TERMS OF REFERENCE
Board of Directors and Sub-Committee Structures 6.2

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VERSION CONTROL SUMMARY			
VERSION	**SECTION REFERENCE**	**DESCRIPTION OF CHANGE**	**DATE APPROVED**
1.0	N/A	First issue	August 2015 for 1 year
2.0	All	Major revision of Board and Sub Committee Terms of Reference	August 2016 for 1 year
2.1	Cover, Appendix 2	Minor change: - Document control front cover inserted, - Audit committee terms of reference amended to authorise committee to act as appointment panel for external audit as agreed at the July 2016 Board meeting.	August 2016
3.0	All	Annual review of Board/Committee terms of reference.	May 2017 for 1 year
4.0	All	Annual review of Board/Committee terms of reference.	September 2017 for 1 year
4.1	All	Minor edits to correct errors.	October 2017
5.0	All	Board approval of updated Board/Committee terms of changes recommended by subcommittees as part of their annual effectiveness reviews. Terms of reference for the new People Participation Committee included for Board approval.	March 2018 for 3 years
5.1	All	General Update to include Trustwide Working Together Group and reflect Gill Thomas new role.	November 2018
5.2	All	- General Update to update with new Non-Executive Committee assignments - Changes recommended by committees - new terms of reference for Joint Children's Partnership Board.	March 2019
5.2.1	All	- General Update to update with change to Board/Committee Structure - Updates to the Estates committee Terms of Reference following a review by the committee	May 2019
6.0	All	- General update to reflect changes to the Board/Committee Structure - Updates to the Infrastructure (previously Estates) committee Terms of Reference following a review by the committee - Removal of Strategic Change	March 2020

		Board - Reconfiguration of Clinical Operational Boards	
6.1	Appendix 4	- Updates to the Infrastructure committee Terms of Reference following a review by the committee	May 2020
6.2		- Addition of Mass Vaccination Operational Board - General update on lead roles: Appendix 10.	March 2021
6.3	All	- Updates and refresh to the full document including; - The removal of the separate mass vaccination clinical operations board arrangements as this is covered under the clinical operations board section as business as usual. - Refresh of the appendices including: Appendix 10 to reflect changes in lead roles Appendix 11 to reflect changes in Non Executive Director appointments and staff roles Appendix 12B to reflect the introduction of the digital transformation board and the reporting of the EPRR operational group to QIS Comm	March 2022

TABLE OF CONTENTS **Page**

1.0 INTRODUCTION

The governance landscape within which the Trust is operating is changing with the introduction of Integrated Care Systems and this will inevitably require adaption of the Trust's governance arrangements and Board terms of reference and sub committee arrangements. It is therefore highly likely that these terms of reference will be reviewed and updated during the course of the year as a result. Once the impact of the changes are clearer this document will be updated for Sub Committee and Board review and approval.

1.1 Purpose and Duties

The purpose and duties of the Board and individual Committees are set out in the attached appendices.

2.0 AUTHORITY OF THE COMMITTEES

2.1 The practice and procedure of the meetings of the Board, and of its Committees, are set out in the Board's Standing Orders, together with the decisions/duties delegated by the Board, to the Committees.

2.2 The Committees are authorised by the Board to investigate any activity within their terms of reference and to seek any information they require from any member of staff. Staff must cooperate with any request made by the Committees.

2.3 The Committees are authorised by the Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if they consider this necessary.

2.4 The Committees shall work within the escalation framework determined by the Board at all times.

3.0 MEMBERSHIP

3.1 The Board shall be comprised of all Executive and Non-Executive Directors, including the Chair and the Chief Executive of the Trust.

3.2 The Board's Committees shall be comprised of the minimum number of Non-Executive Directors (as specified in the committees' terms of reference), one of whom shall be the Chair, appointed by the Board, together with the following, *ex officio*:

<u>Audit</u>

(i) At least one member shall have significant, recent and relevant financial experience.

(ii) The Board Chair shall not be a member of the Committee and the Vice-Chair shall not Chair the Committee.

<u>Charitable Funds</u>

(i) Two Executive Directors

<u>Infrastructure</u>

(i) The Director of Finance & Resources and the Director of Governance.

Clinical Operational Boards

(i) All directors shall be assigned across all the Clinical Operational Boards. The Committee Chair shall be a Non-Executive Director.

Quality Improvement and Safety

(i) The Chief Nurse, Medical Director and Director of Workforce.

Remuneration

(i) The Trust Chair shall not be the Chair of the Committee, but shall act as an *ex-officio* member of the Committee and should be present when the Chief Executive's performance and remuneration is being discussed.
(ii) The Chief Executive and Director of Workforce shall attend the Committee as and when requested.

People Participation

(i) Two Executive Directors.

3.3 Executive members who are unable to attend a meeting are required to send a fully briefed deputy or provide a written update to the Committee members at least two working days prior to the meeting.

3.4 All members are required to attend at least 75% of Board/Committee meetings.

4.0 ATTENDANCE

4.1 Other relevant Directors may attend as needed. In particular:

Audit

(i) The Director of Finance and Resources, Director of Governance, Assistant Director of Corporate Governance and appropriate Internal and External Audit representatives shall attend all meetings.
(ii) The Counter Fraud Specialist shall attend all meetings.
(iii) The Chief Executive, Chair and other organisational managers may be invited to attend meetings for specific agenda items or when issues relevant to their area of responsibility are to be discussed.
(iv) The Chief Executive should be invited to attend, at least once annually, to discuss with the Audit Committee the process for assurance that supports the Statement on Internal Control.
(v) Attendance at Committee meetings shall be disclosed in the Trust's Annual Report and Accounts.

Remuneration

(i) The Chief Executive may attend meetings, as requested, but will withdraw when his/her own remuneration and performance is under review.
(ii) The Director of Workforce for the Trust, or nominee, may be invited to give advice and information, but will withdraw when his/her own remuneration and performance is under review.

4.2 The Committees may invite other managers and staff to meetings to report on specific items relevant to their objectives.

4.3 The Assistant Director of Corporate Governance or a delegated representative shall be in attendance at all Board and Committee meetings.

5.0 QUORUM

5.1 The Quoracy shall consist as follows:

Audit	2 members
Board	One-third, one of whom shall be a Non-Executive Director and one of whom shall be an Executive Director.
Charitable Funds	2 members, at least one of whom shall be a Non-Executive Director and at least one of whom shall be an Executive Director.
Infrastructure	3 members, at least one of whom shall be a Non-Executive Director and one of whom shall be an Executive Director.
Clinical Operational Boards	
Quality Improvement and Safety	
People Participation	
Remuneration	2 members

5.2 A duly convened meeting of the Board or Committee, at which a quorum is present, shall be competent to exercise all or any of the authorities, powers and discretions vested in, or exercisable by, the Board or Committee.

6.0 FREQUENCY

6.1 The Board shall meet every other month in public and in private unless otherwise agreed.

6.2 The Board's Committees shall meet as follows:
(i) Audit shall meet quarterly;
(ii) Clinical Operational Boards shall meet every other month;
(iii) Quality Improvement and Safety shall meet quarterly;
(iv) Remuneration shall meet at least once a year;
(v) Infrastructure shall meet quarterly;
(vi) Charitable Funds shall meet twice yearly; and
(vii) People Participation Committee shall meet quarterly.

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

7.0 REPORTING

7.1 The minutes of Board and Committee meetings shall be formally recorded by the Trust. All Committee minutes shall be made available to all Directors. The Assistant Director of Corporate Governance or a delegated representative shall be in attendance at all Board and Committee meetings to record the minutes of the meeting and be responsible for the safe custody of the minutes.

7.2 To provide assurance on the responsibilities of the Committee, the Chair of the Committee shall submit to the Board a brief report, highlighting any issues that require escalation or disclosure to the full Board, as outlined in the relevant appendices as well as a summary of key issues for the Board's attention.

7.3 Brief key issue reports shall be submitted to the Committees from their sub-groups (as outlined in the appendices), which shall report directly to the Committees as set out in the committee's annual cycle of business. Reports on key milestones in work streams shall also be expected as and when these arise.

8.0 DELEGATION

8.1 The Board shall agree delegation of duties to Committees, as set out in Standing Orders (section A5 and section C).

8.2 Detailed duties of the Board and Committees shall be included in the appendices to these Terms of Reference.

9.0 ADMINISTRATION

The Assistant Director of Corporate Governance or a delegated representative shall support the Board and Committees by:

9.1 Agreement of agenda with the Chair and other members of the committee.

9.2 Providing timely notice of meetings and forwarding details including the agenda and supporting papers to members and attendees in advance of the meetings.

9.3 Enforcing a disciplined timeframe for agenda items and papers, as below:
(i) At least 7 working days prior to each meeting, agenda items will be due from Committee members.
(ii) At least five working days prior to each meeting, papers will be circulated to all members and any attendees, as set out in Standing Orders.

The Assistant Director of Corporate Governance shall have authority to reject papers which are late or have been inadequately prepared in consultation with the Chair.

