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County Durham and Darlington NHS
NHS Foundation Trust

TRUST GOVERNANCE HANDBOOK

Final – Version 1.1

Standards and guidance for Board Members, Directors and Managers involved in corporate governance, clinical governance and risk management in CDDFT

Warren Edge,
Senior Associate Director of Assurance and Compliance (Trust Secretary)

Contents

SECTION 1: INTRODUCTION

Purpose and Expectations

Purpose and objectives

This Handbook has been prepared to set out County Durham and Darlington's approach to governance from the Boardroom down to service / speciality level. It aims to:

- Provide an easy to use source of reference for Board Members, senior managers and middle manager as to their governance responsibilities
- Define the main types of governance within the Trust and key concepts
- Set standards for clinical and non-clinical governance, and for risk management, for Board Members, senior managers and middle managers to follow
- Specify and support behaviours and approaches which help to ensure that governance processes and structures operate effectively and add value
- Provide, in the companion resource pack, tools to support the effective operation of corporate and clinical governance meetings
- Identify the key policy and procedural documents which underpin specific governance requirements such as learning from incidents and financial control.

How to use this handbook

Governance structures and processes, of themselves, will not be effective without the right understanding, commitment, behaviours and engagement from all those involved in operating them. It is the responsibility of all of us to ensure that our governance is effective and adds value. All Board Members, Directors, Associate Directors and Care Group Directors should be familiar with the governance structures, responsibilities, standards, behaviours, and reporting requirements in this Handbook. They should implement structures to fulfil these responsibilities and meet these standards within their areas of responsibility, and should monitor their effectiveness. In addition they should ensure that their senior managers, whether being asked to attend governance meetings or to fulfil governance responsibilities, fully understand what is required of them.

All Board Members and senior management should provide feedback on the Trust's governance arrangements to support continuous improvement of them.

Working in partnership with third parties

The environment in which the Trust provides healthcare is, in the best interests of patients, increasingly collaborative. There are numerous arrangements where the Trust works closely with one or more partners to design and implement care pathways and to run and operate services.

These arrangements **do not** change the Trust's accountability for the safety and quality of its services, for propriety, for regulatory compliance or for the protection of patient records. The governance standards and responsibilities set out in this document therefore apply to all of the Trust's activities including those provided under collaborative or partnership arrangements. There will be a need to apply them pragmatically and flexibly, so as not to undermine the delivery of care in the patients' best interests. It is therefore essential that those involved in working with partners should understand the limits to their delegated authority and the key policy requirements that must be met. It is suggested that they ensure that partnership work reports into their Care Group Governance structure so that their Care Group leadership teams and governance support officers can support them in applying appropriate governance and in reporting any issues or seeking any approvals required from Board / Executive Committees.

Continuous improvement

The Trust is committed to reviewing and improving all of its governance structures to ensure that the deliver value and minimise the burden on busy Directors and managers. As a result some of the structures and requirements within this Handbook may change over time. This Handbook will be updated and reissued as any significant changes occur and then annually thereafter.

SECTION 2: GOVERNANCE – DEFINITIONS AND CONCEPTS

Definitions

Corporate governance

Corporate Governance describes the arrangements through which the Board of Directors directs, monitors and controls the affairs of the Trust to promote its success. For a Foundation Trust 'success' is defined as delivering the maximum benefit to the members of the Trust and the public which we serve. Implicitly, it includes: how the Board sets the Trust's values and strategic direction; how it delegates day to day running to management, and how it monitors and gains assurance that management is delivering on the Board's intent.

Just as the Board directs, communicates and monitors these outcomes from the top down, there need to be arrangements to replicate this approach at the Executive, Care Group / directorate and service levels, to enable assurance to be provided to the Board that risks are being managed and objectives achieved.

The definitions below separate out clinical / quality governance from 'business governance' as it is considered helpful in ensuring that senior managers and clinical (including nursing managers) keep both in mind. In reality, however, governance covers all aspects of the Trust's operations and linkages between the two should be recognised .

Clinical Governance / Quality Governance

Quality Governance refers to the values, behaviours, structures and processes put in place to allow the Board to ensure that: fundamental standards of care (as defined in the Trust's Registration with the Care Quality Commission) are met for all services; all services seek to continuously improve quality and outcomes; and that all staff are motivated and enabled to deliver effective, save and person centred care. Clinical governance involves directing and monitoring clinical activity to ensure that it is safe and to continuously improve patient experience and outcomes

Definitions

'Business' governance

This is not a recognised term ; however, it is used in this handbook to encapsulate the need for systems to direct, monitor and control operations to ensure that non-clinical strategies and objectives are achieved (as it is their achievement that then enables the delivery of quality strategies and objectives). Implicitly it includes the delegation of management powers in these areas. These include financial and workforce strategies and objectives and will include regulatory compliance where it is essentially non-clinical in nature.

Information governance

Information governance is a specific regime concerned with the identification and management of information assets (both clinical records and information and non-clinical) and the risks associated with acquiring, holding , disposing of and providing access to information . The Trust has specific requirements for information governance captured in its Information Risk Management Strategy and specific roles within each Care Group directorate and departments , including specific roles for information asset ownership and administration.

Board roles (Unitary Board, Executive Directors and Non-Executive Directors)

The Board comprises both Executive and Non-Executive Directors. All have an equal voice in decision-making and all are collectively responsible for decisions regardless of the subject area involved - this is the essence of a 'unitary' board.

Executive Directors are those, like the Director of Finance, that, in addition to their role as a Board Member, are charged with 'executing' (hence their title) the Board's intent and given senior management responsibility for doing so in their particular areas. They are appraised by and report to the Chief Executive.

Non-Executive Directors are completely independent of management responsibility, allowing them to objectively represent the interests of the Trust's members and stakeholders (see 'Accountability 'overleaf), to hold the Executive Directors to account for executing strategy and to provide 'critical friend' type challenge based on their experience. They are appointed by the Trust's Governors and are appraised by the Chairman and Governors. An effective Board will ask its non-executive directors to seek assurance (see overleaf) with respect to the delivery of strategy and objectives by Executive Directors and their management teams.

Concepts

Direction (decision-making , standard setting ,communication and monitoring)

Direction comprises the setting of the organisation's strategic direction (vision, mission, strategic objectives) and standards (values, behaviours, organisational policies) and the monitoring of the achievement of objectives and the management of risks to their achievement. Implicitly it also involves the way in which the Board communicates it's decisions and expectations. Effective direction also requires that a Board listens to its staff, public, patients and other stakeholders and responds to feedback to make the right decisions. These same principles apply to direction within a Care Group, Directorate or service.

Assurance

Governance requires Boards (or Care Group / Directorate leadership) to seek (and receive) and, in turn, to provide assurance with respect to the achievement of objectives and the identification and management of risks to their achievement. The concept of assurance can be summed up in a Russian proverb that Ronald Reagan used in negotiating arms reduction agreements at the end of the Cold War – 'Trust but Verify'. Whilst good managers should be trusted and supported to meet their objectives, it is not enough to take their ***reassurance*** alone; additional checks and balances should be in place.

Such checks and balances may include reporting, review and interpretation of reliable performance information, management checks, semi-independent checks or completely independent checks from the likes of Internal Audit. If you only believe that something is working as intended, even if you base that belief on the absence of evidence to the contrary, you do not have assurance. You only have assurance when you have reasonable evidence to supplement that belief.

Care Group / directorate management teams will be asked to seek and provide assurance to the Board. The Board has to provide assurance to regulators such as NHS Improvement, to the commissioners through contract and quality monitoring meetings and to the public; for example, in the annual report.

The process of seeking and providing assurance is often seen as boring and 'non value adding' because it is not involved directly with change and improvement. However, it has huge value in protecting organisations from the costs of addressing issues when things go wrong, and in protecting the public and patients from the consequences of such errors and failures.

