**Appendix 1A – Audit and Risk Committee Annual Report**

**Audit and Risk Committee Annual Report**

**2016/17**

1. **Background**
   1. The Committee performed its role during the year in line with the approved terms of reference, these were reviewed during the year and no amendments were made at this time, with the exception of the number of members required for the meeting to be quorate. During the year papers regarding the work of the endowments sub-committee were noted by the Committee.
   2. Members of the Audit and Risk Committee are appointed by the Board, to whom it is answerable.
   3. The Chair of the Board left the Board in March 2016; this post has been filled on an interim basis by Stewart MacKinnon previous Chair of Audit and Risk Committee. Due to the guidance for members of the audit and risk committee and the independence of the Board Chair Stewart MacKinnon has stepped down on a temporary basis from the role of Chair of the Audit and Risk Committee. The post will be filled on an interim basis by Phil Cox who is an existing member of the Audit and Risk Committee. Recruitment for the Board Chair post will commence in October 2017.
   4. Members of the Audit and Risk Committee during 2016/17 were:-

* Phil Cox (interim chair from 18 March 2016
* Kay Harriman
* Jack Rae
  1. Attendance at the meetings was recorded as follows:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **List members** | 8 November  2016 | 7 February 2017 | 18 April 2017 | 6 June 2017 |
| Phil Cox |  |  |  | Apologies noted |
| Kay Harriman | Apologies noted |  |  |  |
| Jack Rae |  |  |  | (Chair of meeting) |
| Maire Whitehead | - | - | - | (invited to attend to ensure quorate membership) |
| **Attendees** | | | | |
| Jill Young |  | Apologies noted |  |  |
| Julie Carter |  |  |  |  |
| Lily Bryson |  |  |  |  |
| Laura Langan Riach | - |  |  |  |
| PwC |  |  |  |  |
| Scott -Moncrieff |  |  |  |  |

As it is not recognised best practice the Chair of the Board does not as a matter of routine attend meetings of the Audit and Risk committee.

Due to the absence of the interim chair of the committee it was agreed that the June meeting would be chaired by another committee member. In addition to ensure the meeting was quorate it was agreed that a previous member of the committee would be invited to attend for this meeting. This is reflected in the table above.

1. **Meetings**
   1. The Audit and Risk Committee had four formal meetings relating to financial year 2016/17 during the period 1 July 2016 to 30 June 2017. The actual work programme covered a number of areas and is included as an appendix to this report. In addition a number of internal and external audit reports were considered throughout the year, these are detailed later in this report.

1. **Internal Audit Activity 2016/17 – to be updated following receipt of report from Audit** 
   1. During the year the Audit and Risk Committee considered in detail, the following reports from PricewaterhouseCoopers, Board internal auditors:

* **Health and Safety Compliance**

The overall grade of this report was Medium Risk and contained the following number of findings:

High Priority - 0

Medium Priority – 3

Low Priority – 1

All findings and recommendations were accepted.

* **Hotel Review – Staff Rostering**

The overall grade of this report was Low Risk and contained the following number of findings:

High Priority - 0

Medium Priority – 0

Low Priority – 1

Advisory - 2

All findings and recommendations were accepted.

* **Clinical Governance – Incident Reporting**

The overall grade of this report was Medium Risk and contained the following number of findings:

High Priority - 0

Medium Priority – 1

Low Priority – 5

All findings and recommendations were accepted.

* **Procurement - Fraud**

The overall grade of this report was Low Risk and contained the following number of findings:

High Priority - 0

Medium Priority – 0

Low Priority – 1

All findings and recommendations were accepted.

* **Service Review - CSPD**

The overall grade of this report was Low Risk and contained the following number of findings:

High Priority - 0

Medium Priority – 1

Low Priority – 2

All findings and recommendations were accepted.

* **Treatment Times Guarantee**

The overall grade of this report was Low Risk and contained the following number of findings:

High Priority - 0

Medium Priority – 0

Low Priority – 0

All findings and recommendations were accepted.

* **Capacity Planning**

The overall grade of this report was Medium Risk and contained the following number of findings:

High Priority - 0

Medium Priority – 1

Low Priority – 4

All findings and recommendations were accepted.

* **Quality Framework Application**

The overall grade of this report was Medium Risk and contained the following number of findings:

High Priority - 0

Medium Priority – 3

Low Priority – 3

All findings and recommendations were accepted.

* **Financial Controls: financial planning**

The overall grade of this report was xx Risk and contained the following number of findings:

High Priority - 0

Medium Priority – 0

Low Priority – 1

The findings and grading of this report have to be confirmed

Two additional pieces of work were also undertaken which are not graded in the manner above with these being:

* Property Transaction Monitoring – nil return; and
* IT Cyber Security – this will be presented separately.
  1. In addition to this work PwC also facilitated a piece of work including a May Board Innovation Risk workshop to assist in the further development of the risk management arrangements of the Board specifically looking at risk appetite and risk tolerance for innovation. Regular updates were presented to the Audit and Risk Committee.

The internal auditors produce an annual assurance report based on the work they have undertaken during the year. The Internal audit opinion which is contained in the PwC annual report is as follows: ‘Generally satisfactory with some improvements required’.

During the previous financial year, no significant control weaknesses or issues have arisen and no significant failures have arisen in the expected standards for good governance, risk management and control.

It should be noted that whilst no significant control weaknesses have been identified a small number of medium and low risk recommendations were made by internal audit; however these areas would not have an impact on the achievement of the Corporate Objectives.

1. **Work/reviews carried out by external parties**
   1. Scott Moncrieff were re-appointed as Board external auditors with 2016/17 being the first year of their new appointment.

* 1. Scott Moncrieff presented the following reports during the year:
* Annual Plan for 2016/17;
* Interim Management Report;
* Annual Report to the Board and the Auditor General for Scotland (June 2017).

* 1. Scott Moncrieff have also been appointed the external auditors for the Board Charity for the next five years. This appointment will cover additional training for Trustees, Fundholders and finance staff.

1. **Board Papers**

* 1. The draft minutes of each of the Audit and Risk Committee meetings are presented to the Board meeting. Summary outputs from each meeting are also presented to the next available Board; this allows Board Members to be appraised of any governance issues pending final approval of the minutes.

* 1. The final annual report will be presented to Board in June 2017.

1. **Risk Management**

* 1. During 2016/17 work continued to further develop our enterprise risk framework with the appointment of a Chief Risk Officer and establishing a new Strategic Risk Group. The Chief Risk Officer has been appointed on a temporary basis to ‘test out’ the role to consider if any additional resources are required to support this. The Strategic Risk Group was established in November 2016, with terms of reference approved by the Audit and Risk Committee and a work plan agreed.

* 1. The final Risk Management annual report for 2016/17 has been received at the April 2017 Audit and Risk Committee. A report on relevant risks in the Board Risk Register was also received and considered at each meeting of the committee.

* 1. At each Audit and Risk Committee meeting an update was given on counter fraud work, including investigations by the Counter Fraud Service and any work related to the National Fraud Initiative. Updates on the NFI exercise were given as information was available.

1. **Audit Scotland National Reports**
   1. The Audit Committee receives all national audit reports produced by Audit Scotland. Where another Governance Committee is more relevant to consider the report in detail, these will be referred on. Reports considered in the year include:

NHS Specific

* The 2015/16 audit of NHS 24: update on Management of an IT contract – prepared for the Auditor General (published October 2016);
* The 2015/16 audit of NHS Tayside: Financial Sustainability – prepared for the Auditor General (published October 2016);
* NHS in Scotland 2016 – prepared by Audit Scotland (published in October 2016); and
* Scotland’s NHS Workforce (current picture) – prepared by Audit Scotland for the Auditor General (published February 2017).

Non-NHS specific reports published which do not relate specifically to the Board

* Audit Scotland Annual Report and Accounts – prepared by Audit Scotland (published June 2016)
* Climate Change Plan 2015/16-2019/20 – prepared by Audit Scotland (published June 2016);
* Carbon Scrutiny Board Annual Report 2015/16 – prepared by Audit Scotland (published June 2016);
* Equalities update – prepared by Audit Scotland (published June 2016);
* Transparency and Quality annual report 2015/16 – prepared by Audit Scotland (published June 2016);
* The National Fraud Imitative in Scotland – prepared by Audit Scotland (published June 2016);
* 2015/16 Audit of the Scottish Government Consolidated Accounts – prepared for the Auditor General (published September 2016);
* Scotland’s new financial powers – prepared for the Auditor General (published September 2016);
* Equal Pay Review 2016 – prepared by Audit Scotland (published February 2017); and
* Managing New Financial Powers – an update – prepared by Audit Scotland for the Auditor General (published March 2017).

