London Ambulance Service NHS
NHS Trust

LAS Governance Review

CONTENTS

Executive Summary

Work undertaken

1. Analysed existing structure
2. Took account of views of senior staff
3. Noted requirements of National Bodies
4. Reviewed Trust documentation
5. Noted good practice at other Trusts

Findings

1. Existing structure compares well with elsewhere
2. Auditors satisfied with assurance given. Some improvements are needed e.g. wider health community, patients & public, inventory of IT systems, IT training for staff
3. Governance at senior levels is of a high order, however this is not always embedded at lower levels
4. Integration of governance with operational issues needs to occur
5. Some minor duplication in existing structure
6. Latest recommendations suggest monitoring of risk, by Audit Committee to include not only financial but also clinical and organisational risk
7. Committee structure, membership, terms of reference (TORs), agendas, minutes, reporting links & timescales need standardisation

Recommendations

1. Audit Committee to scrutinise areas of organisational and clinical governance in addition to financial governance-one committee overseeing all assurance to the Board
2. Clinical Governance Committee will scrutinise areas of clinical risk and ensure appropriate action plans are in place to reduce these. They will monitor clinical care using clinical audit and other available evidence to do this
3. Senior Management Group to monitor work of the Governance/Operational Groups through cascaded Key Performance Indicators. This Group is the key to the successful working of this structure.
4. The implementation of a Balanced Scorecard as a management tool
5. Risk Compliance and Assurance Group to maintain Risk Register and monitor action plans for clinical, organisational, Information Governance and other high-risk matters.
6. Governance Development Unit to become the LAS Compliance Unit with a pivotal role in the Organisation holding Compliance and Risk Registers and supporting all above committees and groups
7. Standardisation of committee structure, title, membership, TORs, agendas, minutes, reporting links and timescales to increase effectiveness. All committees should undertake regular self-appraisal.
8. Institution of a Complaints Department to ensure complaints analysed, responded to and lessons are learned. This unit must be accountable for achieving compliance with all NHS standards for complaints handling. This should be separate from any disciplinary process. Monitoring to be done by Complaints Panel
9. Publication scheme on Trust website should be routinely updated with active links.
10. Management structures to support these recommendations will require further review
11. LAS should consider whether to begin the process for the appointment of Members and Governors in preparation for Foundation Trust status

Review of Committee Governance in the LAS

1. Background/Introduction

It is regarded as good practice for NHS organisations to review their governance arrangements from time to time, in line with the introduction of new legislation and further requirements of monitoring bodies such as the Department of Health, the National Health Service Litigation Authority, the Audit Commission and the Health Care Commission. The London Ambulance Service reviewed the clinical governance structure in 2003. This present Review was set up at the request of the Chairman of the London Ambulance Service, Sigurd Reinton.

The committees, panels and groups, which exist in the Trust, should operate to maximum efficiency and their effectiveness should be reviewed on a regular basis. Decisions made and actions identified should be clearly indicated and the outcomes recorded. Meeting agendas, minutes, and papers should be easily accessible to whoever has a legitimate reason to access them. The Publication Scheme on the Trust website should be maintained and routinely updated with links to references to the Trust's processes for complying with the Freedom of Information Act. At present, committee documentation is often not easily accessible, and processes lack consistency and sometimes transparency. Committees and panels report via chairs through to the Trust Board but this reporting process often lacks clarity. Continuity is difficult to follow and in many cases the timely outcomes desired are not achieved.

The Vision and Values of the London Ambulance Service (Appendix 1B) are given prominence in ambulance stations and at Induction and in the LAS Annual Report. However a number of issues have been flagged at Board level, which suggests that although governance is taken very seriously at senior level, this is not always the case at lower operational levels. It should be noted that LAS has a workforce, the majority of whom, now have some form of professional registration-this in itself must encourage a change in values and with that, a reduction in overall risk.

At the time of writing, LAS is undergoing a massive regrading exercise with Agenda for Change. It is also facing a 3-4% annual increase in emergency workload with consequent pressure to achieve the 8-minute category A target, leading to the cancellation of study and annual leave. These factors, in particular, have affected morale within the Service.

This document sets out to produce consistency in the Trust's approach to its committees, in order to achieve more effective outcomes and ensure that all staff believe that the governance of LAS is part of their work within the organisation.

All the committees, working groups and panels identified in the LAS Risk Management Framework were included in this review with the exception of the Trust Board itself. The existing committee structure is to be found in Appendix 5

2. Method of Approach

1. The main influencing bodies including the NHSLA, the NHS Appointments Commission, the Department of Health, Audit Commission and the HSE were written to and a literature search of the relevant documents identified was undertaken.
2. All Board members were interviewed using a structured questionnaire and the information obtained has been collated. (See Appendix 2)
3. Recent audits and the views of LAS internal and external auditors were noted
4. Members of the Audit Committee completed The Audit Committee Self-Assessment Checklist, as recommended in the Audit Committee Handbook 2005 (results in 3.8.1).
5. Visits were made to other NHS Trusts to consider lessons learned from their experience. These include Frimley Park Hospital, the Homerton Hospital and the East Anglia Ambulance Service NHS Trusts. (See Appendix 4)
6. Membership and Chairs of all governance committees/working groups were plotted onto a grid. (See Appendix 9)
7. The Terms of Reference, agendas & minutes for all the governance committees over the last 12 months were examined. A limited process map of information flows was produced demonstrating information flows, reporting systems and feedback loops.
8. The author attended a number of meetings, but not of every committee, in order to understand more fully, how they contribute to the organisation's governance.
9. A simple scoring system-Kaplan & Norton's Balanced Scorecard (see Appendix 8), was examined in order to assess whether this could provide regular assurance to the Board.

3. Findings

3.1 Committee Structure and Reporting

- The process is not always clear - the purpose of the committee, why people are present, what their post is within LAS and how they relate to the committee above them
- The scheme of delegation by the Board, giving responsibility to key committees in the governance framework is not always explicit in the terms of reference
- It is often difficult to get a feel for information and advice provided by specialist service groups for the senior governance groups
- Some verbatim comments give a feeling of impotence:
  - 'Staff raised their concerns that this matter is going round and round in circles'
  - 'It was suggested that it might be a good idea if the Service produced a leaflet which crews could leave with non-conveyed callers explaining that ambulances were not a taxi service' – no action recorded

- There was a general consensus that the governance infrastructure, as it stands, is unwieldy and needs streamlining, to make it more dynamic, with more “joined-up” thinking and less silo working.
- The current governance infrastructure has a weak interface with the operational management infrastructure. This threatens compliance with health care standards and government targets.
- Some committees reporting directly to the Board make an annual report to the Board, but not all. These annual reports did not always identify how they contribute to the trust’s governance or what progress has been made to increase assurance for the Board.

3.2 Committee Links and Timescales

Linkages between committees are not always obvious. The timetables for some committee meetings seem to be decided in isolation from each other, so that in cases where matters are referred from one committee to another (whether up or down) there can be a considerable time lag before decisions are made with regard to these items. For example, it was noted that an item considered by the Risk Management Group was delayed by 3-4 months before being considered by the Risk Management Committee. Committees also have meeting dates clustered closely together with similar agendas and little time to prepare decisions reported in one meeting to be communicated by written report in the next Audit Committee, Risk Management Group and Clinical Risk Group and Trust Board all frequently meet within 10 working days. This might explain rushed papers etc.

An agenda item relating to the increased incidence of accidents involving fast response vehicles (FRVs) was tracked through different committees over time:

2/3/04	Clinical Risk Group	Increased number of accidents involving FRVs. Extra training for FRVs. Minimum time in Service
20/8/04	Motor Risk Man Group	Use of Black Box
4/10/04	Clinical Risk Group	Risk posed by FRV responding to red calls without training
6/12/04	Motor Risk Man Group	Black Box trials in FRVs. Staff Council support
31/1/05	Clinical Risk Group	Risks posed by FRV drivers discussed & training needs reviewed
30/3/05	Risk Management Group	Minutes of Clinical Governance Committee of 31/1/05
7/6/05	Clinical Risk Group	No formal assessment of FRV drivers
4/7/05	Audit Committee	Risk 17….FRV driver training-ISoN funding requested to provide specific FRV training-being pursued by Training Services Committee
15/8/05	Clinical Governance Com	Minutes Clinical Risk Group-long standing item that FRV drivers should have their driving assessed…
16/8/05	Training Services Committee	Further training of FRV drivers agreed
27/9/05	Trust Board	Minutes of Clinical Governance Committee-longstanding item that FRV drivers should have their driving assessed
6/9/05	Clinical Risk Group (reported RMC 5/12/05)	Work had begun with regard to training FRV drivers
15/9/05	Motor Risk Man Group (reported RMC 5/12/05)	The “black box” will be trialled on 20 FRVs
11/11/05	Medical Director-personal communication	Graphic evidence that nearly 50% AS have instituted further training for their FRV drivers

In the above example the process is going both upwards and down. There is a considerable time lag between the time when the issue was raised and the resolution. The process is not fully recorded, thus the governance process is incomplete and the Board could not have full assurance because evidence of accident reduction is not yet available to demonstrate an improvement via a routine process.

3.3 **Complaints** and learning the lessons from complaints are a significant governance issue. The Chief Medical Officer, Sir Liam Donaldson, highlighted this originally in his paper about a “Learning Organisation”. The NHSLA and core standard in the Standards for Better Health, 14 [a][b] and [c] all address this important matter.

At present LAS has several routes for addressing complaints. These may be received via the PALs Team and dealt with by them on an informal basis or be referred to the Professional Standards Unit where complaints are investigated formally, usually as part of a disciplinary procedure. Incidents that give rise to complaints may be investigated under the Serious Untoward Incident Procedure. On occasion shortcomings may be identified by the legal department in the investigation process for a Coroner’s Inquest or a Solicitor’s application for records Some complaints originate through the whistle-blowing mechanism. Lessons can be learned from all adverse incidents however a complaint is received or shortcomings identified. In addition, lessons should be learned as a result of dismissals. As far as complainants are concerned, they want to ensure that it is accepted that a mistake occurred and that systems are put in place to prevent a recurrence.

Reporting of complaints and specifically outcomes from them is not comprehensively embedded in the governance infrastructure. Some reporting

of compliance with the 20-day target takes place but there is limited description of lessons learned, the implementation of recommendations or outcomes evidencing improvement in patient care.

When the Review of PSU is published it should provide assurance as to where the gaps are in compliance with the core healthcare standards as above.

It should be noted that the Policy Lead at the Department of Health has stated that this standard will be replaced in the Annual Health Check in 2006 with new standards. Complaints handling as an integral part of the LAS governance system, needs to be place in anticipation of these standards. On the1st December 2005, it was announced that there would be an audit of complaints in every NHS Trust during 2006. This must be taken into consideration when reviewing arrangements within the trust for the management of complaints.

