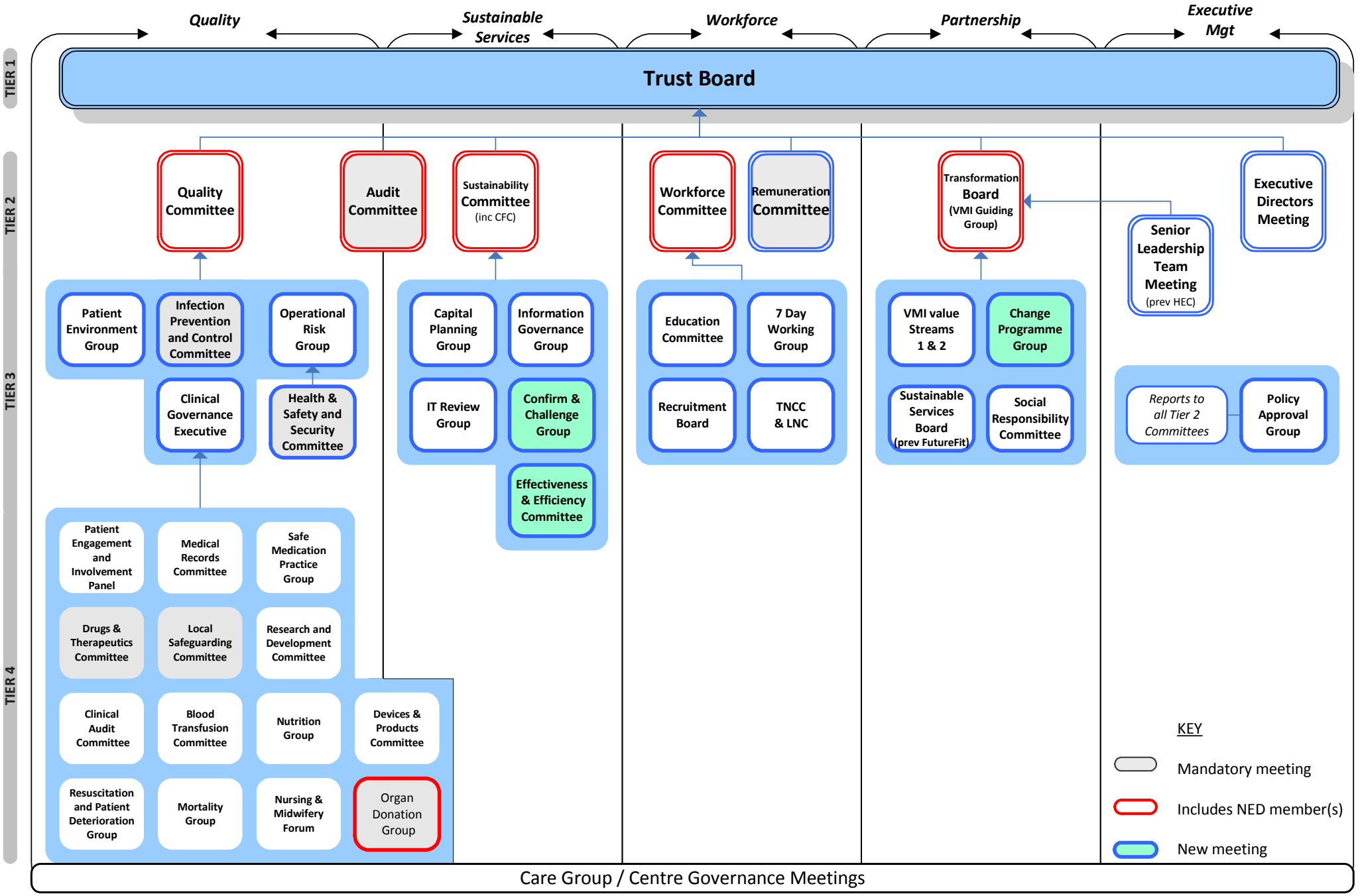
Reporting to:	**Trust Board – 28 April 2016**
Title	Committee Review
Sponsoring Director	Julia Clarke - Director of Corporate Governance
Author(s)	Tony Holt – Governance Manager
Previously considered by	Trust Board - November 2015 (Annual Review)
Executive Summary	As recommended in the *Foundation Trust Code of Governance*, the Trust Board should undertake an annual review of the Trust Board committee structure. Performance of the formal sub-committees of the Board should be periodically appraised to ensure the structure is fit-for-purpose; with clear focus on key strategic imperatives, assurance of systems, the reduction of duplication and delivery against robust plans. An annual review was undertaken as scheduled in November 2015; however in light of recent developments regarding service transformation and improvement, and changes to the Executive team, the Chief Executive felt it necessary to revise the committee structure to reflect and enable a new approach. The Trust Board will continue to receive a short written summary of key issues arising from each Committee, and draft minutes from each Committee are included in the Board members' information pack, which has been identified as best practice by external audit. ▪ **Appendix A** shows the proposed Committee structure ▪ **Appendix B** details the proposed membership of Tier 2 Committees ▪ **Appendix C** shows the Trust Board meeting dates for 2016 **Note:** Committee ToR and meeting dates are included in the Board Information Pack. Quality Committee ToR are draft and subject to further review by the Committee Chair.
Strategic Priorities 1. Quality and Safety	☒ Reduce harm, deliver best clinical outcomes and improve patient experience. ☒ Address the existing capacity shortfall and process issues to consistently deliver national healthcare standards ☒ Develop a clinical strategy that ensures the safety and short term sustainability of our clinical services pending the outcome of the Future Fit Programme ☒ To undertake a review of all current services at specialty level to inform future service and business decisions ☒ Develop a sustainable long term clinical services strategy for the Trust to deliver our vision of future healthcare services through our Future Fit Programme
2. People	☒ Through our People Strategy develop, support and engage with our workforce to make our organisation a great place to work
3. Innovation	☒ Support service transformation and increased productivity through technology and continuous improvement strategies
4 Community and Partnership	☒ Develop the principle of 'agency' in our community to support a prevention agenda and improve the health and well-being of the population ☒ Embed a customer focussed approach and improve relationships through our stakeholder engagement strategies
5 Financial Strength: Sustainable Future	☒ Develop a transition plan that ensures financial sustainability and addresses liquidity issues pending the outcome of the Future Fit Programme
Board Assurance	☒ If we do not deliver **safe care** then patients may suffer avoidable harm and poor clinical outcomes and experience

