INTEGRATED GOVERNANCE STRATEGY

Policy Profile

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<th>Version:</th>
<th>Version 1.0 (March 2012)</th>
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<tr>
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<td>January 2012</td>
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<td>January 2015</td>
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| Lead Director:    | Director for Human Resources and Corporate Affairs  
|                   | (Lead Director for Governance) |

Approval Profile

| Corporate Control Committee: | Via email consultation during February 2012 |
| Executive Management Team:   | 13 & 20 March 2012 |
| Governance Assurance Committee: | Via Trust Board Workshop on 22 February 2012  
|                               | 21 March 2012 |
| Trust Board:                 | 28 March 2012 |
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1.0 Introduction

1.1 This strategy sets out the arrangements for integrated governance within South Eastern Health and Social Care Trust (the Trust) for the three year period April 2012 to March 2015. It is based on the extant integrated governance framework which operates by linking financial governance, risk management (including organizational controls) and clinical and social care governance together as an integrated entity.

1.2 This initial framework was approved by the Executive Management Team at a workshop held on 18 April 2007 and subsequently ratified by Trust Board in May 2007. It also further builds on the proposals emanating from the ‘Review of Governance and Risk Management Infrastructure’ undertaken during September – December 2009; approved by the Trust Board in March 2010 and implemented post April 2010.

1.3 This strategy is closely aligned, and is complementary to, the Trust’s Corporate Plan 2011-2015, the Assurance Framework 2011-2013, the Risk Management Strategy 2011-2013 and the Safety, Quality & Experience Strategy for the period 2012 – 2015.

1.4 This strategy was approved by the Executive Management Team on 20 March 2012 and endorsed by the Governance Assurance Committee at its meeting on 21 March 2012 and presented to the Trust Board on 28 March 2012.

2.0 Context for integrated Governance

2.1 Put simply, Integrated governance is: “The systems, processes and behaviours by which Trusts lead and direct and control their functions in order to achieve organizational objectives, safety and quality of service and in which they relate to patients and carers, the wider community and partner organizations.” (Integrated Governance Handbook, DOH, February 2006). As a Trust we will use this strategy to improve services in a creative and innovative manner.

2.2 Clinical and social care governance is a key aspect of risk management for the Trust and a major determinant of organizational success through its controlling influence and potential for mitigating clinical and social care risks. It is defined as: “A framework through which HPSS organizations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish” (A First Class Service, DOH 1998).

2.3 This is the second strategy for integrated governance developed by the Trust. A highlighted in paragraph 1.2 above, it builds on the work of the Review of Governance and Risk Management Infrastructure (March 2010) which agreed the re-alignment of the Governance infrastructure in line with the Board Assurance

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1 SET Corporate Plan – 2012 -2015
2 SET Assurance Framework 2011-2013
3 SET Risk Management Strategy 2011-2013
4 Safety, Quality & Experience Strategy
Framework\(^5\) issued by the Department of Health, Social Services and Public Safety on 1 April 2009 and, in particular, the adoption of the following four domains:

- Safety and Quality;
- Corporate Control;
- Finance; and
- Operational Performance and Service Improvement.

2.4 To support this framework, the Trust has also adopted the model of Integrated Governance as set out in Figure 1 below. This model is set within the HPSS Quality standards\(^6\) (2006) and illustrates in diagrammatic format how all areas of governance practice are linked together to positively influence the quality of service provided to our patients, clients and service users. Therefore, integrated governance is a means to create greater focus, capacity and enhance capability of the Trust. It facilitates Directors to work corporately as a team, to properly construct the Board agenda, deliver objectives in a coherent way and review the Board support structures to enable them to govern effectively.

Figure 1: South Eastern HSC Trust Model of Integrated Governance

Assuring Safety, Improving Quality and Testing the Patient/Client Experience

Adapted by Barbara Campbell, Linda Kelly and Irene Low (2012) from a diagram adapted by Joe Horton (2010) from an original diagram by C Smyth and L Simmons (2006)

2.5 The key focus for the Trust and, in particular, the Governance Assurance Committee will be that the delivery of care and any changes to service provision are

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\(^5\) DHSSPS Board Assurance Framework

\(^6\) HPSS Quality Standards
directed to provide high quality, safe and effective care which promotes an overall positive experience for the patient/client and carer.

