Integrated Governance Guide

Supporting high-quality governance standards for our colleagues and their teams

better lives, together
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1. Foreword by our Chief Executive

Welcome to our Integrated Governance Guide.

This document draws together, in one place, key information that all of us will find useful about how our governance systems and processes operate across the Trust. Whilst not exhaustive, it should give you a firm foundation in how we wish to work together across areas such as risk management, performance management, and quality governance. It also provides some standardised templates that will help teams to develop a consistent approach to their meetings and recording of actions that ultimately will help to improve patient care. By using this guide, we can all contribute towards achieving our vision of connecting people to the best quality care, where and when they need it and be a national role model as an employer.

Brent Kilmurray
Chief Executive

2. Introduction

This guide is designed to support staff, managers, the Board of Directors and Council of Governors in the understanding and application of the Trust’s governance arrangements. It describes a framework that fosters and embeds a culture of excellence in clinical practice to enable the delivery of safe and high-quality care to our service users.

The benefits of effective governance can be summarised as:

- providing clear escalation routes for staff to safely report risks and concerns;
- understanding and empowering accountability within the work that we do;
- providing clarity about decisions that have been made, by whom, when, and why;
- improving clinical effectiveness, communication and ultimately patient experience; and
- promoting values and behaviours that the whole Trust can embrace.
The primary purpose of the NHS, and everyone working within it, is to provide a high-quality service, free at the point of delivery, to everyone who needs it. This common goal unites all those working within the NHS, from health care professional through to non-clinical colleagues.

The Trust’s vision is to connect people to the best quality care when they need it, and to be a national role model as an employer. We can only achieve our vision if we continually improve the quality of our services in a measured way. To support improvement and deliver high quality and safe care it is important for effective governance arrangements to be in place.

Effective governance is fundamental to the success of our Trust. The aim of effective governance is to provide the Board of Directors with assurance that there is effective and high quality management that is operating consistently throughout our Trust.

4. How is governance applied in practice

As an NHS organisation, the Care Quality Commission (CQC) is one of our Trust’s independent regulator. Established as part of the Health and Social Care Act 2008, the CQC hold this role for health and social care in England. They ensure health and social care services provide people with safe, effective, compassionate, high-quality care. The CQC’s framework is based on five domains: safe; caring; responsive; effective; and well-led. They set out what good and outstanding care looks like, which supports the principles of good governance practice within organisations.

Our other independent regulator is NHS Improvement. They are responsible for overseeing NHS foundation trusts, NHS trusts and independent providers, helping to give service users consistently safe, high quality, compassionate care within local health systems that are financially sustainable.

Good governance should:

- be routine and form part of our daily work;
- support our strategies being embedded within our policies and procedures;
- allow meetings to operate effectively and efficiently; and
- provide a line of sight from services (both non-clinical and clinical) through to the Board of Directors.
5. Living our Trust values

With good governance processes in place, we can support our colleagues, whilst assuring the public and patients, that our Trust is operating effectively, efficiently and safely. At the same time, it helps us deliver our four strategic goals, as outlined over the page.

The creation of our five-year strategy was done in partnership with a variety of stakeholders, including members of staff. The values we hold are complementary to the NHS Constitution principles. They are simple and transparent and will be supported by having good governance processes in place. By doing this, we can be assured that our Trust is operating safely and to the highest standards possible.
6. Statutory and regulatory framework

As a foundation trust, we must ensure that governance arrangements comply with several statutory, regulatory and best practice requirements. They are set out in a variety of documents, including:

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<td>Establishes the principles and values of the NHS in England. It sets out the rights and pledges we are entitled to and how we will achieve delivery of them.</td>
<td>Sets out the statutory basis for the governance arrangements of our Trust. It also establishes the regulatory framework the Trust must operate.</td>
<td>Sets out the overarching governance arrangements of our Trust. It incorporates the scheme of delegation, and standing orders.</td>
<td>NHS providers must hold a licence. Within the licence is several obligations the Trust must adhere to. Failure to comply with the licence provisions can result in enforcement action.</td>
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Our Trust also adheres to the **Foundation Trust Code of Governance (Code)**. The Code is here to support us to be well-led whilst delivering effective governance which is in the best interest of the service users and their carers.

7. Accountability and well led

The NHS is accountable to the people to whom it provides a service. By being a foundation trust, we have freedom from the Department of Health and Social Care in relation to some of the decisions that are made. The concept NHS foundation trusts rests on is local accountability. We are accountable to our members and the wider public, and our Council of Governors.

