POLICY CONTROL SHEET

(updated Dec 2009)

Policy Title And ID number	**Risk and Governance Strategy** Gov 1.1			
Sponsoring Director:	**Director of Quality Standards and Governance**			
Implementation Lead:	Head of Corporate Governance			
Impact:	*(a) To patients*	The Risk and Governance Strategy and Procedure for Risk Assessment & Risk Treatment is a key strategic document. The principles are to be applied to manage risk across the entire organisation.		
	(b) To Staff			
	(c) Financial			
	(d) Equality Impact Assessment (EIA)	No *(delete as applicable)*		
	(e) Counter Fraud assessed	**Not required** *(delete as applicable)*		
	(e) Other			
Additional Costs:			*Budget Code*	*Revenue or Non Revenue*
	(a) Training:	*£*	*Within Divisions*	
	(b) Implementation:	*£*		
	(c) Capital:	*£*		
	(d) Other	*£*	*Audit Department*	
Training implications:	*To be incorporated into induction:* **Yes / No** *(delete as applicable)*		*Other:*	
Date of consultation at:	*Board of Directors*			
	Executive Team			
	Divisional Medical Directors/Clinical Directors			
	Assistant Divisional Directors/Heads of Department			
	Board Committee			
	Joint Partnership Forum			
	Local Negotiating Committee			
	Infection Control Committee:			
	Health & Safety Committee			
	Other (state name/s):			
Alignment	*HR:*		Learning and Development	
	Strategic Direction:		Improving clinical care and standards	
	Board Assurance:		Risk reduction	
	Clinical Governance:		Ensuring excellence and safety	
Date of Final Draft:	*June 2011*		Issue Number:	3
Date of Final Approval:	August 2011		Approved by:	NCGRC
Implementation Date:				
Date of last review:	January 2010	Date of next review:	August 2013	
Circulation Date:				
Circulation:			Yes	Comment
	Directors		✓	
	Non Executive Directors		✓	
	Divisional Medical Directors/Clinical Directors		✓	
	Medical Staff Committee/SMSF		✓	
	Assistant Divisional Directors		✓	
	Assistant Nursing Directors		✓	
	Heads of Department		✓	
	H&S Committee Members		✓	
	Policy database/warehouse		✓	
	Others (to be listed):			

RISK AND GOVERNANCE STRATEGY

GOV 1.1

SPONSORING DIRECTOR: DIRECTOR OF QUALITY STANDARDS AND GOVERNANCE

INDEX

1. STATEMENT OF INTENT

Barnsley Hospital NHS Foundation Trust is committed to delivering integrated corporate governance and assurance framework, the proactive identification and management of risk will be an integral part of the corporate governance strategy.

The Board of Directors is dedicated to an organisational culture that ensures that effective governance is an integral part of everything it does.

Good governance will be ensured through the delivery of systematic processes for developing and approving Trust policies procedures and guidelines.

Adherence to these policy and procedural frameworks will be continually monitored and assessed through a robust audit cycle.

The annual audit activity will be conducted by the Trust internal and clinical audit team and will be externally assessed by an appointed external auditor.

The Trust will maintain a robust process for the control of risk in a strategic and organised structure. It will ensure that risks can be eliminated or reduced to an acceptable level, and improve the safety and experience of patients, staff and visitors.

2. INTRODUCTION

- The Trust will be measured by the quality of its services and the use of its resources. This Governance Strategy supports the Trust's aims and objectives by delivering a 'framework' covering all aspects of corporate governance and risk management within Barnsley Hospital NHS Foundation Trust. The Governance and Risk Management Strategy, together with the Business Plan and Board Assurance Framework support the Trust with the delivery of its objectives. The strategy also aims to

- Ensure that robust processes are in place to minimise risks to patients, public and staff.

- Provide clear processes for the identification and control of risks that may adversely affect the organisations operational ability or achievement of its objectives or operating authority.

- Ensure there is a structure in place whereby both governance and risk issues are identified, managed and regularly reviewed, both at divisional and at Board level.

- Ensure that at Directorate level there are systems in place where operational risks are identified, assessed, and included on the Sentinel Risk Register.

- Utilise internal and external audit, and other external regulatory and assessment bodies, to provide assurance that robust controls exist.

There are processes referred to within the document that are central features of the processes involved with the delivery of a corporate level governance strategy. These processes are briefly defined below:

2.1 Risk Management

Risk is a state of uncertainty where some of the possibilities involve a loss, catastrophe, or other undesirable outcome. This may result in loss or impairment of Trust assets, the creation of previously unrecognised liabilities, and the failure to achieve a significant business objective or damage to the Trust's reputation.

2.2 Governance

Governance is the process by which the Board of Directors assures itself that control measures in place to identify and manage risks of all kinds are effective. This assurance may be from internal or external verification. The Board Assurance Framework (BAF) is the main document that provides the Board with the monitoring of its annual business plan objectives and principal risks associated with achieving them. The Risk Register provides an ongoing identification and monitoring process of operational risks that may adversely impact on the plan.

2.3 Board Assurance Framework

The Board Assurance Framework is a high level report which enables the Board to demonstrate how it has identified and met its assurance needs focussed on the delivery of its objectives through the Annual Business Plan.

2.4 Annual Governance Statement (AGS) Previously The Statement on Internal Control (SIC)

The AGS replaces the previous Statement on Control from 1st April 2011 onwards this document provides enhanced commentary on quality governance. This document is completed at the end point of the annual cycle/ financial year end. It provides a year end statement by the Chief Executive confirming the effectiveness of controls that govern and manage the risks to the organisation achieving its objectives. It confirms that the control measures in place are reasonable, and that any gaps in control or areas of weakness have been addressed through clear action plans to improve upon the controls and the assurance processes where appropriate.

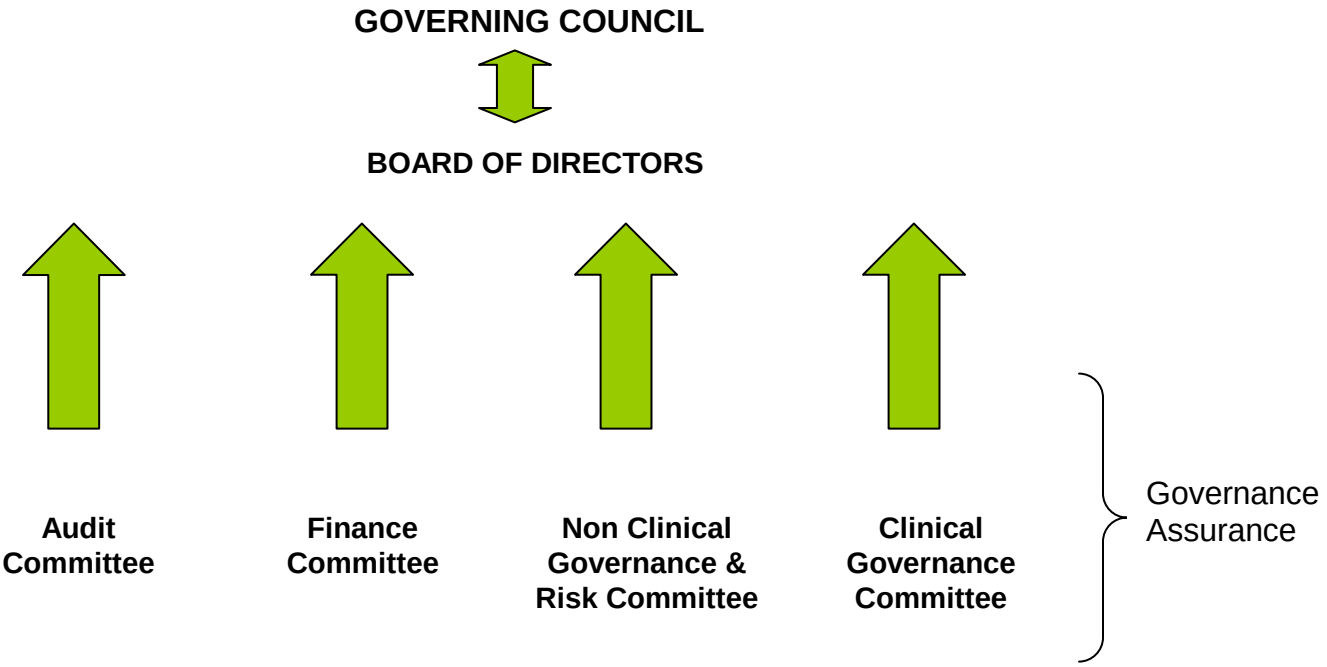
3. IMPLEMENTATION

Implementation of the strategy is the responsibility of Directors and Managers and requires all Directors, Managers and Clinicians to accept the statement of intent and requirements of the strategy document.

3.1 Organisational and Committee Structures

The proactive management of risk and the delivery of well governed services will be delivered through the explicit inclusion of governance within core functions of the Trust.

The Foundation Trust has, through the Board of Directors, set out its management organisation and committee structure as part of its operating authority. These are detailed within the management arrangements below and were substantially reviewed in December 2010.



Performance Board	**Executive Team**

Investment Board	**Workforce Board**	**Quality Safety Improvement & Effectiveness Board**	**Patient Experience Board**

Divisional Governance Groups	**Corporate Working Groups**
	Infection Prevention and Control, Strategic Risk, Safeguarding Children, Safeguarding Adults, Medical Devices Committee, Falls Steering Group, Radiation Safety Committee, Clinical Guidelines and Policy Group, Medicines Management, Nursing Procedures, VTE Prophylaxis Steering Group, Resuscitation Committee, Organ Donation Committee, Information Governance Group, Complaints Review Group, PPI delivery Group, Outpatient Patient Forum, LNC, Joint Partnership Forum, Equality and Diversity Steering Group, Health and Safety Committee, Change Advisory Group, Medical Gas Committee, Decontamination Strategy Group, Sustainability/Carbon Reduction Group, Emergency Planning and Business Continuity, Medical and Surgical Equipment Committee.