3.0 Aims and Objectives of the strategy

3.1 This strategy aims to ensure that the Trust has in place a framework to that includes standards and requirements as required by the DHPSS Improvement and Regulation (NI Order 2003)\(^7\) and the Quality Standards for Heath and Social Care – Supporting Good Governance and Best Practice in the HPSS (January 2006) and fully integrates these within the Trust's operating structures and processes. The integration and utilization of such processes will ensure that the Trust provides high quality, safe and effective care to patients/clients, carers, staff and the public.

3.2 The core objectives of the strategy are, therefore, to ensure that:-

3.2.1 Patients/client and their carers receive high quality care and services and are protected from harm;

3.2.2 Staff are competent in their role, suitably skilled and are meeting their requirements in relation to practice standards and professional development; and

3.2.3 Teams and systems are developed and reviewed in order to ensure the delivery of effective, efficient and patient/client focused services. The Trust is accountable for the quality of services it provides and takes responsibility for maintaining and improving service provision and practice which promotes a positive service user experience.

3.3 These core objectives are linked to the key clinical and social care governance building blocks (adapted from Joshi 1999) as outlined in the Trust's first strategy for integrated governance (February 2008). They are also linked to the wider governance agenda incorporating financial governance and risk management (including organizational controls) and clinical and social care governance.

3.4 Service users, carers and the public deserve good quality and safe services. The Trust has a statutory duty of quality to ensure the provision of quality services. All staff have a responsibility to ensure that good standards of care are maintained and the organization has internal systems to monitor the provision and delivery of our services.

4.0 Accountability and Responsibility arrangements for Governance within the Trust

4.1 The Trust's Governance infrastructure was formally approved by the Trust Board in March 2010, in its document entitled, 'The Review of Governance and Risk Management Infrastructure'.

4.2 The undernoted section summarizes the roles and responsibilities of the Trust Board, Non-Executive Directors, Chief Executive, Directors, Operational Governance Leads, Managers, Professionals and Staff in respect of governance arrangements within the Trust.

\(7\) DHSSPS Improvement & Regulation Order (NI Order 1993)
Trust Board

The Trust Board is responsible for ensuring that appropriate governance structures and arrangements are in place within the organisation and for receiving assurances from the Chief Executive, Directors and relevant Non Executive Directors that these are operating effectively.

Non-Executive Directors

Five Non-Executive Directors are members of the Governance Assurance Committee and are responsible for providing the Chairman of the Trust Board and its members with an assurance of the effectiveness of the Trust’s governance arrangements. As members of the Governance Assurance Committee they will assure themselves and the Trust Board that the committee and its related sub-committees are addressing key governance issues within the Trust and that key issues of concern and best practice are being brought to the attention of the Trust Board, as appropriate.

Chief Executive

The Chief Executive is the Accountable Officer and is responsible for the effective and efficient management of the Trust and for the quality of health and social care provided throughout the organisation. Within this context the Chief Executive is also responsible for the financial arrangements within the Trust and for the statutory duty of quality. As such, he is ultimately responsible for ensuring that the Trust has effective systems in place for delivering and assuring good governance of the organisation.

Lead Director for Corporate Governance

The Director of Human Resources and Corporate Affairs is accountable to the Chief Executive for the overall strategic management and delivery of the Trust’s corporate governance and risk management (including organisational controls) agendas.

He/she is responsible for ensuring that systems and processes by which the organization leads, directs and controls its functions, in order to achieve organizational objectives, and by which they relate to their partners and the wider community are developed. This also includes responsibility for ensuring that a comprehensive organizational-wide system of risk management is developed and integrated at all levels within the organisation.