Fundamental to our governance structures and roles is the chain of accountability as shown in the diagram below.
Figure 1. Your statutory duties, A reference guide for NHS foundation trust governors. Published by Monitor August 2013

Our Trust promotes an organisational culture, which is fair, open, and promotes learning. It encourages colleagues to adopt a responsive and open approach towards identifying and understanding potential risks and facilitating a way in which they can be responded to in a timely manner.

The Board of Directors sets the strategic direction of the Trust and is responsible for the quality of our services, financial performance and the culture in which staff operate.

The Council of Governors is responsible for holding the non-executive directors to account for the performance of the Board of Directors as a whole. In turn, the non-executive directors hold the Executive Management Team to account. Foundation trusts, are accountable to our members and wider public, and this is done via the Council of Governors. The governors have a role to represent the views of the Trust's members and stakeholders including wider public and partner organisations. In line with the Trust Constitution, staff automatically become members when they are recruited.

The Executive Management Team is made up of the Chief Executive, Executive Directors and Associate Directors who are accountable for their individual portfolios and strategic leadership across Trust.

The Senior Leadership Team is responsible for overseeing the Trust's operational business, including ensuring that our governance and service delivery is appropriately managed. Like the Board of Directors, they are pivotal in providing clear leadership and direction for the Trust.

7.1 Accountability of Groups

The above leadership groups also oversee and support Trust-wide committees, who have a 'parenting' role in reviewing the work of sub-groups and service-level groups. For example, the Quality and Safety Committee monitors the effectiveness of the Research and Development Group through six-monthly reviews of their performance.
Terms of reference
These outline the duties that have been delegated to the committees and groups and will require annual reporting back to their senior or ‘parenting’ committee/group so that their progress against these duties can be reviewed. Terms of Reference can be used to draw up a ‘work plan’ for the committee/group. Further information can be found on page 22.

Work plan
In order to plan the work of the committee/group across a financial year, a work plan is devised from the terms of reference of the group/committee. It will include an annual review of their terms of reference and submission of an ‘Annual Report’ (as required) to the ‘parent’ committee/group. Further information can be found on page 22.

Annual effectiveness review
As part of their work plan, the most senior groups/Board committees will each undertake a formal and rigorous annual evaluation of their own performance. This will aim to show whether each group/committee continues to contribute effectively and serve as an opportunity to measure performance against terms of reference and work plan. Further information can be found on page 24.

8. Roles

Every member of staff is responsible for undertaking work that is in the best interests of service users and their carers, whilst contributing to the delivery of one or more of the Trust’s four strategic goals.

The Chair of the Trust is responsible for the leadership of the Board and is pivotal in the creation of the conditions necessary for good governance and overall Board and individual director effectiveness, both inside and outside of the boardroom. The Chair’s role is non-executive and is not involved in the day to day running of our Trust, but ensures that our Trust has the vision, strategy and resources in place to deliver our strategic vision. The Chair is also responsible for leadership of the Council of Governors, ensuring that governors understand their role and have the resources information and knowledge necessary to discharge their duties.

The Chief Executive (CEO) is responsible for the day-to-day leadership and management of the Trust, in line with regulatory requirements and the strategy and objectives approved by the Board. As Accounting Officer, the CEO has a personal responsibility to Parliament for the overall performance and conduct of the Trust. The CEO may make decisions in all matters affecting the Trust’s operations, performance and strategy with the exception of those matters reserved for the Board or Council of Governors, or specifically delegated by the Board to its sub-committees.

The non-executive directors provide independent support, advice, constructive challenge and other specialist skills to the Trust and the Board. They are responsible for monitoring and ultimately holding to account the executive management of the organisation, attending Board and Committee meetings amongst a range of other duties. As identified in the chain of accountability, they are accountable to the Council of Governors for fulfilling the remit of their role.
9. The Board of Directors and governance structures

9.1 Key governance structures across the trust – plan on a page

The key governance meetings do not operate in isolation but have integrated relationships depending on the assurances provided. The diagram below maps out on one page the key governance meetings operating at Board, Governor, Committee and SLT level. Underneath this is a series of Care Group and Corporate Directorate level meetings, which in turn address appropriate quality and safety, finance, estates, IT, HR and other organisational issues.

