Summary of Changes Made	**Pages**
1. Committees reviewed their terms of reference in line with the review dates shown at the bottom of each terms of reference.	various
2. Update to the Board/Committee Structure Charts	38 & 39
3. New People Participation Committee: - Sections 3, 5 & 6 updated to include committee - Terms of reference included in Appendix 9.	 7 & 8 33
4. Provision 9.3 proposed change from 10 working days to 7 working days. Due to use of technology, distribution of papers is now easier and therefore a shorter timeframe should still give members an opportunity to review papers.	9
5. Changes to clinical operational board escalation points proposed by the Head of Management Accounting	25

N.B Areas highlighted in green show where changes have been made.

TERMS OF REFERENCE
Board of Directors and Sub-Committee Structures

Document Type:	Policy		
Document Owner:	Taff Gidi Assistant Director of Corporate Governance		
Document Service:	Corporate		
Medicines:	N/A		
Scope:	Trust wide		
Standards & legislation:	o Risk Management Policy o Standing Orders and Standing Financial Instructions o Board Assurance Framework		
Approved by:	Trust Board		
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Key related documents:	• Risk Management Policy • Standing Orders and Standing Financial Instructions		
Keywords:	Board, terms of reference, assurance, committee, escalation, sub-committee, membership, structure, framework		

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VERSION CONTROL SUMMARY			
VERSION	**SECTION REFERENCE**	**DESCRIPTION OF CHANGE**	**DATE APPROVED**
1.0	N/A	First issue	
2.0	All	Major revision of Board and Sub Committee Terms of Reference	August 2016
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
4.0	All	Annual review of Board/Committee terms of reference.	September 2017
4.1	All	Minor edits to correct errors.	October 2017
4.2	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

Equality & Diversity Impact (Policies only): [to complete]	

Financial Implications:	Where a document has any financial implications on the Trust, the Local Counter Fraud Specialist (LCFS) has the authority to investigate and challenge this document in regards to current fraud and bribery legislation and to ensure appropriate counter fraud measures are in place. LCFS contact details are available on the Trust's Intranet.

Monitoring & Audit: [to complete]	All policy documents must include an audit tool to demonstrate the effectiveness of the document and to ensure that the measurable objectives/standards included have been met or achieved. If your policy does not include a monitoring tool, you can use the document attached.

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1.0 INTRODUCTION

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*:

Audit
(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.

Charitable Funds
(i) Two Executive Directors

Estates
(i) The Director of Finance & Resources and the Chief Nurse.

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

<u>Quality Improvement and Safety</u>

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

<u>Remuneration</u>

(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 shall attend the Committee as and when requested.

<u>Strategic Change Board</u>

(i) The Chief Executive as Senior Responsible Officer (SRO), the Programme Manager, Director of Workforce and Service Redesign, the Board Chair.

<u>People Participation</u>

(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:

<u>Audit</u>

(i) The Director of Finance and Resources, Corporate Secretary 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.

<u>Remuneration</u>

(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 and Service Redesign 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 Corporate Secretary 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.
Estates	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	
Strategic Change Board	One-third, one of whom shall be a Non-Executive Director and one of whom shall be an Executive Director.
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 Operation Boards shall meet every other month;
(iii) Quality Improvement and Safety shall meet every other month;
(iv) Strategic Change Board shall meet quarterly;
(v) Remuneration shall meet at least once a year;
(vi) Estates shall meet quarterly;
(vii) Charitable Funds shall meet quarterly; and
(viii) 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 Corporate

Secretary 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 Corporate Secretary 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 Corporate Secretary 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 Corporate Secretary 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 Corporate Secretary 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 and consider, at the end of each meeting, 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, at the end of each meeting, 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.

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 Governance, Risk Management and Internal Control

(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.

2.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the 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 Estates 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 Serco.

(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) Biannual 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 and Resources, Corporate Secretary 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.

Last Reviewed by Committee: January 2018
Next review: January 2019

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 <u>Charitable Funds Committee</u>

(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 <u>Fundraising Committees</u>

(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.

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 Receipt of Key Issue Reports

(i) Charitable funds accounts.
(ii) Charitable funds bids.
(iii) Audit reports.
(iv) 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: April 2018
Next review: April 2019

APPENDIX 4 – ESTATES COMMITTEE

1.0 Purpose

1.1 To support the Board by ensuring that an Estates Strategy is 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 estates matters.