4. MANAGEMENT ARRANGEMENTS

As accountable officers, the Board of Directors has overall responsibility for corporate governance, including risk management. The Board has adopted a framework to its governance arrangements that operates through six Committees of the Board:

- Clinical Governance Committee
- Non-Clinical Governance Committee
- Finance Committee
- Audit Committee
- Remuneration Committee
- Executive Team

Link to Meeting and Reporting Structure - Micro site

http://bdghnet/msw/

5. RESPONSIBLE INDIVIDUALS

Chief Executive

The Chief Executive is the Accountable Officer and has the responsibility for reviewing the effectiveness of the system of internal control. This statement requires maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, for safeguarding the public funds and the organisation's assets, for compliance with Health and Safety legislation and for ensuring all reasonable actions are taken to minimise risk to patients, public and staff. Elements of this responsibility are delegated to other Directors as specified.

Director of Finance and Information

The Director of Finance is responsible for ensuring that an appropriate risk management strategy is in place and that there is an overall framework and structure for the delivery of the strategy. This includes corporate governance, risk management and controls and assurance processes for the delivery of the Board Assurance Framework and Risk Register.

Chief Operating Officer

The Chief Operating Officer is responsible for ensuring the implementation of the strategy and procedural requirements within Divisions and monitoring performance in year. The Post holder also provides the Executive Director leadership to the Non Clinical Governance and Risk Committee.

Medical Director

The Medical Director has responsibility for Patient Safety, Clinical Performance and Effectiveness. The post holder also provides the Executive Director leadership to the Clinical Governance Committee.

Chief Nurse

The Chief Nurse together with the Medical Director is responsible for the overall quality and patient centred parameters operative in the Trust.

Director of Quality, Standards & Governance

The Director of Quality, Standards and Governance will lead all aspects of risk management, governance and effectiveness for the Trust. The post holder will ensure that the Trust complies with the Quality Care Commission's (The NHS Care Quality regulator) required standards. The post holder also maintains the Board assurance framework document.

Director of Human Resources

The Director of Human Resources has responsibility for staff safety through the Health & Safety Team. The Director of Human Resources has responsibility for providing Directors, Managers and all staff with the appropriate knowledge and skills to implement and comply with the risk strategy. Training requirements are part of the Trust's overarching Training Needs Analysis and Corporate Curriculum.

The Training and Development Department maintains the corporate curriculum to enable staff at appropriate levels of the organisation to access training against identified training needs.

Head of Corporate Governance
To provide leadership in developing the Trust's Strategy on Risk and Governance, establishing robust systems, processes and working practices to enable the organisation to meet its business objectives. Ensure that the organisation discharges its functions whilst meeting all legal, safety, quality and regulatory obligations. The post holder also will also ensure the ongoing development of the Trust- wide Risk Registers.

Directors/Divisional Directors and Associated Divisional Directors
The Directors are the accountable officers for the effective management of governance and risk within their Division/Directorate and for the systematic review of the effectiveness of its governance and risk management.

Executive Directors also have individual responsibility for compliance and assurance on specifically designated domains of the Quality Care Commission Standards. This applies not only within their own Division or Directorate, but also to assurance on compliance with that domain across the Trust.

Managers
Managers are responsible for managing risk effectively and embedding internal controls into the processes by which objectives are pursued within their Division or Directorate. They are responsible for ensuring processes are in place for risk identification and control, and that assurance is provided to Divisional Directors and to governance committees as necessary through escalation.

Risk Manager
The Risk Manager is responsible for maintaining the Trust Risk Registers in a comprehensive and timely manner with Divisional Directors. The Director of Quality Standards and Governance is responsible for maintaining and updating the Board Assurance Framework. The Head of Corporate Governance, Risk Manager, and Clinical Risk Adviser, are responsible for supporting the Divisions and Directorates to develop and implement effective risk management systems; identifying trends from incidents, claims and complaints, self assessing against relevant compliance standards and integrating the lessons learned into polices, procedures and practice. They will also be responsible for providing advice and support to the divisions/departments through the attendance at the divisional governance meetings providing detailed risk and governance information through an integrated monthly report incorporating, updated risk registers and a detailed summary of incidents, claims and litigation.

Non-Executive Directors

Non-Executive Directors provide scrutiny of the work of the organisation and hold executive directors to account. The must also ensure that safety and quality remain a strategic priority. Nominated NEDs are designated Chairs of the Clinical Governance, Non Clinical Governance and Risk Committee, Finance and Audit Committees and are required to challenge governance, risk control and assurance processes.

The Secretary to the Board

The Secretary to the Board (the Secretary) will be responsible for ensuring that Barnsley Hospital NHS Foundation Trust (the NHSFT) complies with the relevant legislation and the terms of authorisation issued by Monitor, the Independent Regulator for NHS Foundation Trusts. The Secretary will advise and/or ensure the provision of appropriate support to the Board of Directors and the Governing Council on all constitutional and corporate governance matters. The post holder will also ensure that meetings of the Board of Directors and the Governing Council, and any committees thereof, run efficiently and effectively and that their decisions are properly recorded.

6. AUTHORITY OF MANAGERS WITH REGARD TO MANAGING RISK

The Trust's Standing Orders, Standing Financial Instructions, and Scheme of Delegation provides the Director Level responsibility for all Trust activities including risk management. The purpose of these documents is to demonstrate how these powers are reserved to the Board (generally matters for which it is held accountable to Monitor) whilst at the same time delegating to the appropriate level of staff the detailed application of Trust policies and procedures.

With specific reference to risk management and risk escalation, there is a framework of expected levels of responsibility based on the impact of a risk assessment. This is at Appendix F.

7. MONITORING

The primary monitoring of the policy is through the review and effectiveness of the Board Assurance Framework Document which provides assurance against the Trust's corporate objectives and principal risks.

The Governance Committees provide scrutiny and assurance on risk registers ensuring that risks are appropriately escalated and risk treatment/action plans are in place. This process also provides synergy between the Board Assurance Framework and the Risk Register.

To demonstrate compliance with monitoring of this policy the Trust must achieve the following minimum requirements:

- The process for the management of risk locally, which reflects the organisation wide risk management strategy

- The duties of key individuals for risk management activities

The Trust will demonstrate the effectiveness of the policy through the following monitoring systems:

7.1 Committee Reporting Structure

The Governance Committees oversees the function of corporate risk management committees or groups through direct reporting lines. The sub-committees will provide minutes and exception reports as programmed by the Governance Committee.

The Governance Committee oversees the effective functioning of the Trust risk registers and will view the full register at least annually.

The Governance Committees also oversees the effective functioning of Divisional/Directorate Governance and Risk Management arrangements and will view local risk/governance meeting minutes at least annually or via the preparation of a Divisional Annual Report.

The Governance Committees will review Extreme and High risks at each meeting; and will assure that progress of treatment/action plans is maintained.

7.2 Executive Team/Performance Management

The Executive Team will review the Risk Register on an annual basis and will consider any new Extreme risks requiring necessary executive actions. Performance Management of Divisions will also be undertaken to ensure risk management is being delivered. .

7.3 Internal and Clinical Audit

Audit Programmes are identified and in place to monitor the effectiveness of certain aspects of the risk management system, including the Board Assurance Framework and Statement of Internal Control.

External compliance assessments are performed and inform the compliance and assurance process. These include NHS Barnsley, NHS Yorkshire and the Humber, Care Quality Commission and NHSLA.

Board Committee attendance is monitored in the Trust Annual Report and Accounts.

8. REFERENCES

NHSLA Risk Management Standards for Acute Trusts (April 2009.

APPENDIX A

TERMS OF REFERENCE FOR CLINICAL GOVERNANCE COMMITTEE

1. CONSTITUTION AND ACCOUNTABILITY

1.1 The Clinical Governance Committee is a committee of the Board of Directors and has no executive powers other than those specified in these Terms of Reference or in the Trust scheme of delegation. The Committee in its workings will be required to adhere to the constitution of the Barnsley Hospital NHS Foundation Trust, the Terms of Authorisation and Code of Governance issued by the Independent Regulator for NHS Foundation Trusts.

1.2 The Committee is authorised to investigate any activity within its Terms of Reference and to seek any information it requires from any employee. All employees are directed to co-operate with any request made by the Committee.

1.3 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise it considers necessary.

2. OVERALL PURPOSE

2.1 The Committee's overall purpose is to provide assurance that the Trust has integrated systems for improving and assuring the standards of clinical care within the Trust, and that the patient interest is paramount in all that the Trust undertakes. This includes assuring safe care practice and processes including accurate diagnosis; early intervention; implementation of practices known to be safe; and moving patients effectively along the care pathway.

2.2 The Committee provides assurance that the Trust has effective Executive mechanisms in place to systematically integrate developmental activity such as: continuing professional education research and development; a safety culture able to promote patient interests, and promotion of clinical effectiveness; as well as monitoring and supervisory activity such as licensing and revalidation; clinical audit; risk management, including untoward events; and anonymous excluded practitioner data and findings.

3. MEMBERSHIP

3.1 Membership shall comprise:

Monthly

- 2 Non Executive Directors Chair and Deputy Chair
- Medical Director – Executive Director Lead
- Chief Nurse
- Director of Quality and Standards
- Chief Pharmacist (As required)
- Head of Governance

- Risk Management Representative – Clinical Risk Coordinator
- Senior Clinical Representatives (Divisional Director and ADoN)
- Head of Midwifery
- Clinical Effectiveness Representative – Manager or Deputy
- Research and Development Lead (As required)
- PGME lead (As required)

3.2 Members will be required to attend a minimum of 10 Committee meetings each year (80% if the committee is held less than monthly) and on the occasions they cannot attend they should send a deputy who is fully briefed and that can speak to their agenda items.