(Image being updated to include the Charitable Funds Committee and amendments to the SLT sub-groups)
9.2 Board of Directors

The Trust is led by a Board of Directors which seeks to exercise it functions effectively, efficiently and economically. It is a unitary Board consisting of a Chair, Non-Executive Directors, Chief Executive and Executive Directors. Further information about all Board members is included below.

The role of the Board is to:

- set the overall strategic direction of the Trust;
- regularly monitor performance against agreed goals;
- provide effective financial stewardship through value for money, financial control and financial planning;
- ensure that the Trust provides high quality, effective services; and
- promote good communications with the people we serve.
To support the Board to undertake their role effectively, the Trust has various mechanisms in place to support the flow of information. This includes a delegated corporate governance framework involving six Board Committees with delegated authority as shown in the diagram below. Terms of reference of each of the Board Committees can be found here [insert hyperlink].
9.3 Council of Governors

The Trust also has in place a Council of Governors consisting of fifteen public, five staff and seven Appointed Governors. The Governing body has two main duties as set out below:

- represent to the Trust the interests of the membership, our staff, partner organisations within the local health economy and the wider community served by the Trust; and
- hold the Non-Executive Directors to account for the performance of the Board, including ensuring the Trust is acting within the terms of its operating licence.

Terms of reference of Council of Governor groups can be found here [hyper link to be inserted] and the Council of Governors’ own assurance structure is set out below.

9.4 Operational Management structures – Assurance routes and Senior Leadership Team

The Senior Leadership Team (SLT) comprising Directors, Deputy Directors and Heads of Professions meets weekly to oversee strategy, business delivery and quality and performance issues. Its key responsibilities are to:

- oversee and be accountable for Trust business;
- ensure appropriate management of Trust governance and service delivery;
- make timely decisions on key items of business;
- provide clear leadership and operational direction for the Trust; and
- ensure delivery on plans, programmes, objectives and performance requirements
There are a number of other high-level assurance groups that report into SLT, on an exception basis, as shown below. Other meetings across the Trust (e.g. local quality and governance groups, report into and area accountable through these senior management groups that are led by Executive Directors.

A description of what each group does can be found here [insert hyperlink of terms of reference].
9.5 System-wide governance structures

The Trust is also involved in system-wide discussions that can affect the provision of local services. Our Chair, Chief Executive and Executive Directors are actively involved in discussions across the following areas, which aim to deliver services differently across our local area and more widely across West Yorkshire:

- West Yorkshire and Harrogate Health and Care Partnership
- West Yorkshire Mental Health Service Collaborative
- local Health and Care Partnerships across both Bradford, and Airedale, Wharfedale and Craven areas

10. Escalation, assurance, and effective flow of information

The purpose of escalation is to effectively share information. It also ensures that the necessary help and support is provided to resolve issues. It is also important for senior staff and the Board to be appropriately briefed on what is happening in our front-line services.

Frameworks and structures exist to support us all. They are there to help us make the right decisions, whilst sharing information appropriately across the Trust. The Trust’s meeting structure has been set-up to support the flow of information with routes and methods of escalation being embedded within the structure.

Looking at the key structures within this document will allow you to visualise how information is shared and managed throughout our Trust. It will enable you to see how it applies within your own area. The Board has a crucial role in ensuring the Trust provides safe, effective care and fulfils its statutory and regulatory obligations. To do so it needs to have in place effective internal and external sources of assurance which includes anything that negatively impacts on quality of care and identification of early warning triggers in relation to workforce, finance, and clinical services.
The value of assurance, based on robust evidence, can be further enhanced through ‘triangulation’. This involves collecting and evaluating evidence relating to a similar subject or activity from several different sources, ideally more than two (known as triangulation) and considering them together rather than separately.

Triangulation enhances our ability to confirm the accuracy and completeness of what is being presented. The examples below demonstrate how triangulation can be used and illustrate its value:

**Triangulation – use**
- visiting front line staff to determine whether data in performance reports is accurate and capturing all concerns
- considering findings from internal reviews and visits alongside papers presented at the meetings to corroborate findings
- reviewing qualitative information such as comments from service user and carer feedback and staff surveys alongside data in performance reports
- identifying potential risk areas through consideration of a range of different data simultaneously (e.g. workforce data on staff turnover, financial data on targets, quality indicators, etc)
- identifying common themes from patient safety incidents, case note reviews, audits and patient feedback