He/she works closely with all Directors in the management of the integrated governance agenda.
and is the lead Director for co-ordinating all elements of the integrated governance agenda on behalf of the Chief Executive.

| Lead Director for Financial Governance | The **Director of Finance & Estates** is accountable to the Chief Executive for ensuring that effective processes and systems are in place to ensure good financial governance within the Trust. |
| Lead Director for Clinical Governance | The **Medical Director** is responsible to the Chief Executive for the overall management and delivery of the Trust’s services for the delivery of the medical workforce. He/she is the named Director with responsibility for the clinical governance agenda. |
| Lead Director for Nursing Governance & Safety, Quality & Experience Programme | The **Director of Primary Care, Older People and Executive Director of Nursing and AHP** is responsible for ensuring effective governance within the nursing and allied health professions across the Trust. He/she will also be the lead Director for the Safety, Quality & Experience programme within the Trust as outlined in the extant SQE Strategy. |
| Lead Director for Social Care Governance | The **Director of Children’s Services/Executive Director of Social Work** is responsible to the Chief Executive for the Trust’s social care governance arrangements and for the delegation of statutory social care functions, and corporate parenting responsibilities (CC302). He/she is the named Director with responsibility for the social care governance agenda. |

**All Directors:**

All Directors are responsible for ensuring that appropriate systems and processes are in place to ensure effective governance arrangements across all the services for which they are responsible. These systems should be in line with the key elements detailed within the Trust’s governance arrangements and should integrate with existing management and professional arrangements and processes.

**Operational Leads for Governance:**

The **Operational Leads** for Risk Management, Safe and Effective Care, and Social Care Governance will be responsible for co-ordinating and delivering the governance programme as agreed within this strategy and line with the agreed programmes of work for the relevant committees and sub committees – Governance Assurance, Corporate Control and Safety & Quality Committees. They will
support in this work by their respective sub committees.

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
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<tr>
<td><strong>Assistant Directors, in conjunction with Clinical Directors</strong></td>
<td>In conjunction with the relevant Director, Assistant Directors/Clinical Directors will be responsible for ensuring that an effective governance framework, systems and process are put in place for their areas of responsibility. This should reflect the overall governance arrangements within the Trust and should ensure the delivery of safe and effective care to the patients/clients to which they provide a service.</td>
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<tr>
<td><strong>Associate Clinical Directors:</strong></td>
<td>In conjunction with the Clinical Director, Associate Clinical Directors will be responsible for supporting the delivery of safe and effective care and for ensuring that appropriate action is taken to address any issues of concern or any areas of risk.</td>
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<tr>
<td><strong>Service Managers:</strong> (i.e. 4th Line Managers, Clinical Managers)</td>
<td>Service Managers will work with the relevant Assistant Director and Clinical Director to ensure the implementation of an effective governance framework and associated processes across the directorate/specialty. They will be responsible for ensuring that systems are in place to promote the delivery of safe and effective care and for the reporting of incidents, near misses and complaints. Service Managers will also be responsible for ensuring that appropriate action is taken to address areas of concern and for ensuring that learning from complaints, incidents etc is disseminated and implemented across the directorate/ specialty.</td>
</tr>
<tr>
<td><strong>Directorate Governance Facilitators (where appointed)</strong></td>
<td>Governance Facilitators at Directorate level will work with Assistant Directors, Clinical Directors, Senior Managers and staff to promote effective governance arrangements/process and implement any plans developed to ensure the delivery of high quality, safe and effective care.</td>
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<tr>
<td><strong>Ward/ Department and Facility Manager</strong></td>
<td>Each Ward/Department/Facility manager will be responsible for assuring the quality of care/service provided to patients/clients. In line with each area’s governance arrangements, each manager will be responsible for minimizing risk and promoting quality in relation to their particular service and for highlighting any areas of concern to their line Manager/and or Assistant Director.</td>
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<tr>
<td><strong>Individual staff members</strong></td>
<td>Each member of staff is responsible for providing each patient/client with the highest possible quality of service and for taking all appropriate actions to</td>
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promote patient and staff safety by minimizing risk.

There is an onus on each staff member to highlight any issues of concern, which he/she may have in relation to patient/client care and safety. This should be via the existing managerial and/or professional lines of accountability. Where individual staff members continue to have specific concerns which impact on the delivery of safe and effective care, they have a duty to highlight this in accordance with the Trust’s Whistle Blowing Policy.

In order to ensure professional competency, individual staff will take responsibility for maintaining their own professional registration and for undertaking any relevant continued professional development in line with this registration, KSF Appraisal and Personal Development Plans.

