FREQUENCY

5.1. The Board shall meet monthly. The Chair may call additional meetings to ensure business is undertaken in a timely way.

6. AUTHORITY

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

6.2. The Committee has decision making powers with regard to the approval of clinical policies.

6.3. The Committee is authorised to create sub-groups or working groups, as are necessary to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers (unless expressly authorised by the Board) and remains accountable for the work of any such group.

6.4. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary or advantageous to its work.

7. SERVICING ARRANGEMENTS

7.1. The Group will be serviced by the Committee Secretary.

7.2. Papers will be sent prior to meetings and members will be encouraged to comment via correspondence between meetings as appropriate.

8. ACCOUNTABILITY AND REPORTING

8.1. The Board is accountable to the Management Board.

8.2. Minutes will be reported to the Management Board once they have been approved by the Chair along with exception reports as agreed by the membership of this Board.

8.3. Appendix B details sub-committees and frequency of reporting.

9. MONITORING EFFECTIVENESS AND REVIEW

9.1. The Board will provide an annual report outlining the activities it has undertaken throughout the year along with a review of its Terms of Reference.

9.2. A survey will be undertaken by the members on an annual basis to ensure that the terms of reference are being met and where they are not either; consideration and agreement to change the terms of reference is made or an action plan is put in place to ensure the terms of reference are met.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

QUALITY ASSURANCE BOARD

TERMS OF REFERENCE

1. PURPOSE OF THE GROUP

1.1. The Quality Assurance Board (QAB) is accountable to the Management Board (MB), and has responsibility for the risk management process, corporate and clinical governance, and for identifying any significant gaps in internal control. It is responsible for co-ordinating and prioritising risk management issues organisation-wide and ensuring that:

1.1.1 there are robust risk management, clinical and quality strategies in place to enable the Trust to demonstrate continuous improvement in patient care and a reduction in risks to patients, staff, and visitors;
1.1.2 the management and mitigation of financial, clinical and non-clinical risk is integrated through the Corporate Risk Register and Board Assurance Framework (BAF);
1.1.3 the Corporate Risk Register and re-evaluation of the risks to achieving strategic and annual objectives are regularly reviewed and amended and the links to the BAF are clear and embedded
1.1.4 there is clear devolution of responsibility and clear accountability for risk assessment and management within governance structures at corporate and divisional levels;
1.1.5 key risks are identified through a standardised risk assessment tool;
1.1.6 there is a single integrated incident reporting system for clinical and non-clinical incidents;
1.1.7 the Trust meets the inspection and monitoring requirements of the Care Quality Commission and other external compliance assessments
1.1.8 Review the clinical negligence claims profile of the Trust and promulgate lessons learned from the internal closed claim review process and from those published by the NHS Litigation Authority.
1.1.9 responsibility for specific clinical aspects of risk and the patient safety programme will be managed via the Clinical Advisory Board and the Patient Safety Board respectively.

1.2. The Group will submit relevant reports to MB, and will report directly to Quality Committee (QC) and the Integrated Audit and Governance Committee (IAGC), the overarching Board Committee with responsibility for risk. Agreed items will be reported to the full Trust Board.

1.3. See Appendix 1 for details of organisational arrangements.

2. OBJECTIVES AND DUTIES

2.1. The overarching objective for the QAB is to ensure that the Trust has the necessary systems, structures, processes and monitoring in place to provide first class clinical care, the highest level of corporate governance, and excellent risk management processes. It will approve appropriate policies, and receive reports across the range of its remit.

2.2. Corporate Governance

2.2.1 To oversee the Trust's corporate governance systems and procedures and ensure that the Trust is adhering to the highest standards of good practice in the conduct of its business. This will include ensuring that:

2.2.1.1. the Trust meets the requirements of the Regulator's Risk Assessment Framework, adheres to its constitution, and maintains its membership profile;
2.2.1.2. there is a process to support the preparation of the annual Governance Statement for IAGC approval, and to implement the actions set contained therein;
2.2.1.3. reports on legal claims against the Trust are received in accordance with an agreed schedule, and provided at least annually to the Board;
2.2.1.4. annual reports are received on the Trust's insurance arrangements;
2.2.1.5. regular reports are received on business continuity and emergency planning risks affecting the Trust.

2.3. Risk Management

2.3.1 To oversee the Trust's Risk Management programme, ensuring that there is an effective strategy to safeguard the Trust's business and assets, and patients, staff and visitors from personal harm. This includes:

2.3.1.1. approving the annual update of the risk management strategy and receiving progress reports on the Trust's integrated risk management programme,
2.3.1.2. receiving a regular update of the Trust's Corporate Risk Register and providing assurance to the IAGC and the Board that risks are managed appropriately;
2.3.1.3. receiving divisional and service reports on their risk management strategies and risk registers
2.3.1.4. receiving regular aggregated reports on incidents (including SI's), complaints and claims, together with details of incident investigation, lessons learned and the corrective action taken;
2.3.1.5. monitoring the Trust's compliance with its Health and Safety obligations and other statutory requirements in relation to clinical and non-clinical risk;
2.3.1.6. monitoring reporting to external agencies and the implementation of guidance received;
2.3.1.7. monitoring actions and ensuring learning from external visits;
2.3.1.8. receiving assurance on the recommendations made from internal and external audit;
2.3.1.9. Review compliance against the Friends and Family test and Net Promoter Score.