3.3 Membership will be regularly reviewed to ensure it appropriately reflects the clinical governance and risk requirements.

3.4 The Committee holds a key governance role in the Trust. For the avoidance of doubt Trust employees who serve as members of the Committee do not do so to represent or advocate for their division or service area but to act in the interests of the Trust as a whole and as part of the Trust wide governance structure.

4. ATTENDANCE AND FREQUENCY OF MEETINGS

4.1 Meetings will be held at least bi-monthly, timings may be amended to meet internal or external deadlines for reporting requiring the Committee's scrutiny.

4.2 The Head of Governance will ensure that an efficient secretariat service is provided to the Committee.

5. QUORUM

5.1 A quorum shall be eight members of which at least one must be a Non Executive Director and one an Executive Director.

6. DUTIES AND RESPONSIBILITIES

6.1 The Committee will ensure that adequate and appropriate governance structures, processes and controls are in place across the Trust and in each division to promote and maintain good clinical governance in particular to clinical issues integral to the Trust's Risk Register, Board Assurance Framework and Business Plan, and

- promote safety and excellence in patient care by ensuring that clinical governance is focused on the patient and that patients are fully involved and informed about their care.
- be provided with assurance that divisions are identifying, prioritising and managing risks arising from clinical care on a continuing basis, and that extreme and high risks are escalated to the committee on an exception basis.
- promote evidence based clinical practice through the policy approval role of the committee.

- be assured that the Trust is responding appropriately to serious clinical incidents and other risk and incident data received which have serious implications for the Trust's clinical services.
- be assured that there is effective implementation of the National Patient Safety Agency (NPSA) reporting system.
- promote and monitor research and other innovation within the Trust through the receipt and the review of an Annual Report.

6.2 The Committee will play a co-ordinating role in ensuring that the Board Assurance Framework accurately reflects, where applicable:

- the clinical risks faced by the Trust
- the key controls in place to manage these risks
- the sources of assurance to the Board that these controls are effective
- any gaps in controls or assurances that exist

The Committee will also play a key role in managing the delivery of any actions that arise from the clinical risk elements of the Board Assurance Framework – specifically including actions to improve controls or provide further assurances.

6.3 The Committee will provide assurance to the Board on the following key duties:

6.3.1 Trust wide clinical governance priorities and divisional clinical governance plans

6.3.2 To review at least annually the Trust's definitions, investigations and documentation of serious clinical incidents

6.3.3 To ensure comprehensive and appropriate action plans for all serious clinical incidents and monitor their implementation until discharged. Through the receipt of exception report from the Strategic Risk group and the review of the Annual risk and governance report

6.3.4 To promote a safety conscious open and honest learning culture able to benefit from learning from and reporting incidents that may threaten the quality of patient care and delivering changed policy and practice arising from such reflection

6.3.5 Approve the Terms of Reference and membership of its reporting Sub Committees and oversee their work, receiving *exception* reports from them for consideration and action as necessary

6.3.6 Ensure there is an appropriate process in place to monitor and promote compliance across the Trust with mandatory clinical standards and guidelines such as NICE guidance radiation use and protection regulations (IR(ME)R) and the NHSLA Risk Management Standards

6.3.7 To review and discuss exclusions and restriction reports monthly and provide assurance to the Board

6.3.8 Receive the outcome of clinical accreditation visits, external reviews and audits as appropriate

6.3.9 Overview the clinical aspects of the Corporate Risk Registers and its links to the Board Assurance Framework

6.3.10 Review patient safety data and trends, including significant clinical complaints, incidents and all Coroners Inquests and ensure appropriate action has been taken in respect of these and that examples of good practice are disseminated within the Trust. This duty will be discharged through the divisional exception reports monthly and through the annual Governance and Risk Report

6.3.11 Ensure appropriate mechanisms are in place for action to be taken in response to the results of clinical audit and the recommendations of any external reports (eg Care Quality Commission reports)

6.3.12 Monitor the Trust Compliance with the Care Quality Commission standards and registration requirements in order to provide relevant assurance to the Board to inform the declaration of compliance

6.3.13 Overview the Trust's Quality Account to provide assurance to the Board of effective delivery and guide the development of key performance measures for clinical quality

6.3.14 Review new policy in order to be able to recommend approval by the Board of Directors / approve amendments to existing relevant policies and note significant new procedures

6.3.15 Review annual reports including but not limited to:

- Annual Patient Experience Report including complaints section
- Annual Risk and Governance Report
- Annual District IP&C report
- Annual Clinical Audit priorities and Annual Report
- Annual Deanery Quality Assessment
- Annual Safeguarding Reports – Adult & Children
- Research and Development Annual Plan and Actions
- Annual report on Staff Suspensions and professional body referrals

7. REPORTING

7.1 The Committee will report its discussions and activity monthly to the Board.

7.2 The Chair of the Committee will present the minutes of the meeting to the Board drawing attention to any issues which require particular attention or requires the Board to take action.

7.3 The Chair of the Committee will ensure that copies of the minutes of the meeting are provided to the Audit Committee in a timely manner, and undertake to provide additional reports to the Audit Committee on any

specific issues identified that might be identified from time to time as necessary to enable the Audit Committee to fulfil its duties.

7.4 The Chair will ensure that copies of the minutes of the meeting are provided to the PCT Commissioning team.

7.5 The Chair of the Committee will ensure that key issues and actions from the committee meetings are reported to the Communications team for them to communicate to staff as appropriate, through existing briefing processes.

8. OTHER MATTERS

The Committee shall receive Executive support from the Head of Governance, whose duties will include:

- Agreement of agenda with Chair and collation of papers
- Ensuring appropriate minutes are taken and a record of matters arising and issues carried forward is maintained
- Advising the Committee on pertinent areas

Date of Approval by Board of Directors: April 2011

To be reviewed annually; date for next review: April 2012

APPENDIX B

TERMS OF REFERENCE FOR NON CLINICAL GOVERNANCE AND RISK COMMITTEE

1. CONSTITUTION AND ACCOUNTABILITY

1.1 The Non Clinical Governance and Risk Committee is a Committee of the Board of Directors and has no executive powers other than:

a) Those specified in these Terms of Reference or in the Trust scheme of delegation
b) Those specified in GOV 1.2 (Policy on Procedural Development)

1.2 The Committee in its workings will be required to adhere to the Constitution of the Barnsley Hospital NHS Foundation Trust, the Terms of Authorisation and Code of Governance issued by the Independent Regulator for NHS Foundation Trusts, Monitor.

1.3 The Committee is authorised to investigate any activity within its Terms of Reference and to seek any information it requires from any employee. All employees are directed to co-operate with any request made by the Committee.

1.4 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise it considers necessary.

2. OVERALL PURPOSE

2.1 The Committee's overall purpose is to provide assurance to the Board on the strategy, business, human resource and organisational development risks faced by the organisation and the controls and governance processes to mitigate risk. In particular it ensures there is an integrated system for planning within the Trust which incorporates service/finance/workforce/facilities/IM&T and quality standards, and reviews the relevant strategic, business and Trust development plans to ensure they are capable of delivering the Trust's Annual Plan.

3. MEMBERSHIP

3.1 Membership shall comprise:

- 2 Non Executive Directors -Committee chair and deputy
- Director of Human Resources and Organisational Development
- Chief Operating Officer
- Risk Management representative – Clinical Risk Coordinator
- ADD from each division
- Director of Finance
- Director of Quality and Standards
- Director of Strategy and Business development
- Chief Transformation Officer
- Head of Estates & Facilities
- Head of Governance

- Information Governance Manager

3.2 Members will be required to attend at least 75% of Committee meetings each year and are encouraged to send deputies on the exceptional occasions when they cannot attend in person.

3.3 Membership will be regularly reviewed to ensure it appropriately reflects the non clinical governance and risk requirements.

4. ATTENDANCE AND FREQUENCY OF MEETINGS

4.1 Meetings will be held no less than bi -monthly. Timings may be amended to meet internal or external deadlines for reporting requiring the Committee's scrutiny.

4.2 The Head of Governance will ensure that an efficient secretariat service is provided to the Committee.

5. QUORUM

5.1 A quorum shall be six members but one must be a Non Executive Director and one an Executive Director.

6. DUTIES AND RESPONSIBILITIES

6.1 The Committee is responsible for co-ordinating the provision of assurance to the Board on the strategy, business, human resource and organisational development risks faced by the organisation and the controls and governance processes to mitigate risk. In particular it will ensure there is an integrated system for planning within the Trust which incorporates service/finance/workforce/facilities/and quality standards, by review of strategy, business and organisational development plans, and the Board Assurance Framework, produced within the organisation.

6.2 The Committee will play a key co-ordinating role in ensuring that the Board Assurance Framework accurately reflects:

- the non-clinical risks faced by the Trust
- the key controls in place to manage these risks
- the sources of assurance to the Board that these controls are effective
- any gaps in controls or assurances that exist

The Committee will also play a key role in managing the delivery of any actions that arise from the non-clinical elements of the Board Assurance Framework – specifically including actions to improve controls or provide further assurances.

