Governance Manual

Governance Manual

Barts Health NHS Trust

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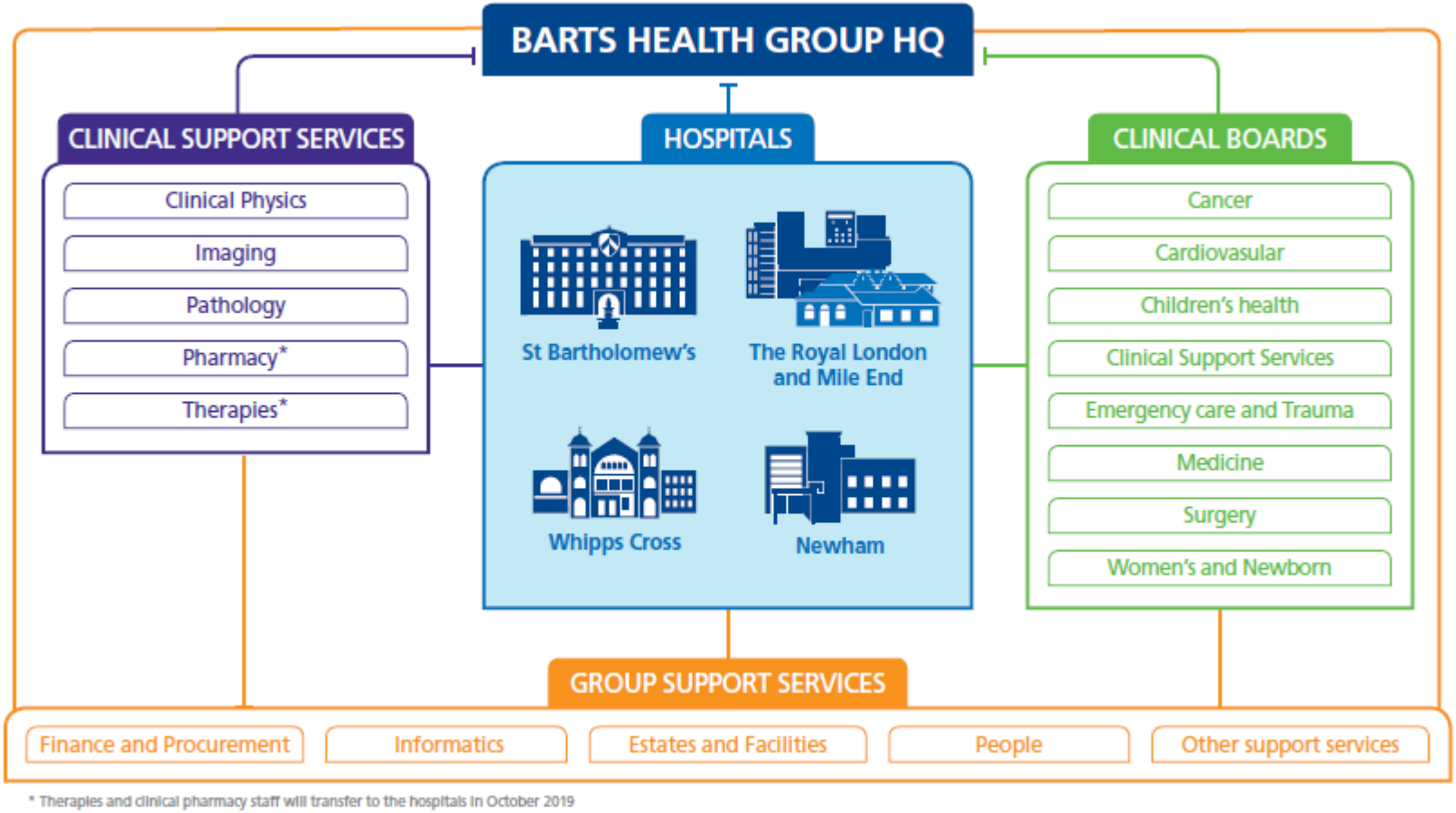
The Corporate Governance Manual sets out the internal governance arrangements for Barts Health NHS Trust with the intent that this is refreshed annually. The arrangements should be seen in the wider context of external partnerships, commissioning and stakeholder engagement (which in turn have identified governance arrangements not detailed here).

Group Executive Board approval: 17 December 2019
Trust Board approval: 22 January 2020

Section 1. Group Model overview, governance and structures

Barts Health
NHS Trust

Barts Health Group model



* Therapies and clinical pharmacy staff will transfer to the hospitals in October 2019

Our operating model: purpose and role of the key functions of the group

Barts Health NHS Trust

We have defined the role of each element of the group function and how they interact with each other:

Group Leadership (HQ): Comprises the Group Executive and its direct support (with steps being taken to ensure clear definition of this). The core functions of Group Leadership are communication and engagement, strategy and planning, improvement, developing leadership and commissioning Group Support Services (GSS).

- Responsible for ensuring that the Trust effectively discharges its statutory responsibilities as a public body
- Responsible for implementation of Trust strategy and strategic delivery plans
- Holds to account the hospitals, CSS, the clinical boards and Group Support Services

Hospitals: Led by a hospital Chief Executive who reports to the Group Chief Executive and supported by a Hospital Executive Board. Each hospital has a divisional structure led by a Divisional Director and supported by a divisional triumvirate. The hospitals are responsible for the oversight and delivery of services and the bulk of the group's staff and resources are managed by the hospitals. There are standardised governance arrangements in place across each hospital.

- Accountable to Group Leadership for delivery of the operational plan
- Hold Divisions to account
- RLH and SBH responsible for selected networked services at other hospitals

Clinical Boards: There are eight clinical boards each with a chair drawn from a triumvirate of a medical lead, nursing/AHP lead and a management lead. The clinical boards have a trustwide role for the specialities within their remit. The clinical boards role designation is strategy and vision, standards and variation, collaboration and partnership and workforce, research and innovation.

- Accountable to Group Leadership
- Hold clinical networks to account
- Regular interface with hospitals and CSS

Our operating model: purpose and role of the key functions of the group

Barts Health NHS Trust

Clinical Support Services (CSS): Led by a Managing Director who reports to the Deputy Chief Executive and supported by an Executive Board, CSS is a group of clinical services clustered around the Carter principles of maximising efficiency and clinical effectiveness through scale and networks which will involve areas of hub and spoke consolidation. The vision is to become a commercially agile group of services supporting front line clinical delivery able to respond to demand from the STP and beyond.

- Accountable to Group Leadership for delivery of the operational plan
- Hold Divisions to account
- Provides professional leadership to specified services managed operationally by the hospitals
- Accountable to the hospitals for service impact on their service

Group Support Services (GSS): Led by a Management Board and consisting of corporate services. A transformation programme is underway to evolve this structure (from existing separate corporate directorates) with two workstreams – delivering a new operating model that is service-led and delivering prioritised improvement projects, led by functions. Functions within GSS tend to be customer facing but work is underway to clearly define which functions are part of GSS and which are part of Group Leadership.

- Accountable to Group Leadership, hospitals, CSS, and clinical boards

Group Accountability Framework

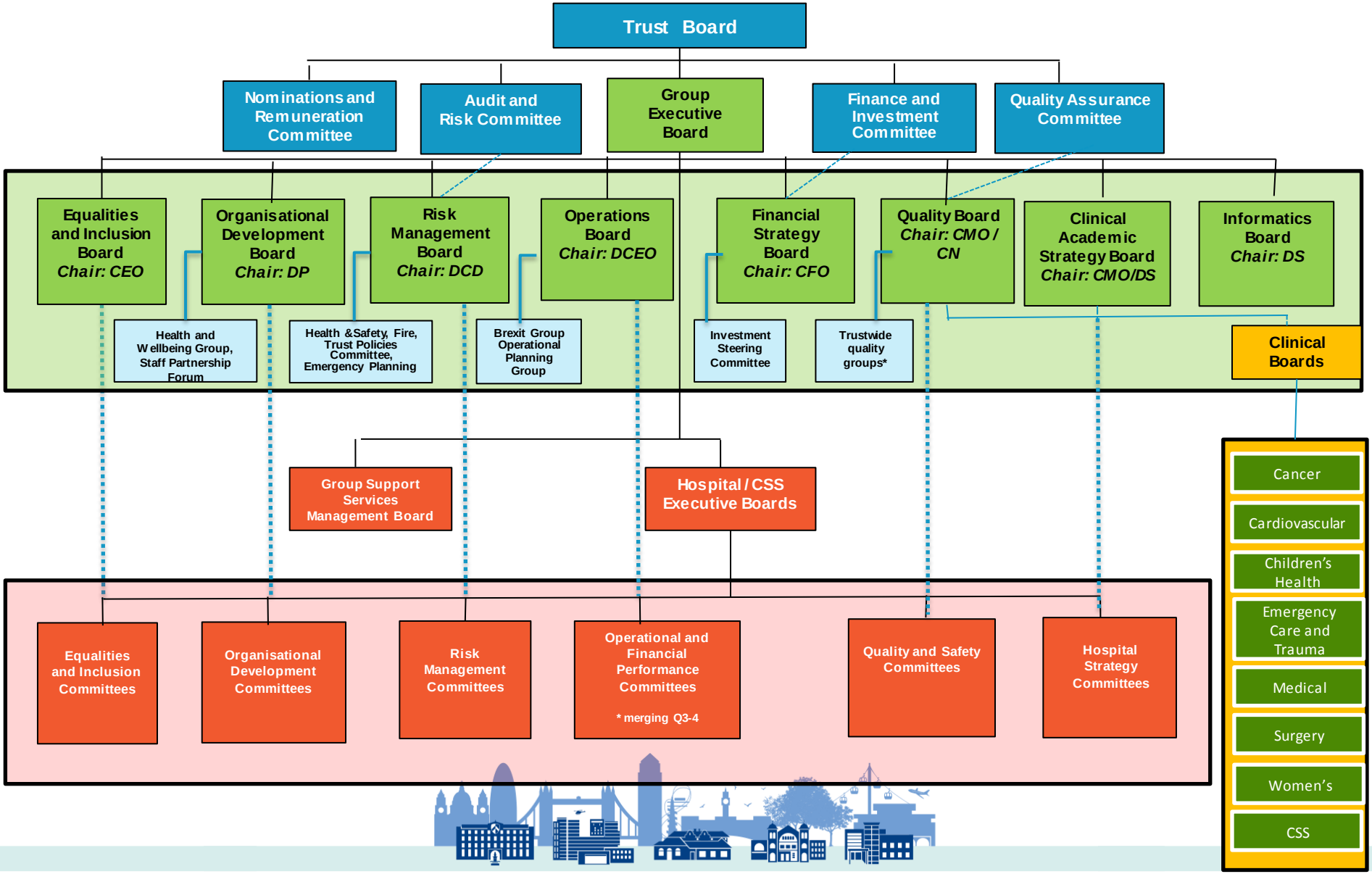
Barts Health NHS Trust

This Accountability Framework describes delivery expectations, devolved authority, performance reporting oversight and support and intervention. Guiding principles of the Framework include:

Clear delivery expectations	clear, agreed objectives and measures of success for each part of the Group, supporting delivery of the Group's vision, goals and strategic priorities.
Integrated approach	joined up understanding of performance across the Trust's six strategic priorities with quality at the heart of what we do.
Consistent rules-based approach	clarity over the triggers for intervention at hospital, clinical board and divisional level that is proportionate to risk
Localise where possible but centralise where necessary	authority and accountability as close as possible to patient services, while recognising that the role of Group Leadership needs to be 'tighter' in certain circumstances
Recognise inter-dependencies within the Trust and with other partners	there are clear inter-dependencies within the Trust between the hospitals and between all components of the Group model and with the wider system
Encouraging openness and honesty	promote openness and honesty over issues and risks, and the support needed.

Group governance structure

Barts Health NHS Trust



Quality Board Reporting Structure (Trustwide quality groups)

Barts Health NHS Trust

Hospital/CSS Quality and Safety Groups **

Clinical Boards **

Quality Assurance Committee

Quality Board

Group Executive Board

Information Governance Committee

Safety Committee

Clinical Effectiveness Committee *

Patient Experience Committee *

End of Life Committee *

Integrated Safeguarding Assurance Committee *

Medicine Governance Board *

Infection Prevention & Control Committee *

Safety Academy

Mortality Review Group

Nutrition & Hydration Committee

Deteriorating patient group

Transfusion Committee

VTE Group

Screening oversight committee

Medical Devices Committee

Radiation Protection Committee

NATSSIPS

Quality Governance Group

Regulatory Compliance Group

CQC BAU meeting

Hospital/CSS Performance Review meetings Monthly Chair: GCEO

Hospital/CSS Quality Deep Dive meetings Bi-monthly Chair: GCMO/GCNO **

* Each group has a sub structure – see separate structure

** Themes and issues from the deep dives, Hospital/CSS Quality and Safety Groups and Clinical Boards would be fed into quality board for action and visa versa.

Performance Review Process (quality)

Performance reviews

Barts Health NHS Trust

The formal committee structure is accompanied by robust performance review mechanism to focus on a) current risks/issues and b) strategic developments (in a Part 2 meeting format).

Group level

- Monthly divisional PRs with hospital/CSS/GSS leadership teams and group executives (with hospital CEOs attending for GSS PRs).
- Serviced by Trust secretariat; with standardised agendas alongside identified topics relevant to each hospital.
- Escalation to Group Executive Board.
- PRs are informed by 'deep dive' meetings (bimonthly quality performance reviews

Hospital level

- Monthly divisional PRs
- Serviced by hospital executive leads, with standardised agendas alongside identified topics relevant to each hospital.
- Escalation to Hospital Executive Board.

Clinical Board

- Clinical Board assurance meetings.
- Held quarterly providing assurance on progress against key objectives.
- Escalation to Group Executive Board.