2.4. Clinical Governance

2.4.1 To oversee the Trust's Clinical Governance programme, ensuring that there is an effective quality strategy to deliver high quality clinical care, which is achieved, and adequately monitored as part of the Shared Purpose Framework. This will include

2.4.1.1. inspection and monitoring requirements of the Care Quality Commission, including the grading for specific services provided and lessons learned from the internal closed claim review process and from the NHS Litigation Authority.
2.4.1.2. receiving exception reports from Divisions on a rolling basis. Divisions will also be held to account at their quarterly Executive Performance Reviews.

2.5. Information Governance

2.5.1 To oversee the Trust's work programme to review, improve, and audit progress with the Information Governance Toolkit, through exception reports. This will include:

2.5.1.1. approving the Information Governance Work Programme;
2.5.1.2. receiving exception reports on progress against the plan;
2.5.1.3. approving the Information Governance Toolkit self assessment scores prior to submission to IAGC, the Trust Board and the Department of Health;
2.5.1.4. monitoring information governance security, SIs relating to information governance, and requests under the Freedom of Information Act 2000.

3. DELEGATED AUTHORITY

3.1. The Group will have delegated authority from the MB to act within the remits of its individual members. Significant issues affecting of a Trust wide nature will be referred to MB or IAGC for approval.

4. MEMBERSHIP AND ATTENDANCE

4.1. Core Membership

- **Chair:** Chief Nurse and Director Quality and Operations
- Chief Executive
- Director of Finance or representative
- Director of HR and Corporate Services or representative
- Director of Strategic Development and Capital Planning or representative
- Deputy Chief Nurse and Head of Quality
- Deputy Director of Risk, Quality and Patient Safety
- Head of Patient Safety and Clinical Risk Management
- Trust Secretary
- Senior divisional management representation (Divisional Director or Divisional Head of Nursing)
  - Urgent Care and Long-term Conditions
  - Surgical Services
  - Specialist Services
  - Clinical Support
- Head of Midwifery and Gynaecological Nursing
- Health and Safety/non-clinical Risk Manager
- Public/Patient representative
- Emergency Planning and Business Continuity Manager
- Clinical Risk Manager

4.2. Others who may be invited to attend include:-
- Departmental Heads of Service – as required

4.3. Members must attend nine of the 12 meetings annually. If members are unable to be present, they must nominate a deputy to attend in their place, and their attendance will be recorded in the minutes. The meeting will be considered quorate when 50 per cent of the membership is present.

4.4. Divisional managers, divisional risk management and divisional patient safety leads will be asked to attend on a rolling programme.

4.5. Other staff may be co-opted to attend meetings as considered appropriate by the Group.

5. SUB-COMMITTEES

5.1. Appendix 2 details a list of Sub-Committees reporting to the QAB and frequency of reporting.

5.2. The list may be expanded to include other groups as appropriate, or when established, for example in the area of business continuity and resilience.

5.3. The Group may set up permanent groups or time limited working groups to deal with specific issues and report back to it, and will determine their terms of reference.

6. MEETINGS

6.1. The Group shall meet monthly.

6.2. A meeting is considered quorate when 50 per cent of Group members are present.

6.3. Minutes of the meeting will be cleared by the Group Chair and shared with contributors. Papers will be received by the Chair two weeks before each meeting. Papers will be disseminated to Group members approximately five working days before every meeting.

7. SERVICING ARRANGEMENTS

7.1. Papers will be sent prior to meetings and members will be encouraged to comment via correspondence between meetings as appropriate. The Group will be serviced by the Corporate Secretariat.

7.2. Papers will be sent prior to meetings and members will be encouraged to comment via correspondence between meetings as appropriate.

8. REPORTING ARRANGEMENTS

The Group is accountable to the MB. Minutes will be reported to the MB. Reporting to the QC and IAGC will be via the MB minutes.