Framework (BAF) Risks	☒ If we do not work with our partners to reduce the number of patients on the **Delayed Transfer of Care** (DTOC) lists, and streamline our internal processes we will not improve our 'simple' discharges. ☒ Risk to **sustainability** of clinical services due to potential shortages of key clinical staff ☒ If we do not achieve safe and efficient **patient flow** and improve our processes and capacity and demand planning then we will fail the national quality and performance standards ☒ If we do not get good levels of **staff engagement** to get a culture of continuous improvement then staff morale and patient outcomes may not improve ☒ If we do not have a clear **clinical service vision** then we may not deliver the best services to patients ☒ If we are unable to resolve our (historic) shortfall in **liquidity** and the structural imbalance in the Trust's **Income & Expenditure** position then we will not be able to fulfil our financial duties and address the modernisation of our ageing estate and equipment
Care Quality Commission (CQC) Domains	☒ Safe ☐ Effective ☐ Caring ☒ Responsive ☒ Well led
☐ **Receive** ☒ **Review** ☒ **Note** ☒ **Approve**	**Recommendation** Trust Board members are asked to: - **REVIEW** and **APPROVE** the Committee structure - **NOTE** the membership of each Committee - **APPROVE** the Board Schedule of Business for 2016

Appendix A

SaTH Committee Structure – April 2016



Appendix B

Membership (Apr-16) – Trust Board (Tier 1) and Committees (Tier 2)

TRUST BOARD (Frequency: at least bi-monthly. Admin: Sarah Mattey)

Prof P Latchford	Chair
Mr H Darbhanga	Non Executive Director
Mr C Deadman	Non Executive Director
Dr R Hooper	Non Executive Director
Mrs D Leeding	Non Executive Director
Mr B Newman	Non Executive Director
Dr S Walford	Non Executive Director
Mrs S Bloomfield	Director of Nursing & Quality
Dr E Borman	Medical Director
Mrs D Kadum	Chief Operating Officer
Mr N Nisbet	Finance Director
Mr S Wright	Chief Executive
In attendance	
Mr P Cronin	Non Executive Director (Associate)
Mrs J Clarke	Director of Corporate Governance (as Company Secretary)
Miss V Maher	Workforce Director
Quoracy	*One ED (or deputy), one NED and one-third of Board*

CORPORATE TRUSTEES (Frequency: at least twice per year. Admin: Sarah Mattey)

Prof P Latchford	Chair
Mr H Darbhanga	Non Executive Director
Mr C Deadman	Non Executive Director
Dr R Hooper	Non Executive Director
Mrs D Leeding	Non Executive Director
Mr B Newman	Non Executive Director
Dr S Walford	Non Executive Director
Mrs S Bloomfield	Director of Nursing & Quality
Dr E Borman	Medical Director
Mrs D Kadum	Chief Operating Officer
Mr N Nisbet	Finance Director
Mr S Wright	Chief Executive
Quoracy	*6 voting Board members or deputy, including one NED*

QUALITY COMMITTEE* (Frequency: Monthly. Admin: Louise Allmark)

Dr S Walford	Non-Executive Director (Chair)
Mr B Newman	Non-Executive Director
Mr P Cronin	Non-Executive Director
Mrs S Bloomfield	Director of Nursing and Quality
Dr E Borman	Medical Director
Mrs H Jenkinson	Deputy Director of Nursing and Quality
Mrs D Kadum	Chief Operating Officer
Mrs M Fellows	Patient Representative
Quoracy	*4 members or deputy including one NED and one Executive Director*

REMUNERATION COMMITTEE (Frequency: at least three times per year. Admin: Alison Kerr-Gold)

Prof P Latchford	Chair of the Trust (Chair)
All NEDs	
In attendance	
Miss V Maher	Workforce Director
Quoracy	*4 x NEDs*

SUSTAINABILITY COMMITTEE inc CHARITABLE FUNDS COMMITTEE (Frequency: Monthly. Admin: Amanda Young)

Mr C Deadman	Non-Executive Director (Chair)
Mr H Darbhanga	Non-Executive Director
Mr N Nisbet	Finance Director
Mrs J Price	Deputy Finance Director
tbc	Deputy Workforce Director
Mrs K Shaw	Associate Director of Service Transformation
Mrs D Jones	Care Group Director – Support Services Care Group
Mr A Tapp (interim)**	Care Group Director – Women & Children's Care Group
Mrs H Davies (interim)	Assistant Chief Operating Officer – Unscheduled Care Group
Mrs K Malpass	Assistant Chief Operating Officer – Scheduled Care Group
Quoracy	*One NED and FD/Deputy*

AUDIT COMMITTEE (Frequency: at least five times per year. Admin: Marie Devitt)

Dr R Hooper	Non-Executive Director (Chair)
Mr C Deadman	Non-Executive Director
Mr H Darbhanga	Non-Executive Director
In attendance	
Mrs J Clarke	Director of Corporate Governance
Mr N Nisbet	Finance Director
Mrs C Jowett	Head of Assurance
Mr M Owen	Deloitte LLP (Internal Audit)
Ms L Barry	Deloitte LLP (LCFS – min x2 PA)
Mr H Rohimun	Ernst & Young (External Audit)
Quoracy	*Two NEDs (and CEO annually)*

TRANSFORMATION BOARD (Frequency: Monthly. Admin: Rachel Hanmer)

Mr S Wright	Chief Executive (Chair)
Mrs C Smith	KPO Lead (Deputy Chair)
Mr N Nisbet	Finance Director
Mrs D Kadum	Chief Operating Officer
Mr E Borman	Medical Director
Mrs S Bloomfield	Director of Nursing & Quality
Mrs J Clarke	Director of Corporate Governance
Ms V Maher	Workforce Director
Mr T Fox	Deputy Medical Director
tbc	Virginia Mason Executive Sensei
Quoracy	*Three members including Chair or Deputy Chair*

WORKFORCE COMMITTEE (Frequency: Bi-monthly. Admin: Alison Kerr-Gold)