6.3 The Committee will approve the Terms of Reference and membership of its reporting Sub Committees and oversee their work, receiving *exception* reports from them for consideration and action as necessary

6.4 The Committee will ensure that adequate and appropriate governance structures, processes and controls are in place across the Trust and in each division to:

- Protect the Heath and Safety of Employees and all others to whom the Trust owes a duty of care, and approve those policies developed under the Trust's Health & Safety framework (per GOV 1.2, Policy on Procedural Development)
- Oversee both the policies and implementation of good HR/OD practice
- Review compliance with the provisions of Equality Legislation and adherence in the Trust
- Ensure appropriate workforce arrangements and planning to deliver the Trust's strategy and Business Plans
- Review the Trust's up to date Board Assurance Framework, Risk Register and profile
- Consider and challenge risk prioritisation including discussion of discrepancy
- Monitor the risk profile of the Trust against risk thresholds and provide the Board of Directors with regular assessments of the risks facing the organisation based on agreed categorisations and an overview of the management of risk
- Monitor the effectiveness of risk management systems within the Trust and review the risk management strategy and annual risk management report
- Provide assurance that there is an effective system of internal control across the organisation and scrutinise, quality assure and standardise divisional level governance structures and monitor remedial actions
- Test the systems and processes in place to develop and sustain compliance with all relevant standards and Key Performance Indicators
- Provide assurance on compliance with the Trust's Terms of Authorisation
- Management of all aspects of financial and non clinical risk (eg emergency planning and resilience)
- Overview Codes of Conduct and legislative and regulatory risk
- Review new policies in order to be able to recommend approval by the Board of Directors / Approve amendments to existing relevant policies and procedures
- Scrutinise Policy Management Frameworks and NHSLA standards and adherence
- Overview the non clinical aspects of The NHS constitution
- Oversee the single equality scheme

7. REPORTING

7.1 The Committee will report its deliberations monthly to the Board.

7.2 The Chair of the Committee will present the minutes of the meeting to the Board drawing attention any issue which require particular attention or require the Board to take action.

7.3 The Chair of the Committee will ensure that copies of the minutes of the meeting are provided to the Audit Committee in a timely manner, and undertake to provide additional reports to the Audit Committee on any specific issues identified that might be identified from time to time as necessary to enable the Audit Committee to fulfil its duties.

7.4 The Chair of the Committee will ensure that key issues and actions from the committee meetings are reported to the Communications team for them to communicate to staff as appropriate, through existing briefing processes.

8. OTHER MATTERS

The Committee shall receive Executive support from the Head of Governance, whose duties will include:

- Agreement of agenda with Chair and collation of papers
- Ensuring appropriate minutes are taken and a record of matters arising and issues carried forward is maintained
- Advising the Committee on pertinent areas of governance

Date of Approval by Board of Directors: **April 2011**

To be reviewed annually; date for next review: **April 2012**

APPENDIX C

TERMS OF REFERENCE - FINANCE COMMITTEE

1. CONSTITUTION AND ACCOUNTABILITY

1.1 The Finance Committee is a committee of the Board of Directors and has no executive powers, other than those:

a) specifically delegated in these Terms of Reference
b) within the Trust's Scheme of Delegation to advise the Board regarding borrowing arrangements, political positioning and financial consequences of strategic decisions on behalf of the Trust

1.2 The Committee in its workings will be required to adhere to the constitution of the Barnsley Hospital NHS Foundation Trust, the Terms of Authorisation and Code of Governance issued by the Independent Regulator for NHS Foundation Trusts, Monitor.

1.3 The Committee is accountable to the Board of Directors. It is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

1.4 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with the relevant experience and expertise it considers necessary.

2. OVERALL PURPOSE

2.1 The overall purpose of the Finance Committee is to ensure that the financial plans of the Trust are realistic and explicit, and that all financial risks have been identified and mitigated. In addition the Committee will provide assurance on financial reporting to the Board and overview Treasury Management issues.

3. MEMBERSHIP

3.1 The Committee shall be appointed by the Board from amongst the Non-Executive Directors (NEDs) and Executive Directors of the Trust and shall consist of not less than three members, one of whom is nominated as Chair.

Membership

2 Non Executive Directors
– Paul Spinks – Committee Chair
Chief Executive Officer
Director of Finance
Medical Director
Chief Operating Officer
Director of Strategy and Business Development
In Attendance
Head of Governance
Secretarial Support to the Committee

3.2 Members are required to attend at least 75% of all meetings of the Committee and may send deputies where appropriate on the exceptional occasions when they cannot attend in person.

4. ATTENDANCE AND FREQUENCY OF MEETINGS

4.1 Meetings will be held at least quarterly. Timings may be amended to meet deadlines for internal and external reporting requiring the Committee's scrutiny.

4.2 The Head of Governance will ensure that an efficient secretariat service is provided to the Committee.

5. QUORUM

5.1 Minimum attendance of at least one Non Executive Director and one Executive Director is required for meetings to be quorate.

6. DUTIES AND RESPONSIBILITIES

The duties and responsibilities of the Finance Committee can be categorised as follows:

6.1 Assurance

6.1.1 The Committee will play a key co-ordinating role in ensuring that the Board Assurance Framework accurately reflects:

- the financial risks faced by the Trust
- the key controls are in place to manage these risks
- the sources of assurance to the Board that these controls are effective
- any gaps in controls or assurances that exist

6.1.2 The Committee will also play a key role in managing the delivery of any actions that arise from the financial elements of the Board Assurance Framework – specifically including actions to improve controls or provide further assurances.

6.1.3 The Committee will discuss specific reports produced by both Internal and External Audit, with appropriate risks identified included in the Board Assurance Framework.

6.2 **Financial Reporting**

6.2.1 The Committee shall review the content and presentation of financial reports produced within the organisation and have a understanding of this position in relation to the regional financial context.
Detail to Include:

- Forecasting , assumptions appraisal and sensitivity analysis
- Cash Flow Analysis – debtor and creditor payment days (outstanding internal audit recommendation)
- Financial landscape report

6.2.2 The Committee shall undertake a detailed risk appraisal of the FRR 12 month forecast assumptions, providing recommendations to the Board of Directors in advance of the quarterly FRR Monitor submissions.

6.2.3 The Committee shall provide assurance on strategic business unit delivery through the oversight of progress and resource allocation to Trust Wide of:-

- Service Line Reporting (SLR)
- Service Line Management(SLM)
- Patient Level Costing(PLC)

6.2.4 The Committee will provide assurance on the delivery of planned Capital Expenditure Plan review of performance in terms of:

- impact on Trust financial plan
- implications on FRR

6.2.5 The Committee will oversee significant investment proposals through oversight and financial assessment of the associated business case.

They may also request specific reports on individual issues that are identified, to further enhance the accuracy and transparency of financial reporting.

6.3 **Financial Planning**

6.3.1 The Committee shall review the financial elements of the Trust's Annual Plan, ensuring that key assumptions made are realistic and explicit. The Board of Directors remains responsible for approval of the Annual Plan, prior to submission to Monitor.

6.4 **Treasury Management**

6.4.1 The Committee shall review the policies of the Trust to manage its cash resources to ensure appropriate prudence and oversight of cash management and investment decisions.

6.4.2 The Committee will also monitor compliance with Treasury Management policies and procedures.

6.4.3 Decisions on the investment of Trust Funds (charitable) remain the responsibility of the Trustees.

6.5 **Other Matters**

6.5.1 The Committee will provide the opportunity to overview key financial issues that require detailed discussions prior to consideration by the Board of Directors which would include: exceptional expenditure, single tender actions; the write off of any bad debts and single payments; and may include specific business cases proposals.

6.5.2 The Committee has delegated authority for approving borrowing arrangements on behalf of the Trust, and is required to report on same to the Board of Directors.

7. REPORTING

7.1 The minutes of the Finance Committee shall be formally recorded and submitted to the members of the Board of Directors.

7.2 The Chair of the Committee shall draw the attention of Board members to any issues that require disclosure to the full Board of Directors, or require Executive action.

7.3 The Chair of the Committee will ensure that key issues and actions from the committee meetings are reported to the Communications team for them to communicate to staff as appropriate, through existing briefing processes.

8. OTHER MATTERS

8.1 The Committee shall receive Executive support from the Head of Governance, whose duties will include:

- Agreement of agenda with Chair and collation of papers
- Ensuring appropriate minutes are taken and a record of matters arising and issues carried forward is maintained
- Advising the Committee on pertinent areas

Date of Approval by Board of Directors: April 2011
To be reviewed annually; date for next review: April 2012

APPENDIX D

TERMS OF REFERENCE FOR AUDIT COMMITTEE

1. CONSTITUTION AND ACCOUNTABILITY

1.1 The Audit Committee is a Non-Executive Committee of the Board of Directors and has no executive powers, other than those specifically delegated in these Terms of Reference. The Audit Committee in its workings will be required to adhere to the Constitution of the Barnsley Hospital NHS Foundation Trust and the Terms of Authorisation and Code of Governance issued by the Independent Regulator for NHS Foundation Trusts, Monitor.

1.2 The Committee is accountable to the Board of Directors. It is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

1.3 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with the relevant experience and expertise it considers necessary.

2. OVERALL PURPOSE

2.1 The overall purpose of the Audit Committee is to provide the Board of Directors with assurance on the adequacy of the Trust's underlying assurance processes that indicate the degree of achievement of corporate objectives and to validate this assurance function through the Statement on Internal Control.

2.2 The Audit Committee also provides the Board with an independent commentary on the fitness for purpose of the Board Assurance Framework and the adequacy of the Board's governance, risk management and internal control mechanisms. The Committee focuses the work of the Internal Audit Annual Plan to support this assurance and liaises with External Audit in relation to their findings.

3. MEMBERSHIP

3.1 The Audit Committee shall be appointed by the Board from amongst the Non-Executive Directors (NEDs) of the Trust and shall consist of not less than three members, one of whom is nominated as Chair. At least one member of the Audit Committee must have recent and relevant financial experience. The Chairman of the Trust shall not be a member of the Committee.