3.4 Committee Membership

- Not all members of committees/working groups make a contribution or contribute towards outcomes
- Some committees have attendees who are not on the membership list
- The reasons for including an NED member or having a Patient Forum member in attendance is not always clear
- Some have very large memberships
- Attendance is often much larger than the membership
- There is no process for the regular review of membership
- It is not always clear who is the chair and a vice-chair is not usually identified
- It is not clear how membership is decided
- Performance of Committee members is not reviewed
- No terms of office, especially for Chairs, are identified
- There is no training to develop skills in committee work
- There are no clear guidelines regarding attendance by deputies, who must be empowered, where such attendance is agreed
- Where a committee has an agreed reporting line upwards it does not always have at least one member who sits on the higher committee and who could report and feedback items to both committees and thus provides the essential continuity
- Performance measures for committees and groups (i.e. their contribution to compliance with external assessments, standards and targets) are absent

3.5 Terms of Reference

Although the Terms of Reference for risk management committees and groups are well documented in the Risk Management Framework there is some variation in coverage. The Terms of Reference for other committees vary considerably, potentially resulting in a lack of clarity and confusion between the roles of similar groups. The terms of reference do not have a requirement for committees and groups to review annually if they are fit for purpose or if they need to change to accommodate new director or staff roles.

3.6 Communications

- The Board Chairman uses a forward planner, which sets out clearly the work schedule of the Board. Board members are asked to contribute to this.
- Only Trust Board agendas, minutes and papers are readily available on the Internet and these are not always kept up to date.
- Draft versions of Clinical Governance Committee, Audit Committee, Risk Management Committee, Charitable Funds Committee, and Service Development Committee are included as enclosures for Trust Board agenda items. Draft status is not always indicated on the minutes themselves. A similar system exists for lower committees. For example the Risk Management Group and Information Governance Panel report to the Risk Management Committee and their minutes are considered by, and are minuted in, the Risk Management Committee Minutes, but not given in full. In all these cases the minutes are a summary of the meeting. There are no agendas or papers. There needs to be clearer advice on when minutes are draft and when they are not. There should be more clarity about when the Board is being asked to receive minutes and when the Board is being asked to approve recommendations from committees.
- The Freedom of Information (FOI) Publication Scheme provides a link to the Trust Board documents and states that Audit, Clinical Governance and Risk Management agendas and Minutes can be made available. At present there are no links to these. The Publication Scheme however, states that 'we will state how you can obtain the information outlined within each class'. This is not so. Links are needed in order to achieve this. These will need to be routinely updated
- Oral Communication within LAS:
  - Corporate Induction Programme All staff are expected to attend this 2-day programme. It includes basic life support, complaints and disciplinary matters, hand hygiene, health and safety and diversity issues. The Chief Executive speaks at this about the Vision and Values of the London Ambulance Service.
  - Chief Executive's Consultation Meetings Each year, the Chief Executive gives all staff working for LAS an opportunity to attend one of the 32 meetings held around London. He attends these meetings with the Medical Director and the Director of Communications. Presentations are the core of the meetings with an update for staff on new developments within LAS. These also act as a prompt for staff to comment and question on any topic of relevance. All questions are answered, if not immediately, within a short space of time. The Director of Communications keeps a written record of the meetings

and a summary is presented to the Board. Important matters may be added to the Service Improvement Programme.

- Written Communications within LAS:
  - *Pulse* - This is the corporate intranet publication available to all employees. It includes directories of staff and sites, news, personnel information and corporate information such as policies and procedures. The Pulse has a section for Summaries of Meetings but at present this only includes issues from the Clinical Risk Group based on the action points from Clinical Risk Group meetings and notes of one Operational Management Group meeting from 31 January 2005. There are no agendas, minutes, or papers of governance meetings available on The Pulse. The word governance is not on the main home page and governance issues are not flagged as such. The Pulse can provide video-messaging regarding significant events. The CEO has used this medium.
  - *RIB* - On the *Pulse* has updated policies and vacancies for posts advertised to internal candidates
  - *LAS News* - This staff newsletter contains Patient Care News, with articles on clinical and practice issues and advice on management, also a fairly vocal letters section. Substantial space is given to letters of thanks but only occasional mention given to lessons learned from complaints and adverse incidents. There is no dedicated page for sharing good practice
  - *Complex Newsletters* - These are locally produced and contain items of general LAS information and of local interest
  - *Personal Communications from the CEO*-These are very well received by staff, who hold the CEO in very high regard

3.7 Meeting Agendas, Minutes, and Papers

- There is no consistent house style for agendas, papers, minutes or action points
- The quality of minutes was very variable from reporting in the third person to a verbatim conversation between two or three individuals
- Action points and to whom these are delegated, are often not clear
- One committee does not appear to produce minutes, although decisions are made at this committee
- Minutes are generally only circulated [electronically and hard copy] to staff, who are members of the committee. Apart from the Trust Board there is no easy availability for either staff or those external to the Trust to access committee documents

3.8 Committee Titles

- There is no agreed titling format for committees, panels or groups.

3.9 Audit Committee Self-Assessment Checklist

The Audit Committee checklist (*Audit Committee Handbook*) was circulated to Trust Board members for their review and comment in December 2005. The general feedback was that our Audit Committee was fit for purpose as currently constituted. This useful exercise will be repeated on an annual basis as part of our governance review.

3.10 The view of Internal Audit (Bentley Jennison) on Corporate Governance within LAS-finished in October 2005

Their overall conclusion on this reads as follows:

"…in their opinion the controls within the system, as currently laid down and operated, provide substantial assurance that risks material to the achievement of the organisation's objectives for the system are adequately managed and controlled".

Two issues were identified as meriting attention:

1. "A self assessment of the effectiveness of the Trust Board's Audit Committee and the Risk Management Committee should be undertaken by the Trust on a periodic basis, utilising best practice guidance, where appropriate"
2. "Consideration should be given for an annual report of the Audit Committee to be produced and submitted to the Trust Board for review"

3.11 The Annual Audit Letter (which serves as an Annual Report from the Audit Committee) produced by the Audit Commission gave the following opinion:

1. "We found no major weaknesses in the Trust's overall arrangements for meeting standards of financial conduct and prevention and detection of fraud and corruption, and for ensuring the legality of its transactions"
2. "… that performance management was good, with good allocation of resources to priority areas and robust monitoring procedures".
3. "...that the Trust should further improve its ability to work in partnership with others, these include:
   - clarifying the objectives and terms of reference of the various groups that work together to improve response times
   - ensuring that the Trust's service planning arrangements are fully understood by the wider health economy
   - reviewing how the Trust involves patients and the public more closely in the planning of services
4. "…satisfactory overall arrangements for information management and governance in place. These can be improved by ensuring that:
   - staff are made fully aware of the availability of, and security requirements for, information held by the Trust
   - there is an inventory of information systems within the Trust
   - there is an information strategy

- the Trust's website is updated regularly and is more accessible to people with disabilities & to those who do not have English as their first language
- the adequacy of IT training for staff is reviewed
- there is integration of payroll/personnel systems and operational systems

3.12 Scoring Systems

LAS has, for the last 5 years, had in place a Service Improvement Programme (SIP). This has included over 300 initiatives under the following headings:

- Organisation development
- Bringing resources in line with demand
- Strengthening management
- Improving support for staff
- Improving staff safety
- Managing demand
- Improving clinical effectiveness
- Improving productivity and response times
- Developing and modernising the Patient Transport Service
- Improving staff involvement
- Implementing NHS policy
- Improving risk management

These fell into three categories, Patients, People and Performance. The status of all the initiatives has been tracked by the Trust Board using a traffic light system to indicate whether the target has been achieved and the likelihood of it being achieved by the target date of March 2006. To date 24 of the original 300+ initiatives have not been achieved, 7-8 of these may not be achieved by March 2006. The SIP has brought about enormous changes for the better within LAS. The Organisation received considerable financial support to achieve this work. A simpler scoring system for use by the Board is needed to succeed the SIP.

The best known of the commonly used scoring systems is the Kaplan & Norton Balanced Scorecard (Appendix 8). This is a management system (not only a measurement system), which enables organisations to clarify their vision and strategy and translate them into action. It provides feedback around both internal processes and external outcomes in order to improve in an ongoing way, strategic performance and results. When fully deployed, the balanced scorecard can transform strategic planning from an academic exercise into the nerve centre of an organisation.

The Balanced Scorecard retains the traditional financial measures, but these can only tell the story of what has already happened, which was fine when customer relationships and support of the workforce were not seen as essential. Today this is no longer adequate. Organisations must aim to create future value through investment in customers, suppliers, employees, processes, technology and innovation

The Balanced Scorecard is a simple scoring system, which aligns the financial/business priorities with those of the patients and staff. It enables progress to be tracked over time. It evaluates process changes. The idea of "balancing" the four different elements underlines that all components have equal importance. The balance takes into account the future and the past, the internal process and external outcomes, strategic performance and results.

It can use KPIs set by the Board and cascaded down through teams to individuals working on the shop floor.

Within LAS this could look at:

Patients & Public: The NHS has been slower than more business orientated organisations in realising the importance of patients and the public (who are likely to become future patients). All encounters with LAS staff need to focus on them to ensure that they are satisfied with their treatment by the LAS. Poor performance in this respect is a leading indicator of future decline.

In LAS this includes: PPI, findings of the Patients' Forum, patient satisfaction, dealing with complaints, letters of thanks, legal claims etc

People, Learning & Innovation: This includes learning, using mentors, tutors and technological tools within the organisation and allows ease of communication among employees, enabling them to get help with a problem, when this is needed. It also includes employee training and corporate cultural attitudes related to both individual and corporate self-knowledge. In a knowledge-worker organisation, such as LAS, people are the main resource and the only repository of knowledge. Learning is a continuous lifelong process.

In LAS this includes: attendance at courses, advances up the skills escalator, involvement in audit/research, SUI and accident reviews, new learning & innovation, % having PDRs, BME staff recruited, staff turnover, % sickness,

Performance: This includes financial data with timely and accurate income and expenditure, which is a high priority in the NHS and is closely scrutinised in those organisations wishing to become Foundation Trusts. It also includes targets set by outside agencies and cost-benefit data

In LAS this includes: A8/ A14//B19/GP urgents, financial balance, Standards for Better Health-Rating, other Government targets.

Process: This relates to internal business processes enabling managers to know how well the organisation is running and whether the services are those required by the users. In addition to the strategic management process, two kinds of business processes may be identified-mission orientated, which are those where the responsibility lies with senior management and support processes which are more repetitive, easier to measure and benchmark.
In LAS this includes CPI audit, clinical audit, high impact changes, CAD resilience, process management

A Balanced Scorecard must be linked to the vision and strategy. It will *only* work with high quality data and adequate infrastructure to analyse the data. It is essential that all executives, management and staff buy into it, so it should not be too complex and they should receive some benefit from using it. Prior to setting up a definitive Balanced Scorecard, it would be useful to have an annual rolling total with a number of possible KPIs, in order to ascertain which would provide the Board with information giving the greatest assurance.

4. The main issues which need addressing are

- The weak interface between the current governance structure and the operational management infrastructure
- Making the Assurance for the Board more accessible
- Integration of complaints and the patients and public into the governance structure
- The standardisation of committees, their terms of reference, the aligning of committees within the Trust timetable of meetings, membership, conduct of business and their contribution to the governance structure, to make them more effective
- Internal and external communication systems for governance including the publication system and other requirements of the Freedom of Information Act
- The need for a Compliance Register to address changes in legal requirements and the needs of the inspectorates attached to LAS main monitoring organisations
- The need for timely and accurate information systems, together with an appropriate supporting infrastructure.