Section 2. Standing orders and Standing Financial Instructions and related corporate governance articles

Standing orders and Standing Financial Instructions and related corporate governance articles

Barts Health NHS Trust

The Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions (Sos and SFIs) provide a regulatory framework for the business conduct of the Trust – and are a statutory requirement for trusts to produce, based on a national model.

- The SOs and SFIs represent the governing instruments of the Trust, upon which all Trust policies, guidelines and procedures are founded and are reviewed annually by the Trust – setting out the levels of authority delegated to the Board, its committees and to directors and other officers as well as Nolan Principles on standards for holding public office. These are published on the website: SOs and SFIs.

The SOs and SFIs are supported by the Trust's Standards of Business Conduct policy, which sets out requirements of individuals in upholding the integrity of the organisation and its officers, such as declaring details of interests, gifts and hospitality to support transparency and assuring on effective use of public funding. Related additional requirements that apply to the Board and its directors are set out in Fit and Proper Person's Test requirements.

Section 3a. Board Committee ToR

- *summary format only to illustrate key duties (the Trust Board reviews and approves more detailed versions, which are available on request)*

Trust Board - Terms of Reference (summary)

Barts Health NHS Trust

Frequency: Every Two Months
Duration: 2.5 hours
Location: Rotates across hospital sites
Chair: Trust Chairman

Objectives:

- Formulating the Trust's strategy to deliver safe and compassionate, high quality, patient-centred care. This includes agreeing the vision, annual plan / objectives and major investment decisions.
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and for organisational performance, and through seeking assurance that systems of control are robust and reliable. This includes arrangement to monitor and improve clinical quality; efficient, effective and economic use of resources; and its statutory duties.
- Establishing the values of the Trust and promoting these in the way that the Board does business and interacts with the rest of the organisation and external stakeholders.
- To receive and approve statutory reporting (Annual Accounts, Annual Report and Quality Account) to be adopted at an annually convened Trust Annual General Meeting.
- To consider any matters escalated from the Board's sub committees.
- To establish and maintain a Board seminar programme to support strategy development and board development.

Membership:

- Chair and seven NEDs, Group Chief Executive, Group Deputy Chief Executive, Group Chief Medical Officer, Group Chief Nurse, Group Chief Finance Officer (voting members).
- Group Director of People, Group Director of Strategy, Group Director of Corporate Development.

Quorum: at least one third of the whole number of the Chair and members (including at least two Executive directors and two Non Executive Directors)

Authority:

Reporting into: N/A
Receives reports from: Executive and Board committees, national and local partner organisations and regulators

Inputs:

- Integrated Performance Report.
- Standing progress reports

Outputs:

- Minutes and action log
- Statutory reporting adopted at AGM.

Other:

- Terms of Reference to be reviewed and agreed two yearly.
- All agenda, papers and Minutes/action logs to be stored on central committee folder (as administered by Trust Office)
- Confidential matters will be reviewed in a separate closed Part 2 session.

Audit and Risk Committee - Terms of Reference (summary)

Barts Health NHS Trust

Frequency: Quarterly (at least four times a year)
Duration: 2.5 hours
Location: tbc
Chair: Non Executive Director

Objectives:

- To review the establishment and maintenance of an effective system of governance, risk management and internal control to support the achievement of Trust objectives.
- To review the annual accounts and report, accounting and associated audit process to determine completeness,, integrity and accuracy.
- To assess adequacy of: risk management structures and processes (including high risk register); risk and control-related disclosures (e.g. Annual Governance Statement and Audit opinions); assurance processes; compliance with laws and regulations, including fraud and corruption; arrangements for raising concerns in confidence (e.g. whistleblowing).
- To recommend appointment and review effectiveness of Internal Audit and External Audit functions and review national policy / findings of external assurance functions.
- Reviews proposed amendments to SOs and SFIs.

Membership:

- Three NEDs (including the chair of the committee)

In attendance:

- Chief Executive, Chief Financial Officer, Director of Corporate Development
- Secretariat provided by Director of Corporate Development

Quorum:

- Two members

Authority:

Reporting into: Trust Board
Receives reports from: Chief Financial Officer, Internal and External Audit, Risk Management Board, Quality Assurance Committee

Inputs:

- Standing progress reports from Internal Audit and External Audit against audit plans.
- Counter fraud progress reports.
- Waivers (below Board threshold), special payments and losses reports.
- Annual report and accounts (including AGS).
- Board Assurance Framework and High Risk Register.

Outputs:

- Minutes and action log
- Exception report to Trust Board (templated)
- Annual Report to the Trust Board
- Recommendations to the Trust Board relating to annual accounts and amendments to SOs and SFIs.

Other:

- Terms of Reference to be reviewed and agreed every two years by the Trust Board
- All agenda, papers and Minutes/action logs to be stored on central committee folder (as administered by Trust Office)

Nominations and Remuneration Committee - Terms of Reference (summary)

Barts Health NHS Trust

Frequency: Scheduled for three times a year – and as required between scheduled meetings
Duration: 1½ hours
Location: *tbc*
Chair: Chair of the Trust

Objectives:

- Review the structure, size and composition of the Board and the Executive Team and recommend any changes to the Board.
- Undertake succession planning for the Chief Executive and Executive Directors.
- Oversee the process for recruitment of a Group Chief Executive and Executive Directors as vacancies arise, including agreeing the role definition and job description.
- Consider any matter relating to the continuation in office of the Chief Executive or an Executive Director, including the suspension or termination of service.
- Agree and keep under review the overall remuneration policy of the Trust, including setting pay ranges and flexibility parameters for very senior management grades.
- Set individual remuneration, allowances and other terms and conditions of office (including termination arrangements) for the Group Chief Executive and Executive Directors.
- Monitor and evaluate performance of the Group Chief Executive and Executive Directors against objectives for the previous year and note forward objectives.
- Agree any compromise agreements, settlements and redundancies before any external submission.
- Review the outcome of local Clinical Excellence Awards rounds.

Membership:

- Chair and Non Executive Directors

In attendance:

- Chief Executive, Director of People
- Secretariat provided by Director of Corporate Development

Quorum: Three members

Authority:

- **Reporting into:** Trust Board
- **Receives reports from:** Chief Executive and Director of People

Inputs:

- Exception reports from Hospital Management Boards and operational programme boards
- Integrated Performance Report (including by site)
- Finance report (including by site)
- Quality and Safety dashboard (including by site)
- Trust risk register (cut by site)
- Other reports as required

Outputs:

- Minutes and action log
- Exception report to Trust Board (templated)

Other:

- Terms of Reference to be reviewed and agreed every two years by the Trust Board
- All agenda, papers and Minutes/action logs to be stored on central committee folder (as administered by Trust Office)

Finance and Investment Committee - Terms of Reference (summary)

Barts Health NHS Trust

Frequency: Monthly – 1st week of the month
Duration: 2 hours
Location: *tbc*
Chair: Non Executive Director

Objectives:

- Oversee the development of the Trust's annual financial plan (including capital programme) and long-term financial strategy and the underpinning assumptions.
- Review monthly financial performance (including CIPs and capital programme) and identify issues and risks requiring escalation to the Trust Board.
- Review specific aspects of financial performance as requested by the Trust Board.
- Review the outputs of service line reporting and the implications for investment and disinvestment decisions.
- Review and approve all business cases (SOC, OBC and FBC) and asset disposals with a value in excess of SFI thresholds thereby requiring FIC approval.
- Approve the establishment of joint ventures or other commercial partnerships/ relationships including the incorporation of start-up companies.

Membership:

- Three NEDs (including the chair of the committee)

In attendance:

- Group Chief Executive, Deputy Chief Executive, Chief Financial Officer, Director of People, Director of Financial Improvement
- Secretariat provided by Director of Corporate Development

Quorum:

- Two members

Authority:

- **Reporting into:** Trust Board
- **Receives reports from:** Chief Financial Officer, Financial Strategy Board

Inputs:

- Monthly financial performance report
- Monthly QCIPs report
- Capital programme update reports
- Business cases >£1 million
- Other reports as required

Outputs:

- Minutes and action log
- Exception report to Trust Board (templated)
- Annual Report to the Trust Board

Other:

- Terms of Reference to be reviewed and agreed every two years by the Trust Board
- All agenda, papers and Minutes/action logs to be stored on central committee folder (as administered by Trust Office)

Quality Assurance Committee - Terms of Reference (summary)

Barts Health NHS Trust

Frequency: Every Two Months
Duration: 2.5 hours
Location: tbc
Chair: Non Executive Director

Objectives:

- To review the implementation of the Quality Strategy and any related CQC improvement plans including progress against key milestones.
- To review progress against constitutional standards and quality indicators including any flagged as of concern through escalation reporting or as requested by the Trust Board.
- To agree a programme of thematic reports on key quality assurance areas including complaints, incident reporting, clinical audit, mortality, guardian of safe working, medicines management, safeguarding and infection control.
- To oversee Trust arrangements to support patient experience and engagement.
- To receive and review the annual Quality Account and progress on annual quality objectives.
- To consider Internal Audit and External Audit reviews linked to quality and safety.
- To consider key quality and safety issues and risks, including BAF risks for which the Committee leads on.
- To consider matters escalated from the Quality Board and Risk Management Board and identified.

Membership:

- Three NEDs (including the chair of the committee)
- Group Deputy Chief Executive/CEO, Chief Medical Officer, Chief Nurse, Quality Improvement Director, Director of Corporate Development.

In attendance:

- Secretariat provided by PMO.

Quorum: A third of members.

Authority:

- **Reporting into:** Audit and Risk Committee
- **Receives reports from:** CMO and CNO, Internal Audit, Quality Board

Inputs:

- Quality Dashboard.
- Standing progress reports

Outputs:

- Minutes and action log
- Exception report to Trust Board (templated).

Other:

- Terms of Reference to be reviewed and agreed every two years.
- All agenda, papers and Minutes/action logs to be stored on central committee folder (as administered by Trust Office)

Section 3b. Executive Boards ToR

Group Executive Board – Terms of Reference

Barts Health NHS Trust

Frequency: Fortnightly
Duration: 3 hours
Location: Rotates across hospitals
Chair: Chief Executive, Barts Health

Objectives / Duties:

- Review operational delivery, quality and safety, and financial performance for the group against national/local regulations, standards and action plans; and agree necessary actions to improve performance.
- Monitor and oversee establishment and delivery of the Trust's strategies, business plans and objectives - including management and mitigation of key risks and issues; implementation / reprioritisation of capital plans; equalities and inclusion issues; consultant and other significant workforce investments; operational delivery; development of the group model; service developments; charitable bid submissions; and horizon scanning on national policy.
- Monitoring and oversight of key duties of executive boards and committees reporting into the group executive board.
- Review Organisational Development/leadership development plans.
- Provide oversight and assurance of the overall Quality Improvement programme.
- Support Executive Directors to deliver their delegated responsibilities by providing a forum for exchange of information, mutual support, resolution of issues and recognition of key achievements.
- Make management decisions on issues within the ToR/remit of the Group Executive Board and provide the Trust Board with assurance on executive delivery of plans and strategies with appropriate escalation of significant issues.
- Ensure that there is appropriate integration and liaison between clinical and corporate and between strategic and operational functions, within the Trust and the interface with external partners.

Membership:

Chief Executive (Chair)
Chief Medical Officer
Chief Finance Officer
Director of People
Director of Corporate Development
Director of Communications and Engagement
Managing Director of St Bartholomew's Hospital
Managing Director of Whipps Cross Hospital
Deputy Chief Executive
Chief Nurse
Director of Group Operations
Director of Strategy
Director of Estates and Facilities
Managing Director, RLH and ME Hospitals
Managing Director of Newham Hospital
Managing Director, CSS
Director of Improvement
Director of Transformation
Chief Information Officer

In attendance: Secretary to Board; others on invitation as required **Quorum:** 1/3 of members

Authority:

- **Reporting into:** Trust Board
- **Receives reports from:** Equalities Board, OD Board, Risk Management Board, Operations Board, Quality Board, Clinical Academic Strategy Board (monthly). *Committees* – Trust Policies Committee, Health and Safety Committee, Information Governance Committee, Informatics Committee, Emergency Planning Steering Committee, Staff Partnership Forum (quarterly)

Inputs:

- IPR, exception reports from reporting committees, BAF, Internal Audit limited assurance reports, retrospective waivers, Board sub-committee papers
- Exception reports from above groups

- **Outputs:**

Minutes and action log

Other:

- Terms of Reference to be reviewed and agreed with Trust Board three yearly
- All agenda, papers and Minutes/action logs to be stored centrally and available via VBR

Equalities and Inclusion Board –Terms of Reference

Barts Health NHS Trust

Frequency: Every two months
Duration: 2 hours
Location: Rotate across sites
Chair: Group Chief Executive

Objectives:

- Agree and monitor equality objectives in line with statutory requirements, national and local priorities.
- Receive and monitor on behalf of the Trust Board, implementation of Equality Delivery System (EDS2), WDES, Workforce Race Equality Standard, Gender Pay Gap and other national standards.
- Identify, agree and monitor other KPIs arising from staff and patient experience feedback.
- Assess and agree risk to delivery of Trust plans, mitigation and Equality Assessment (Equality Analysis) processes.
- Assure on staff training and development to support equality objectives and support research promotion and transferability.
- Ensure appropriate evidencing of compliance with CQC and other regulatory standards.
- Support engagement with community and partner organisation stakeholders.
- Oversight of positive action charter progress.

