Our Vision
The best care for every patient

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Organisational Framework for Governance

The Trust's Strategic Commitments (2022 – 2027):

1. **Our Patients: Together, we will develop services so that everyone has the best experience of care and treatment.**
2. **Our Team: Together, we will support each other to be the best we can be, to be valued and proud of our hospital for all.**
3. **Our Partners: Together, we will join up services to improve the health and wellbeing of our diverse communities.**
4. **Our Services: Together, we will provide nationally recognised, clinically led services that are high quality, safe and based on evidence and research.**
5. **Our Resources: Together, we will use public money to maximum effect.**

January 2024

The purpose of this Guide and how it is structured?

This guide outlines the structure, accountabilities and processes by which governance and onward assurance to the Board of Directors is achieved in the Norfolk & Norwich University Hospitals NHS Foundation Trust. It is relevant to governance across the activities of the Foundation Trust but it is particularly applicable to two of the Key Lines of Enquiry in the Well-Led Framework:

- Are there clear responsibilities, roles and systems of accountability to support good governance and management (KLOE 4)?
- Are there clear and effective processes for managing risks, issues and performance (KLOE 5)?

It is structured in three main sections:

i) corporate governance;
ii) management committees; and
iii) integrated governance, which incorporates the key domains of governance in the Trust:

- **clinical governance** – including clinical quality and safety and patient experience
- **financial governance** – including capital planning and major projects
- **workforce governance**
- **education governance**
- **information governance**
- **research governance**
- **performance & divisional governance**

In addition, there is a brief summary relating to charity governance which emphasises that the funds and interests of the N&N Hospitals Charity must be protected and considered separately from those of the Foundation Trust, in order to comply with charity law and requirements of the Charity Commission

Fundamentally, the purpose of this Guide is to explain and document the governance processes that the Board and Executive have put in place to facilitate and to gain assurance that the Trust is 'well-led', operating efficiently, achieving its objectives and delivering the best possible care for its patients.

External Validation

This framework is based on best practice guidance and examples, from within and without the NHS Foundation Trust sector, in corporate and integrated governance. It has been the subject of repeated external & independent review:

(i) ***CQC Report (April 2020)***

"The governance structure was effective in supporting the delivery of the current strategy and of supporting the divisions and staff to deliver high quality care";

(ii) ***RSM Internal Audit Review of Risk Management & Governance (October 2022) – Substantial Assurance***

"*We identified an approved and comprehensive Organisational Framework for Governance which defined the governance framework and detailed the remits of and relationships between the Trust Board and Board Assurance Committees, supported by appendices on the reporting and accountability structure, and information flows".*

Review, updating and version control

The framework is not intended to be a static document; it is adapted and updated to reflect the changing circumstances and challenges of the Trust. It will be regularly reviewed to ensure it continues to provide a relevant guide to arrangements in the Trust.

This document will be maintained by the Trust's Board Secretary. Updates will be subject to review and approval by the Board's Audit Committee and Board of Directors as appropriate.

The significant changes in this latest version (January 2024) reflect particularly the Board's decision to create a new assurance committee focussed on Research and Education.

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Executive Summary

Governance in this context is the system by which the Trust is directed and controlled. The Board of Directors is responsible for overseeing the governance of the Trust. This includes setting the Trust's Strategic Commitments and providing the leadership to put those Commitments into effect. The Governance Framework enables the Board of Directors to supervise the management of the Trust. It is to be distinguished from the day to day operational management of the Trust by the executives.

Supporting good governance is the business and concern of everyone in the organisation – so that we can collectively promote the culture necessary to deliver our Vision of delivering ***the best care for every patient***. For the Board to undertake its duties effectively (and for the Trust to provide the best services to patients) it requires the structure, people and process of governance to be integrated into the fabric of the organisation. In this way we can ensure that policies and best practice are followed and that any "Ward to Board" risks and issues are well-articulated and escalated via an easily navigated path. A key role of the Board is to seek assurance that risks to its Strategic Commitments are known and that there are clear plans in place to mitigate, eliminate or manage those risks. The Board is the key place where all the aspects of governance (clinical, financial, performance, workforce, staffing, information, research etc.) come together.

This document aims to improve understanding of governance in the Trust through documenting the associated structures, systems and processes.

Using the building blocks of the Well-Led Framework for the NHS and best practice in corporate and integrated governance, this document explains how the Trust uses available information and intelligence to plan at strategic and operational levels to improve services and manage risks to delivery, assurance is provided with regard to performance, how it identifies when to take action to effect change and how the Board of Directors exercises its accountability to those who deliver and use its services.