5.0 Organizational Arrangements for Governance within the Trust

5.1 As outlined in section 2 above, in March 2010, the Trust Board approved new structures for Governance which was fully aligned to the four domains as reference in the Department’s Assurance Framework document viz: Corporate Control, Safety & Quality, Finance and Operational Performance & Service Improvement.

5.2 These extant organizational arrangements are illustrated in diagrammatic form at Appendix 1a and 1b. They are also set out in the Trust's Board Assurance Framework (March 2011) and Risk Management Strategy (March 2011).

5.3 This structure identifies an overarching Governance Assurance Committee, which is the strategic committee with responsibility to the Trust Board in all matters pertaining to integrated governance. It is also responsible for setting the strategic direction for governance and for ensuring that the coordination of the various building blocks which comprise this very important agenda operate effectively viz, its two supporting sub committees - the Corporate Control Committee and the Safety & Quality Committee which lead the strategic and operational agenda in relation to risk management and the delivery of safe and effective care including the promoting of a positive user experience.

5.4 Professional governance fora also support the work of all governance committee’s and provides an opportunity for associated professional groups to work collaboratively to identify and address governance issues in a multi-disciplinary and multi professional basis.

5.5 An important element of these arrangements is the need for robust, embedded governance within operational and corporate Directorates. This aspect is managed through the Trust’s Operating Cycle and Performance Management and Accountability Review Processes and is further outlined in section 7.0 below.
6.0 Linkages between the Governance and Safety Quality and Experience (SQE) Strategy

6.1 The Trust has placed improving safety, quality and the patient/client experience as a priority corporate objective for 2011-2015. How this will be achieved on a day to day basis is detailed in the SQE strategy. The term ‘assuring safety, improving quality and testing the experience of the patient/client’ is, therefore, synonymous with achieving good corporate governance. For ease of reference, the terms are defined below:-

- **Assuring Safety**: avoiding and preventing harm to patients and clients from the care, treatment and support that are intended to help them.
- **Improving Quality**: involves monitoring and use of deliberate and defined improvement processes focused on efficiency, effectiveness, performance, accountability and outcomes, which improve the health and social care of the individuals and communities we serve.
- **Testing the Experience of the Patient/Client**: recognizing that patients and clients have a right to experience respectful and professional care, in a considerate and supportive environment, where their privacy is protected and dignity maintained.

6.2 The SQE Strategy complements this Governance Strategy and the Trust’s Operating Cycle. Together they support the alignment of the systems, processes, procedures and behaviours within the organization to ensure effective integrated governance is embedded throughout the organization. This enables the Executive Management Team to “lead and direct and control their functions in order to achieve organizational objectives, safety and quality of service and in which they relate to patients and carers, the wider community and partner organizations.” (Integrated Governance Handbook, DOH, February 2006).

7.0 Performance Management Arrangements for Governance

7.1 The Trust’s Performance Management Operating Cycle (Figure 2) below has been embedded at Corporate and Directorate level within the organization over the past four years. This framework ensures that the Trust planning and accountability cycle systematically and methodically monitors performance against the business and other plan. *Figure 2 bellows depicts this cycle in diagrammatic format.*
In addition, the Trust’s Corporate Plan 2011 - 2015 sets out a clear vision for the Trust to be a leading provider of health and social care and identifies a number of priorities to ensure this vision is realized. The overall direction provided in this Corporate Plan is elaborated upon with the development of an annual Corporate Management Plan and Directorate Management Plans to ensure that there is clarity with regards to responsibilities and the actions required to ensure the Trust delivers the highest quality of care to its population base on these plans. Integrated governance objectives are included within these plans, together with SQE priorities. Figure 3 below illustrates in diagrammatic form the linkages between the Corporate Plan, Operating Cycle and the Governance and Safety, Quality and Experience Strategies.