Membership:

Chief Executive, Director of People, Director of People Development, Chief Nurse, Chief Medical Officer, CE/MD-nominated representative from each Hospital and CSS, Education Academy Lead/Rep, Public Health Director, Staff Side Chair (SPF and JLNC), Associate Director Inclusion, Director of Communications, Executive Champions of Diversity subgroups

In attendance: Minute taker, Patient/stakeholder representative (tbc on invitation)

Quorum: Three members

Authority:

Reporting into: Group Executive Board

Receives reports from: Staff diversity network and sub-groups

Inputs:

Workforce Equality information
Workforce Race Equality Standard (including site level reports)
Workforce Disability Equality Standard (soon to be launched)
Patient Equality Information
Reports from internal Equality Fora such as Trust wide Staff Diversity Network and the respective sub groups for Disability, BME and LGBTQ+

Outputs:

- Annual review of equality information
- Trust Board rolling reporting
- Minutes and action log. Minutes to Group Executive Board and HEBs
- Exceptions reports

Other:

- Terms of Reference to be reviewed and agreed annually
- All agenda, papers and Minutes/action logs to be stored by OD team

Organisational Development Board - Terms of Reference

Barts Health NHS Trust

Frequency: Monthly
Duration: 2 hours
Location: Rotate across sites
Chair: Group Director of People

Objectives:

- To support the implementation of the Trust's vision and values
- To oversee the effective implementation of the People Strategy across the Group
- Oversee and support the Outstanding Place to Work Collaborative
- Oversee and provide thinking to the development of the Trust's group model
- To learn from outside the Trust
- Oversee the development of new workforce models; including ways of working with system partners
- To lead the development of an inclusive talent & succession system
- To agree and oversee leadership development plans, including commissioning of related educational and training activities
- To review progress on 'Well Led' improvement planning
- To identify key themes of staff surveys and other sources of insight; developing a method of measuring culture for improvement
- To provide oversight and support to the Health & Wellbeing Committee – in particular positively addressing physical and mental health
- To review and input to people communications and engagement plans
- To oversee the development and management of reward

Membership:

- Group Director of People (Chair), Group Chief Executive, Director of People Development, Group Chief Nurse, Group Chief Medical Officer, Managing Director of Education Academy, Hospital CEOS & CSS Managing Director or nominated representatives, Group Director of Corporate Development, Head of Group Development, Director of Communications, Director of Public Health, Director of People Strategy, Director of Transformation, Director of Quality Improvement, Chair of Staff Representatives, A nominated Chair of Staff Networks

In attendance: Secretariat provided by Group Director of People

Quorum: A third of members

Authority:

- **Reporting into:** Group Executive Board
- **Receives reports from:** Hospital & CSS OD Boards, Health &Wellbeing Committee, Staff Partnership Forum, Commissioned workstreams

Inputs:

- Staff survey results, engagement
- WeImprove QI updates
- Work-stream reports
- Culture mapping reports

Outputs:

- Action log
- Exception report to Group Executive Board

Other:

- Terms of Reference to be reviewed and agreed with Group Executive Board at least annually
- All agenda, papers and Minutes/action logs to be stored on electronic storage (VbR)

Risk Management Board - Terms of Reference

Barts Health NHS Trust

Frequency: Monthly
Duration: 2 hours
Location: Across sites
Chair: Director of Corporate Development

Objectives:

- To ensure the establishment and continuing improvement of a system of risk management and internal control to support the achievement of Trust objectives.
- Review the Risk Management Policy, for approval by the Trust Board on at least a three yearly basis.
- Develop, approve and review progress against a risk management strategy, to include actions to promote a risk management culture.
- Regularly review high risks and metrics providing assurance of effective risk management.
- Agree an annual work programme with deep dives to identify thematic Group-wide issues, and risk management performance issues for follow up in hospital and CSS performance reviews.
- Receive the Board Assurance Framework at each meeting.
- Provide risk-based input to the development of Internal Audit, External Audit and Clinical Audit work plans and the Trust capital plan.

Membership:

Director of Corporate Development (Chair of the Committee), Deputy Chief Executive or Director of Clinical Operations, Chief Medical Officer, Chief Nursing Officer, Director of Capital, Costing and Development, Managing Director of Education Academy, Trust Secretary, Hospital/CSS Directors (representation determined by respective hospital and CSS CEs/MD), Associate Director, Estates and Facilities Risk and Compliance, Trust Risk Manager Assistant Trust Secretary (secretary), Head of Compliance

In attendance:

- Secretariat provided by Director of Corporate Development

Quorum:

- five members (including a minimum of two GEB members and three hospital reps)

Authority:

- **Reporting into:** Group Executive Board with regular report to Audit and Risk Committee
- **Receives reports from:** Hospital Risk Management Groups, Risk Review Group, Emergency Planning Steering Group, Fire, Health and Safety and Trust Policies Committee

Inputs:

- Risk report (including risks scoring 15 and above) monthly.
- Quarterly report on Risk Strategy.
- Deep dive reports from hospitals, CSS and corporate directorates and group themes.
- Emergency Planning Steering Group, Fire, Health and Safety and Trust Policies Committee exception reports.
- Board Assurance Framework.

Outputs:

- Minutes and action log
- Minutes to Group Executive Board and HEBs
- Regular reports to Audit and Risk Committee.
- Recommendations to the Trust Board relating to BAF.

Other:

- Terms of Reference to be reviewed and agreed every three years by the Group Executive Board
- All agenda, papers and Minutes/action logs to be stored on electronic storage (VbR)

Operations Board - Terms of Reference

Barts Health NHS Trust

Frequency: Fortnightly
Duration: 2 hours
Location: TBC
Chair: Deputy CEO (Vice chair – Director of Group Operations)

Objectives:

- To provide oversight & scrutiny to the delivery of operational plans in line with the Trust's strategic direction & annual plan.
- To ensure operational plans are aligned with the Trust's clinical strategy.
- To monitor delivery of constitutional standards; emergency care standards, all elective care standards, 18 weeks – Referral to Treatment (RTT), Diagnostics and Cancer Waiting Times (CWT) , DM01 etc
- To agree any performance escalation from hospitals / CSS and to help inform performance review agendas.
- To review group and site performance against the financial plan, including CIPs workstream reporting.
- To receive regular reporting on core operational transformation workstreams.
- To receive rolling reports on estates and informatics issues; with exception reporting on any informatics issues with operational impact (e.g. planned outtages).
- To review workforce plan delivery and themes from People section of the IPR.
- To receive reports on emergency planning and business continuity.

Authority:

- **Reporting into:** Group Executive Board
- **Receives reports from:** ICT, Estates, HEBs by exception, Hospital/site PRs, Operational Planning & Contracting Group, EU Exit Group

Inputs:

- Integrated Performance Report
- Quality and Safety dashboard
- Estates and ICT rolling/exception reports
- CIP reporting
- Other reports as required

Outputs:

- Minutes and action log
- Minutes to Group Executive Board and HEBs

Membership:

DCEO, Director of Group Operations, Managing Directors *or* nominated senior deputy (eg. Deputy Managing Directors/Directors of Operations), Director of People or deputy, Director of Strategy or deputy, Director of Performance, Managing Director CSS, Director for RTT, Director for Emergency Care Improvement, Chief Finance Officer, Director of Income, Director of Transformation & Efficiency, Head of Emergency Planning, [Chief Information Officer, Director of Estates as required for rolling reports]

In attendance: Minute taker

Quorum: A third of members

Other:

- Terms of Reference to be reviewed and agreed with Group Executive Board annually
- All agenda, papers and Minutes/action logs to be stored on electronic storage (VbR)

Financial Strategy Board - Terms of Reference

Barts Health NHS Trust

Frequency: Monthly
Duration: 1.5 hours
Location: Whitechapel or Prescot St
Chair: Chief Financial Officer

Authority:

Reporting into: Group Executive Board

Receives reports from: Investment Steering Committee, Operational Planning & Contracting Group

Objectives:

- Oversee the development of the Trust's annual financial plan (including capital programme) and long-term financial strategy, multi-year rolling CIPs programme and underpinning assumptions.
- Review wider system integration and horizon scan on implications of new financial regimes.
- Review key themes arising from financial performance (including CIPs and capital programme) and identify issues and risks requiring escalation at FIC.
- Consider any proposals for the establishment of joint ventures or other commercial partnerships/relationships including the incorporation of start-up companies or subsidiaries.
- Review operational finance reporting, including balance sheet and PFI.
- Review and monitor progress on Use of Resources action plans.
- Review productivity opportunities identified through SLR, model hospital and GIRFT, and steps to triangulate available productivity data.
- Make recommendations on the Trust's audit plan priorities and oversee implementation of recommendations.

Inputs:

- Monthly financial performance report
- SLR, Reference Costs, Model Hospital and GIRFT outputs
- Capital programme update reports
- 3 year financial plan
- Other reports as required

Outputs:

- Minutes and action log
- Minutes to Group Executive Board and HEBs
- Annual Report to GEB

Membership:

- Chief Financial Officer, Deputy Chief Executive, Director of People, Director of Strategy, Director of Transformation and Efficiency, Director of Operational Finance, Director of Capital and Costing, Director of Income, Director of PMO Assurance, Head of Central Financial Management Commercial Director, Director of Audit – on invitation, Hospital Heads of Finance representatives – on invitation

In attendance: Minute taker

Quorum: Two members

Other:

- Terms of Reference to be reviewed and agreed annually
- All agenda, papers and Minutes/action logs to be stored on virtualboardroom

Clinical and Academic Strategy Board - Terms of Reference

Barts Health NHS Trust

Frequency: Monthly
Duration: 2 hours
Location: *tbc*
Chair: Chief Medical Officer / Director of Strategy

Objectives:

- Oversee the development of the Trust's clinical strategy and co-ordinate development and approval of associated enabling strategies for workforce, estates and digital aligned with national NHS and local commissioner policy and priorities.
- Oversee the development and monitoring of supporting education and research strategies and delivery plans.
- Review progress of key strategic programmes by exception and consider issues and risks escalated to the Clinical and Academic Strategy Board.
- Receive regular reports from Clinical Boards on the development of clinical networks and key strategic issues.
- Review and make recommendations on development of national, regional and borough collaborative working.
- Receive reports on education delivery and research strategy implementation.
- Review and monitor workforce transformation opportunities.

Authority:

- **Reporting into:** Group Executive Board
- **Receives reports from:** Clinical Boards, strategic programme boards including TST and Lifesciences Board, Commercial Strategy Group, Trust Research Board, Education Committee, Quality Improvement

Inputs:

- Exception reports from Clinical Boards and strategic programme boards, Education Committee and Research Board
- Other reports as required

Outputs:

- Minutes and action log
- Minutes to Group Executive Board and HEBs
- Decisions to establish any new strategic programme boards

Membership: Chief Executive, Deputy CEO, Director of Strategy, Chief Medical Officer, Chief Nurse, Chief Financial Officer, Director of Human Resources, Director of Corporate Development, Hospital Managing Directors, Commercial Director, Clinical Board Chairs, Chief CIO, Director of Estates, Head of Planning, Deputy CMO, Director of Public Health, QM representative, Director of AHSC, Director of Education

In attendance: On invitation

Quorum: A third of members

Secretariat provided by Strategy function

Other:

- Terms of Reference to be reviewed and agreed at least annually
- All agenda, papers and Minutes/action logs to be stored on electronic storage (VbR)

Barts Health Quality Board –Terms of Reference

Barts Health NHS Trust

Frequency: Monthly
Duration: 2.5 hours
Chair: Group Chief Medical Officer /Group Chief Nurse
Location: Trust Executive Offices

Objectives:

- Lead on the development and implementation of our Quality Strategy
- Provide direction and leadership support to the WeImprove Quality Improvement Programmes
- Provide strategic direction/vision and a framework for clinical effectiveness, patient safety and patient experience in order to assure the delivery of high quality patient care and outcomes
- Review the Trust Quality Dashboard, spot light reports, risk register, thematic reviews and surveillance themes to identify areas of concern that may require further analysis, intervention or escalation
- Provide direction to quality interventions and initiatives that require trust wide leadership and consistency
- Oversee and ensure delivery of trust quality objectives and production of the Quality Account
- Ensure that there is a robust quality assurance framework providing Ward to Board Assurance
- Ensure quality and safety is effectively and consistently measured and triangulated across the Trust using metrics and thematic analysis and where hot spots/areas of concern identified deep dives/other reviews are commissioned as needed
- Discuss key themes/issues from hospital quality and safety committees, deep dives, and clinical Boards to support appropriate actions to ensure consistent application of learning and standards across the organisation
- Oversee compliance with quality and safety related accreditation standards and education and training (e.g. safeguarding)
- Receive highlight and exception reports from Sub-Groups of the Quality Board
- Support the Trust Policies Committee by reviewing relevant policies and recommend quality and safety related policies and guidelines when gaps are identified
- Oversee compliance with CQC and other regulation requirements and inspections through clinical leadership discussions on key issues of concern and oversight of the CQC BAU processes
- Consider and respond to the quality and safety implications of workforce challenges and oversee the QIA process for CIPs with a constant eye to improving quality and efficiency in unison
- Ensure the Trust has embedded systems that demonstrate learning from incidents and patient feedback
- Horizon scan

Inputs:, Quality Dashboard and Spot lights reports , annual reports, internal and external audit reports, independent review reports, CQC reports and reports on compliance, peer and external review reports, reports from sub-committees

Outputs: Minutes and action log, exception and action reports to GEB and QAC, annual report to QAC, recommendations to sites and corporate departments

Authority:

- **Reporting into:** Group Executive Board and the Trust's Quality Assurance Committee
- **Receives reports from:** see attached sub-committee structure
- **Linked committees/groups:** Risk Management Board, Operational Delivery Board, Equalities and Inclusion Board

Membership:

Group Chief Nurse (co-chair)
Group Chief Medical Officer (co-chair)
Deputy Chief Nurse
Deputy Chief Medical Officer
Director of Quality Governance
Head of Quality Governance
Group Director of Corporate Development
Director of Quality Improvement
Director of Development
Director of Group Operations
Director of Organisational Development
Managing Director of Education Academy
Director of Nursing (RLH/SBH/NUH/WXH) *
Medical Director (RLH/SBH/NUH/WXH) *
Director of Quality Performance CSS
Director of Nursing (Babies, Children and Young People)
Chief Pharmacist
Director of Midwifery
Director of Public Health
Director of AHPs
Clinical Director of Infection Prevention and Control
Head of Research and Development
*either the DoN or MD for each Hospital must attend

Quorum: A third of members
Coordination and secretariat: Business Managers to CNO and CMO
ToR to be reviewed: Yearly

Informatics Board - Terms of Reference

Barts Health NHS Trust

Frequency: Monthly
Duration: 90 Minutes
Location: ICT Centre
Chair: Director of Strategy

Objectives:

- Keep current and deliver the Trust's Informatics Strategies aligning priorities with clinical requirements and financial resources and oversee resource allocation. Ensure that the ICT strategies remain aligned with the Trust's strategy and objectives.
- Oversee the planning, procurement and deployment of new IT systems and the effective operation and availability of existing systems.
- Coordinate all informatics projects and programmes running in the Trust, setting and monitoring against budgets, objectives , milestones and KPIs.
- Manage ICT and programme risks and keep the Executive informed of rising tide risks.
- Ensure effective communications with users and other key management groups of the Trust including Hospital Executive Boards and Clinical Boards.
- Management of the Trust's ICT infrastructure including ensuring the security of the Trust's data and ensuring adequate defense against loss, destruction, theft or corruption of data including defense against external threats (cyber security).
- Provide assurance to the Group Executive and / or Board as required.