9. CONFIDENTIALITY

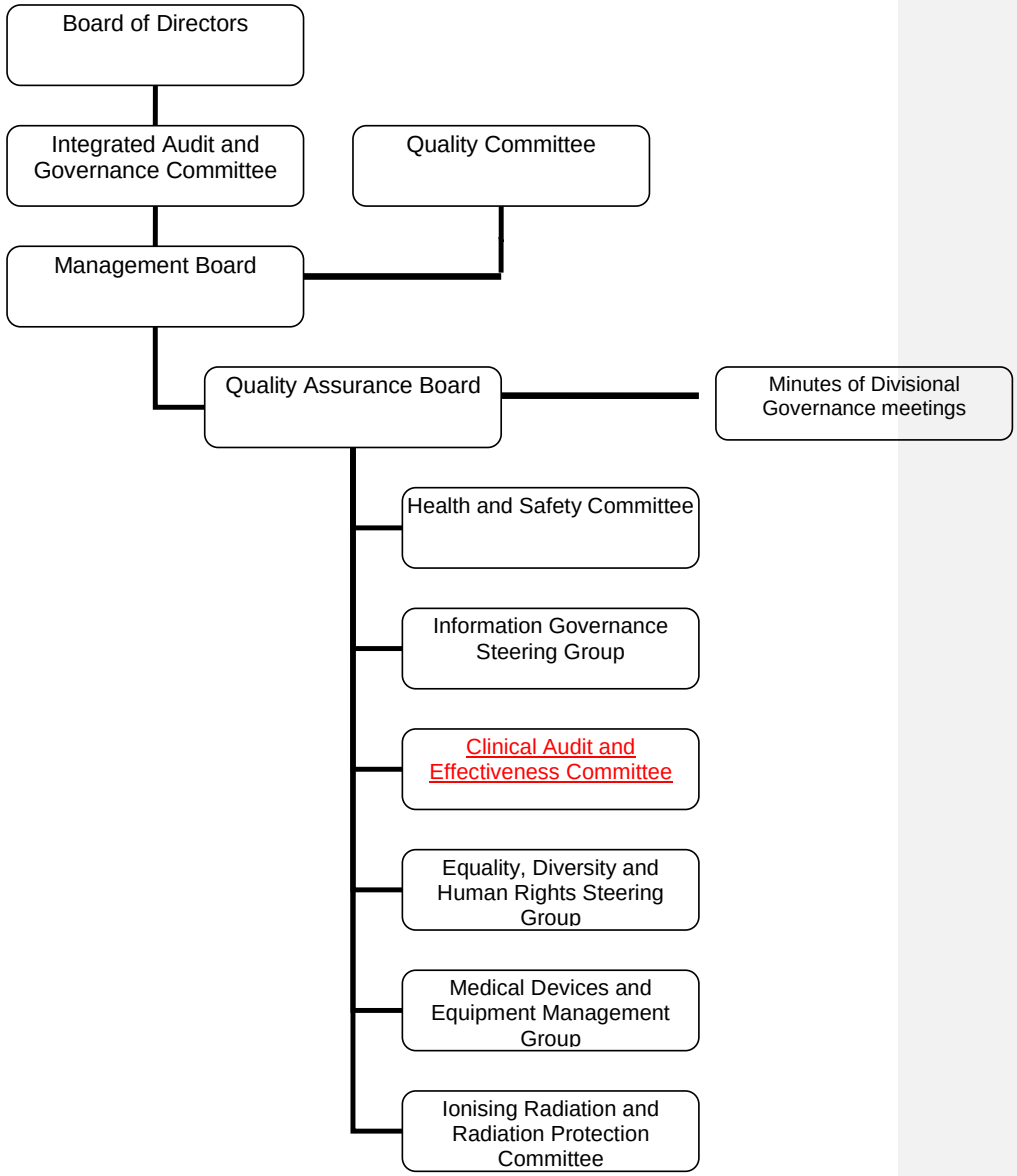
9.1. The minutes of the Board, unless deemed confidential, will be available publicly. Confidential minutes will be maintained, where necessary, for staff or patient or other necessary consideration of confidentiality.

10. MONITORING AND REVIEW ARRANGEMENTS

10.1. Minutes of the QAB will be presented to MB for monitoring purposes.
10.2. Minutes and exception reports will be presented to each MB. Reporting to the QC and IAGC will be via MB minutes.

10.3. A work plan for QAB is held by the Corporate Secretariat and is monitored to ensure reporting requirements are in line with these terms of reference.

Appendix 1 – Quality Assurance Board governance / reporting arrangements



APPENDIX 2 – REPORTING COMMITTEES

The following Committees will report to the Quality Assurance Board:

COMMITTEE NAME	TYPE OF REPORTING	FREQUENCY
Surgical Division: Governance Board	• Minutes • Report Front Sheet to be used for each meeting to report by exception	Monthly
UCLTC Division: Governance Board	• Minutes • Report Front Sheet to be used for each meeting to report by exception	Monthly
Specialist Services Division: Governance Board	• Minutes • Report Front Sheet to be used for each meeting to report by exception	Monthly
Clinical Support Services Division: Governance Board	• Minutes • Report Front Sheet to be used for each meeting to report by exception	Monthly
Standards Monitoring Group	• Minutes • Report Front Sheet to be used for each meeting to report by exception	Quarterly
Information Governance Steering Group	• Minutes • Report Front Sheet to be used for each meeting to report by exception • Toolkit Assessment: Annual • Toolkit Assessment: Mid Year Review	Quarterly Toolkit Assessment aligned to IAGC reporting
Equality, Diversity and Human Rights Steering Group	• Minutes (if available) • Report Front Sheet to be used for each meeting to report by exception • Annual Equality and Diversity Report	Quarterly Align Annual report to Board Reporting
Strategic Health and Safety Committee	• Minutes (if available) • Report Front Sheet to be used for each meeting to report by exception	Quarterly
Trust Radiation Advisory Committee	• Minutes • Report Front Sheet to be used for each meeting to report by exception	Quarterly