1. **Governance Reports**
   1. As part of the terms of reference for the governance committees, each committee is required to produce an annual report summarising the work of the committee during the year, with this being presented to each committee for approval and to the audit and risk committee for information. The reports are as follows:

* Audit and Risk Committee (effective)
* Clinical Governance committee (safe)
* Staff Governance/Person Centred Committee (Person Centred)
* Endowment Sub-Committee Report (reporting to the Trustees) and provide for information to the Audit and Risk Committee

* 1. In addition to the above formal reports to the governance committees, additional reports have been prepared to also inform the governance statement, with these being:
* Report on Information Governance; and
* An annual risk management report

1. **Chair’s Conclusion (Draft)**
   1. The Audit and Risk Committee continues to develop the contribution that the Committee makes to ensure the continued provision and improvement in Internal Control arrangements within the Board and, in accordance with its Terms of Reference, will seek to maintain that progress. The Audit and Risk Committee has undertaken work as per the audit plan during the year. In addition at the end of each meeting the Committee reflects on the performance of the Committee including the papers presented and the assurance provided. This has proven very effective.
   2. The Chair of the Audit and Risk Committee concludes that the Audit and Risk Committee has fulfilled its remit and considers that there are adequate and effective internal financial control arrangements in place to assure the Board of its corporate governance duties.

**Chair of the Audit and Risk Committee – Phil Cox**

**18 April 2017**

**AUDIT AND RISK COMMITTEE - TERMS OF REFERENCE (June 2016)**

1. *Introduction*

The Board has established an Audit and Risk Committee as a standing committee of the Board to support them in their responsibilities for the issues of risk, control and governance and associated assurance through a process of constructive challenge. The purpose of the Committee is to assure the Board that an appropriate system of internal control has been implemented and is working effectively. In meeting this requirement the Chair of the Audit and Risk Committee submits an annual report summarising the activities of the Committee to assure the Board that the Committee’s responsibilities are being discharged in accordance with its remit.

1. *Membership*

In order to preserve its independence from operational management, the Audit and Risk Committee does not have any executive membership. It is the only standing committee for which the Chair of the Board does not have ex-officio status.

The current membership of the committee is listed below:

* Interim Chair – P Cox (from 18 March 2016 )
* J Rae – from 1 October 2011
* K Harriman – from 30 June 2015
* To be filled following appointment of Board Chair

The committee will be provided with a secretariat function by the personal assistant to the Director of Finance. Minutes of the meeting shall be submitted to the next meeting of the Committee and thereafter submitted by its Chair to the first ordinary meeting of the Board for noting. In the interim an update on the proceedings will be submitted to the Board for information.

The committee has the right to require the attendance of any Director or member of staff, persons attending in this capacity are not entitled to a vote in the decision making process.

The committee has a number of attendees who are detailed below:

J Carter – Director of Finance (Executive Lead)

J Young – Chief Executive (Accountable officer)

L Bryson – Assistant Director of Finance

The Chair of the Board may attend but in an ex-officio capacity

Representative from PricewaterhouseCoopers (PwC) – Board Internal Auditors

Representative from Scott-Moncrieff – Board External Auditors

1. *Executive Director Lead*

The Designated Executive Lead will support the Chair of the Committee in ensuring that the Committee operates according to /in fulfilment of its agreed Terms of Reference. The named Executive Lead for the Committee is the Director of Finance. Specifically they will:

* Support the Chair in ensuring that the Committee remit is based on the latest guidance and relevant legislation, and the Board’s best value framework;
* Liaise with the Chair in agreeing a programme of meetings for the business year, as required by its remit;
* Oversee the development of the annual workplan for the Committee which is congruent with its remit and the need to provide appropriate assurance at the year-end, for the endorsement of the Committee and approval by the Board;
* Agree with the Chair an agenda for each meeting, having regard to the Committee’s remit and workplan;
* Lead a mid-year review of the Committee Terms of Reference and progress against the annual workplan, as part of the process to ensure that the workplan is fulfilled; and
* Oversee the production of an annual report on the delivery of the Committee’s remit and workplan, for endorsement by the Committee and submission to the Board.

1. *Quorum*

A quorum shall consist of three Members.

1. *Meetings*

The committee shall meet no fewer than four times per annum, with meetings schedule in line with the following timetable and detailed agreed timetable and workplan for the forthcoming financial year.

The detailed workplan will be presented to the Summer audit committee meeting and will include, as a minimum, the indicative agenda items listed below:

|  |  |
| --- | --- |
| **Audit Meeting** | **Proposed Items for Agenda** |
|  |  |
| Autumn Meeting -  Nov | * Internal audit progress Report – standing item * External Audit – update – standing item * National Fraud Initiative – standing item * Update on Shared Services – Standing item * Fraud update - Standing Item * Audit Scotland Reports – standing item * Update on Property and Asset Management Strategy – 6 month review * Amendments to SFIs if required\* * Update on Review of Enterprise Risk Framework * Board Risk Register (standing agenda item) * Review of Board Standing Orders * Review of Golden Jubilee Conference Hotel Beverage Audits |
| Winter Meeting -  February | * Internal Audit Progress Report * External Audit annual plan * External Audit – Interim management report * Update on Governance statement guidance * Fraud Update * Updated fraud policy * update on Audit Scotland reports * Procurement Strategy update * Shared Services update * Enterprise Risk update * Board Risk Register * Amendments to SFIs if required\* * Update on work on asset lives |
| Spring Meeting -  April  NB the accounting policies need to be approved prior to prep of accounts.  NB the governance statement needs to be approved prior to inclusion in accounts | * Internal Audit Progress Report * Internal Audit Draft plan for 2016/17 for approval * Internal Audit Annual Report\* * External Audit * Standing Committee Annual Reports (Draft) * Information Governance Annual Report * Risk Management Annual Report * Output from NFI\* * Accounting Policies for approval\* * Fraud update * Risk update * Board Risk Register * Governance statement for approval (to include in annual accounts)\* * update on Audit Scotland reports * Draft annual report for committee * Amendments to SFIs if required\* |
| Summer meeting –  early June | * External Audit Annual Report with opinion * Annual report and Accounts * Statement of Assurance * Final Annual Report for the committee. * Proactive fraud plan for year * ISAE3402 – financial controls assurance for National Single Instance * Any other external assurance papers Terms of Reference for committee – annual review * Work plan for committee for following year * Fraud update * Risk update * Board Risk Register * Endowments Annual Report and Accounts – for noting |

The Chair of the Committee may convene additional meetings, as is felt necessary.

Meetings will normally be attended by those identified as regular attendees in point 2 above.

The Audit and Risk Committee may ask any other official of the organisation to attend to assist it with its discussions on particular matters.

The Audit and Risk Committee may ask any or all of these who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

The Accountable Officer may ask the Audit and Risk Committee to convene further meetings to discuss particular issues on which the Accountable Officer wishes the committee’s advice, guidance or opinion.

1. *Reporting*

* The Audit and Risk committee will formally report in writing to the Board and the Accountable Officer after each meeting. This, typically, will be through the submission of Minutes of meetings but if necessary may include an additional report on individual matters of materiality.
* The Audit and Risk committee will provide to the Board and Accountable Officer with an Annual Report, timed to support the finalisation of the accounts and the Corporate Governance Statement, summarising its conclusions from the work it has done during the year.
* Where the review of the terms of reference results in amendments, the revised Terms of Reference must be submitted to the Board for formal approval.
* The committee will approve at the start of each financial year a detailed work plan for approval by the Board.
* The committee annual report will inform the submission of the statement of assurance from the Committee to the Board at year-end.

1. *Responsibilities/Remit*

The Committee has responsibility for ensuring that the Board’s activities are within the guidelines for corporate governance within the NHS and that an effective internal control system is maintained. The duties of the Audit Committee are in line with the NHS Audit Committee Handbook and are detailed below. The audit committee will advise the Board and the Accountable Officer on:

* The strategic process for risk, control and governance and the Corporate Governance Statement;
* Independent scrutiny of the arrangements and action plans for the risk management processes which are in place within the Board including review of the Board Risk Register;
* The accounting policies, the accounts, and the annual report for the organisation, including the process for review of the accounts prior to submission to audit, levels of error identified, and the management’s letter of representation to the external auditors;
* The planned activity and results for both internal and external audit;
* The adequacy of management responses to issues identified by audit activity, including external audit’s management letter/report;
* The effectiveness of the internal control environment;
* Assurances relating to the corporate governance requirements of the Board;
* Proposals for tendering for internal audit services or for the purchase of non-audit services from contractors who provide audit services;
* Anti-fraud policies, whistle-blowing processes and the arrangements for special investigations; and
* The acceptability of any proposed changes to the standing orders, the scheme of delegation and the standing financial instructions.

The audit committee will also periodically review its own effectiveness and support the results of the review to the Board and Accountable Officer.

1. *Rights*

The Audit and Risk committee may:

* Co-opt additional members for a period not exceeding a year to provide specialist skills, knowledge and experience; and
* Procure specialist ad-hoc advice at the expense of the organisation, subject to budgets agreed by the Board or Accountable Officer.

1. *Access*

The designated Chief Internal Auditor and the representative from External Audit will have free and confidential access to the Chair of the Committee. Meetings may be arranged as required at a minimum on an annual basis.

1. *Information Requirements*

For each meeting the Audit Committee will be provided with:

* A report summarising the significant changes to the organisation’s risk register;
* A progress report from the Chief Internal Auditor;
* A progress report from External Audit; and
* A report on any fraud investigations or fraud prevention activity since the previous meeting.