Membership: Director of Strategy, Chief Information Officer, Director of ICT, Director of Clinical Systems, Director of Performance, Chief Clinical Information Officer (and/or Deputy), Chief Nursing Information Officer, Information Governance Manager

In attendance: Others at the invitation of the chair

Quorum: 5 members

Authority:

- **Reporting into:** Group Executive Board
- **Receives reports from:** Information Services, Information Governance, ICT, Clinical Systems, Clinical Informatics Board, Technical Design Authority

Inputs:

- Programme updates and progress reports including risks and issues to projects.
- Policies and Strategies for review / approval
- IG Report
- Business Cases for investment
- SI reports

Outputs:

- Guidance for ICT Users
- Occasional subject reports to GEB and / or Board
- Strategies and Policies to GEB and / or Board
- Terms of Reference to be reviewed annually

Section 3c. Hospital / CSS /GSS Executive Boards and Sub Committee model ToR

The attached set out the model adopted by Hospitals for their committee structures – any local variations to these have been signed off by Chief Executives and the Group Executive Board.

Hospital Executive Board - Terms of Reference

Barts Health NHS Trust

Frequency: Fortnightly
Duration: 2-3 hours
Location: Hospital sites
Chair: Managing Director

Objectives:

- Review operational delivery, quality and safety, and financial performance for the hospital against national/local standards and action plans; and agree necessary actions to improve performance.
- Provide oversight and assurance of the overall hospital [or CSS] strategy, ensuring Clinical Board input and recommendations.
- Provide oversight and assurance of the overall hospital [or CSS] quality improvement plan and related programmes.
- Review the hospital risk register and identify risks requiring additional mitigation / escalation.
- Review Organisational Development/leadership development plans.
- Review assurance reporting on Estates, Informatics and CSS issues.
- Agree key communication and engagement messages and monitor/improve effectiveness of internal communications.
- Receive upward reporting from divisional boards and identified subgroups and hold divisions to account. Ensure hospital [or CSS] subgroups interface effectively with Group-level equivalent boards.
- Consider hospital [or CSS] capital and revenue business cases for investment ahead of any subsequent group approval mechanism.
- Identify operational issues/risks requiring escalation to the Group Executive Board.

Authority:

- **Reporting into:** Group Executive Board
- **Receives reports from:** Divisional Boards, Hospital [or CSS] subcommittees (including Quality and Safety Committee, Inclusion Committee, Operational Delivery Committee, Organisational Development Committee, Financial Delivery Committee)

Inputs:

- Integrated Performance Report (hospital or CSS element)
- Minutes of listed HEB sub-groups
- Hospital risk register and site assurance framework
- Other reports as required including rolling reports from Clinical Boards.

Outputs:

- Minutes and action log
- Exception report to Group Executive Board
- Divisional Director feedback to respective divisions

Membership: Managing Director (Chair), Deputy MD, Medical Director, Director of Nursing and Governance, Director of Operations, Head of Finance, Associate Director of People, Estates and FM Lead, Divisional Directors, Communications Lead

In attendance / on invitation: CSS lead, Head of Improvement, Other Divisional leads, Board secretary / Minute taker, [others for items]

Quorum: A third of members

Other:

- Terms of Reference to be reviewed and agreed with GEB annually
- All agenda, papers and Minutes/action logs to be stored on virtualboardroom

GSS Management Board Terms of Reference - draft

Barts Health NHS Trust

Frequency: Monthly
Duration: 1.5 Hours
Location: Ashfield Street
Chair: Rotating Chair & Vice Chair every 6 months, commencing with Director of Procurement. Vice Chair; Director of People Services

Authority:

- **Reporting into:** GEB
- **Receives reports from:** Operational Groups; relevant Programme/Project Steering Groups

Objectives:

- Accountable for shaping the vision for GSS within the Barts Health Group Model
- Responsible for coordinating and integrating the delivery of high-quality group support services
- To ensure services are effective and efficient, with an eye for commercial growth
- To manage and continually improve GSS and external provider performance
- To ensure the voice of the customer is reflected in the delivery of services
- Be responsible for annual business planning for GSS, including identifying and delivering CIP as a collective and by function
- Be responsible for the reputation and perception of GSS
- To develop our people and make GSS an outstanding place to work and seeking assurances that external providers are doing the same
- To be accountable for the GSS Transformation Change Group activities
- To work together cross-functionally and break down barriers

Inputs:

- GSS performance against KPI's by service/function/site
- External provider performance against SLAs
- Well Led standards of leadership
- Reports from relevant Programmes/Projects
- Model Hospital and other benchmarking

Outputs:

- Performance reports for GEB
- Performance reports for customers e.g. HEBs
- Realising the Target Operating Model
- Maintaining state of continual improvement
- High customer satisfaction
- High staff satisfaction

Membership: Agreed representation from GSS: Finance, Procurement, Operations, ICT, BI, People, Corporate Development, Communications, Strategy, Commercial, E&F, R&D, Transformation, Education Academy, Group CNO & Group CMO

In attendance: Minute taker

Quorum: Minimum of 60% representation

Review: Terms to be reviewed each quarter until finalised

Equality & Inclusion Committee - Terms of Reference

Barts Health NHS Trust

Frequency: Every two months
Duration: 1.5 hours
Location: Main Hospital Site
Chair: [Deputy Hospital CEO – or other as determined by Hospital CEO]
Purpose: The Equality and Inclusion Forum is committed to driving real change across the hospital, with members who have given their time to ensure we create and maintain a diverse and inclusive place to work.

Objectives:

- To lead and drive the development and delivery of the different workstreams necessary to achieve the Trust and hospital-specific equality objectives.
- Provide assurance to the HEB on steps to meet the Public Sector Equality Duty (equality legislation) and national requirements, and use of workforce and patient equalities monitoring data, including data from ESR, staff surveys and patient surveys to target improvements.
- Identify and review equalities impact assessments associated with clinical service reconfigurations or policy changes.
- Develop, monitor and support progress on staff experience KPIs: including Bullying and Harassment, embedding WeCare values, engaging staff on EU Exit implications, equitable recruitment, reasonable adjustments and career progression for staff with protected characteristics.
- Monitor patience experience and patient access for those with protected characteristics to address health inequalities.
- Review staff training and development to support equality objectives.

Membership:

- To include: Deputy Hospital CEO, Hospital Director of People, Divisional representative, Staff side representative, Lead Clinical site Manager, Associate General Manager, Hospital Inclusion Lead, Hospital Lead for Learning Disabilities, Quality Manager, Hospital Diversity Network Chair

Authority:

- **Reporting into:** Hospital Executive Board
- **Receives reports from:** Hospital/site based work streams; Task & Finish groups

Inputs:

- Site level Workforce Equality information
- Site level Employee Relations (ER) reports
- Patient Data - Equality Information
- Progress reports against agreed equality objectives
- Key Performance Indicators (as developed)
- Other reports as required

Outputs:

- Action log
- Equality Objective Action Plan with progress update
- Annual Work Programme
- Reports to Equality & Inclusion Working group as required
- Update to staff via site bases communications channels

Other:

- Terms of Reference to be reviewed and agreed every 3 years
- All agenda, papers and Minutes/action logs to be stored by site team

Organisational Development Committee - Terms of Reference

Barts Health NHS Trust

Frequency: Monthly
Duration: 1.5 hours
Location: TBC
Chair: Assistant Director of People

Objectives:

- To agree a clear vision and priorities of the hospital improvement programme and expectations for 'Well Led'. This is to include recommendations from CQC, HEE and CIP transformation schemes and Quality Improvement themes.
- To agree the hospital staff survey improvement plan and undertake oversight and any improvement actions from the quarterly SFFT results for the hospital.
- To review performance against workforce and staff satisfaction measures for the hospital, in order to assure the delivery of a high performing workforce
- To oversee the development of new workforce models and organisational design.
- To determine and monitor delivery of the communications and engagement plan.
- To review and develop methods for sharing learning share within and across hospitals.
- To agree and oversee leadership development plans, including commissioning of related educational and training activities.
- To input to Quality Improvement plans.
- To input to development of the group model, accountability framework and interface with Clinical Boards.

Membership:

- Assistant Director of People (Chair), Director of Operations, Deputy Director of Nursing, Deputy Medical Director, General Managers, Associate Directors of Nursing, Organisational Development Hospital/CSS lead, Head of Quality & Efficiency, Recruitment Lead, Nominated Clinical Board Lead, Hospital Education Lead

In attendance:

- Secretariat provided by Hospital Management Team

Quorum: A third of members

Authority:

- **Reporting into:** Hospital Executive Board,
- **Receives reports from:** Hospital recruitment leads,

Inputs:

- Workforce dashboard
- Risk Register – workforce related risks
- Organisational Development update
- Staff engagement / QI updates

Outputs:

- Action log
- Workforce Exception report to Hospital Executive Board

Other:

- Terms of Reference to be reviewed and agreed with Hospital Executive Board at least annually
- All agenda, papers and Minutes/action logs to be stored on central committee folder

Operational Performance and Finance Committee - Terms of Reference

Barts Health NHS Trust

Frequency: Monthly
Duration: 1 hour
Location: TBC
Chair: Director of Operations

Objectives:

- Oversee operational performance for the Hospital/CSS against national/local standards and improvement trajectories, approve necessary actions to improve performance and identify issues and risks requiring escalation to the Hospital Executive Board.
- Oversee financial performance for the Hospital/CSS against the financial plan and CIPs, agree necessary actions to improve performance and identify issues and risks requiring escalation to the Hospital Executive Board.
- Oversee the Hospital/CSS capital investment programme.
- Oversee the Hospital/CSSs Business planning process.
- To agree any performance escalation from divsions and CSS to inform performance review agendas.
- To receive regular reporting on core operational transformation workstreams and productivity (including SLR and Model Hospital data).
- To receive rolling reports on estates and ICT issues ; with exception reporting on any ICT/Estates issues with operational impact (e.g. planned outtages).
- To review workforce plan delivery and themes from People section of the IPR.
- To oversee the Hospital/CSSs resilience programme, receive reports on emergency planning and business continuity.

[NB. Planned implementation from Q3 2019 of separate finance and ops committees to deliver objectives]

Membership:

- Director of Operations, [Hospital Chief Executive], Head of Finance, Deputy Director of Operations, Director of Nursing, Medical Director, Associate Director of People, Associate Director of Estates and FM, Divisional Directors, Head of Quality and Efficiency, Informatics Lead, Emergency Planning Lead

In attendance:

- Secretariat provided by Senior Leadership Team

Authority:

Reporting into: Hospital Executive Board

Receives reports from:

- Finance and contracting
- Theatre productivity
- Emergency Flow Improvement Board
- Hospital/CSS Resilience
- Capital Investment
- Business Planning
- Brexit Group

Inputs:

- Integrated Performance Report (Hospital/CSS element)
- Finance report (Hospital/CSS element) and SLR reports
- Other reports as required

Outputs:

- Minutes and action log within 5 working days
- Exception report to HEB, Divisional Director feedback to respective Divisions

Other:

- Terms of Reference to be reviewed and agreed with Operations Board at least annually
- All agenda, papers and Minutes/action logs to be stored on central committee folder

Quality and Safety Committee – Terms of Reference

Barts Health NHS Trust

Frequency: Monthly

Chair: Hospital CEO (or as nominated by Hospital CEO)

Duration: 1.5 hours

Location: TBC

Objectives:

- Oversee the delivery of the hospital's quality and safety agenda, CQC improvement plans/actions and regulatory compliance.
- Ensure quality and safety is effectively and consistently measured and triangulated across the hospital using established quality metrics (including CQUINs and annual quality objectives) and thematic analysis and oversee related improvement actions.
- Review quality and safety comparisons to local and national benchmarks.
- Monitor key quality and safety indicators at Hospital/CSS level, with escalation as appropriate on:
    - Reported risks, complaints and serious incidents, quality dashboards
    - Triangulation of quality performance metrics with evidence from patient feedback from national surveys, friends and family test
    - Outcomes of external audits, inspections and reviews of clinical services.
    - Specific priorities, e.g. patient safety alerts, safeguarding, Sign up to Safety, Duty of Candour, National Early Warning System, infection control, NatSSIPs, DoLS, HSMR, SHMI, MCA, NICE guidelines
- Oversee compliance with quality and safety related accreditation standards and education and training (eg safeguarding)
- Receive highlight and exception reports of peer and external reviews.
- Co-ordinate quality and safety improvement initiatives and nput to development and monitoring of quality improvement initiatives.
- Develop engagement of patients, carers and staff (protected time) in quality improvement.
- Ensure the hospital embeds learning from incidents and shared learning across the group.