Mrs D Leeding	Non-Executive Director (Chair)
Mr P Cronin	Non-Executive Director (Associate)
Ms V Maher	Workforce Director
Mrs S Bloomfield	Director of Nursing and Quality
Mrs D Kadum	Chief Operating Officer
Mrs J Price	Deputy Finance Director
Mr T Fox	Deputy Medical Director
tbc	Deputy Workforce Director
Mrs P Dabbs	Head of OD and Transformation
Mrs C Smith	KPO Lead
Mrs J Yale	Head of Facilities
Mrs K Malpass	Assistant Chief Operating Officer Scheduled Care
Mrs H Davies (interim)	Assistant Chief Operating Officer Unscheduled Care
Mrs D Jones	Care Group Director Women and Children's Care Group
Mr A Tapp (interim)**	Care Group Director Support Services
Quoracy	*Three members or deputy (including one NED)*

SENIOR LEADERSHIP TEAM MEETING (Frequency: Monthly. Admin: Barrie Reis-Seymour)

Mr S Wright	Chief Executive (Chair)
Mr N Nisbet	Finance Director (Deputy Chair)
Mrs D Kadum	Chief Operating Officer
Dr E Borman	Medical Director
Mrs S Bloomfield	Director of Nursing & Quality
Mrs J Clarke	Director of Corporate Governance
Ms V Maher	Workforce Director
Mr M Cheetham	Care Group Medical Director: Scheduled Care
Mr K Eardley	Care Group Medical Director: Unscheduled Care
Mr A Tapp	Care Group Medical Director: Women and Children
Mr A Tapp (interim)	Care Group Medical Director: Support Services
Mr B McElroy	Care Group Director: Scheduled Care
Mrs D Jones	Care Group Director: Support Services
Mrs H Davies (interim)	Care Group Director: Unscheduled Care
Mr A Tapp (interim)**	Care Group Director: Women and Children
Mrs L Gill	Care Group Head of Nursing: Scheduled Care
tbc	Care Group Head of Midwifery: Women and Children
Mrs A Trumper	Care Group Head of Nursing: Unscheduled Care
Mr M Foster	Associate Director of Estates
Mrs J Yale	Head of Facilities Management
Dr Patricia O'Neill	Director of Infection and Prevention & Control
Mrs J Price	Deputy Finance Director
Mrs S Biffen	Deputy Chief Operating Officer
Mrs H Jenkinson	Deputy Director of Nursing & Quality
tbc	Deputy Workforce Director
Mr T Fox	Deputy Medical Director
Mr J Jones	Deputy Medical Director
Mr P Hodson	Head of Contracts
Mr J Cliffe	Chief Information Officer
Mr N Appleton	Head of IT
Mrs K Shaw	Associate Director of Service Transformation
Mrs P Dabbs	Head of OD and Transformation
Mrs C Smith	KPO Lead
tbc	Medical Education
Quoracy	*Three Directors and two Care Group representatives*

NED Leads

▪ Health & Wellbeing ▪ Whistleblowing	Mrs D Leeding
▪ Medical exclusions	Dr S Walford
▪ Security	Mr R Hooper
▪ Education and Training	Mr P Latchford
▪ Procurement	Mr B Newman
▪ Social Responsibility	Mr P Cronin

** ToR under review*

*** Mrs L Donovan commences in post Aug-16*

Appendix C

The Shrewsbury and Telford Hospital NHS Trust

FORMAL TRUST BOARD MEETINGS IN PUBLIC 2016

BOARD DATES (Thurs)	TIME	VENUES	Deadline for papers
28 April	09.30-17.30	BRIDGNORTH (Severn Centre, Highley, WV16 6JG)	Wed 20 April
2 June (Special for Accounts)	13.00-15.00	Seminar 1&2, SECC, RSH	Wed 25 May
30 June	09.30-17.30	WELSHPOOL (Town Hall)	Wed 22 June
August	NO MEETING PLANNED		
29 September	09.30-17.30	WHITCHURCH (Civic Centre)	Wed 21 Sept
1 December	09.30-17.30	LUDLOW (VENUE TBC)	Wed 23 Nov

AUDIT COMMITTEE
TERMS OF REFERENCE

1. Constitution

1.1 The Trust Board resolves to establish a Committee of the Board to be known as the Audit Committee. As a Committee of the Trust Board the Standing Orders of the Trust shall apply to the conduct of the working of the Audit Committee. The Committee is a Non Executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

2. Membership

2.1 The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than three members.

2.2 One of the members will be appointed Chair of the Committee by the Board. The Chairman of the Trust shall not be a member of the Committee.

3. Attendance

3.1 The following members of staff and partners will normally be in attendance at every meeting:

Finance Director
Director of Corporate Governance
Internal Auditors
External Auditors
The Counter Fraud Specialist will attend a minimum of two committee meetings a year.

3.2 The Chief Executive should be invited to attend and should discuss at least annually with the Audit Committee, the process for assurance that supports the Annual Governance Statement. He should also attend when the Committee considers the draft Annual Governance Statement, the draft Internal Audit Plan and the Annual Accounts.

3.3 Other Directors / managers may be invited to attend meetings particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director / Manager. The Committee has the power to co-opt, or to require to attend, any member of Trust staff, as felt necessary.

3.4 At least once a year, the Committee should meet privately with the external and internal auditors. .

3.5 The Head of Internal Audit, representative of external audit and counter fraud specialist have a right of direct access to the Chair of the Committee.

3.6 The Director of Corporate Governance will ensure that an efficient secretariat service is provided to the Committee and provide appropriate support to the Chair and Committee members

4. Quorum

4.1 A quorum shall be two Non Executive Directors.

5. Frequency of Meetings

5.1 The Committee will meet at least five times per year at appropriate times in the reporting and audit cycle. The Agenda will be circulated with papers at least 5 days before the meeting. The Trust Board, Chief Executive, external auditors or Head of Internal Audit may request a meeting if they consider that one is necessary.

6. Authority

6.1 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 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.

7. Duties

The duties of the Committee can be categorised as follows:

7.1 Governance, Risk Management and Internal Control

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

In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control-related disclosure statements (in particular the Annual Governance Statement), together with an accompanying Head of Internal Audit statement, External Audit Opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors.
- The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self certification.
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State's Directions and as required by NHS Protect (formerly NHS CFSMS).

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

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key committees (for example, the Quality and Safety Committee) so that it understands processes and linkages. However, these other committees must not usurp the Committee's role.

7.2 Internal Audit

7.2.1 The Committee shall ensure that there is an effective Internal Audit function that meets Public Sector Internal Audit Standards, 2013 and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Considering the provision of the Internal Audit service, and the costs involved.
- Reviewing and approving the annual Internal Audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the Assurance Framework.
- Considering the major findings of Internal Audit work (and management's response), and ensuring co-ordination between the Internal and External Auditors to optimise audit resources.
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.
- Monitoring the effectiveness of Internal Audi and carrying out an annual review.