Figure 3 – Diagram depicting linkages between the Corporate Plan, Operating Cycle and Governance and SQE Strategies

7.3 The current Performance Monitoring & Improvement Meetings (PM&IM) are held on a monthly basis and co-chaired by the Corporate Directors (Planning, Information & Performance Management, Finance, Human Resources & Corporate Affairs) and are attended by each of the four Operational Directors with his/her senior teams. To date, Governance has been discussed on a regular basis at these meetings. However, with effect from April 2012, new reporting time intervals have been agreed and these are now included in the Operating Cycle as follows:-

- **Monthly** - Governance will remain a standing agenda item at all monthly PM&IM for operational Directorates. Agenda items will be identified primarily byDirectorates but provision has been made to accommodate items of a corporate nature via the Operational Governance Leads, as and when these arise;
o **Quarterly** - Governance will be the first item agenda item discussed at the quarterly PM&IM (ie, April/August/November/January). The agenda will be set by the Performance Improvement & Commissioning staff with input from the Operational and/or Director Leads for Governance, as required. This will be based on priorities outlined in the Trust’s Delivery Plan, the Annual Corporate Management Plan and Directorate Management Plans (including SQE Priorities);

o **Bi-annual basis** – Governance issues will be discussed at the Mid and End of Year Accountability Review Meetings with the Chief Executive attended by Directors and their respective Assistant Directors.

o In addition, SQE plans (incorporated into Directorate Management Plans) will be reported through quarterly Performance & Improvement Meetings and the Bi-annual accountability review meetings. Dashboard reporting will be used to support plans.

7.4 In addition, the key building blocks of integrated governance (Figure 1) have been fully integrated into the Trust’s corporate plan across the six key themes as outlined in the Corporate Plan 2011-2015.

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<tr>
<th>Corporate Plan Objectives</th>
<th>Integrated Governance Building Blocks (as per Figure 1)</th>
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| Safety, Quality & Experience | Safe & Effective Practice  
Assuring Safety, Improving Quality and Testing the Patient Experience  
Effective Communication and Information  
- Risk Management  
- Adverse incidents/near misses  
- Research, Evidence Based Practice and informed decision making  
- Information Management  
- Standards and outcomes  
- Audit  
- Complaints/compliments |
| Access | Quality Services through meaningful engagement and effective outcomes for service users and carers |
| Health & Well Being | Promoting, protecting and improving health and social well being |
| Efficiency & Service Reform | Quality Services through meaningful engagement and effective outcomes for service users and carers |
| Our Staff | Leadership and Accountability  
- Leadership and management  
- Human and financial resources  
- Organizational learning and continuous professional development  
- Supervision and performance appraisal  
- Regulation and registration |
| Stakeholder Engagement | Accessible, flexible and responsive services  
- Integrated working  
- Service/user involvement |
7.5 The Operational Leads for Governance are currently redrafting the NI Social Care Governance Workbook and adapting it into a South Eastern HSC Trust Integrated Governance Workbook that can be used by Assistant Directors, Senior Managers and their teams to further embed the principles of integrated governance throughout the organization.

7.6 Once the SET Workbook is developed it will be presented for approval to the Corporate Control and Safety & Quality Committees and then submitted to the Governance Assurance Committee, for endorsement. An implementation plan for roll out of the workbook will be considered in the context of Directorate Management Plans and SQE priorities.

8.0 Arrangements for Governance within Operational and Corporate Directorates

8.1 Operational Directorates (Adult Services, Children’s Services, Hospital Services and Primary Care & Older People Services)

8.1.1 The operational arrangements for governance at Directorate level are the responsibility of the Directors, in conjunction with, their Assistant Directors, Clinical Directors and Senior Managers. The Trust recognizes the diverse nature of both Operational and Corporate Directorates and, therefore, rather than be prescriptive about these arrangements it has allowed for flexibility based on the following guiding principles. It is intended to review governance arrangements at operational level in the forthcoming year to improve consistency in our approach.

8.1.2 Each Operational Directorate (Adult Services, Children’s Services, Hospital Services and Primary Care & Older People Services) should:-

- Develop terms of reference for a Governance Committee which should meet on a frequent basis. This should be no less than 3 times per year. It can be a separate committee meeting or built into another standing committee meeting that would facilitate discussions around governance issues;

- Appoint a Chairman of the Committee. This should be at Director level with input from each Assistant Director area, as appropriate;

- Report issues to relevant committees and sub committees. The Chairperson should report relevant governance issues via normal line management chain of command. The Operational Director/s will also report relevant issues, as appropriate, to either the Corporate Control and/or Safety & Quality Committee. Issues from these committees are escalated via a formal report on a quarterly basis to the Governance Assurance Committee.