9.4 Recording and circulating formal minutes of meetings and keeping a record of matters arising and issues to be carried forward, circulating draft minutes within five working days from the date of the last meeting to the Board or Committee Chair and Lead Executive.

9.5 Advising the Chair and the Board/Committee about meeting procedures, fulfilment of the Board/Committee's Terms of Reference and related governance matters, risk management and internal control systems.

9.6 Reports which do not require discussion shall be starred. Any member of the Committee wishing to discuss a starred item should contact the Assistant Director of Corporate Governance at least 24 hours before the Committee meets. Reports will not be un-starred after this time.

9.7 Items of Any Other Business (AOB) shall be raised with the Chair or Assistant Director of Corporate Governance by close of play on the day before the

Board/Committee meets. Items of AOB raised by members on the day of the meeting may be discussed at the discretion of the Chair.

9.8 The minutes of any confidential part of a Committee meeting shall be presented to Board meetings in private in line with 3.17(i) of the Board's Standing Orders:

> *"That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" Section 1(2), Public Bodies (Admissions to Meetings) Act 1960.*

10.0 REVIEW

10.1 The Board shall undertake a self-assessment on an annual basis to consider its effectiveness in discharging its responsibilities as set out in these Terms of Reference.

10.2 Committees shall undertake a self-assessment at least once a year (including level of attendance (quoracy), regularity of meetings, reporting arrangements into and out of Committees and Board) and consider their effectiveness in discharging their responsibilities as set out in these Terms of Reference and report back to the Board on an annual basis.

10.3 The Board/Committee shall review its Terms of Reference at least once a year to ensure it is operating at maximum effectiveness. Any proposed changes shall be submitted to the Board for approval.

APPENDIX 1 - BOARD

1.0 Purpose

1.1 The Board leads the Trust to enable the organisation to provide high quality services by undertaking three key roles:

(i) Formulating strategy.
(ii) Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable.
(iii) Shaping a positive culture for the Board and the organisation.

1.2 The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the corporation as a whole and for the public.

2.0 Main Duties

2.1 General responsibilities

The general responsibilities of the Board are:

(i) to work in partnership with service users, carers, local health organisations, local government authorities and others to provide safe, accessible, effective and well governed services for service users;
(ii) to ensure that the Trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity; and
(iii) to exercise collective responsibility for adding value to the Trust by promoting its success through direction and supervision of its affairs in a cost effective manner.

2.2 Leadership

The Board provides active leadership to the organisation by:

(i) ensuring there is a clear vision and strategy for the Trust that people know about and that is being implemented, within a framework of prudent and effective controls which enable risk to be assessed and managed;
(ii) ensuring the Trust is an excellent employer by the development of a workforce strategy and its appropriate implementation and operation.

2.3 Strategy

The Board:

(i) sets and maintains the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;
(ii) monitors and reviews management performance to ensure the Trust's objectives are met;
(iii) oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;
(iv) develops and maintains an annual business plan and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders;
(v) ensures that national policies and strategies are effectively addressed and implemented within the Trust.

2.4 Culture

The Board is responsible for setting values, ensuring they are widely communicated and that the behaviour of the Board is entirely consistent with those values.

2.5 Governance

The Board:

(i) ensures that the Trust has comprehensive governance arrangements in place that guarantee that the resources vested in the Trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements;
(ii) ensures that the Trust complies with its governance and assurance obligations in the delivery of clinically effective, personal and safe services taking account of patient and carer experiences;
(iii) ensures compliance with the principles of corporate governance and with appropriate codes of conduct, accountability and openness applicable to NHS Trusts;
(iv) formulates, implements and reviews Standing Orders and Standing Financial Instructions as a means of regulating the conduct and transactions of Trust business;
(v) ensures that the statutory duties of the Trust are effectively discharged;
(vi) acts as Corporate Trustee for the Trust's charitable funds.

2.6 Risk Management

The Board:

(i) ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities;
(ii) ensures that there are sound processes and mechanisms in place to ensure effective user and carer involvement with regard to development of care plans, the review of quality of services provided and the development of new services;
(iii) ensures there are appropriately constituted appointment arrangements for Executive Directors and other senior positions within the Trust.

2.7 Ethics and Integrity

The Board:

(i) ensures that high standards of corporate governance and personal integrity are maintained in the conduct of Trust business;
(ii) establishes appeals panels as required by employment policies, particularly to address appeals against dismissal and final stage grievance hearings;
(iii) ensures that Directors and staff adhere to any codes of conduct adopted or introduced from time to time.

2.8 Committees

The Board is responsible for maintaining Committees of the Board with delegated powers as prescribed by the Trust's Standing Orders and/or by the Board, from time to time. The Board retains legal responsibility for the full range of its duties and reserves to itself certain duties, as detailed in Standing Orders, Section C.

2.9 Communication

The Board:

(i) ensures an effective communication channel exists between the Trust, its staff and other stakeholders;
(ii) ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback;
(iii) ensures that those Board proceedings and outcomes that are not confidential are communicated publically, primarily via the Trust's website;
(iv) publishes an annual report and accounts.

2.10 Financial and Quality Success

The Board:

(i) ensures that the Trust operates effectively, efficiently and economically;
(ii) ensures the continuing financial viability of the organisation;
(iii) ensures the proper management of resources and that financial and quality of service responsibilities are achieved;
(iv) ensures that the Trust achieves the targets and requirements of stakeholders within the available resources;
(v) reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

Last Reviewed by Board: March 2022
Next review: March 2023

APPENDIX 2 – AUDIT COMMITTEE

In line with requirements of NHS Codes of Conduct and Accountability, the NHS Audit Committee Handbook 2014, the UK Corporate Governance Code 2014 and the Higgs Report, the Trust is required to establish an Audit Committee.

1.0 Purpose

1.1 To provide the Trust Board with an independent and objective review on its financial systems, information used by the Trust and compliance with laws, guidance, and regulations governing the NHS, including assurance, performance and risk management systems.

1.2 By independently reviewing internal control, the Committee provides assurance to the Chief Executive, as Accountable Officer, about the fulfilment of duties under the terms of the National Health Service Act 2006.

2.0 Main Duties

The duties of the Committee may be categorised as follows:

2.1 <u>Governance, Risk Management and Internal Control</u>

(i) The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management, internal control and quality accounts, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. In particular, the Committee shall review the adequacy of:

- all risk and control related disclosure statements (in particular the Statement on Internal Control and declarations of compliance with the Quality and Safety Standard (CQC), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements;
- the policies and procedures for all work related to fraud, corruption and bribery, as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service;
- the Trust's whistle blowing policies and procedures to ensure that arrangements are in place for proportionate and appropriate investigation.

(ii) In carrying out this work, the Committee shall primarily utilise the work of Internal Audit, External Audit, counter fraud and other assurance functions, but shall not be limited to these audit functions. It shall 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.

(iii) This shall be evidenced through the Committee's use of effective Assurance Systems to guide its work and that of the audit and assurance functions that report to it.

(iv) Review of relevant risks

(v) Discussion of emerging risks and significant issues

2.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This shall be achieved by:

(i) consideration of the provision of the Internal Audit service, the cost of the audit and any questions of appointment, reappointment, resignation and dismissal;
(ii) 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;
(iii) consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the Internal and External Auditors to optimise audit resources;
(iv) ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;
(v) annual review of the effectiveness of internal audit and completeness of actions arising from audits.

2.3 External Audit

Under the Local Audit and Accountability Act 2014, NHS trusts and clinical commissioning groups (CCGs) must select and appoint their own auditors and directly manage their contracts for the audits for the financial year starting on 1 April 2017.

The Committee shall review the work and findings of the External Auditors appointed by the Trust and consider the implications and management's responses to their work, assuring itself that the management of the Trust has implemented the agreed recommendations of External Audit reports in a timely and effective way. This shall be achieved by:

(i) consideration of the provision of the External Audit service, the cost of the audit and any questions of appointment, reappointment, resignation and dismissal;
(ii) discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy;
(iii) discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee;
(iv) reviewing all External Audit reports, including agreement of the ISA 260 before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

2.4 Clinical Audit

The Responsibility for Clinical Audit sits with the Quality Improvement and Safety Committee. The Audit Committee shall receive assurance that Quality Improvement and Safety Committee has:

(i) Reviewed and approved an annual clinical audit programme and advised the Board on learning from the outcomes from audit reports.
(ii) Ensured that management processes are in place which provide assurance that the Trust has taken appropriate action in response to relevant clinical audit reports, considered the implications and management's responses to their work, assuring itself that the management of the Trust has implemented the agreed recommendations of Clinical Audit reports in a timely and effective way.

2.5 Financial Reporting

(i) The Audit Committee shall review the Annual Report and Financial Statements

before submission to the Board, focusing particularly on:

- the wording in the Statement on Internal Control and other disclosures relevant to the terms of reference of the Committee;
- changes in, and compliance with, accounting policies and practices;
- unadjusted miss-statements in the financial statements,
- major judgemental areas and significant adjustments resulting from the audit.

(ii) 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.