Membership: Hospital Chief Executive, Medical Director, Director of Nursing, Divisional Directors, Associate Directors of Nursing, Head of Midwifery, Head of Governance, Quality Improvement Hospital lead, Divisional Representative, Lead Pharmacist/CSS lead, Patient Representative, Chairs of reporting committees according to agenda

Quorum: Chair plus representation from at least 3 Hospital divisions

Coordination and secretariat: Hospital team to confirm

Authority:

- **Reporting into:** HEB, Dotted-line reporting into Quality Board
- **Receives reports from:** Hospital quality sub-committees

Inputs: Hospital IPR (quality sections), Hospital/CSS quality dashboards, exception and highlight reports, independent review reports, CQC reports, peer and external review reports, reports from quality sub-committees

Outputs: Minutes and action log, exception and action reports to HEB (template), recommendations to departments. Reporting by exception to Quality Board.

ToR to be reviewed: every two years and all documentation to be stored on central committee folder

Risk Management Committee - Terms of Reference

Barts Health NHS Trust

Frequency: Every month
Duration: 1 hour
Location: Hospital site tbc
Chair: Director of Nursing (or other nominated by Hosp CEO and attends Group RMB)

Objectives:

- To ensure the establishment and continuing improvement of a system of risk management and internal control.
- Develop, approve and review progress against a risk management strategy, to include actions to promote a risk management culture including risk management training.
- Regularly review high risks, metrics and approve/validate new high risks providing assurance of effective risk management.
- To horizon scan identifying emerging threats and opportunities
- To receive the Site Assurance Framework at each meeting (and support/advise on its development).
- Agree an annual work programme with deep dives to identify thematic issues, and issues for follow up in hospital and CSS performance reviews.

Membership:

Director of Nursing (Chair of the Committee), Medical Director, Head of Finance, Managing Director of Education Academy, Trust Secretary, CSS Lead (representation determined by respective hospital and CSS MDs), Associate Director, Estates and Facilities, Head of Governance

In attendance:

- Secretariat provided by hospital team

Quorum:

- five members

Authority:

- **Reporting into:** Hospital Executive Board
- **Receives reports from:** Risk Review Group

Inputs:

- Risk report (including risks scoring 15 and above) monthly.
- Deep dive reports from divisions.
- Site Assurance Framework.

Outputs:

- Minutes and action log
- Exception report to Hospital Executive Board with regular reports to group Risk Management Board.
- Recommendations relating to SAF for HEB and BAF.

Other:

- Terms of Reference to be reviewed and agreed every three years by the Group Executive Board
- All agenda, papers and Minutes/action logs to be stored on electronic storage (VbR)

Hospital Strategy Committee - Terms of Reference

Barts Health NHS Trust

Frequency: Quarterly
Duration: 2 hours
Location: *tbc*
Chair: Hospital Chief Executive

Objectives:

- Oversee the alignment of the Hospital's strategic plans with the Trust's clinical strategy, quality improvement plan and enabling estates, commercial, workforce, digital, research and education strategies.
- Share details and provide feedback on group strategy developments.
- Review and make recommendations on development of regional and borough collaborative working, STP and ICS developments.
- Provide a forum for discussion of communication with sector commissioners to agree local priorities, protocols and engagement plans.
- Provide an interface with and receive regular reports from Clinical Boards on the development of clinical networks and key strategic issues.
- Receive reports on education delivery and research strategy implementation.
- Review and monitor progress on major business case developments, workforce and service redesign transformation opportunities, including transformational CIPs.

Authority:

- **Reporting into:** Hospital Executive Board
- **Receives reports from:** Clinical Boards, strategic programme boards including TST and Lifesciences Board, Commercial Strategy Group, Trust Research Board, Education Committee, Quality Improvement

Inputs:

- Exception reports from Clinical Boards and strategic programme boards, Education Committee and Research Board
- Other reports as required

Outputs:

- Minutes and action log
- Minutes to HEBs
- Decisions to establish any new strategic programme boards

Membership: Hospital Chief Executive, Deputy Hospital CEO, Medical Director, Director of Nursing, Divisional Directors, Assistant Director of People, Clinical Board representatives (on a rotating basis), Head of Estates,

In attendance: On invitation

Quorum: A third of members

Secretariat provided by Hospital management team

Other:

- Terms of Reference to be reviewed and agreed at least annually
- All agenda, papers and Minutes/action logs to be stored on electronic storage (VbR)

Barts Health NHS Trust

Organisation structures

2019/20

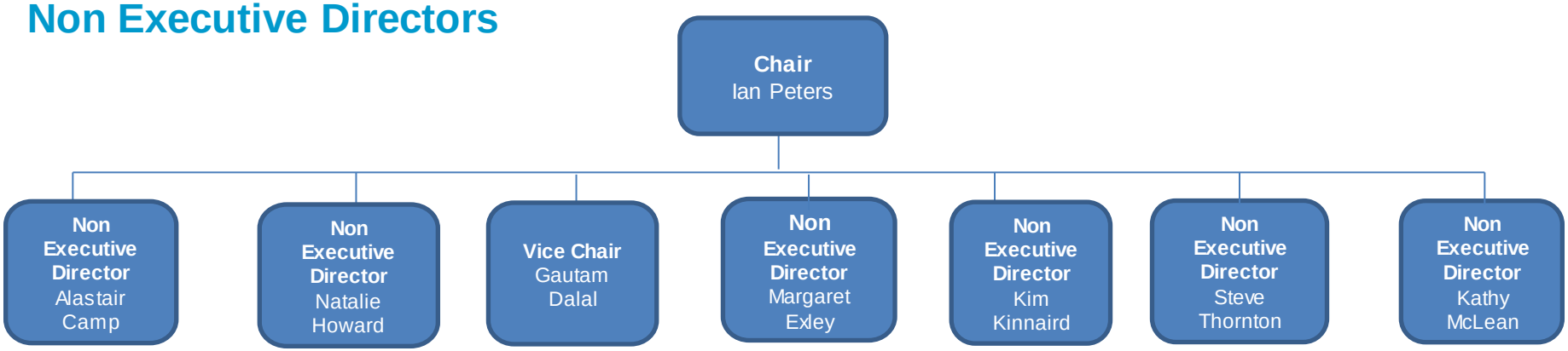
NHS
Barts Health
NHS Trust

Section 4. Organisational structure: Board and Executive

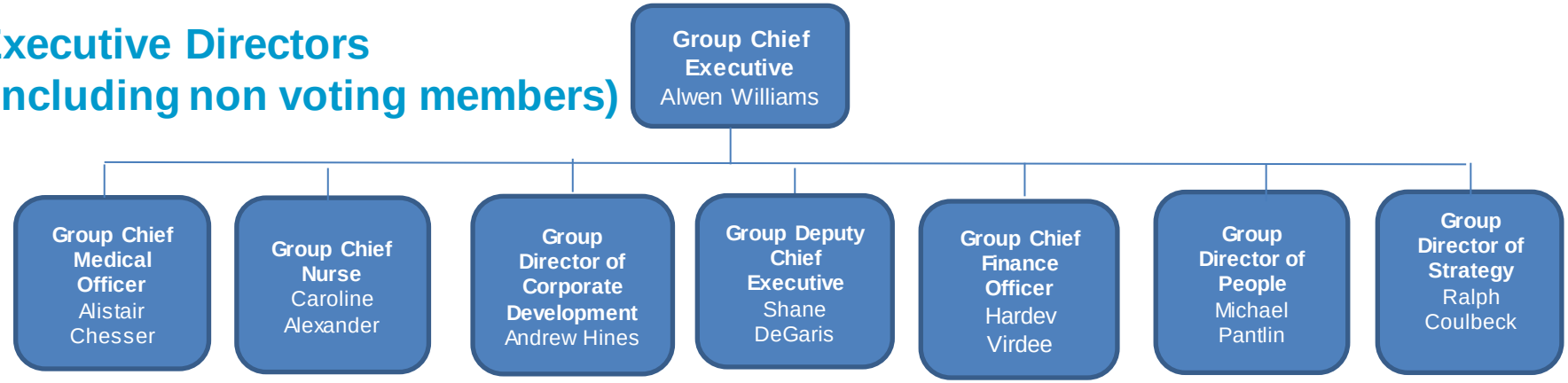
Trust Board members

Barts Health NHS Trust

Non Executive Directors



Executive Directors (including non voting members)



Non executive directors

Barts Health NHS Trust

Chair
Ian Peters

Non Executive Director & Vice Chair
Gautam Dalal

Non Executive Director
Natalie Howard

Non Executive Director
Steve Thornton

Non Executive Director
Kim Kinnaird

Non Executive Director
Alastair Camp

Non Executive Director
Margaret Exley

Non Executive Director
Kathy McLean

Executive directors

Group Chief Executive
Alwen Williams

Group Deputy Chief Executive
Shane DeGaris

Group Chief Finance Officer
Hardev Virdee

Group Director of Corporate Development
Andrew Hines

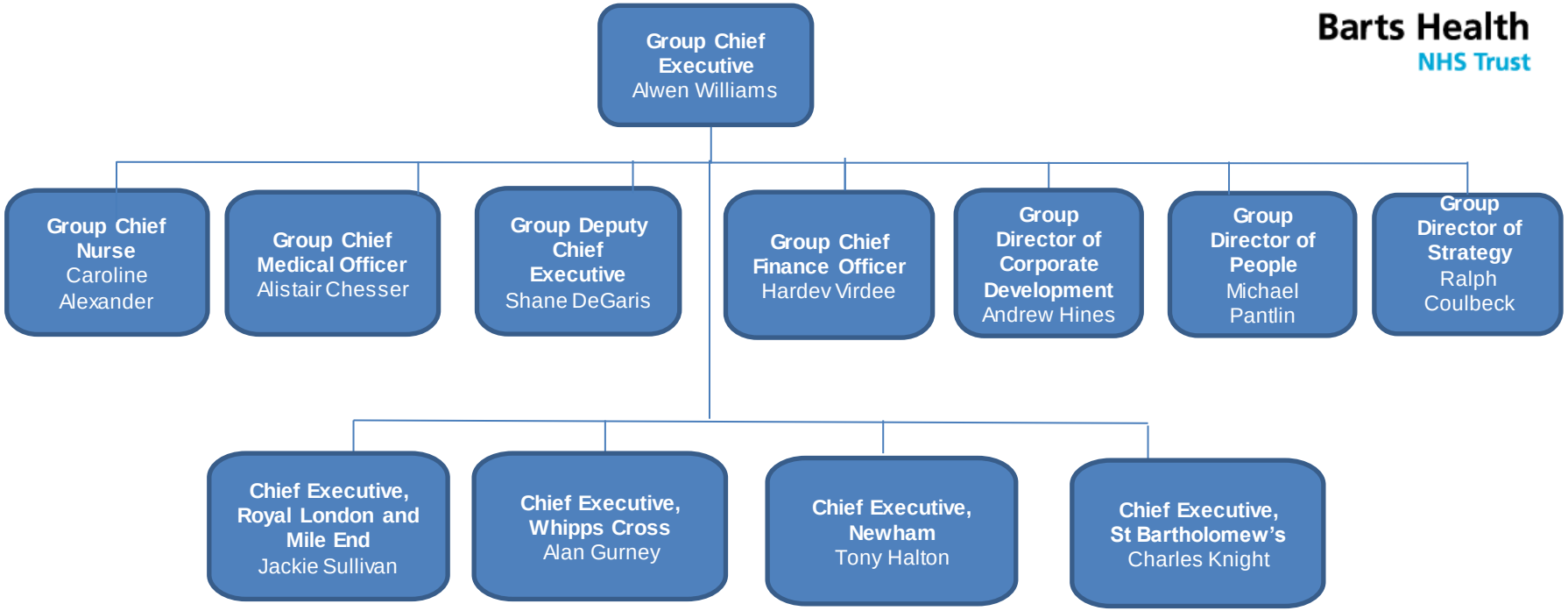
Group Chief Medical Officer
Alistair Chesser

Group Chief Nurse
Caroline Alexander

Group Director of People
Michael Pantlin

Group Director of Strategy
Ralph Coulbeck

Executive Director portfolios



Group Chief Nurse

Professional lead for nursing, midwifery and AHPs
Quality & governance
Patient experience & engagement
Infection prevention & control
Safeguarding

Group Chief Medical Officer

Professional lead for medical staff
Safety, quality and effectiveness
Academic Health Sciences
Public health
Primary care

Group Deputy Chief Executive

Estates and Facilities
Performance improvement
Emergency planning
Business continuity
Clinical support services

Group Chief Finance Officer

Operational finance
Income & contracting
Recovery
Finance PMO
Procurement
Commercial

Group Director of Corporate Development

Group development
Corporate governance
Legal and risk management
Communications and engagement
Archives and museums
Information governance
Planning

Group Director of People

Recruitment
Workforce improvement
Organisational development
Occupational Health

Group Director of Strategy

Organisational strategy
Service development
Transformation projects
Informatics
Business Intelligence

Section 4. Organisational structure: Hospitals and clinical support services

The following section outlines current site and supporting divisional structures

Royal London & Mile End Hospital Leadership Team

Barts Health NHS Trust

DIRECTORS

Jackie Sullivan
Chief Executive officer

Susan Finn
Board Secretary

Lucie Butler
Director of Nursing & Midwifery

Kat Davison
Director of Operations & Transformation

Neil Ashman
Deputy Chief Executive Officer

Simon Harrod
Medical Director

Craig Finch
Head of Finance

Damian McGuinness
Associate Director of People

Kenny Hanlon
Associate Director of Estates & Facilities

Helen Callaghan
Associate Director of Nursing: Clinical Governance, Professional Standards & Compliance

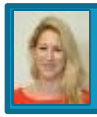
Gabrielle Walters
Head of Quality & Efficiency