7.3 External Audit

7.3.1 The Committee shall review and monitor the external auditor's independence and objectivity and effectiveness of the audit process. In particular, the Committee will review the work and findings of the External Auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit.
- Discussing and agreeing with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan,
- Discussing with the external auditors their evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
- Reviewing all external audit reports, including the report to those charged with governance, (before its submission to the Board) and any work undertaken outside the Annual Audit Plan, together with the appropriateness of management responses.

- Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

7.4 Other Assurance Functions

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

7.4.2 These will include, but will not be limited to, any review by Department of Health arm's length bodies or regulators/ inspectors (for example, the Care Quality Commission, NHSLA etc) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies etc).

7.4.3 In addition this Committee will review the work of other Committees within the Trust whose work can provide relevant assurance to the Audit Committee's own areas of responsibility. In particular this will include the Quality and Safety Committee; Workforce Committee, Finance Committee, and Risk Committee.

7.4.5 In reviewing the work of the Quality and Safety Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy itself in the narrative of the assurance that can be gained from the clinical audit function

7.5 Counter Fraud

7.5.1 The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Protect's standards and shall review the outcomes of work in these areas.

7.6 Management

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

7.6.2 The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit).

7.7 Financial Reporting

7.7.1 The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

7.7.2 The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

7.7.3 The Audit Committee shall review the Annual Report and financial statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques.
- Unadjusted mis-statements in the financial statements.
- Significant judgements in preparation of the financial statements.
- Significant adjustments resulting from the audit.
- Letter of representation.
- Explanations for significant variances.

8. Whistleblowing

8.1 The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

9. Reporting

9.1 The Committee shall report to the Board on how it discharges its responsibilities.

9.2 The minutes of the Audit Committee meetings shall be formally recorded by the Director of Corporate Governance and submitted to the Board. The Chair of the Committee shall, in summarising the recent work of the Committee, draw to the attention of the Board any material issues that require disclosure to the full Board, or require executive action.

9.3 The Committee will report to the Board annually on its work in support of the Annual Governance Statement specifically commenting on

- The fitness for purpose of the Assurance Framework,
- The completeness and 'embeddedness' of risk management in the organisation,
- The integration of governance arrangements,
- The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business
- The robustness of the processes behind the quality accounts.

9.4 The Annual Report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

10. Administrative Support

10.1 The Committee shall be supported by the Director of Corporate Governance whose duties in this respect will include:

- Agreement of agendas with Chair and attendees
- Preparation, collation and circulation of papers in good time
- Ensuring that those invited to each meeting attend

- Ensuring minutes are taken at the meeting and helping the Chair to prepare reports to the Board
- Keeping a record of matters arising and issues to be carried forward
- Arranging meetings for the Chair – for example with the internal / external auditors for local counter fraud specialist.
- Maintaining records of members' appointments and renewal dates etc
- Advising the Committee on pertinent issues/ areas of interest / policy developments
- Ensuring that action points are taken forward between meetings
- Ensuring that Committee members receive the development and training they need.

11. Review

The Terms of Reference will be reviewed annually.

The Shrewsbury and Telford Hospital NHS
NHS Trust

QUALITY COMMITTEE
TERMS OF REFERENCE

1. Constitution

1.1 The Trust Board resolves to establish a Committee of the Board to be known as the Quality and Safety Committee. As a committee of the Trust Board, the Standing orders of the Trust shall apply to the conduct of the working of the Quality and Safety Committee.

2. Membership

2.1 The Committee shall be appointed by the Chairman of the Trust and shall comprise the following:

3 Non-Executive Directors
Medical Director
Director of Nursing and Quality
Deputy Director of Nursing and Quality
Chief Operating Officer
Patient Representative

2.2 The Committee will be chaired by a Non-Executive Director on the Committee nominated by the Trust Chairman. In the absence of the nominated Chairman, another NED member shall be elected chairman by the other members of the Committee.

3. Attendance

3.1 All other members of the Trust Board shall be entitled to attend and receive papers to be considered by the Committee, as agreed with the Committee Chair. If unable to attend a meeting, the Directors may be represented by a nominated deputy, but this must be agreed before the meeting with the Committee Chairman. It is expected that a member or their nominated deputy will normally attend for a minimum of 80% of meetings in a year.

3.2 Other managers/staff may be required to attend meetings depending upon issues under discussion with the prior approval of the Committee Chairman. The Committee has the power to co-opt, or to require to attend, any member of Trust staff as necessary, and to commission input from external advisors as agreed by the Chair. The Directors may be represented by a nominated deputy, but this must be previously agreed with the Committee Chairman

3.3 The Director of Nursing and Quality's Executive Assistant will ensure that an efficient secretariat service is provided to the Committee. Namely :

- that Directors are aware fully of their responsibilities in the delivery

of reports in sufficient time to allow meeting papers to be circulated within the defined timescales.
- that Directors are reminded that papers not circulated in time may not be considered at the meeting.
- To manage the action summary and matters arising to ensure their timely follow through.

4. Quorum

4.1 A quorum will consist of 4 members, including 1 Non-Executive Director and 1 Executive Director.

5. Frequency of meetings

5.1 The Committee will normally meet monthly and not less than 6 times per year.

5.2 The Agenda will be circulated with papers at least 3 working days before the meeting. The Agenda will be approved by the Committee Chairman prior to circulation. Requests for non-routine agenda items are to be forwarded to the Committee Chairman normally at least 10 working days prior to the meeting.

5.3 Additional meetings may be held at the discretion of the Chairman of the Committee.

6. Authority

6.1 The Committee has responsibility for leading the Quality Governance Framework and ensuring the Committee receives quarterly updates from the Chief Nurse and prospective processes are in place for validating assurances.

6.2 The Committee is authorised by the Trust Board to investigate any Trust activity within its Terms of Reference and is expected to make recommendations to the full Trust Board. 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.

6.3 With prior consent from the Trust Chairman the Committee Chair is authorised to obtain outside legal or other independent professional advice, and to secure the attendance of others from outside the Trust with relevant experience and expertise, if it considers it necessary. This authority will only be used in exceptional circumstances.