1.3 To provide an effective reporting, escalation and engagement route for appropriate sub groups of the Estates 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 Strategy ensuring that it is delivered in a proactive, efficient and incremental fashion, to the benefit of all staff, patients and visitors.
(ii) To ensure estates 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 remains statutorily compliant.
(ii) To ensure that there are effective systems in place to provide the Board with assurance of the Trust estate's 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) Review of Risks
(iv) Standardised report on progress on projects, Freehold Property, Leasehold Property Management, Capital Projects and Cost Improvement Programme.

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 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) 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 Estates 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 Estates Committee shall be a Non-Executive Director.

5.3 The Assistant Director of Estates & Facilities shall be in attendance. The Head of ICT shall attend at least once annually. 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 Committee: February 2018
Next review: February 2019

APPENDIX 5 – CLINICAL OPERATIONAL BOARDS

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

- Children and Young People's Services
- Ambulatory Care Services
- Luton Children and Adults' Services

Clinical Operational Boards shall meet every other month alternative to Public Board meetings

Each Clinical Operational Board has the same responsibilities and these are set out below:

1.0 Purpose of the Clinical Operational Boards

1.1 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.

1.2 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.

1.3 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 Unit specific action plans relating to commissioners, regulatory matters or audits.
(vii) Review of key unit risks.
(viii) Patient and Staff experience.

2.0 Main Duties

Operational performance:

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

2.2 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.

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

2.4 To receive reports from project and operational work streams identified within the

Unit's annual plan.

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

2.6 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

2.7 To review and monitor the risks in the unit register with regard to quality, financial, workforce and performance issues.

2.8 Assure the Board that unit risks have appropriate mitigation and oversight.

2.9 To receive assurance that at unit 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 unit(s) are reported and advise on controls for high risks.

2.10 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 unit level) risk profile.

Efficiency and Economy, Effectiveness and Efficacy:

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

(i) Advise the Trust Board on whether the Unit 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 units);
  - use of off framework providers; and
  - overrides.

Policies and strategy

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

Developmental issues:

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

(i) Developing the governance capability of the leadership team.
(ii) Supporting the unit(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

2.14 To ensure that staff, visitors and portable assets are secure across the Unit.

Standing Items

2.15 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 Unit Quality, Finance, Workforce and Performance.

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

3.0 Items Requiring Escalation

3.1 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 Early Warning Trigger Tool (EWTT) scores of over 16 in any service plus any service which has not submitted a EWTT 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) CQC areas of formal concern.
(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) Any themes from staff stories or staff experience reports that may have Trust wide implications

4.0 Membership, Chairship and Quorum

4.1 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.

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

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

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

4.5 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.

Last Reviewed by Committee: February 2018
Next review: February 2019

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 Registration Compliance and Accreditation

(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 Risk

(i) To take cognisance of the work of the Trust's Audit Committee and work with it 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.

2.3 Quality Improvement

(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 unit 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) Bi-annual Workforce Report

5.0 Membership, Chairship and quorum

5.1 The Quality Improvement & Safety Committee shall comprise of 2 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: December 2017
Next review: December 2018

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 Remuneration

(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.

3.0 Items Requiring Escalation

(i) Recommendations on changes to Board composition.
(ii) Recommendations on Executive Director suspension or termination.

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 Committee: March 2017
Next review: July 2018

APPENDIX 8 – STRATEGIC CHANGE BOARD

1.0 Purpose

1.1 To support the Trust Board by monitoring the delivery of the Trust's portfolio of strategic change programmes relating to the achievement of the Trust's strategic objectives as set out in the Integrated Business Plan.

1.2 To drive the strategic change programmes forward and provide oversight of the effectiveness of changes that are implemented to ensure that the outcomes and benefits of these are realised, sustained and embedded within the organisation.

2.0 Main Duties

2.1 To take responsibility for:

(i) Ensuring the strategic change programmes deliver within their agreed parameters in terms of costs, organisational impact, rate and scale of adoption and expected/actual benefits realisation.
(ii) Ensuring that the appropriate governance arrangements are in place for all proposed changes.
(iii) Resolving strategic and directional issues between projects, which need input and agreement of senior stakeholders to ensure the progress of the programme.
(iv) Defining the acceptable risk profile and risk thresholds for the programmes and their constituent projects. To ensure that quality management systems are in place to provide assurance that service quality and effectiveness will be maintained through the life of the programmes and proposed changes are quality assured, monitored and reviewed.
(v) Ensuring the integrity of benefit profiles and realisation plans.