(iii) The Committee shall be responsible for reviewing schedules of losses and compensations (or special payments) and making recommendations to the Board, as necessary.

2.6 Other Assurance Functions

(i) The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

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

(iii) In addition, the Committee shall review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This shall particularly include the Quality Improvement and Safety Committee and the Infrastructure Committee.

(iv) In reviewing the work of the Quality Improvement and Safety Committee, and issues around clinical risk management, the Audit Committee shall wish to satisfy itself on the assurance that can be gained from the clinical audit function.

(v) The Committee shall review the assurance mechanisms in place at the Trust to ensure value for money from third party Shared Services Providers.

(vi) The Committee shall monitor compliance with the Trust Standing Orders and Standing Financial Instructions.

(vii) Where the Audit Committee considers there is evidence of *ultra vires* transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health, (to the Director of Finance and Resources in the first instance).

2.7 Management

(i) The Committee shall request and review reports and positive assurances from Directors and managers on the overall arrangements for governance, risk management and internal control.

(ii) It may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

2.8 NHS Security Management Measures

(iii) The Chair of the Audit committee shall be the Non-Executive Director responsible to the Board for NHS security management to comply with the Secretary of State Directions on NHS Security Management Measures 2004.

(iv) To set the overall systems of control and to ensure financial and information governance security are covered in the committee's work.

2.9 Standing Items

(i) Quarterly review of the Board Assurance Framework.
(ii) Internal and External Audit Reports including Local Counter Fraud Service.
(iii) Annual Audit Letter (annually).
(iv) Annual Report and Accounts (annually).
(v) Issues from other committees.
(vi) Losses, Waivers and Special Payments.
(vii) Gifts and Hospitality Register (annually).
(viii) Legal Updates (when appropriate).

3.0 Items Requiring Escalation

(i) The Committee shall report to the Board annually on its work in support of the Statement on Internal Control, specifically commenting on the fitness for purpose of the risk management and internal control processes, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against the Quality and Safety Standards (CQC).
(ii) Losses above £250k, or which may have a significant impact upon the Trust.
(iii) Risks for which mitigating actions are overdue, insufficient mitigation is identified or the risk ratings are questioned.

4.0 Membership, Chairship and quorum

4.1 The Audit Committee will be comprised of three Non-Executive Directors. Other Board members may attend if required.

4.2 The Board Chair shall not be a member of the Committee and the Vice-Chair shall not Chair the Committee.

4.3 At least one member shall have significant, recent and relevant financial experience.

4.4 The quorum of the committee shall consist of 2 members.

4.5 Other relevant parties may attend as needed. In particular:

(i) The Director of Finance and Resources, Director of Governance and Assistant Director of Corporate Governance shall attend all meetings.
(ii) Appropriate Internal and External Audit representatives shall attend all meetings.
(iii) The Counter Fraud Specialist shall attend all meetings.
(iv) The Chief Executive, Chair and other organisational managers may be invited to attend meetings for specific agenda items or when issues relevant to their area of responsibility are to be discussed.
(v) The Chief Executive shall be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Statement on Internal Control.
(vi) Attendance at Committee meetings shall be disclosed in the Trust's Annual Report and Accounts.

5.0	**Extraordinary Audit Committee Meeting**
5.1	The Audit Committee shall hold at least one Extraordinary Audit Committee meeting each year to: o receive the Head of Internal Audit Opinion;

	○ receive the Annual Audit Letter; and ○ sign-off the annual governance statement and annual accounts.
5.2	The Board Chair shall and Chief Executive shall be in attendance for this meeting.

Last Reviewed: March 2022
Next review: March 2023

APPENDIX 3 – CHARITABLE FUNDS

1.0 Purpose

1.1 To advise the Board of Directors, as Corporate Trustee, on the management and use of the Trust's charitable funds.

1.2 The Committee is a committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference. Responsibility for the Charitable Funds rests entirely with the Board. The Board shall retain overall control of the charity's activities, taking into account the recommendations submitted by the Committee. The Board shall set out its investment policy in writing.

2.0 Main Duties

2.1 Charitable Funds Committee

(i) Consider and recommend to the Board any changes in investment policy.
(ii) Review performance of current investments in respect of both income and capital appreciation
(iii) Review the fundraising methods used and ensure that they are acceptable in terms of a health/public body context.
(iv) The Committee shall determine the strategy for fundraising and the gift acceptance policy
(v) To agree the expenditure strategy and policies of the Funds within the framework of the Governing Document which defines the purposes for which the charity has been established.
(vi) To monitor compliance with the strategy and policies and ensure that the wishes of the donors are met.
(vii) To approve Charitable Fund bids for expenditure in accordance with the relevant procedures.
(viii) All fundraising bids to external bodies shall be subject to committee approval.
(ix) To determine the format of the performance information it requires, in order to manage the Charitable Funds in the most effective manner. This shall include information on fundraising, expenditure and investment.
(x) To review, and recommend to the Board for approval, the Charitable Funds Annual Accounts and Annual Report.
(xi) To receive reports from both the Internal and External Auditors for the Trust concerning Charitable Funds and monitor and review the implementation of any recommendations.
(xii) To review the Charitable Funds Audit Report prior to submission to the Trust's Audit Committee.
(xiii) The committee shall appoint member(s) of the different funds and annually approve their continued membership
(xiv) The committee shall determine a process for appealing decisions and who sits on the appeals panel.
(xv) The Committee shall review investments in accordance with the following objectives:
    - Ensuring that funds are properly protected and that, as far as possible, capital is not put at risk and will be protected against inflation.
    - Obtaining best income from the investments with which to carry out the purposes of the various individual funds.

2.2 Fundraising Committees

(i) Fundraising committees shall be formed and membership shall be agreed by the
(ii) Charitable Funds Committee.

(iii) The fundraising committees shall undertake a programme of fundraising activities in line with the fundraising strategy.
(iv) The fundraising committees may have delegated authority regarding the use of the charitable funds, in line with the Strategy for Charitable Funds
(v) Any expenses incurred by the fundraising committees shall be defrayed against funds raised and must first be approved by the Secretary to the Charitable Funds Committee.
(vi) Minutes of the fundraising committees shall be submitted to the next meeting of the Charitable Funds Committee, for information.

2.3 Risks
(i) Review of relevant risks
(ii) Discussion of emerging risks and significant issues

3.0 Conversion to independent status

3.1 Below are the provisions for dissolution or winding up of NHS Charitable Funds referred to as 'Conversion to independent status'. In this context, this involves:

- the creation of a new charity suggested to be corporate in form – either a company limited by guarantee (CLG) or a charitable incorporated organisation (CIO) - in relation to which the Secretary of State for Health / Department of Health has no formal powers;
- the transfer to the New Charity of all the whole undertaking of the NHS Charity; and
- the winding up of the NHS Charity

3.2 (i) Provisions for dissolution or conversion to independent status:NHS Charity trustees agree to investigate conversion.
(ii) The Charitable Funds Committee shall review advantages and disadvantages and collect information.
(iii) If the Charitable Funds Committee decides NOT to convert no further action is required.
(iv) If the Charitable Funds Committee agrees to convert then the committee will need to present the proposal to the Board, as Corporate Trustee, for approval.
(v) If approved by the Board, the Charitable Funds Committee shall notify the Department of Health and the Charities Commission of intention to convert.
(vi) The Charitable Funds Committee shall then:
- Collate details of charity assets and liabilities.
- Develop governing instrument for the New Charity.
- Analyse the staffing and accommodation position.

(vii) If the Charitable Funds Committee if proposes to transfer the charitable funds into an existing charity, the committee shall:
- Conduct due diligence of the Charity.
- Ensure the objects of the Charity are similar to the objects of the charitable funds.
- Develop with the Charity terms of agreement or memorandum of understanding.

(viii) If a New Charity is being established, the Charitable Funds Committee shall develop, with the New Charity, terms of agreement or memorandum of understanding and create the new Charity.
(ix) The New Charity must apply for registration with the Charities Commission and HMRC.
(x) NHS Charity trustees and the New Charity then take the following steps:
- Finalise and execute terms of agreement or memorandum of

understanding with NHS body.
- Notify the Department of Health.
- Notify/consult employees. The New Charity obtains NHS pensions scheme 'direction employer' status (if relevant). Transfer assets to the New Charity and wind up the NHS Charity. Register merger of the NHS Charity with the New Charity with the Charities Commission.

4.0 Items Requiring Escalation

(i) Any expenditure likely to amount over £5,000 in one year or £10,000 over a 3 year period.
(ii) Any outstanding audit actions.
(iii) Any fraud or other crime related to the Charitable Funds.
(iv) Any risks with a rating of 15 or above and/or for which mitigating actions are overdue, insufficient mitigation is identified or the risk ratings are questioned.

5.0 Standing Items and Receipt of Key Issue Reports

(i) Dreamsdrops Update
(ii) Charitable funds accounts.
(iii) Charitable funds bids.
(iv) Audit reports.
(v) Review of risks and discussion of emerging risks
(vi) Minutes of fundraising sub-committees.