6.4 The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

7. Duties and responsibilities

7.1 The Committee will ensure that the Trust has appropriate and effective systems in place that cover all aspects of Clinical Quality and Safety to include the following:

- To ensure that the Trust fulfils its obligations with regard to the Health Act (2009) and, specifically, with regard to the Health Service Regulations (2013), in relation to the preparation of the annual Quality Account.

- To provide assurance to the Trust Board on Clinical Quality and Safety (including Clinical Effectiveness, Patient Safety and Patient Experience).
- Utilising best practice metrics to ensure that the Trust has robust clinical governance processes that deliver safe, high quality and patient centred care.
- To drive an improvement culture to promote best practice in patient care across the domains of Quality and Clinical Effectiveness, Patient Safety and Patient Experience.
- To set clear quality performance expectations and ensure the development of high quality care and continuous improvements through innovation and other quality initiatives such as CQUIN.
- To identify and advise on quality improvement priorities, for example, by commissioning in depth reviews of service areas and receiving exception reports from QIPP workstreams and external reviews of provider services.
- To receive and ensure that the Trust acts upon external reviews from regulatory and advisory organisations.
- To ensure that Risk Screening/Quality Impact Assessments are completed for all Cost Improvement Programmes and reconfigurations of service.
- To maximise organisational learning from alert systems, organisational reviews and quality related data.
- To monitor the performance of all reporting groups, approving Terms of Reference and receiving minutes, action plans and exception reports.

7.2 Key Responsibilities for Patient Safety

7.2.1 To ensure that the Trust is meeting all regulatory and mandated care standards, with robust response and tracking processes in place to meet national alert requirements, national guidelines and relevant external quality and safety standards with a focus on patient sensitive indicators.

7.2.2. To receive an agreed level of patient safety and outcomes data which provides trends and themes from care delivery, utilising clinical metrics to uniform and analyse the range of clinical services across the Trust.

7.2.3. To advise the Trust Board, through the Board Assurance Framework and Corporate Risk Register Framework., about the level of assurance or risks as regards the standards of care provided across the range of Trust services, including actions in place to drive improvements and mitigate risks.

7.2.4. To receive and review regular progress reports for achieving and maintaining compliance against all aspects of the CQC Essential Standards of Quality and Safety and develop a Quality Assurance Framework to support the governance arrangements required as would apply for a Foundation Trust.

7.3 Incident Reporting and Investigation

7.3.1 To monitor the effectiveness of the Trust's systems for reporting and investigating Never Events, Serious Incidents (SIs), Near Misses and other incidents.

7.3.2 To review the outcomes of investigations and external inspections, ensuring that the information is presented in sufficient detail to enable failings, and positive learning points in patient care to be identified and shared.

7.3.3 To receive, review and ensure implementation of action plans and progress reports proposed by management in response to SIs, Near Misses and other incidents.

7.4 Key Responsibilities for Patient Experience

7.4.1 To receive assurance regarding the delivery of the Patient Experience strategy across the Trust, overseeing the development, implementation and monitoring of the Patient Experience Strategy and Quality Strategy and associated action plans.

7.4.2 To review the findings of Patient Surveys (NHS, external organisations and local) and ensure implementation of the related action plans.

7.4.3 To ensure that policies and guidelines relating to Patient and Public involvement are developed, agreed and implemented.

7.4.4 To monitor the effectiveness of the Trust's systems for complaints handling, and review trends and themes

7.4.5 To monitor the effectiveness of the Trust's system for patient advocacy and the encouragement of feedback from patients and relatives.

7.4.6 To receive the Complaints Annual Report.

7.4.7 To receive a patient story to be presented at the beginning of the meeting.

7.5 Key Responsibilities for Clinical Effectiveness

7.5.1 To review and monitor compliance with new and existing statutory and accreditation standards and legislative requirements in relation to quality and consider recommendations for the timely implementation of guidance.

7.5.2 To review the Quality Dashboard and consider the information contained therein to ensure that assurance is received on all quality and safety of patient care matters.

7.5.3 To review assurances received on clinical practice and be advised of the progress of any major quality initiatives in the Trust.

7.5.4 To receive updates on outcomes being improved in the Trust, eg Patient Reported Outcome Measures (PROMs).

7.5.5 To review the effectiveness of the Trust's arrangements for the systematic monitoring of mortality.

7.5.6 To receive Clinical Audit reports and the action plans related to these.

7.5.7 To review learning from external visits and ensure all necessary recommendations have been implemented to improve the safety and quality of care.

7.5.8 To receive updates on Trust participation in national confidential enquiries, ensuring consideration of relevant recommendations and appropriate implementation arising from reports.

7.5.9 To receive and comment on exception reports for the implementation and compliance with National Institute for Clinical Excellence (NICE) guidance, and other national guidance.

7.5.10 To review compliance and responses to National Patient Safety Alerts (NPSA) ensuring completion of actions.

7.6 **Key Responsibilities for the Quality Agenda**

7.6.1 To ensure that there are robust systems in place for the production of an annual Quality Account.

7.6.2 To agree the Quality priorities of the Trust following the necessary consultation with Staff, external organisations and representatives from the local population and, in due course, the FT Governors.

7.6.3 To receive a quarterly report on the Quality priority targets prior to reporting progress to the Trust Board.

7.6.4 To ensure that there are systems in place to ensure that External Audit undertake an assurance exercise of the Quality Account and that action is taken with regard to any recommendations that result from this exercise.

8. **Reporting**

8.1 The Quality and Safety Committee reports to the Trust Board. The Committee Chairman shall report formally to the Board on its proceedings after each meeting on all matters within its duties and responsibilities.

The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed or where it has significant concerns.

8.2 The Committee receives assurance from the following working groups:

- Clinical Governance Executive
- Infection Control Committee
- Patient Experience and Involvement Panel
- Clinical Audit Committee

8.3 The draft minutes of the Committee shall be circulated to Committee members within 5 working days of the subsequent meeting and presented at the Trust Board following their approval.

9. **Review**

9.1 The Terms of Reference of the Committee shall be reviewed by the Trust Board at least annually.

Terms of Reference
Senior Leadership Team Meeting

Constitution and Purpose

The Board hereby resolves to establish a Committee of the Board to be known as the Senior Leadership Team [SLT] (referred to herewith as The Committee).