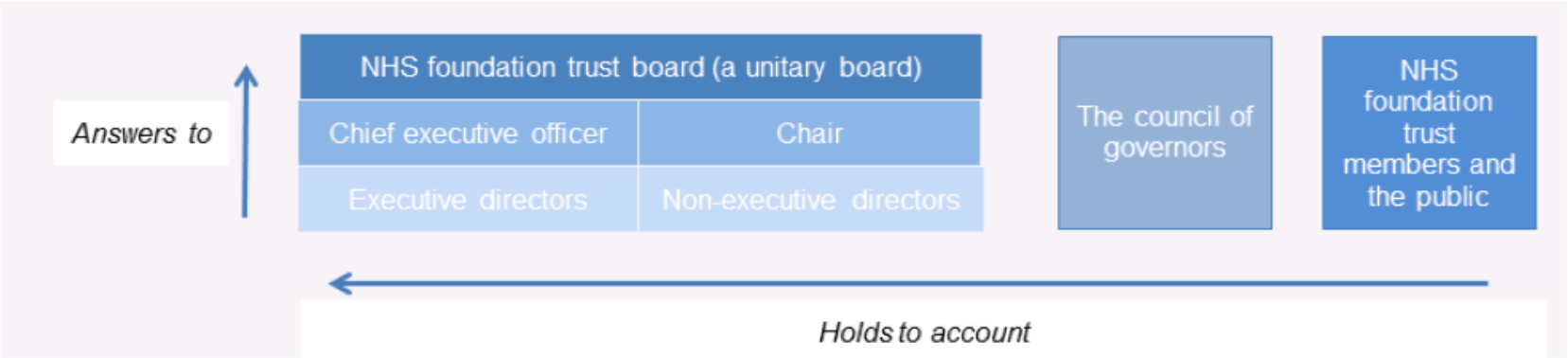
Concepts

Membership and public accountability

The concept of accountability underpins corporate governance more than any other. It recognises that, in a public body, Board Members are essentially stewards of the organisation entrusted to run it for the maximum benefit of its stakeholders – for a Foundation Trust that is primarily the patients and the public the FT serves, in addition to its staff.

Parliament created a very specific model of accountability for FTs, to balance out their freedom from direct control by the Secretary of State. In essence, the public can choose to become formal members of the Trust, with a right to elect public governors to represent their views; staff are automatically deemed to be members unless they choose to opt out, and can elect staff governors to represent their views. In order to make the Board accountable to the Trust's membership and public through the governors, a Council of Governors is established which appoints, appraises and remunerates the Non-Executive Directors and holds them to account, individually and collectively for the performance of the Board. In this way, Non-Executive Directors have a clear responsibility to consider the views of members and the public in decision-making and in constructively challenging Executive Directors at Board meetings.

This model is shown in the diagram below. In this Trust the Council consists of: 20 elected public governors covering County Durham, Darlington and neighbouring areas; 9 staff governors, and 10 governors appointed by stakeholder organisations such as our CCGs. The Council meets four times a year and has four standing committees to support its work.



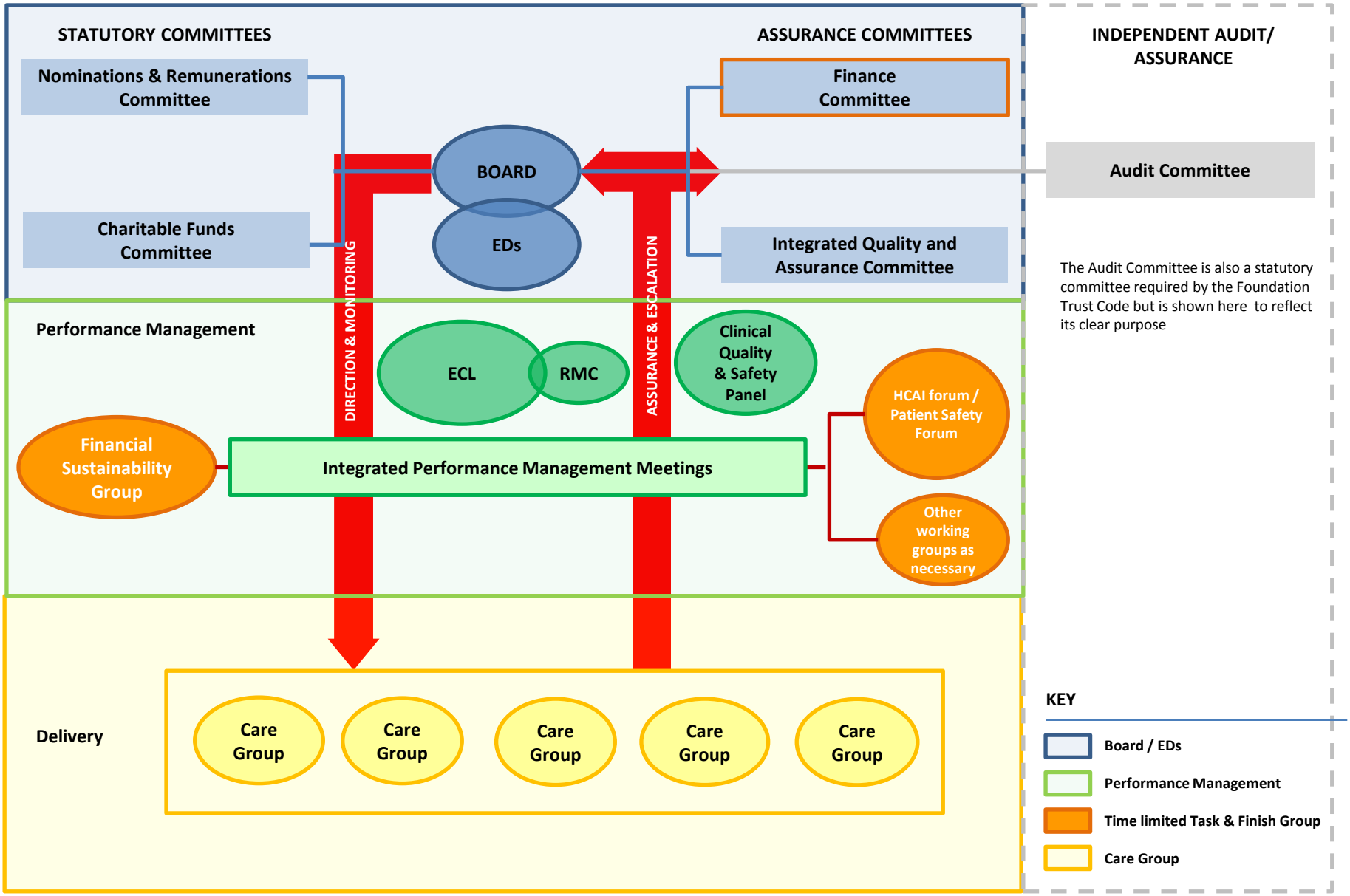
SECTION 3 - TRUST GOVERNANCE MODEL

Summary explanation

The Trust's governance model is summarised in the diagram overleaf. The fundamental principles are summarised as follows:

- On a day to day basis, management of operations takes place within Care Groups and corporate directorates. Associate Directors and Clinical Directors are expected to take action to achieve Care Group / directorate objectives and to manage risks to their achievement, escalating risks where necessary to Executive Directors (before they become issues). Corporate directorates supporting operations should, where possible, attend Care Group meetings to enable joint working on risks and issues as they arise.
- Working groups, such as the Financial Sustainability Programme Group (FSP) are in place to enable Executive Directors, and their corporate teams, to work jointly with Care Groups on issues requiring their combined focus; for example, in the case of FSP, expenditure run rates and cost improvement schemes.
- Performance in meeting objectives is monitored through the Integrated Performance Framework, consisting of integrated reporting (aiming for one version of the truth capable of representation at Trust and Care Group / directorate level – in development) and a two-tier review process in which key issues are escalated to a quarterly performance review meeting with Executive Directors.
- Risks and issues which need to be escalated for Executive-level decisions and / or action are escalated to the Executive and Clinical Leadership Committee or, depending on the extent to which issues do not require support or consensus from the Clinical Leadership they may be taken into meetings of the Executive Directors Group. The key point is that the quarterly ED review meetings are designed to ensure monitoring of performance and accountability; issues and risks should be dealt with through the Executive Committees on a timely basis.
- In addition to the Committees mandated by statute or the FT Code of Governance, the Board establishes Assurance Committees to enable Non-Executive Directors to seek assurance from Directors on the achievement of core operational and strategic objectives, including the development and implementation of strategy, management of key risks and meeting of compliance obligations. In seeking assurance from Directors, these committees will draw upon performance metrics, the results of independent assurance work and corroborative enquiry with managers and clinical leaders in Care Groups and corporate directorates.