5. Recommendations

5.1 Committees

Overview

The scope of this Review does not include the Board. However, in view of the recommendations of the Review, the Board may wish to undertake a form of self-assessment.

Titles

Committees are those with a delegated responsibility from the Board, Their function is to manage and approve the majority of trust-wide policies (excluding those requiring Board level review by the NHSLA). Thus committees provide assurance to the Board, reviewing the quality of assurance on behalf of the Board. They also routinely record and note management reports with evidence of progress towards NHS or local targets or the reduction in the risk that threatens the achievement of the Trust objectives. Membership usually includes NEDs and patient representatives (currently from the Patients' Forum)

Groups require a purpose that ensures specific work is done. They provide an annual report to the Board. .i.e. Complaints Group, Infection Control Group, Information Governance Group

Panels - these will include short term groups listed on the diagram as single purpose such as time limited project management based to remedy, improve or resolve performance or non-compliance. E.g. Motor Risk Panel

NED membership

An NED should sit on those committees/groups, where they can add value by challenging policy and where strategic and governance issues are considered. It should be noted that the presence of an NED changes the committee action style and the dynamics of any interaction

Patients' Forum member in attendance

A Patients' Forum member in attendance can add value where patient care is a prominent part of that committee's agenda. It should be borne in mind that the Patients' Forum is the successor to the Community Health Council, the LAS Patients' Forum oversees the work, but it is not an integral part of the LAS.

Observing meetings should be permissible, with the agreement of the Chairman, however an observer should take no part in the meeting, unless specifically invited to do so by the Chairman.

It is proposed that the Board committees include:

a) Audit Committee

The existing Audit Committee of LAS is a well-managed committee and is well regarded by both the Internal and External Audit scrutinisers.

The membership of Audit Committee, within NHS Trusts is by statute, composed entirely of NEDs, who may invite attendees as they require.

The Audit Committee should provide an independent overview of the Board's process for ensuring that there is an effective internal control system. The work of the Audit Committee will facilitate the completion of the Statement of Internal Control by the Chief Executive. For this reason it should be separate from the line structure.

It will maintain its focus on ensuring strong financial management, take an overview of clinical risk and monitor the risks, controls and related assurances concerning the Trusts objectives as set out in the LAS Risk Management framework. The Audit Committee should *not* take on these roles, but ensure that they are working effectively. It should be noted that the existing committee has undertaken a self-appraisal and may act upon the results obtained from this. The Terms of Reference, chair and membership should be based on those set out in *The Audit Committee Handbook 2005.*

Internal and External Audit Teams, Local Counter Fraud and the LAS Compliance Unit should provide support.

The LAS Risk Compliance and Assurance Group will provide the Audit Committee with the evidence that all the principal risks are assessed, that

key controls intended to manage these principal risks are in place and are underpinned by core controls assurance standards.

The number of meetings per annum may need to increase in order to support the additional workload.

The Audit Committee will receive the minutes of the Risk Compliance and Assurance Group and the Clinical Governance Committee.

b) Clinical Governance Committee

This Committee will review and consider the evidence given concerning the provision of clinical care within LAS and provide assurance to the Board in this respect. It will achieve this using the framework of the *Standards for Better Health*.

It will review risks associated with clinical practice and untoward clinical events, taking on the work of the Clinical Risk Committee. It will ensure that appropriate action plans are set up to reduce these risks, as a standing agenda item. These risks together with action plans will be referred to the Risk Compliance & Assurance Group, which will grade them and place them on the Risk Register. The Audit Committee will monitor the action plans.

The LAS differs from other acute service providers in that senior staff are not working on the shop floor in day-to-day contact with patients and therefore not always in a position to comment on inadequate clinical care. Patients and their clinical care are the raison d'être of the LAS and thus clinical governance is of particular importance to the Board. It is recommended therefore that this committee continues to report to the Board and has NED and Patient Forum representation.

The Clinical Governance Committee will receive the minutes from the following sub-groups and panels:

Clinical Audit & Research Steering Group, the Clinical Steering Committee, the Training Services Group, the Infection Control Group, The Race Equality and Diversity Group and the PPI Committee. The Clinical Governance Committee should work with the Trust Compliance Unit (see recommendation below, under 4.6) and the Patient Advice and Liaison Service. A key facilitator will be the Head of Governance.

All these recommendations can be developed from existing resources. One Executive and one NED should be common to both The Audit Committee and The Clinical Governance Committee.

Any areas of risk identified will be referred to the Risk Compliance and Assurance Group

c) Remuneration & Review Committee

The role of this committee will continue as at present

d) Appointments Committee

This will be set up as an ad hoc committee for the appointment of senior executives to the Trust. Membership to be agreed with the Chairman.

e) Charitable Funds Committee

This will agree the disbursement of donated monies given to improve staff facilities and welfare. Membership will include the Financial Controller and one NED the latter to ensure equable distribution of these monies.

Other Groups integral to the Governance Structure include:

a) The Risk Compliance and Assurance Group

This Group has delegated responsibility from the Trust Board through the Audit Committee for taking an overview of all risk management activities within LAS. It will:

- Be responsible for the provision of a systematic and focussed approach to the management of risks within LAS
- Monitor the implementation of the Risk Management Framework and the NHSLA Risk Management Standards
- Accept risks onto the Risk Register and agreeing their priority rating together with a proposed risk reduction plan
- Ensure that any changes in legislation are incorporated into the policies and practices of the Trust etc.

This Group will meet monthly before the Senior Management Group. The LAS Compliance Unit will support the Risk Compliance and Assurance Group.

It will receive the minutes of the Senior Management Group, the Information Governance Group and those of any other time-limited groups set up to deal with high-risk issues. It will also receive from the Clinical Governance Committee a list of identified clinical risks together with action plans to manage these risks.

b) Governance/Clinical/Operational Groups (GCOGs)

The Senior Management Group

The SMG has a key function in this new structure. It will direct vigorously and visibly, using the infrastructure of the GCOGs. Assurance will be provided primarily to the Senior Management Group and secondarily to the Governance Committees, using Key Performance Indicators (KPIs). This structure could enable the operational work to integrate with the governance of the organisation.

The KPIs (annual rolling sheet e.g. December 2004-December 2005) for both the Complex and the Area Governance/Operational Groups should include:

- All elements of the core and developmental Standards for Better Health-7 Domains i.e. enumerate those achieved in last 2 months
- DoH Targets
- PRF completion/CPI records
- Education and training
- Patient satisfaction

- Risks
- Legal cases
- Complaints (to include feedback to and from PALs & the Complaints Panel)
- Incidents/errors/Serious Untoward Incidents (SUIs)

KPIs can form part of each employee's Personal Development Review and agreed at that individual's annual appraisal

These reports will be based on KPIs set by the Executive Operations Standards Committee and agreed by the Board. The Governance/Operational Groups will need the support of high quality IT. Ultimately the KPIs could be incorporated into a Balanced Scorecard agreed by the Board.

It is likely that this process could take time to implement. Key facilitators in this process will be the Head of Governance other senior managers working in the corporate support structures. (See recommendation below, under 5.3). These two will link external audit with internal audit to provide compliance process and avoid duplication by groups and committees in future.

5.2 Recommended standards for all Committees, Panels and Groups:

- Have the Terms of Reference written in a standard format. It should include function, membership (including chair and vice-chair), quorum, frequency, tasks/processes, expected outcomes, reporting lines, communications channels (including reporting of decisions to staff), and should be reviewed annually (see template in appendix 10.3)
- Review membership and roles regularly.
- State clearly the terms of office for all members
- Allow deputies, under the Terms of Reference, and these must be empowered to make decisions and expected to take a full role in the work of the committee when they attend.
- Board sub-committees should have a work-plan set by the Board, using a forward planner similar to that used by the Board.
- Meetings should be planned in alignment to ensure that a decision taken in one group can be acted upon in a timely manner for the next meeting of a linked panel or committee.
- All Sub-Committees should make an annual report to the Board.
- Sub-committees should supply the Board with summaries of items discussed with action points.
- Have their performance and membership reviewed annually
- Have at least one member of each committee sitting on any higher committee to which it reports.
- Have time-limited objectives and be disbanded when appropriate.

5.3 Complaints and Information Governance

Key areas of risk for the Risk Compliance and Assurance Group to focus on are Complaints and Information Governance. These are both Groups where NED membership and a Patients Forum member in attendance add value.

Complaints should be analysed using a tool set up for the purpose and it should be ensured that all staff learn from the analyses. Senior managers might be considered for this training also so that they can be held more accountable for achieving local resolution.

5.4 Support

In order to achieve integration of the governance committees, the skills and experience required to support these new arrangements should be reviewed and strengthened.

These should include:

- A responsibility for ensuring that all committees are fully serviced
- Advice on terms of reference and procedural matters.
- Assurance that the Board understands compliance with authorisations where appropriate and how it is meeting its agreed objectives.
- The production of a routine report on how effectively the Board received assurance from the governance infrastructure.
- A monthly appraisal of where the Board currently lies in relation to its strategic cycle
- Persons with sufficient knowledge of the NHS to gain the respect of operational staff at all levels as well as commitment from corporate managers.

5.5 Meetings

- Timetables for all committee meetings must be carefully co-ordinated so that in cases where matters are referred from one committee to another (whether up or down) there is no time lag greater than two months. These conduits between committees should be flexible so that they can respond to urgent changes that may require a rapid response
- Meetings should be scheduled *before* important decisions are made
- Each meeting should have a nominated person who writes the minutes and the Board Secretary will determine how they meet the required quality and standards to satisfy the Board
- The minutes must convey information so that the Board can instantly access what assurance it is being given, what gaps exist and what plans are in place to deal with them
- The minutes of each meeting should:
  - Follow a consistent concise format, being precise but informative (see template in Appendix 10). They should be written in the third person. They should not be written as a verbatim report, but concentrate on the decisions agreed
  - Detail the title of the committee/panel etc

- Detail the place, date, and time of the meeting
- State the committee chair
- State the minute taker
- List members who attended and their job function, then similar details of other attendees.
- Include Apologies, and the minutes and date of the last meeting
- Have an Action Column. All Action points should include the initials of the person responsible for carrying out the action and a timescale for the action to be completed where this is before the next committee meeting date. Action points should be reported upwards where a committee reports to another
- Be able to identify when a policy or procedure had been approved on behalf of the Board or when it could recommend a policy or procedure as being suitable for going to the Board for approval
- Be listed in running order for the year i.e. 1/05, 2/05, 10/06, 25/06 etc.
- Spell out acronyms in full with the abbreviation given in brackets when first written in any set of minutes, papers or agendas.
- Include the date of the next meeting, which must be fixed at the end of each meeting

- Dates of meetings should then be held on a database available to all senior managers so that they can see the time available for preparing routine reports and papers
- Action points from the meetings should be circulated as soon as possible when they have been agreed by the Chairman, rather than wait for the full minutes to be drafted
- The chairman should sign off draft minutes, as soon as possible following the meeting, before being circulated
- Papers should be written in a standard format
- Papers and presentations should have a standardised Front Sheet giving details and date of the meeting, the item number, the sponsoring member, the paper/presentation title and author, a summary and the purpose of the paper including the desired outcome. (See template in appendix 10)
- The minutes and date of last meeting should be given on the agenda

5.6 Communications

- Trust-wide committee agendas, minutes and papers should be made available as widely as possible, both internally and externally, so that decisions made and actions to be taken are widely known. Particularly relevant points should be sent out to all staff through the Pulse/RIB.
- Final versions of committee meeting agendas, minutes and papers, apart from restricted sections, should be made available through the FOI Publication Scheme and responsibility allocated for keeping them updated throughout the trust business cycle and calendar.
- Members of committees should receive agendas, minutes and papers, if possible a week in advance of the meeting. They should be available for all others to access electronically on The Pulse or the network and in addition to the Trust Board papers; other key committees should be accessible on the Trust website. Links could be emailed to key staff to

remind them of the outcomes of meetings, especially where they have been allocated specific actions to complete.