The primary purpose of the Committee is to ensure, on behalf of the Board, a high performing organisation with an effective and coherent strategy that aims to be at the heart of expert and compassionate healthcare and that is owned and delivered throughout the organisation.
It has delegated powers to:

- Implement the delivery of the Trust's Operating Plan and other duties as delegated by the Trust Board.
- Ensure the hospital is run effectively and efficiently.

The Committee will be required to adhere to the Standing Orders of the Trust.

Membership

The Chief Executive will be the Chair of the Committee, with the Finance Director acting as Chair in their absence.

Core members or their nominated deputy are expected to attend a minimum of 75% of meetings in a year:

Chief Executive (Chair) Finance Director (Deputy Chair) Chief Operating Officer Medical Director Director of Nursing & Quality Director of Corporate Governance Communications Director Workforce Director	Directors
Care Group Medical Director: Scheduled Care Care Group Medical Director: Support Services Care Group Medical Director: Unscheduled Care Care Group Medical Director: Women and Children Care Group Director: Scheduled Care Care Group Director: Support Services Care Group Director: Unscheduled Care Care Group Director: Women and Children Care Group Head of Nursing: Scheduled Care Care Group Head of Midwifery: Women and Children Care Group Head of Nursing: Unscheduled Care	Care Group Medical Directors / Care Group Managers/Care Group Heads of Nursing

Associate Director of Estates Head of Facilities Management Director of Infection and Prevention & Control Deputy Finance Director Deputy Chief Operating Officer Deputy Director of Nursing & Quality Deputy Workforce Director Deputy Medical Director x 2 Head of Contracts Chief Information Officer Head of IT Associate Director of Service Transformation Head of OD Virginia Mason Lead (KPO) Medical Education (tbc)	Other Senior Managers

Distribution of Papers and Attendance by Invitation:
The papers of the meeting are also sent to the following individuals, who are notified by the relevant SLT Member of agenda items requiring their attendance:

Role	Invited by
• Clinical Directors	Care Group Medical Director
• Head of Assurance • Head of Legal Services	Director of Corporate Governance
• Chief Pharmacist • Head of Therapies • Head of Radiology • Head of Pathology	Care Group Director: Support Services
• Associate Directors of Nursing	Director of Nursing & Quality

Quorum

For the Committee to be quorate, it requires the presence of a minimum of three Directors together with two Care Group Representatives.

Attendance

It is expected that this Committee is prioritised as an essential meeting. Apologies are accepted only in the case of annual leave and in such cases members should appoint one suitable deputy to represent them at meetings they cannot attend. Deputies must attend all meetings when core members are not available. It is expected that a core member will attend for a minimum of 75% of meetings in a year, with their nominated deputy attending where required to ensure full attendance from all areas across 100% of meetings in a year.

Frequency

The Committee shall meet twice monthly, and a minimum of 9 times per annum.

Additional meetings may be held at the discretion of the Chair.

Authority

The Committee has delegated powers from the Trust Board to provide leadership, deliver performance and ensure necessary actions are taken to correct any deviations from plans.

Duties

Decision Making	▪ To take such decisions as are delegated by the Trust Board. ▪ To be responsible for planning, organising, directing and controlling the organisation's systems and resources to achieve service objectives and quality development through implementation of the Trust's Operating Plan. ▪ To approve and recommend to the Board, and monitor the implementation of, relevant Trust Policies, guidelines and protocols.
Leadership and Advisory	• To implement the Trust's strategic objectives and reinforcing the Trust's leadership model
Co-ordination and Monitoring	• To co-ordinate the significant programmes of work prioritised by the Trust Board and to provide progress reports to the Board on the status of the agreed programmes. • To ensure that the organisation's objectives and standards for service, high level performance and quality set by the Trust Board, are managed and cascaded throughout the entire organisation. • To focus only on those areas that have cross-organisational impact and co-ordinated action and decision-making is required beyond an individual directorate.
Values and Behaviours	• To be relentless in pursuit of the patient's interests, supporting a fully engaged organisation that is action-orientated and embraces constructive challenge. • To demonstrate that we are living the Trust's values

Reporting from the Committee
The Committee will be directly accountable to the Transformation Board.

The Chairman of the Committee will report on the proceedings of each meeting to the next meeting of the Trust Board and will draw to the attention of the Transformation Board any matters of concern.

Reporting arrangements to the Committee
The following groups will report to SLTM:
- Information Governance Group
- IT Review Group
- Executive Directors decisions (for information)

Support to the Committee
The Committee will be minuted and co-ordinated by the Trust's Senior Leadership Team Meeting Secretary. The Agenda will be approved by the Meeting's Chair.

Review

The Terms of Reference will be reviewed by the Trust Board at least annually.

Version 3.0, 12 April 2016

THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

Terms of Reference

Sustainability Committee

Constitution

The Trust Board resolves to establish a Committee of the Board to be known as the Sustainability Committee. As a Committee of the Trust Board, the Standing Orders of the Trust shall apply to the conduct of the working of the Sustainability Committee.

Membership

The Committee will be chaired by a Non-Executive Director, appointed by the Chairman of the Trust Board and shall comprise the following:

Two Non-Executive Directors
Finance Director
Chief Operating Officer
Director of Nursing and Quality
Deputy Finance Director
Deputy Workforce Director
Associate Director of Service Transformation
Care Group Director – Support Services Care Group
Care Group Director – Women & Children's Care Group
Assistant Chief Operating Officer – Unscheduled Care Group
Assistant Chief Operating Officer – Scheduled Care Group
Attendance when required:
Other managers/staff may be required to attend meetings depending upon issues under discussion with the prior approval of the Committee Chairman. The Committee has the power to co-opt, or to require to attend, any member of Trust staff as necessary, and to commission input from external advisors as agreed by the Chairman.

Quorum

For the Committee to be quorate, the presence of a minimum of one Non-Executive Director, one Executive Director together with three Deputies/Care Group Representatives, or their nominated deputy is required.

Attendance

Members may appoint suitable deputies to represent them. Deputies must attend when required. It is expected that a member or their nominated deputy will attend for a minimum of 75% of meetings in a year. Attendance will be monitored by an attendance matrix.

Frequency

The Sustainability Committee will normally meet monthly before the monthly Trust Board Meeting and not less than 8 times per year.

Additional meetings may be held at the discretion of the Chair.

Authority

The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference and is expected to make recommendations to the full Trust Board. 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 Trust Board to obtain outside legal or other independent professional advice, and to secure the attendance of others from outside the Trust with relevant experience and expertise, if it considers it necessary. This authority will only be used in exceptional circumstances and prior approval of the Trust Board is required.