2.2 Standing Items

(i) Progress reports on the delivery of the change programmes
(ii) Programme risk registers
(iii) Other relevant risks e.g. transition risks

3.0 Items Requiring Escalation

(i) Variances against programme plans desired outcomes, timelines/milestones, or where milestones/timelines are not defined.
(ii) 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.

4.0 Membership, Chairship and Quorum

4.1 The Strategic Change Board shall comprise of 3 Non-Executives and 2 Executives.

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

4.3 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.

Due for Review by Committee: June 2018
Next review: June 2019

APPENDIX 9 – PEOPLE PARTICIPATION COMMITTEE - NEW

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.

2. Main Duties

2.1 Strategy
To support the development and implementation of the Trust's People Participation Strategy ensuring that it is delivered in a proactive and efficient way; driving improvements in patient experiences.

2.2 Improving Quality and Patient Experience
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
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.

2.4 Collaborating with other Committees
The Committee will refer matters by exception and as appropriate to the Quality Improvement and Safety Committee and Estates Committee (if appropriate).

2.5 Standing Items
(v) Progress on implementation of the people participation strategy.
(vi) Key Issues from the Trustwide Working Together Group.
(vii) Key Issues from the Diversity and Inclusion Steering Group
(viii) Service specific thematic report on the engagement going on with the communities we serve and the changes made as a result.
(ix) National guidance regulatory reports

4. Receipt of Key Issue Reports
(ii) Working Together Groups
(iii) Diversity and Inclusion Steering Group

5. Items Requiring Escalation

(i) 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.

(ii) Any non-compliance with legal requirements
(iii) Any action three months or more beyond its due date

6. Frequency of meetings

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

7. Membership, Chairship and Quorum

7.1 The People Participation Committee shall be comprised of two Non-Executive Directors and two Executive Directors.

7.2 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.

7.3 The following shall be in attendance when required:

- Deputy Chief Nurse
- Head of Clinical Quality (Head of People Participation & Outcomes)
- Trust Lead for Diversity and Inclusion
- Patient experience and engagement leads for each division. (as required)
- Service Directors and other staff members may also attend at the request of the committee.
- Public/ Patients/Service User Representatives – (Ambassadors)
- The committee will also invite representatives from relevant external stakeholders including HealthWatch, representatives from community groups and other healthcare partners.

7.4 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.

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	Louise Sheldon-Tabor	Mark Robbins	Oliver Judges
Safeguarding Adults and Children	Caroline Halls	Julia Sirett	Dr Anne McConville
Caldicott Guardian	-	Dr David Vickers	-
Infection Control	Chris Sharp	Julia Sirett (Director of Infection Prevention & Control)	Dr Anne McConville
Counter Fraud and Bribery	Julie McCarthy	Mark Robbins	Geoff Lambert
Accountable Officer - Controlled Drugs	Anne Darvill	Dr David Vickers	-
Responsible Officer	-	Dr David Vickers	-
Senior Information Risk Officer	-	Mark Robbins	-
Whistleblowing	Taff Gidi (Freedom to Speak Up Guardian)	Anita Pisani	Geoff Lambert
Guardian of Safe Working Hours	Dr Jorge Zimbron	Dr David Vickers	-
Senior Independent Director	-	-	Gill Thomas
Breastfeeding Champions	Sian Larrington / Tina Charlton	Julia Sirett	Dr Gillian Thomas
Risk: Strategic	Taff Gidi	Mark Robbins	Geoff Lambert
Risk: Operational	Taff Gidi	Julia Sirett	Geoff Lambert
Health & Safety	Chris Leonard	Mark Robbins	Oliver Judges
Emergency Planning	Jo Downey	Julia Sirett	Dr Anne McConville
Prevent	Jo Downey	Julia Sirett	-
Freedom of Information	Sarah Priestley	Mark Robbins	Richard Cooper
Data Protection Champion	Sarah Priestley (Data Protection Officer)	Mark Robbins	Richard Cooper
Patient Experience	Louise Palmer	Julia Sirett	Dr Anne McConville
People Participation	Louise Palmer	Julia Sirett	Nicola Scrivings
Patient Safety	Hussein Khatib	Julia Sirett Dr David Vickers	Dr Anne McConville
Clinical Audit	Sue Turner	Julia Sirett	Dr Anne McConville
Internal Audit	Taff Gidi	Mark Robbins	Geoff Lambert
Energy and Sustainability Champion	Chris Leonard	Mark Robbins	Oliver Judges
Diversity and Inclusion Champion	Taff Gidi	Anita Pisani	Nicola Scrivings
Fire	Chris Leonard	Mark Robbins	Oliver Judges
Estates & Property	Rob Freake	Mark Robbins	Oliver Judges