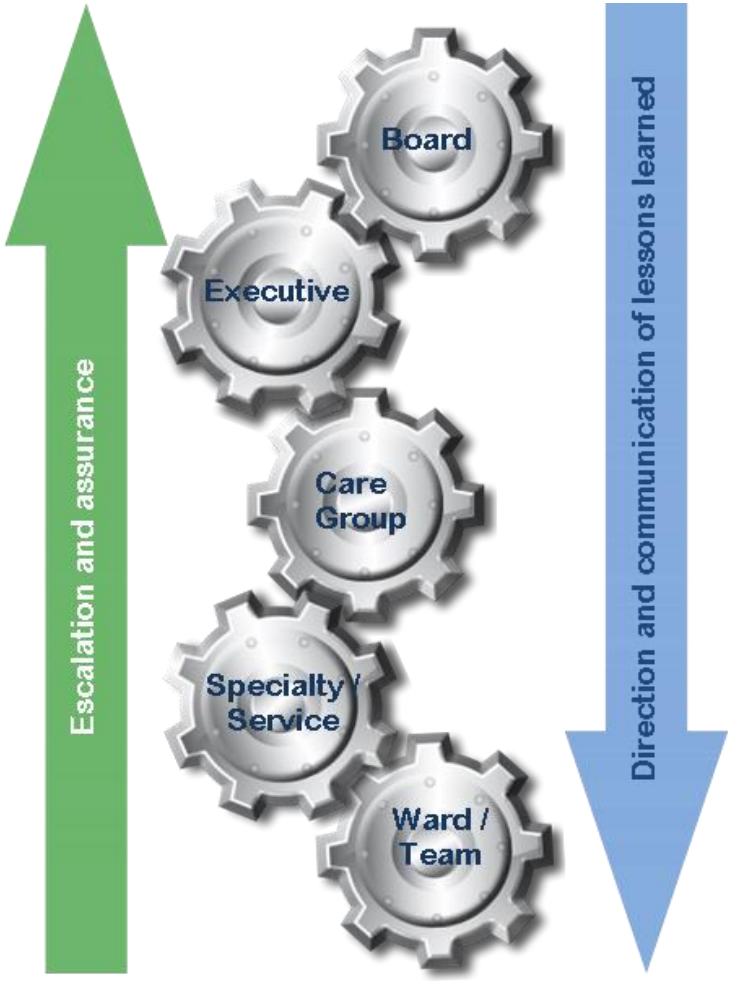
Governance model diagram



SECTION 4: GOVERNANCE STANDARDS IN CDDFT

The standards in this section effectively summarise what is expected from governance systems at all levels within the Trust.

They are effectively high level statements of requirements from key policies (see section 8), and should be treated as a compact between the individual leader and senior management. Where there are barriers to meeting these standards they should be shared with senior management so that they can be addressed.



Clinical / Quality Governance – Standards

- We check that we are meeting fundamental care standards.
- We follow fundamental infection control requirements, and check that we do.
- We deal with and learn from incidents:
    - We actively encourage all staff to report incidents, near misses and concerns as soon as they are known;
    - We monitor near miss situations
    - We investigate all incidents and understand fully what went wrong and how it affected the patient and their family;
    - We put right what we can;
    - And do our very best to make sure that it doesn't happen again;
    - We tell those who need to know (inside and outside our organisation) when serious incidents happen;
    - We are open and honest in talking to the patient and others about what happened;
    - And we check constantly that we are doing this well.
- We know how good our patients' experience is, and we learn and improve from everything they tell us.
- We listen to staff and act on their comments and concerns.
- We deal with and learn from complaints.
- We know how well we perform clinically, compared to others, making the most of regional, peer group, national datasets, clinical audits, mortality data and other information.
- We understand our mortality performance. Where we do not, we actively work with others to close gaps in our understanding and we act on what we learn to improve.
- We know the standards we are measured against and how we are doing against them (NICE, Royal College, Peer Networks, BHP, Regulatory standards and others). We take action to meet standards where we fall short.

Clinical / Quality Governance – Standards

- We continually review the safety, effectiveness, responsiveness and caring delivery of our services.
- We review and improve our clinical practice, through our own clinical audit plans and through proactive participation in research and development; we agree and follow through actions to take opportunities to improve clinical practice.
- We implement safety alerts on time.
- We ensure that staffing levels are sufficient to provide the care we aspire to, or escalate issues where they are not.
- We ensure that our staff understand their roles and objectives and are trained to provide the care we aspire to and that job descriptions reflect this
- We reflect on all of the above and what we know from our own staff, our observations and patient discussions, to understand where we are at risk and we take action address those risks. We act on what we learn to improve.
- Where we cannot do these things because of barriers, we escalate those barriers to senior clinical leadership and senior management and seek assistance to remove them.
- We share our good news stories, and the lessons we have learned, with others in the Trust.
- We learn from other organisations
- We remove hazards and we recognise (register) and manage risks.
- We identify areas for improvements from triangulated information.

We seek advice from the Nursing or Medical Directorates or ARC where unsure

Business Governance Standards - Finance and commercial

We:

- Manage within budget.
- Deliver cost improvement schemes to realise cost improvement targets, substituting schemes in respect of any schemes which cannot be realised
- Seek approval through the vacancy control processes prior to recruiting staff
- Seek approval from the CEO or Finance Director to vary our establishments
- Ensure that all non-pay expenditure is only committed through the Cardea ordering system
- Ensure that expenditure is only authorised in line with delegated limits
- Ensure that expenses have been properly incurred prior to authorisation
- Seek approvals through the business case process for capital spend
- Follow the Trust's Standing Financial Instructions
- Observe propriety in tendering and procuring services
- Complete fairly for contracts, avoiding bribery and corruption
- Declare conflicts of interest and seek approval for hospitality

Seek advice from Finance / the Trust Secretary where unsure

Business Governance Standards - Workforce & OD

We:

- Ensure that all our staff have an appraisal and objective-setting meeting at least annually.
- Ensure that all our staff attend Essential Training.
- Ensure all staff receive an effective induction.
- Support our staff in maintaining professional registration and in meeting revalidation requirements.
- Take concerns raised serious and investigate them under the Trust's policies (Raising Concerns, Dignity at Work, Disciplinary Policy, Anti-Fraud Policy, Grievance Procedure)
- Manage sickness absence in line with the Attendance Management Procedure, supporting staff to return to work effectively as far as possible.
- Tackle, rather than tolerate negative behaviours such as bullying, harassment or discrimination.
- Follow and exemplify the Trust's behaviours and values.
- Work to retain staff.
- Help staff cope with stress and maintain personal resilience.

Seek advice from Workforce and OD where unsure

Risk Management Standards

- We anticipate adverse events, which deflect us from our purpose / objectives. We do not wait until problems arise and fill in a risk register just to recognise them.
- If we identify a potential risk, we decide whether it matters and, if so, we follow the risk management process. That means deciding if we can live with the risk or, if not, deciding to do something about it.
- When we record risks, we are clear about the circumstances giving rise to an adverse outcome, how they could cause it, and how that outcome would impact on our core purpose or objectives.
- Accountability for managing risks lies with the team or department with the responsibility, and ability, to influence the outcome of the risk and they should seek help when they need it.
- We have clear levels of authority to manage risks and for escalation, whilst encouraging staff to be proactive and show initiative.
- In deciding what to do, we are clear what will be done, when and by whom and what support, if any, they will need. That means the Care Group or corporate function taking a collective view of the risk, including how far it can be mitigated and by when, at the point when the risk is added to the risk register.
- We agree short-term actions (e.g. contingency plans / escalation measures) as well as long-term actions, to manage those risks where the preferred solution requires time to implement or is contingent on others e.g. on commissioner approval.
- Action owners agree actions down to them and then deliver them or seek help if they cannot do so.
- Risk owners, relevant risk groups and RMC monitor and ensure follow through of action plans (within their spheres of responsibility) or escalate risks if they cannot do so. That means checking that actions have been implemented and – using data or audits, for example - that they are effective in practice.

Risk Management Standards

- We take time to look forwards and externally in order to anticipate significant risks arising from our external environment.
- We use our understanding of risks to inform decision-making across the Trust's decision-making forums; we do not do risk management in isolation of them.

Seek advice from Assurance, Risk and Compliance where unsure.

Information Governance Standards

We:

- Only share information with those authorised to receive it, unless it is non-sensitive.
- Nominate and train Senior Information Asset Owners, Information Asset Owners and Information Asset Administrators and support them in fulfilling their roles.
- Record and classify personal and corporate information according to its sensitivity and apply controls to the storage, transfer, disposal and destruction of information in line with this classification.
- Retain and dispose of information in line with retention schedules specified by the Department of Health.
- Keep full records of the movement and destruction of information.
- Ensure that information is shared with third parties where necessary for effective patient care, but only with required consents and safeguards and in line with clear information sharing agreements.
- Recognise any request for person identifiable information and seek Caldicott approval to provide information.
- Comply with requests from the Information Governance and Freedom of Information teams necessary to ensure comply with the Data Protection Act and FOIA.
- Comply with Trust's policies on the security of IT equipment and data whether within the workplace or working remotely.