Members
2 Non Executive Directors –Chair and Deputy Chair
Director of Finance

In Attendance
Internal Auditors
External Auditors
Deputy Director of Finance
Head of Governance
Financial Accountant – As required
Secretarial Support to the Committee

3.2 Members are required to attend at least 75% of all meetings of the Committee and must send deputies on the exceptional occasions when they cannot attend in person.

4. ATTENDANCE AND FREQUENCY OF MEETINGS

4.1 The Director of Finance and appropriate Internal and External Audit representatives shall normally attend meetings. At least once a year the Committee should meet privately, and separately, with the External and Internal Auditors.

4.2 On occasion, an invitation shall be extended to all NEDs to attend meetings with the exception of the Trust Chair who will be invited to attend at least annually to gain assurance around the effectiveness of the Committee.

4.3 The Chief Executive and other Executive/Associate Directors should be invited to attend as appropriate, but particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

4.4 The Chief Executive shall be invited to attend at least two meetings each year, to discuss with the Audit Committee the Internal Audit plan and the process for assurance that supports the Statement on Internal Control.

4.5 Meetings will be held at least quarterly. Timings may be amended to meet deadlines for the final Accounts and other returns requiring Audit Committee scrutiny. The External Auditor or Head of Internal Audit retain the right to request a meeting with the Committee if they consider this necessary.

4.6 The Head of Governance will ensure that the Agenda enables the Committee to fulfil its purpose and function and that an efficient secretariat service is provided to the Committee.

5. QUORUM

5.1 A quorum shall be two members.

6. DUTIES AND RESPONSIBILITIES

The duties and responsibilities of the Committee can be categorised as follows:

6.1 **Governance, Risk Management and Internal Control**

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

In particular the Committee shall review the adequacy of:

- All internal and control related disclosure statements (in particular the Statement on Internal Control and declarations of compliance with the Standards for Better Health), together with the accompanying Head of Internal Audit statement, external audit reports and opinions of other appropriate independent bodies, prior to submission to the Board of Directors.

- The underlying assurance processes indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service.

- Arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate (including divisions), concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Board Assurance Framework to guide its work and through scrutiny of the Executive audit and assurance functions undertaking related work within the Trust. The Committee will receive and review the Board Assurance Framework at every meeting.

6.2 **Internal Audit and Counter Fraud**

The Committee shall ensure that there is an effective Internal Audit function that meets mandatory Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

- Consideration of the provision of the Internal Audit service, setting and monitoring agreed key performance indicators and reviewing changes in personnel as may be appropriate

- Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that it is consistent with the audit needs of the organisation as identified in the Board Assurance Framework

- Consideration of the major findings of internal audit work, including the degree of assurance given and management's response

- Ensure co-ordination between Internal and External Auditors to optimise audit resources and ensure that the Internal Audit function has appropriate recognition and authority in the organisation

- Review and approval of the Counter Fraud Strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the counter fraud needs of the organisation

- Review the annual Counter Fraud Report

- Annual review of the effectiveness of Internal Audit

- Ensure that the Internal Audit and Counter Fraud function is adequately resourced and has appropriate standing within the organisation

6.3 **External Audit**

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

- Consideration of the appointment and performance of the External Auditor

- Discussion and agreement with the External Auditor, before audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure effective co-ordination with Internal Audit

- Discussion with the External Auditors of their local evaluation and audit risks and assessment of the Trust

- Review and monitor the External Auditor's independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory processes. To include a review of External Audit reports, including ISA260 before submission to the Board or other relevant Trust forum, and any additional work as required by the Committee together with the appropriateness of management's response

- Develop and implement policy on the engagement of the External Auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the External Audit firm

6.4 **Other Assurance Functions**

- The Committee shall review the findings of other assurance functions, both internal and external to the Trust, and consider the implications to the governance of the Trust. This will include, but will not be limited to, reviews by Arms Length Bodies or Regulators/Inspectors (eg Care Quality Commission, NHSLA), and professional bodies with responsibility for the performance of staff or functions (eg Royal Colleges, accreditation bodies etc)

- In addition the Committee will review the work of other Committees within the Trust, whose work can provide relevant assurance to the Committee's own scope of work. With regard to clinical governance, the Committee's considerations will include, but not be limited to, the assurance that can be gained from the clinical audit function

- The Committee will receive the minutes of other Committees (Board and Executive) in the Trust as deemed necessary to allow it to fulfil its functions and duties and ensure integrated governance arrangements are being met. The Committee may also request further reports from the other Committees of identified issues from time to time in order to be able to discharge its duties

6.5 **Management**

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

- They may also request specific reports from individual functions within the Trust (eg clinical audit) as may be appropriate to the overall governance arrangements

6.6 **Financial Reporting**

- The Audit Committee shall review the Annual Report and Financial Statements prior to submission to the Board of Directors with particular focus 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 procedures, including compliance with the requirements of Monitor, the Independent Regulator for Foundation Trusts
    - Unadjusted mis-statements in the financial statements
    - Major judgemental areas
    - Significant adjustments resulting from the audit

- Quality disclosures

- The Committee should also ensure that systems for any financial reporting to the Board, including those of budgetary control, provide the appropriate level of assurance with particular reference to the completeness and accuracy of information provided

7. REPORTING

7.1 The minutes of the Audit Committee shall be formally recorded and submitted to the members of the Board of Directors. The Chair of the Committee shall draw to the attention of Board members any issues that require disclosure to the full Board of Directors or require Executive action.

7.2 The Committee will report to the Board of Directors and to the Governing Council annually on its work, specifically commenting on the work in support of the Statement on Internal Control and the fitness for purpose of the Assurance Framework. In addition it shall comment on the integration of governance arrangements, the adequacy and approach on risk management of the organisation and the appropriateness of the self–assessment against the Standards for Better Health.

7.3 The Committee may report to the Governing Council at any time to identify any matters in respect of which it considers that action or improvement is needed and making recommendations as to steps to be taken.

7.4 The Chair of the Committee will ensure that key issues and actions from the committee meetings are reported to the Communications team for them to communicate to staff as appropriate, through existing briefing processes.

8. OTHER MATTERS

The Committee shall receive Executive support from the Head of Governance, whose duties will include:

- Agreement of agenda with Chair and collation of papers
- Ensuring appropriate minutes are taken and a record of matters arising and issues carried forward is maintained
- Advising the Committee on pertinent areas

Date of Approval by Board of Directors: April 2011

To be reviewed annually; date for next review: April 2012

APPENIDIX E

TERMS OF REFERENCE
REMUNERATION AND TERMS OF SERVICE COMMITTEE

1. CONSTITUTION AND ACCOUNTABILITY

1.1 The Remuneration and Terms of Service Committee is a non executive committee of the Board of Directors and has no executive powers other than those specifically delegated in these terms of reference. The Committee will adhere in its workings to the Constitution of the Barnsley Hospital NHS Foundation Trust and the Terms of Authorisation and Code of Governance issued by the Independent Regulator for NHS Foundation Trusts, Monitor.

1.2 The Committee is accountable to the Board of Directors. It is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any requests made by the Committee.

1.3 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with the relevant experience and expertise it considers necessary.

1.4 The Remuneration and Terms of Service Committee is a formal committee of the Trust's Board of Directors. The Standing Financial Instructions and Standing Orders of the Trust apply to the decisions of the committee. There is no requirement to hold meetings of the committee in public.

2. OVERALL PURPOSE

2.1 The overall purpose of the Committee is to appoint, appraise and remunerate senior executives in accordance with the 'Code of Conduct and Code of Accountability' published by the Department of Health (1997) and the National Health Service Act 2006. This also reinforces good practice for Corporate Governance and complies with the Code of Governance for NHS Foundation Trusts issued by Monitor, the Independent Regulator.

3. MEMBERSHIP

3.1 The Committee will comprise the Chairman and the Non-Executive Directors of the Trust. The composition of the Committee will be detailed in the Trust's Annual Report. At any meeting of the Committee, the Chairman if present will preside.

4. ATTENDANCE AND FREQUENCY OF MEETINGS

4.1 The members have the discretion to invite the Chief Executive to attend meetings of the Committee as appropriate. The Director of Human Resources & Organisational Development will be invited to support the Committee with professional opinion but will not be present for discussions about his or her own personal remuneration and terms of service. The Trust Board Secretary will maintain accurate minutes of the committee and retain these securely in line with Trust policy.
In the event that the Chief Executive or Director of Human Resources is unable to attend when invited, deputies may attend in their stead if required.

4.2 The Committee has the delegated authority to invite attendance and commission independent professional opinion to help in their deliberations.

4.3 Any officer of the Trust in attendance at the meeting who may potentially benefit from a proposal should declare an interest and subsequently absent themselves when the committee reaches a decision.

4.4 The Committee should meet at least twice a year but additional meetings may be called at the discretion of the Chairman.

5. QUORUM

5.1 The Committee will be quorate with the Chairman (or in his or her absence the Deputy-Chairman) and a minimum of two of the Non Executive Directors.

6. DUTIES AND RESPONSIBILITIES

6.1 To ensure that all staff not on Agenda for Change or any other recognised national pay structure ("applicable staff") are fairly rewarded for their contribution to the organisation. This should have proper regard to the organisation's circumstances and performance and to the provisions of any national arrangements for staff where appropriate.