As and when appropriate the Committee will also be provided with:

* Proposals for the terms of reference of internal audit;
* The internal audit strategy;
* The chief internal auditor’s annual report and opinion;
* Quality assurance reports on the internal audit function;
* The draft Directors’ Report and Annual accounts;
* The draft Governance Statement;
* A report on changes to accounting policies;
* External audit’s management letter/report;
* A report on any relevant service audit reports on the controls operating around processes undertaken by another body on the Board’s behalf;
* A report on any proposals to tender for audit functions;
* A report on co-operation between internal and external audit;
* Clinical Governance and Staff Governance annual reports;
* The risk management annual report;
* A summary of any relevant Audit Scotland reports, the implications for the Board and assurances as to actions being taken;
* A report on the national fraud initiative; and
* A summary of any reports by external bodies (eg HIS) which will not be considered by any other governance committee or which contains significant the committee needs to take into account in it’s assessment of the internal control arrangements.

The above list, which is not exhaustive, is the suggested minimum requirements for the inputs which should be provided to the committee, more items may be provided as appropriate.

*June 2016*

**Work Plan 2016/17**

|  |  |
| --- | --- |
| **Audit Meeting** | **Proposed Items for Agenda** |
|  |  |
| Autumn Meeting -  Nov | * Internal audit progress Report – standing item * External Audit – update – standing item * National Fraud Initiative – standing item * Update on Shared Services – Standing item * Fraud update - Standing Item * Audit Scotland Reports – standing item * Update on Property and Asset Management Strategy – 6 month review * Amendments to SFIs if required\* * Update on Review of Enterprise Risk Framework * Board Risk Register (standing agenda item) * Review of Board Standing Orders * Review of Golden Jubilee Conference Hotel Beverage Audits |
| Winter Meeting -  February | * Internal Audit Progress Report * External Audit annual plan * External Audit – Interim management report * Update on Governance statement guidance * Fraud Update * Updated fraud policy * update on Audit Scotland reports * Procurement Strategy update * Shared Services update * Enterprise Risk update * Board Risk Register * Amendments to SFIs if required\* * Update on work on asset lives |
| Spring Meeting -  April  NB the accounting policies need to be approved prior to prep of accounts.  NB the governance statement needs to be approved prior to inclusion in accounts | * Internal Audit Progress Report * Internal Audit Draft plan for 2016/17 for approval * Internal Audit Annual Report\* * External Audit * Standing Committee Annual Reports (Draft) * Information Governance Annual Report * Risk Management Annual Report * Output from NFI\* * Accounting Policies for approval\* * Fraud update * Risk update * Board Risk Register * Governance statement for approval (to include in annual accounts)\* * update on Audit Scotland reports * Draft annual report for committee * Amendments to SFIs if required\* |
| Summer meeting –  early June | * External Audit Annual Report with opinion * Annual report and Accounts * Statement of Assurance * Final Annual Report for the committee. * Proactive fraud plan for year * ISAE3402 – financial controls assurance for National Single Instance * Any other external assurance papers Terms of Reference for committee – annual review * Work plan for committee for following year * Fraud update * Risk update * Board Risk Register * Endowments Annual Report and Accounts – for noting |

**\* - dependent on the date of the meeting some items may move between meetings**

**Other items may be added as required**

* Standing items for each meeting:
* Internal audit progress report
* External audit
* Fraud update
* Risk update
* Board Risk Register
* Audit Scotland update – reports as applicable
* NFI updates
* Update on national shared services

**Appendix 1B – Audit and Risk Committee Work Plan 2017/18**

**Work plan for 2017/18**

|  |  |
| --- | --- |
| **Audit Meeting** | **Proposed Items for Agenda** |
|  |  |
| Autumn Meeting -  Oct | * Internal audit progress Report – standing item * External Audit – update – standing item * National Fraud Initiative – standing item * Update on Shared Services – Standing item * Fraud update - Standing Item * Audit Scotland Reports – standing item * Update on Property and Asset Management Strategy – 6 month review * Amendments to SFIs if required\* * Update on roll out of Enterprise Risk Framework * Board Risk Register (standing agenda item) * Review of Board Standing Orders * Update on work on asset lives * Gifts and Hospitality Policy * Cyber update * Update on expansion programme |
| Winter Meeting -  February | * Internal Audit Progress Report * External Audit annual plan * External Audit – Interim management report * Update on Governance statement guidance * Fraud Update * Updated fraud policy * Update on Audit Scotland reports * Procurement Strategy update * Shared Services update * Enterprise Risk update * Board Risk Register * Amendments to SFIs if required\* * Update on expansion programme |
| Spring Meeting -  April  NB the accounting policies need to be approved prior to prep of accounts.  NB the governance statement needs to be approved prior to inclusion in accounts | * Internal Audit Progress Report * Internal Audit Draft plan for 2017/18 for approval * Internal Audit Annual Report\* * External Audit * Standing Committee Annual Reports (Draft) * Information Governance Annual Report * Risk Management Annual Report * Accounting Policies for approval\* * Fraud update * Risk update * Board Risk Register * Governance statement for approval (to include in annual accounts)\* * update on Audit Scotland reports * Draft annual report for committee * Amendments to SFIs if required\* * Update on expansion programme |
| Summer meeting –  early June | * External Audit Annual Report with opinion * Annual report and Accounts * Statement of Assurance * Final Annual Report for the committee. * Proactive fraud plan for year * ISAE3402 – financial controls assurance for National Single Instance * Any other external assurance papers Terms of Reference for committee – annual review * Work plan for committee for following year * Fraud update * Enterprise Risk update * Board Risk Register * Endowments Annual Report and Accounts – for noting * Update on expansion programme |

**\* - dependent on the date of the meeting some items may move between meetings**

**Other items may be added as required**

* Standing items for each meeting:
* Internal audit progress report
* External audit
* Fraud update
* Strategic Risk Committee update
* Board Risk Register
* Audit Scotland update – reports as applicable
* NFI updates
* Update on national shared services

**Appendix 1C – Audit and Risk Committee Terms of Reference 2017/18**

**NATIONAL WAITING TIMES CENTRE BOARD**

**AUDIT AND RISK COMMITTEE - TERMS OF REFERENCE**

1. *Introduction*

The Board has established an Audit and Risk Committee as a standing committee of the Board to support them in their responsibilities for the issues of risk, control and governance and associated assurance through a process of constructive challenge. The purpose of the Committee is to assure the Board that an appropriate system of internal control has been implemented and is working effectively. In meeting this requirement the Chair of the Audit and Risk Committee submits an annual report summarising the activities of the Committee to assure the Board that the Committee’s responsibilities are being discharged in accordance with its remit.

1. *Membership*

In order to preserve its independence from operational management, the Audit and Risk Committee does not have any executive membership. It is the only standing committee for which the Chair of the Board does not have ex-officio status.

The current membership of the committee is listed below:

* Interim Chair – P Cox (from 18 March 2016 )
* J Rae – from 1 October 2011
* K Harriman – from 30 June 2015
* To be filled following appointment of Board Chair

The committee will be provided with a secretariat function by the personal assistant to the Director of Finance. Minutes of the meeting shall be submitted to the next meeting of the Committee and thereafter submitted by its Chair to the first ordinary meeting of the Board for noting. In the interim an update on the proceedings will be submitted to the Board for information.

The committee has the right to require the attendance of any Director or member of staff, persons attending in this capacity are not entitled to a vote in the decision making process.

The committee has a number of attendees who are detailed below:

J Carter – Director of Finance (Executive Lead)

J Young – Chief Executive (Accountable officer)

L Bryson – Assistant Director of Finance (Governance and Financial Accounting)

L Langan-Riach – Interim Chief Risk Officer

The Chair of the Board may attend but in an ex-officio capacity

Representative from PricewaterhouseCoopers (PwC) – Board Internal Auditors

Representative from Scott-Moncrieff – Board External Auditors

1. *Executive Director Lead*

The Designated Executive Lead will support the Chair of the Committee in ensuring that the Committee operates according to /in fulfilment of its agreed Terms of Reference. The named Executive Lead for the Committee is the Director of Finance. Specifically they will:

* Support the Chair in ensuring that the Committee remit is based on the latest guidance and relevant legislation, and the Board’s best value framework;
* Liaise with the Chair in agreeing a programme of meetings for the business year, as required by its remit;
* Oversee the development of the annual workplan for the Committee which is congruent with its remit and the need to provide appropriate assurance at the year-end, for the endorsement of the Committee and approval by the Board;
* Agree with the Chair an agenda for each meeting, having regard to the Committee’s remit and workplan;
* Lead a mid-year review of the Committee Terms of Reference and progress against the annual workplan, as part of the process to ensure that the workplan is fulfilled; and
* Oversee the production of an annual report on the delivery of the Committee’s remit and workplan, for endorsement by the Committee and submission to the Board.

1. *Quorum*

A quorum shall consist of three Members.

1. *Meetings*

The committee shall meet no fewer than four times per annum, with meetings schedule in line with the following timetable and detailed agreed timetable and workplan for the forthcoming financial year.