Seek advice from Information Governance or the Freedom of Information teams where unsure

Last but by no means least…

- Governance at all levels should uphold and exemplify the Trust's values and behaviours!

SECTION 5: THE BOARD, ITS COMMITTEES AND HOW TO SERVE THEM

Board Role and Composition

Role

The role of the Board is to direct the affairs of the Trust to promote the maximum benefit to the Trust's membership and for the public. This involves: determining the Trust's strategic objectives and approving plans to achieve them; determining the Trust's vision, values , mission, behaviours and key policies; identifying and directing the management of significant risks to the achievement of objectives; monitoring activities; and seeking assurance as to the achievement of objectives and compliance with regulatory obligations

The Chairman and Chief Executive

The Chairman is responsible for the running of the Board and the Council of Governors, for their effectiveness and the extent to which they fulfil their accountability to members and the public. He is not responsible for running the day to day business. That is the responsibility of the Chief Executive, supported by the Executive Directors, and other senior managers classed as Directors but without a vote at Board level.

The Executive Directors and Other Directors

The Board consists of five Executive Directors (CEO, Finance Director, Director of Nursing, Medical Director and Director of Operations), plus five Non-Executive Directors and the Chairman (who is also non-executive). The Foundation Trust Code of Governance requires an equal number of Executive and Non-Executive Directors plus a Non-Executive Chairman. There are two other Directors who do not have Executive status (they do not have a vote in board business): the Director of Estates and Facilities and the Director of Workforce and OD. The Directors are responsible for running the business on a day to day basis, including implementing the strategy within the parameters approved by the Board. As Board members, they contribute to decision-making equally alongside the Non-Executive Directors.

Non-Executive Directors (NEDs)

NEDs are independent board members, with no day to day management responsibility. They contribute to decisions and hold the Executive Directors to account using their business experience and knowledge. Their role is to provide constructive challenge, rather like a 'critical friend'.

Board Statutory Committees

Nominations Committee

This Committee oversees the appointment of Executive Directors and other designated senior managers. It meets jointly with the Remuneration Committee. It comprises all of the Non-Executive Directors .

Remuneration Committee

This Committee sets the remuneration policy for Executive Directors and other designated senior managers and approves remuneration for each Director / designated manager based upon recommendations from the Chief Executive. The Committee also approves severance packages and departures from contractual payment entitlements for senior managers. It comprises all of the Non-Executive Directors and meets jointly with the Nominations Committee three to four times per annum.

Audit Committee

This Committee comprises three Non-Executive Directors. It is charged with seeking assurance on behalf of the Board on the reliability of financial reporting and control, including the annual accounts, and on the reliability of systems of governance, risk management and internal control. The Committee both relies on, and oversees the effectiveness of, the external auditors (whose work is focused on the annual accounts and annual quality report) and the internal auditors, who complete an annual plan of work covering risk management, internal control and governance more generally. The Committee meets around six times per annum and is a key source of assurance to the Board and to the Chief Executive.

Charitable Funds Committee

The Board is legally the Trustee for the County Durham and Darlington FT Charitable Trust Funds. This Committee, which meets four times per annum consists of two Non-Executive Directors (including the Chairman), the Director of Finance , a Governor representative and a staff fund-holder representative. It agrees major items of expenditure from charitable funds and policies, for example in respect of fund-raising.

Board Assurance Committees

Purpose of assurance committees

As stated earlier in this Handbook, the Board needs to seek assurance that business objectives are being achieved and that risks to their achievement are being identified and managed. These will include objectives concerning strategic developments and delivery, business performance (covering all areas such as operations, finance, workforce and quality) and regulatory compliance. Assurance-seeking is a key role for Non-Executive Directors in particular, as they (unlike the Executive Directors) are independent from day to day management and are expected to act as 'critical friends', constructively challenging management decisions when things are off track or at risk of becoming so. There is not sufficient time in each Board meeting for Non-Executive Directors to scrutinise all business objectives in detail, hence the Board establishes Committees to carry out that more detailed level of scrutiny and report back to it.

The current assurance committees are summarised overleaf. Maintaining the right focus within assurance committees can be challenging. It can be tempting to try to dictates solutions where problems are apparent or to try to hold Care Groups or corporate directorates to account. Implementing solutions and holding senior and middle management to account are management functions which rest with Executive and other Directors, hence in both cases NEDs would be straying beyond the Committee's remit. It is, however, right and proper for NEDs to challenge Executive Directors to find solutions to problems, make suggestions from their experience and hold Executive Directors to account.

To help ensure that the right focus is maintained within Assurance Committees the Board has agreed to adopt the working model overleaf. Committees will be greatly supported in their work and assisted in being efficient and effective where those reporting to them write reports with this remit in mind.

Board Assurance Committees

Assurance Committees working model

1. Board Committees to work to a clear 'assurance seeking' model which can be articulated as follows:
   a. Seek assurance that performance is on track/ compliance obligations are met
   b. If assured, stop.
   c. If not assured, seek assurance that there is an action plan in place with clear accountability and timeframes and seek assurance that it is robust and being implemented?
   d. If assured, stop. If not, require the relevant Executive Director (or the Executive Directors as a whole) to take further action and advise the Board in the Committee's escalation report.
   e. If not assured, request the updated action plan to be presented and…
   f. Seek assurance of implementation and improved performance later in the year.

Finance Committee

This Committee comprises two NEDs , the Chief Executive and Directors of Finance and Operations and seeks assurance on the development and delivery of annual and medium to long-term financial plans, including the overall Financial Recovery effort within the Trust. The Committee meets every month and routinely seeks assurance on cost control, monthly financial performance, cost improvement and investment performance. The Committee was established as a response to the Trust's deterioration in financial performance – to allow a strong NED focus on efforts to achieve turnaround – and is expected to remain in place until such time as the Trust returns to long-term financial sustainability.

Assurance is sought from Executive and other Directors who will invite other members of their teams to provide further detail as required by the Committee.

Care Group representatives may be asked to attend to provide updates to the Committee, primarily to allow the Committee to test and corroborate assurances provided by the Directors NOT to be held directly to account.

Board Assurance Committees

Integrated Quality and Assurance Committee

This Committee comprises two Non-Executive Directors and the Medical, Operations and Nursing Directors. It seeks assurance across the full spectrum of planning, operational performance (access targets), workforce issues, IT, estates and in respect of programme and across the quality agenda. The last of these covers: assurance in respect of patient safety, experience and outcomes using a variety of reports, including analyses of trends in incidents and complaints, reports on patient feedback, clinical audit outcomes and compliance with quality standards.

Assurance is sought from Executive and other Directors who will invite other members of their teams to provide further detail as required by the Committee.

Because of the subject matter, and in line with post-Francis expectations from CQC and others, all Care Groups attend and a level of detailed scrutiny is applied to safety and quality within each Care Group's operational areas. However, it is ultimately the Executive Directors who should be held to account, not the Care Groups' directly. Care Group reporting is designed to allow the Committee to test and corroborate assurances provided by the Directors NOT to hold Care Groups directly to account.

Reporting to Board

At the end of each Committee meeting the Committee considers whether there are matters which should be reported to the Board, either because it is considered that all Board Members need to be aware of them or for escalation. In the latter case, it would be assumed that the Board as a whole needed to take a view on risk and to make decisions with respect to mitigation. Escalation reports are a standing item on the Board's meeting agenda and a template report is included – for each Committee's use – in the resource pack.

Each Committee should also provide an annual report, following an annual self-assessment of its effectiveness, to the Board on compliance with its terms of reference.

If you attend or report to Board / Committee meetings

Reporting

Follow the principles within the structure below to help the Committee focus on the key issues from an assurance perspective. Do not provided detailed reports or presentations used for other purposes or swamp the committee with extensive data analysis.

Section 1 - Introduction and key messages
Set out the purpose of the paper (e.g. to advise the Committee of the assurance position with respect to…, risks arising and actions being taken) and highlight key points

Section 2 - Assurance position
State the objectives of the process / area being assured, including any regulatory requirements and any quality / performance standards monitored by regulators, commissioners, NHS England etc. i.e. what is it that we have to achieve
Summarise the current assurance position – this will be a self-assessment to some extent but headline datasets and the results of any independent reviews can be referred to.
Do not set out extensive data analysis but summarise the key information. Do include any Internal Audit / other independent assessment outcomes.