6.2 In considering the remuneration and terms of service, the Committee shall take the following factors into account:

- remuneration packages must be such as to enable people of appropriate ability to be recruited, retained and motivated within levels of affordability;

- all NHS bodies are part of the public sector and what they do, including the pay of their employees, must be publicly defensible;

- a properly defensible remuneration package requires a clear statement of responsibilities with rewards linked to their measurable discharge;

6.3 In developing remuneration packages, the Committee should ensure that it has:

- a clear statement of the responsibilities of the individual post holder and their accountabilities for meeting the objectives of the organisation;

- current comparative salary and benefits information from the NHS and where appropriate, other comparable public sector organisations, together with current national guidance

- where differential performance related payments are awarded, the reasons for any difference in performance pay award should be recorded

6.4 The Chief Executive will report on the annual performance of Executive Board Directors and will seek support from the Committee in evaluating their capability and performance within the Trust. The Chairman will evaluate the annual performance of the Chief Executive and report his or her findings to the Committee for discussion and agreement.

6.5 To advise on and oversee appropriate contractual arrangements for such staff; including the proper calculation and scrutiny of termination payments taking account of national guidance. This should including guidance dated 1st November 2007 from the Chief Executive of the NHS. The Committee should note that extra contractual or novel termination arrangements, whether or not covered by a compromise agreement, should be exceptional and only paid after due diligence and where there is a public interest. As a general rule, the Committee in discharging its due diligence responsibility should ensure:

- legal advice has been received
- use of disciplinary or performance procedures are not a more appropriate resolution route if performance or conduct are issues
- where any severance payments are “novel or unusual” approval has been sought in advance from HM Treasury in line with “Managing Public Money” Guidance
- any categories of proposed severance payment are provided for under the contract of employment

7. REPORTING ARRANGEMENTS

7.1 The Committee will report its decisions to the Board of Directors. The Non-Executive directors of the Board will remain responsible for taking decisions on the remuneration and terms and conditions of service of Executive Directors and other applicable staff’s Terms and Conditions of Service. Minutes of the Board’s meetings will record such decisions.

8. OTHER MATTERS

The Committee shall be supported administratively by the Secretary to the Board whose duties will include:

- Agreement of agenda with Chair and collation of papers
- Ensuring appropriate minutes are taken and a record of matters arising and issues carried forward is maintained
- Advising the Committee on pertinent areas with appropriate support.

Date of Approval by Board of Directors: **28th July 2011 *[tbc]***

To be reviewed annually; date for next review: **July 2012**

Barnsley Hospital NHS
NHS Foundation Trust

TERMS OF REFERENCE EXECUTIVE TEAM COMMITTEE

1. CONSTITUTION AND ACCOUNTABILITY

1.1 The Chief Executive has delegated powers from the Board of Directors and also from Parliament through various statutory duties vested in the Chief Executive, including the Accountable Officer role. The Chief Executive exercises these powers and responsibilities through the Scheme of Delegation and through the individual Directors and Lead Officers.

1.2 The Executive Team will be a forum answerable to the Chief Executive who is the Chair of the Executive Team.

1.3 The Executive Team members have delegated authority from the Chief Executive to ensure that strategy, day-to-day management and proper processes are in place within the Trust for its proper management.

1.4 The Executive Team will be accountable to the Chief Executive who, along with responsible Directors, is required to assure the Board that work undertaken is co-ordinated and prioritised to meet the Trust's objectives with particular reference to the Business Plan.

2. OVERALL PURPOSE

2.1 The Executive Team is the mechanism through which the Chief Executive regularly scrutinises and overviews the matters delegated and takes decisions relative to those.

2.2 The Executive Team will be responsible for over viewing the performance of all aspects of services delegated to individual Directors/officers throughout the Trust to ensure overall effective delivery of the Business and Annual Plan.

3. MEMBERSHIP

3.1 Membership shall comprise:

- Chief Executive (Chair)
- Chief Operating Officer
- Medical Director
- Chief Nurse
- Director of Finance and Information
- Director of Quality, Standards and Governance
- Director of Human Resources and Organisational Development
- Divisional Director from each Division
- Associate Director of Communication and Marketing

3.2 Membership will be regularly reviewed to ensure it appropriately reflects the delivery and decision making requirements of the committee.

4. ATTENDANCE AND FREQUENCY OF MEETINGS

4.1 Meetings will be held weekly three times a month excepting the week before the monthly Board of Directors Meeting.

4.2 In the event that an Executive Team Committee member is unable to attend where possible a nominated deputy will attend the meeting.

4.3 The Executive Assistant to the Chief Executive will ensure that efficient secretariat is provided to the committee.

4.4 Where appropriate the team may consider it necessary to establish sub-groups to address certain issues. Membership of these groups will reflect expert advice within the Trust.

5. QUORUM

5.1 The Quorum should be no less than five members of which two will be Executive Directors.

6. DUTIES AND RESPONSIBILITIES

6.1. The Executive Team will request and receive reports from internal and external committees, bodies and/or Directors appropriate to the day-to-day smooth running of the Trust's business aspects.

6.2. Approve the Terms of Reference and membership of its reporting Sub Committees and oversee their work, receiving exception reports from them for consideration and action as necessary.

6.3. All decisions of the Executive Team will be reached by consensus and matters not reaching consensus will be reviewed or decided upon by the Chief Executive.

6.4. The Executive Team will review all new policies that have corporate or financial consequences ensuring the content and implications of the policy are fully considered prior to recommending to the Board for approval.

6.5. The Executive Committee meetings will deliver a programme of collective development to its members through external presentations and meetings used to address specific skills gaps or other identified development requirements.

6.6. On a bi monthly basis the committee will extend its membership in order that the committee meeting can be used for collective senior management development.

7. REPORTING ARRANGEMENTS

7.1. The Executive Team will circulate appropriate notes in timely fashion after each meeting to its membership who will cascade them as appropriate. These will be available to the Board of Directors if so requested.

7.2. The minutes will be kept by the Chief Executive in the form of action points and distributed as noted above.

8. OTHER MATTERS

The Committee shall be supported administratively by the Executive Assistant to the Chief Executive whose duties will include:

- Agreement of agenda with Chair and collation of papers
- Ensuring appropriate minutes are taken and a record of matters arising and issues carried forward is maintained

The Committee's Terms of Reference will be kept under review during the Service Leadership model development process at the Trust.

Date of Approval: **28 July 2011**
To be reviewed annually; date for next review: **July 2012**

RISK MANAGEMENT
AND ASSESSMENT PROCEDURES

INTRODUCTION

Pivotal to the success of risk management is the process of risk identification and the flow of information across the organisation to ensure a robust bottom up and top down line of communication. This procedure details the risk management process.

Top Down Identification

It is the responsibility of the Board to agree the Trust's objectives annually in its business plan and agree the principal risks to those objectives. The outcome to this annual process is documented in the Board Assurance Framework Document.

The assurance that key controls and processes are both adequate and effective in mitigating and managing those risks is the responsibility of individual Directors, and collectively by the Executive Team. The Governance Committees are responsible for ensuring the process is in place and the controls and assurances presented to it are robust.

The Governance Committees will agree the stratification of objectives on the BAFD into red, amber and green and the assessment of principal risks into extreme, high, moderate and low; and agree the reporting cycle for assurance based on severity of risk and reliance on controls.

Assurance against red objectives and high risks will be reported and assessed bi-monthly by the Governance Committees. A monthly progress report on the action plan in place to deliver the objective and mitigate any attendant risk will be reported to the Board of Directors.

Bottom up Identification

The corporate risk management team is responsible for the collation of risk information. Risk Management will ensure the effectiveness of incident reporting and that these are recorded on the incident database and that themes and trends are identified to the relevant divisional and corporate Governance Committee.

The Divisional Directors and Assistant Directors will be responsible for ensuring the identification and control of risks within Divisions or Departments and will maintain the Risk Registers for the Division. Those risks that cannot be managed at Divisional level will be reported/escalated to the Clinical Governance and Non Clinical Governance and Risk committees and where sufficiently corporate will be transferred to the Board Assurance Framework Document.

Risks will be identified using the NPSA risk scoring framework and the risk identification matrix within the risk assessment procedures document.

The Risk Management Process

Risk Management is a proactive and systematic process of risk identification, analysis, treatment and evaluation of potential and actual risks. Risk Management

is also a retrospective process of monitoring, review and analysis to learn and improve from near misses, adverse incidents, complaints, claims and other feedback mechanisms from which preventative strategies can be developed. The primary purpose of these processes is to enable individuals and the Trust to competently deal with risks in the workplace or the delivery of business objectives.

Through the implementation of this policy and appropriate training, it is anticipated that staff will develop a deeper understanding of the breadth of their statutory duties of care. This should lead to staff feeling confident in identifying potential risks and in reporting untoward incidents and near misses, freely participating in audits and peer reviews and having ownership of polices, procedures and guidelines.

Managers in particular should appreciate the value of their contribution to Risk Management through implementing the risk assessment process within their area. Local Risk Management Groups must be established in all Divisions and Directorates that mirror the overall principles of this policy and procedure.

Risk Assessment

The over-riding principle is that the Trust will have in place a robust and commonly applied risk assessment process. The standard and matrix set out below has been drawn up to set out the way in which risk assessment is operated in practice throughout the Trust. The Risk Assessment Tool for performing a Risk assessment and documenting an Action Plan is provided as a further appendix to the procedure.

Risk Management Standard

The Trust has adopted the NPSA Risk Matrix – A risk matrix for risk managers NPSA January 2008. Risk can be defined as “the chance of something happening that will have an impact on objectives. It is measured in terms of consequences and likelihood”. Thus risk is made up of two factors:

Risk = Consequences x Likelihood.

The Trust’s approach to quantifying risk is to define qualitative measures of consequences and likelihood and these are set out below. This has allowed the construction of a Risk Matrix to score and prioritise risks, and as the basis for identifying acceptable and unacceptable risks.

For some risks there may be physical as well as financial consequences. When assessing the score for the consequences of such a risk, as a general rule the clinical assessment (eg serious injury or death) will always take precedence over the financial assessment.