- It should be made explicit how decisions are to be communicated to front-line and support staff.
- There is no mention of the word governance on the Pulse and effort needs to be made to identify it as a core part of the organisation's functions, which is not separate from operational performance.

5.7 Outcomes/Compliance

- It is recommended that actions, policies and procedures be reported to a central compliance register to enable the Trust to succeed in external accreditation i.e. Healthcare Commission, Annual Health Check, and Monitor etc. This should make use of existing databases and systems. The Head of Records Management can assist with information retrieval and retention schedules, and systems for reporting progress and highlighting the achievement of key milestones that enhance assurance
- The existing Governance Development Unit already undertakes a major part of the work of compliance. It is recommended that this unit becomes the LAS Compliance Unit. The work of this unit will include:
  - The development of a central Compliance Register which is able to evidence progress against performance indicators and the reporting of assurance, to satisfy the Board and external assessors, ensuring that this readily available at short notice
  - The management of the Risk Register on behalf of Risk Compliance & Assurance Committee
  - The Provision of support the Audit and Clinical Governance Committee
  - The increased use of Internal Audit & inspection
- Evidence of compliance and reporting it to the Compliance Unit, will need to be owned as the responsibility of all staff groups, not solely those managers or teams that are currently directly involved.
- As all ambulance and other NHS Trusts will expect to apply for Foundation Status by 2008. It is recommended that LAS should consider whether to initiate the process of seeking members and appointing Governors. This has the following advantages:
  - It will increase the public involvement with the service, enabling education of the work undertaken and matters relating to the provision of the service.
  - It should encourage diversity within the membership and amongst the Governors
  - It will increase patient involvement, ensuring that the service has a greater understanding of their needs
  - With the appointment of staff members, pride in the delivery of service could improve still further
  - It will facilitate the LAS statutory duty to work with other public service partners

Dr Beryl Magrath,
Non-Executive Director, London Ambulance Service

Acknowledgements: *The author would like to acknowledge the support and help given by John Wilkins, Stephen Moore, Mike Dinan, Sylvia Brooke, Paul Stanton, Christine McMahon, Claire Glover, Nicola Foad, Barry McDonald, LAS Board Members, Jason Parker, The Kings Fund, Sue Slipman, Frimley Park and the Homerton Foundation Trusts, the East Anglia Ambulance Trust and members of my Governance Learning Set at the Kings Fund.*

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3. Building the Assurance Framework-A Practical Guide for NHS Boards-Department of Health
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6. NHSLA Risk Management Standard for the Provision of Pre-Hospital Care in Ambulance Trusts-National Health Service Litigation
7. Making Things Better? A report on the reform of the NHS complaints procedure in England-The Health Service Ombudsman
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11. J Montgomery, Health Care Law 2003

APPENDICES

Appendix 1A: Definition of Governance

Good governance is about achieving the desired results and achieving them in the right way (the "right way" is largely shaped by the cultural norms and values (Appendix 1B) of the organisation).

Thus it is the action and the system of governing affairs. In a healthcare organisation this includes financial, organisational and clinical aspects of the organisation. There are two main components:

*An explicit means of setting policies

*An equally explicit means of monitoring those policies

The Trust Board has overall responsibility for good governance but the actual process is undertaken in day-to-day activities by management. All staff should be involved in governance and should know what it is. A fully integrated governance approach must therefore be able to link a chain of communication that travels down from the Board and back up to it.

Good Governance means:

- Focusing on the purpose of the London Ambulance Service and on outcomes for the public and service users
- Performing effectively in clearly defined functions and roles
- Promoting the values (Appendix 1B) of the London Ambulance Service and demonstrating the values of good governance through behaviour
- Taking informed, transparent decisions and managing risk
- Developing the capability and capacity of the Trust Board to be effective
- Engaging stakeholders and making accountability real (adapted from The Good Governance Standard for Public Services)

Appendix 1B

Vision of LAS:

A world-class ambulance service for London staffed by well trained, enthusiastic and proud people who are all recognised for contributing to the provision of high-quality patient care.

Values of LAS:

Clinical Excellence
Respect and courtesy
Integrity
Teamwork
Innovation and flexibility
Communication
Accept responsibility
Leadership and direction

Appendix 2: Summary of Board Members' Views

Current Structure

- Good systems compared with other public bodies e.g. Transport for London, Metropolitan Police, which are robust and transparent
- However when reviewing the Governance Committee chart there was a general consensus that the governance infrastructure, as it stands, is unwieldy and needs streamlining, to make it more dynamic, with more "joined-up" thinking and less silo working
- Clear clinical reporting lines, with feedback loops to those accountable for taking action, are essential for a strong governance structure, which is not always the case at present
- The reporting systems need to have more focus with clearly defined papers setting out developments proposed, risks and other issues which the Board needs to know, in order to make a decision
- The reintroduction of front sheet briefings for all meetings. These should have bullet points on key issues giving essential information for decision making
- More preparation by committee members before meetings will shorten meetings and improve the quality of work done
- Minutes should be available, however action summaries, recommendations and proposals should go to the Board to enable it to understand the issues considered
- Committees are too large and tend to work reactively not proactively
- The responsibility for chairing committees and groups should be shared between empowered senior managers as well as Directors (There is a perception that Director's presence will ensure action).
- Recommendations should always be time limited and with feedback loops to enable reporting of what impact they made and whether further action is required.

Concerns

- Is the Board focussing on the right issues?
- Is the Assurance Framework sufficient? Does anything fall through the net?
- Board working-are the changes in the pipeline deliverable within the financial and performance constraints?
- The Board needs to be sure that the biggest risks to the organisation are appropriately identified and managed. There needs to be some scrutiny of what these are and how they are managed
- Complaints are a problem and not dealt with in an entirely satisfactory manner
- Minutes are often too long with verbatim reporting.

- Details can get lost in tabled minutes to Board and other committees. They need more prominence for good governance
- There is a need to sequence: who tasks whom, who provides the evidence, who monitors what & where
- Meetings are costly, they must therefore be efficient and effective

Gaps

- Reporting of incident type-but are LAS protocols working?
- LAS should lead ambulance sector-at present agendas determined by medical world
- How does Board pick up what is not happening? At present some basic management systems not working e.g. Team Leaders
- The distinction between the SDC and the Board agendas is not clear. SDC agendas too full with too much routine business. “Blue Sky” thinking is an important distinction of SDC
- Groups and committees should be given a life span. The Terms of Reference should be reviewed regularly to ensure that these are fit for purpose
- PPI committee and Patients Forum should be integral to the organisation
- There needs to be clear links between Diversity & Clinical Governance

Duplication

- There is some duplication of minutes in different committees/groups
- Risk Register - should map principal risks that threaten achievement in each domain of Health Care Standards
- An overlap in committee functions was commonly cited and proposals were made to combine the following committees within a carefully judged time frame:
  - Risk Management Group and Risk Management Committee
  - Clinical Risk Group and Clinical Steering Group
  - Clinical Risk Group and Clinical Governance Committee
  - Vehicle Equipment Working Group and Motor Risk Management Group
  - Manual Handling Steering Group and Corporate Health & Safety Group
  - SDC & Trust Board

Appendix 3: External Governance Requirements

1. Legislative Requirements of the Trust Board

   a) The duty to achieve financial balance, value for money and the financial objectives set by the Secretary of State (NHS and Community Care Act 1990 Section 10)

   b) The corporate duty of quality (Section 18 Health Act 1998) to establish and maintain arrangements for improving the quality of health care provided to individuals and the environment in which such services are provided (J Montgomery, Health Care Law 2003)

      - Applies to all services provided or commissioned by the NHS
      - Unique to the NHS
      - Defined through "Standards for Better Health" (2004)

   c) The duty of patient and public involvement (Section 11 Health & Social Care Act 2002)-to involve patients and public in all elements of planning, delivery, monitoring and evaluation of services

   d) The duty of "care" to the staff group (conforming to UK and EU employment law)

   e) The statutory duty of partnership, which is common to all public sector bodies

2. NHS Appointments Commission
   (Information taken from Governing the NHS produced by the NHS Appointments Commission 2003)

   The function of the Board is leadership within a framework of controls, which involves 3 overlapping systems:

   - Controls Assurance/Healthcare Standards
   - Clinical Governance
   - Risk Management

   The following committees, Board constituted and Board sub-committees are required:

   Board Constituted Committees:

   - Remuneration and Terms of Service Committee-agrees the remuneration and terms of service of the Chief Executive (CEO) and other senior members of staff (membership 2 Non Executive Directors (NEDs) and Chair)
   - Charitable Funds Committee-agrees the management and disbursement of monies donated to the organisation for the benefit of staff and patients (membership 1 NED, the Finance Director and Director of Human Resources)

   Statutory Sub-Committees of the Board

   - Audit Committee-responsible for ensuring effective internal controls (membership 3 NEDs, but not the Chair)

- Clinical Governance Committee-responsible for the quality of healthcare required in the Statement of Internal Control (membership does not statutorily require an NED, but good practice supports a NED member)

Desirable Sub-Committee of the Board

- Risk Management Committee-ensures the organisation has a strategy for:
  - The continuing identification and prioritisation of risks
  - A description of action taken to manage each risk
  - The identification of how risk is managed

(Membership does not statutorily require a NED, but a NED is usually a member, because of its importance and links with Audit Committee)

In smaller organisations the responsibility for risk management will be part of the remit of the Audit Committee or it has been incorporated into a joint clinical governance and risk management committee

3. NHS Litigation Authority
(Information taken from NHSLA Risk Management Standard for the Provision of Pre-Hospital Care in the Ambulance Service)

Board Responsibility

- Board approval of risk management strategy-annually reviewed
- Board approval for policy/procedure for recording, reporting & managing Serious Untoward Incidents
- Board approval of a documented complaints procedure, which meets NHS requirements
- Board approval of a documented claims management procedure, which meets NHS requirements
- Board receives independent assurances that there is a comprehensive risk management system is in place

Board Sub-Committee-The Audit Committee. The role of this committee must be clearly defined to ensure that any separation of clinical, financial & organisational risks is kept under review. It should be responsible for overseeing all aspects of risk management; this will include reviewing and providing verification on the systems in place for risk management. It will receive reports on risk management, which are copied to the overarching committees responsible for risk & any other relevant committee/group

Membership should include the CEO and designated Executive Directors with responsibility for specific aspects of risk management and at least 1 NED)