Clinical Audit and Effectiveness Committee	• Minutes • Report Front Sheet to be used for each meeting to report by exception	Six Monthly (aligned to QC Reporting)

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

RISK MANAGEMENT AND GOVERNANCE GROUP

TERMS OF REFERENCE

1.PURPOSE OF THE GROUP

1.1.The Risk Management and Governance Group (RMGG) is accountable to the Corporate Performance Management Team (CMPT), and has responsibility for the risk management process, corporate and clinical governance, and for identifying any significant gaps in internal control. It is responsible for co-ordinating and prioritising risk management issues organisation-wide and ensuring that:

1.1.1there are robust corporate and clinical governance and risk management strategies in place to facilitate continuous improvement in patient care and a reduction in risks to patients, staff, and visitors

1.1.2the management and mitigation of financial, clinical and non-clinical risk is integrated through the Corporate Risk Register and Board Assurance Framework (BAF)

1.1.3the Corporate Risk Register and re-evaluation of the risks to achieving strategic and annual objectives are regularly reviewed and amended and the links to the BAF are clear and embedded

1.1.4there is clear devolution of responsibility and clear accountability for risk assessment and management within line management structures

1.1.5key risks are identified through a standardised risk assessment tool

1.1.6there is a single integrated incident reporting system for clinical and non-clinical incidents

1.1.7the Trust meets the requirements of the Care Quality Commission Essential Standards for Quality and Safety and the NHS Litigation Authority risk management standards for general and maternity services. Operational management of these external compliances will be devolved to the Standards Monitoring Group (SMG), where there is a clear line of accountability to the RMGG.

1.1.8Responsibility for specific clinical aspects of risk and the patient safety programme will be managed via the Clinical Management Board and the Patient Safety Board respectively.

1.2.The Group will submit reports to CMPT, and will report directly to the Integrated Audit and Governance Committee (IAGC), the overarching Board Committee with responsibility for risk. Agreed items will be reported to the full Trust Board.

1.3.See Appendix 1 for details of organisational arrangements.

2.OBJECTIVES AND DUTIES

2.1.The overarching objective for the RMGG is to ensure that the Trust has the necessary systems and structures in place to provide first class clinical care, the highest level of corporate governance, and excellent risk management processes. It will approve appropriate policies, and receive reports across the range of its remit.

2.2.Corporate Governance

2.2.1To oversee the Trust's corporate governance systems and procedures and ensure that the Trust is adhering to the highest standards of good practice in the conduct of its business. This will include ensuring that:

2.2.1.1.the Trust meets the requirements of the Regulator's compliance framework, adheres to its constitution, and maintains its membership profile
2.2.1.2.the Board Assurance Framework is regularly updated and submitted to the IAGC Committee and to the Board in accordance with an agreed schedule
2.2.1.3.there is a process to prepare the annual Statement on Internal Control for IAGC approval, and to implement the actions set contained therein
2.2.1.4.reports on legal claims against the Trust are received in accordance with an agreed schedule, and provided at least annually to the Board
2.2.1.5.annual reports are received on the Trust's insurance arrangements
2.2.1.6.regular reports are received on business continuity and emergency planning risks affecting the Trust.

2.3.Risk Management

2.3.1To oversee the Trust's Risk Management programme, ensuring that there is an effective strategy to safeguard the Trust's business and assets, and patients, staff and visitors from personal harm. This will include:

2.3.1.1.approving the annual update of the risk management strategy and receiving progress reports on the Trust's integrated risk management programme, including progress with achieving the NHS Litigation Authority standards of risk management for general and maternity services through the SMG
2.3.1.2.receiving a regular update of the Trust's Corporate Risk Register and providing assurance to the IAGC and the Board that risks are managed
2.3.1.3.receiving divisional and service reports on their risk management strategies and risk registers
2.3.1.4.receiving regular aggregated reports on incidents (including SI's), complaints and claims, together with details of incident investigation, lessons learned and the corrective action taken
2.3.1.5.monitoring the Trust's compliance with its Health and Safety obligations and other statutory requirements in relation to clinical and non-clinical risk
2.3.1.6.monitoring reporting to external agencies and the implementation of guidance received
2.3.1.7.monitoring actions and ensuring learning from external visits
2.3.1.8.receiving assurance on the recommendations made from internal and external audit.