6.0 Membership, Chairship and quorum

6.1 The membership of the Committee will be comprised as follows:
- 2 Non-Executive Directors.
- 2 Executive Directors.
- A quorum will be 2 members, at least one of whom shall be a Non-Executive Director and at least one Executive Director.

Due for Review by Committee: March 2022
Next review: March 2023

APPENDIX 4 – INFRASTRUCTURE COMMITTEE

1.0 Purpose

1.1 To support the Board by ensuring that the Estates and Digital Strategies are developed and implemented and that there are effective structures and systems in place to support quality services and safeguard high standards of patient care.

1.2 To advise the Board on Trust compliance with legal requirements best practice including health and safety, infection control and sustainability and other Infrastructure matters.

1.3 To provide an effective reporting, escalation and engagement route for appropriate sub groups of the Infrastructure Committee and key internal stakeholders.

2.0 Main Duties

2.1 Strategy

(i) To provide oversight of the development and implementation the Trust's Estates and Digital Strategies ensuring that they are delivered in a proactive, efficient and incremental fashion, to the benefit of all staff, patients and visitors.
(ii) To ensure estates and IT planning and delivery is as appropriate as possible, reflecting the needs of services and key stakeholders.
(iii) To review development issues including estate requirements in support of delivering the Integrated Business Plan and relocation issues.

2.2 Compliance

(i) To ensure the Trust estate and IT infrastructure remain statutorily compliant.
(ii) To ensure that there are effective systems in place to provide the Board with assurance of the Trust infrastructure statutory compliance.

2.3 Maintenance

(i) To have oversight of service issues requiring further attention or escalation.
(ii) To ensure appropriate participation in, and completion of, annual returns.

2.4 Capital Projects

(i) To approve a rolling capital plan for the Trust.
(ii) To review progress against the capital plan including:
- Adverse variance which is higher than £100,000 or 10% for each specific project or overall capital plan.
- Adverse variance which is higher than £100,000 or 10% of year to date budget.
- Delivery of projects against agreed timeline.

2.5 Policy and Strategy

(i) To review all Trust policies relating to the Committee's remit on behalf of the Board.
(ii) To review all Trust strategies relating to the Committee's remit and make recommendations on their adoption to the Board.

2.6 NHS Security Management Measures

To ensure that physical assets and people working, visiting or receiving treatment in them are secure.

2.7 Standing Items

(i) Reports on the performance of the estates Management Service Contracts as

set out in Service Level Agreements and contract documents, e.g. planned maintenance programme delivery.

(ii) Issues concerning the delivery of the estates Strategy and service on Trust sites that have not been resolved at the operational / delivery level.
(iii) Ensure that a joined up approach to estates and IT implementation plans.
(iv) Review of Risks
(v) Standardised report on progress on projects, Freehold Property, Leasehold Property Management, Capital Projects and Cost Improvement Programme.

2.8 Risks

(i) Review of relevant risks
(ii) Discussion of emerging risks and significant issues

3.0 Items Requiring Escalation

(i) Variances against programme/plan desired outcomes/timelines/milestones, or where milestones/timelines are not defined.
(ii) Adverse variance which is higher than £250,000 and 15% of year-to-date target for cost improvement plans.
(iii) Adverse variance which is higher than £250,000 and 15% for each specific project or overall capital plan.
(iv) Any risk with a rating of 15 or above and/or for which mitigating actions are overdue, insufficient mitigation is identified or the risk ratings are questioned.
(v) Any non-compliance with legal requirements
(vi) Any action three months or more beyond its due date

4.0 Receipt of Key Issue Reports

(i) Health and Safety Group
(ii) Infection Prevention and Control Group
(iii) Sustainability Group

5.0 Membership, Chairship and quorum

5.1 The Infrastructure committee shall be comprised of two Non-Executive Directors and two Executive Directors, but other Board members may attend if required.

5.2 The Chair of the Infrastructure Committee shall be a Non-Executive Director.

5.3
- The Assistant Director of Estates & Facilities shall be in attendance.
- The Assistant Director of ICT shall be in attendance.
- Service Directors and other staff members may also attend at the request of the committee.

5.4 The quorum of the committee shall consist of 3 members, one of whom shall be a Non-Executive Director and one of whom shall be an Executive Director.

Last Reviewed by Board: March 2022
Next review: March 2023

APPENDIX 5 – CLINICAL OPERATIONAL BOARDS

1.0 Introduction

1.1 There are three Clinical Operational Boards at Cambridgeshire Community Services NHS Trust:

- Children and Young People's Services
- Adults Services
- Large Scale Vaccination

1.2 Clinical Operational Boards shall meet bi- monthly.

1.3 The Clinical Operational Board have the same responsibilities and these are set out below:

2.0 Purpose of the Clinical Operational Boards

2.1 To support the Trust Board by undertaking integrated governance analysis (reviewing the interrelationships between quality, finance, workforce and performance) for the areas of service and geographic responsibility covered by the Clinical Operational Boards.

2.2 To provide assurance of the achievement of standards relating to quality, finance, performance and workforce and highlight areas of concern and recommendations for change to the Board.

2.3 Areas of specific responsibility, on which assurance is to be given:

(i) Achievement of quality standards (patient safety, patient experience and clinical effectiveness).
(ii) Financial strategy, budget setting, investment proposals, delivery of cost improvement plans and activity information to support the continuing financial viability of the Trust.
(iii) Achievement of performance objectives - Key Performance Indicators (KPIs).
(iv) Efficiency and Economy, Effectiveness and Efficacy.
(v) Progress on the tendering, negotiation and finalisation of contracts with commissioners and suppliers.
(vi) Oversight of the implementation of any service specific action plans relating to commissioners, regulatory matters or audits.
(vii) Review of key service risks and discussion of emerging risks and significant issues.
(viii) Patient and Staff experience.

3.0 Main Duties

Operational performance:

3.1 To report to the Trust Board on the status of the quality, financial (including cost and service improvement plans), workforce and operational performance for the service. These areas should be analysed in an integrated matter with a clear understanding on the interdependent issues impacting on patient care.

3.2 At each bi-monthly meeting, assess the potential shortfalls and risks facing services and recommend any Trust Board level actions/decision making that is needed to address these issues.

3.3 To advise the Trust Board on the consequences of any significant breaches or failure of performance in line with the escalation framework.

3.4 To receive reports from project and operational work streams identified within the service's annual plan.

3.5 To review, analyse, assess and validate corrective action plans for any performance and operational metric where the service is not currently achieving, or projected not to achieve the agreed/specified outcome.

3.6 Report on specific workforce initiatives covering all aspects of workforce development, education, training and development including divisional level staff stories or staff experience reports.

Risks

3.7 To review and monitor the risks in the risk register with regard to quality, financial, workforce and performance issues including emerging risks and significant issues.

3.8 Assure the Board that service risks have appropriate mitigation and oversight.

3.9 To receive assurance that at service level:

- the systems are in place and operating effectively for the identification, assessment, prioritisation and management of potential and actual risk;
- the trends and significant risks across the service(s) are reported and advise on controls for high risks.

3.10 To recommend areas requiring further audit (internal and external) attention to the Audit Committee and assist it in ensuring that the Trust's Audit plans are focused on relevant aspects of the Trust's (and service level) risk profile.

Efficiency and Economy, Effectiveness and Efficacy:

3.11 As part of the annual planning process (and more frequently if needed)

(i) Advise the Trust Board on whether the service is being run as efficiently, economically and effectively as possible or whether a better approach could be provided utilising benchmarking data.
(ii) To advise the Trust Board on opportunities and challenges of co-operating with local providers and commissioners.
(iii) To monitor delivery of Cost Improvement Plans
(iv) To monitor agency usage in the division, including:
    - trends in agency usage and spend (i.e. high agency dependent services);
    - use of off framework providers; and
    - overrides.

Policies and strategy

3.12 Oversee the development of annual plans for the service and associated supporting strategies to bring the service operational plan into reality.

Developmental issues:

3.13 The Clinical Operational Board will provide a forum to discuss and agree priorities for development of the service(s). Specifically this will include:

(i) Developing the governance capability of the leadership team.
(ii) Supporting the service(s) to operate as a quasi-Board – understanding responsibilities, lead roles and accountability for actions and behaviour. Ensure leaders move from reactive to proactive planning over a longer time frame.
(iii) Development of an appropriate cycle of business – linking into other Committees of the Board

NHS Security Management Measures

3.14 To ensure that staff, visitors and portable assets are secure across the service.

Standing Items

3.15 Regular information and issues to be discussed at appropriate frequency at the Clinical Operational Board shall include (but not be limited to) integrated analysis of service Quality, Finance, Workforce and Performance.

3.16 As set out in the cycle of business approved by the Board.

4.0 Items Requiring Escalation

4.1 The Clinical Operational Boards will report to the Trust Board the items listed below. All escalation points should make clear if an escalation is for information only or if the Trust Board is being asked to make a decision.

