The Royal Wolverhampton NHS Trust

Trust Board Report

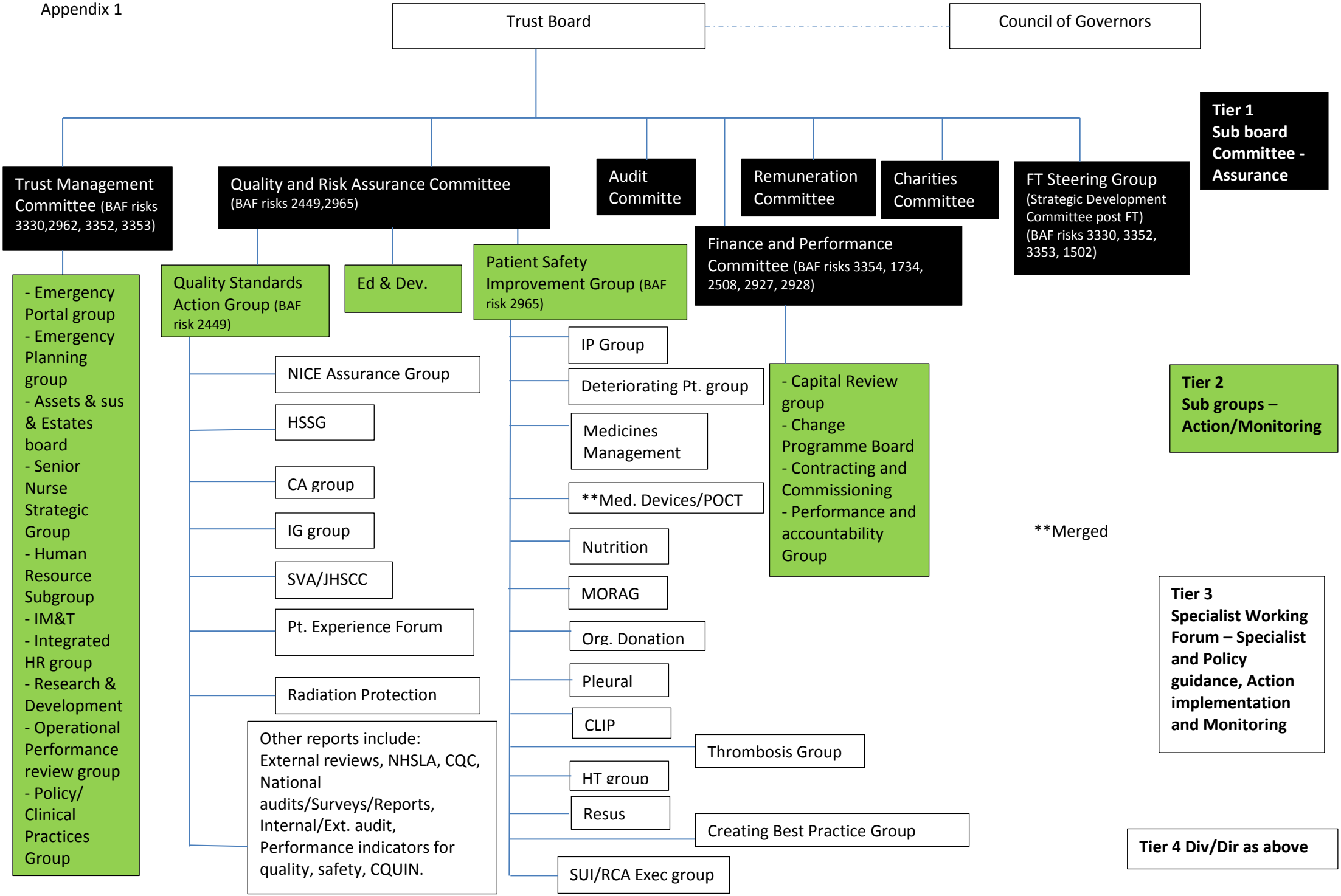
Meeting Date:	22 July 2013
Title:	Governance Committee Structure
Executive Summary:	This report provides a brief update on the proposed committee structure and draft Terms of Reference for consideration
Action Requested:	The board is asked to agree: • The allocation of BAF risks to committee • The appropriate assignment of strategic objectives • Terms of Reference
Report of:	Ms Cheryl Etches, Chief Nursing Officer
Author: **Contact Details:**	Ms Cheryl Etches, Chief Nursing Officer Tel 01902 695950 Email c.etches@nhs.net
Resource Implications:	
Public or Private: **(with reasons if private)**	Public Session
References: **(eg from/to other committees)**	Monitor
Appendices/ **References/** **Background Reading**	The proposed committee structure
NHS Constitution: **(How it impacts on any decision-making)**	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: Equality of treatment and access to services High standards of excellence and professionalism Service user preferences Cross community working Best Value Accountability through local influence and scrutiny