The detailed workplan will be presented to the Summer audit committee meeting and will include, as a minimum, the indicative agenda items listed below:

|  |  |
| --- | --- |
| **Audit Meeting** | **Proposed Items for Agenda** |
|  |  |
| Autumn Meeting -  Oct | * Internal audit progress Report – standing item * External Audit – update – standing item * National Fraud Initiative – standing item * Update on Shared Services – Standing item * Fraud update - Standing Item * Audit Scotland Reports – standing item * Update on Property and Asset Management Strategy – 6 month review * Amendments to SFIs if required\* * Update on roll out of Enterprise Risk Framework * Board Risk Register (standing agenda item) * Review of Board Standing Orders * Update on work on asset lives * Gifts and Hospitality Policy * Cyber update * Update on expansion programme |
| Winter Meeting -  February | * Internal Audit Progress Report * External Audit annual plan * External Audit – Interim management report * Update on Governance statement guidance * Fraud Update * Updated fraud policy * Update on Audit Scotland reports * Procurement Strategy update * Shared Services update * Enterprise Risk update * Board Risk Register * Amendments to SFIs if required\* * Update on expansion programme |
| Spring Meeting -  April  NB the accounting policies need to be approved prior to prep of accounts.  NB the governance statement needs to be approved prior to inclusion in accounts | * Internal Audit Progress Report * Internal Audit Draft plan for 2016/17 for approval * Internal Audit Annual Report\* * External Audit * Standing Committee Annual Reports (Draft) * Information Governance Annual Report * Risk Management Annual Report * Accounting Policies for approval\* * Fraud update * Risk update * Board Risk Register * Governance statement for approval (to include in annual accounts)\* * update on Audit Scotland reports * Draft annual report for committee * Amendments to SFIs if required\* * Update on expansion programme |
| Summer meeting –  early June | * External Audit Annual Report with opinion * Annual report and Accounts * Statement of Assurance * Final Annual Report for the committee. * Proactive fraud plan for year * ISAE3402 – financial controls assurance for National Single Instance * Any other external assurance papers Terms of Reference for committee – annual review * Work plan for committee for following year * Fraud update * Enterprise Risk update * Board Risk Register * Endowments Annual Report and Accounts – for noting * Update on expansion programme |

The Chair of the Committee may convene additional meetings, as is felt necessary.

Meetings will normally be attended by those identified as regular attendees in point 2 above.

The Audit and Risk Committee may ask any other official of the organisation to attend to assist it with its discussions on particular matters.

The Audit and Risk Committee may ask any or all of these who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

The Accountable Officer may ask the Audit and Risk Committee to convene further meetings to discuss particular issues on which the Accountable Officer wishes the committee’s advice, guidance or opinion.

1. *Reporting*

* The Audit and Risk committee will formally report in writing to the Board and the Accountable Officer after each meeting. This, typically, will be through the submission of Minutes of meetings but if necessary may include an additional report on individual matters of materiality.
* The Audit and Risk committee will provide to the Board and Accountable Officer with an Annual Report, timed to support the finalisation of the accounts and the Corporate Governance Statement, summarising its conclusions from the work it has done during the year.
* Where the review of the terms of reference results in amendments, the revised Terms of Reference must be submitted to the Board for formal approval.
* The committee will approve at the start of each financial year a detailed work plan for approval by the Board.
* The committee annual report will inform the submission of the statement of assurance from the Committee to the Board at year-end.

1. *Responsibilities/Remit*

The Committee has responsibility for ensuring that the Board’s activities are within the guidelines for corporate governance within the NHS and that an effective internal control system is maintained. The duties of the Audit Committee are in line with the NHS Audit Committee Handbook and are detailed below. The audit committee will advise the Board and the Accountable Officer on:

* The strategic process for risk, control and governance and the Corporate Governance Statement;
* Independent scrutiny of the arrangements and action plans for the risk management processes which are in place within the Board including review of the Board Risk Register and updates provided from the work of the Strategic Risk Committee;
* The accounting policies, the accounts, and the annual report for the organisation, including the process for review of the accounts prior to submission to audit, levels of error identified, and the management’s letter of representation to the external auditors;
* The planned activity and results for both internal and external audit;
* The adequacy of management responses to issues identified by audit activity, including external audit’s management letter/report;
* The effectiveness of the internal control environment;
* Assurances relating to the corporate governance requirements of the Board;
* Proposals for tendering for internal audit services or for the purchase of non-audit services from contractors who provide audit services;
* Anti-fraud policies, whistle-blowing processes and the arrangements for special investigations; and
* The acceptability of any proposed changes to the standing orders, the scheme of delegation and the standing financial instructions.

The audit committee will also periodically review its own effectiveness and support the results of the review to the Board and Accountable Officer.

1. *Rights*

The Audit and Risk committee may:

* Co-opt additional members for a period not exceeding a year to provide specialist skills, knowledge and experience; and
* Procure specialist ad-hoc advice at the expense of the organisation, subject to budgets agreed by the Board or Accountable Officer.

1. *Access*

The designated Chief Internal Auditor and the representative from External Audit will have free and confidential access to the Chair of the Committee. Meetings may be arranged as required at a minimum on an annual basis.

1. *Information Requirements*

For each meeting the Audit and Risk Committee will be provided with:

* A report summarising the significant changes to the organisation’s risk register;
* A progress report from the Chief Internal Auditor;
* A progress report from External Audit; and
* A report on any fraud investigations or fraud prevention activity since the previous meeting.

As and when appropriate the Committee will also be provided with:

* Proposals for the terms of reference of internal audit;
* The internal audit strategy;
* The chief internal auditor’s annual report and opinion;
* Quality assurance reports on the internal audit function;
* The draft Directors’ Report and Annual accounts;
* The draft Governance Statement;
* A report on changes to accounting policies;
* External audit’s management letter/report;
* A report on any relevant service audit reports on the controls operating around processes undertaken by another body on the Board’s behalf;
* A report on any proposals to tender for audit functions;
* A report on co-operation between internal and external audit;
* Clinical Governance and Staff Governance annual reports;
* The risk management annual report;
* A summary of any relevant Audit Scotland reports, the implications for the Board and assurances as to actions being taken;
* A report on the national fraud initiative;
* A summary of any reports by external bodies (eg HIS) which will not be considered by any other governance committee or which contains significant the committee needs to take into account in its assessment of the internal control arrangements; and
* Update reports from the Strategic Risk Committee

The above list, which is not exhaustive, is the suggested minimum requirements for the inputs which should be provided to the committee, more items may be provided as appropriate.

**Appendix 2A – Clinical Governance Committee Annual Report**

**Clinical Governance Committee**

**Annual Report**

**2016/17**

**1 Background**

Members of the Clinical Governance Committee are appointed by the Board, to whom it is accountable. Members of the Clinical Governance Committee during 2016/17 were:

* Chair Mark MacGregor
* Stewart MacKinnon
* Maire Whitehead
* Philip Cox

Attendance at the meetings was recorded as follows:

**Table 1 – Attendance**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **List members** | 26/04/16 | 23/08/16 | 22/11/16 | 24/01/17 |
| Mark MacGregor, Non-Executive Director, Chair |  |  |  |  |
| Stewart MacKinnon, Interim Chairman |  |  |  |  |
| Maire Whitehead, Non-Executive Director |  |  |  |  |
| Philip Cox, Non-Executive Director | Apologies noted |  |  |  |
| **In attendance** | | | | |
| Jill Young, Chief Executive |  |  |  |  |
| Anne Marie Cavanagh, Nurse Director |  |  | Apologies noted |  |
| Mike Higgins, Medical Director |  |  | Apologies noted |  |
| Laura Langan Riach, Head of Clinical Governance |  |  |  |  |
| Jane Christie Flight, Employee Director |  |  |  |  |
| Stewart Craig, Clinical Governance Lead Cardiac Surgery |  |  | n/a | n/a |
| Rhona Siegmeth, Consultant Anaesthetist, SSD Co-chair | Apologies noted | n/a |  | n/a |
| Theresa Williamson, Head of Nursing, Co-Chair SSD |  | n/a |  | n/a |
| Alistair Macfie, Associate Medical Director, SSD |  |  |  | n/a |
| John Payne, Clinical Governance Lead RNM, RNM Co-Chair | n/a |  | n/a | n/a |
| Jennifer Hunter, Clinical Nurse Manager, RNM Co-Chair | n/a | Apologies noted |  |  |
| Jane Rodman, Clinical Nurse Manager, RNM Co-Chair | n/a | Apologies noted | n/a |  |

**2. Meetings**

The Clinical Governance Committee had four formal meetings during the period 1 April 2016 to 31 March 2017. The attached report has been approved by all members of the committee. The work programme was around Safe, Effective and Person Centred Care with the following reports and issues considered by the committee:

**Table 2: 2016 /2017 Work Plan**

|  |  |
| --- | --- |
| April 2016  Surgical Services Division update  HAIRT Report  Closed Events  Schedule of Reports  Annual Learning Summary | July 2016  SPSP Report  Regional National Medical Division update  HAIRT Report  Closed Events  Patient Stories update  Clinical Outcomes Framework Update  Surgical Brief Improvement Work |
| *May 2016*  *Specialist Sub Groups annual presentation* |
| October 2016  Surgical Services Division update  HAIRT Report  Closed Events  Complaints & Claims Report | January 2017  SPSP Report  Regional National Medical Division update  HAIRT Report  Annual Learning Summary  Closed Events |