(i) All Quality Early Warning Trigger Tool (QEWTT) scores of over 16 in any service plus any service which has not submitted a QEWTT form for two consecutive months.
(ii) Red rated KPIs for 2 consecutive months (including contract, quality, finance and workforce metrics).
(iii) KPIs not turning green at the planned point on the action plan.
(iv) KPIs for which there is no green-rated action plan.
(v) Adverse variance which is higher than £100,000 and 10% of year-to-date target for cost improvement plans.
(vi) Adverse variance which is higher than £100,000 and 10% of year to date budget.
(vii) Areas of formal concern from CQC and other regulators.
(viii) Commissioning contract queries.
(ix) Any risks with a rating of 15 or above and/or for which mitigating actions are overdue, insufficient mitigation is identified or the risk ratings are questioned.
(x) Discussion of emerging risks and significant issues
(xi) Any themes from staff stories or staff experience reports that may have Trust wide implications
(xii) Outstanding Practice or Innovation

5.0 Membership, Chairship and Quorum

5.1 Each of the Clinical Operational Boards will be comprised of two Non-Executive Directors and two Executive Directors, but other Board members may choose to attend any meeting.

5.2 The Chair of the Clinical Operational Board shall be a Non-Executive Director.

5.3 The relevant Service Director and supporting corporate staff will also attend. Other members of the service may also attend at the request of the Chair or Service Director.

5.4 The expectation is that clinical leaders within the service will be invited to attend the Clinical Operational Board frequently.

5.5 The quorum of the committee shall consist of 3 members, one of whom shall be a Non-Executive Director and one of whom shall be an Executive Director.

APPENDIX 6 – QUALITY IMPROVEMENT AND SAFETY COMMITTEE

1.0 Purpose

1.1 To foster a culture of continuous improvement with regard to the following:

(i) To ensure patient safety is at the heart of the delivery of services within the Trust and to provide assurance that the Trust meets all its duties and responsibilities to its patients, users and staff.

(ii) To ensure that there are effective structures and systems in place to support the continuous improvement of quality services and safeguard high standards of patient care.

(iii) To advise the Board on Trust compliance with quality regulatory requirements and accreditation (e.g. NHS Improvement, Care Quality Commission (CQC), NHS Resolution, National Patient Safety Agency (NPSA), National Institute for Health and Clinical Excellence (NICE).

2.0 Main Duties

2.1 <u>Registration Compliance and Accreditation</u>

(i) To review reports from external agencies e.g. NHS Resolution and Care Quality Commission etc.

(ii) To advise the Board on the clinical and practice governance consequences of any significant breaches or failure of performance, in accordance with national guidance and ensure that appropriate action is taken.

(iii) To review the Care Quality Commission self-assessments and other accreditation and assessment submissions and identify Trust-wide themes.

(iv) To receive relevant annual reports and identify themes and areas for improvement.

2.2 <u>Risk</u>

(i) To take cognisance of the work of the Trust's Audit and Health & Safety Committee's and work with them as necessary to ensure an effective overall risk management system.

(ii) To recommend areas requiring further attention to the Audit Committee and assist it in ensuring that the Trust's Audit plans are focused on relevant aspects of the Trust's risk profile.

(iii) To review the effectiveness of the Committee's sub-groups and governance arrangements in partnership with the Audit Committee.

(iv) To review NHS Resolution claims scorecards for themes and trends

(v) To review and monitor the QISCOM Risk Register and receive reports from risk owners regarding the proposed actions and ongoing progress. To receive assurance that:

- The Trust systems are in place and operating effectively for the identification, assessment, prioritisation and management of potential and actual risk;
- The trends and significant risks across the organisation are reported and advise on controls for high risks.

(vi) Review of relevant risks

(vii) Discussion of emerging risks and significant issues

2.3 <u>Quality Improvement</u>

(i) To ensure new methods of working or changes in service delivery meet both national and Trust clinical and practice governance requirements;

(ii) To review the analysis of data on incidents, complaints, compliments, case reviews, patient feedback, and clinical audit, advise the Board on thematic interpretation and ensure that learning is disseminated across the Trust.
(iii) To analyse trends relating to Serious Incidents
(iv) To review and monitor working practices and accountability systems to ensure effective clinical governance of the organisation.
(v) To review lessons learnt and improvement actions agreed relating to learning from deaths in line with Trust policies.
(vi) To learn lessons from thematic reviews including staff and patient experience reviews.

2.4 Clinical Audit

(i) To review and approve an annual clinical audit programme and advise the Board on learning from the outcomes from audit reports.
(ii) To ensure that management processes are in place which provide assurance that the Trust has taken appropriate action in response to relevant clinical audit reports, independent reports, government guidance, statutory instruments and *ad hoc* reports from inquiries and independent reviews.

2.5 Policy and Strategy

(i) To review appropriate strategies relating to the Committee's remit and make recommendations on their adoption to the Board.
(ii) To approve EPRR self-assessment.
(iii) To approve relevant policies relating to the Committee's remit.
(iv) To approve the annual Quality Account.

2.6 Standing Items

(i) Quality Report
(ii) Review of Risks (where applicable)
(iii) External agency reports
(iv) Key issues reports
(v) Relevant annual reports

3.0 Items Requiring Escalation

(i) Serious Incidents where recommendations and actions are overdue.
(ii) Clinical Audits concluding insufficient assurance.
(iii) Risks relating to accreditation or clinical registration.
(iv) Any risks with a rating of 15 or above and/or for which mitigating actions are overdue, insufficient mitigation is identified or the risk ratings are questioned.
(v) To escalate to Clinical Operational Boards any service specific issues from clinical audits and other thematic reviews

4.0 Receipt of Key Issue Reports

(i) Clinical and Professional Committee
(ii) Emergency Planning and Business Continuity
(iii) Infection Prevention and Control
(iv) Medicines Safety & Governance
(v) Research
(vi) Clinical Audit and Effectiveness
(vii) Information Governance
(viii) Safeguarding Children & Adults and Prevent

(ix) Learning from Deaths
(x) Health & Safety Committee

5.0 Membership, Chairship and quorum

5.1 The Quality Improvement & Safety Committee shall comprise of 3 Non-Executives, the Medical Director, the Director of Workforce and Chief Nurse.

5.2 The Chair of the committee shall be a Non-Executive Director.

5.3 The quorum of the committee shall consist of 3 members, one of whom shall be a Non-Executive Director and one of whom shall be an Executive Director.

Last Reviewed by Committee: March 2022
Next review: March 2023

APPENDIX 7 – REMUNERATION COMMITTEE

Under NHS Codes of Conduct and Accountability, the Trust is required to establish a Remuneration Committee. Its role is to ensure fairness, equity and consistency in remuneration practices on behalf of the Trust Board.

1.0 Purpose

1.1 The Committee's purpose is to advise the Board on the appropriate remuneration and terms of service for the Chief Executive, Executive and any staff on Very Senior Managers terms and conditions, including:

(i) The remuneration structure and boundaries for the Trust, including remuneration levels and incentives, perquisites and benefits.
(ii) Contracts of Employment.
(iii) NHS annual cost of living pay awards for Senior Managers on local contracts of employment (pre 1/12/04) who have opted to remain on local terms and conditions.
(iv) Merit awards for medical staff under the Clinical excellence award scheme.
(v) Remuneration levels for other Trust staff on local terms and conditions.
(vi) National pay arrangements for all Medical and Dental staff employed by the Trust.

1.2 In reaching its decisions the Committee will take account of:

(i) Department of Health 'Very Senior Managers' Pay Frame work.
(ii) Any specific terms of the Contract of Employment.
(iii) Any other relevant guidance on NHS pay systems.
(iv) NHS Code of Conduct, Accountability and Openness.
(v) FT Code of Governance.
(vi) The performance of Chief Executive and Executive Directors (as articulated in the annual appraisal).
(vii) Fit and Proper Person Test.

2.0 Main Duties

2.1 <u>Remuneration</u>

(i) With input from the Chief Executive, to keep under review all aspects of the reward strategy within the Trust.
(ii) To ensure Senior Managers are fairly rewarded for their individual contribution to the Trust having proper regard to local circumstances, performance and national arrangements.
(iii) To oversee and monitor the level and structure of total remuneration including contractual and performance payments, benefits and perquisites for employees above the upper pay point of Band 9 Agenda for Change.
(iv) To set remuneration for all Executive Directors on behalf of the Board, considering and approving or declining to approve:
- Band caps, requests for increases above one increment on a pay band, or recruitment and retention premium payments.
- All requests for role reclassification where the net remunerative effect is an increase of more than 10% to any group or individual.
- Any at risk remuneration schemes, performance metrics, incentives and bonuses.
- Termination payments and other contractual requirements.

(vi) To recommend and monitor the level and structure of remuneration for senior management.

2.2 Nomination

(i) To review the structure, size and composition (including skills, knowledge and experience) required of the Board compared to its current position and make recommendations to the Board Chair with regard to any changes.

(ii) To review succession planning arrangements prepared by the Chief Executive on an annual basis.