Background Details

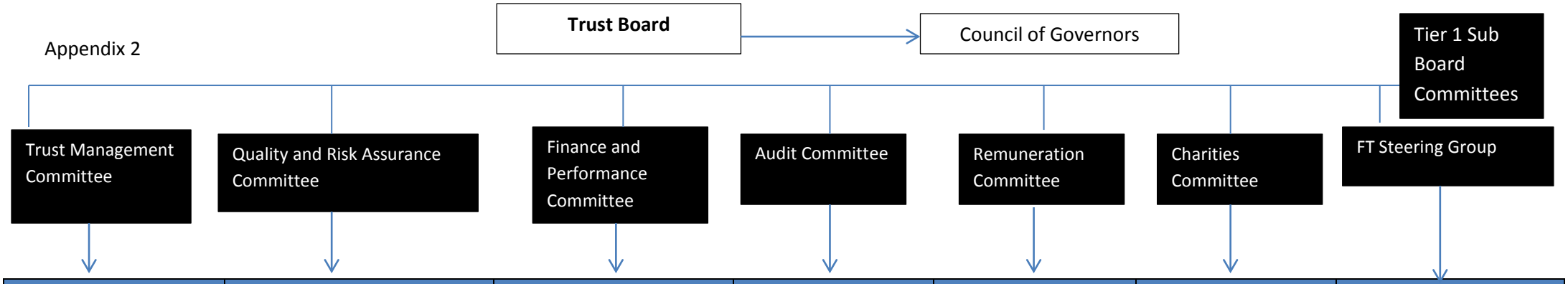
1.	Following feedback from Monitor in 2012, it was agreed to commission an external review of the Trust's governance arrangements. This review was undertaken by Price Waterhouse Cooper (PWC) and completed in April 2013. The findings have previously been presented to the Trust Board. The action plan included a review of sub Board committees. The draft committee structure has been developed and presented to Trust Board in June 2013 and subsequently discussed at the Trust Board Away Day on 4 July 2013. Changes which have taken place since the previous Trust Board paper include:

	• Inclusion of Board Assurance Framework, risks allocated to Trust committees to oversee the assurance and escalation process • Mapping of the strategic objectives to the committee which would provide supportive evidence of achievement and delivery • Identification of the frequency of meetings The allocation of Non-Executive Director chairmanship is currently under review and confirmation is due imminently. Appendix 1 identifies the overarching sub-board committee structure with key relevant supporting groups into committees. It also identifies the BAF/Risk which the committee will oversee monitoring and implementation of actions/mitigations. Appendix 2 reflects the frequency of the committees and the strategic objective to which committee function relates. It is anticipated that each committee will provide appropriate assurance through evidence or escalation of concern against strategic objective delivery. Appendix 3 contains the draft Terms of Reference of each of the sub-board committees. At this point the allocation of Governors to committees has yet to be agreed. However, it is important that the Board agree the committee structure to enable the first sub-committees to take place from 1 September 2013.

Appendix 1


Trust Board
Council of Governors
Tier 1
Sub board Committee - Assurance
Trust Management Committee (BAF risks 3330,2962, 3352, 3353)
Quality and Risk Assurance Committee (BAF risks 2449,2965)
Audit Committe
Remuneration Committee
Charities Committee
FT Steering Group (Strategic Development Committee post FT) (BAF risks 3330, 3352, 3353, 1502)
Finance and Performance Committee (BAF risks 3354, 1734, 2508, 2927, 2928)
- Emergency Portal group
- Emergency Planning group
- Assets & sus & Estates board
- Senior Nurse Strategic Group
- Human Resource Subgroup
- IM&T
- Integrated HR group
- Research & Development
- Operational Performance review group
- Policy/ Clinical Practices Group
Quality Standards Action Group (BAF risk 2449)
Ed & Dev.
Patient Safety Improvement Group (BAF risk 2965)
NICE Assurance Group
HSSG
CA group
IG group
SVA/JHSCC
Pt. Experience Forum
Radiation Protection
Other reports include: External reviews, NHSLA, CQC, National audits/Surveys/Reports, Internal/Ext. audit, Performance indicators for quality, safety, CQUIN.
IP Group
Deteriorating Pt. group
Medicines Management
**Med. Devices/POCT
Nutrition
MORAG
Org. Donation
Pleural
CLIP
Thrombosis Group
HT group
Resus
Creating Best Practice Group
SUI/RCA Exec group
- Capital Review group
- Change Programme Board
- Contracting and Commissioning
- Performance and accountability Group
Tier 2
Sub groups – Action/Monitoring
**Merged
Tier 3
Specialist Working Forum – Specialist and Policy guidance, Action implementation and Monitoring
Tier 4 Div/Dir as above