Risk Matrix

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 1 Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table. Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

(Table 2)

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur,possibly frequently

Table 3 Risk scoring = Consequence x Likelihood (C x L)

	Likelihood Score				
	1	**2**	**3**	**4**	**5**
Consequence ↓ Score	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

Instructions for use

1 Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

2 Use table 1 to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.

3 Use table 2 (above) to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.

4 Calculate the risk score by multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score).

5 Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.

Risk Treatment
The above four categories of risk rating (high, significant, moderate, or low) provide an initial prioritisation for management action. The precise timing of actions will be set out in the Action Plan. In general, the four categories of risk will be treated as follows:

- **Extreme risks: immediate <u>action</u> required**. A Director must be informed and he/she will take responsibility for immediately planning action. Progress to be reviewed *monthly.*
- **High risks**: urgent Director/Senior management attention needed. Within one month an appropriate action point must be agreed, usually with a deadline for completion of no more than 6 months. To be reviewed *Quarterly.*
- **Moderate risks**: specific responsibility for risk assessment and action planning must be allocated to a named person. Usually, deadline for completion will be within 6 to 12 months and will depend on resource availability. To be reviewed *6 monthly.*
- **Low risks**: can be managed by routine procedures. To be reviewed *annually*

Managerial Authority to Act on Risks

The table below provides the management level where identified risks would normally be managed through the routine chain of management. It should be noted that a number of Trust policies require immediate escalation of risks or incidents up to Director level, based on the risk rating score. However, the management of the risk and action plan may subsequently be delegated.

	Supervisor Sister or Staff Nurse	Lead Nurse Or Department Manager	Assistant/ Divisional Director	Director ET
Extreme Risk/SUI				√
High Risk			√	
Moderate Risk		√		
Low Risk	√			

Risks likely to have a corporate impact must also be subject to consideration by a Director and the Executive Team (ET) as part of the management process in respect of prioritisation and funding requirements. Directors and Assistant Directors must ensure ET is informed of all relevant risk issues at the earliest opportunity.

Legal requirements
Certain actions may need to be planned to deal with specific legal requirements, eg Health and Safety notices/directions. Based on the above matrix alone, it is possible that such actions need not be undertaken urgently as the risk has been assessed and categorised as low. However, it is the policy of the Trust that it will seek to comply with any legal requirements at the earliest possible opportunity irrespective of what would be

the usual date for action. Such items will be marked appropriately in the Action Plan and the deadline for action will usually be less than one year.

Acceptable Risks
Qualitative assessments of risk will be based on objective and subjective assessments by staff within the Trust. As these assessments become more objective, and also more consistent across the Trust, it may be possible to define an acceptable risk as one that has a certain score set out on the charts above. Thus in the future an acceptable risk may be defined as one having a score below a certain number. In the meantime acceptable risk has been defined as follows:

Acceptable risk is the residual risk remaining after appropriate controls have been applied to associated hazards that have been identified, quantified to the maximum practicable, analysed, communicated to the appropriate level of management and accepted after proper evaluation.

For a risk to be deemed acceptable, it must be:
- Identified and entered on a risk register
- Quantified to the maximum possible (consequences and likelihood)
- Analysed
- Communicated to the appropriate level of management, and then
- Appropriately controlled and kept under review.

Risk Registers
Each Division/Directorate will be responsible for developing and monitoring their own risk register and action plan. This register should be current and readily available and held centrally on the risk management database.

A comprehensive Risk Register will be compiled to cover the whole Trust. All extreme and high risks will be entered and analysed in the register. An assessment will be made of the consequences should the risk happen and also the likelihood of the risk actually happening. The Risk Register where appropriate, will contain a reference linking the risk to the overall Trust Action Plan. The more significant risks will be afforded a higher priority in the Action Plan and the prioritisation will be based on the four categories of risk set out in the Risk Assessment Matrix shown above.

Risk Registers must contain the basic components:

1. Source of the risk (e.g. risk assessment, incident, complaint, claim etc)
2. Description of the risk
3. Risk score
4. Summary risk treatment plan
5. Lead Officer
6. Date of review
7. Residual risk rating

Risk Registers will be prepared in the same format (minimum data set) and this will facilitate the aggregation of information across the Trust.

Action Plans
For each risk identified, there will be a treatment/action plan relating to the risks contained in the register.

It is recommended that an action plan is established with SMART Objectives. Minimum data requirements for an action plan are:

1. Specify the aim or objective
2. Detail the actions or tasks required to deliver the objective
3. Time scale to delivery
4. Responsible officer

Actions identified should be SMART i.e. will be Specific, Measurable, Achievable, Realistic and Timely.

It will be the responsibility of each Division/Directorate to ensure that its risk register and action plan are regularly reviewed to keep them up to date. Risks are constantly changing and actions should be progressively implemented. By updating their details, departments will automatically update the aggregated Trust-wide register and plan, which is used to keep the Senior Management Team informed of progress.

The Division/Directorate Treatment/Action Plan will contain details of each action required to manage the identified risks. Each action will be assessed as to its importance and its priority. An individual will be named and given responsibility for ensuring the action is carried out by the chosen due date. Where possible an assessment will be made of the resources required to undertake the action. The assessment of the resources required should contain an analysis of staff resources as well as revenue and capital financial resources.

As this system of risk assessment and management continues to mature the Trust expects to incorporate within these risk management procedures a robust system for assessing in relation to each planned action:

- the costs of the action - both recurring and non-recurring, and
- the benefits arising from the action – both direct and indirect.

Monitoring and Review

Each Division/Directorate must regularly monitor its risk register through its local risk management and governance arrangements. As a minimum this should be on a quarterly basis and documented through the local risk management or governance group minutes.

The Risk Register will be reviewed monthly with individual Directors, Assistant Directors. A report identifying extreme and high risks will be presented to each meeting of the Governance Committees. The report will demonstrate how the policy is being implemented and reviewing progress with both the Risk Register and the Treatment/Action Plan. The Board of Directors receives a report via the Governance Committee. The Chief Nurse, through the Risk Manager, is responsible for ensuring this procedure is reviewed in accordance with current best practice.

APPENDIX H

BARNSLEY HOSPITAL NHS FOUNDATION TRUST

MANAGEMENT OF HEALTH AND SAFETY AT WORK REGULATIONS 1999

(This form to be used in conjunction with Risk Assessment notes)

RISK ASSESSMENT

(Clinical and Non Clinical)

Assessors Name(s):	
Ward/Department:	
Date:	
Reference Number:	
Review of Assessment Dated:	
Task/Operation Being Assessed:	

SPECIFIC LEGISLATIVE REQUIREMENT APPLICABLE

HAZARDOUS SUBSTANCES INVOLVED

Name of Substance	Assessment Date

SPECIFIC WORK EQUIPMENT PROVIDED

ASSESSMENT OF RISK

Hazards Identified	Risks Identified	Persons at Risk	Current Control Measures	Risk Rating Score		
				Severity	Likelihood	Risk Rating

SUMMARY OF RISK

Manual Handling Risk	**Yes**	**No**
Has a manual handling risk been identified?		
Is a further detailed manual handling risk assessment required?		
If the answer to the above question is Yes, a separate manual handling Risk Assessment will be required to fulfill the requirements of the Manual Handling Operations Regulations 1992.		

Associated Assessments	**Yes**	**No**
Is a noise assessment required by a competent person?		
Is a hand/arm vibration assessment required by a competent person?		
Is a COSHH assessment required?		
Is health surveillance required?		

Personal Protective Equipment	**Yes**	**No**
Is Personal Protective Equipment required?		
If the answer to the above question is Yes, please list the PPE required		
•		
•		
•		
•		
Is training/instruction required?		
Is there a need for special storage accommodation?		
Is there a need for test/examination		
Is all PPE compatible		

BARNSLEY HOSPITAL NHS FOUNDATION TRUST
ACTION PLAN

Action Plan
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Task(s) Requiring Action: **Date:**

Section 1 - Details of Hazard	**SECTION 2 Person(s) responsible and time-scales for action**	**Section 3 – Review**	**Section 4 Completion**
Date of Assessment etc: Person carrying out Assessment etc: Designation: Forwarded to: (for completion of Section 2) Date Forwarded:	Name of Person: Designation: Date Received: Copies forwarded for action to: Date Forwarded:	Status as at (Date): **High Risk:** **- Action Immediate** **Significant Risk:** **- Action within 6 months** **- Review within 3 months** **Medium Risk** **- Action within 12 months** **- Review at 3 month Intervals**	To be completed by persons responsible for action in Section 2.

Item No.	Problem requiring attention (include risk rating) and the recommendations of how to eliminate	Date first reported	Person(s) Responsible for action	Agreed time of action – specify date	Comments on actions	Has the Action been Completed		If no, What is the status of the action?	Date Signed as Completed	Signature
						Yes	**No**			

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Section 1 - Details of Hazard			**SECTION 2 Person(s) responsible and time-scales for action**			**Section 3 – Review**			**Section 4 Completion**	
Item No.	Problem requiring attention (include risk rating) and the recommendations of how to eliminate	Date first reported	Person(s) Responsible for action	Agreed time of action – specify date	Comments on actions	Has the Action been Completed		If no, What is the status of the action?	Date Signed as Completed	Signature
						Yes	**No**			

RISK REGISTER APPLICATION

If funding is not available within your Department/Directorate, the Director/Manager must ensure that the risk and the control measures required are entered onto the Risk Register

This proforma must be completed and forwarded to the Risk Manager

Department/Ward: -	CMT: -
Name(s) of Assessors: -	Assessment Date: -

Description of Risk	Hazard Consequence	Risk Likelihood	Risk Rating

Description of Control Measures Required	Cost

Who is Monitoring the Risk/Control Measures

Name: Please Print	Signature	Date

Date forwarded to Risk Manager:

RISK MANAGEMENT USE ONLY

Date Entered onto Risk Register	
Date copy returned to Originator	
By whom	

GUIDANCE NOTES FOR RISK REGISTER NOTIFICATION

Board Assurance

In accordance with the Assurance Framework, the Board will set objectives for the Trust and identify the principal risks that may threaten the achievement of those objectives. This exercise will take place annually as part of the Business planning process. The Senior Management Team or individual Directors will assess corporate risks arising from the Business Plan and notify the Risk Manager for recording on the risk register as a corporate risk for the organisation.