(iii) To oversee the board recruitment and termination process to ensure the appropriate balance of skills and capabilities, and constitutional and statutory compliance, including:

- The convening of appointment panels for Executive Director appointments.
- To oversee the process to appoint acting Directors to ensure constitutional compliance.
- To be advised and to make recommendations to the Board upon the suspension or termination of employment of any Executive Director.
- On any Board restructuring arrangements.

2.3 Agenda for Change Redundancies

To approve recommendations for redundancies for submission to the NHS Improvement, including:

- reasons for the redundancy
- details of the proposed redundancies.
- details of the Search for Suitable Alternative Employment and assessment of likely success of continued search.

2.4 Review of relevant programme risks and discussion of emerging risks and significant issues.

3.0 Items Requiring Escalation

(i) Recommendations on changes to Board composition.

(ii) Recommendations on Executive Director suspension or termination.

(iii) Any risk with a rating of 15 or above and/or for which mitigating actions are overdue and insufficient mitigation is identified or the risk ratings are questioned.

4.0 Receipt of Key Issue Reports

(i) Benchmarking data on remuneration

5.0 Membership, Chairship and quorum

5.1 The Remuneration Committee shall comprise of 3 Non-Executives.

5.2 The Chair of the committee shall be a Non-Executive Director.

5.3 The quorum of the committee shall consist of 2.

Last Reviewed by Board: March 2022
Next review: March 2023

APPENDIX 8– PEOPLE PARTICIPATION COMMITTEE

The Trust fully recognises the importance of consulting, involving and listening to the people within the communities it serves and to respond appropriately to their views and experiences.

1. Purpose

The Committee's purpose is to provide the Board with assurance on the Trust's overall approach to people participation and ensure that there is a culture of continuous, positive improvement driven by engagement with people in the communities we serve. The Committee exists to:

- have oversight of the Trust's overall approach to people participation including the implementation of the People Participation Strategy.
- consider information on the process of engaging, listening and acting on feedback received from the communities we serve; ensuring that there is a robust process in place for monitoring patient experience and patient feedback.
- approve and monitor the implementation of improvement action plans put in place to improve the Trust's services in collaboration with the Working Together Groups. Action plans can be developed through the Committee and the Committee can also approve action plans that are developed by the Working Together Groups and being cognisant of the work of other committees.
- make a difference to patient/service user experience through positive engagement with the people in the communities we serve, our staff and external stakeholders such as our commissioners, other healthcare partners, HealthWatch, community groups, and other patient groups.
- listen to the views of, and involve our key stakeholders – including other healthcare partners, HealthWatch, community groups, and other patient groups – to consider them as a critical friend and to explore ways in which the Trust can respond positively to their views.
- ensure that a culture of people participation is embedded to support our service improvement projects, quality reviews and estates refurbishments and developments as defined in the People Participation Strategy.
- engage the people in the communities we serve in line with the People Participation Strategy.
- engage our staff, including contractors, other temporary staff and volunteers, in line with the People Participation Strategy.
- ensure that the Trust continues to fulfil any requirements relating to public and patient engagement as determined by the Care Quality Commission and other regulators.

- Ensure the needs and interests of all service users are taken into consideration including people who fall under the 9 characteristics that are protected under the Equality Act 2010 and people with specific illnesses or conditions.

- annually review the progress that has been made within services as a result of people participation. The Committee also has a responsibility to identify those issues that have been more difficult to improve.

- have oversight of the Trust's overall approach to Workforce Diversity and Inclusion.

2. Main Duties

2.1 Strategy

2.1.1 To support the development and implementation of the Trust's People Participation Approach (Priority Three of the Quality and Clinical Strategy) ensuring that it is delivered in a proactive and efficient way; driving improvements in patient experiences.

2.1.2 To support the development and implementation of the Workforce Diversity and Inclusion Workstream of the Workforce Strategy ensuring that it is delivered in a proactive and efficient ; driving improvements in staff experiences.

2.2 Improving Quality and Patient Experience

2.2.1 To ensure learning from people participation is embedded into day-to-day service delivery, service redesign, transformation and estates work.

2.3 Diversity and Inclusion

2.3.1 Ensure the needs and interests of all service users are taken into consideration with particular focus on people who fall under the 9 characteristics that are protected under the Equality Act 2010 and people with specific illnesses or conditions.

2.3.2 Ensure the needs and interests of our diverse workforce are taken into consideration with a particular focus on staff who fall under the 9 characteristics that are protected under the Equality ACT 2010, and in eliminating inequality and bias.

2.4 Collaborating with other Committees

2.4.1 The Committee will refer matters by exception and as appropriate to any other Committee as required.

2.5 Standing Items

(i) Progress on implementation of the people participation approach (Priority Three of the Clinical and Quality Strategy).
(ii) Key Issues from the Trustwide Working Together Group.
(iii) Key Issues from the Diversity and Inclusion Steering Group
(iv) Service specific thematic report on the engagement going on with the communities we serve and the changes made as a result.
(v) National guidance regulatory reports
(vi) Review of relevant risks
(vii) Discussion of emerging risks and significant issues

3. Receipt of Key Issue Reports

(i) Working Together Group
(ii) Diversity and Inclusion Steering Group

4. Items Requiring Escalation

(i) Any risks with a rating of 15 or above and/or for which mitigating actions are overdue, insufficient mitigation are identified or the risk ratings are questioned.
(ii) Any non-compliance with legal requirements
(iii) Any action three months or more beyond its due date

5. Frequency of meetings

The Committee shall meet quarterly. Additional meetings may be held on agreement with the Chair of the Committee.

6. Membership, Chairship and Quorum

6.1 The People Participation Committee shall be comprised of:

- Two Non-Executive Directors.
- Two Executive Directors as follows:
  - Deputy Chief Nurse
  - Director of Workforce & Service Redesign
- Head of Clinical Quality (Head of People Participation & Outcomes)
- Assistant Director of Corporate Governance (Trust Lead for Diveristy and Inclusion)
- Assistant Director of Workforce (Trust Lead for Workforce Diversity and Inclusion)
- Public/Patients/Service User Representatives – (Ambassadors)

6.2 The following shall be in attendance when required:

- Patient experience and engagement leads for each division.
- Service Directors
- The committee will also invite representatives from relevant external stakeholders including HealthWatch, representatives from community groups and other healthcare partners.

6.3 The Chair of the Committee shall be a Non-Executive Director who shall also be the Non-Executive Lead for People Participation for the Trust.

6.4 The quorum of the committee shall consist of 3 members, one of whom shall be a Non-Executive Director and one of whom shall be an Executive Director.

Last Reviewed by Committee: March 2022
Next review: March 2023

APPENDIX 9 – CCS/CPFT Joint Children's Partnership Board

1.0 Introduction

1.1 Cambridgeshire Community Services NHS Trust ("CCS") and Cambridge and Peterborough NHS Foundation Trust ("CPFT") are working together to deliver a truly integrated service for Children, Young People and Families in Cambridgeshire and Peterborough.

1.2 This provides the opportunity to rethink the delivery of services to ensure that they are fit for the future, to work jointly with all stakeholders to deliver this vision and to ensure the experience of those already accessing and those delivering the services is captured in order to influence the appropriate design of services across the wider system

1.3 The Joint Children's Partnership Board is a sub-committee which is responsible for providing sufficient levels of assurance to CCS and CPFT regarding the integrated service for Children, Young People and Families in Cambridgeshire and Peterborough to enable both organisations to fulfil their statutory responsibilities.

1.4 CCS and CPFT recognise that implementation of the Joint Children's Partnership Board will be done in a phased approach. Milestones have been agreed with full implementation expected. Therefore, each Trust will continue to rely on its current approach to assurance until a joint approach is fully implemented.

2.0 Purpose:

2.1 This Joint Children's Partnership Board reports into the CCS and CPFT Boards of Directors. There will also be the opportunity to report into the CPFT/CCS Board to Board meetings. The purpose of the Board is:

- To have oversight of the partnership approach and monitor the implementation of the programme for delivering an integrated Children, Young People and Families Service across Cambridgeshire and Peterborough.
- To have oversight of Children, Young People and Families Service across Cambridgeshire and Peterborough by undertaking integrated governance analysis (reviewing the interrelationships between quality, finance, workforce, risk and performance) for the areas of service and geographic responsibility covered by the Service.
- To provide assurance to both CPFT and CCS Board of Directors of the achievement of standards relating to quality, finance, performance, risk and workforce and highlight areas of concern, how concerns will be mitigated and recommendations for improvements.
- To ensure that information and metrics received by the Joint Children's Partnership Board are triangulated, scrutinised and used to inform the

progression of work and influence the vision/ direction of a fully integrated Children, Young People's and Families Services across the geographic responsibility of both Trusts.