Appendix 2



Frequency	Frequency	Frequency	Frequency	Frequency	Frequency	Frequency
Monthly	Bi Monthly	Monthly	Quarterly	Annual	Quarterly	Monthly
Strategic Objectives	**Strategic Objectives**	**Strategic Objectives**	**Strategic Objectives**	**Strategic Objectives**	**Strategic Objectives**	**Strategic Objectives**
1. To provide our patients and staff with a safe environment	1. To provide our patients and staff with a safe environment	1. To provide our patients and staff with a safe environment	6. Deliver services within financial allocations	6. Deliver services within financial allocations	6. Deliver services within financial allocations	1. To provide our patients and staff with a safe environment
2. To be the employer of choice	4. To progressively improve the image and perception of the Trust	3. To achieve a balance between demand and capacity of services	10. To consolidate our position as a leading Healthcare provider in a commercial environment.	2. To be the employer of choice	10. To consolidate our position as a leading Healthcare provider in a commercial environment.	3. To achieve a balance between demand and capacity of services
4. To progressively improve the image and perception of the Trust	5. To be in the national NHS top quartile of benchmarks	4. To progressively improve the image and perception of the Trust				4. To progressively improve the image and perception of the Trust
5. To be in the national NHS top quartile of benchmarks	7. To be high quality educator	5. To be in the national NHS top quartile of benchmarks				5. To be in the national NHS top quartile of benchmarks
7. To be high quality educator	10. To consolidate our position as a leading Healthcare provider in a commercial environment.	6. Deliver services within financial allocations				7. To be high quality educator
8. To agree appropriate population catchment areas for RWT service		10. To consolidate our position as a leading Healthcare provider in a commercial environment.				8. To agree appropriate population catchment areas for RWT service
9. To develop our position as a tertiary centre						9. To develop our position as a tertiary centre
10. To consolidate our position as a leading Healthcare provider in a						10. To consolidate our position as a leading Healthcare provider in a

commercial environment.						commercial environment.

The Royal Wolverhampton NHS
NHS Trust

AUDIT COMMITTEE

TERMS OF REFERENCE

Trust Strategic Objectives	6. Deliver services within financial allocations 10. To consolidate our position as a leading Healthcare provider in a commercial environment.
Meeting Purpose/Remit	The Audit Committee provides the Board with a means to undertake and obtain independent and objective reviews of financial systems / financial information and help ensure compliance with relevant law, guidance and codes of conduct. The Audit Committee's role has been enhanced to take a wider view over internal controls across the whole of the Trust's activities – in particular so that it can advise the Board as to the status of Internal Control that currently the Annual Governance statement and Trust's Annual Accounts.
Responsibilities	**1. Internal Control** The Committee shall review the establishment and maintenance of an effective system of internal control. In particular, the Committee will review:- • The Statement on Internal Control, and the related Head of Internal Audit Opinion, prior to the endorsement of the Annual Accounts by the Trust Board. In order to undertake such a review, the Audit Committee will need to seek assurance from the activities of the Board Assurance Committee, not least to ensure that, between the Audit Committee and the Board Assurance Committee, full coverage is achieved. To support this process, the Audit Committee will meet annually with the Board Assurance Committee. • the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, and the operational effectiveness of such policies and related procedures • the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service • the timeliness of the implementation of agreed action plans arising from all audit reports within the purview of the Committee **2. Internal Audit** The Committee shall ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee and Board. This will be achieved by: • The consideration of the provision of the Internal Audit service, the audit fee and any questions of resignation and dismissal • The review and approval of the Internal Audit strategy and annual plans, ensuring that these are consistent with the audit needs of the Trust • The review of progress against the agreed annual internal audit plan

	• The consideration of the major findings of internal audit reviews [and management's response] • Ensuring that the quality of the Internal Audit service is maintained and that the service has appropriate standing within the Trust • Ensuring co-ordination between the Internal and External Auditors to optimise audit resources • The review of an Annual Report, provided by the Head of Internal Audit, summarising audit activities during the year • Note: for the purposes of the above section, references to Internal Audit are deemed to include Counter Fraud work. **3. External Audit** The Committee shall review the work and findings of the External Auditor and consider the implications of, and management response to, their work. This shall be achieved by: • The consideration of the appointment and performance of the External Auditor • The discussion with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Audit Plan, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy • Reviewing External Audit reports, including the agreement of the annual audit letter before its submission to the Trust Board, together with the appropriateness of management responses. This requirement does not extend to value for money / performance related reports, which will be reviewed by the Trust Board. **4. Financial Reporting** The Audit Committee shall review the Annual Accounts before submission to the Board, focusing particularly on: • The Statement on Internal Control and other disclosures relevant to the Terms of Reference of the Committee • Changes in, and compliance with, accounting policies and practices; • Unadjusted mis-statements in the Annual Accounts • Major judgmental areas • Significant adjustments resulting from the audit. The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board. **5. Other** The Committee shall review proposed changes to Standing Orders, the Scheme of Reservation and Delegation, and Standing Financial Instructions, and advise the Board accordingly. The Committee shall examine the circumstances associated with each occasion when Standing Orders are waived.
Authority & Accountabilities	The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. The Committee shall transact all business in accordance with the policy of the Trust on openness and conformity with the principles and values of the

	Public Services. The Committee shall transact its business in accordance with national/local policy and in conformity with the principles and values of public service (GP01)
Reporting Arrangements	The minutes of Audit Committee meetings shall be formally recorded and submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues of significance or that require disclosure to the full Board. The minutes of the Audit Committee meetings shall also be copied to the Trust Quality and Risk Assurance Committee. The Chair of the Audit Committee shall provide to the Board an Annual Report of the activities of the Committee.
Membership	The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than 3 members. The Chairman of the Trust Board shall not be a member of the Audit Committee. The Chairman of the Audit Committee shall be appointed by the Chairman and Non-Executive Directors of the Trust.
Attendance	The Director of Finance and Information and appropriate representatives from internal and external audit shall normally attend meetings, and the Audit Committee can require the attendance of any officer of the Trust relevant to the discussion of a specific issue. At least once a year the Committee may wish to meet with the External and Internal Auditors without any Executive Board Director present.
Chair	NED Chair
Quorum	A quorum shall be 2 members.
Frequency of meetings	Meetings shall be held not less than four times a year. The External Auditor or Head of Internal Audit may request a meeting if either considers that one is necessary.
Administrative support	The Finance and Information Department will provide administrative support. Agenda and papers will be circulated one week prior to the meeting.
Standards	Monitor Governance Framework The Health NHS Board – Principles of good governance Corporate Governance – Principles of Public Life (GP01)
Standard Agenda	TBC
Subgroups	As instigated or identified by the Committee
Date Approved	July 13
Date Review	TBC