APPENDIX 11 – BOARD AND COMMITTEE MEMBERSHIP & LEADS

1.0 Trust Board & Trust Board Strategy/Development Workshops

Non-Executive Members		
Nicola Scrivings - Chair ** Geoff Lambert **	Dr Anne McConville ** Gill Thomas **	Richard Cooper** Oliver Judges**
Executive Members		
Matthew Winn ** Julia Sirett **	Mark Robbins ** Anita Pisani**	Dr David Vickers **
In Attendance		
Karen Mason	Taff Gidi	

2.0 Audit Committee

Non-Executive Members		
Geoff Lambert (C) **	Dr Anne McConville**	Richard Cooper **
In Attendance		
Mark Robbins External Auditors	Julia Sirett Internal Auditors	Taff Gidi Local Counter Fraud Specialist

3.0 Charitable Funds Committee

Non-Executive Members		
Geoff Lambert (C) **	Nicola Scrivings **	
Executive Members		
Anita Pisani **	Mark Robbins **	
In Attendance		
Karen Mason	Taff Gidi	Emily Gladwish (minutes)

4.0 Estates Committee

Non-Executive Members		
Oliver Judges (C) **	Gill Thomas **	Nicola Scrivings **
Executive Members		
Mark Robbins **	Julia Sirett **	
In Attendance		
Robert Freake Taff Gidi Emily Gladwish (minutes)	Chris Sharp Linda Sharkey Chris Leonard	Tracey Cooper John Peberdy

5.0 Clinical Operational Boards

5.1 Ambulatory Care

Non-Executive Members		
Richard Cooper** (C)	Dr Anne McConville**	Nicola Scrivings
Executive Members		
Matthew Winn**	Dr David Vickers**	
In Attendance		
Tracey Cooper Phillipa Davies Sarah Saul	Cliona Hann Angela Hartley Alison Hope (minutes)	Mike Passfield Julia Hallam-Seagrave Andrew Bateman

5.2 Children & Young People's

Non-Executive Members		
Gill Thomas (C)**	Oliver Judges (C) **	Nicola Scrivings

Executive Members		
Julia Sirett**	Mark Robbins**	
In Attendance		
John Peberdy Cliona Hann Andrea Graves Vicki Budd (minutes)	Sian Larrington Sarah-Jane Gill Sarah Hughes Charlotte Driver	Alison Sansome Nicola Sturgeon Alex Keep

5.3 Luton Children & Adults

Non-Executive Members		
Geoff Lambert (C) **	Nicola Scrivings**	
Executive Members		
Anita Pisani**	Dr David Vickers**	
In Attendance		
Linda Sharkey Tina Charlton Linda Thomas Zoe Bain (minutes)	Chris Morris Cliona Hann Augustina Williams	Lesley Innes Catherine Kearney Mukund Katechia

6.0 Quality Improvement & Safety Committee

Non-Executive Members		
Dr Anne McConville (C) **	Oliver Judges **	
Executive Members		
Julia Sirett **	Dr David Vickers **	Anita Pisani **
In Attendance		
Quality and Professional Practice Leads	Deputy Chief Nurse	Vicki Budd (minutes)