4. Department of Health (*as set out in Building the Assurance Framework: A Practical Guide for NHS Boards*)

Board Responsibility-to set the framework and strategy

Board Sub-Committees

- Risk Management or Governance Committee-to coordinate and filter the risk assessment processes that are being conducted throughout the organisation

- Audit Committee-to review the overall operation of the risk management arrangements & will be informed by the internal auditors

Standards for Better Health was published by the Department of Health in 2004. It includes 7 domains with 4 core standards. The core standards represent a level of service that all patients and service users of all ages should be able to expect from the NHS. These standards are the basis for the assessment of any Health Service organisation by the Healthcare Commission. A brief summary in tabular form is set out below:

Standards for Better Health (Department of Health)

	Domain	**Core Standards**
1.	Safety	C1 a) learn from pt safety incidents & b) safety notices & alerts acted upon C2 child protection C3NICE guidelines C4 a) HC acquired infection, hygiene & cleanliness b) risks from medical devices c) reuseables d) medicines handled safely e) waste disposal
2.	Clinical & Cost Effectiveness	C5a) NICE b) clinical supervision c) CPD d) regular audit & reviews C6cooperation with SS
3.	Governance	C7a) clinical & corporate governance b) employee honesty, openness, use of resources c) systematic risk assessment d) financial economy effective use resources e) equality, respect f) existing performance requirements C8a) whistle blowing b) PDP C9record management C10a) professional registration b) professional codes of conduct C11a) recruitment qualifications b) mandatory training c) CPD C12research governance
4.	Patient Focus	C13a) dignity & respect b) consent c) confidentiality C14a) complaints b) no discrimination against complainers c) act on complaints (C15 food) C16information
5.	Accessible & Responsive Care	C17patient views sought C18access & choice C19promptness for emergencies
6.	Care Environment & Amenities	C20a) safe environment b) patient privacy C21clean optimum environment
7.	Public Health	C22a) cooperate with other organisations b) DPH report conforms c) partnership C23health promotion & disease prevention C24response to national & local incidents

Core Standard 1 Health care organisations protect patients through systems that:

[a] Identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents; and

[b] Ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required time-scales

Core Standard 14-Health Care Organisations should have systems in place to ensure that patients, their relatives and carers:

[a] Have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of service
[b] Are not discriminated against when complaints are made
[c] Are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery

Core Standard17 - The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving health care services.

Developmental Standard 8 - Health care organisations continuously improve the patient experience, based on the feedback of patients, carer and relatives

5. The National Patient Safety Agency (NPSA)

As well as making sure that incidents are reported in the first place, the NPSA aims to promote an open and fair culture across the health service, encouraging clinical and other staff to report incidents and "near misses", when things almost go wrong. A key aim is to encourage staff to report incidents without fear of personal reprimand and know that by sharing their experiences, others will be able to learn lessons and improve patient safety. The change of emphasis is more about the "how" than the "who".

The NPSA helps the NHS learn from things that go wrong and develops solutions to prevent harm in the future. This is done by working with patients and staff locally and nationally to foster a culture where errors can be investigated and innovative solutions developed. This is also done by collecting and analysing information from staff and patients using root cause analysis via the NPSA national reporting and learning system and other sources.

6. Health Service Ombudsman (*taken from Making things better? A report on reform of the NHS complaints procedure in England*)

Board Responsibility

- That the complaints management systems are integrated into the clinical governance/quality framework of the Trust with feedback loops to enable lessons to be learned and improved compliance with outcome reporting requirements.
- That there is clear leadership so that complaints are welcomed and learning is secured
- That there is rigorous and evidence based investigation into complaints by competent, trained staff
- That there are just remedies for justified complaints

7. NHS Audit Committee Handbook 2005

This was launched in October 2005. It is a joint publication of the Department of Health and the Healthcare Financial Management Association. It advocates a system of integrated governance. It is clearly intended that this model should be used by the more financially driven businesses, such as NHS Foundation Trusts.

It acknowledges that the main focus of the work of the Audit Committee is internal financial control. It suggests broadening the remit of the Audit Committee to include consideration of the adequacy and effective operation of the organisation's overall internal control system and to take an overview of clinical risks and ensure that these are embedded in the Assurance Framework. Thus the Committee must have a clear understanding of the broad framework of governance of the organisation, particularly with regard to what other committees are doing. It sees the Committee concentrating on high-risk areas.

Internal Audit

An effective Audit Committee is dependent, in many respects on the existence of an effective internal audit function. It should:

- Be an independent and objective appraisal service within the organisation for the CEO, the Board and the Audit Committee. It should indicate the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives
- Provide an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements

The Audit Committee should be proactive in influencing the internal audit strategy and requesting work from internal audit that focuses on the assurance needs of the Committee and the Board

External Audit

These are appointed by the Audit Commission and are central to the work of the Audit Committee. They review and report on:

- The audited body's financial statements and on its Statement of Internal Control
- Whether the audited body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources

Mandatory Reports:

- To those charged with governance (incorporating the report required under ISA [UK&I] 260) that sets out the main matters arising from the audit of financial statements and the use of resources work
- Statutory report and opinion on the accounts
- Annual Audit letter

The Audit Committee should:

- Consider excluding the Committee Chairman, which is a critical appointment, from other committee responsibilities.
- Provide training for the members
- Hold private discussions with the auditors
- Satisfy itself that there are adequate arrangements in place to counter fraud
- Satisfy itself that clinical objectives and risks are included in the Assurance Framework
- That its work and that of the Clinical Governance Committee are coordinated to avoid duplication or omission

(Membership: minimum 3 NEDs [quorum of 2]. In attendance: Finance Director, Trust Secretary and representatives of Internal and External Audit. The Chief Executive and Chairman would attend by invitation)

8. Personal Feedback from Chairman of LAS Audit Committee, Barry MacDonald

This follows a meeting with Sir William Wells, Chairman NHS, Paul Stanton, NHS Clinical Governance Support Team and Sarah Blackburn, Healthcare Commission

- The Board should have only three committees: Audit, Remuneration and Appointments (Sir William Wells)
- Clinical Governance is an Executive matter and not a Board committee. The Audit Committee should oversee whether it was being undertaken satisfactorily. Board involvement under this approach was not clear
- Audit Committee Handbook
- Development of Audit Committee members competences

9. Integrated Governance Handbook

This was published in February 2006 at the request of the NHS CEO. The intention is to emulate, within the NHS, the good corporate practice of FTSE 100 city institutions.

It acknowledges that clinical governance is the central business of a healthcare organisation and is the Board's core accountability issue. It states that the quality of patient care should not be pushed from the agenda by more immediate operational issues. It proposes that clinical governance should be managed through the organisations line management via clinical directorates or their equivalents. The clinical governance programmes should be drawn up by various sources and signed off by the clinical governance committee, which should be monitored by the Audit Committee and ultimately by the Board.

The Handbook identifies 10 key action points for Boards, who should:

1) Confirm the purpose of the Trust. Establish the strategic direction over next 5 years. Set objectives consistent with government policy and local needs
2) Manage the agenda through the annual business cycle, outlining the approach to accountability through the Assurance Framework
3) Ensure an integrated assurance system is in place
4) Move to decision making by intelligent information, ensuring that reporting requirements for external agencies are aligned to objectives and the Assurance Framework. That core reporting of activity, quality and finance are established and supported by IT. The Board must comply with all relevant policy guidance through a dynamic Assurance Framework aligned to risk and organisational objectives.
5) Review and simplify the committee structure with
   - A clear and appropriate membership
   - A clear remit
   - Defined accountability arrangements
6) Establish new terms of reference for the audit committee, which will be the key scrutinizer of all sub-committees to the Board. The membership must have the skills, abilities and supports to undertake the integrated governance agenda
7) Appoint adequate support in the form of a Corporate or Company Secretary who should ideally be accredited by a professional body such as the Institute of Chartered Secretaries and Administrators (ICSA)
8) Ensure the Board is fit for purpose
9) Ensure Board etiquettes are seen and applied
10) Develop requirements leading to a corporate Board

Compliance Unit The authors recommend setting up such a unit, which is complementary and supported by the work of the internal auditors. The Compliance Unit would ensure that the monitoring of internal controls is a continual process. It would provide assurance to the Board that internal controls were being implemented and followed through. It would not design or manage these systems, but become a central aspect of the controls Assurance Framework.

Appendix 4: Foundation Trusts and an Ambulance Trust

The purpose of visiting Foundation Trusts (FTs) was to see how the governance structure of Foundation Trusts differed from other Trusts and how LAS could benefit from introducing a similar structure. At present no ambulance Trust is a Foundation Trust, thus the Foundation Trusts visited were acute hospital Trusts. It was felt useful to review additionally, the structure in a three star Ambulance Trust.

The two Foundation Trusts visited were Frimley Park Hospital in Surrey and The Homerton Hospital in Hackney. The Ambulance Trust visited was the East Anglia Ambulance Trust.

Both Foundation Trusts had achieved three stars in the Commission for Health Improvement assessment. It was clear that risk was core to Monitor's assessment for Foundation status. In both cases The Risk Register was reviewed and risks associated with Financial Governance, Management Services and the Standards for Better Health were assessed.

Monitor looks for the following, when making an assessment of the financial status of potential FTs:

- Financial plans consistent with strategic plans
- Corroboration of savings plans targets etc.
- Contingency plans i.e. "what if scenario", plan B
- Previous performance against Cost Improvement Programmes-regarded as very important
- Examples of NEDs challenging performance
- Return on assets/liquidity/surplus margins-looking for consistency
- Transparent financial reports & long term planning

The Government, in introducing Foundation Trusts, intended that these became answerable to their local catchment population.
They are legally Public Benefit Corporations, which provide NHS services to NHS patients. They must:

- Seek a membership, of the public, patients, staff and stakeholders.
- Arrange for the election of Governors by the membership.
- Be approved by the Independent Regulator (Monitor)
- Arrange for Governors to appoint non-executive directors including the chairman.

They are:

- Accountable to NHS Commissioners through legally binding contracts
- Allowed new freedoms to decide how best to provide services that reflect local needs and priorities

Foundation Trust status allows:

- The borrowing of money to invest in patient care and services
- A more rapid change in direction and policies

- Staff to influence key decisions
- Greater involvement of local people, patients and partner organisations
- Freedom to pay staff at the market rate

Governors:

- Hold meetings of the Board of Governors
- Represent the interests of their members.
- Work with the Board of Directors to shape plans for the future development of the Trust
- Receive reports on the performance of the Board of Directors and agree the remuneration of the non-executive directors and the chairman, initially with advice and support from the Foundation Trust Network.
- Appoint or remove auditors.