CHARITY COMMITTEE

TERMS OF REFERENCE

Trust Strategic Objectives	6. Deliver services within financial allocations 10. To consolidate our position as a leading Healthcare provider in a commercial environment.
Meeting Purpose/Remit	To offer strategic direction and guidance to ensure that The Royal Wolverhampton Hospitals Charity has all the hallmarks of an effective Charity, as set out in the standards issued by the Charity Commission. To ensure the management and administration of the Charity, in accordance with the Charity's purposes, as set out in its Governing Documents.
Responsibilities	1. To determine a Charitable Funds Strategy and to set annual objectives. 2. To ensure that Charitable Funds are managed in line with the measures and actions set out in the Strategy. 3. To ensure any fundraising element of the Charitable Funds Strategy works within recognised good practice frameworks and identifies methods of fundraising appropriate for the Charity. 4. To determine a Charitable Funds Investment Policy and monitor performance of any investments made in line with Governing Documents and the Trustee Act 2000. 5. To appoint and consider the performance of any investment advisor / manager. 6. To ensure Trust Policy and Procedures are sufficient with regard to Charitable Fund business. 7. To ensure financial controls are in place to account for all funds received and that governance arrangements are appropriate and effective. 8. To ensure that timely annual reports and accounts are produced and an unqualified external audit opinion is received.
Authority & Accountabilities	The Committee shall transact its business in accordance with national/local policy and in conformity with the principles and values of public service (GP01)
Reporting Arrangements	TBC
Membership	Chief Executive or nominated Executive Director 3 Non-Executive Directors. One of the non-executives present to take the Chair
Attendance	Representative from Finance Department. Secretary to the Trust Investment advisor / manager as required.

	The Committee may request the attendance of any officer relevant to the items on the Committee's agenda.
Chair	NED
Quorum	Any 3 of the above 5 members.
Frequency of meetings	TBC
Administrative support	TBC
Standards	Charity Commission Stipulations Corporate Governance – Principles of Public Life (GP01)
Standard Agenda	TBC
Subgroups	As instigated or identified by the Committee
Date Approved	July 13
Date Review	TBC

The Royal Wolverhampton NHS
NHS Trust

FINANCE AND PERFORMANCE COMMITTEE

TERMS OF REFERENCE

Trust Strategic Objectives	1. To provide our patients and staff with a safe environment 3. To achieve a balance between demand and capacity of services 4. To progressively improve the image and perception of the Trust 5. To be in the national NHS top quartile of benchmarks 6. Deliver services within financial allocations 10. To consolidate our position as a leading Healthcare provider in a commercial environment.
BAF Risks	3354, 1734, 2508, 2927, 2928
Meeting Purpose/Remit	To provide the Board assurance on the effective financial and performance management of the organisation. It will also support the development, implementation and delivery of the Medium Term Financial Plan (MTFP) and the efficient use of financial resources.in order to review the Trusts Financial strategy, performance and business development.
Responsibilities	1. Utilise the assurance reporting processes (BAF/TRR) to inform the Trust Board of Finance, performance, investment or related risk and redress actions. 2. Monitor and support the development of a Medium and Long Term Financial and investment Plan in relation to both capital and revenue, with clear assumptions on allocations, activity and investment. 3. Review and endorsement of the annual revenue and capital budgets before they are presented to the Board for approval. 4. Approve the development of financial and contractual reporting in line with best practice. 5. Monitor income and expenditure against planned levels and make recommendations for corrective action should excess variances occur. 6. To receive and review the trust wide and divisional reports on finance and contractual performance before they are presented to the Board. The focus will be on forecast outturn, risks to delivering the plan and the mitigation plans. 7. Review expenditure against the agreed capital plan. 8. Review any matters which impact adversely on the financial performance or reputation of the Trust. 9. Oversee the development of Service line reporting. 10. Approve financial returns prior to submission to any other external accountable authority, e.g. reference costs, ERIC, etc. 11. Ensure the appropriate training and support is in place for budget holders/managers.