7.0 Remuneration Committee

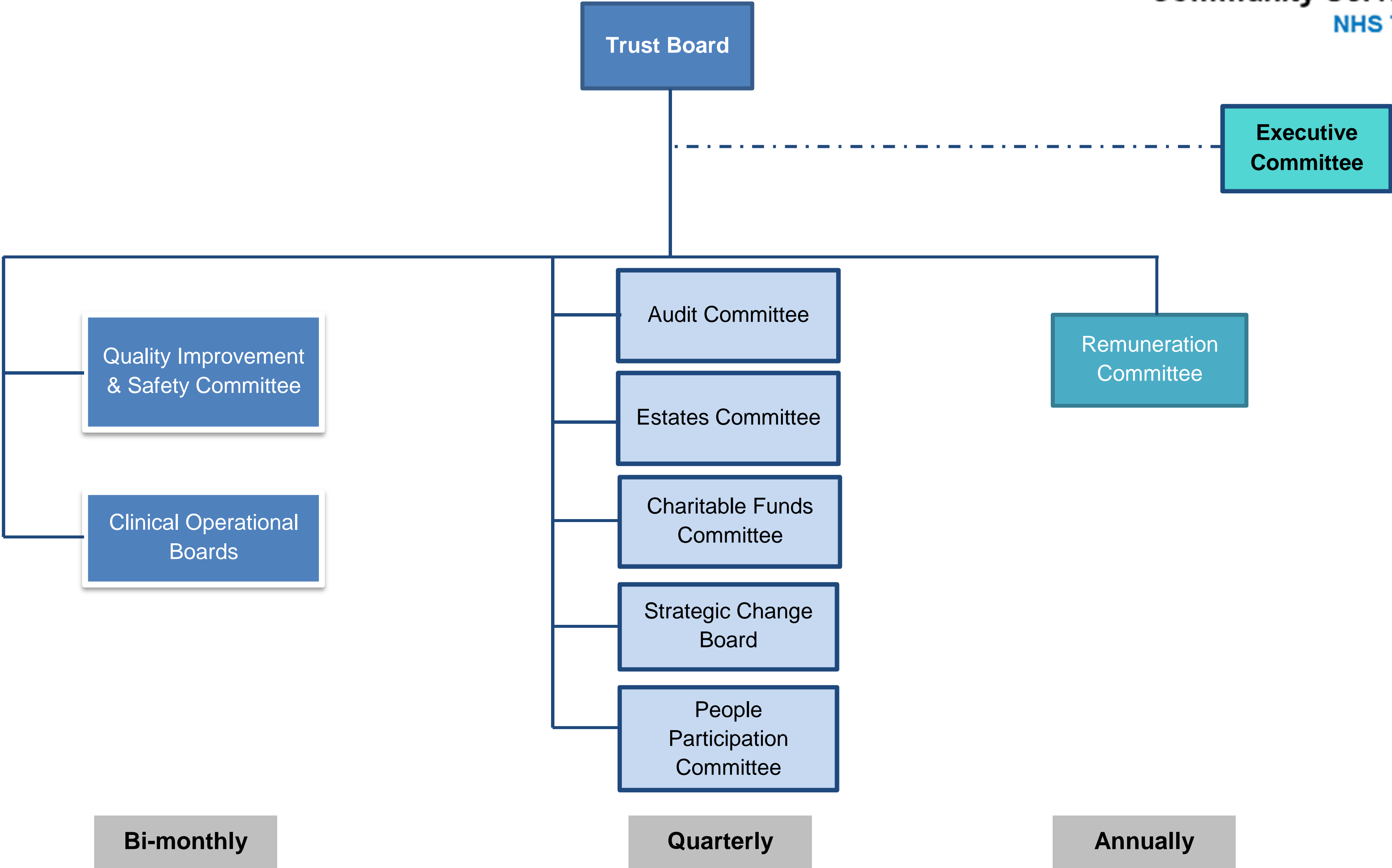
Non-Executive Members		
Gill Thomas (C) **	Geoff Lambert**	Nicola Scrivings **
In Attendance		
Matthew Winn	Anita Pisani	Taff Gidi