**Triangulation – value**
- indicators or metrics of quality performance are valid and reliable
- concerns about findings can be escalated
- there are detailed, credible and evidence-based findings underpinning action plans which can be delivered
- there is confidence in how Board/committee/group members work together and challenge evidence and action plans and resolve concerns
- the Board/committee/group avoids bias and undue influence
- ‘peers’ would be likely to reach a similar judgment based on the same information, in the same context

**Escalation of issues**
All members of staff have a responsibility to consider whether services are safe and when issues might need to be escalated to more senior managers for consideration/action. There are five major processes in which staff can triangulate information and trigger effective escalation to senior management:
11. Supporting systems

11.1 Risk management

There are several well-known definitions of risk including:

- the chance of something happening that will have an impact on individuals and/or organisations;
- consequence and likelihood of something going wrong;
- possibility of incurring misfortune or loss;
- likelihood of adverse consequences arising from an event; or
- the chance of something happening that will have an impact upon objectives.

Risk is measured in terms of cause/effect/consequence/impact and likelihood/probability.

Risk management is the design and implementation of relevant strategies, policies, procedures, systems and processes to limit the likelihood of a risk occurring and/or to limit its impact should it occur. Identifying, assessing analysing, understanding and acting on risk issues in order to reach an optimal balance of risk, benefit and cost.
Escalation of Risk

Set out below are the expected escalation and accountability points within the Trust dependent upon the risk score assigned.

**Audit Committee**

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<tr>
<td>• 15+ Risk Register</td>
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<td>• Board Assurance Framework</td>
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<td>• Corporate Risk Register</td>
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<td>• Seeking assurance on behalf of the Board that the processes in place for risk management are fit for purpose</td>
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<td>• Seeking assurance through committees that risk is being managed effectively at the trust</td>
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<tr>
<td>• Seeking assurance on behalf of the Board that strategic risks identified through the Board Assurance Framework are being appropriately managed</td>
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<tr>
<td>• Scrutiny and challenge of risks scoring 15+</td>
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<tr>
<td>• Holding Care Group to account for timely and appropriate management of risk</td>
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<tr>
<td>• Recommending risks for addition to BAF/CRR</td>
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<tr>
<td>• Scrutiny and challenge of risks scoring 12+</td>
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<tr>
<td>• Holding departments and services to account for effective and timely management of risk</td>
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<tr>
<td>• Ensuring the effective and timely management of risks held by the Department/Service/Ward</td>
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Individual responsibilities and reporting routes
Our Trust is fully signed up to the importance of effective risk management as a fundamental part of our governance framework and system of internal control. The identification, management, mitigation and prevention of risk should be uppermost in staff attitudes and behaviours. A responsibility rests with every Trust employee at all levels, as well as the various committees and groups previously mentioned. Staff complete IRE forms when incidents occur that help to manage risks across the organisation.

Specific committee/group responsibilities regarding risk management
Once a risk has been raised and reported, there are clearly defined routes and responsibilities to enable the risk to be mitigated on a timely basis. These routes are supported by a number of committees and groups within the governance structure.

Care group leadership teams are responsible for maintaining a systematic awareness of risks to quality and safety in order to eliminate, reduce and manage risk. This is achieved through effective use of risk registers supported by accurate performance data. Review of risk registers at individual group meetings should result in issues escalated to the ‘parent’ group or committee as appropriate, for further consideration.

The Audit Committee is responsible for maintaining oversight of the risk management process and gaining assurance that the process is being followed and remains robust and effective. The work of the Audit Committee therefore ensures local governance structures and colleagues are held to account for their actions.

The Board of Directors regularly consider strategic risks which could impact on the ability of the Trust to achieve its strategic objectives. These risks, controls and associated sources of assurance are recorded and monitored on the Board Assurance Framework and Corporate Risk Register. Alongside these, red risks (graded 15 and above) that are not at BAF or CRR level are also regularly reviewed.

The Board Assurance Framework (BAF) provides a structure and process that enables NHS organisations to focus on those risks that might compromise achieving their principle organisation goals. The risks have been grouped together around the four enabling goals within the new organisational strategy:

- to provide seamless access to the best care;
- to provide excellent quality services;
- to provide our staff with the best place to work;
- to support people to live to their fullest potential, to be as healthy as possible; and
- In additional we have a fifth enabling goal in the BAF around financial sustainability: to deliver a financially sustainable organisation.

The Corporate Risk Register (CRR) holds the key strategic risks facing the organisation and is discussed at Board, committee and SLT level. The diagram overleaf summarises where risks at different levels are managed across the organisation.
Risks are measured by multiplying the likelihood that an adverse event may occur (1-4) and the impact of that event if it occurs (1-5). Risks are managed at an appropriate level based on the overall score and whether it affects a team, department, or the whole Trust.