2.4.Clinical Governance

2.4.1To oversee the Trust's Clinical Governance programme, ensuring that there is an effective strategy to deliver high quality clinical care, which is achieved, and adequately monitored. This will include

2.4.1.1.the Trust meets the requirements of the Care Quality Commission's Essential Standards for Quality and Safety, and that the risks associated with

maintaining. Registration without conditions is maintained for all Trust sites and for all core services

2.4.1.2.the Trust meets the NHS Litigation Authority risk management standards for general and maternity services

2.4.1.3.receiving exception reports from Divisions on a rolling basis. Divisions will also be held to account at their quarterly Executive Performance Reviews.

2.5.Information Governance

2.5.1To oversee the Trust's work programme to review, improve, and audit progress with the Information Governance Toolkit, through exception reports. This will include

2.5.1.1.approving the Information Governance Work Programme
2.5.1.2.receiving exception reports on progress against the plan
2.5.1.3.approving the Information Governance Toolkit self assessment scores prior to submission to IAGC, the Trust Board and the Department of Health
2.5.1.4.monitoring information governance security, SIs relating to information governance, and requests under the Freedom of Information Act 2000.

3.DELEGATED AUTHORITY

3.1.The Group will have delegated authority from the CPMT to act within the remits of its individual members. Significant issues affecting of a Trust wide nature will be referred to CPMT/CEG or IAGC for approval.

4.MEMBERSHIP AND ATTENDANCE

4.1.Core Membership

- **Chair:** Chief Nurse and Director Quality and Operations
- Chief Executive
- Director of Finance or representative
- Director of HR and Corporate Services or representative
- Director of Strategic Development and Capital Planning or representative
- Deputy Chief Nurse and Head of Quality
- Deputy Director of Risk, Quality and Patient Safety
- Head of Patient Safety and Clinical Risk Management
- Senior divisional management representation (Divisional Director or Divisional Head of Nursing)
  - Urgent Care and Long-term Conditions
  - Surgical Services
  - Specialist Services
  - Clinical Support
- Head of Midwifery and Gynaecology Nursing
- Health and Safety/non-clinical Risk Manager
- Public/Patient representative
- Emergency Planning and Business Continuity Manager
- Clinical Incident Manager

4.2.Others who may be invited to attend include:
- Commissioners/CCG representative – all meetings
- Operational Management representative – as required

4.3.Members must attend nine of the 12 meetings annually. If members are unable to be present, they must nominate a deputy to attend in their place, and their attendance will

be recorded in the minutes. The meeting will be considered quorate when 50 per cent of the membership is present.

4.4.Divisional managers, divisional risk management and divisional patient safety leads will be asked to attend on a rolling programme.

4.5.Other staff may be co-opted to attend meetings as considered appropriate by the Group.

5.WORKING GROUPS

5.1.The Risk Management and Governance Group will be supported by committees/ working groups to advise on risk areas, and receive their work programme reports. These will include the following

- Standards Monitoring Group (Monthly)
- Information Governance Steering Group, including Freedom of Information (Quarterly)
- Equality Diversity and Human Rights Steering Group (Annual)
- Trust overarching Health and Safety Committee (Monthly)
- Divisional governance and risk groups (Monthly)
- Clinical Audit and Effectiveness Committee (Six Monthly) (Also reports to the Clinical Management Board)

5.2.The list may be expanded to include other groups as appropriate, or when established, for example in the area of business continuity and resilience.

5.3.The Group may set up permanent groups or time limited working groups to deal with specific issues and report back to it, and will determine their terms of reference.

6.MEETINGS

6.1.The Group shall meet monthly.

6.2.A meeting will be considered quorate when 50 per cent of Group members are present.

6.3.Minutes of the meeting will be cleared by the Group Chair and shared with contributors. Papers will be received by the Chair two weeks before each meeting. Papers will be disseminated to Group members five working days before every meeting.

7.SERVICING ARRANGEMENTS

7.1.Papers will be sent prior to meetings and members will be encouraged to comment via correspondence between meetings as appropriate. The Group will be serviced by the Committee Secretary.

7.2.Papers will be sent prior to meetings and members will be encouraged to comment via correspondence between meetings as appropriate.

8.REPORTING ARRANGEMENTS

8.1.The Group is accountable to the CPMT. Minutes will be reported to CPMT and IAGC. IAGC will also receive exception reports accompanying minutes. The IAGC Chair will report significant issues to the Board of Directors via a Chair's summary.

9.CONFIDENTIALITY

9.1.The minutes of the Group, unless deemed confidential, will be available publicly. Confidential minutes will be maintained, where necessary, for staff or patient or other necessary consideration of confidentiality.