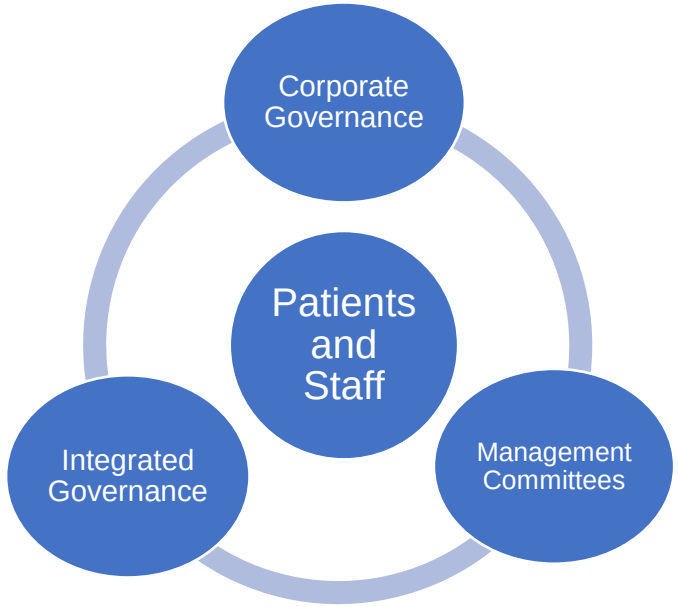
The hope is that this document will provide a useful reference guide for those people, internally and externally, who have an interest in the governance of the Trust. For staff and leaders in the Trust it should provide information to facilitate the escalation of risks and enhance understanding of where and what reports should be made. It also explains why the flow of information from Ward to Board, and vice versa, is so important if the Trust is to achieve its potential and if we are to provide the best possible care to our patients in an efficient, reliable, and sustainable way and with the care and kindness that we would want for those we love the most.

This document is the output of discussions with governors, board members, clinical and departmental leaders. It documents the results of review of the Board's Risk Appetite, the way that the Board works together with its committees, and the way that the Non-Executive Directors work together with the Trust's governors. It is subject to periodic review. Through being clear and transparent about our structures and the ways in which the Board will oversee performance, gather information, obtain assurance and make decisions the aim is to strengthen the governance of the Trust as a core component of our ongoing Journey to Outstanding.

Introduction

This Guide describes the way in which the organisation effectively "governs" its business in order to deliver its Strategic Commitments.

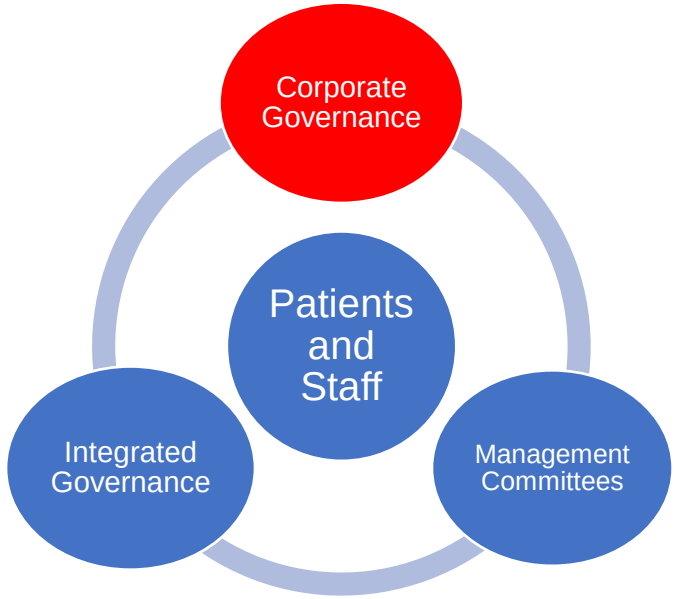
- The Board of Directors leads the ***Corporate Governance*** oversight within the organisation, providing both internal and external assurance about our work. It achieves that by oversight of the Trust's management and operational processes. Section 1 of this document describes the Trust's Corporate Governance processes, the context within which the Trust operates and how it identifies and manages risk.
- Responsibility for managing the Trust to deliver the ambitions of the Board rests with the Executive Directors and the relevant ***Management Committees*** and groups are detailed at Section 2. They provide oversight of core risks and strategic threats and coordinate actions to improve or mitigate risk. They take direction from Executives and the Management Board whilst also providing assurance on the delivery of quality and performance measures and targets.
- The next tier of governance is closest to the delivery of services. ***Integrated Governance*** (section 3) describes the framework through which the Executives lead, direct and control the functions of the Trust in order to achieve its Commitments and ensure the safety, quality and efficiency of its services for patients. A key part of that is ***Divisional Governance.*** Clinically-led, our divisions are the key to implementing high quality patient care in a workplace that is fair, inclusive, kind, well-managed and supports the achievement of excellence.