Helen Byrne
Director of Integration & Strategy

DIVISIONAL LEADERSHIP

Emergency Care and Trauma

Malik Ramadhan
Divisional Director



Emily Carter
Divisional Manager

Michael Moeller
Associate Director of Nursing

Specialist Medicine

Kevin Walsh
Divisional Director

David Fitzgerald
Divisional Manager

Interim : Kevin Walsh
Associate Director of Nursing

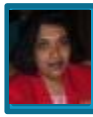
Surgery, Peri-op & Critical Care

Mane Healy
Divisional Director

Christopher Kennedy
Divisional Manager

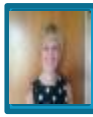
Interim: Nicola Rudkin & Denyse Ghisayawan
Associate Director of Nursing

Women's Health



Anita Sanghi
Divisional Director

Thomas Logan
Divisional Manager



Allison Herron
Associate Director of Midwifery

Children's Hospital*

Mamta Vaidya
Divisional Director

Gavin James
Divisional Manager

Interim: Sara Summers
Associate Director of Nursing

NON-DIVISIONAL LEADERSHIP

Jo Middleton
Clinical Support Services Lead

Rehan Khan
Director of Education

Whipps Cross Leadership Team

DIRECTORS

Alan Gurney
Chief Executive

Alastair Finney
Redevelopment Programme Director

Zebina Ratansi
Director of Nursing and Governance

Claire Burden
Dep. Chief Executive

Madeleine Hughes
Director of Unplanned Care (Acting)

Heather Noble
Medical Director

David Pilkington
Head of Finance

Simon Steward
Assistant Director of People

Rob Speight
Deputy Director of Estates & Facilities

DIVISIONAL LEADERSHIP

Medicine

Tristan Kerr
Divisional Director

Kath Potts
Divisional Manager

Mark Elliot - Medicine
Julie Day - ED
Associate Directors of Nursing

Lucy Simister
Fawaz Molotoo
Mary Holland (AGM)
General Managers

Surgery

John Peters
Divisional Director

Sue Row
Divisional Manager

Jackie Marshall
Associate Director of Nursing

Neil Carter (AGM)
Innocent Chimhini (AGM)
General Managers

Women & Children's

Funlayo Odejinmi
Divisional Director

Kirsty Webb-Wood
Divisional Manager

Deborah Goldsmith-Women's
Ghislaine Stephenson- Children's
Associate Directors of Nursing

St Bartholomew's Leadership Team

DIRECTORS

Prof Charles Knight
Chief Executive

Angela Robinson
Interim Director of Nursing

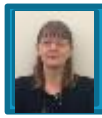
Justin Creigh
Deputy Chief Executive

Edward Rowland
Medical Director

Nick Geatches
Head of Finance

Nicole Porter-Garthford
Assistant Director of People

David Ambrose
Associate Director of Estates



Karen Bates
Director of Operations

Sara Little
Head of Quality and Efficiency

DIVISIONAL LEADERSHIP

Barts Heart Centre

Prof Charles Knight
Divisional Director

Dave Cooper
Divisional Manager/ Deputy Director of Operations

Samantha Philpott-Jones
Divisional Nurse (Cardiology)

Heather Byers
Divisional Nurse (Surgery/POM/Respiratory)

Barts Cancer Centre

Prof Tom Powles
Divisional Director

Komal Whittaker-Axon
Divisional Manager/ Deputy Director of Operations

David Curran
Divisional Nurse

Newham Hospital Leadership Team

DIRECTORS

Tony Halton
Hospital Chief Executive

Debby Madden
Deputy Hospital Chief Executive

Andrew Kelso
Medical Director

Louise Crosby
Director of Nursing and Governance

Ben Fraser
Head of Finance

Victoria Robinson-Collins
Interim Assistant Director of People

Justin Pereira
Deputy Director of Estates & Facilities

Emma Senyard
Deputy Director of Nursing

Nayna Manya
Director of Transformation

Tom Kirby
Associate Director of Governance

DIVISIONAL LEADERSHIP

Medicine

Lisa Niklaus
Divisional Director & Clinical Director

Robert Selley
Divisional Manager

Andrea McDonnell
Associate Director of Nursing

Pippa Hanson
Clinical Directors Specialist Medicine

Helen Parker
Clinical Directors Emergency & Acute Medicine

Surgery

Jane McNeill
Divisional Director & Clinical Director

Gareth Powell
Divisional Manager

Annamma George
Associate Director of Nursing

James Napier
Clinical Directors Critical Care & Perioperative Medicine

Vacant
Clinical Director Surgical Specialties

Women's and Children's

Sherry Manning
Divisional Director and Divisional Nurse

Oluseye Oyawoye
Clinical Director

Imdad Ali
Clinical Directors Children's Health

Giuseppe Labriola
Associate Director of Midwifery & Nursing

NON-DIVISIONAL LEADERSHIP

Emma Young
Director of Medical Education

Joanne Middleton
CSS Director of Ops

Suzette Fernandes
Imaging Lead

Moji Owie-Sanbanjo
Outpatients General Manager

Erutase Oputu (Tase)
Pharmacy Lead

Amy Mulkerrins
Therapies Lead

Pamela McColgan
Pathology

Murali Kayyalackakathu
Clinical Physics

Clinical Support Services Leadership Team

Simon Ashton
Managing Director

Anju Sahdev
Director of Research

Jan Flint
Director of Quality Performance

Joanne Middleto
Director of Operational Performance

Liela Thorogood
Interim Head of Finance

Felicity Found
Assistant Director of People

Paul Bird
BIU Business Partner

VACANT
Associate Director of Governance

Chris James
Deputy Director of Operational Performance

DIVISIONAL LEADERSHIP

Imaging

Dr Matthew Matson
Group Clinical Director for Diagnostic Imaging

Martin Fottles
Group Head of Imaging

Pathology

Dr Tom Butler
Group Clinical Director for Pathology

Nicole Gresham
Group Head of Pathology

Pharmacy

Raliat Onatade
Group Chief Pharmacist

Clinical Physics

Dr Malcolm Birch
Group Director of Clinical Physics

Therapies

Pauline Miller
Group Head of Therapies

Fully networked services

Barts Health NHS Trust

- There are a small number of "fully networked services" where clinical services across a number of sites are managed as a single unit. These managed networks are:

  1. Renal services
  2. Dental services
  3. Sexual health services
  4. Some elements of cardiovascular services

- Each managed network area is aligned to one of the sites (for the purpose of operational oversight) and to one of the Clinical Boards (for the purpose of strategic development):

Managed network	Site	Clinical Board
Renal	The Royal London / MEH	Medicine
Dental	The Royal London / MEH	Surgery
Sexual health	The Royal London / MEH	Medicine
Cardiovascular	St Bartholomew's	Cardiovascular

NHS
Barts Health
NHS Trust

Section 4. Organisational structure: Clinical Boards and clinical networks

Each board has a chair drawn from a triumvirate of a Board chair, a clinical lead and a operational lead. There are also strategy leads aligned to each board and a research director.

Each network is led by a clinical network director.

The clinical board and network membership includes multi disciplinary representatives from sites (clinical and managerial), strategy, research and education. In some cases wider stakeholders are also members of the network boards.

A support & assurance framework has been developed and implemented to ensure that clinical boards and networks can achieve their objectives.

CLINICAL BOARDS

CANCER
Dr Angela Wong – Board Chair
Alison Hill – Nursing Lead
Mark Warren – Operational Lead

CARDIOVASCULAR
Prof Adam Timmis– Board Chair
Vacant – Nursing Lead
Vacant – Operational Lead

CHILDREN'S HEALTH
Kath Evans– Board Chair
Vacant – Medical Lead
Sue Row – Operational Lead

EMERGENCY CARE AND TRAUMA
Dr Malik Ramadhan – Board Chair
Lucie Butler – Nursing Lead
Deborah Madden – Operational Lead

MEDICINE
Dr Neil Ashman – Board Chair
Dr Louise Langmead – Deputy Chair
Andrea McDonnell – Nursing Lead
Davide Fasana – Operational Lead

SURGERY
Mr Stephen Edmondson – Board Chair
Jason Saunders – Deputy Chair
Jackie Marshall – Nursing Lead
Chris Kennedy – Operational Lead

WOMEN & NEWBORN HEALTH
Mr Rehan Khan – Board Chair
Mary Olusile – Nursing Lead
Gloria Rowland – Midwifery Lead
Vacant – Operational Lead

CLINICAL SUPPORT SERVICES
Prof Finbarr Cotter– Board Chair
Vacant – Nursing Lead
Vacant – Operational Lead

CLINICAL NETWORKS

CANCER

CARDIOVASCULAR

CHILDREN'S HEALTH
Children's Surgery
Integrated Care
Specialist Networks

EMERGENCY CARE & TRAUMA
Emergency Care
Trauma
Pre-Hospital

MEDICINE
Acute medicine
Dermatology
Diabetes
Endoscopy/Gastroenterology
Haematology
Hepatology
Infectious Diseases
Neurosciences
Older People's Services
Renal
Respiratory
Rheumatology
Sexual Health & HIV
Stroke

SURGERY
Breast surgery
Colorectal
Critical Care
Dental / OMFS
ENT
General Surgery
Gynae-Oncology
Hepatobiliary
Interventional Radiology
Ophthalmology
Orthopaedics
Neurosurgery
Pain
Perioperative
Plastics
Upper GI
Urology
Vascular

WOMEN & NEWBORN HEALTH
Gynaecology
Perinatal

Cancer Board

Barts Health NHS Trust

Nicholas Lemoine
Research Lead

Owen Amadasun
Strategy Lead

Alison Hill
Nursing Lead

Angela Wong
Board Chair

Mark Warren
Operational Lead

John Peters
WCH
Cancer Clinical Director

Arjun Jeyarajah
RLH
Cancer Clinical Director

Tom Powles
SBH
Cancer Clinical Director

Jason Saunders
NUH
Cancer Clinical Director

Cardiovascular Board

Steffen Petersen / Pier Lambiaise
Research Lead

Scott Smith
Strategy Lead

Vacant
Nursing Lead

Adam Timmis
Board Chair

Vacant
Operational Lead

Children's Health and Network

Barts Health NHS Trust

Deanna Gibbs / Stewart Cleeve
Research Lead

Claire Davies
Strategy Lead

Vacant post
Medical Lead

Kath Evans
Board Chair

Sue Row
Operational Lead

Vacant post
Integrated Care Network

Ashwini Joshi
Children's Surgery Network

Vacant post
Specialist Network

Emergency Care & Trauma Board and Networks

Barts Health NHS Trust

Karim Brohi
Research Lead

Lorraine Baker
Strategy Lead

Lucie Butler
Nursing Lead

Malik Ramadhan
Board Chair

Deborah Madden
Operational Lead

Anne Weaver
Trauma

Lisa Niklaus
Emergency Care

Medicine Board and Networks

Barts Health NHS Trust

Kieran McCafferty
Research Lead

Helen Wensley
Strategy Lead

Louise Langmead
Deputy Chair

Neil Ashman
Board Chair

Davide Fasana
Operational Lead

Andrea McDonnell
Nursing Lead

Ananda Chapagain
Acute Medicine

Vacant
Dermatology

Karl Metcalfe
Diabetes

Sean Preston / Louise Langmead
Endoscopy / Gastroenterology

Louise Bowels
Haematology

Graham Foster
Hepatology

Mark Melzer
Infectious Diseases

Ben Turner
Neurology/ Neurophysiology

Claire Dow
Older People's Services

Raj Thuraisingham
Renal

Veronica White
Respiratory Medicine

Stephen Kelly
Rheumatology

Liat Sarner
Sexual Health & HIV

Sageet Amlani
Stroke

Surgery Board and Networks

Barts Health NHS Trust

Hemant Kocher / John Prowle Research Lead						
Mark Johnson / Jennifer Morris Strategy Lead	Jackie Marshall Nursing Lead	Stephen Edmondson **Board Chair**	Christopher Kennedy Operational Lead	Jason Saunders Deputy Chair		
Faisal Mihaimeed Breast	Michael Machesney Colorectal	Marie Healy Critical Care	Phillip Taylor Dental / OMFS	Khalid Ghufoor ENT	Frances Hughes General Surgery	Arjun Jeyarajah Gynae-Oncology
Satya Bhattacharya HPB	Ian Renfrew Interventional Radiology	TBC Neurosurgery	Sudeshna Patra Ophthalmology	Sebastian Dawson-Bowling Orthopaedics	Jane McNeill Peri-Operative	Vivek Mehta Pain
Simon Myers Plastic Surgery	Bijendra Patel Upper GI	James Green Urology	Harpaul Flora Vascular			

Women & Newborn Health Board and Networks

Barts Health NHS Trust

Vacant
Research Lead

Claire Davies
Strategy Lead

Mary Olusile
Nursing Lead

Rehan Khan
Board Chair

Gloria Rowland
Midwifery Lead

Vacant
Operational Lead

Anupama Shahid
Gynaecology

Ferha Saeed/
Michael Hird
Perinatal/
Neonatal

TRUST COMMITTEES
STANDARD OPERATING PROCEDURE

EFFECTIVE FROM	July 2019
DISTRIBUTION	Group Executive Board
RELATED DOCUMENTS	Standing Orders and Standing Financial Instructions COR/POL/002/2018-001 Risk Management Policy COR/POL/004/2014-001 LOM governance structure
STANDARDS	-
OWNER	Director of Corporate Development
AUTHOR/FURTHER INFORMATION	Trust Secretary
STORED	VbR

1 EXECUTIVE SUMMARY

1.1 ***This SOP sets out the duties - and practical arrangements - for all Executive Boards and Committees in relation to maintaining a. terms of reference, membership and meeting schedules b. Escalation arrangements c. Notes of meetings d. Production of an annual report (2-4 pages maximum).***

2 INTRODUCTION

2.1 This document establishes the standard requirements for Board and Executive Committees. This reflects the expectations of the Trust Board and its Quality Assurance Committee that the business of the Trust (including risks and issues) is managed at the appropriate level of the organisation with escalation and cascade in line with the agreed terms of reference for each committee.