10. MONITORING AND REVIEW ARRANGEMENTS

10.1.Minutes of the RMGG will be presented to CPMT for monitoring purposes.
10.2.Minutes and exception reports will be presented to each Integrated Audit and Governance Committee (IAGC) for review. The Chair of the IAGC will report any significant issues to the Board of Directors via a Chair's summary.
10.3.A work plan for RMGG is held by the Corporate Secretariat and is monitored to ensure reporting requirements are in line with these terms of reference.

Approved August 2012

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

TERMS OF REFERENCE OF THE HEALTH AND SAFETY COMMITTEES

1. Constitution

1.1. The East Kent Hospitals University NHS Foundation Trust hereby resolves to establish:

1.1.1. A Strategic Health and Safety Committee.
1.1.2. Site based Health and Safety Committees.
1.1.3. Site based Health and Safety Link Persons meetings

2. Remit

2.1. All NHS Trusts are required to establish a Health and Safety Committee in accordance with the requirements of:

2.1.1. Section 2 (7) of the Health and Safety at Work Act 1974.
2.1.2. Regulation 9(1) of the Safety Representatives and Safety Committees Regulations 1977.
2.1.3. Regulation 5© of the Health and Safety (Consultation with Employees) Regulations 1996.

3. Accountability

3.1. The Strategic Health and Safety Committee will report to the Risk Management and Governance Group.

3.2. The site based Health and safety Committees will report to the Strategic Health and Safety Committee.

3.3. The site based Health and Safety Link Persons Committee will be representative of the Trust's key stakeholders, including a staff side representative and one representative of the Trade Unions. Two members of staff will also be included as part of the membership as site based teams develop.

4. Membership

4.1. The membership of the Strategic Health and safety Committee will be representative of the trust's key stakeholders including a staff side representative and one representative of the

Trade Unions. Two staff members will also be included as part of the membership as site based teams develop.

4.2. **Strategic Health and Safety Committee**

4.2.1. Director of Strategic Development
4.2.2. Deputy Director of Estates and Facilities
4.2.3. Senior Health and Safety Advisor
4.2.4. Occupational Health representative
4.2.5. Human Resource representative
4.2.6. Nominated Health and Safety Representatives from recognised trade unions
4.2.7. Staff side representative
4.2.8. Infection Control representative
4.2.9. Deputy Director of Risk, Governance and Patient Safety
4.2.10. Head of Radiation Protection
4.2.11. Emergency Planning and Business Continuity Manager
4.2.12. Hospital Manager(s)

4.3. **Site based Health and Safety Committee**
The membership of the site based H&S committee will be representative of the Divisional structure, plus site based H&S representatives of all Trade Unions

4.3.1. Hospital Manager
4.3.2. Health and Safety Manager/Officer
4.3.3. Divisional representatives of the Trust with sufficient status to enable them to implement actions requested or required by the committee
~~4.3.3.~~4.3.4. Occupation Health representative
~~4.3.4.~~4.3.5. Manual Handling Advisor
~~4.3.5.~~4.3.6. Infection control advisor
~~4.3.6.~~4.3.7. Health and Safety representative from recognised trade unions
~~4.3.7.~~4.3.8. Estates Manager or representative.

4.4. The chair and vice chair will be appointed on an annual basis.

4.5. Additional members with specific expertise may be co-opted to the Health and Safety committees as required.

5. Authority

5.1. **The Strategic Health and Safety Committee**

5.1.1. The Strategic Health and Safety Committee is authorised by the Risk Management and Governance Group to carry out any activity within its terms of reference. It is authorised to seek clarification and further investigation of any health and safety matter and to request any relevant information from employees.
5.1.2. The Strategic Health and Safety Committee is authorised by the Risk Management and Governance Group to obtain outside or other independent professional advice

5.2. **Site based Health and Safety Committees**

5.2.1. Site based Health and Safety Committee is authorised by the Strategic Health and Safety Committee to carry out any activity within its terms of reference. It is

authorised to seek clarification and further investigation of any health and safety matter and to request any relevant information from employees within the base site.

6. Duties

6.1. The Strategic Health and Safety Committee

6.1.1. To identify a strategy designed to improve the overall H&S focus within EKHUFT
6.1.2. To keep under review the Trusts legal obligations with regard to health and safety statutory requirements by adopting the principles contained in HSG 65 'successful health and safety management' as a management tool for this purpose.
6.1.3. To receive summary reports on health and safety, safety audits, fire, security, incident statistics and trends, health and environmental monitoring, communications from enforcing authorities, site health and safety committees, to make recommendations and to implement any corrective action that is required.
6.1.4. To implement the Trust wide metrics strategy and formally monitor the H&S KPIs.
6.1.5. To submit regular reports to Risk Management and Governance Group which covers health and safety activities within the ~~Trust .~~ Trust.
6.1.6. To monitor the adequacy of health and safety training, make recommendations and initiate action for its continuous improvement.
6.1.7. To monitor the adequacy of health and safety communication and publicity within the organisation, make recommendations and initiate action for any improvements.
6.1.8. To action all changing legislation and to review policies and procedures to enable the Trust to meet all health and safety statutory requirements.
6.1.9. To ensure that all relevant Trust policies remain updated and distributed.
6.1.10. To identify actions and maintain regulations in line with other Trust Committees such as Consumable Users Group / MDMC/ Infection Control.
6.1.11. Submit regular reports to the Strategic Health and Safety Committee in line with monitoring of non-patient slips, trips and falls, Security and violence and aggression.