	12. To make arrangements as necessary to ensure that all members of the Board and senior officers of the trust maintain an appropriate level of knowledge and understanding of key financial issues affecting the Trust. 13. Periodically review financial policies and procedures including the SFIs, scheme of delegation, etc. to ensure that they are still relevant and appropriate. 14. Seek assurance that appropriate systems and processes are in place to recover income from private and overseas patients. 15. Review financial and contractual performance against the main healthcare contracts. 16. Oversee the contract negotiations giving direction as necessary. 17. Periodically review the fitness of purpose and robustness of the information systems including Finance, Procurement, business systems, etc. 18. ??? to go here or to the Charities Committee - Ensure proper safeguards are in place for security of Trust funds and compliance with Treasury policies and procedures. 19. In line with Monitor Compliance Framework, assess if any proposed investments should be reported to Monitor in the annual planning process or in year prior to financial closure. 20. Establish the overall methodology, processes and controls which govern investments. 21. To receive and undertake investment appraisals of submitted developments and maintain an oversight of the Trust's investments, ensuring compliance with the Trust's policy and external requirements e.g . Monitor guidance on Investments decisions for NHS Foundation Trusts. 22. Ensure risks of any investments are properly evaluated and risk management arrangements put in place, including: a. Obtaining independent professional advice where appropriate b. Evaluate, scrutinise and monitor investments c. Ensure Investments are supported by relevant stakeholders. d. To examine any relevant matters referred to it by the Board of Directors. 23. To examine any relevant matters referred to it by the Board of Directors.
Authority & Accountabilities	The Finance and Performance Committee is established pursuant to the Standing Orders. The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee shall transact its business in accordance with national/local policy and in conformity with the principles and values of public service (GP01)
Reporting Arrangements	Monthly report to Trust Board Monthly report to Trust Management Committee
Membership	Chair TBC Trust Chairman NED members x 4 CEO Chief Nurse Medical Director

	COO Finance Director Deputy Directors of Finance Director of Planning and Contracts Head of Performance Divisional managers
Attendance	Sub – group chairs – where indicated Specialist Leads – where indicated Head of Estates and Facilities – at indicated intervals
Chair	TBC
Quorum	4 members must be present and must include the Director of Finance or the Deputy Director of Finance; another Executive Director and Divisional representation.
Frequency of meetings	Monthly
Administrative support	The Finance/Performance Directorate will provide administrative support. Agenda and papers will be circulated ???? prior to the meeting.
Standards	Standing Orders Standing Financial Instructions Monitor Risk Assessment Framework Monitor guidance on Investments decisions for NHS Foundation Trusts
Standard agenda	TBC
Subgroups	• Capital Review Group • Change Programme Board • Contracting and Commissioning • Operational Performance Review Group Need confirmation on these staying in existence and reporting to Finance and Performance.
Date Approved	July 13
Date Review	??Frequency

THE ROYAL WOLVERHAMPTON NHS TRUST

FOUNDATION TRUST STEERING GROUP

TERMS OF REFERENCE

The Foundation Trust Steering Group has been established to oversee the programme of work to support the Trust's reactivation of its application with Monitor and is charged with the following:

1. To monitor the delivery of the FT Action Plan providing support and action where issues arise and timescales are not being met

2. To ensure that all requirements of the TDA and Monitor are undertaken within the agreed timescale

3. To provide assurance to the Trust Board on progress towards reactivation of the Trust's application with Monitor

4. To ensure that all changes to monitoring and reporting as described in the TDA Accountability Framework are incorporated into the relevant Trust processes

5. To oversee the delivery of the agreed actions arising from the external review of Quality Governance

6. The meeting will be quorate with 50% of core members present.

7. The Steering Group will meet monthly on the second Wednesday and report to the Trust Board in that same month to ensure timeliness of reporting

MEMBERSHIP

Chairman
Acting Vice Chair – Jeremy Vanes
Associate Non-Executive Director – Sue Rawlings
Chief Executive
Chief Nursing Officer
Chief Financial Officer
Medical Director
Chief Operating Officer
Director of Human Resources
Director of Planning and Contracting
Head of Strategy & Service Redesign

The Royal Wolverhampton NHS
NHS Trust

QUALITY AND RISK ASSURANCE COMMITTEE

TERMS OF REFERENCE

Trust Strategic Objectives **BAF Risks**	1. To provide our patients and staff with a safe environment 4. To progressively improve the image and perception of the Trust 5. To be in the national NHS top quartile of benchmarks 7. To be high quality educator 10. To consolidate our position as a leading Healthcare provider in a commercial environment. 2449, 2965
Meeting Purpose/Remit	The Quality and Risk Assurance Committee will have overall responsibility for the effective implementation of the Integrated Governance Strategy and related policies. The Committee will ensure that all statutory elements of quality [clinical] and corporate governance are adhered to within the Trust.
Responsibilities	1. To approve the Terms of Reference and membership of its reporting subgroups (and oversee the work of the sub-groups, receiving reports for consideration and action as necessary. 2. Co-ordinate the identification of risks utilising the Board Assurance Framework (BAF)/Trust Risk register framework (TRR) to manage controls, assurances/gaps in assurance and further action. 3. Establish risk management priorities within the Trust and assign responsibilities to appropriate individuals and subgroups for redress. Working in partnership with the Audit Committee to ensure the annual audit programme is linked to areas of identified risk. 4. Provide strategic direction and guidance for the development and implementation of risk management initiatives. 5. Utilise the assurance reporting processes to inform the Audit Committee and Trust Board on the management of risk, assurance and gaps in assurance. 6. To integrate and hold a joint annual meeting with the Audit Committee providing a combined recommendation to Trust Board. 7. To make recommendations to the Audit Committee concerning the annual programme of Internal Audit work, to the extent that it applies to matters within these Terms of Reference. 8. Review the Integrated Governance strategy and monitor its delivery (along with Risk management policies OP10) across the Trust including Divisional compliance with Governance and Risk processes and outcomes (via Divisional agreement). 9. To review the Annual Governance Statement together with any accompanying Head of Internal audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.