Section 3 - Risks and issues
Summarise any significant risks and issues impacting on the achievement of objectives (risk, cause, challenges)
This section does not require a detailed analysis of problems, but a focused description of the risk / issue challenges

Section 4 - Actions being taken and progress
Set out the actions being taken to address the risk in SMART fashion
Set out the progress in implementing actions and, where actions have been taken, the outcomes being observed with any qualifying statements
Advise the Committee of your expected trajectory, or why you cannot specify one (including any assumptions).

Section 5 - Remaining challenges and / or concerns
Set out any remaining challenges, uncertainties / concerns after the above actions have been taken (or which may impede their implementation)
Say what you are doing about them (with Exec help where relevant – NOTE: as the Committee's purpose is to seek assurance it is expected that issues will have been escalated to EDs for help where necessary beforehand).
Note any support required from the Board

Section 6 - Conclusion
Reiterate key messages

If you attend or report to Board / Committee meetings

Behaviours

Ensure that those attending adopt the following behaviours to assist the Committee in focusing effectively on its remit.

1. Understand the purpose of the meeting and what the Committee requires from you / your report. Seek clarification if unsure.
2. Submit papers on time or agree any extension with the Executive Sponsor / Chairman in advance of the deadline where necessary.
3. If you sponsor attendance / presentations from others ensure that they are fully briefed as to 1 and 2 above, the purpose of the presentation and how it should address the Committee's purpose.
4. Present key points succinctly and be clear as to any decisions, views or support you are requesting from the Committee. Assume that the paper has been read in advance.
5. Be honest and open in reporting any issues but do not present issues and problems to Committees which you have not attempted to resolve internally and, as necessary, with Executive Directors beforehand (at least without clarifying that you are in the process of having such discussions).
6. In both papers and presentations set out actions being taken in respect of issues, how they are being overseen and the outcomes from such actions to date.
7. Follow the Chairperson's direction.

SECTION 6: EXECUTIVE COMMITTEES

Executive Committees

Executive and Clinical Leadership Committee (ECL)

This Committee comprises all of the Trust's Executive Directors, supported by other Directors and the Care Group leadership teams, meeting weekly. The primary purpose of ECL is to seek Trust-wide consensus and secure Trust-wide action on Trust-wide issues, initiatives and programmes of work, including informing operational decisions and the development of strategy. ECL can consider any matter within this remit. In practice, however, ECL will seek to ensure that the matters covered focus on decisions and action commensurate with the seniority of the membership and attendees.

Legally, only formal Board members (Executive Directors) can be members of the Committee. However, the Committee seeks to operate as a single management group, enabling views to be shared freely by all members and attendees. Decisions reached on the basis of a consensus, and ratified within the meeting by Committee members, will be implemented under the powers delegated to the Chief Executive or the relevant Director. ECL minutes are sent to all Board Members.

Executive Directors Group

The Executive Directors and other Directors meet separately, usually weekly, to make decisions within their remit. Their practice is, however, to refer decisions to ECL where there is a clear need to understand the views of the Trust's Clinical Leadership.

Risk Management Committee

This Committee comprises all of the Trust's Executive Directors, working with other Directors and representatives from each Care Group leadership team. The Committee meets quarterly to review the Board Assurance Framework and the Trust's key risks and overall risk profile. The remit of the Committee is to ensure that key risks to the achievement of Trust objectives are being identified and managed effectively; a significant part of the Committee's remit is looking ahead to anticipate and plan the Trust's response to emerging risks. The Committee also ensures that the Trust has adequate resilience and emergency preparedness arrangements in place and reports directly to the Board.

Integrated Performance Framework

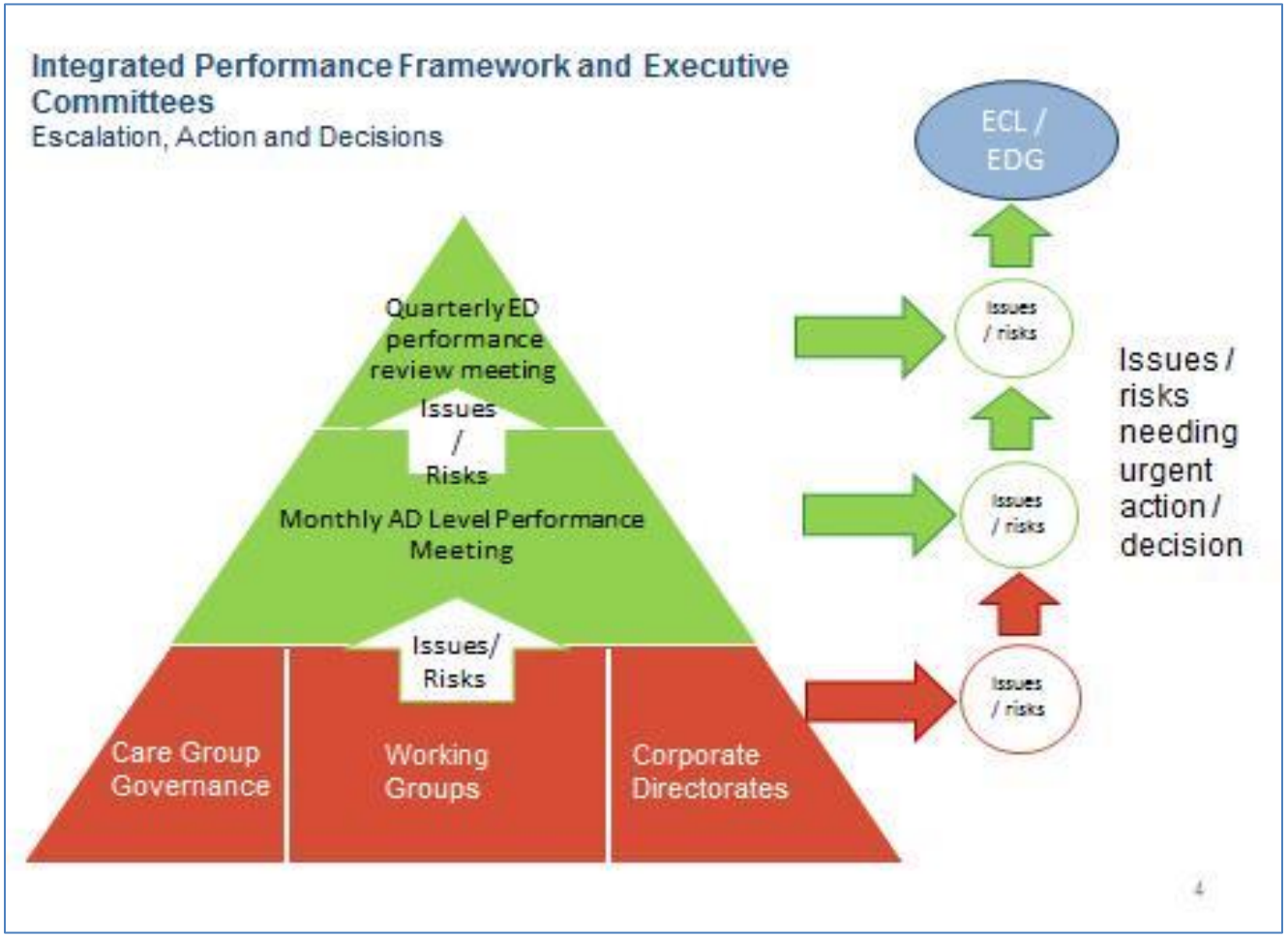
- The principles underpinning the Integrated Performance Framework and the handling of significant risks and issues are illustrated in overleaf. These are consistent with the governance model outlined in Section 2.

- The approach is designed to minimise the burden on both Directors and Care Group leadership teams whilst, at the same time, maintaining the discipline of a semi-independent review, each month, at Associate Director level to assist in identifying (and initiating actions on) any areas where performance is going off track which the Care Groups themselves have not yet identified. These meetings are chaired by the Director of Performance but require representation on behalf of all Directors. Such representatives perform the function of a 'critical friend' and Directors expect that joint action (Care Group and the relevant corporate directorate), where necessary. The meetings are informed by the integrated performance reports, from risk assessment in Care Groups, issues identified in Working Groups and through review and monitoring processes exercised in corporate directorates.

- Quarterly performance reviews are undertaken with Executive Directors focusing, by exception, on key performance issues (and relying on the monthly meetings to provide assurance of wider scrutiny of performance which is reported as on track).