6.2. Site based Health and Safety Committees

6.2.1. To ensure that all departments/wards have in place;

i. Divisional senior representatives who regularly attend the site based H&S committees and who oversee health and safety within their Divisions and are empowered to implement necessary actions.
ii. Departmental Health and safety risk assessments
iii. Departmental control of substances hazardous to health (COSHH) risk assessments.
iv. Departmental Manual handing risk assessments.
v. Departmental security and violence and aggression risk assessments.
vi. Departmental risk registers
vii. Departmental fire evacuation plans.
viii. Departmental Health and Safety communications notice boards.
ix. Departmental local security plans.

6.2.2. Ensure that the Trust reporting (Datix) and investigation procedure for incidents is adhered to.
6.2.3. Ensure monitoring of local site trends of incidents, dangerous occurrences and notifiable diseases, so that recommendations may be made to the relevant services for corrective action to be taken.

6.2.4. Receive a site based report on safety related issues from the; Health and Safety advisor, Occupation Health, Infection Control and Manual Handling Advisor and take action on any recommendation made.
6.2.5. To submit a copy of the site health and safety committee minutes to the Strategic Health and Safety Committee
6.2.6. To monitor and provide evidence of the adequacy of health and safety communication and publicity (site based), make recommendations and initiate action for any improvements.
6.2.7. To provide a forum to enable employees to communicate to management any health and safety related issues through the named representative for their Division.
6.2.8. To provide evidence to the Strategic Health and Safety Committee that representation has been made by each Division at all site Health and Safety Committee meetings.

6.3. **Site based Heath and safety Link Persons Liaison meetings**

6.3.1. To support actions from Site based Health and Safety Committees and the Strategic Health and Safety Committee.
6.3.2. To distribute news and allow consultation on any proposed changes relating to health and safety, fire and security.
6.3.3. To ensure that all Health and Safety Link Persons are made aware of the Trusts control measures and requirements regarding health and safety, fire and security.
6.3.4. To provide toolbox training to all Health and Safety Link Persons.
6.3.5. To provide a forum for Health and Safety Link Persons questions, queries and clarification requests on health and safety, fire and security matters.
6.3.6. To provide feedback to the Site based Health and Safety committees via the Health and Safety manager or Officer on heal and safety, fire and security matters.

7. Frequency of Meetings

7.1. **The Strategic Health and Safety Committee**

7.1.1. Meetings will be held at such intervals as the Chair shall judge necessary to discharge the responsibilities of the Trust Health and Safety Committee, but shall be no less than four times per year.

7.2. **Site based Health and Safety Committees**

7.2.1. Site based Health & Safety Committees will meet monthly.

7.3. **Site based Health and Safety Link Persons Liaison meetings**

7.3.1. Site based Health and Safety Link Persons Liaison meetings will meet quarterly.

8. Date approved

8.1. 16th November 2012

9. Date for review

9.1. These terms of reference will be reviewed after six months by the Strategic Health and Safety Committee and thereafter on an annual basis.

Appendix 10

Equality and Human Rights Impact Analysis

Part One – Screening Tool

Name of the policy, strategy, function or methodology:	Risk Management Strategy

Details of person completing the EHRIA	
Name	Helen Goodwin
Job Title	Deputy Director of Risk, Governance and Patient Safety
Directorate/Department	~~Human Resources & Corporate Affairs~~Clinical Quality & Patient Safety
Telephone Number	01227 864384 Ext. 74423

1. Identify the policy, strategy, function or methodology aims

What are the main aims, purpose and outcomes of the policy, strategy, function or methodology?
Aim: To improve the visibility and consistency of risk management functions across the Trust Objectives: To manage risk proactively and improve existing guidance Outcomes: Accurate completion of the annual Governance statement based on the
Does it relate to our role as a service provider and/or an employer?
The Trust's organisational arrangements for addressing risk management are in keeping with best practice guidance and it is recognised that a systematic approach to assessing and managing risk is essential in order to deliver high quality patient care and the Health & Safety of staff and the public.

2. Assess the likely impact on human rights and equality

Use this table to check if the policy, strategy, function or methodology:

- could have a negative impact on human rights or on any of the equality groups, or
- could have a positive impact on human rights, contribute to promoting equality, equal opportunities or improve relations.

It is not necessary to complete each box, or to mark whether it is positive or negative, although you can do this if you find it helpful.