11.2 Performance reporting

Performance management in the Trust identifies and tracks progress against operational plan targets/milestones and is focused on continuous improvement and the delivery of the best outcomes for service users. The Trust’s performance management framework aims to provide a comprehensive understanding of how services and the organisation are performing in the domains of quality and safety, clinical and non-clinical outcomes, workforce, patient activity, finance and regulatory requirements. The Trust’s performance management arrangements include:

- the production of a suite of reports at various levels throughout the organisation which highlight variances in performance against a set of agreed performance indicators, standards and targets; and
- a range of forums where performance is reported and discussed, resulting in appropriate corrective action being agreed as necessary.

Performance management is supported by daily lean management which is being introduced across the Trust, ensuring any delivery risks or issues are identified quickly and rapid actions taken to adjust and improve performance where necessary.

11.3 The Care Trust Way

The Care Trust Way is the philosophy and way of working that enables us to best use and prioritise our resources.

The elements that make up the Care Trust Way is underpinned by our quality improvement methodology using tools, techniques, coaching and strategic programme deployment to deliver our strategic framework. The Care Trust Way is a fundamental mechanism to achieving our organisational strategy within and beyond our organisation.

Our Trust is committed to Continuous Quality Improvement and this is instrumental in the delivery of our strategic vision and the four goals that we will be delivering over the next five-years. Governance of our key programmes will adopt The Care Trust Way philosophy and develop an enabling communications structure to have accountable and supportive strategic oversight and scrutiny in place. As with our strategic vision, it is service user centred and will be used as a tool that support understanding of how systems connect whilst working together to deliver high quality results.
11.4 Service user, carer, and staff experience

Insight and feedback about the experience people have with the Trust can come from:

- people who use our services;
- someone who helps to look after a patient or service-user (who may describe themselves as carers but equally, may not);
- individuals, groups or organisations who can bring us a wider range of views including from people who may not directly connect with us; and
- members of staff, in all teams, departments, roles and services.

This information can come to us in a wide variety of ways, ranging from informal conversations, feedback direct to a service or team (e.g. letters or cards), taking part in formal feedback mechanisms (friend and family test, surveys, forums, contacts through Patient Advice and Complaints, NHS and other websites that invite feedback), or attending meetings, events etc.

This is vitally important to the ongoing developments of our Trust. Encouraging and enabling people to share their views with us, in a way that is right for them is something that every single member of staff can and should do, wherever they work and whatever their role is.

There are various reporting mechanisms that allow colleagues to review much of the feedback that has been made, and where possible, triangulate it against other data sources. Where there is no established mechanism to share the feedback you have received, this should still be shared at an appropriate level and in an effective way. If you have received some feedback that you think is important, and are unsure what to do with it, you can contact the Trust Patient Experience Team for advice. Our Trust values the importance of learning from these insights and feedback so we know what we are doing well and where we need to improve, and to support the delivery of quality improvement initiatives.

12. Providing a reporting framework for good governance and consistency in meetings

We need to ensure that our meetings are:

- effective (carry out actions);
- timely;
- attended by the right people; and
- recorded.

Paperwork that supports meetings, whether it’s an action log, reports, action notes or full minutes are often requested for review by external bodies such as the CQC, and the external auditors.

A suite of supporting templates have been produced to provide help and support for all meetings that take place in our meeting structure (clinical, directorate, operational and corporate meetings).
It covers the ‘architecture’ or framework for meetings; the agreed standards of practice and provides the templates to be used.

It doesn’t describe the behaviours expected of members in meetings. However, members and those attending should always act in accordance with the Trust’s values and seek to create a psychological safe space to challenge and feel comfortable to be challenged with the aim of achieving the right outcome for our service users and their carers.

Whilst this framework has been written for all meetings in the formal meeting structure, staff involved in local meetings (for example team meetings) should apply the good practice set out in the framework and use those templates that are applicable to ensure risks, decisions and actions are appropriately evidenced, recorded and progressed.

12.1 Overarching principles

**The Trust’s style guide**
Documentation must follow a standard format (which will be set out in the Trust’s style guide). Documents must be written in predominantly Arial size 12 font and have page numbers in the footer. You can set your version of Word to default to Arial 12 through the font drop down box using the “set as default” button. The Trust logo must also be applied in accordance with the style guide. Further information can be obtained from the Trust’s Communications Team.