- The performance review process is not the vehicle for escalating issues, seeking decisions and Director-level support or action. Issues should be taken through ECL (and potentially the Executive Directors Group where appropriate) on a timely basis. However, the performance review process can identify such issues or expedite the escalation process.

Integrated Performance Framework



Other Executive Groups

Financial Sustainability Programme

Regular meetings take place between the CEO, Finance Director, Director of Operations and each Care Group to review the delivery of cost reduction schemes and cost control within Care Groups, the aim of which is to ensure that the Trust's plans for turnaround of current financial deficits are realised and the Trust returns to long-term financial sustainability. Once this objective is achieved, the need for an additional, regular meeting will be reviewed.

Clinical Quality and Safety Panel

This is a fortnightly meeting of the Medical and Nursing Directors, supported by two Non-Executive Directors, with the Care Group Clinical Directors and Associate Directors of Nursing along with other nursing and clinical leaders to review serious incidents and significant complaints and to implement and disseminate rapid learning. The Panel is an advisory committee of the Board and can consider any issue relevant to improving safety and quality in the light of learning from incidents and complaints, including reviewing clinical pathways and service strategies. In due course, it is hoped to expand the remit of the Panel to consider clinical audit outcomes and other sources of learning.

Other working groups are in place but the above represent those core to the Executive Direction of the Trust at the present time.

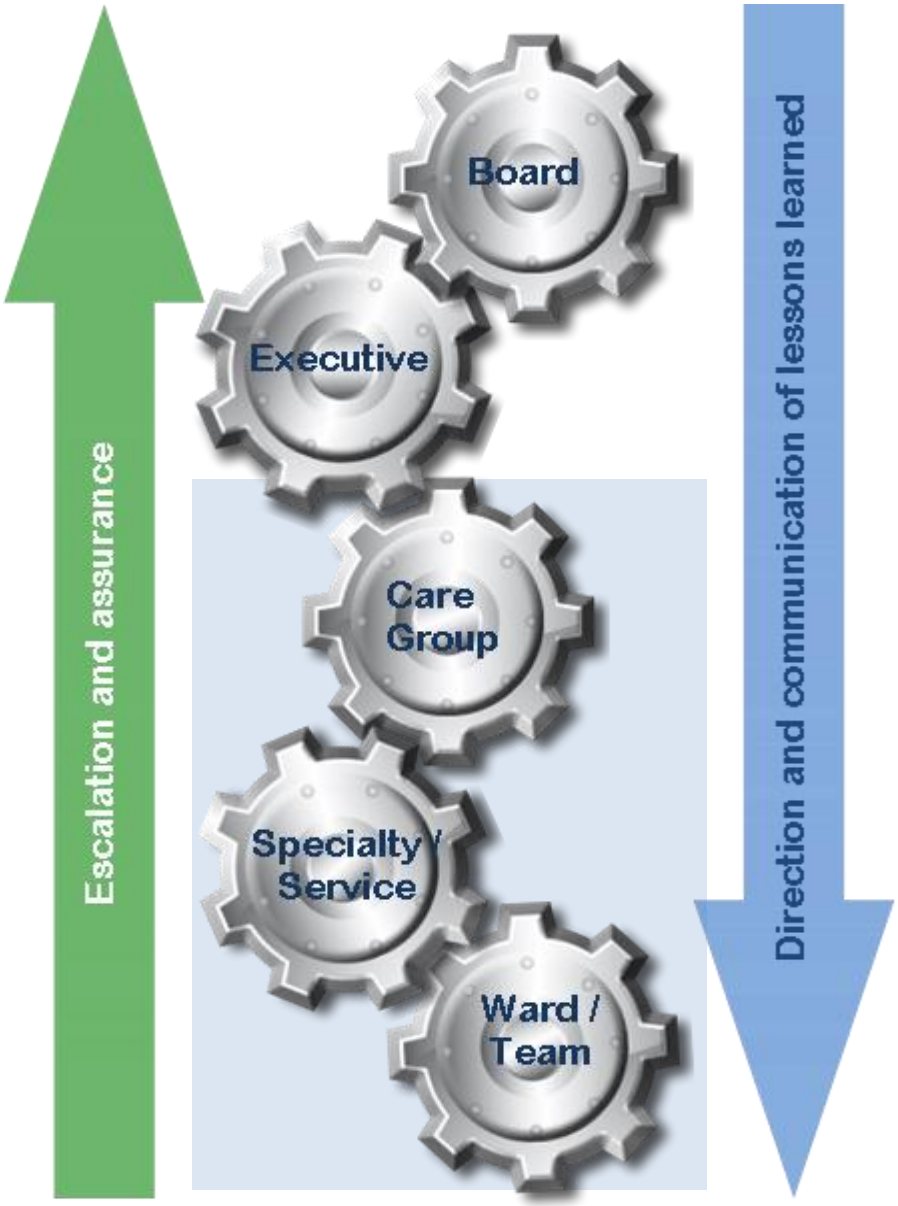
SECTION 7: CARE GROUP AND SPECIALTY GOVERNANCE

Care Group Governance and fit with the Trust's Governance Model

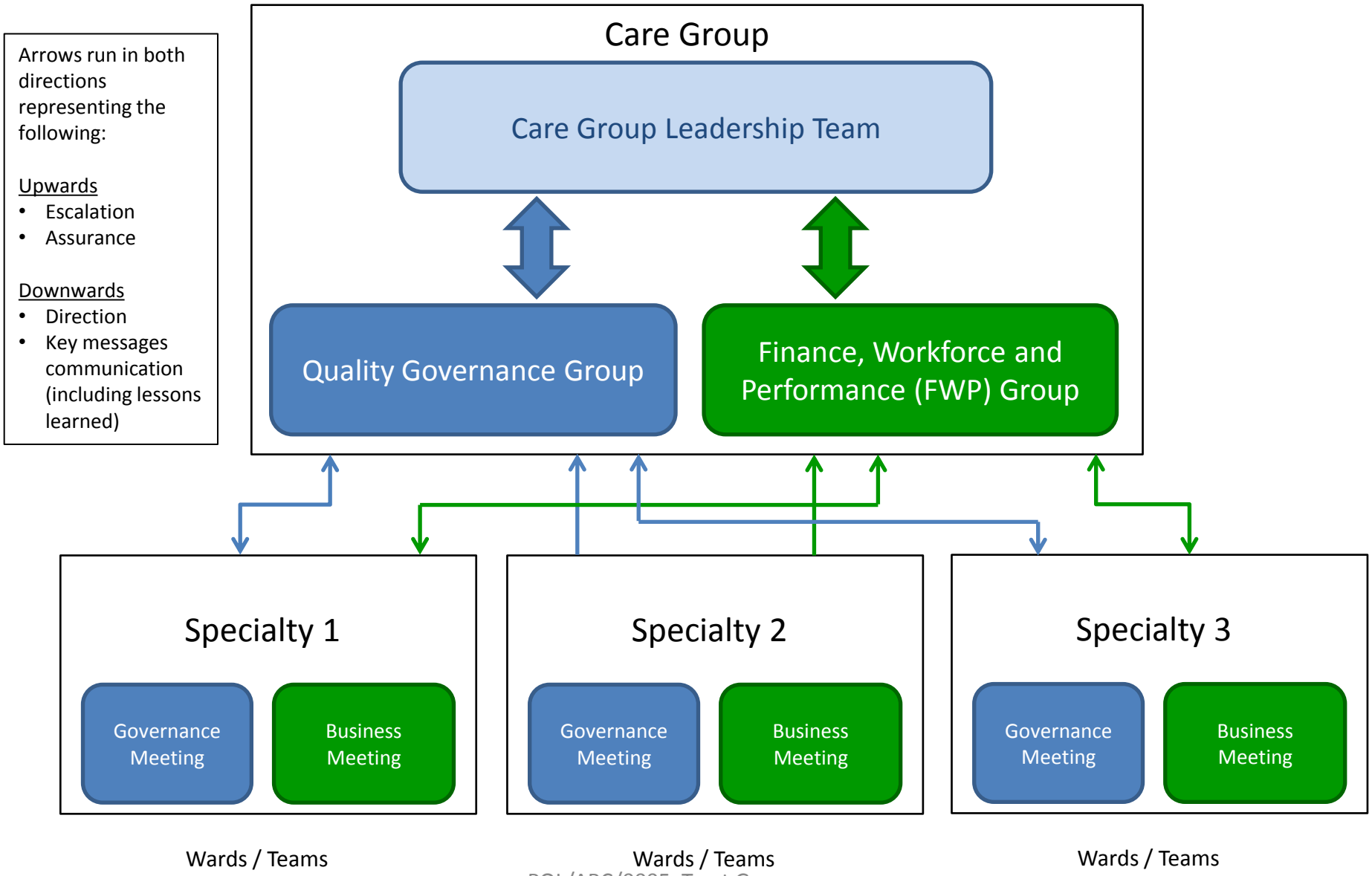
The objectives are: seamless escalation and management of issues; efficient and reliable assurance; clear and consistent direction and communication, and expedient action to learn lessons – with linkages working to these ends.