On 31May 2016 the Clinical Governance Committee received the annual presentations from the Specialist Groups and Committees that report to the Clinical Governance and Risk Management Group as follows:

* Infusion Devices Committee
* Drugs & Therapeutics Committee
* Health & Safety Committee
* Hospital Transfusion Committee
* Acute Pain Service
* Radiation Safety Committee
* Food, Fluid & Nutritional Care Group
* Research & Development Steering Group
* Infection Control Committee
* Resuscitation Committee

Each committee presented an overview of the work in last year highlighting successes and challenges and the key areas of focus for 2016/2017.

|  |  |
| --- | --- |
| 3. | Work Plan  The committee commissioned the developed of an Annual Learning report with agreement to review two 6 monthly drafts in year whilst the report is developed. This report combines data from adverse events and complaints to identify themes and trends with the aim being to link these to ongoing improvement work to reassure on key activity areas but also to promote discussion on any areas where further improvements may be required.  There has been a review of the reporting of the Divisions to the committee in year with agreement that moving forward both clinical Divisions will be invited to provide reports to the committee at each meeting. The format of these reports has been revised with a new report agreed themed on Safe, Effective and Person Centred to provide the committee with an overview of Division activity across these areas. Both Divisions have presentd using the revised format which was well received with good discussion on areas such as medicines reconciliation and learning from significant adverse events.  The Complaints policy was refreshed in year to align to the changes in national guidance which are effective from 1st April 2017. The committee receive 6 monthly reports on complaints noting the more detailed scrutiny is undertaken via the Person Centred Committee.  Work has continued on the development of a Clinical Outcomes Framework with support from E-Health and updates on progress have been presented to the Committee.  The HAIRT report is a standing item on each governance committee meeting and allows members to be regularly updated on key Prevention and Control of Infection  areas.  The surgical brief improvement work was not progressed as planned and is continuing into 2017/2018 when an update will be presented to the committee. Surgical brief and pause continue to take place as one of the safety essentials, the work planned is to review the quality of these and the standard design of surgical brief to improve existing process. |
|  |  |
| **4.** | **Board Papers** |
|  |  |
|  | The minutes of each of the Clinical Governance Committee meetings are presented to the next available Board meeting for discussion. Summary outputs from each meeting are presented to the first available Board meeting; this allows Board members to be appraised of any governance issues pending final approval of committee minutes. |
|  |  |
| **5.** | **Risk Management** |
|  |  |
|  | There were no risks discussed at the committee that could impact on the governance statement. The Committee agreed that adequate control measures were in the place for those risks described in the Board risk register. |
|  |  |
|  | The committee was involved in the review of Board risk arrangements via Board workshops (See RM annual report for further detail) and continued to view the Board risk register. |
|  |  |
|  |  |
| **6.** | **Chair’s Conclusion** |
|  | The Clinical Governance Committee continues to develop in the contribution that the Committee makes to ensuring the continued provision and improvement in Internal Control arrangements within the Board and, in accordance with its Terms of Reference, will seek to maintain that progress. |
|  | The Chair concludes that the Clinical Governance Committee has fulfilled its remit and considers that there are adequate arrangements in place to ensure that clinical governance arrangements are in place to fulfil the requirements of the code of governance. |

**Mark MacGregor, Chair – Clinical Governance Committee**

**Presented to committee April 2017**

**Included the committee terms of reference for note:**

**CLINICAL GOVERNANCE COMMITTEE**

## TERMS OF REFERENCE (Agreed March 2016)

1. **Purpose**

The NHS Scotland Healthcare Quality Strategy is about putting people at the heart of everything we do, delivering measureable improvement and creating confidence that NHSScotland is delivering the highest quality healthcare.

This Committee shall be a standing committee of the NWTC Board which is part of the governance framework for NHS Boards and will:

1.1 lead the ‘Safe and Effective’ Ambitions within the NHS Healthcare Quality Strategy for this Board. This builds upon the responsibility to provide assurances to the Board that appropriate structures are in place for effective and safe clinical governance in accordance with MEL(2009)29 and that appropriate action is being taken to address any areas of concern.

1.2 ensure that appropriate assurance, scrutiny and measures are in place that are subject to review by Health Improvement Scotland as part of the Healthcare Scrutiny Framework.

1. **Role**

The role of the Clinical Governance Committee is to

2.1 provide coordination and leadership to enable effective delivery of the Safe and Clinical Governance elements within the Healthcare Quality Strategy for NHS Scotland. The lead role for person centred and patient focus will be taken by the Person Centred and Staff Governance Committee.

2.2 assure the Board that appropriate structures and processes are in place to meet statutory obligations and any other guidance issued by the Scottish Executive and Healthcare Improvement Scotland.

2.3 Review outcomes of patient care through scrutiny of relevant reports and self assessments

1. **Membership**

The Committee shall comprise of:

* Four Non-Executive Directors of the Board, one of whom will Chair this Committee:
  + Mark MacGregor (chair)
  + Maire Whitehead
  + Stewart MacKinnon
  + Phil Cox

The following people should attend the committee:

* + Dr Mike Higgins, Medical Director.
  + Anne Marie Cavanagh, Nurse Director
  + Laura Langan Riach, Head of Clinical Governance

The following people may attend the committee:

* + Jill Young, Chief Executive
  + Board Chair

Invitations to meetings may include clinicians and infection control manager to discuss specific issues. Clinicians with responsibility for Clinical Governance may be invited to attend as observers.

Stewart McKinnon, Non Executive Director was appointed as Interim Board Chair in March 2016. As noted Stewart is also a member of this committee; it has been agreed that the membership of the CGC will not be revised on the basis of the interim arrangements and we will await the outcome of the formal appointment process before making any further changes.

**3.1 Executive Director Lead**

The Designated Executive Lead will support the Chair of the Committee in ensuring that the Committee operates according to /in fulfilment of its agreed Terms of Reference. The named Executive Lead for the Committee is the Medical Director. Specifically they will:

* Support the Chair in ensuring that the Committee remit is based on the latest guidance and relevant legislation, and the Board’s best value framework;
* Liaise with the Chair in agreeing a programme of meetings for the business year, as required by its remit;
* Oversee the development of the annual schedule of reports for the Committee which is congruent with its remit and the need to provide appropriate assurance at the year-end, for the endorsement of the Committee and approval by the Board;
* Agree with the Chair an agenda for each meeting, having regard to the Committee’s remit and schedule of reports;
* Lead a mid-year review of the Committee Terms of Reference and progress against the annual plan, as part of the process to ensure that the plan is fulfilled; and
* Oversee the production of an annual report on the delivery of the Committee’s remit activity plan and reports, for endorsement by the Committee and submission to the Board.

**4 Quorum**

A quorum will consist of three non-executive directors.

**5 Conduct of Business**

* The Committee shall meet at least four times a year.
* The conduct of business will be in accordance with the Board’s Standing Orders.
* Prior to the full approved Minutes of the Committee being available, a template covering the main points of discussion will be shared at the next available Board meeting. The full Minutes of this Committee will be reported to the NWTC Board.
* Reports to the Board will be required to have a standard cover sheet clarifying whether the report is being presented for information, for discussion or for approval. Papers are required to be circulated within 5 working days prior to the Committee taking place.
* There will be a requirement to produce an Annual Report at the end of each financial year.

**6 Framework Agenda**

The framework for the Committee for NWTC Board will be scheduled as part of a forward monitoring plan and will include the following:

* Clinical Risk Management
* Adverse Incident Reporting and Response
* Control of infection / decontamination / management of healthcare environment procedures
* Monitoring and improving practice to provide Quality Assurance
* Handling of complaints
* Drugs and therapeutics issues
* Clinical records
* Clinical audit plan
* Service provision, organisation and redesign
* Clinical and ehealth Information management –
* Monitoring the implementation of appropriate National Guidelines and Standards
* Monitoring of Scottish Patient Safety Programme implementation

The Committee is authorised by the NWTC Board to investigate any activity within its Terms of Reference and conduct investigations within agreed procedures.

**7 Responsibilities and Remit of the Clinical Governance Committee:**

The Committee will:

Ensure the Board has mechanisms in place in respect of all relevant legislation and policy relating to the provision of safe and effective clinical care:

* As part of the Healthcare Scrutiny Framework ensure an appropriate framework is in place where delivery against the Board’s Quality Risk Profile is being achieved;
* monitor and evaluate reports, strategies and implementation plans relating to safe and effective care e.g. Harm Free Care programmes and prevention of Hospital Acquired Infection
* ensure a robust system is in place for the timely submission of all clinical governance information required for national monitoring arrangements e.g. Clinical Care Self-assessments
* review and agree the clinical audit work plan
* provide an annual report to the Board for the statement of internal control;
* to provide assurance that systems and procedures are in place to manage the issues set out in MEL (2009)29

**8. Review of Terms of Reference**

These terms of reference will be reviewed annually.