Terminology/Definitions

Terms of Reference (ToR)	Statement of the a) objectives and purpose of a committee b) the scope / powers of a committee and its key duties (including limitations to its powers) c) its reporting and escalation arrangements d) membership and quoracy [if applicable] e) meeting frequency.
Committee	For the purposes of this SOP, this term covers all board committees and executive boards that sit beneath the Trust Board and feature on the Trust's committee chart.
Subcommittees	The Group Executive Board will agree which subcommittees report into executive or board committees with the expectation that these follow this SOP unless explicitly agreed by Chief Executives (for hospital specific subcommittees), Clinical Board chairs for clinical boards and networks or Group Executives chairing any other

	subgroups. [It is also recognised that a number of local or specialism-based working groups exist for which appropriate local arrangements, rather than those outlined here, should be agreed].
Notes	For the purposes of this SOP this term covers all minutes, notes and action logs recorded arising from each committee meeting. All Trust boards and committees are required to evidence the production of notes/action logs (and store these in line with para 5.1).
Exception forms	For each Board committee meeting, an exception form must be completed and stored in line with para 5.1 (and, if any issues for escalation are identified, this form must be submitted to the senior committee to which it reports). It is recommended that similar approach is taken at hospital level.
Chair	Every Board / Committee must identify a Chair with responsibility for committees to produce ToR and operate in line with ToR.
Secretary	The Chair of each Committee must nominate a secretary responsible for production and storage of meeting notes, escalation reports and agendas (in addition to any local arrangements for other committee papers). In the absence of a secretary the Chair will have this responsibility.
Virtual boardroom	A shared resource, accessed via the intranet, for dissemination nad storage of documents.

Process

2.2 This SOP is intended to govern all Board committees and executive boards appearing on the Trust's published committee chart(s), managed by the Trust Secretary (see definitions section above). In the absence of a committee with formally delegated duties appearing on this chart, executives chairs will be asked to advise on how duties for key areas within their remit are discharged and governed; including steps to ensure that issues and risks are managed, communicated, escalated and cascaded effectively and transparently.

2.3 The below section identifies the requirements that each committee must fufill continuously in order to be included on the above chart.

3 DUTIES AND RESPONSIBILITIES

3.1 The below summarises key duties – supporting detail and examples are provided later in this SOP.

Responsibilty	**By whom**	**Comments**
Terms of reference	Chair / Executive Team	Must be produced and reviewed annually, and agreed with the senior committee to which it reports.
Notes	Secretary	Produced, agreed with the Chair as accurate and saved to Virtual Board Room.
Standing item on each agenda - 'Risks/issues for escalation'	Chair and Secretary	Must ensure that either minutes are shared or an exception form

		is completed after every meeting and, if any issues for escalation are identified ensuring these are submitted to the committee to which it reports
Annual report	Chair	Produce a concise report (2-6 pages) annually confirming compliance with terms of reference.
Committee Chart(s)	Trust Secretary	Maintain and publish chart(s).
Senior Committee (to which each committee reports into)	Chairs	Receive annual reports, receive exception reports and escalate arising issues as required to Board or Board committees.
Subcommittees (1) Hospital-specific subcommittee terms of reference and reporting	Chief executives	Oversee appropriate reporting arrangements for all sub-committees reporting into hospital management boards
Subcommittees (2) Clinical boards and networks	Clinical Board chairs	Oversee appropriate reporting arrangements for all clinical network groups reporting into Boards

Terms of reference

3.2 All committees must produce and review, on an annual basis, their Terms of Reference (ToR) – see 'definitions at para 1.1 regarding key features of ToR. Terms of Reference will identify the senior committee to which it reports on an annual and in-year basis. For Board Committees, for example, annual reports will typically be provided to the Trust Board. Chairs/secretaries must ensure the most up-to-date version is agreed and stored centrally (see paragraph 5.1) in addition to any local storage, so that these are available as a resource for Executive Team members (in addition to any local arrangements).

Meeting Notes and action logs

3.3 Meeting Notes/action logs, or equivalent records of meetings (e.g. more formal minutes), must be produced following each committee meeting. **These must be stored in Virtual Boardroom, in addition to any local storage for all other related committee papers (which will continue to be determined by chairs and secretaries).** The aim is that these are available as a resource to share learning. This arrangement will evidence that the business of the committee is in line with its ToR.

Exception Reports / Minutes shared in-year

3.4 The ToR for each Committee should identify the senior committee to which it reports. Key issues escalated in year should be reported to this along with any other committees identified as appropriate by the Chair. ***A standing item should appear on every meeting agenda to identify any issues that require escalation, which should then appear in the related exception report form (or minutes) and reported upwards following each meeting.*** Exception reports must be stored centrally in the same way as meeting notes as indicated at

para 5.1. The senior committee will identify whether it requests exception reports or minutes to be shared, with advice on the optimal approach available from the Trust Offices.

3.5 Risks (but not ongoing issues) identified should also be reported in this way, but may also need to be recorded/updated on Datix in line with the Trust's risk management policy. Similarly uncovered incidents may need to be reported in line with the Trust's adverse incident policy.

Annual reports

3.6 As indicated in para 3.2, ToR should identify upward reporting arrangements (e.g. the Audit and Risk Committee provides an annual report to the Trust Board). Arrangements will be agreed with lead directors and confirmed to the Trust Secretary.

3.7 Annual reports should be concise, ideally 2-4 pages, and focus on the following for assurance purposes:

- Whether each of the headings within the ToR have been met. Any areas where the committee has not fully met ToR duties.
- Details of principal issues/risks identified during the year (and if escalated). This should in particular highlight issues/risks which remain an ongoing concern for the Committee at the time of writing.
- A paragraph summaring key business in past year and/or priorities for subsequent year.

***Annual reports should not seek to be exhaustive, extend beyond the work of the committee (e.g. to record all work of a function, team or department) or developed to meet standards set for such reports by external bodies*.** If national guidance exists requiring a specific format, these reports should be produced separately and treated as an appendix to the main report, with an executive summary included in the main report.

4. TEMPLATES

4.1 Standard templates for a) meeting notes/action logs b) committee annual reports c) exception reporting and d) ToR are available in appendices to this SOP. Examples of completed templates e.g. minutes/action notes/ToR are available on request from the Trust Secretary.

5. CENTRAL STORAGE OF NOTES/ACTION LOGS, EXCEPTION REPORTS AND COMMITTEE ANNUAL REPORTS

5.1 A dedicated folder for each hospital and each executive board has been identified on Virtual Boardroom portal for dissemination and storage of papers for this purpose.

6 MONITORING COMPLIANCE

6.1 The Trust Office will arrange audits of the requirements of this SOP and report to the Executive Team on compliance. Where requirements of this SOP are not met, the

respective committee(s) will either a) be flagged on the chart to indicate that there are outstanding requirements and/or b) be suspended from appearing on the Committee Chart(s). ***Lead directors may, in such circumstances, be required to report to the Executive Team on mitigating arrangements in place to assure effective management and reporting***.

END

v.1 approved by Executive Team 2013

v.2.1 August 2015 LOM model

v.3.1 June 2019

TRUST COMMITTEES
STANDARD OPERATING PROCEDURE

EFFECTIVE FROM	July 2019
DISTRIBUTION	Group Executive Board
RELATED DOCUMENTS	Standing Orders and Standing Financial Instructions COR/POL/002/2018-001 Risk Management Policy COR/POL/004/2014-001 LOM governance structure
STANDARDS	-
OWNER	Director of Corporate Development
AUTHOR/FURTHER INFORMATION	Trust Secretary
STORED	VbR

1 EXECUTIVE SUMMARY

1.1 ***This SOP sets out the duties - and practical arrangements - for all Executive Boards and Committees in relation to maintaining a. terms of reference, membership and meeting schedules b. Escalation arrangements c. Notes of meetings d. Production of an annual report (2-4 pages maximum).***

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v.2.1 August 2015 LOM model

v.3.1 June 2019

TRUST COMMITTEES
STANDARD OPERATING PROCEDURE

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STORED	VbR

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Annual report	Chair	Produce a concise report (2-6 pages) annually confirming compliance with terms of reference.
Committee Chart(s)	Trust Secretary	Maintain and publish chart(s).
Senior Committee (to which each committee reports into)	Chairs	Receive annual reports, receive exception reports and escalate arising issues as required to Board or Board committees.
Subcommittees (1) Hospital-specific subcommittee terms of reference and reporting	Chief executives	Oversee appropriate reporting arrangements for all sub-committees reporting into hospital management boards
Subcommittees (2) Clinical boards and networks	Clinical Board chairs	Oversee appropriate reporting arrangements for all clinical network groups reporting into Boards

Terms of reference

3.2 All committees must produce and review, on an annual basis, their Terms of Reference (ToR) – see 'definitions at para 1.1 regarding key features of ToR. Terms of Reference will identify the senior committee to which it reports on an annual and in-year basis. For Board Committees, for example, annual reports will typically be provided to the Trust Board. Chairs/secretaries must ensure the most up-to-date version is agreed and stored centrally (see paragraph 5.1) in addition to any local storage, so that these are available as a resource for Executive Team members (in addition to any local arrangements).

Meeting Notes and action logs

3.3 Meeting Notes/action logs, or equivalent records of meetings (e.g. more formal minutes), must be produced following each committee meeting. **These must be stored in Virtual Boardroom, in addition to any local storage for all other related committee papers (which will continue to be determined by chairs and secretaries).** The aim is that these are available as a resource to share learning. This arrangement will evidence that the business of the committee is in line with its ToR.

Exception Reports / Minutes shared in-year

3.4 The ToR for each Committee should identify the senior committee to which it reports. Key issues escalated in year should be reported to this along with any other committees identified as appropriate by the Chair. ***A standing item should appear on every meeting agenda to identify any issues that require escalation, which should then appear in the related exception report form (or minutes) and reported upwards following each meeting.*** Exception reports must be stored centrally in the same way as meeting notes as indicated at

para 5.1. The senior committee will identify whether it requests exception reports or minutes to be shared, with advice on the optimal approach available from the Trust Offices.

3.5 Risks (but not ongoing issues) identified should also be reported in this way, but may also need to be recorded/updated on Datix in line with the Trust's risk management policy. Similarly uncovered incidents may need to be reported in line with the Trust's adverse incident policy.

Annual reports

3.6 As indicated in para 3.2, ToR should identify upward reporting arrangements (e.g. the Audit and Risk Committee provides an annual report to the Trust Board). Arrangements will be agreed with lead directors and confirmed to the Trust Secretary.

3.7 Annual reports should be concise, ideally 2-4 pages, and focus on the following for assurance purposes:

- Whether each of the headings within the ToR have been met. Any areas where the committee has not fully met ToR duties.
- Details of principal issues/risks identified during the year (and if escalated). This should in particular highlight issues/risks which remain an ongoing concern for the Committee at the time of writing.
- A paragraph summaring key business in past year and/or priorities for subsequent year.

***Annual reports should not seek to be exhaustive, extend beyond the work of the committee (e.g. to record all work of a function, team or department) or developed to meet standards set for such reports by external bodies*.** If national guidance exists requiring a specific format, these reports should be produced separately and treated as an appendix to the main report, with an executive summary included in the main report.

4. TEMPLATES

4.1 Standard templates for a) meeting notes/action logs b) committee annual reports c) exception reporting and d) ToR are available in appendices to this SOP. Examples of completed templates e.g. minutes/action notes/ToR are available on request from the Trust Secretary.

5. CENTRAL STORAGE OF NOTES/ACTION LOGS, EXCEPTION REPORTS AND COMMITTEE ANNUAL REPORTS

5.1 A dedicated folder for each hospital and each executive board has been identified on Virtual Boardroom portal for dissemination and storage of papers for this purpose.

6 MONITORING COMPLIANCE

6.1 The Trust Office will arrange audits of the requirements of this SOP and report to the Executive Team on compliance. Where requirements of this SOP are not met, the

respective committee(s) will either a) be flagged on the chart to indicate that there are outstanding requirements and/or b) be suspended from appearing on the Committee Chart(s). ***Lead directors may, in such circumstances, be required to report to the Executive Team on mitigating arrangements in place to assure effective management and reporting***.

END

v.1 approved by Executive Team 2013

v.2.1 August 2015 LOM model

v.3.1 June 2019

APPENDIX 1 – TEMPLATE FOR NOTES/ACTION LOGS

VENUE [Room, Building, Site]	**[COMMITTEE NAME: DATE OF MEETING]**	**ACTIONS AGREED**
Attendance and apologies for absence	**Present:** [Name / Job Title of each member present] **In attendance:** [Name/Job Title of each attendee present not listed in formal ToR/Membership] **Apologies:** [Name/Job Title of each member sending apologies]	
Notes	Notes of the meeting held on 3 December 2014 were approved.	
Matters Arising and Actions from Previous Meeting (appended)	[Detail under a) sub headings for each matter arising listed on the agenda or b) action from the previous meeting, including detailing decisions to close completed actions]	[Insert job title for any action identified in the centre column in following format **ACTION: [job title]**]
[**[Title of first agenda item:** **Introduced by: [name]**]	[Detail headline points made with focus on areas of discussion and any agreed actions]	[Insert job title for any action identified in the centre column in following format **ACTION: [job title]**]
[**[Title of 2nd agenda item:** **Introduced by: [name]**]	[Detail headline points made with focus on areas of discussion and any agreed actions]	[Insert job title for any action identified in the centre column in following format **ACTION: [job title]**]
[**[Title of 3rd agenda item:**	[Detail headline points made with focus on areas of discussion and any agreed actions]	[Insert job title for any action identified in the centre column in

Introduced by: [name]]		following format **ACTION: [job title]]**
Items for escalation	[Committee reviews any items it needs to report upwards via the escalation reporting form].	Insert job title for any action identified in the centre column in following format **ACTION: [job title]]**
Any other business		
Details of next meeting	[insert details of time/venue]	

ACTION LOGS (DETAILING ACTIONS FROM PREVIOUS MEETINGS)

[COMMITTEEE: DATE OF MEETING]			
Page	**Action**	**Lead**	**Timescale**
1.	[Detail agenda heading]: (i) [summarise action required] (ii) [summarise action required]	[initials/title] [initials/title]	[date] [date]
3.	[Detail agenda heading]: (i) [summarise action required] ~~(ii) [summarise action required]~~ ~~strikethrough to indicate action completed between meetings and being reported back for closure~~	[initials/title] ~~[initials]~~	[date] ~~[date]~~

APPENDIX 2 - EXAMPLE ANNUAL REPORT

BARTS HEALTH NHS TRUST

QUALITY ASSURANCE COMMITTEE: 3 JULY 2019

QUALITY ASSURANCE COMMITTEE ANNUAL REPORT 2018/19

INTRODUCTION AND SCOPE

1. The Terms of Reference of the *Barts Health Quality Assurance Committee (QAC)* require the submission of an annual report to the *Audit and Risk Committee* on the effectiveness of QAC's work and findings. This is in addition to regular reporting to the *Audit and Risk Committee* via the circulation of *QAC action logs/oral reports to each Audit and Risk Committee members and oral updates to the Trust Board after each QAC meeting*.