Directorate and Departmental Assessments

Directorates and Departments will subsequently undertake a similar exercise locally in accordance with the Business planning process. Review of CMT Business Plans and Departmental Risk Strategies would be useful sources of information, to establish the principal risks for that area. The Divisional Director, Assistant Directors and Departmental Managers have responsibility for risk management at operational level.

Periodic Risk Assessment Exercises

Designated members of staff, with relevant skills, will also carry out periodic (at least annually) Risk Assessments and Audit exercises ***for all the functions*** within their area of responsibility to identify new and to review existing risks both operationally or strategically. Designated Managers are also required to review or carry out a new risk assessment and review safe systems of work ***following any incident or near miss***.

Committee and Group Functions

It is recommended that all Statutory Committees or Advisory Groups within the Trust itemise any risk identified at that meeting and ensure that a member of that group is tasked with liaison with an appropriate Designated Director or the Risk Manager direct.

Risk Register Notification

Any risk assessed to be either high or significant must be escalated in accordance with the Risk Management Procedures.

In addition, following an appropriate investigation, the Risk Assessment, Risk Assessment Action Plan (and Investigative Report where appropriate) Risk Register Form and Risk Register Action Plan, should be forwarded to the Risk Manager/QC Department for input onto the Risk Register.

Risk Register Analysis and Reports

Extreme risks will be reported and discussed at each Clinical and Non Clinical Governance and Risk Committee meeting and full risk registers reviewed on an annual basis by both the Executive team and the governance committee's.
Departmental / Speciality reports will also be circulated on a monthly basis, along with the Incident, Complaints and Claims reports that is already distributed for discussion and review at monthly Divisional Governance meetings.

Where an action plan has been implemented, Designated Managers must ensure that the Register is updated on progress / completion on a monthly basis. Periodic review of action plans will be undertaken to audit completion dates but it is the Designated Manager's responsibility to notify completion.

Risk Assessment and Gaining Assurances
Risks will fall into three main areas: -

- Financial
- Organisational (to include Controls Assurance/Standards for Better Health)
- Clinical

In all instances, this process should be carried out on the Trust's Risk Assessment documentation comprising of: -

- Risk Assessment Form*
- Risk Action Plan*
- Risk Register Form*
- Risk Register Action Plan*

The purpose of any risk assessment is to look critically at four key issues:

1. What 'controls' mitigate those risks, (eg policy, procedure, safe system of work etc).
2. Who 'assures' the effectiveness of those controls (e.g. a committee, an audit, accreditation, etc).
3. Are there any 'gaps' in your controls and what are you doing about them?
4. Are there any gaps in your assurances and what are you doing about them?

Each CMT/Department must escalate risks appropriately and should maintain a ***local list of all risks*** and an action plan on how the risk is being eliminated, reduced or accepted as a residual risk.

* Confirmation must be noted on the IR1 / IR2 form

DEVELOPING THE BOARD ASSURANCE FRAMEWORK

The Assurance Framework is, first and foremost, a tool for the Board. The Board should:

- Provide leadership;
- Set values and standards;
- Set the organisations strategic objectives;
- Ensure that finances support the objectives
- Monitor and review management performance
- Ensure that the obligations to stakeholders are met

To ensure these principles are met there must be a sound system of internal control and the Board is required, at least annually, to conduct a review of these internal controls.

Whilst the risks to achieving the organisations strategic objectives should be reduced through these internal controls they can rarely be eliminated. The Assurance Framework should provide an outline of the controls and where assurances can be sought (and should avoid the minutia of day to day management).

Components of the Assurance Framework

The Assurance Framework is required to include certain key components as follows:

Principal Objectives
Principal Risks
Classification of Principal risks
Key Controls
Assurances on Controls
Board Reports
    Positive Assurances
    Gaps in Control
    Gaps in Assurance

The assurance Framework needs to include these items. They should be clear and explicit.

Board Engagement

The Board needs to be appropriately engaged in developing and maintaining the assurance framework. The specific level of input depends on the Board, and its underpinning arrangements. The Board may determine to delegate the detailed population and management of the assurance framework to one or other of its committees. This should be properly constituted and include non-executive director input.

The arrangement at Barnsley hospital is for the Clinical and Non Clinical and Risk Governance Committee's to review the Assurance Framework on a bi monthly basis. The Finance and Audit Committee will also review the framework on a bi annual basis. The outcome of these reviews will be documented in the notes of that meeting and reported to the Board of Directors at each meeting.

The Board will be appraised of progress on a regular basis, through exception reporting, with a once per quarter full review of the framework and the process annually. The Assurance Framework should be appropriately placed on the Board's agenda so that ample time is allowed for discussion.

Principal Objectives
The objectives need to be sufficiently strategic, well balanced and across all areas of activity. They need to specifically reflect the healthcare standards.

A usable assurance framework cannot be developed without good objectives. For an objective to be sufficiently strategic it should be a long term aim. Objectives should explicitly reflect the healthcare standards. The standards themselves are not necessarily long term objectives but the domains are and the current advice is that the domains should be adapted to create the long term, high level strategic objectives for the Trust. If the Governance domain is split into four separate objectives covering finance, performance, HR and clinical & corporate governance for example there are ten objectives which would be sufficient for the organisation to handle.

Risk Identification
Risks must be sufficiently strategic/high level and complete (ie are potential risks not just residual risks).

One of the failings in assurance frameworks is in the identification of risks. The risks on the assurance framework should be risks on a strategic level. They should be those risks that may prevent the Trust's objectives from being met. Because of the high level and strategic nature of the risks most of them will not be completely resolved and will require ongoing control. Ideally risk should be proactive and forward looking.

Often the control, or even the assurance is identified as the risk (eg failure to develop a strategy) and the real risk is missed. An example is 'failure to develop partnership working'. Here the real risk is that clients and patients do not benefit from a coordinated approach to care across agencies, and the control would be developing partnership working arrangements.

Classification of Principal Risks
Classifying the risk should include the source of the risk, and the lead Director who will be reporting to the Board on progress.

Key Controls
Controls are the systems, actions and mechanisms that are put in place to manage the risk to reduce the likelihood of an adverse event occurring or reducing the

impact if it did occur. Many controls will be long standing, others will be initiatives to put other better controls in place.

Controls must be material and dependable, and the Trust must evaluate how well the controls work. The NHS guidance tells us that controls should be monitored and their design subject to scrutiny by independent reviewers.

There is often confusion between a control and an assurance. One of the most commonly cited controls is monitoring which, on its own, cannot control a risk. There must be processes, strategies, policies and procedures in place and agreed standards against which to monitor activity.

Sources of Assurance on Controls

There are two types of assurance, internal, non-independent sources such as clinical audit and internal performance management reports; and external independent reports including internal audit, external audit and the NHS agencies and regulators such as the Litigation Authority, the Healthcare Commission and monitor.

Benchmarking and evidence based statistics can also be counted as external assurances. Independent assurances are not always available so the Board must evaluate the quality of internal assurances, including understanding the source of information provided in routine reports.

Positive Assurances, Gaps in Control and Assurance

When the risks and controls have been assured the Board should be informed where there is positive assurance and also where there is concern that the controls are inadequate or there are concerns over the assurances. It is common to ascribe positive assurance to an audit report whilst ignoring any criticism in the report or the narrow scope of the audit.

Mapping the Components

Components of the assurance framework should all be explicitly mapped out against each other so that an assurance can be mapped back to an objective with ease. The assurance framework is likely to be presented along with other Board reports and it is important to ensure maximum engagement by providing simple and clear mapping processes.

Fit for Purpose

To be 'fit for purpose' the assurance framework should provide the Board with evidence based assurances on the way in which it manages the organisations risks at a strategic level. It provides a simple but comprehensive method for the effective and focussed management of the principal risks to meeting the Trust's objectives. It intends to simplify Board reporting and the prioritisation of action plans allowing more effective performance management. This should be considered by the Board and those charged with the development of the framework.

Issues escalated to the Board
Significant issues arising from the assurance framework must be escalated to the Board and traced through the Board agenda. The assurance framework can be used to drive the Board agenda, including ensuring that Board reports are timetabled and that positive assurances are presented to the Board.

All the risks, controls and assurances will need to be referenced in the annual business plan. Issues on the assurance framework – objectives, risks, controls, assurances and gaps, should be translated into the personal objectives of the Directors.

Arrangements to follow-up Gap in Control and Assurance
The Board must have arrangements in place to ensure that gaps in control/assurance are followed up where necessary. Actions to close gaps in control and assurance should be built into the annual business plan, and included in the Board timetable so that the Board knows in advance when to expect new controls and assurances to be in place. The Audit Committee should also use the assurance framework as a reference for the development of the annual audit plan.

Statement of Internal Control (SIC)/ Annual Governance Statement (AGS)
The framework should also inform appropriate declarations to be made in the Statement of Internal Control (SIC)/(AGS). This document forms part of the annual reporting requirements of the Foundation Trust and has to be signed by the Chief Executive every year and provides assurance that risk and governance systems in the Trust are robust, especially the assurance framework.