Executive and Non-Executive Directors:

- Meet regularly as a Board of Directors
- Set the strategy and ensure that the Trust follows the principles of good governance
- Are responsible for the governance of the Trust
- Prepare the Trust's forward planning, approve business plans and budget
- Approve the Trusts Human Resources strategy and policy
- Produce Annual Accounts, Annual Report and Audit for the Council of Governors

Non-Executive Directors:

- Appoint the Chief Executive Officer
- Agree the Terms and Conditions and remuneration of the Chief Executive Officer and the Executive Officers
- Monitor and review the auditors functions
- Are more likely to come from a legal or accountancy background
- No longer represent the local population

<u>Learning Points for LAS Governance</u>

1) Membership and how to recruit effectively from the diverse population served by LAS should start as soon as possible. It is never too soon to start. Although the two FTs visited had achieved a reasonable size membership, neither had achieved a membership greater than 2% of the catchment population
2) Recruiting the membership costs £54,000+. Maintaining the membership costs around £100,000
3) Members need to be in place and Governors elected, before the Trust achieves Foundation Trust status
4) The Single Transferable Vote system should be used to elect Governors. Thus if a Governor steps down, then the next member with the largest vote becomes a Governor and there is no need to call a further election

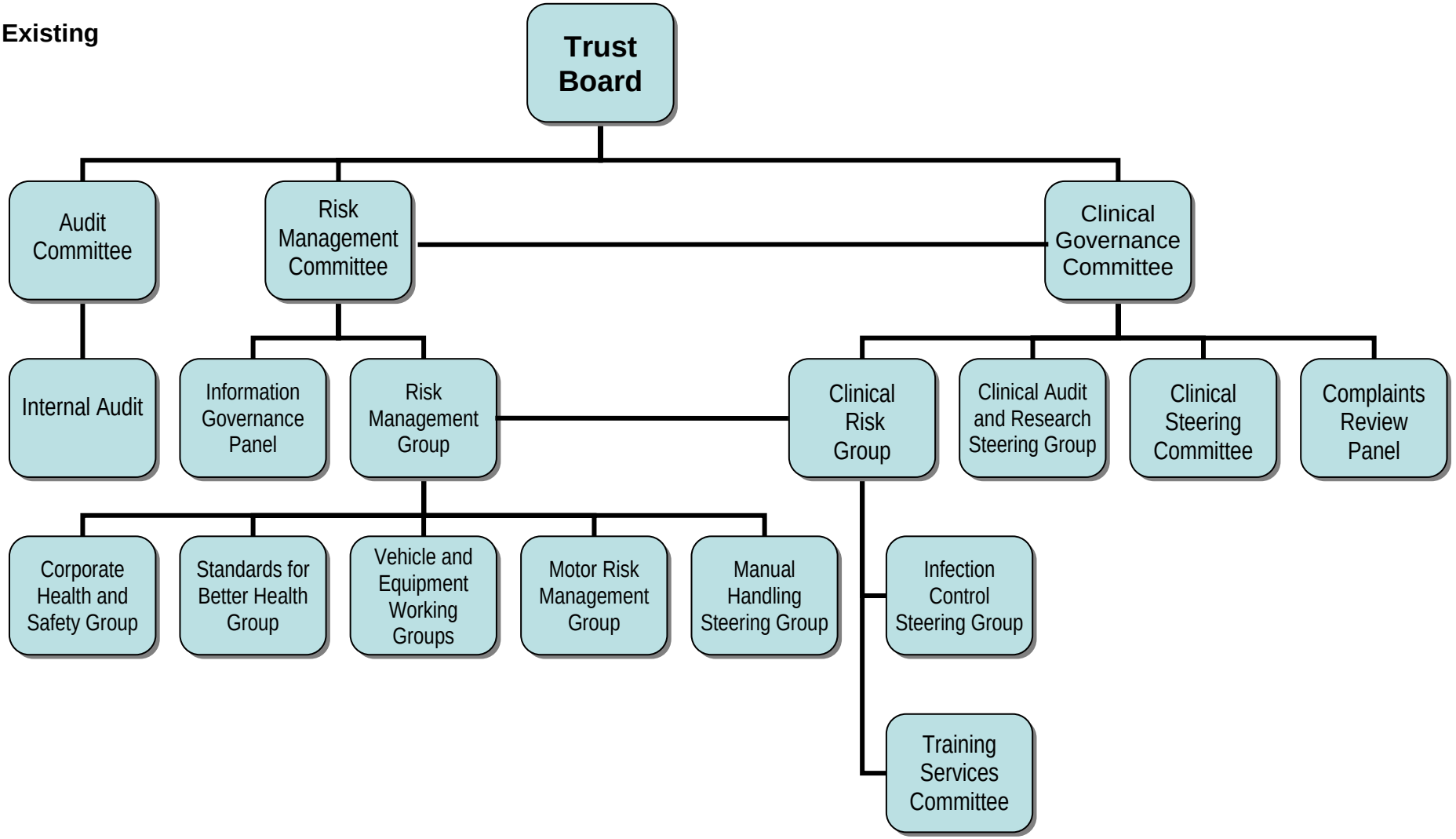
5) Membership database, if purchased, will cost £12,000 pa to maintain. It may be more cost effective to purchase the software and maintain it in-house
6) There needs to be a clear definition of roles between Members, Governors, Non-Executives and Executives ab initio.
7) The Board of Directors is answerable to the Board of Governors. In neither FT visited, has the Board of Governors used this power to discipline Directors.
8) The Board of Directors in both FTs visited now held their meetings in private, with only Board members present. This enabled the Board to focus more on strategy and less on detail.
9) The Board of Governors meetings are open to the public and held in the evening. The meeting hall needs to accommodate up to 100 people.
10) The Chairman acts as conduit between the two Board, as he chairs both. The task of the Chairman is almost doubled.
11) A review mechanism must be built into the Constitution (initial cost £5,000), as changes are inevitable
12) The governance structure of both FTs visited, altered to take into account the Board of Governors; the remaining governance committee structure did not change appreciably with FT status. Changes are now being made in both FTs to reflect the "NHS Audit Committee Handbook 2005" recommendations.
13) AGMs change dramatically, 200-300 people attend. The meeting hall needs to accommodate such numbers
14) Both Foundation Trusts visited are more financially orientated, with new NEDs being appointed from legal and financial backgrounds. Both have an Appeals Department with very active major fund-raising
15) Cash flow is all-important in a Foundation Trust, as is accurate coding of work undertaken for correct payment
16) Governors, not NEDs, represent the local population
17) Although contracts are legally binding (not Service Level Agreements) between Foundation Trusts and their Commissioners, legal action has not been taken in either FT to recover costs for work undertaken.

<u>Visit to East Anglia NHS Ambulance Trust-Learning Points for LAS Governance:</u>

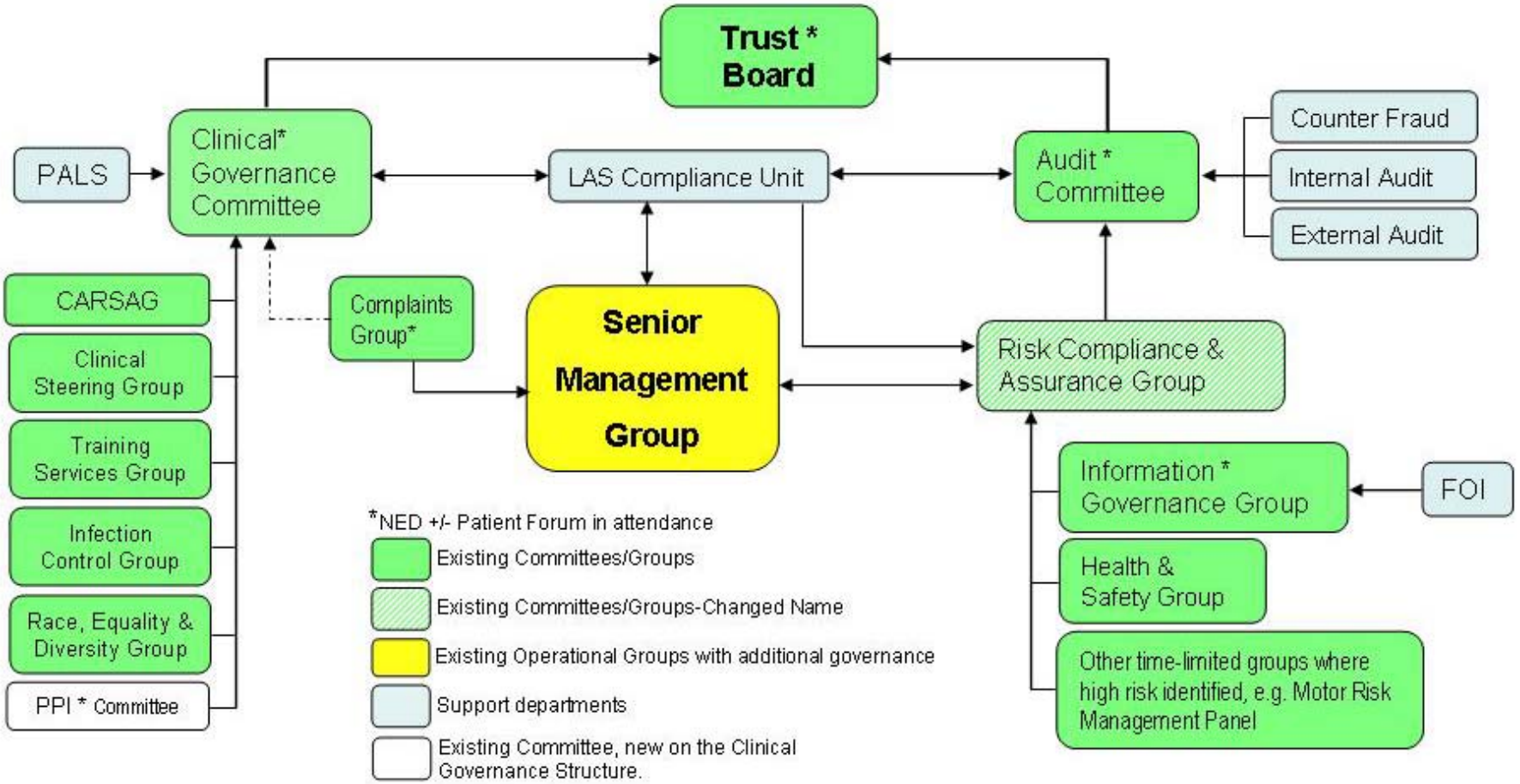
1. Head of Integrated Governance appointed (January 2005) to make integrated governance a reality in the Trust
2. Two Board sub-committees with NED chairmen:
   - Operations Governance Committee which has representatives from 16 "Assurance Groups" filtered by 2 internal groups, the Integrated Governance Group and the Senior Management Team
   - Audit Committee with reports from Internal & External Audit, which receives the minutes of the Operations Governance Committee
3. The Audit Committee and the Operations Governance Group meet in a joint meeting twice a year to provide assurance for members
4. The 16 "Assurance Groups" play a similar role to the 3rd & 4th tier groups/committees at LAS
5. The Board is a "Partnership Board" in that trade union representatives are in attendance (at the table)