**Circulation of agenda and supporting papers**
Agendas and papers must be circulated to members in good time to allow them time to prepare for the meeting. Papers should be sent out ideally five working days before a meeting, although for weekly meetings local arrangements will be determined by the Chair of those meetings. Corporate Governance meetings, namely the Board of Directors and its sub-committees; and the Council of Governors and its sub-committees, will circulate agendas and papers seven days prior to the meeting taking place.

**Verbal items and tabled papers**
Substantive agenda items must only be verbal or tabled in exceptional circumstances. It is essential that everyone who attends the meeting has time to prepare and consider what is being asked of them. Papers also provide evidence of what the rationale was for a particular decision or course of action.

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In supplying information to other committees or groups, understanding and providing firm assurance is paramount to ensuring that the information you gather, analyse and present answers the ‘so what’ question. What we have achieved or will achieve must be relevant and applicable to the Trust’s strategic priorities and must be supported by evidence-based assurance.
12.2 Documents to be used for meetings

The sections that follow (and the related appendices) set out the template documents to be used when holding a meeting:

- agenda template (appendix 1 and 1a)
- minutes template (appendix 2)
- action notes template (appendix 3)
- action log template (appendix 4)
- terms of reference template (appendix 5)
- annual work plan template (appendix 6)
- cover sheet template (appendix 7)
- assurance and escalation report to ‘parent’ committee (appendix 8)
- committee effectiveness review (appendix 9)
- annual report template (appendix 10)
- supporting papers (appendix 11 and 11a)

If more information about these is needed you can contact the Corporate Governance Team. See contact details at the end of this guide. The suite of templates is available on Connect [insert hyperlink]. Please note the term ‘committee’ as used in this document should be equally applied to any committee, group or forum etc.

**Agenda template (appendix 1)**

The agenda is the notice to members of the items that are to be discussed at the meeting. Individual agendas are built from the committee’s work schedule, action logs and any other items notified to the administrator in the period between meetings.

All agendas must, as a minimum, include the following standing items: apologies; declaration of any conflicts of interest in any agenda items to be discussed; minutes of the last meeting; matters arising; the action log; and a concluding item considering everything that has been discussed at the meeting and whether there is anything to escalate to the ‘parent’ committee.

The number of items on an agenda shouldn’t be so big that they can’t all be reasonably discussed in the time allotted for the meeting. Shorter agendas will ensure that all items are properly considered with well thought out conclusions.

The agenda is:

- drafted by the administrator of the meeting in sufficient time to allow it to be agreed by the chair of the meeting and circulated to paper authors
- required to show the date, time and venue for the meeting
- circulated to document authors in sufficient time (who may or may not be members of the committee) indicating which papers they are required to write
 ✓ sent out as part of the final meeting paperwork.

Within this guide you will see two agenda templates. One is aimed at corporate meetings, with the other for service and operational meetings. Chairs are free to use whichever template suits the needs of their meeting. The templates are here to provide the framework of what should be included within each agenda and will be personalised to the need of each individual meeting that takes place.

**Minutes template** (appendix 2)

Minutes are an official summary record of what happened at the meeting. It is important that the right type of record is made of the meeting and the chair of the meeting is accountable for deciding what the style of minute is made and ensuring they provide an accurate record.

Minutes should record:

 ✓ the context of the paper being presented
 ✓ the important points of discussion
 ✓ the rationale for the decision/s
 ✓ any challenges to the proposal/s or decision/s (including the responses made to the challenge)
 ✓ any actions agreed at the meeting (including information about what, who and by when).

Minute numbers should be expressed in a clear format that allows the reader to move between the minute document, the action log, and any other supporting paperwork that is linked to that minute.

Some minutes are internal facing, some are public facing but the quality of minutes should always be of the highest standard as they may be called on as evidence for external inspections, audits, fact finds, inquests, Freedom of Information requests etc. Their importance should not be underestimated.

Minutes of meetings are not line-for-line reporting, but they must:

 ✓ be written by the person administering the meeting within seven working days of the meeting taking place, unless the meeting is weekly then it is within two working days
 ✓ be written in the past tense (it is a record of what happened at a meeting that took place in the past)
 ✓ use professional, formal language
 ✓ include a brief outline of the context of the item / discussion so the reader understands something about the item that was discussed
 ✓ record any risks / benefits highlighted and what was being done in relation to these
 ✓ capture any challenge to the proposals / decisions
 ✓ record any actions agreed ensuring they include who is responsible for the action and when it must be completed by
 ✓ be checked by the chair of the meeting
 ✓ be circulated to members of the committee as part of the meeting paperwork for the next meeting.
It is the responsibility of the chair to check the minutes before they are presented at the next meeting. It is during the course of the meeting that they are checked for accuracy.