	10. To review the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the Governance statement disclosure. 11. To review the Annual Quality Account before submission to the Board ensuring it is consistent with the quality and risk priorities of the Trust. 12. To review the Annual Audit plan before submission to the Board ensuring it is consistent with the audit priorities of the Trust. 13. Review reports on the operation of education systems and processes. 14. Review assurance reporting mapped to the achievement of the Trust Corporate objective for education. 15. Seek assurance on the appropriate use of Education funding and management of funding streams. 16. Maintain an issues log to manage reports and lines of inquiry to obtain assurance. 17. Review the BAF and TRR at each meeting to advise the Trust Board on the observed effectiveness of controls, actions and assurances. 18. Review Divisional risk registers to receive assurance on the local management of risks and or addition of new risks identified by the Committee. 19. Monitor and advice the Trust Board on performance against the domains of Quality, Safety, Effectiveness and Patient Experience. 20. Review new and existing risks extrapolated from reports enabling appropriate management/escalation to Division Risk register/Trust Risk Register/ BAF and the Trust Board. 21. Promote a culture within the Trust which encourages open and honest reporting of risk and an educative and supportive approach to the management of risk. 22. To monitor Trust assurances in addressing risk management trends and recurring themes. 23. To examine any relevant matters referred to it by the Board of Directors.
Authority & Accountabilities	The Quality and Risk Assurance Committee is established to evaluate and report on the operation of risk management systems and controls to the Trust Board. The Committee is authorised by the Trust Board to investigate any activity within its terms of reference obtaining independent advice if necessary. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee shall transact its business in accordance with national/local policy and in conformity with the principles and values of public service (GP01)
Reporting Arrangements	The Minutes of each Committee meetings shall be provided to the Board. The Chairman of the Committee shall provide a report of each meeting drawing to the attention of the Board any issues that require disclosure to the full Board, or require executive action. The Committee shall review reports of its subgroups (in line with agenda plan)
Membership	NED members x 2 – 3 CEO Chief Nurse

	Medical Director COO Director of HR Finance Director Director of Planning and Contracts Deputy Chief Nurse Head of Governance and Legal Services Head of Performance CCG member Divisional management members (i.e. Divisional Medical Director, Divisional Nurse, Divisional Manager) or Chair of Divisional Governance Committee
Attendance	Sub – group chairs – where indicated Specialist Leads – where indicated Head of Estates and Facilities – at indicated intervals
Chair	NED Chair
Quorum	4 members must be present consisting of an Executive Director, a Divisional management member for each Division, a central governance member.
Frequency of meetings	Bi Monthly
Administrative support	The central Governance department will provide administrative support. Agenda and papers will be circulated one week prior to the meeting.
Standards	CQC Essential Standards of Quality and Safety NHSLA Risk Management Standards Annual Governance Statement
Standard Agenda	• BAF and TRR • Divisional Risk register • Subgroup reports • Divisional Compliance/Performance (via Divisional agreement, Quality and performance indicators, Compliance reports) • Audit plan progress and outcomes • Committee issues log
Subgroups	• Quality Standards action group • Patient Safety Improvement group • Education and Training group
Date Approved	July 13
Date Review	July 14

REMUNERATION COMMITTEE

TERMS OF REFERENCE

Trust Strategic Objectives	6. Deliver services within financial allocations 2. To be the employer of choice
Meeting Purpose/Remit	1. The Committee shall be established to consider, endorse or reject matters relating to terms of service for the Chief Executive and other Executive Director posts. The Remuneration Committee will agree the framework by which the remuneration and conditions of the Chief Executive and other Executive Directors will be set. The framework will be managed by the Chief Executive, assisted by the Director of Human Resources, but will allow for the following:- a] That the Remuneration Committee will agree the parameters within which pay and conditions will be negotiated, and will be satisfied as to their affordability; b] That negotiations on pay and conditions will be led by the Chief Executive for Executive Directors and the Chairman for the Chief Executive; c] That the Chief Executive will be empowered to negotiate within the parameters set at points 9.4 [a] and 9.4 [b] of Standing Financial Instructions but will report the outcome of these negotiations to the Remuneration Committee. 2. Advice to the Remuneration Committee should include all aspects of salary, including any performance related elements and bonuses, provisions for other benefits, including pensions and cars, terms and conditions, as well as arrangements for termination of employment and other contractual terms. 3. The Remuneration Committee should be mindful that all NHS Bodies are parts of the public sector and their work, including the pay of their employees, and must be publicly defensible. 4. The Remuneration Committee should record in writing the basis for its recommendations.
Responsibilities	1. To make such recommendations on the remuneration and terms of service of the Chief Executive and Executive Directors to ensure they are fairly rewarded for their contribution to the organisation, having proper regard to the organisation's circumstances and performance and to the provision of any national arrangements for staff where appropriate. 2. To monitor and evaluate the performance of the Chief Executive and individual Executive Directors as to the corporate performance of the Trust.
Authority & Accountabilities	The Committee shall transact its business in accordance with national/local policy and in conformity with the principles and values of public service (GP01)
Reporting Arrangements	TBC