**Appendix 2B – Clinical Governance Committee Work Plan 2017/18**

**CGC Work plan for 2017/2018**

The following has been agreed:

|  |  |
| --- | --- |
| April 2017  Division Updates  HAIRT Report  Closed Significant Events  Schedule of Reports  SPSP Report  Claims Report | July 2017  Division Updates  HAIRT Report  Closed Significant Events  Complaints Report  Annual Learning Report  Clinical Outcomes Framework |
| *May 2017*  *Specialist Sub Groups annual presentation* |
| October 2017  Division Updates  HAIRT Report  Closed Significant Events  Claims Report  Surgical Brief Improvement Work  Duty of Candour | January 2018  Division Updates  HAIRT Report  Closed Significant Events  SPSP Report  Complaints Report |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **April** | **July** | **October** | **January** |
| **HAIRT Report** | Latest monthly report presented at each meeting | | | |
| **Closed Significant Events** | Standing Item to report on any SAE closed since the last meeting and update on SAE action plan status | | | |
| **Division Updates** | Standing item | | | |
| **GJNH Complaints Report** |  | X |  | X |
| **Annual Learning Report Annual** |  | X |  |  |
| **SPSP Report (6 monthly)** | X |  |  | X |
| **Claims Report** | X |  | X |  |

**Appendix 2C – Clinical Governance Committee Terms of Reference 2017/18**

**CLINICAL GOVERNANCE COMMITTEE**

**Terms of Reference considered April 2017**

## TERMS OF REFERENCE

1. **Purpose**

The NHS Scotland Healthcare Quality Strategy is about putting people at the heart of everything we do, delivering measureable improvement and creating confidence that NHSScotland is delivering the highest quality healthcare.

This Committee shall be a standing committee of the NWTC Board which is part of the governance framework for NHS Boards and will:

1.1 lead the ‘Safe and Effective’ Ambitions within the NHS Healthcare Quality Strategy for this Board. This builds upon the responsibility to provide assurances to the Board that appropriate structures are in place for effective and safe clinical governance in accordance with MEL(2009)29 and that appropriate action is being taken to address any areas of concern.

1.2 ensure that appropriate assurance, scrutiny and measures are in place that are subject to review by Health Improvement Scotland as part of the Healthcare Scrutiny Framework.

1. **Role**

The role of the Clinical Governance Committee is to

2.1 provide coordination and leadership to enable effective delivery of the Safe and Clinical Governance elements within the Healthcare Quality Strategy for NHS Scotland. The lead role for person centred and patient focus will be taken by the Person Centred and Staff Governance Committee.

2.2 assure the Board that appropriate structures and processes are in place to meet statutory obligations and any other guidance issued by the Scottish Executive and Healthcare Improvement Scotland.

2.3 Review outcomes of patient care through scrutiny of relevant reports and self assessments

1. **Membership**

The Committee shall comprise of:

* Four Non-Executive Directors of the Board, one of whom will Chair this Committee:
  + Mark MacGregor (chair)
  + Maire Whitehead
  + Stewart MacKinnon
  + Phil Cox

The following people should attend the committee:

* + Dr Mike Higgins, Medical Director.
  + Anne Marie Cavanagh, Nurse Director
  + Laura Langan Riach, Head of Clinical Governance
  + Jill Young, Chief Executive

The following people may attend the committee:

* + Board Chair
  + Employee Director
  + Director of Quality, Innovation & People
  + Chairs of Divisional Clinical Governance Groups

Invitations to meetings may include clinicians and infection control manager to discuss specific issues. Clinicians with responsibility for Clinical Governance may be invited to attend as observers.

Stewart McKinnon, Non Executive Director was appointed as Interim Board Chair in March 2016. As noted Stewart is also a member of this committee; it has been agreed that the membership of the CGC will not be revised on the basis of the interim arrangements and we will await the outcome of the formal appointment process before making any further changes.

**3.1 Executive Director Lead**

The Designated Executive Lead will support the Chair of the Committee in ensuring that the Committee operates according to /in fulfilment of its agreed Terms of Reference. The named Executive Lead for the Committee is the Medical Director. Specifically they will:

* Support the Chair in ensuring that the Committee remit is based on the latest guidance and relevant legislation, and the Board’s best value framework;
* Liaise with the Chair in agreeing a programme of meetings for the business year, as required by its remit;
* Oversee the development of the annual schedule of reports for the Committee which is congruent with its remit and the need to provide appropriate assurance at the year-end, for the endorsement of the Committee and approval by the Board;
* Agree with the Chair an agenda for each meeting, having regard to the Committee’s remit and schedule of reports;
* Lead a mid-year review of the Committee Terms of Reference and progress against the annual plan, as part of the process to ensure that the plan is fulfilled; and
* Oversee the production of an annual report on the delivery of the Committee’s remit activity plan and reports, for endorsement by the Committee and submission to the Board.

**4 Quorum**

A quorum will consist of three non-executive directors.

**5 Conduct of Business**

* The Committee shall meet at least four times a year.
* The conduct of business will be in accordance with the Board’s Standing Orders.
* Prior to the full approved Minutes of the Committee being available, a template covering the main points of discussion will be shared at the next available Board meeting. The full Minutes of this Committee will be reported to the NWTC Board.
* Reports to the Board will be required to have a standard cover sheet clarifying whether the report is being presented for information, for discussion or for approval. Papers are required to be circulated within 5 working days prior to the Committee taking place.
* There will be a requirement to produce an Annual Report at the end of each financial year.

**6 Framework Agenda**

The framework for the Committee for NWTC Board will be scheduled as part of a forward monitoring plan and will include the following:

* Clinical Risk Management
* Adverse Incident Reporting and Response
* Control of infection / decontamination / management of healthcare environment procedures
* Monitoring and improving practice to provide Quality Assurance
* Handling of complaints
* Drugs and therapeutics issues
* Clinical records
* Clinical audit plan
* Service provision, organisation and redesign
* Clinical and ehealth Information management –
* Monitoring the implementation of appropriate National Guidelines and Standards
* Monitoring of Scottish Patient Safety Programme implementation

The Committee is authorised by the NWTC Board to investigate any activity within its Terms of Reference and conduct investigations within agreed procedures.

**7 Responsibilities and Remit of the Clinical Governance Committee:**

The Committee will:

Ensure the Board has mechanisms in place in respect of all relevant legislation and policy relating to the provision of safe and effective clinical care:

* As part of the Healthcare Scrutiny Framework ensure an appropriate framework is in place where delivery against the Board’s Quality Risk Profile is being achieved;
* monitor and evaluate reports, strategies and implementation plans relating to safe and effective care e.g. Harm Free Care programmes and prevention of Hospital Acquired Infection
* ensure a robust system is in place for the timely submission of all clinical governance information required for national monitoring arrangements e.g. Clinical Care Self-assessments
* review and agree the clinical audit work plan
* provide an annual report to the Board for the statement of internal control;
* to provide assurance that systems and procedures are in place to manage the issues set out in MEL (2009)29

**8. Review of Terms of Reference**

These terms of reference will be reviewed annually.

**Appendix 3A – Person Centred Committee Annual Report**

**Person Centred Committee**

**Annual Report**

**(Staff Governance)**

**2016-17**

|  |  |
| --- | --- |
| **1.** | **Background** |
|  |  |
| 1.1 | Members of the Person Centred Committee (Staff Governance) are appointed by, and answerable to, the Board. Membership and record of attendance are detailed in appendix 1. |
|  |  |
| **2.** | **Meetings** |
|  |  |
| 2.1 | The Person Centred Committee met four times during the period 1 April 2016 to 31 March 2017. There are a number of standing agenda items that allow the PCC to monitor staff governance and person centred activities as a routine. The PCC has also overseen the development of the Board’s Involving People Strategy and other corporate activities. Agenda items are listed below.   |  |  | | --- | --- | |  |  | | **Standing agenda items** | | | * Complaints Scrutiny Report * Involving People Update * Sickness Absence Analysis Report * Partnership Forum Report | | | **26 April 2016** | **12 July 2016** | | * Mandatory Training End of Year Report * Person Centred Programme Report * Staff Governance Report * Values/iMatter Report * KSF End of Year Report and Divisional Feedback * Partnership Forum Report * Medical Appraisal & Revalidation 6 Monthly Report * Medical Education Strategy * Person Centred Committee Annual Report * PCC Terms of Reference 2016/17 * PCC Work Plan 2016/17 * Spiritual Care Policy Consultation * Workforce Plan 2016-17 * Communication Strategy Update * Small Grants Funding Progress | * Learning & Development Plan & Annual Activity Report * Person Centred Programme Report * Values/iMatter Report * Occupational Health & Safety 6 Month Report. * Quarterly KSF Report * Band 1 Review Update * Communication Scorecard * Communication Strategy Update | | **18 October 2016 – note 1** | **31January 2017** | | * Person Centred Programme Update * Quarterly KSF Report * Mandatory Training Report * Medical Appraisal and Revalidation 6 Month Report * Corporate L&OD 6 Month Report * Band 1 Review Update * Staff Governance Policy Tracker * Health Promotion Report | * New Complaints Handling Procedure * Quarterly KSF Report * Occupational Health & Safety 6 Month Report * Band 1 Review Process Summary * Values/iMatter Report * Communication Scorecard & Strategy | |
|  | Note 1 – it should be noted that the meeting on 18 October whilst it did proceed was not quorate and therefore no decisions were made at this meeting. |
| 2.2 | The Committee also received an update from the Board’s Remuneration Committee, held on 28 July 2016. |
|  |  |
| **3.** | **Work/reviews carried out by internal parties** |
|  |  |
| 3.1 | Policies affecting staff are approved by the Partnership Forum which in turn reports to the PCC against the Staff Governance Standard. There were no policies for the Committee to note in 2016/17: |
|  |  |
| **4.** | **Work/reviews carried out by external parties** |
| 4.1 | None during this time period. |
| **5.** | **Board Papers** |
|  |  |
| 5.1 | The approved minutes from each meeting are presented at the subsequent Board meeting for discussion. Summary outputs from each meeting are presented to the first available Board meeting to allow Board members to be appraised of any governance issues pending final approval of committee minutes. |
| 5.2 | The annual report will be presented to the May 2017 NWTC Board Meeting. |
| **6.** | **Risk Management** |
|  |  |
| 6.1 | No risks were reported to the Committee. No risks were identified by the Committee.  6.3 |
|  |  |
| **7.** | **Audit Scotland National Reports (or other national reports)** |
| 7.1 | None received. |
| **8.** | **Chair’s Conclusion** |
| 8.1 | The Person Centred Committee continues to ensure appropriate scrutiny and governance around the person centred quality agenda and, in accordance with its Terms of Reference (attached at the end of this report), will seek to maintain that position. |
| 8.2 | The Chair concludes that the Person Centred Committee has fulfilled its remit and considers that there are adequate systems in place to ensure that Staff Governance arrangements meet the requirements of the Code of Governance. |
|  |  |
|  |  |