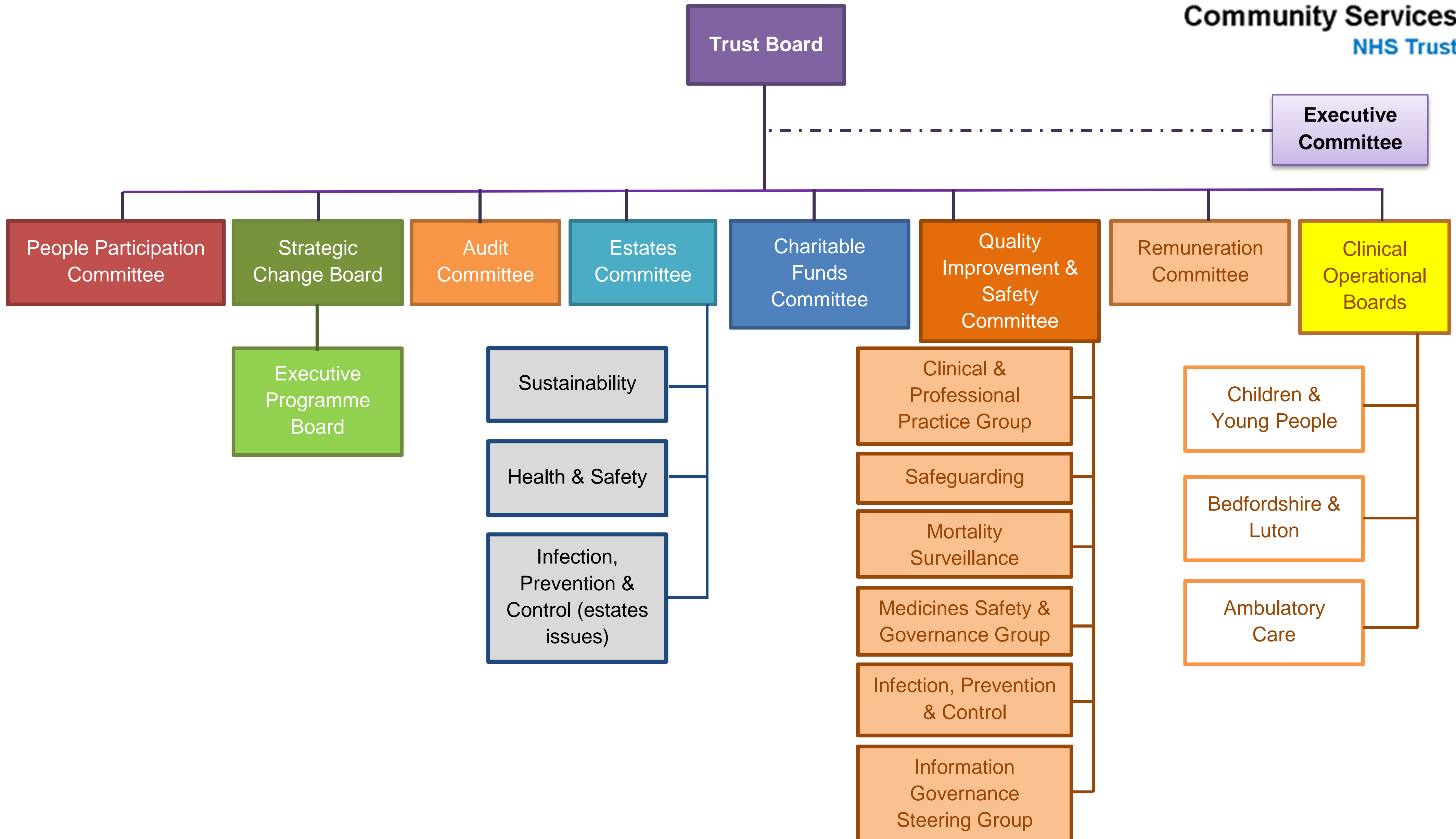
8.0 Strategic Change Board

Non-Executive Members		
Nicola Scrivings (C) **	Gill Thomas **	Richard Cooper **
Executive Members		
Matthew Winn (VC)**	Anita Pisani **	
In Attendance		
Julia Sirett Sam Carr Service Redesign Team Karen Childs (minutes)	Dr David Vickers Karen Mason Anne Foley	Mark Robbins Bruce Luter Angela Hartley

** = Voting rights

APPENDIX 12A - BOARD AND SUB-COMMITTEES STRUCTURE CHART




APPENDIX 12B - BOARD AND SUB-COMMITTEES STRUCTURE & SUBGROUPS
NHS
Cambridgeshire
Community Services
NHS Trust
Trust Board
Executive Committee
People Participation Committee
Strategic Change Board
Audit Committee
Estates Committee
Charitable Funds Committee
Quality Improvement & Safety Committee
Remuneration Committee
Clinical Operational Boards
Executive Programme Board
Sustainability
Health & Safety
Infection, Prevention & Control (estates issues)
Clinical & Professional Practice Group
Safeguarding
Mortality Surveillance
Medicines Safety & Governance Group
Infection, Prevention & Control
Information Governance Steering Group
Children & Young People
Bedfordshire & Luton
Ambulatory Care