- Prepare an agenda for each meeting. As a minimum this should include the four key building blocks of governance as outlined in Figure 1 – Model for Integrated Governance:-
  - Leadership and accountability;
  - Safe and effective practice;
  - Accessible, flexible and responsive services; and
  - Effective Communication and information;
All elements should lead to Assuring Safety, Improving Quality and Testing the Patient/Client Experience.

- Prepare an annual Directorate Management Plan which incorporates key priorities for governance including safety, quality and experience priorities.

8.1.3 Arrangements for incorporating SQE priorities into Directorate Plans have been developed and will be operational wef 1 April 2012. These include the following key elements:

- A standardized template for the completion of Directorate Plans will be issued via the Planning and Performance Directorate for completion by end of March each year.

- The template will facilitate alignment of Directorate objectives with the Corporate Plan objectives. Safety, Quality and Experience Directorate priority objectives should be included under the first Corporate objective (1.1): To ensure that services are safe, effective and contribute towards improving outcomes.

- Directorate SQE objectives will reflect priorities for the Directorate and Service Areas in assuring patient/client safety, improving quality and testing the patient experience. Whilst many objectives will be guided by corporate priorities and best practice guidance/commissioning standards/Departmental directives etc, other priorities may be identified at local level. Consideration of themes and trends identified through complaints, incidents/near misses, audits, lessons learned can often lead to local metrics which can provide the most rigorous measurement of performance against the Safety Quality and Experience agenda.

- A range of priority SQE objectives may be aligned to a number of the other corporate goals within Directorate Plans. Assistant Directors and Senior Managers must decide which objectives provide the assurance that a service is safe, of high quality and enables a positive patient experience and therefore need to be included in the SQE plan. Other objectives will continue to be represented in the Directorate plan against the relevant corporate objective.

- Dashboard reports will provide the required assurance by way of analysis, monitoring level of compliance, identifying required improvements and areas of high achievements. Where possible dashboard reporting should complement the Directorate Plans for Accountability and Performance Monitoring & Improvement Meetings.

- Directorate plans can be further developed to inform service specific plans.

8.1.4 Reporting and Monitoring Arrangements at Operational Directorate Level

Monitoring of the implementation of the plans will be via the PM&IM which are held on a monthly basis. Directorate Governance Committees will, therefore, report via the Trust’s Operational Performance & Service Improvement Processes/cycle. This is illustrated in diagrammatic format on Appendix 1a. The mechanism for escalation of issues will be via this route.
SQE plans (incorporated into Directorate Management Plans) will be reported through quarterly PM&IM and the Bi-annual accountability reviews. Dashboard reporting will be used to support plans.

8.1.5 Arrangements for Corporate Directorates (Finance & Estates, Human Resources & Corporate Affairs, Planning, Information & Performance Management)

In terms of Corporate Directorates, it is expected that Corporate Directors will implement similar structures/processes as outlined in 8.1 and 8.2 above. However, the format for meetings may be integrated into existing meeting structures currently in place at Directorate and Assistant Directorate level. Corporate Directors will also ensure that their Directorate Management Plans incorporate objectives for governance and safety, quality & experience issues.

8.1.6 Operational Arrangements for Governance at Assistant Director Level (Operational and Corporate functions)

Some Operational Assistant Directors already have local Directorate Governance Committees in operation which feed into the Operational and Corporate Directorate Governance Committees as outlined as paragraphs 8.1.2 and 8.1.5 above. In terms of operating arrangements for these Committees, the same principles would apply as outlined in section 8.1.2 above, where appropriate:

- Develop terms of reference for a Governance Committee which should meet on a frequent basis. This should be no less than 3 times per year. It can be a separate committee meeting or built into another standing committee meeting that would facilitate discussions around governance issues;

- Appoint a Chairman of the Committee. This should be at Assistant Director / level with input from each service area/s, as appropriate;

- Report issues to relevant Director and/or Professional Directors, as appropriate. The Chairperson should report relevant governance issues via normal line management chain of command.