- Oversight of the service redesign and transformation work in support of new models of care

3.0 Scope

3.1 Using the CQC's 5 Key Lines of Enquiry as a framework; to provide effective challenge and monitor the following key areas:

- Achievement of quality standards (patient safety, safe staffing, clinical audit and clinical effectiveness).
- Financial strategy, budget setting, investment proposals, delivery of cost improvement plans, performance against achievement of any QUIPP or CIP related income or other financial incentive schemes and activity information to support the continuing financial viability of the Children, Young People and Families Service across Cambridgeshire and Peterborough.
- Delivery of Key Performance Indicators (KPIs) and oversee any action plans to resolve any areas where KPIs are consistently not being met.
- Delivery of outcomes and oversee any action plans to resolve any areas where outcomes are not being met.
- The effective use of resources within the Children, Young People and Families Service across Cambridgeshire and Peterborough in line with NHS Improvement and CQC guidance.
- The implementation of any Directorate specific action plans relating to commissioners, regulatory matters or clinical and non-clinical audits.
- Review of all risks scoring 12 or above
- Meaningful patient and staff experience and engagement including engagement with the local communities that we serve and how this is reflected in service change.
- There are effective and robust governance arrangements in place to provide assurance that the Children, Young People and Families in Cambridgeshire and Peterborough is fit for the future
- Reporting to respective boards, including all matters requiring escalation, is carried out promptly and in a consistent manner as to content of reports and escalations.

4.0 Authority

4.1 The Joint Children's Partnership Board is responsible to both CPFT and CCS Boards for overseeing the delivery of safe, responsive and forward thinking services that deliver quality care. The Board will be co-chaired by a Non-Executive Director from CPFT and CCS on a rotating basis.

4.2 Decisions can only be made by the Joint Children's Partnership Board where there is agreement of both CPFT and CCS Members and such Members are acting within the terms of their delegated authority. All other decisions will be escalated to the boards of CCS and CPFT.

5.0 Reporting/Accountability:

5.1 Responsibility will fall to the Director of Operations (CPFT) and the Deputy Chief Executive (CCS) to report on progress to each partner organisation and to provide assurance to their respective Board of Directors. All such reports shall be consistent to ensure the respective boards receive the same information.

5.2 Responsibility will fall to the Associate Director of Operations (CPFT) and Service Director (CCS) to ensure integrated governance reporting to the Joint Children's Partnership Board.

5.3 Transformation Leads will responsible for reporting to the Joint Children's Partnership Board on the delivery of the Transformation plan and recommendations of the Joint Working Group.

5.4

6.0 Frequency and duration

- The Joint Children's Partnership Board will meet at least 4 times a year.

- The frequency and duration of meetings will be reviewed form time to time by the Joint Children's Partnership Board.

7.0 What will be reported to the Joint Children's Partnership Board:

- Integrated analysis reporting against the five key lines of enquiry and relevant Quality Improvement initiatives.
- All joint strategic risks
- Operational risks scored at 12 or above
- Key performance metrics – once agreed
- Patient engagement, experience and feedback
- Progress against the Transformation plan
- Financial performance
- Achievement of CIP plans
- Engagement with commissioners on contract and performance.
- Engagement with the wider system through the Transformation Steering Group
- Progress on the development of the contractual joint venture arrangements
- Feedback and challenge from the partner organisations.

7.1 Committee members are able to request any other items by notifying the co-chairs in advance of the meeting.

8.0 Review of Effectiveness

8.1 The Joint Children's Partnership Board shall conduct an annual review of its own effectiveness in line with best practice.

9.0 Escalation Points

- Areas of formal concern from Care Quality Commission or other regulatory bodies
- Commissioning contract queries
- Risks of 15 or above
- Emerging risks and significant issues
- Themes from staff/patient stories that impact adversely on the joint venture
- Outstanding practice and innovation
- Significant workforce concerns/gaps
- Any risks associated with not being able to evidence performance in relation to the incentive payments

10.0 Urgent Actions

10.1 Any urgent issues arising between the Joint Children's Partnership Board meetings will be dealt with by the Urgent Actions Group and ratified at the next meeting.

10.2 The Membership of the Urgent Actions Group will be as follows:

Co-Chair (CCS)	Anna Gill
Co-Chair (CPFT)	TBC
Executive Lead (CCS)	Anita Pisani
Director of Operations and Stakeholder Partnership (CPFT)	Debbie Smith

11.0 Review

11.1 Next review in March 2023

12.0 Governance

12.1 Output from the Joint Children's Partnership Board:

- Minutes and Action Log (to be agreed)
- Key issues and escalation points to partner organisations. Each organisation will determine its own route for internal reporting.

13.0 Administration

13.1 The Joint Children's Partnership Board will be administered by the Associate Director of Corporate Governance and Trust Secretary (CPFT) and the Assistant Director of Corporate Governance (CCS) on an alternating basis.

14.0 Membership

Members	
Co-Chair (CCS)	Anna Gill
Co-Chair (CPFT)	TBC
Executive Lead (CCS)	Anita Pisani
Director of Operations and Stakeholder Partnerships (CPFT)	Debbie Smith
Chief Nurse (CCS)	Kate Howard
Director of Nursing, AHPs and Quality (CPFT)	TBC
Medical Director (CCS)	Dr David Vickers
Medical Director (CPFT)	TBC

In Attendance	
Service Director (CCS)	John Peberdy
Service Director (CPFT)	Elaine Young
Clinical Lead (CPFT)	Dr Paul Millard
Clinical Lead (CCS)	Dr Jackie Taylor
Programme Lead – Service Redesign (CCS)	Nicola Hall
Service Lead, Cambridgeshire and Peterborough (CCS)	Andrea Graves
Head of Nursing and Quality (CPFT	Rowena Harvey
Associate Director Corporate Governance (CPFT)	Caroline Macpherson,
Assistant Director Corporate Governance (CCS)	Mercy Kusotera
Head of Clinical Quality (CCS)	Louise Palmer
Associate Director, Service User, Patient and Stakeholder Partnerships (CPFT)	Anna Tuke
Assistant Director of Business Development and Strategy (CCS)	Bruce Luter
AD of Contracts, Commissioning and Business Development (CPFT)	Nicky Brookes-Jones

- The Co-Chairs of the Joint Children's Partnership Board shall be Non-Executive Directors and shall alternate the responsibility to Chair the meetings.

- Other members of the directorate may also be invited to attend as required.

- The quorum of the committee shall consist of four members, one of whom shall be a Non-Executive Director and one of whom shall be an Executive Director. At least one Executive Director from each Trust shall be present. At least two members from each Trust shall be present.

- Members and those in attendance can nominate an alternate to attend the meeting on their behalf by notifying the Co-Chairs or Corporate Secretaries in advance of the meeting.

Last Reviewed by Committee: March 2022
Date of Next review: March 2023

APPENDIX 10 - SUMMARY OF LEAD ROLES

	Trust wide management leads	Director Lead	Non-Executive Lead
Accountable Officer	-	Matthew Winn	-
Accountable Officer for Finance	-	Mark Robbins	-
End of Life Lead	-	Dr David Vickers	-
Security	Jon Lamb	Mark Robbins	Oliver Judges
Safeguarding Adults and Children	Debbie Shulver / Vijay Patel	Kate Howard	Dr Anne McConville
Caldicott Guardian	-	Dr David Vickers	-
Infection Control	Chris Sharp	Kate Howard (Director of Infection Prevention & Control)	Dr Anne McConville
Counter Fraud and Bribery	Julie McCarthy	Mark Robbins	Catherine Dugmore
Accountable Officer - Controlled Drugs	Anne Darvill	Dr David Vickers	-
Responsible Officer - GMC	-	Dr David Vickers	-
Senior Information Risk Officer	Monty Keuneman	Mark Robbins	-
Whistleblowing/Raising Concerns Guardian	Mercy Kusotera	Anita Pisani	Catherine Dugmore
Guardian of Safe Working Hours	Dr Jorge Zimbron	Dr David Vickers	-
Senior Independent Director	-	-	Oliver Judges
Breastfeeding Champions	Sian Larrington /Glenda Hall/Jacqui Wynn	Kate Howard	Anna Gill
Risk: Strategic	Mercy Kusotera	Rachel Hawkins	Catherine Dugmore
Risk: Operational	Mercy Kusotera	Rachel Hawkins	Catherine Dugmore
Health & Safety	Chris Leonard	Mark Robbins	Oliver Judges
Emergency Planning	Alex Perry	Rachel Hawkins	Dr Anne McConville
Prevent	Kate Howard	Kate Howard	-
Freedom of Information	Monty Keuneman	Mark Robbins	-
Data Protection Champion	Monty Keuneman (Data Protection Officer)	Mark Robbins	-
Patient Experience	Claire D'Agostino	Kate Howard	Dr Anne McConville
People Participation	Claire D'Agostino	Kate Howard	Fazilet Hadi
Patient Safety	Liz Webb	Kate Howard Dr David Vickers	Dr Anne McConville
Clinical Audit	Heather Howe	Kate Howard	Dr Anne McConville
Internal Audit	Mercy Kusotera	Mark Robbins	Catherine Dugmore
Energy and Sustainability Champion	Chris Leonard	Mark Robbins	Oliver Judges
External Audit	Paul Spencer	Mark Robbins	Catherine Dugmore
Diversity and Inclusion Champion	Mercy Kusotera	Anita Pisani	Fazilet Hadi
Fire	Chris Leonard	Mark Robbins	Oliver Judges