The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

Duties

The Sustainability Committee shall undertake on behalf of the Trust Board objective scrutiny of the Trust's financial plans, major investment decisions and performance. The purpose of the Committee is to provide the Board with an objective review of the financial position and performance of the Trust and oversee the delivery of performance, including taking any decisions delegated to it. The Committee will operate at a strategic level as the Executive is responsible for the day to day operational delivery and management. Additionally, the Trust Board may request that the Committee reviews specific aspects of performance where the Board requires additional scrutiny and assurance. The key responsibility of the Committee is to provide assurance to the Trust Board on finance and performance issues utilising best practice metrics that support robust governance processes, including the following:

Strategic and Business Planning	• Consider processes for the preparation and the content of Strategic and Business Plans and Annual Revenue, Capital and Workforce Budgets, and test the key assumptions and risks underpinning such plans. • Review the Trust Annual Operating Plan and Annual Budgets before submission to the Trust Board. • Monitor performance compared with the annual Operating Plan and budgets and investigate variances. • Review and prioritise capital investment proposals within the Capital Budget. • Consider financial aspects of Business Cases for significant revenue or capital expenditure, as defined in the Trust's Standing Financial Instructions and Scheme of Delegation, prior to submission to the Board of Directors. • Consider financial aspects of Business Cases retrospectively for return on investment/benefits realisation. • Identify and evaluate opportunities for increasing activity/income from market intelligence analyses. • Review the development of the Trust's Marketing strategy • Review the development of the Trust's Financial Strategy and Long Term Financial Model. • Develop the Trust's Investment Policy and ensure that it is consistent with best practice. • Monitor the implementation of the IT strategy. • Monitor the implementation of the Estates strategy.
Financial Management	• Monitor the financial performance and workforce targets of individual Clinical Centres, as well as the complete organisation, and the proposed

	corrective actions where necessary. • Consider explanations of significant variances/deviations from Budget by Clinical Centres on a regular basis, and to consider the proposed corrective actions, their envisaged impact and the planned timescale for recovery. • Develop a strategic approach to managing Cost Improvement Programmes. • Consider the Cost Improvement Programme, including the short and medium term prospects, monitor performance against it, and consider any proposed corrective or contingency actions and make recommendations regarding this to the Board. • Consider performance against external benchmark performance targets, including those set by the Care Quality Commission, Monitor, and as agreed in legally binding contracts and the proposed corrective actions where necessary. • Ensure the development, implementation and maintenance of an effective service line accountability framework. • Consider detailed expenditure, cash flow and working capital plans and forecasts. • Consider regular financial performance reports and forecasts, focusing particularly on risks and assumptions. • Commission and consider various financial reports and analyses, as appropriate.
Legally Binding Contracts with Third Parties	• Consider regular reports of Trust performance in respect of contracts agreed with third party organisations and to take appropriate action. • Ensure that Local Delivery Plans and contracts with Clinical Commissioning Groups (CCGs) and other bodies are determined, managed and delivered.

Charitable Funds	• To be accountable to the Corporate Trustee and ensure the on-going management of Charitable Funds is consistent with the objectives and operational framework set by the Corporate Trustee.
	• To monitor compliance against Corporate Trustee policies, procedures and plans that include:
	  • Appropriate use of Charitable Funds
	  • Appropriate sources of Charitable Funds
	  • Investment Policy
	  • Expenditure Plans
	• To advise the Corporate Trustee and monitor compliance against the requirements of the Charities Acts and Charities Commission Guidance.
	• To consider the Annual Accounts and Report before submitting to the Corporate Trustee for approval.
	• To monitor compliance against relevant internal audit reports and counter fraud initiatives and to report progress to the Corporate Trustee.
	• To monitor the performance of Charitable Funds investments and report to the Corporate Trustee at least quarterly.
	• To monitor the performance of the Charitable Funds Investment Manager(s) and advise the Corporate Trustee appropriately.
	• To ensure, via the Finance Director and the Finance Department, that Charitable Funds are managed in accordance with the Trust's Standing Financial Instructions.
	• To review the financial implications on any proposal for fund raising activities that the Trust may initiate, sponsor or approve.
	• To co-ordinate and work with the Leagues of Friends, Lingen Davies and other local charities on appropriate projects/schemes.

Reporting from the Committee

The Committee will be directly accountable to the Board and will prepare a summary of the main actions/points at each meeting for presentation to the Board (plus minutes for the Board Information Pack).

Reporting to the Committee

The Committee will routinely receive the following reports:

Finance Report covering:

- Income/expenditure performance in the month and cumulatively, of the Trust.
- A reconciliation of actual performance against budget together with the proposed corrective actions.
- Balance sheet performance
- 12 month rolling income/expenditure forecast
- 12-month rolling cash forecast
- Performance against activity plans with proposed corrective actions and timescale for implementation
- Performance against contracts with local CCGs with proposed corrective actions and timescale for implementation
- Investment and charitable funds activity

Operational Performance Report covering:

- RTT
- Diagnostics
- Cancer
- A&E
- Quality Standards
- Workforce

The following groups will report to the Sustainability Committee:

- Capital Planning Group
- Effectiveness and Efficiency Group

Review

The Terms of Reference will be reviewed by the Trust Board.

Annually the Sustainability Committee will review its performance during the previous year, identify improvement measures and report its conclusions to the board.

Reviewed 26.4.16
NN/CD/AJY

Terms of Reference
Transformation Board

Constitution and Purpose
The Board hereby resolves to establish a Committee of the Board to be known as the Transformation Board.

The primary purpose of the Transformation Board is to ensure, on behalf of the Board, a high performing organisation with an effective and coherent strategy that aims to be at the heart of expert and compassionate healthcare and that is owned and delivered throughout the organisation.

It has delegated powers to:

- Implement the delivery of the Trust's Operating Plan and other duties as delegated by the Trust Board.
- Implement the Transforming Care Production System and other duties as delegated by the Trust Board.
- Ensure the Trust has an effective continuous improvement methodology and philosophy
- Ensure the hospital is run effectively and efficiently.

The Transformation Board will be required to adhere to the Standing Orders of the Trust.

Membership
The Chief Executive will be the Chair of the Transformation Board, with the Kaizen Promotion Office (KPO) Lead acting as Chair in their absence.

Core members are expected to attend all meetings in a year (as a minimum 75%).