All Care Groups should implement governance arrangements to meet the principles and recommendations on pages 38 to 43 with room for local variation tailored to the needs of particular services .

The Trust's Assurance and Compliance Team will seek assurance as to the implementation and operation of governance arrangements through the review of Care Group meeting minutes and specialty level meeting outputs. Any gaps or concerns will be picked up as part of the integrated performance framework.



Care Group Governance (Recommended Model)



Speciality level meetings (recommended)

Meeting	Remit	Outputs	Membership
Speciality Governance Suggested frequency: bi-monthly / monthly where preferred 2hours?	• Review the progress of complaint and incident investigations within the speciality and agree actions with respect to any delays or issues. • Review, understand and secure learning from incidents, complaints and claims investigated since the last specialty meeting. • Review the progress of the specialty-level clinical audit plan and agree actions with respect to any delays or issues. • Review clinical audit outcomes, and the outcomes of any similar benchmarking exercises, secure learning and agree action plans. • Review the progress of assessments against new NICE guidelines and agree actions with respect to any delays or issues. • Review and confirm assessments of compliance with NICE guidelines, safety alerts • Review staffing levels for safety • Review the specialty-level risk register. Identify any new risks from discussion , record and / or escalate them to senior Care Group management • Assure preparations for / self-assessment for relevant inspections / peer or Royal College reviews • Review outcomes of such inspections and agree action plans • Review CQC actions implementation	• Action log capturing actions agreed with owners and deadlines (to be checked and followed up at each meeting and copied to ARC) • Risks – captured to the risk register • Note of matters to escalate to the Care Group Quality Governance Group (significant risks and issues and good news stories) • Note of key messages / lessons learned for wards/ teams	• Specialty Clinical Lead / Clinical Governance Lead if separate (Chair) • Consultants • Matrons and senior nurses • Head of Service / Senior Manager • AHPs as applicable • Pharmacists as applicable • Scientists as applicable NB: Other attendees may have standing invitations e.g. Governance Officer? Or they may be invited for particular items
Speciality business Suggested frequency: monthly?? 1.5 hours if focused?	• Review the position against the specialty-level budget and agree actions with respect to any issues • Review specialty-level position with respect to workforce including training, appraisal and sickness rates and agree actions with respect to any issue • Review demand forecasts and capacity (including workforce capacity / job planning), considering current and forecast needs and agree actions as necessary • Review operational performance and agree actions as necessary • Identify any risks to be captured / updated in the risk register and / or escalated to senior care group management • Review progress in implementing change plans within the service / speciality and agree actions as necessary	• Action log capturing actions agreed with owners and deadlines (to be checked and followed up at each meeting) • Risks – captured to the risk register • Note of matters to escalate to the Care Group FWP meeting(significant risks and issues and good news stories)	• Specialty Clinical Lead (Chair) • Consultants • Matrons • Head of Service / Senior Manager NB: Other attendees may have standing invitations e.g. Business Support Officer? Or they may be invited for particular items

Care Group Level Meetings (recommended)

Meeting	Remit	Outputs	Membership
Quality Governance Group Monthly 2-3 hours	• Review the progress of complaint and incident investigations within Care Group and agree actions with respect to any delays or issues. • Review, understand and secure learning from incidents, complaints and claims which have been investigated since the last meeting. • Review the progress of the Care Group's clinical audit plan and agree actions with respect to any delays or issues. • Review clinical audit outcomes, and the outcomes of any similar benchmarking exercises, secure learning and agree action plans. • Review the progress of assessments against new NICE guidelines and agree actions with respect to any delays or issues. • Review and confirm assessments of compliance with NICE guidelines, safety alerts • Review staffing levels for safety • Review the Care Group risk register (clinical risks). Identify any new risks from discussion to be captured or escalated to Care Group Leadership • Review Patient Experience information / feedback and agree actions as necessary • Assure preparations for / self-assessment for relevant inspections / peer or Royal College reviews • Review outcomes of such inspections and agree action plans. • Review quality performance data (Best Practice Tariff, Quality Accounts, CQUIN etc. as it affects the Care Group and agree any necessary actions, including thematic data (falls, ulcers, Failure to Rescue etc). • Review mortality data • Disseminate any key messages / follow through any issues from Quality and Health care Goverance Committee / ECL / ED Performance review • Review regulatory compliance including CQC action plans **The agenda needs to cover the above from a top down perspective but seeking assurances from specialities and providing room for specialties to raise issues**	• Minutes • Action log capturing actions agreed with owners and deadlines (to be checked and followed up at each meeting) • Risks – captured to the risk register • Note of matters to escalate to the Care Group Leadership Team • Note of key messages / lessons learned for specialties	• AND (Chair) • Matrons • Speciality Clinical Leads • Heads of Service? NB: Other attendees may have standing invitations e.g. Governance Officer. Or they may be invited for particular items

Care Group Level Meetings (recommended)

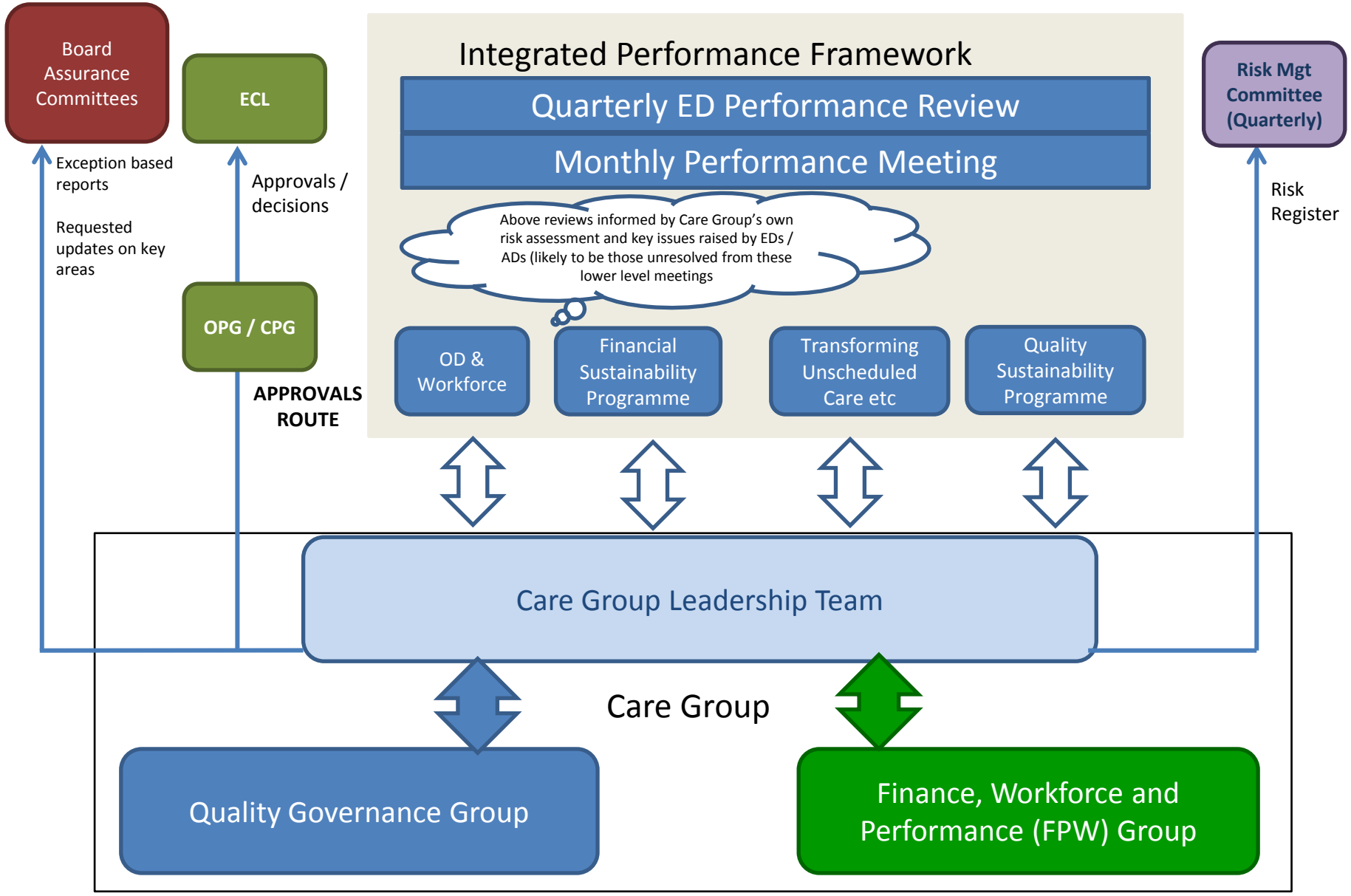
Meeting	Remit	Outputs	Membership
Financial, Workforce and Performance Group Monthly 2 hours?	• Review the position against the Care Group budget, and the forward forecast position, understanding variances at both Care Group and service level and agreeing actions with respect to any issues • Review draft Care Group business cases • Review specialty-level position with respect to workforce including training, appraisal and sickness rates and agree actions with respect to any issue. This will also include workforce engagement • Review demand forecasts and capacity (including workforce capacity / job planning), considering current and forecast needs and agree actions as necessary • Review operational performance and agree actions as necessary • Review the Care Group risk register (non-clinical risks). • Identify any risks to be captured / updated in the risk register and / or escalated to Care Group Leadership • Review progress in implementing change plans within services. • Disseminate any key messages / follow through any issues from Integrated Quality and Assurance Committee/ Finance Committee / ECL / ED Performance review **The agenda needs to cover the above from a top down perspective but seeking assurances from specialities and providing room for specialties to raise issues**	• Minutes • Action log capturing actions agreed with owners and deadlines (to be checked and followed up at each meeting) • Risks – captured to the risk register • Note of matters to escalate to the Care Group Leadership Team (significant risks and issues and good news stories) • Note of key messages / lessons learned for specialties	• ADO (Chair) • Heads of Service • Matrons • Clinical Leads NB: Other attendees may have standing invitations e.g. Business Support Officer? Or they may be invited for particular items