	Trust wide management leads	Director Lead	Non-Executive Lead
Infrastructure & Property	Rob Freake	Mark Robbins	Oliver Judges
Digital	Associate Director BI & Digital	Mark Robbins	Gary Tubb
Suicide Alliance	-	Kate Howard	-
Health & Wellbeing Guardian	Angela Hartley	Anita Pisani	Dr Anne McConville

Last reviewed: March 2022

APPENDIX 11 – BOARD AND COMMITTEE MEMBERSHIP & LEADS

1.0 Trust Board & Trust Board Strategy/Development Workshops

Non-Executive Members		
Mary Elford - Chair ** Gary Tubb**	Dr Anne McConville ** Oliver Judges** Catherine Dugmore (wef 1 April 2022)**	Fazilet Hadi** Anna Gill** Geoff Lambert (until 30th Sept 2022)
Executive Members		
Matthew Winn ** Kate Howard **	Mark Robbins ** Anita Pisani**	Dr David Vickers ** Rachel Hawkins
In Attendance		
Karen Mason	Mercy Kusotera	

2.0 Audit Committee

Non-Executive Members		
Catherine Dugmore (wef 1 April 2022)**	Oliver Judges** Geoff Lambert (until 30th Sept 2022)	Fazilet Hadi**
In Attendance		
Mark Robbins External Auditors	Rachel Hawkins Internal Auditors	Mercy Kusotera Local Counter Fraud

3.0 Charitable Funds Committee

Non-Executive Members		
Mary Elford **	Gary Tubb** (C)	
Executive Members		
Anita Pisani **	Mark Robbins **	
In Attendance		
Michelle Robinson (minutes)		

4.0 Infrastructure Committee

Non-Executive Members		
Oliver Judges (C) **	Gary Tubb **	
Executive Members		
Mark Robbins **	Rachel Hawkins **	
In Attendance		
Robert Freake Michelle Robinson (minutes)	Bella Ahmed Chris Leonard Mercy Kusotera	Tracey Cooper John Peberdy Simon Harwin Peter Reeve

5.0 Clinical Operational Boards

5.1 Adults

Non-Executive Members		
Gary Tubb** (C)		Fazilet Hadi**
Executive Members		
Mark Robbins**	Dr David Vickers**	
In Attendance		
Rachel Hawkins Tracey Cooper Phillipa Davies Sarah Saul Dr Nelson David Beth Mclean	Cliona Hann Angela Hartley Peter Reeve Chris Morris Ronnie Hilbert (minutes)	Mike Passfield Julia Hallam-Seagrave Leyla Prince Lesley Innes Jo Robertson Mukund Katechia

5.2 Children & Young People's

Non-Executive Members		
Oliver Judges**	Anna Gill** (C)	Dr Anne McConville**
Executive Members		
Kate Howard**	Anita Pisani**	
In Attendance		
John Peberdy Cliona Hann Andrea Graves Alex Keep Michelle Robinson (minutes)	Sian Larrington Sarah-Jane Gill Sarah Hughes Charlotte Driver Dr Catherine Kearney Dr Chinniah Yemula	Dr Jacqueline Taylor Simon Harwin Helen Unsworth Nicola Sturgeon

5.3 Mass Vaccination Programme

Non-Executive Members		
Dr Anne McConville** (C)	Fazilet Hadi**	
Executive Members		
Owen O'Sullivan**	Dr David Vickers**	Kate Howard**
In Attendance		
Matthew Wiin	Mike Passfield	
Nicky Srahan	Nicola Lee	Michelle Robinson (minutes)

6.0 Quality Improvement & Safety Committee

Non-Executive Members		
Dr Anne McConville (C) **	Anna Gill**	Gary Tubb**
Executive Members		
Kate Howard **	Dr David Vickers**	Anita Pisani **
In Attendance		
Quality and Professional Practice Leads	Liz Webb Louise Palmer	Michelle Robinson(minutes)

7.0 Remuneration Committee

Non-Executive Members		
Mary Elford **	Catherine Dugmore** wef 1 April 2022	Dr Anne McConville**
In Attendance		
Matthew Winn	Anita Pisani	Mercy Kusotera

8.0 People Participation Committee

Non-Executive Members		
Fazilet Hadi (C) **	Anna Gill **	Mary Elford **
Executive Directors		
Anita Pisani **	Kate Howard**	
In Attendance		
Karen Mason Alison Hope (minutes)	Mercy Kusotera Angela Hartley Claire D'Agostino	Liz Webb Lisa Wright

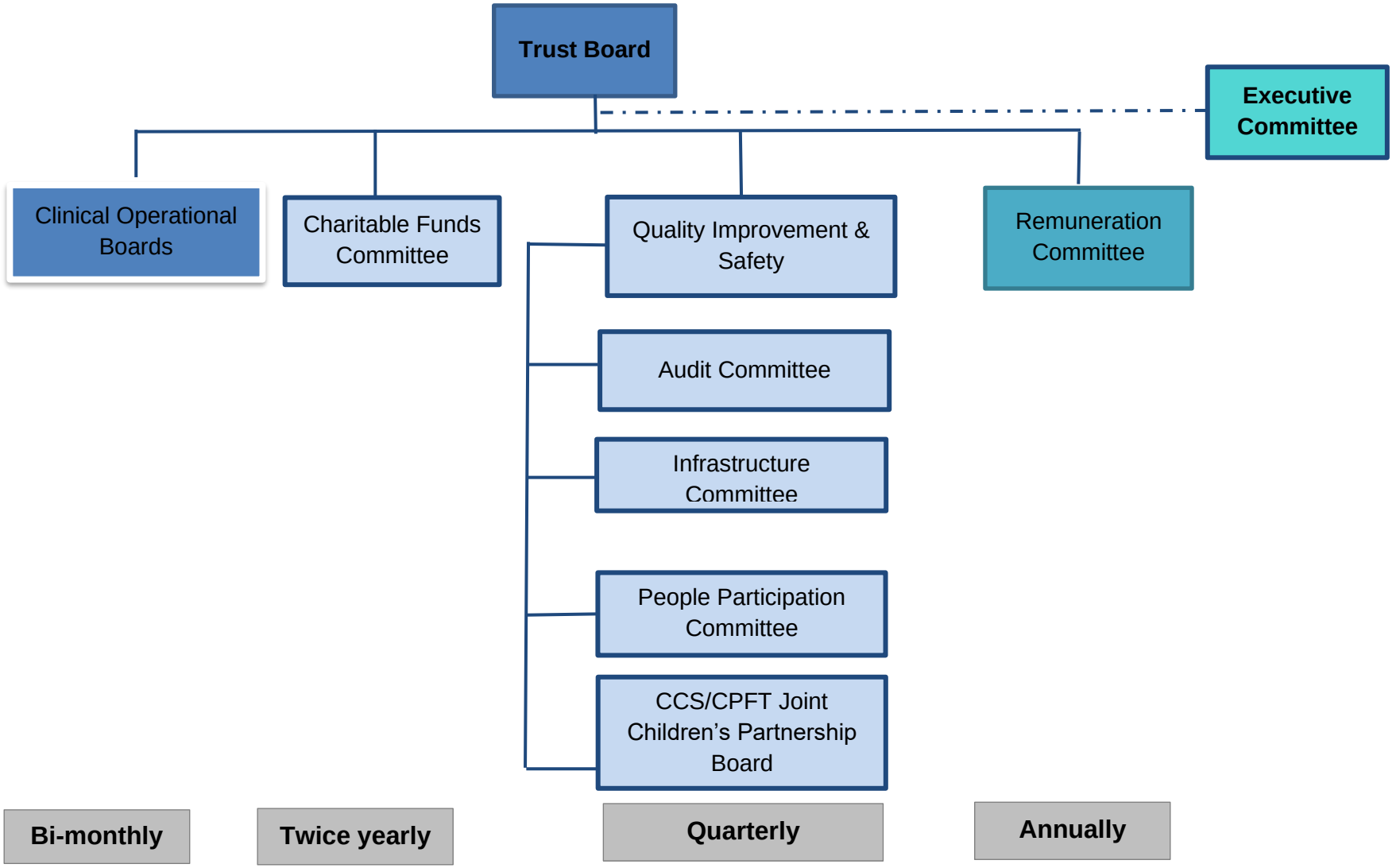
9.0 CCS/CPFT Joint Children's Partnership Board

Non-Executive Members		
Anna Gill (Co-chair)		
Executive Directors		
Anita Pisani	Dr David Vickers	Kate Howard
In Attendance		
Mercy Kusotera Andrea Graves	Bruce Luter	Dr Jackie Taylor John Peberdy

** = Voting rights

NHS
Cambridgeshire
Community Services
NHS Trust

APPENDIX 12A - BOARD AND SUB-COMMITTEES STRUCTURE CHART



APPENDIX 12B - BOARD AND SUB-COMMITTEES STRUCTURE & SUBGROUPS