	Protected Characteristic								
	Race	**Sex**	**Disability**	**Sexual Orientation**	**Religion or belief**	**Age**	**Gender reassignment**	**Marriage & Civil Partnership**	**Pregnancy & Maternity**
Could this policy, procedure, project or service affect this group differently from others? **YES/NO**	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**N**
Could this policy, procedure, project or service promote equal opportunities for this group? **YES/NO**	**N**	**N**	**Y**	**N**	**N**	**N**	**N**	**N**	**N**
Right to life *e.g. decisions about life-saving treatment, deaths through negligence in hospital*	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**N**
Right not to be tortured or treated in an inhuman or degrading way *e.g. dignity in care, abuse or neglect of older people or people with learning disabilities.*	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**N**
Right to respect for private and family life e.g. *respecting lgb relationships, confidentiality*	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**N**
Right to freedom of thought, conscience and religion *e.g. respect for cultural and religious requirements*	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**N**
Right to freedom of expression *e.g. access to appropriate communication aids*	**N**	**N**	**Y**	**N**	**N**	**N**	**N**	**N**	**N**
Right to freedom of assembly and association *e.g., right to representation, to socialise in care settings*	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**N**
Right to education *e.g. access to basic knowledge of hygiene and sanitation*	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**N**
Right to liberty *e.g. informal detention of patients who do not have capacity*	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**N**

3. How does it impact on people's human rights and equality?

Using the table above, explain anticipated impacts. If a full EHRIA is recommended, you can summarise the impacts - it is not necessary to set these out in detail,

Could people's human rights be impacted negatively? Could the policy, strategy, function or methodology result in inequality or discrimination?
This strategy does not impact negatively on the human right's of any individual.
Could this policy, strategy, function or methodology result in positive impacts on people's human rights or equality? Could it present opportunities to promote equality?
Accessible documents produced will allow disabled people to engage in public life by being consulted by the trust more effectively.

4. Recommendations

Is a full EHRIA recommended? If not, give reasons
A full EHRIA is not necessary because areas for improvement have been acted upon.

5. Publication of EHRIA

Give details of where Screening Tool or the full EHRIA will be published and when this will take place	
The EHRIA will be published on the trust website.	
Details of person completing the EHRIA	
Name	Helen Goodwin

Signed …… Date: ……

Approval and sign-off	Name
Head of Department/Director	

Signed …… Date: ……

	Name
Trust Board approval and sign-off	

Signed …… Date: ……

Appendix 11

AUTHOR'S CHECKLIST OF COMPLIANCE WITH THE RISK MANAGEMENT STRATEGY

To be completed and attached to any policy when submitted to the appropriate committee for consideration and approval.

	Requirement:	Compliant Yes/No/ Unsure	Comments
1.	**Style and format**	Yes	Arial font 12 used to aid reading
2.	**An explanation of any terms used in documents developed**	Yes	
3.	**Consultation process**	Yes	
4.	**Ratification process**	Yes	
5.	**Review arrangements**	Yes	
6.	**Control of documents, including archiving arrangements**	Yes	
7.	**Associated documents**	Yes	
8.	**Supporting references**	Yes	
9.	**Relevant NHSLA criterion specific requirements**	Yes	
10.	**Any other requirements of external bodies**	Yes	
11.	**The process for monitoring compliance with NHSLA and any other external and/or internal requirements**	Yes	

Appendix 12

PLAN FOR DISSEMINATION OF POLICIES

To be completed and attached to any policy when submitted to the appropriate committee for consideration and approval.

Acknowledgement: University Hospitals of Leicester NHS Trust (Amended)

Title of document:	Risk Management Strategy		
Version Number:	~~9~~8		
Approval Date:	tbc	**Dissemination lead:**	Deputy Director of Risk, Governance and Patient Safety
Previous document already being used?	Yes		
If yes, in what format (paper / electronic) and where (e.g. Directorate / Trust wide)?	Trust Wide Document on SharePoint		
Proposed instructions regarding previous document:	To be retained for the purposes of audit and monitoring of compliance		

To be disseminated to: **All staff Trust Wide**	**How will it be disseminated, who will do it and when?** **Following ratification**	**Format (i.e. paper or electronic)**	**Comments:**
	~~05/11/2012~~November 2014	Electronic	

Author's Dissemination Record - to be used once document is approved – to be kept with the master document

Date document forwarded to be put on the Trust's central register / in SharePoint:	**tbc**	**Date document put on Divisional register (if appropriate) / on Divisional webpage (if applicable)**	**N/A**

Disseminated to: (either directly or via meetings, etc.)	**By Whom?**	**Format (i.e. paper or electronic)**	**Date Disseminated:**
IAGC	Helen Goodwin	Paper	October 2014~~August 2013~~
BoD	Julie Pearce	Paper	October 2014
~~RMGG~~QAB	Helen Goodwin	Paper	September 2014