- Prepare an agenda for each meeting. As a minimum this should include the four key building blocks of governance as outlined in Figure 1 – Model for Integrated Governance:-

  o Leadership and accountability;
  o Safe and effective practice;
  o Accessible, flexible and responsive services; and
  o Effective Communication and information;

All elements should lead to assuring Safety, Improving Quality and testing the Patient/Client Experience.

- Ensure that their annual Directorate Management Plan incorporates key priorities for governance including safety, quality and experience priorities.
9.0 Governance Strategy: Communication and Implementation

9.1 Communicating the strategy

This strategy will be made widely available, both internally and to external stakeholders, via a range of communication modes including:

- The Trust’s intranet and internet site;
- Direct distribution to stakeholders, where appropriate;
- Senior Staff Communication briefings;
- Team Briefings; and
- Cascaded through Directorate communication structures.

It is the responsibility of Assistant Directors, in conjunction with their Senior Managers and Heads of Departments, to ensure that this strategy is effectively communicated to their staff.

9.2 Implementation of the strategy

The strategy was approved by the Governance Assurance Committee at its meeting on 21 March 2012 and endorsed by the Trust Board on 28 March 2012. Day to day implementation of the strategy and associated activities is managed by the Operational Leads for Governance; it is delivered and directed at local Directorate level by Assistant Directors, in conjunction with their Senior Managers, Heads of Department and staff.

To support the implementation of this strategy, the Integrated Governance Workbook (as referenced in paragraphs 7.5 and 7.6) will be rolled out post April 2012. A plan for roll out of the workbook will be considered in the context of the Directorate Management Plans and SQE priorities.

19 March 2012
SOUTH EASTERN HEALTH & SOCIAL CARE TRUST
Lower Level Sub Committee Structure

TRUST BOARD

Governance Assurance Committee

Corporate Control Committee

Executive Management Team

Safety & Quality Committee

- Adult Safeguarding Sub Committee
- Blood Transfusion Sub Committee
- Clinical Nutrition Sub Committee
- Clinical & Social Care Guidelines Sub Committee
- Drug & Therapeutics Sub Committee
- Infection Control Sub Committee
- Multi Prof. Audit Steering Sub Committee
- Organ Donation Sub Committee
- Patient Safety Leadership Sub Committee
- Policy Sub Committee
- Public & Personal Involvement Sub Committee
- Research Sub Committee
- Resuscitation Sub Committee
- Safeguarding Sub Committee

Operational Performance & Service Improvement Processes

- Decontamination Sub Committee
- Emergency Planning & Business Continuity Sub Committee
- Environmental Cleanliness Sub Committee
- Environmental & Waste Management Sub Committee
- Fleet & Transport Management Sub Committee
- Fire Safety Sub Committee
- Food Safety Sub Committee
- Health & Safety Sub Committee
- Information Governance Sub Committee
- Lessons Learnt Sub Committee
- Medical Devices & Equipment Sub Committee
- Organisation & Workforce Development Sub Committee
- Radiation Protection Sub Committee
- Security Sub Committee

STANDING ADVISORY GROUPS

- Adult Safeguarding Sub Committee
- Blood Transfusion Sub Committee
- Clinical Nutrition Sub Committee
- Clinical & Social Care Guidelines Sub Committee
- Drug & Therapeutics Sub Committee
- Infection Control Sub Committee
- Multi Prof. Audit Steering Sub Committee
- Organ Donation Sub Committee
- Patient Safety Leadership Sub Committee
- Policy Sub Committee
- Public & Personal Involvement Sub Committee
- Research Sub Committee
- Resuscitation Sub Committee
- Safeguarding Sub Committee

- Decontamination Sub Committee
- Emergency Planning & Business Continuity Sub Committee
- Environmental Cleanliness Sub Committee
- Environmental & Waste Management Sub Committee
- Fleet & Transport Management Sub Committee
- Fire Safety Sub Committee
- Food Safety Sub Committee
- Health & Safety Sub Committee
- Information Governance Sub Committee
- Lessons Learnt Sub Committee
- Medical Devices & Equipment Sub Committee
- Organisation & Workforce Development Sub Committee
- Radiation Protection Sub Committee
- Security Sub Committee

Appendix 1b

LL Gov Structure – SET – April 2012