• Chief Executive (Chair) • KPO Lead (Deputy Chair) • Finance Director • Chief Operating Officer • Medical Director • Director of Nursing & Quality • Director of Corporate Governance • Communications Director • Workforce Director • Deputy Medical Director	Directors
• Virginia Mason Executive Sensei	

Distribution of Papers and Attendance by Invitation:
The papers of the meeting are also sent to individuals, who are notified by the relevant Committee member of any agenda items requiring their attendance:

Quorum
For the Transformation Board to be quorate, it requires the presence of a KPO member.

Attendance
It is expected that this Group is prioritised as an essential meeting. Apologies are accepted only in the case of annual leave and in such cases members should appoint one suitable deputy to represent them at meetings they cannot attend. Deputies must attend all meetings when core members are not available. It is expected that a core member will attend for a minimum of 75% of meetings in a year, with their nominated deputy attending where required to ensure full attendance from all areas across 100% of meetings in a year.

Frequency
The Transformation Board shall meet on a monthly basis, and a minimum of 9 times per annum.

Additional meetings may be held at the discretion of the Chair.

Authority
The Transformation Board has delegated powers from the Trust Board to provide leadership, delivery of the transforming care programme in partnership with VMI, and ensure necessary actions are taken to correct any deviations from plans.

Duties

Decision Making	▪ To take such decisions as are delegated by the Trust Board. ▪ To be responsible for planning, organising, directing and controlling the organisation's systems and resources to achieve service objectives and quality development through implementation of the Trust's Operating Plan. ▪ To approve and recommend to the Board, and monitor the implementation of, relevant Trust Policies, guidelines and protocols.
Leadership and Advisory	• To implement the Trust's strategic objectives as required implementing the Transforming Care Production System in partnership with VMI.
Co-ordination and Monitoring	• To co-ordinate the significant programmes of work prioritised by the Trust Board and to provide progress reports to the Board on the status of the Transforming Care Production System in partnership with VMI. • To ensure that the organisation's objectives and standards for service, high level performance and quality set by the Trust Board, are managed and cascaded throughout the entire organisation. • To focus the Value Stream on those areas that have organisational priority to ensure organisational objectives are progressed.
Values and Behaviours	• To be relentless in pursuit of the patient's interests, supporting a fully engaged organisation that is action-orientated and embraces constructive challenge. • To demonstrate that we are living the Trust's values

Reporting from the Transformation Board
The Transformation Board will be directly accountable to the Trust Board.

The Chairman of the Transformation Board will report on the proceedings of each meeting to the next meeting of the Trust Board and will draw to the attention of the Trust Board any matters of concern.

Reporting arrangements to the Transformation Board
The following groups will report to TRANSFORMATION BOARD:

- Value Stream Sponsor Teams
- Senior Leaders Team

Support to the Transformation Board
The Transformation Board will have outcomes taken by the Chair and distributed by the Trust's KPO Administrator.
The Agenda will be approved by the Chair.

Review
The Terms of Reference will be reviewed by the Trust Board at least annually.

Version 1: 07.04.16

Terms of Reference

Workforce Committee

Constitution

The Workforce Committee reports to Trust Board, the Committee will be required to adhere to the Standing Orders of the Trust.

Membership

The Committee will be chaired by a Non-Executive Director, appointed by the Chairman of the Trust Board and shall comprise the following:

2 Non Executive Directors
Workforce Director
Director of Nursing and Quality
Chief Operating Officer
Deputy Finance Director
Deputy Medical Director
Deputy Workforce Director
Head of OD and Transformation
KPO Lead
Head of Facilities
Assistant Chief Operating Officer Scheduled Care
Assistant Chief Operating Officer Unscheduled Care
Care Group Director Support Services
Care Group Director Women and Children's Care Group
Attendance when required: Other managers/staff may be required to attend meetings depending upon issues under discussion with the prior approval of the Committee Chairman. The Committee has the power to co-opt, or to require to attend, any member of Trust staff as necessary, and to commission input from external advisors as agreed by the Chairman.

Quorum

For the Committee to be quorate, the presence of a minimum of one Non-Executive Director, One Director together with three Deputies / Representatives.

Attendance

Members may appoint suitable deputies to represent them. Deputies must attend when required. It is expected that a member or their nominated deputy will attend for a minimum of 75% of meetings in a year. Attendance will be monitored by an attendance matrix.

Frequency

The Workforce Committee shall meet monthly before Trust Board Meeting and not less than 8 times a year. Additional meetings may be held at the discretion of the Chair.

Authority

The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference and is expected to make recommendations to the full Trust Board. 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 Trust Board to obtain outside legal or other independent professional advice, and to secure the attendance of others from outside the Trust with relevant experience and expertise, if it considers it necessary. This authority will only be used in exceptional circumstances and prior approval of the Trust Board is required.

The Committee has no executive powers other than those specifically delegated in these Terms of reference.

Duties

The Workforce Committee shall undertake on behalf of the Trust Board objective scrutiny of the Trust's Workforce plans and performance. The purpose of the Committee is to provide the Board with an objective review of the workforce position and performance of the Trust and oversee the delivery of performance, including taking any decisions delegated to it. The Committee will operate at a strategic level as the Executive is responsible for the day to day operational delivery and management. Additionally, the Trust Board may request that the Committee reviews specific aspects of performance where the Board requires additional scrutiny and assurance. The key responsibility of the Committee is to provide assurance to the Trust Board on workforce issues utilising best practice metrics that support robust governance processes, including the following:

- Effectiveness of the Trust's People Strategy
- People Performance
- Organisational Development Plan
- Workforce Planning and Transformation
- Education and Training
- Staff Experience and engagement
- Recruitment and Retention
- Leadership
- Cultural Development
- Staff Health and Wellbeing

Reporting from the Committee

The Committee will be directly accountable to the Board and will prepare a summary of the main actions/points at each meeting for presentation to the Board (plus minutes for the Board Information Pack).

The Chairman of the Committee will report on the proceedings of each meeting to the next meeting and will draw to the attention of the Trust Board any matters of concern.

Reporting to the Committee

The groups/committees reporting to the Workforce Committee will be

- Integrated Education Committee
- Medical Education Committee
- 7 Day services
- Trust Negotiation and Consultation Committee
- Local Negotiation Committee

Review

The Terms of Reference will be reviewed by the Trust Board annually.

Reviewed 22.4.2016
VM