Appendix 5 Committee Structures

Existing

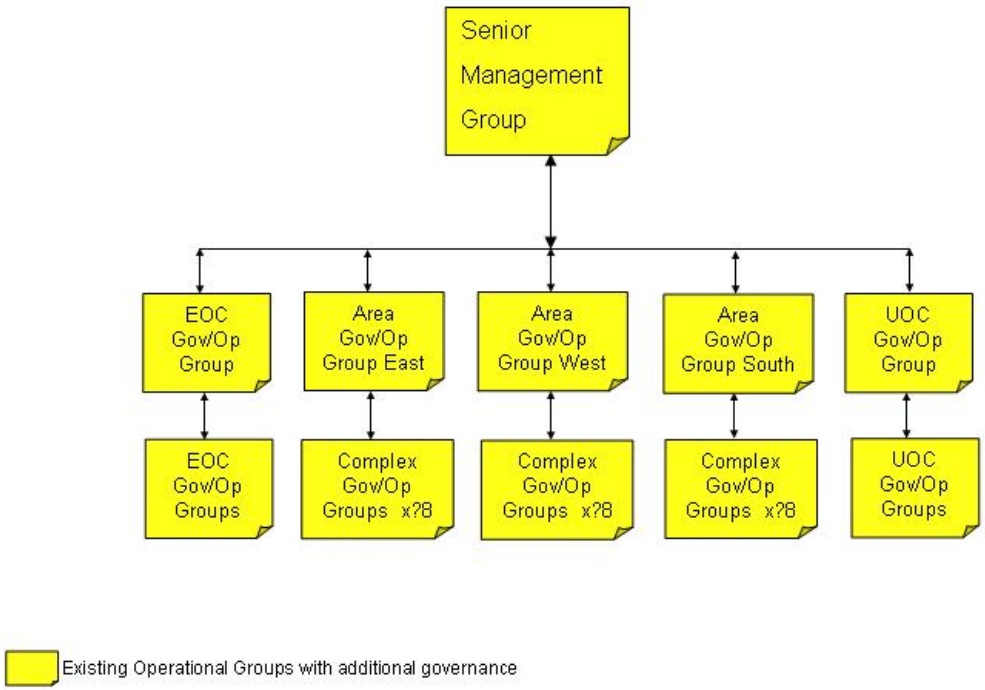


Proposed Structure



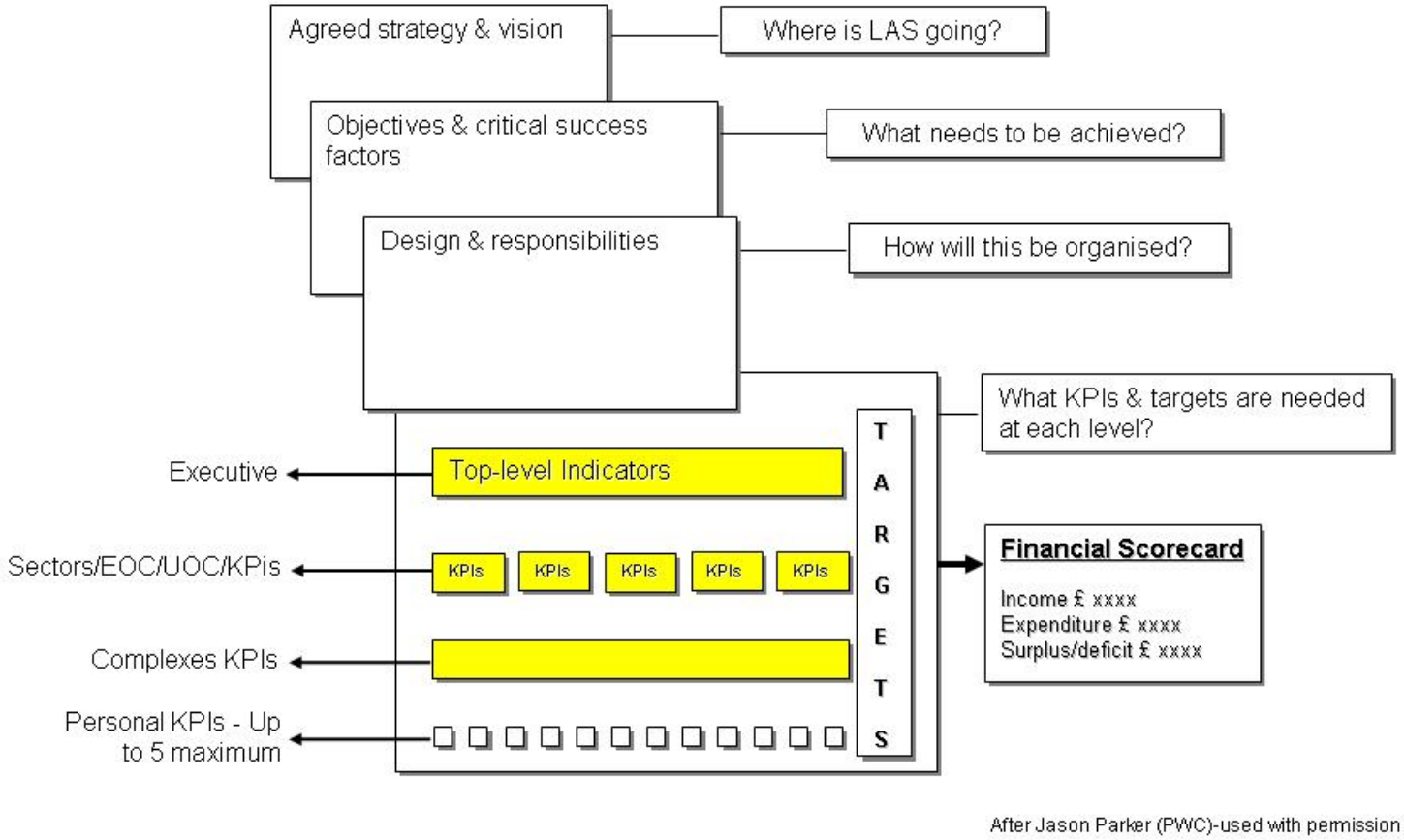
♦ **Committees** have delegated authority from the Trust Board ♦ **Groups** assure that specialist work is done ♦ **Panels** are short term with a single purpose

Proposed Structure



Appendix 6

Key Performance Indicators: Framework



After Jason Parker (PWC)-used with permission

Appendix 7 - Possible Assurance

Reporting to the Clinical Governance Committee:

Infection Control Group

Clinical Audit/Research Group

Clinical Steering Group

Training Services Group

Complaints Panel

Reporting to Risk Compliance and Assurance:

Information Governance Group

Health and Safety Committee

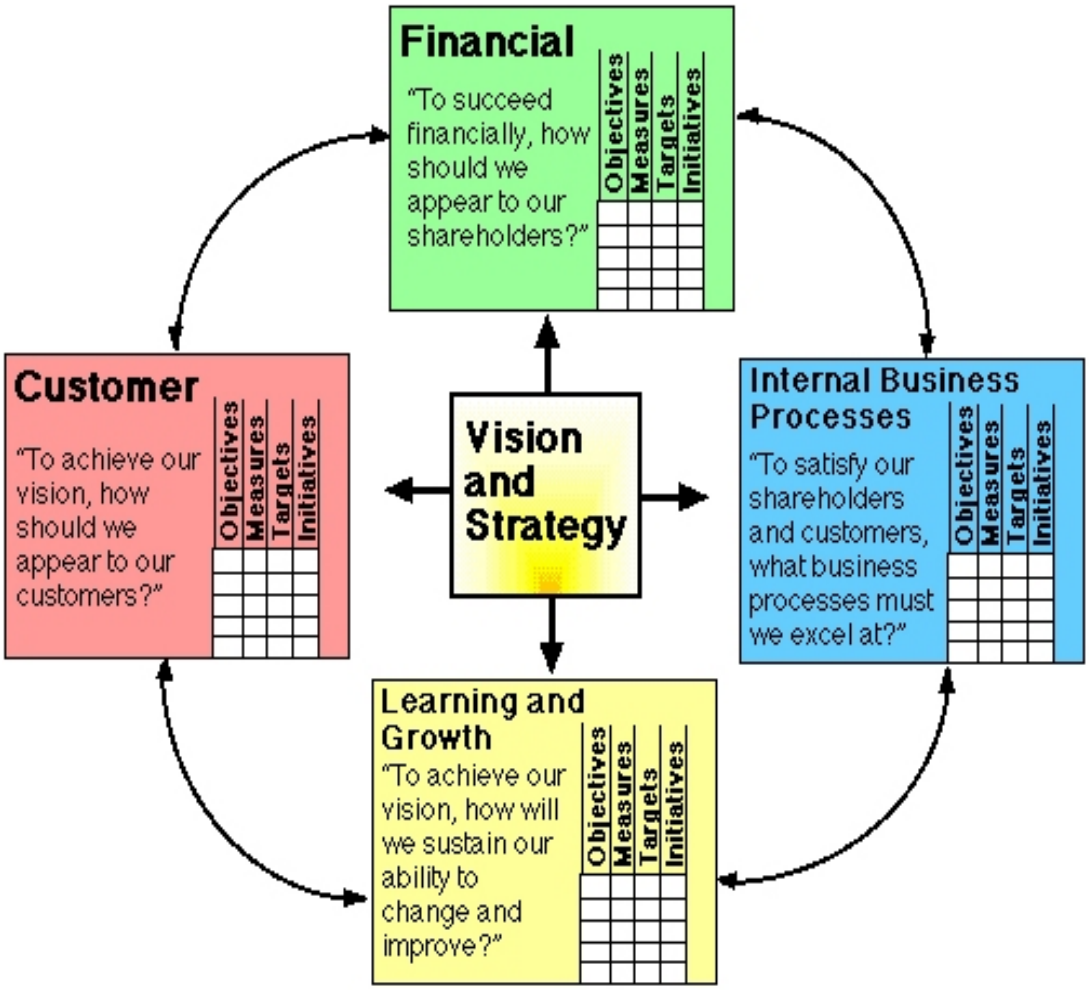
Standards for Better Health Panel

Motor Risk Management Panel

Support for the Audit Committee, Clinical Governance Committee and the Risk Compliance and Assurance Group will come from the LAS Compliance Unit and theTrust Secretary

Appendix 8

The Balanced Scorecard of Kaplan & Norton



Appendix 9 - Review of Current Membership and Chairs of the Governance and Feeder Committees and Working Groups

This revealed that:

1) One NED chaired 2 committees and one chaired 1 committee
2) One Executive Director chaired 4 committees and co-chaired another, one chaired 3 and one chaired one committee
3) One Director co-chaired one committee
4) One senior manager chaired 3 committees

LAS Membership numbers of committees is as follows:

	Title	Membership	NEDs	Executive Directors	Directors	Senior Managers	Managers	Others
1	Risk Management Committee	8	3	4	1			
2	Clinical Governance Committee	11	3	1	1	2	8	
3	Audit Committee	3	3					
4	Risk Management Group	11		4	2	5		
5	Information Security Panel	12		1	1	2	8	
6	Clinical Risk Group	18		1		4	13	
7	Clinical Steering Committee	6		1		2	3	
8	Clinical Audit & Research Group	13		1	1	2	9	
9	Complaints Review Panel	11	1	2	3	4	1	
10	Corporate Health & Safety Group	12		1	2	5	4	
11	Standards for Better Health Group	8		3	2	2	1	
12	Vehicle Equipment WG	16				1	12	3
13	Motor Risk Management Group	12		1		1	10	
14	Manual Handling Steering Group	?				1		
15	Infection Control Steering Group	12				3	9	
16	Training Services Committee			2	1	1		

It should be noted that a 3-hour meeting of 12 persons earning £45,000 per annum would cost (with on-costs) in the region of £1,100. Meetings attended by Directors could double that cost.