**Action notes template** (appendix 3)

Action notes are far less detailed than minutes. They do not capture any discussion but record only the agreed actions. These can be used for those meetings where it is not necessary to make a formal record of the discussion / challenge. It will be for the chair of the meeting to decide if formal minutes or action notes are required.

Action notes are a record of the meeting. Any actions agreed at the meeting will need to be transferred to and managed through the 'Action Log' to ensure that actions can be effectively managed, especially those with distant future dates are not lost sight of.

**Action log** (appendix 4)

Action logs are an important tool and source of evidence for committees, and those being assured of the work of the committee. Actions are captured in the minutes of the meeting; however, the action log is in a different format to the minute. The log also provides a mechanism for ensuring the committee doesn’t lose sight of those actions with completion dates set in the future.

Actions in the log may need to be brought to the attention of people who don’t normally attend the meeting. The administrative support for the meeting is usually the person who will circulate the log to members and if necessary, to others outside of the meeting who are named as action leads.

It is also the administrative support person who will capture comments from action leads between meetings and prepare the most up to date log so it can be reviewed at the next meeting. The cumulative action log should be a standing item at each meeting, so it is reviewed regularly by the committee.

A template for the cumulative action log is attached. However, committees may want to devise their own format for the log but it must as a minimum:

- be linked back to the minute and the paper on the agenda (so there is an audit trail of where the action came from)
- clearly articulate what the action is, who is responsible for completing it and by when
- show the date it was agreed so the committee can see how long it has been outstanding for
- have a column into which comments on progress or assurance about completion can be added to save time updating the action log in the meeting.

As good practice, where a particular minute has a number of actions these should be split up and each given a separate log number so each separate action can be tracked individually (this is particularly important if they have different completion dates and different leads).
Terms of reference template (appendix 5)

‘Terms of Reference’ is the name of the document that formally establishes a committee. Every committee in the Trust’s meeting structure must have this document in place. The Terms of Reference:

- clearly set out information about the committee including: membership and anyone in attendance; its position in the meeting structure; which committee it reports to and any subordinate committee that reports into it; its duties and its powers of decision making; and the minimum number of members required at the meeting to be quorate
- must be agreed by the committee itself and then ratified by the committee which acts as ‘parent’ in the meeting structure
- must be reviewed on an annual basis (at the least) by the committee to ensure the information still reflects what it was set up to do
- must be ratified by the ‘parent’ committee if there are any changes or revisions.

Annual work plan template (appendix 6)

Note: whilst the format of the template is suggested all meetings must have a work schedule in place.

Once the Terms of Reference have been agreed a work schedule should be drawn up. This is a document which assists with drawing up future agendas. It:

- plots the duties set out in the Terms of Reference across the meetings that will take place over a period of time (usually a year)
- shows both standing items that must be taken at each meeting and those that occur at particular points in the period
- should be agreed by the committee each year or if there are any significant changes to the committee’s duties during the period.

Cover sheet template (appendix 7)

The cover sheet is a way of conveying standard information about each agenda item. With the exception of the committees’ own minutes and cumulative action log, every written agenda item must have a cover sheet. The cover sheet:

- shows the title of the paper which should match the one on the agenda (or vice-versa)
- shows who is presenting the paper at the meeting and who has written the paper (these could be different people)
- should be written in plain language and be concise, define acronyms the first time they are used and avoid jargon
- must have an executive summary which sets out the key issues for consideration and be no more than 100 words. Any longer and a supporting paper will need to be written and attached to the cover sheet. (See below for details of how to prepare a supporting paper)
- clearly outlines the recommendation and what is required by the committee (see template 4 for more information on the types of recommendations you may need to use).
**Assurance / escalation process and report to ‘parent’ committee** (appendix 8)

On each meeting agenda there will be a standing item for the committee to consider whether there is anything to escalate to the ‘parent’ committee. If there is, it will be the responsibility of the chair of the reporting committee to ensure this is done.