Care Group Level Meetings (recommended)

Meeting	Remit	Outputs	Membership

Care Group Leadership Team
 	
Monthly – 2 hours
	• Approval of Care Group IBP
	• Monitoring of progress against IBP
	• Oversight of change programme for clinical services
	• Higher level review of the following relying on the scrutiny of the Quality Governance and FWP Group meetings:
	  ○ Significant incidents
	  ○ Complaints
	  ○ Quality data (CQUIN, Quality Accounts, Mortality, BPT)
	  ○ NICE compliance position
	  ○ Regulatory compliance
	  ○ Patient Feedback
	  ○ Clinical audit position
	  ○ Quality / clinical risks
	  ○ Workforce indicators
	  ○ Demand and capacity issues (including forecast positions
	  ○ Operational performance
	• Approval of Care Group led business cases for submission to CPG / OPG
	• Approval of the Care Group risk register for submission to RMC (quarterly)
	• Approval of Care Group issues for escalation into the ED Performance Framework / ECL / EDs
	• Communication of key messages to Care Group senior management (from Board, EDs, ECL etc).
	• Receive and act, as necessary, on escalation reports from Quality Governance Group and FWP Group
		• Minutes (copied to ARC)
		• Action log capturing actions agreed with owners and deadlines (to be checked and followed up at each meeting)
		• Risks – captured to the risk register
		• Note of matters to escalate into the ED Performance Framework
		• Note of key messages / lessons learned for specialties
			• Care Group Clinical Director (Chair)
			• ADO
			• ADN
			• Clinical Leads
			• Matrons
			• Heads of Service

Interfaces between Care Group and Corporate Governance / Performance Management



SECTION 8: BEHAVIOURS

Essential behaviours – at all levels – for Governance to work well

Behaviours – all members / regular meeting attendees

Negative behaviours can undermine the effectiveness of well designed governance arrangements; positive behaviours can make badly designed governance arrangements effective, and in so doing improve their design over time.

Governance meetings represent a significant investment of time on the part of busy Board Members, Directors and managers. It is everyone's responsibility to behave in a way that helps meetings to be effective and to recognise a return on that investment, by observing the following core meeting standards.

1. Understand the purpose of the meeting.
2. Understand your role in attending.
3. Submit papers on time or agree any extension with the Executive Sponsor / Chairman in advance of the deadline where necessary.
4. Submit papers with the appropriate cover sheet and with an Executive Summary.
5. Attend all meetings where you are required unless unavailable i.e. not at work or attending another meeting with the prior agreement of the Chairman / Executive Sponsor.
6. Arrive before the meeting starts, with your papers (hard copy or electronic) and stay for the whole of the meeting unless leaving to attend other commitments with the prior agreement of the Chairman / Executive Sponsor.
7. If you cannot attend, submit apologies.
8. If you send a deputy, ensure that they understand 1 and 2 above and are able to fulfil your role.
9. If you sponsor attendance / presentations from others ensure that they are fully briefed as to 1 and 2 above, the purpose of the presentation and how it should address the Committee's purpose.

Behaviours – all members / regular meeting attendees

- Come prepared – ensure you have read all the papers before the meeting and:
  - Are ready to succinctly present the key points for your own papers (in the expectation that others will have read them; and
  - Have prepared questions to challenge or clarify matters reported on by others where it furthers the Committee's remit.
  - Have completed actions allocated you and are able to provide the Committee with a full update in respect of them.
- Declare any conflicts of interests at the outset of the meeting or, if not known at that point, as they arise.
- Present key points succinctly and be clear as to any decisions, views or support you are requesting from the Committee.
- Be honest and open in reporting any issues.
- In both papers and presentations set out actions being taken in respect of issues, how they are being overseen and the outcomes from such actions to date.
- Challenge constructively and freely in support of the Committee's purpose.
- Deal with minor points of clarification outside (preferably before) the meeting.
- Be respectful of others' contributions and questions.
- Follow the Chairperson's direction.

SECTION 9: KEY DOCUMENTS AND RESOURCE PACK

Key policies and procedures

Area	Policy / Procedure	Where located
Quality and Safety	• Being Open Duty of Candour Policy • Clinical Audit and Effectiveness Policy • Complaints and Concerns Policy • Incident Management Policy • Infection Control Policy • Learning from Experience Policy • Policy for the receipt, distribution and review of national reports, guidance, advice and alerts (NICE and Patient Safety Alerts) • Claims Handling Policy • Visits, audits, inspections and assessments by external bodies.	Policies and Procedures site on Staff Net.
Risk Management	• Risk Management Strategy • Business Continuity Policy • Emergency Preparedness Procedure	Policies and Procedures site on Staff Net.
Finance and Commercial	• Standing Financial Instructions • Scheme of Delegation • Gifts and Hospitality Policy (includes conflict of interests procedures) • Anti-Fraud Policy	Policies and Procedures site on Staff Net.

Key policies and procedures

Area	Policy / Procedure	Where located
Workforce and OD	• Capability Policy • Disability Policy • Disciplinary Policy • Dignity at Work Policy • Equality, Diversity and Human Rights Policy • Grievance Procedure • Management of Attendance Policy • Management of Stress in the Workplace Policy • Managing Organisational Change and Redundancy • Performance and Development Appraisal Policy • Raising Concerns Policy • Recruitment and Selection Policy • Staff Induction Policy • Training Needs Analysis, Monitoring and Evaluation • Medical Staff Appraisal and Revalidation Policy • Temporary Staffing Policy • Appointment of medical locums procedure	Policies and Procedures site on Staff Net Manager on Call site on intranet

Key policies and procedures

Area	Policy / Procedure	Where located
Information Governance	• Information Governance Policy • Information Risk Management Procedure • Confidential Waste Policy • Clinical Information Confidentiality Policy • IT Security Policy	Policies and Procedures site on Staff Net

Resource Pack

- Board / Committee Member responsibilities guidance
- Board Committee Assurance Reporting Template
- Board Committee Escalation Report Template
- Board Report Cover Sheet
- Committee Report Cover Sheet
- Specialty Governance – Example Work Plan
- Speciality Governance - Example Agenda
- Speciality Governance – Example Action Log
- Speciality Governance – Example Lessons Learned Communication