Section 1 - Corporate Governance

This section outlines the corporate oversight of the organisation by describing:

- The way in which the organisation takes into account external stakeholders and regulatory context
- The overall vision and strategy of the Trust
- The way in which the Board receives and uses information in order to make decisions and gain assurance through its Committee structure
- The role of the Council of Governors and its relationship with the Membership and Board of Directors
- The approach to risk management and related processes within the Trust



Regulatory Framework

- Two main regulators hold NHS Foundation Trusts to account for the quality of care they deliver and how they are run.
  - **The Care Quality Commission** is the independent regulator of health and social care services, they register, inspect and monitor providers of health services including NHS Foundation Trusts, and enforce action where necessary
  - **NHS England is** responsible for overseeing providers of NHS funded care acting as both an economic regulator and supporting providers to meet standards set by the CQC.
- The **NHS Oversight Framework** outlines the approach NHS England will take to oversee organisational performance and describes how all NHS providers will be held to account.- NHS England » NHS Oversight Framework There are five themes, which align to quality, financial, operational, strategic and leadership indicators. Good governance of the organisation ensures that the Board is able to give an account to stakeholders of its strategic and operational management of the organisation. Our improvement programme, Strategic Commitments and performance measures are therefore aligned to this framework and this is illustrated on the next page.
- An updated **Code of Governance for NHS Provider Trusts** came into effect from April 2023 - NHS England » Code of governance for NHS provider trusts . It sets out an overarching framework for the corporate governance of NHS trusts, reflecting developments in UK corporate governance and the development of integrated care systems. NHS England explains that *"in the NHS this means delivering high quality services in a caring and compassionate environment while collaborating through system and place-based partnerships and provider collaboratives to integrate care".* NHS providers must comply with each of the provisions of the Code or explain any points on which the Trust has departed from the Code. In our Trust, this requirement is implemented through an annual review overseen by the Audit Committee and reported publicly by the Board of Directors in the Trust's Annual Report.

How the Regulatory Framework ‘maps’ onto our Board Committee structure

NHS England Oversight Framework

Quality of Care	Finance and Use of Resources	Operational Performance	Leadership & Improvement	Strategic Change
CQC Domains Safe Effective Caring Research Governance Divisional Governance	Sustainability & Efficiency Controls Information Governance Divisional Governance	CQC Domain Responsive NHS Constitutional Standards Divisional Governance	Well-led framework Education Governance Transformation & innovation Divisional Governance	N&W Integrated Care System (ICS) N&W Acute Hospital Collaboration
Quality & Safety Committee Research & Education Committee	Finance, Investments & Performance Committee Major Projects Assurance Committee	Finance, Investments and Performance Committee	People & Culture Committee Research & Education Committee Major Projects Assurance Committee	Board of Directors Committees in Common

Our Vision and Strategic Commitments

One of the hallmarks of a well led organisation is a compelling organisational vision that puts quality of care and the safety of its patients central to all of its activities, having been agreed in consultation with stakeholders, patients and staff. The Trust's vision and Strategic Commitments are explicitly stated and are detailed below.

The Vision and Commitments are the context within which the Board is able to measure organisational success and to effectively scrutinise performance through the Board Assurance Framework (BAF). The BAF therefore enables the Board to monitor progress, identify areas for further focus and to drive overall improvement.

Vision – the best care for every patient					
Strategic Commitments	Strategic Commitment 1 **Our Patients:** Together, we will develop services so that everyone has the best experience of care and treatment	Strategic Commitment 2 **Our Team:** Together, we will support each other to be the best we can be, to be valued and proud of our hospital for all.	Strategic Commitment 3 **Our Partners:** Together, we will join up services to improve the health and wellbeing of our diverse communities.	Strategic Commitment 4 **Our Services:** Together, we will provide nationally recognised, clinically led services that are high quality, safe and based on evidence and research.	Strategic Commitment 5 **Our Resources**: Together, we will use public money to maximum effect.
Strategic Goals	• Develop our physical capacity • Develop our digital capacity • Develop services at Cromer Hospital • Reduce unnecessary variation and adopt best practice • Implement a 24/7 acute hospital service	• Strengthen our specialist services • Become recognised as a centre of excellence for cancer, neurosciences and heart attack services • Invest in facilities and staff to ensure we are able to build our range of specialist services e.g. ITU and diagnostic services	• Promote a stronger research culture • Develop new models of education and work-based learning • Use values and behaviours to invest in leadership • Invest in the well-being of our staff and develop innovative recruitment plans • Play a leading role in the Quadram Institute Partnership • Build links across the East of England to promote the life science industry e.g. clinical trials, large-scale data analysis and evaluation of medical devices	• Collaborate with our acute hospital partners in Norfolk • Work with the Norfolk and Waveney STP to promote the well-being of patients and the financial and operational efficiency of our services • Work with primary, community and social care to improve how we look after our older patients and those with long-term conditions • Work with our partners to reduce demand for emergency admission and the time spent in hospital	• Work within the financial envelope and rules set by NHSE (including capital expenditure and delivery of agreed CIP programmes) • Create and deliver a Use of Resources Action Plan, that will see improvement in the Trust's assessed and actual use of resources