**Chair – Person Centred (Staff Governance) Committee**

**Director of Quality, Innovation & People**

**NATIONAL WAITING TIMES CENTRE BOARD**

**PERSON CENTRED COMMITTEE (PCC)**

**(April 2016)**

## TERMS OF REFERENCE

1. **Purpose**

The purpose of this Committee is to ensure appropriate scrutiny and governance around the person centred quality agenda. Person centred encompasses a range of stakeholders including patients, families, staff, customers, volunteers, carers and any relevant 3rd sector parties.

The NHS Quality Strategy for Scotland recognises the need to have an engaged, motivated and healthy workforce to deliver the quality ambitions of delivering person centred, safe and effective healthcare services.

1. **Role**

It is the responsibility of the Person Centred Committee to assure the NWTC Board that appropriate structure and processes are in place for the effective governance of the Board’s person centred agenda. The Committee shall be responsible for ensuring that the governance processes to meet statutory obligations and any other guidance issued by the Scottish Executive and Health Improvement Scotland are met.

This Committee shall be a standing committee of the NWTC Board which is part of the governance framework for NHS Boards.

The Person Centred Committee is toprovide coordination and leadership to enable effective delivery of the Involving People Strategy and the Staff Governance Standard. This will include supporting the delivery of the highest standard possible of person centred care including an understanding that staff management is the responsibility of everyone working within the system and is built upon partnership and collaboration.

1. **Membership of the Person Centred Committee**

The Person Centred Committee membership shall comprise of:

* Jack Rae, Non-Executive Director (Chair)
* Jane Christie-Flight, Employee Director
* Maire Whitehead, Non Executive Director
* Mark MacGregor, Non Executive Director
* Kay Harriman, Non Executive Director
* Sylvia McCulloch, Lay Representative (Unison)
* Judith Ross, Lay Representative (RCN)

In addition, the following people may attend the committee:

* Jack Tait, Lay Representative (Chair of Quality Public Partnership Group)
* David Miller, Acting Director of Human Resources
* Jill Young, Chief Executive
* Stewart MacKinnon, Interim Board Chair
* Anne Marie Cavanagh, Nurse Director
* Others invited by the Committee

1. **Quorum**

A quorum will consist of three non-Executive Directors of the Committee.

1. **Executive Director Lead**

The Designated Executive Lead will support the Chair of the Committee in ensuring that the Committee operates according to / in fulfilment of its agreed Terms of Reference. The named Executive Lead for the Committee is the Director of HR. Specifically he/she will:

* Support the Chair in ensuring that the Committee remit is based on the latest guidance and relevant legislation, and the Board’s best value framework;
* Liaise with the Chair in agreeing a programme of meetings for the business year, as required by its remit;
* Oversee the development of the annual work plan for the Committee which is congruent with its remit and the need to provide appropriate assurance at the year-end, for the endorsement of the Committee and approval by the Board;
* Agree with the Chair an agenda for each meeting, having regard to the Committee’s remit and work plan;
* Lead a mid-year review of the Committee Terms of Reference and progress against the annual work plan, as part of the process to ensure that the work plan is fulfilled; and
* Oversee the production of an annual report on the delivery of the Committee’s remit and work plan, for endorsement by the Committee and submission to the Board.

1. **Conduct of Business**
2. The Committee shall meet at least four times a year.
3. The conduct of business will be in accordance with the Board’s Standing Orders.
4. Prior to the full approved Minutes of the Committee being available, a template covering the main points of the discussion will be shared at the next available Board meeting. The full Minutes of this Committee will be reported to the NWTC Board.
5. Reports to the Board will be required to have a standard cover sheet clarifying whether the report is being presented for information, for discussion or for approval. Papers are required to be circulated a minimum of 5 working days in advance of the Committee taking place.
6. There will be a requirement to produce an Annual Report at the end of each financial year.
7. The framework for the Person Centred Committee for NWTC Board will be scheduled as part of a formal monitoring plan and will include the following:

Involving People Strategy

Trends of complaints

Trends from adverse incidents/Scottish patient safety programme

Volunteering Strategy

Advocacy Strategy

Equality and Diversity Information

Health Improvement Scotland Standards

Participation Standards

Summary of feedback from

Quality Walkrounds (patient/execs/volunteers)

Care Governance/Health and Social Care Programme

Staff Governance

Self Assessment Audit Tool

Staff Governance Action Plan

Workforce Strategy and Workforce Plan

Learning and development Strategy

Medical Education and Training

Medical Revalidation

Occupational Health and Safety Programme

Partnership Activities

Internal/external Workforce Audits

Corporate

Knowledge services

Corporate Communications

1. **Reporting Arrangements**

Through the Person Centred Committee, the Remuneration Committee is required to provide assurance that systems and procedures are in place to manage the issues set out in MEL (1993) 114 (amended) so that overarching staff governance responsibilities can be discharged.

1. **Responsibilities & Remit of the Person Centred Committee:**

**Involving People Strategy**

The Committee will:

1. Ensure the Board has mechanisms in place in respect of all relevant legislation and policy relating to the Quality Strategy, Patient Focus Public Involvement and the Equalities legislation relating to the General and Specific public sector duties of the Equality Act. This incorporates:

* providing assurance on the patient centeredness quality domain including for example, carers, volunteers and 3rd sector parties.
* monitoring and evaluating the effectiveness of interventions.
* demonstrating positive outcomes related to the general and specific duties of the single equality act.
* highlighting any potential risks.
* ensuring robust and accessible communication, monitoring and reporting mechanisms are in place and that appropriate committees, as indicated by accountability arrangements, receive regular progress reports.

**Staff Governance Standard**

The Committee will:

* ensure appropriate frameworks are in place which ensure that delivery against the Staff Governance Standard is being achieved;
* monitor and evaluate strategies and implementation plans relating to people management;
* recommend any policy amendment, funding or resource submission to the Board to achieve the Staff Governance Standard;
* take responsibility for the timely submission of all staff governance information required for national monitoring arrangements;
* monitor benefits realisation processes; and
* provide staff governance information for the statement of internal control;
* to provide assurance that systems and procedures are in place to manage the issues set out in MEL 1993 114 amended (the Remuneration Committee).