Appendix 10 Suggested Templates

10.1) Front Sheet for a Committee Paper

LAS Logo London Ambulance Service *NHS*

XXX Committee Report Sheet

Date of Meeting:	**SMG Sponsor:**
Title of Report:	**Agenda Item:**
	Attachment:
Aims: *(include a brief background/what is the report trying to tell the committee?)*	
Summary: *(what are the main decision points and issues arising?)*	
Recommendations or actions required: *(are there a set of actions being put forward for agreement?)*	
Outcomes: *(are there outcomes from incidents or projects that could be shared across LAS?)*	
Author and date:	

The format for papers should include a front sheet as illustrated above with the detail of the paper in order as presented in the summary.

10.2) Minutes–Format and Style

LAS Logo London Ambulance Service *NHS*

Minutes of the XXX Committee

Date/ Place held/ Time

Present:
Name (Chairman)-post
Name (Vice Chairman)-post
Name (Minute Secretary)-post
Names and posts held of other members
Names and posts held of those in attendance & reason for attendance

Apologies for absence:

Minutes of last meeting and date held:

Record of Minutes: Should be recorded in the third person, indicating the topic discussed, decisions agreed and action points

Items: Should be listed in running order for the year i.e. 1/05, 10/06, 25/06 etc.

Action column: All action points should include the initials of the person responsible for the action and the timescale for the action to be completed. Action points should be reported upwards, where the committee reports to another

Acronyms: On the first appearance these should be spelled out in full with the abbreviation given in brackets in any set of agendas, papers or minutes

Date of next meeting: Should be agreed at end of meeting and indicated at the end of minutes

10.3) Terms of Reference

These should be written in a standard format to include:

- Function of the committee
- Membership, including the Chairman and Vice-Chairman. This should be reviewed regularly
- The use of empowered deputies
- Terms of office of the Chairman and Vice-Chairman
- Numbers constituting a quorum
- Frequency of meetings
- Tasks and processes. (The Board should set a forward work-plan for the committee)
- Outcomes
- Reporting lines
- Reporting lines, including the reporting of decisions to staff
- Should be reviewed annually
- The provision of an Annual Report to the Board
- The nomination of one empowered member (usually the Chairman or Vice-Chairman to sit on a higher committee to which that reports
- A time limitation on sub-committees

Specimen Terms of Reference for the revised Audit Committee can be found in the *NHS Audit Committee Handbook 2005, Appendix A*

10.4) Minute Summary Sheet for the Board

LAS logo *NHS*

London Ambulance Service

Trust Board-Date

Summary of Minutes of … Committee-Date

Chairman of Committee:	*Name*
Purpose:	
Summary: Matters Arising: *(Indicate those of relevance to the governance of LAS with Action Points with time scale)* Reports and Presentations: *(Indicate those made and any Action Points with time scale, relevant to the governance of LAS)* Standing Items and Minutes received by the Committee: *(Enumerate those received and indicate any matters of relevance to the governance of LAS)*	
Recommendations:	

Appendix 11 Guidelines to be followed when setting up a Committee, Working Group or Panel

1. Document the justification for a new group. Ask why it is required and define clearly its objectives and what is needed to achieve them i.e. project plans etc. Would be possible to achieve the desired outcome by other means e.g. tele-conferencing, e-mail, one to one etc.?

2. Ask whether the objectives of an existing group could be altered or extended to deal with the issues as a short-term solution.

3. Determine the type of group that is needed to achieve the desired outcome. Is there a specific requirement for the group to address and should it be time-limited? Review what management arrangements will need to be included in any group to 'make things happen'.

4. Define the desired outcomes and put in place measures, which will provide assurance that these outcomes have been achieved, together with a process that will ensure monitored feedback on a regular, to be determined, basis. Also consider a project management approach using milestones to register progress or delay.

5. Determine where this new group will stand in the committee governance structure and where it will report, both upwards and downwards.

6. Ensure that the scheduling of the first and subsequent meetings takes into account the committee structure and reporting requirements.

7. Determine what authority is required before the group can be established. i.e. is Trust Board approval required and will the Board delegate any authority?

8. Establish a plan for the conduct of the group's work over the first year with review dates.

9. Establish who should be members of the group and clearly determine their roles and what is expected of them. Who will take the roles of chair, vice-chair, and secretary and to whom are they accountable?

10. Determine whether or not the proposed members of the group will require specific training in order to fulfil their roles successfully.

11. Determine the workload to be generated by the group as a whole and ensure that members are aware of their expected contributions as individual members of the group prior to joining. Their performance will be reviewed against the objectives of the group and the achievement of any work plan.

12. Write the Terms of Reference for the group in the standard format as detailed in Appendix 10.

13. Determine who should have access to the documentation produced by the group and liaise with the Head of Records Management to ensure that it is retained and stored electronically in the correct location to facilitate ease of access.

Appendix 12 To show actions deriving from main recommendations, with the aim of ensuring that governance becomes integrated with operational business within LAS

1. Audit Committee to scrutinise areas of organisational and clinical governance in addition to financial governance - one committee overseeing all assurance to the Board. **Action Barry MacDonald**
2. Clinical Governance Committee will scrutinise areas of clinical risk and ensure appropriate action plans are in place to reduce these. They will monitor clinical care using clinical audit and other available evidence to do this **Action Beryl Magrath**
3. Risk Compliance and Assurance Group to maintain Risk Register and monitor action plans for clinical, organisational, Information Governance and other high-risk matters. **Action Peter Bradley**
4. Governance Development Unit to become the LAS Compliance Unit with a pivotal role in the Organisation holding Compliance and Risk Registers and supporting all above committees and groups. **Action Mike Dinan**
5. Standardisation of committee structure, title, membership, TORs, agendas, minutes, reporting links and timescales to increase effectiveness. All committees should undertake regular self-appraisal. **Action John Wilkins**
6. Institution of a Complaints Department to ensure complaints analysed, responded to and lessons are learned. **Action Peter Bradley**
7. Publication scheme on Trust website should be routinely updated with active links. **Action John Downard**
8. LAS should begin the process for the appointment of Members and Governors in preparation for Foundation Trust status. **Action John Wilkins/ Margaret Vander**
9. When the Review of PSU is published it should provide assurance as to where the gaps are in compliance with the core healthcare standards as above. **Action Peter Bradley/John Wilkins**
10. Implementation of a Balanced Scorecard. **Action Mike Dinan**

Appendix 13 : Table to indicate membership, core tasks and timing of meetings of main governance committees

Committee/Group	Frequency	Membership + Core tasks	Position of meeting
Audit Committee	Quarterly	3 NEDS (One to chair) *Delegated authority from the Board to ensure effective internal controls* *Verifying systems in place for risk management*	Meetings must take place after Clinical Governance Committee and Risk Compliance and Assurance Group in the meetings calendar and relate to the Trust Board meetings that review progress against Final Declaration requirements
Clinical Governance Committee	Quarterly	3 NEDS (One to chair) Director of Operations Medical Director Director of Communications Director of Service Development Head of Governance Head of Education and Development Consultant in Emergency Medicine Head of Employment Services PPI Manager Chairman, Patients Forum *Scrutinise areas of clinical risk, reviewing APs.. Monitoring development and practice of clinical care using clinical audit and other available evidence*	Meetings must be timed to take place before the Audit Committee meets so that clinical governance reports can be made to the Audit Committee in its enhanced role of monitoring clinical governance activity and progress
Risk Compliance & Assurance Group	Bi -monthly	Chief Executive (Chair) Director of IM&T Director of Finance Medical Director Director of HR and OD Director of Operations +co-opted key managers i.e. Head of Governance *Overall management of the Risk Register and all risks within the trust*	Timed to report to the Audit Committee
Clinical Audit and Research Group	Quarterly	Medical Director (Chair) Head of Education and Development Head of Clinical Audit and Research Director of Service Development Clinical Education Manager Clinical Practice Manager	Regularly reports to Board via Medical Director's report

Committee/Group	Frequency	Membership + Core tasks	Position of meeting
		AOM, Team Leader EMT Consultants in Emergency Medicine, A&E, clinical toxicology, Cardiology Intensive Care Midwife *Management of research governance including clinical audit with NHS Partners*	
Information Governance Group	Quarterly	Director IM&T} Medical Director}Joint Chairs, 1 NED Senior Operations Officer (EOC) Senior HR Manager Legal and Risk Services Manager Head of Governance PALS Manager Information Security Officer Complaints Manager Head of Records Management Management Information Manager Head of Software Development and Support *Management of Information governance including the Information Governance toolkit and compliance with the Freedom of Information Act*	Must be planned to avoid conflicting dates with Clinical Governance Committee and Risk Management and Assurance Group
Health and Safety Group	Quarterly	Director of HR and OD Director of Operations Head of Fleet Head of Estates Safety and Risk Advisers Staff Safety Officer Head of Employee Services Head of Education and Development Support Services Manager Occupational Health Representative Health and Safety representatives (1per area,1 PTS, Fleet and A&C Rep) PTS Manager *Co-ordinating Health and Safety plan and promotion of a positive Health and Safety Culture Service wide*	Must be planned to meet external accreditation by HSE and other external Health and Safety agencies
Clinical Steering Group	Quarterly	Medical Director (chairman) Head of Clinical Audit and Research	

Committee/Group	Frequency	Membership + Core tasks	Position of meeting
		Head of Education and Development Senior Clinical Advisor Senior Training Officer Assistant Head of Training Consultant Paediatric Intensivist Consultant Paediatrician Consultant Cardiologist Consultant Anaesthetist Consultant Obstetrician Senior Lecturer Obs&Gov *Strategic group contributing to the development of Emergency care*	
Training Services Committee	Bi monthly	Medical Director Director of Operations Director of HR&OD Head of Education and Development Determining the planning and delivery of training programmes for operational staff	Must take place to enable forward planning of training for new and existing operational staff
Complaints Group	? (awaiting PSU review implementation)	Finance Director (Chair) Director of Communications 1 NED Senior Operations Manager Senior Complaints Manager Chair, Patients Forum Head of Governance Head of Education and Development EOC Manager complaints lead Staff representative Frontline staff (X3) PPI manager Head of Urgent Care *Monitoring Trust's compliance with NHS Complaints policy and standards- subject to change relating to PSU Review*	Must report to Board to supplement current complaints reports included in routine CEO's report so full compliance is achieved with Healthcare core and developmental standards
Infection Control Group	Quarterly	Head of Operational Support (Chair) Head of Governance Head of Employee Services Clinical standards Manager Consultant Adviser in Infection Control Staff side representative Estates Manager Governance Manager Audit Manager AOM *Co-ordinating Infection*	Annual report made to the Board and updates from the Minutes included in Medical Director's report

Committee/Group	Frequency	Membership + Core tasks	Position of meeting
		Control Policy compliance including Annual infection control audit programme	
PPI Committee	*Quarterly*	Director of Communications (Chair) Director of Service Development PPI Manager PALS Manager Chair, Patients Forum Senior Operations Manager EOC PTS Manager PALS Officer Diversity Manager Diversity Officer Head of Governance AOMs (X2) *Monitoring the development and delivery of the Trust's PPI strategy and annual work programme*	