Membership	The Committee should comprise the Chairman and Non-Executive Directors. The Chief Executive should not be present for discussions about his own remuneration and terms of service, but will attend meetings of the Committee to discuss remuneration and terms of service of the Executive Directors.
Attendance	The TMC may request the presence of any senior manager/clinician to interpret/ comment on data (with notice). For the purpose of leadership development occasional shadowing at this meeting will be allowed following prior discussion and agreement with the Chair.
Chair	NED
Quorum	A Quorum shall be the Chairman and two Non-Executive Directors.
Frequency of meetings	Monthly
Administrative support	The Secretary to the Committee will be the Director of Human Resources.
Standards	Monitor Governance Framework Corporate Governance – Principles of Public Life (GP01)
Standard Agenda	TBC
Subgroups	As instigated or identified by the Committee
Date Approved	July 13
Date Review	TBC

The Royal Wolverhampton NHS
NHS Trust

STRATEGIC DEVELOPMENT COMMITTEE

TERMS OF REFERENCE

Trust Strategic Objectives	1. To provide our patients and staff with a safe environment 3. To achieve a balance between demand and capacity of services 4. To progressively improve the image and perception of the Trust 5. To be in the national NHS top quartile of benchmarks 7. To be high quality educator 8. To agree appropriate population catchment areas for RWT service 9. To develop our position as a tertiary centre 10. To consolidate our position as a leading Healthcare provider in a commercial environment.
Meeting Purpose/Remit	The Strategic Development Committee (SDC) has been established to assist the Executive Team and the Trust Board in developing, implementing and monitoring an integrated and coordinated approach to strategic development and business planning within the Trust. Its remit is to increase the Trust's overall effectiveness, promote innovation, manage risk and improve the Trust's long term plan financial, contractual and Service stability.
Responsibilities	The SDC remit is to: 1. Ensure that all Trust functions within this remit support and comply with Monitor's governance and reporting requirements; 2. Monitor and make recommendations about the effectiveness of strategic development and annual planning processes in the Trust; 3. Support the development of the Trust's Strategic Plan and its Enabler Strategies; 4. Develop, manage and review the Annual Business Planning process; ?TMC 5. Prioritise developments which support the Trust's strategic priorities and make recommendations to the Finance Committee about the allocation of capital resources; 6. Develop, manage and review the service development process; 7. Review the Trust's (current and anticipated) strategic risks and ensure that these are adequately monitored, and that appropriate mitigation is in place (or planned); 8. Determine the non-financial criteria which will be applied to the setting of priorities for proposals; 9. Review and approve business cases for service developments, making recommendations to the Trust Management Committee/Executive Team and/or the Board where cases exceed delegated limits;

	10. Ensure that the interdependencies between projects are managed effectively in order to optimise delivery of organisational objectives; 11. Ensure that appropriate programme and project management resources are in place to supporting robust and timely project planning; 12. Ensure alignment of strategic projects with the delivery of the Trust's strategic objectives and risk profile; 13. Ensure the effective planning of proposals so that they are fully ready for implementation once approved; 14. Ensure that there is appropriate stakeholder involvement and engagement in service and strategy development processes; 15. Ensure that benefits realisation planning is embedded in the proposal development process.
Authority & Accountabilities	The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee shall transact its business in accordance with national/local policy and in conformity with the principles and values of public service (GP01)
Reporting Arrangements	Quarterly report to Trust Board Quarterly report to Trust Management Committee
Membership	Chairman NED members x 2 CEO Chief Nurse Medical Director COO Director of HR Finance Director Director of Planning and Contracts
Attendance	Divisional management – where indicated Specialist Leads – where indicated Head of Estates and Facilities – where indicated
Chair	TBC
Quorum	For a meeting to be quorate all of the follow members (or their designated deputies) must be present: Chief Nurse (designated deputy name) COO (designated deputy name) Director of Finance (designated deputy name) Director of Planning and Contracts (designated deputy name)
Frequency of meetings	Quarterly
Administrative support	Administrative support will be provided by ???. Agenda and papers will be circulated one week prior to the meeting.
Standards	TBC

Date Approved	July 13
Date Review	

TRUST MANAGEMENT COMMITTEE (TMC)

TERMS OF REFERENCE

Trust Strategic Objectives **BAF Risks**	1. To provide our patients and staff with a safe environment 2. To be the employer of choice 4. To progressively improve the image and perception of the Trust 5. To be in the national NHS top quartile of benchmarks 7. To be high quality educator 8. To agree appropriate population catchment areas for RWT service 9. To develop our position as a tertiary centre 10. To consolidate our position as a leading Healthcare provider in a commercial environment. 2962, 3330, 3352, 3353
Meeting Purpose/Remit	The TMC will provide a formal platform for the major decision making process regarding clinical and non clinical operations. It informs and supports the CEO and Executive Team in delivering the Strategic objectives of the Trust. The TMC will review performance of the organisation and agree actions where required. The TMC will delegate responsibility for specific aspects of performance and management to a number of subgroups and working groups.
Responsibilities	1. The TMC will advise on and be responsible to the Trust Board on all matters relating to Trust operations. This will include responsibility for the following activities:- • Direct and monitor progress with implementation of key Trust strategies • Approval of Trust wide strategy, policies and procedures • Annual approval of the rolling 5 year service strategies for the Trust, via the Divisional structure • Approve business cases to deliver key Trust strategies and the corporate business plan which are in excess of £100,000 but below £500,000. • Monitor delivery of the service strategies for Divisions • Monitor delivery of the Trust site strategy (? Move this responsibility to Strategic Development group once commenced with a report from the group to TMC) • Monitor and redress as appropriate financial performance across operational service areas • Monitor the delivery of the Trust Nursing & Midwifery programme, ensuring effective integration into operational areas • Monitor the operational performance and implementation