2. This annual report from *QAC*, which is due to be presented to the *Audit and Risk Committee* on 3 July 2019, covers the financial year - 1 April 2018 to 31 March 2019. During this period, the chairmanship of the Committee changed from *Ms Sally James* to *Ms Tessa Green* (following the November 2018 meeting). The below table summarises key duties and steps taken to meet these in-year.

Table 1

TERMS OF REFERENCE HEADINGS	**REQUIREMENT**	**DETAIL**
Authority/Purpose	Role ✓	Met purpose.
Membership / frequency	Meetings quorate ✓ Attendance (of members/attendees) satisfactory ✓ No of meetings per year (6) ✓	[Details published in Trust Annual Report]
Reporting / escalation	Escalation of issues in-year ✓	Every Board meeting / Each ARC meeting
	Annual report ✓	17/07/18
	Annual work plan ✓	Agreed 10/07/18
Terms of Reference	Annual review ✓	10/07/18
Compliance with key duties	Reports received and reviewed ✓ (i) Safety (Review of incidents and complaints, Sharing the Learning – implementing lessons learned, CIPs quality impact assessments) (ii) Outcomes (performance reports, CAG exception reports, mortality outliers, pressure ulcers, Board Assurance Framework entries on quality	Appendix 1 details papers received (and date) – ***avail on request***. <u>*Sources of assurance included:*</u> Management information - at CAG, site and organisational level. Independent sources of

	and safety) (iii) Experience (patient experience updates, Cancer survey, Staff Survey, Friends and Family Test, Environment including backlog maintenance)	assurance (Royal College of Surgeon's review, OPS Programme review, Internal Audit and Clinical Audit reports, SHMI/CQC/other national bodies' mortality reviews).
Possible gaps in compliance with key duties	Reports on progress against quality priorities. Coverage of all CQC Essential Standards in rolling reviews. Board patient stories updates. Follow up on audit recommendations. Infection control systems and processes updates.	*(n.b. QAC received reports on these areas during 2013/14 but coverage potentially fell short of ToR requirements)*

KEY AREAS OF FOCUS IN 2018/19

3. In 2018/19, QAC has undertaken a significant role in providing assurance to the Board on quality and safety risks including a specific role on performance as delegated by the Trust Board. It continued to review the overall quality framework put in place in the Trust (see Appendix 1), including:

- The Trust's response to the CQC risk rating and inspections during 2018.
- Development of a robust quality impact assessment for CIP savings schemes.
- Review of the Trust's Quality Account (and External Audit assessment of this).
- Issues identified as priorities in-year arising from Board/other reports such as patient stories (e.g. safeguarding, learning disabilities, breast screening, backlog maintenance, the effectiveness of patient experience structures).
- QAC has also reviewed and sought assurance on the core domains of the Essential Standards of Quality and Safety (compliance with these are required as part of CQC Registration).

ISSUES HIGHLIGHTED / ESCALATED TO ARC OR TRUST BOARD

4. Key risks and issues highlighted / escalated by the Committee during the year included:

- CQC inspections (including warning notices in place earlier in the year relating to medicines management and Newham maternity services), Well Led improvements and progress on related action plans.

- Risks identified in hospital escalation reports including: diagnostics and scanning access issues, complaints and SI investigation backlogs, work to reduce Never Events, cardiotocography risks and leadership support in clinical boards.

- Estates issues including fire safety and cleanliness/infection prevention/backlog maintenance issues, particularly in relation to the Whipps Cross estate.

5. In relation to the above, the Quality Assurance Committee escalated its ongoing concerns regarding the volume of never events and lack of progress in evidencing improvement on sepsis management. [This concern was most recently escalated to the Trust Board in November 2018]. In this context, management and learning from never events, complaints and SIs will continue to be an area where further assurance will be required as part of its workplan for 2019/20.

PRIORITIES FOR 2019/20

6. The Barts Health Quality Improvement priorities for 2019/20 are reflected in the Trust's objectives, CQUINs and QI goals identified in the Quality Account and will be further influenced by the overall context of challenges facing the Trust in the coming year.

CONCLUSION

7. The Committee continued to develop its role during 2018/19, meeting its work plan and addressing duties required under its terms of reference.

8. The Audit and Risk Committee is asked to approve the Quality Assurance Committee annual report.

Sean Collins
Trust Secretary

Thoreya Swage
Chair, Quality Assurance Committee

Appendix 3

House style

Rationale - what our Minutes and Notes are used for	Notes and minutes primarily used to confirm decisions and/or rationale for decisions for (i) cascade or use for wider teams (ii) as an audit trail for the organisation (iii) for upwards reporting to other committees (iv) as an audit trail for external scrutiny (including FoI) if required. *Templates are separately available - with guidance notes - for producing committee reports.*

Minutes vs Notes vs Action Logs

Minutes should be full and describe actions and relevant discussion	Minutes should be a full summary of all key discussion points made in relation to agenda items, including attribution of comments to individuals. Written in full form to provide context to provide an audit trail and evidence rationale for decisions and points of view. All actions captured with target dates and leads. [Omitted = introductions/details of contents of committee reports /presentations available from the papers]. Target to produce =<2 weeks of each meeting. Generally used for all Board and Board Sub Committees. *(Standard font – Calibri 12pt, justified).*
Notes should confirm decisions and summarise key points raised	All actions captured with target dates and leads. Summarised key points made by members, with attribution where necessary but not always required. [Omitted = as above, but also less formal in terms of contextual discussion]. Target to produce =< 2wks of each meeting. Generally used for all executive committees. *(Standard font – Calibri 12pt, justified).*
Action logs should list actions and be produced quickly	Table indicating solely actions agreed with target dates and leads. Used as separate document circulated immediately after meeting to ensure timely follow-up. Appended to agendas of subsequent meeting. Target to produce = < 2 days of each meeting. Generally used for all executive and Board committees. *(Standard font – Calibri 12pt, justified).*
Style – minutes	Full sentences but never a verbatim record unless expressly agreed beforehand; all acronyms and abbreviations written in full the first time these appear; job titles used where possible in preference to names; avoid unless necessary use of adjectives/adverbs/'hyperbole' (e.g. 'Director x was ~~absolutely~~ certain that xx'); style should be formal and be 'neutral'/objective where possible while seeking to accurately present any differing views expressed. Different views should not be presented as argumentative but as constructive contributions. Care should be taken on attributing specific views to an entire group, although the final conclusions (e.g. on next steps to take) following debate is a key element to capture. These should be written in a way that a lay reader can follow the arguments without necessarily having detailed/expert knowledge of the topic or

	papers in front of them (while not restating all the points in separately available reports).
Style – notes	Differs from above in that views expressed are typically in highly summarised form (e.g. in bullets) rather than reported in full, with attribution only where necessary. Initials may be used for individuals rather than full names/titles.

Frequently used terms and style

In trying to achieve the above, the Trust Office's house style tends towards use of certain terms to describe how individuals report at a meeting, respond when in debate and how a discussion is concluded. This approach is illustrated below in 'minutes' style. Similar would apply for 'notes' style but without attribution and often in bullet point, summary form.

Presenting a report

Preferred:

'The Director of xx introduced FT xx/20, a paper outlining key duties for the Trust Board in relation to xx'.

Avoided:

'The Director of xx outlined the following ten points in the paper to support the proposal:…xx'

Discussion

Preferred:

'The Director of xx noted that../highlighted that.../confirmed that…/supported the view that.../emphasised that…/queried whether…/asked if.../felt that[1]…/suggested[2] that…/explained that.../observed that…/emphasised that…/agreed that../recalled that…/reported that…/remained unclear whether.../proposed that../sought confirmation that…/was uncomfortable with the proposal that…'

Avoided:

'The Director of xx said../argued that../stated that…/thought that…'

Summing up a discussion (generally this should seek to represent the overall conclusion of the group, or failing that, the chair)*:*

Preferred:

'It was agreed that xxx'. 'A further report was requested from the Director of xx to enable approval at the next meeting, which was due to be held on xx'.

Avoided:

'No decision was made'. **n.b.** Key recommendations in reports to committees should be assumed as being agreed unless specified otherwise; or some other action (e.g. further information required) indicated that meant approval was not possible.

[1] Helpful to use when expressing a personal opinion as distinct from factual assertion

Appendix 1

Interview test (written as verbatim/rough notes below)

1. Present – guy Harvey, director of operations, Sean Collins, Deputy trust secretary, Tom Brown – Pharm project manager, Raj Choudhry, Dep medical director, Sarah Cox, Chief nurse and apologies received from Sam Wright director of strategy due to attending a conference.

2. Welcome – done/apologies.

3. Minutes of 12 Dec meeting – Approved as accurate

4. m.arising – a) public health

GH congratulated RC on the recent HSJ award for the work of the public health team on smoking cessation, rc noted the hard work of the team and claimed this would help with messages to staff and wider out in the public but lots still to do.

- *Pharmacy project*

TB said no progress on this since last time; combination of sickness and staff not finding time to help on design stage. TB gave examples about AHPs on study days not able to help, the pmo manager sick etc.

GH – understand that project management office short staffed but what is go forward plan? Drift? CEO expecting report ideally / hopefully by end of this wk.

TB – said he had personally taken on project but not yet seen clinical input commitment to kickstart this.

RC and SC agreement to identify clinical representatives including from T&O to help.

Agreed. TB to email all, confirm above happened along with revised date for CEO to expect report.

Extract of above written in house style (n.b. justified, numbered subheadings italicised but not numbered, paragraphs justified and single line spaced)*:*

4. Matters Arising

(i) Public Health

4.1 The Director of Operations congratulated the Chief Nurse on the recent Health & Social Journal (HSJ) award for the work of the Public Health Team on smoking cessation. The Chief Nurse commended the team for the hard work and noted that this award would support the effectiveness of related messages to staff. However, it was recognised that further work was still required to develop this.

(ii) Pharmacy project

4.2 The Pharmacy Project Manager reported that no significant progress on the pharmacy project had been made since the last meeting. This was in part due to sickness absences in the Project Management Office and other priorities (including disruption due to study leave commitments), with the result that engagement of key clinical staff had not been secured at the design stage. He confirmed that this issue had now been escalated and that he would be leading on the project. The Director of Operations requested clarification on the next steps, highlighting the expectation that a progress report would be provided to the Chief Executive in the next week.

4.3 Following discussion, it was agreed that:

- The Deputy Medical Director and Chief Nurse would liaise with the Pharmacy Project Manager to identify suitable clinical representatives.

ACTION: Deputy Medical Director and Chief Nurse

- An update would be sent by email to all members confirming the current status of the pharmacy project, any progress on the above step to identify clinical representatives and confirming the anticipated timescale for reporting to the Chief Executive.

ACTION: Pharmacy Project Manager

Appendix 4 – Exception reporting template

Draft EXCEPTION REPORT TO TRUST EXECUTIVE COMMITTEE – {INSERT NAME OF COMMITTEE/BOARD}

<table>
<tr><td>Meeting date</td><td colspan="5">{insert number} {insert Month} 2018</td></tr>
<tr><td>Chair</td><td>{insert Director name}</td><td>Author</td><td>{insert name, job title}</td><td>Papers held by</td><td>{insert name, job title}</td></tr>
<tr><td>Meeting held?</td><td>Y/N [if N – provide this nil return without details below]</td><td>Attendance</td><td colspan="3">{insert details if any issues associated with attendance, representation or quoracy}</td></tr>
<tr><td colspan="4">Significant new issues/achievements for the Trust Executive Committee to note:

- {insert agenda item title – insert summary description and rationale for notifying TEC}
- {insert agenda item title – insert summary description and rationale for notifying TEC}
- {continue as above}</td><td colspan="2" rowspan="3">Agenda Items scheduled for subsequent Trust Board or Board Committee review: {insert agenda item title – indicate if regularly reported upwards or if a specific request}

Indicate any relevant legal, regulatory or unfunded resource implications: {insert}

Detail any relevance to BAF, Site Assurance Framework or high risk register entries (existing or proposed new risks): {insert}</td></tr>
<tr><td colspan="4">Decisions / approvals for the Trust Executive Committee to note:

- {insert agenda item title: insert key conclusions, decisions and approvals of the committee for TEC to note}
- {insert agenda item title: insert key conclusions, decisions and approvals of the committee for TEC to note}
- {continue as above}</td></tr>
<tr><td colspan="4">Issues for escalation to the Trust Executive Committee to resolve /approve:

- {insert agenda item title: insert recommended action for TEC to consider and resolve / approve}
- {insert agenda item title: insert recommended action for TEC to consider and resolve / approve }
- {continue as above}</td></tr>
</table>