**8. Review of Terms of Reference**

These terms of reference will be reviewed annually.

|  |
| --- |
| **Appendix 1: Membership and record of attendance**  Membership of the Person Centred Committee 2016/17   * Jack Rae (Chair) * Maire Whitehead (Non- executive) * Mark McGregor (Non- executive) * Kay Harriman (Non- executive) * Jane Christie-Flight ( Employee Director) * Judith Ross (RCN) * Sylvia McCulloch (Unison) * Jack Tait (Lay Member) |
|  |
| Attendance at the meetings was recorded as follows:   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Members** | 26/04/16 | 12/07/16 | 18/10/16 | 31/01/17 | | Jack Rae |  |  |  |  | | Maire Whitehead |  |  | Apologies noted |  | | Mark McGregor |  | Apologies noted | Apologies Noted | Apologies noted | | Kay Harriman | Apologies noted | Apologies noted | Apologies noted |  | | Jane Christie Flight |  |  |  |  | | Jack Tait |  |  |  |  | | Judith Ross |  |  |  | Apologies Noted | |
|  |
| **The following people were in attendance:**   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | 26/04/16 | 12/07/16 | 18/10/16 | 31/01/17 | | David Miller | Apologies noted |  |  |  | | Jill Young |  |  |  | Apologies Noted | | Safia Qureshi | - | - | - |  |   **The following individuals attended as required:**   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | 26/04/16 | 12/07/16 | 18/10/16 | 31/01/17 | | Mike Higgins | - | - |  | - | | Anne Marie Cavanagh | - | - | Apologies noted |  | | Theresa Williamson | - | - |  | - | | Marie Smith | - |  |  |  | | David Wilson | - | - |  |  | | Birgit Clark | - | - |  | - | | Elizabeth Reilly | - | - |  | - | | Lynn Heatley | - | - | - | - | | Laura Liddle |  | - | - | - | | Laura Langan Riach |  | - |  |  | | Lynn Graham |  | - | - | - | | Sandie Scott | Absent | - | - |  | | Kathryn Macpherson | - |  | - |  | | Natalie Moffat | - |  | - | - | |

Appendix 3B – Person Centred Committee Work Plan 2017/18

**Work Plan for Person Centred Committee (2017/18) (April 2017)**

|  |  |  |  |
| --- | --- | --- | --- |
| **25 April 2017** | **25 July 2017** | **10 October 2017** | **Jan 2018** |
| Deadline: Mon 17th April | Deadline: Mon 17th July | Deadline: Mon 2nd Oct | To be advised |
| SMT: 9th March | SMT: 20th July | SMT: 5th Oct |  |
| PF: 21st April | PF: 14th July | PF: 25th August |  |
| KSF end of year report 16/17 | Quarterly KSF Report (Staff Governance Report) | Quarterly KSF Report (Staff Governance Report) | Quarterly KSF Report (Staff Governance Report) |
| Sickness Absence end of year report 16/16 | Quarterly Sickness Absence Report (Staff Governance Report) | Quarterly Sickness Absence Report (Staff Governance Report) | Quarterly Sickness Absence Report (Staff Governance Report) |
|  |  | Values/iMatter Report |  |
| Complaints Report | Complaints Report | Complaints Report | Complaints Report |
| Involving People Report | Involving People Annual Report | Involving People Report | Involving People Report |
| Partnership Forum Report | Partnership Forum Report | Partnership Forum Report | Partnership Forum Report |
|  | Occupational Health & Safety 6 monthly report | Human Factors annual update | Occupational Health & Safety 6 monthly report |
| Mandatory Training End of Year Report |  |  |  |
|  | Corporate L&D Plan & Annual Report on Activity | Corporate L&D 6 monthly report |  |
| Medical Appraisal & Revalidation 6 monthly report |  | Medical Appraisal & Revalidation 6 monthly report |  |
|  | Communication Strategy | Communication Strategy Performance Update | Communication Strategy Performance Update |
| Staff Governance Self Assessment |  | Staff Governance policy tracker update |  |
|  |  |  | Annual PCC Report 2017/18 |
|  | Board Workforce Plan and Annual Workforce Monitoring Report |  | Annual Results of Participation Standards |
| **Staff Governance Standards** | | | |
| Well informed | | | |
| Trained | | | |
| Involved in Decision | | | |
| Fair & Consistent | | | |
| Safe Working Environment | | | |

Appendix 3C – Person Centred Committee Terms of Reference 2017/18

**PERSON CENTRED COMMITTEE (PCC)**

**(April 2017)**

## TERMS OF REFERENCE

1. **Purpose**

The purpose of this Committee is to ensure appropriate scrutiny and governance around the person centred quality agenda. Person centred encompasses a range of stakeholders including patients, families, staff, customers, volunteers, carers and any relevant 3rd sector parties.

The NHS Quality Strategy for Scotland recognises the need to have an engaged, motivated and healthy workforce to deliver the quality ambitions of delivering person centred, safe and effective healthcare services.

1. **Role**

It is the responsibility of the Person Centred Committee to assure the NWTC Board that appropriate structure and processes are in place for the effective governance of the Board’s person centred agenda. The Committee shall be responsible for ensuring that the governance processes to meet statutory obligations and any other guidance issued by the Scottish Executive and Health Improvement Scotland are met.

This Committee shall be a standing committee of the NWTC Board which is part of the governance framework for NHS Boards.

The Person Centred Committee is toprovide coordination and leadership to enable effective delivery of the Involving People Strategy and the Staff Governance Standard. This will include supporting the delivery of the highest standard possible of person centred care including an understanding that staff management is the responsibility of everyone working within the system and is built upon partnership and collaboration.

1. **Membership of the Person Centred Committee**

The Person Centred Committee membership shall comprise of:

* Jack Rae, Non-Executive Director (Chair)
* Jane Christie-Flight, Employee Director
* Maire Whitehead, Non Executive Director
* Mark MacGregor, Non Executive Director
* Kay Harriman, Non Executive Director
* Sylvia McCulloch, Lay Representative (Unison)
* Judith Ross, Lay Representative (RCN)

In addition, the following people may attend the committee:

* Jack Tait, Lay Representative (Chair of Quality Public Partnership Group)
* Safia Qureshi, Director of Quality, Innovation and People
* David Miller, Associate Director of Human Resources
* Jill Young, Chief Executive
* Stewart MacKinnon, Interim Board Chair
* Anne Marie Cavanagh, Nurse Director
* Others invited by the Committee

1. **Quorum**

A quorum will consist of three non-Executive Directors of the Committee.

1. **Executive Director Lead**

The Designated Executive Lead will support the Chair of the Committee in ensuring that the Committee operates according to / in fulfilment of its agreed Terms of Reference. The named Executive Lead for the Committee is the Director of Quality, Innovation and People. Specifically he/she will:

* Support the Chair in ensuring that the Committee remit is based on the latest guidance and relevant legislation, and the Board’s best value framework;
* Liaise with the Chair in agreeing a programme of meetings for the business year, as required by its remit;
* Oversee the development of the annual work plan for the Committee which is congruent with its remit and the need to provide appropriate assurance at the year-end, for the endorsement of the Committee and approval by the Board;
* Agree with the Chair an agenda for each meeting, having regard to the Committee’s remit and work plan;
* Lead a mid-year review of the Committee Terms of Reference and progress against the annual work plan, as part of the process to ensure that the work plan is fulfilled; and
* Oversee the production of an annual report on the delivery of the Committee’s remit and work plan, for endorsement by the Committee and submission to the Board.

1. **Conduct of Business**
2. The Committee shall meet at least four times a year.
3. The conduct of business will be in accordance with the Board’s Standing Orders.
4. Prior to the full approved Minutes of the Committee being available, a template covering the main points of the discussion will be shared at the next available Board meeting. The full Minutes of this Committee will be reported to the NWTC Board.
5. Reports to the Board will be required to have a standard cover sheet clarifying whether the report is being presented for information, for discussion or for approval. Papers are required to be circulated a minimum of 5 working days in advance of the Committee taking place.
6. There will be a requirement to produce an Annual Report at the end of each financial year.
7. The framework for the Person Centred Committee for NWTC Board will be scheduled as part of a formal monitoring plan and will include the following:

Involving People Strategy

Trends of complaints

Trends from adverse incidents/Scottish patient safety programme

Volunteering Strategy

Advocacy Strategy

Equality and Diversity Information

Health Improvement Scotland Standards

Participation Standards

Summary of feedback from

Quality Walkrounds (patient/execs/volunteers)

Care Governance/Health and Social Care Programme

Staff Governance

Self Assessment Audit Tool

Staff Governance Action Plan

Workforce Strategy and Workforce Plan

Learning and development Strategy

Medical Education and Training

Medical Revalidation

Occupational Health and Safety Programme

Partnership Activities

Internal/external Workforce Audits

Corporate

Knowledge services

Corporate Communications

1. **Reporting Arrangements**

Through the Person Centred Committee, the Remuneration Committee is required to provide assurance that systems and procedures are in place to manage the issues set out in MEL (1993) 114 (amended) so that overarching staff governance responsibilities can be discharged.

1. **Responsibilities & Remit of the Person Centred Committee:**

**Involving People Strategy**

The Committee will:

1. Ensure the Board has mechanisms in place in respect of all relevant legislation and policy relating to the Quality Strategy, Patient Focus Public Involvement and the Equalities legislation relating to the General and Specific public sector duties of the Equality Act. This incorporates:

* providing assurance on the patient centeredness quality domain including for example, carers, volunteers and 3rd sector parties.
* monitoring and evaluating the effectiveness of interventions.
* demonstrating positive outcomes related to the general and specific duties of the Single equality act.
* highlighting any potential risks.
* ensuring robust and accessible communication, monitoring and reporting mechanisms are in place and that appropriate committees, as indicated by accountability arrangements, receive regular progress reports.

**Staff Governance Standard**

The Committee will:

* ensure appropriate frameworks are in place which ensure that delivery against the Staff Governance Standard is being achieved;
* monitor and evaluate strategies and implementation plans relating to people management;
* recommend any policy amendment, funding or resource submission to the Board to achieve the Staff Governance Standard;
* take responsibility for the timely submission of all staff governance information required for national monitoring arrangements;
* monitor benefits realisation processes; and
* provide staff governance information for the statement of internal control;
* to provide assurance that systems and procedures are in place to manage the issues set out in MEL 1993 114 amended (the Remuneration Committee).

**8. Review of Terms of Reference**

These terms of reference will be reviewed annually.