	of the IM&T strategy • Receive advisory reports on the operation of governance, risk management and compliance deliverables across the Trust. • Approve annual sign off of the IG Toolkit requirements. • Receive regular updates and advice from the Finance, HR, Governance Directors to ensure effective operational integration with the following: - Policy - Strategy - Developments - National & local strategies, policies and developments - Legal issues 2. To monitor the delivery of the Trust Strategic objectives and plans. 3. Review and acts upon operational performance information including the Quality and Performance KPI/Activity Report, financial position and key governance reports. 4. Receive and comment upon service delivery change plans. 5. Review Divisional risk registers to be assured on the progressive management and identification of risks. 6. To approve the Terms of Reference and membership of its reporting subgroups and oversee the work of the sub-groups, receiving reports for consideration and action as necessary. 7. Review all reports to the Committee with a view to extrapolating risks to inform the Board Assurance Framework (BAF)/Trust Risk register or Divisional risk registers. 8. Review new/existing red and high amber risks across the Trust to inform appropriate progression and/or escalation. 9. Promote a culture within the Trust which encourages open and honest reporting of risk and an educative and supportive approach to the management of risk. 10. To examine any relevant matters referred to it by the Board of Directors or other Board Sub Committee.
Authority & Accountabilities	The TMC is authorised by the Executive Team to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee shall transact its business in accordance with national/local policy and in conformity with the principles and values of public service (GP01)
Reporting Arrangements	The Minutes of each Committee meetings shall be provided to the Board. The Chairman of the Committee shall provide a report of each meeting drawing to the attention of the Board any issues that require disclosure to the full Board, or require executive action. The Committee shall review reports of its subgroups (in line with agenda plan)
Membership	CEO (Chair) Chief Nurse (Deputy Chair) Medical Director COO Director of HR Finance Director Director of Planning and Contracts

	Head of Estates Development Divisional Medical Director x 5 Divisional Managers x 3 Heads of Nursing/Midwifery x 3 Director of Infection Prevention and Control Director of Research, Development and Innovation Director of Clinical IT Lead Cancer Clinician Members are expected to attend regularly and should not send deputies without the prior permission of the Chairman.
Attendance	The TMC may request the presence of any senior manager/clinician to interpret/ comment on data (with notice). For the purpose of leadership development occasional shadowing at this meeting will be allowed following prior discussion and agreement with the Chair.
Chair	CEO
Quorum	The Committee will be quorate when a minimum of 10 members are present and with two from: - Chair/Deputy Chair - Chief Operating Officer - Medical Director - Chief Financial Officer
Frequency of meetings	Monthly
Administrative support	The CEO secretariat will provide administrative support. Agenda and papers will be circulated one week prior to the meeting.
Standards	Monitor Compliance Framework CQC Essential Standards of Quality and Safety NHSLA Risk Management Standards Annual Governance Statement
Standard Agenda	Monthly: Performance report (Chief Operating Officer) to include feeds from new Finance and Performance Committee Divisional reports Directors' reports Finance Report (Director of Finance) to include feeds from new Finance and Performance Committee NHSLA General Standards Project Team Change Programme Board – moved to Finance and Performance Quarterly: Progress reports on site strategy Progress reports on IM&T Integrated Medical Records Committee Contracting and Commissioning – moved to Finance and Performance Director of Infection Prevention and Control report Research & Development Innovation report Cancer Report IM&T report Sustainability & Carbon Reduction Group Capital Review Group– moved to Finance and Performance

	Emergency Planning Committee Senior Nurse Strategic Group (Nursing Programme) Revalidation Steering Group Modernisation Programme Board 6 Monthly Waste Management Group Annual: Trust corporate business plan (Chief Operating Officer) Service strategy plan Divisional Medical Directors Risk escalation reports can be added from other Board subcommittees.
Subgroups	Highlights require confirmation that group still exists/ reports to TMC?? • Divisional Management Groups • Emergency Portal Group • Emergency Planning Group • Assets & Sustainability Estates Board • Senior Nurse Strategic Group • Human Resource Subgroup • Information Management & Technology • Integrated Health Records Group • Research and Development • Operational Performance Review group • Policy Group • Clinical Practices Group • Urgent Care Strategy Group • End of Life Care Strategy Group • Care of the Elderly Strategy Group • Waste Management Group • Sustainability and Carbon reduction Group • Revalidation Steering Group • Modernisation Programme Group • NHSLA Project Group Moved /changed subgroups: • Contracting and Commissioning – moved to Finance and Performance Committee • Capital Review Group - moved to Finance and Performance Committee • Change Programme Board - moved to Finance and Performance Committee • Operational Finance Committee – is now a standing Finance and Performance Committee providing a report to TMC.
Date Approved	July 13
Date Review	TBC