The Assurance and Escalation Report is a high-level, one-page report designed go to the ‘parent’ committee. In proving the report the chair will be acting on behalf of the group, though the content of which will probably have been discussed at the meeting. It might be agreed that there is nothing to report, this should be agreed by the committee during the formal meeting, under the standing agenda item ‘Assurance and Escalation Report’.

The Assurance and Escalation Report will provide an opportunity to:

- give a high-level overview of the key discussion points. This sets out the points in short bullets. It is not the minute for that item, and it is not all the agenda items listed. It is just the key points discussed
- outline any decisions that were made which you want to bring to the attention of the ‘parent’ group. This will be on an exceptions basis only. You do not need to list every decision taken; you will only need to report on anything you feel is significant.
- provide an opportunity for the chair to outline any information they think should be shared with their ‘parent’ committee. Again, this would be by exception. It might, for example, include new innovations, good practice or any opportunities
- highlight any risks or concerns for escalation. This would be anything which the committee agreed should be escalated. It would include something which was identified as being outside of the remit of the committee and therefore needing to be escalated, or something that the committee was unable to resolve and needing a committee higher in the hierarchy to help resolve.
- It should also include why this matter is being escalated and what the ‘parent’ group is being asked to do.

The report is not a way of passing on responsibility. The meeting structure is designed to ensure that committees are empowered to make decisions for themselves but sometimes things are identified as being outside of the remit of the committee and therefore need to be escalated via the chair’s report.

The Assurance and Escalation Report should be completed as soon as possible after the meeting and submitted to the admin support for the ‘parent’ committee. This is so the report can go to the next available meeting and the issues kept live and current. Due to the timing of the meeting it may need to be tabled, especially if the issue is a risk or a concern.

On receipt of the report the ‘parent’ group should consider what action to take. Where the chair of the committee making the report is a member of the ‘parent’ committee they will be able to report back to their committee the outcome of the discussion. Where the chair of the reporting group is not a member of the ‘parent’ committee the chair of the ‘parent’ committee should ensure
feedback is provided to the reporting committee. This will ensure there is communication both up and then back down the meeting hierarchy.

The Assurance and Escalation Report will normally be received by the ‘parent’ committee under the governance section of the agenda.

**Committee effectiveness** (appendix 9)

All committees must take time to consider if they are still effective and what, if any, changes need to be made to the way they operate or to their duties. Any changes made will need to be reflected in the Terms of Reference which will then need to be agreed by the committee and approved by the ‘parent’ committee.

All those listed on the Terms of Reference (members and regular attendees) must be offered the opportunity to review the effectiveness of the committee. The review must be carried out on an annual basis.

This will be set out in the Terms of Reference. The outcome should be reported to the committee itself so it can evaluate the results, consider comments and ideas and take action to address any weaknesses found. The outcome should also be reported to the ‘parent’ committee via the assurance / escalation process.

**Committee Annual Report** (appendix 10)

For those committees required by their ‘parent’ committee to provide an annual report summarising its work over the course of the year, a template has been provided.

**Supporting papers** (appendix 11 and 11a)

For some items it will not be possible to convey all the information to the reader via the cover sheet, therefore a supporting paper may need to be attached to set out the information more fully.

Where a supporting paper is necessary this should be written specifically for the audience it is being presented to. You may need to re-draft a paper to make sure the focus of your paper meets the needs of the target audience.

Whilst it is not possible to design a template for every type of supporting paper that might be written, there are some standard sections that should be included in papers.
There is also information that should be considered when writing the paper. A set of helpful questions and prompts has been included in appendix 11 to assist paper authors with the writing of their paper.

The format of supporting papers must:

- ideally be no longer than four sides of A4 to ensure it remains clear and succinct for the reader and gets the message across quickly and efficiently. Only if the subject is particularly complex should it be longer than this but then by exception
- be formatted in Arial 12 point for narrative (different size font may be necessary for graphs and tables)
- have page numbers on it
- be laid out well and visually easy to read
- use plain language and be concise
- use bullets or flow charts as a way of getting across complex issues in easy ‘bite-size’ pieces of information
- define acronyms the first time they are used in the document and avoid jargon
- have the document’s author/s name and title and the date at the end of the paper.

Paragraphs should be numbered in a consistent way to help with identification of discussion points during the meeting (sub-numbering of paragraphs should be included where this is applicable).

12. Ownership of this guide and keeping it up to date

This guide will be updated every three months to reflect any changes in the Trust’s governance arrangements. It will be posted on Connect and referenced in the new starter induction programme. For further details please contact:

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