Foundation Trust Governance Structure

Accountability from the Trust flows outwards to national healthcare regulators as well as to the public who access services locally. The Council of Governors, collectively, is the body that connects the Trust with its patients, staff and wider stakeholders in the community that it serves. It comprises governors who are elected by the public and by staff members. It also includes stakeholder governors who are appointed by organisations who have an important relationship with the Trust – such as University of East Anglia and Local Government.

Governors have key statutory duties to hold the non-executives, individually and collectively, to account for the performance of the Board of Directors and to represent the interests of the Members and the public. Governors therefore need to understand how the Board of Directors uses information and intelligence to understand and be assured that the Trust provides high quality sustainable services. This depends on a good flow of information between the Board of Directors and Council of Governors in order to support effective and informed dialogue and debate.

The interaction between the Council of Governors and the Board of Directors is therefore a key relationship in the governance of foundation trusts and the Trust Chair leads both the Council of Governors and the Board of Directors.

Council of Governors

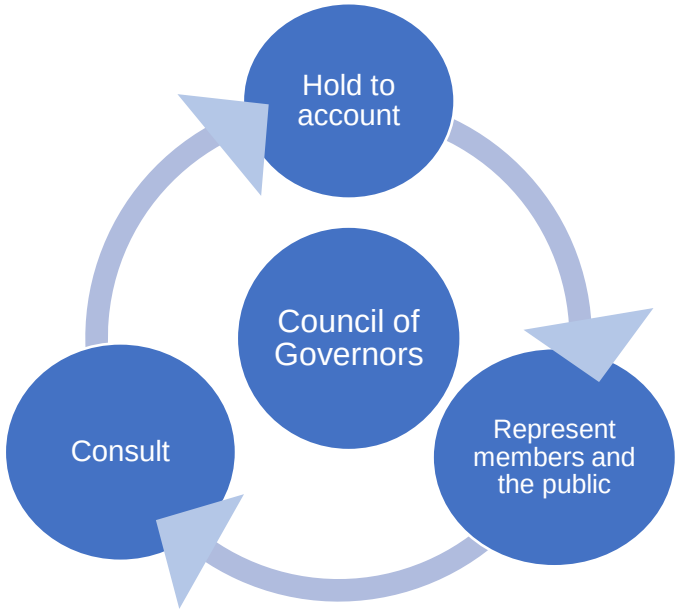
The Council of Governors has connected duties, to hold the non-executives to account for the performance of the board of directors and to represent the interests of Trust members and the public.

While the meaning of 'the public' is not specified in legislation, NHSE has provided guidance to reflect the creation of Integrated Care Systems. *"To support collaboration between organisations and the delivery of better, joined-up care, councils of governors are required to form a rounded view of the interests of the 'public at large'. This includes the population of the local system of which the NHS foundation trust is part. No organisation can operate in isolation, and each is dependent on the efforts of others"*. NHS England » Addendum to your statutory duties – reference guide for NHS foundation trust governors

While governors represent specific constituencies, when holding NEDs to account for the performance of the Board, they are therefore also expected to seek assurance that the Board has considered the consequences of decisions on other partners within their system, and the impact on the 'public at large'.

- Appoint Non-Executive Directors (NEDs) (inc Chair) - Approve CEO appointment
- Appoint external auditors - Receive the Trust's annual report and accounts
- Obtain information about performance of the Trust and the directors' performance of their duties, including taking into account the expectation that provider trusts will work in partnership to achieve the objectives of the ICS and promote the interests of the public at large.

- Information about the Trust's strategy and forward plans is shared with members
- Governors liaise with 'public' members and represent views to the Council of Governors and Board of Directors
- Council must approve any significant transactions - ie mergers, acquisitions, dissolutions etc.



- Consider and make suggestions on the Trust's strategy and forward plans ensuring the interests of members and the public have been taken into account
- Ensure views of members, public and stakeholders are put forward and represented

Council of Governors

Members (we have a Membership of around 25,000 staff and public)
Public, Staff and Partners

Partners appoint and Members elect governors to sit on the Council of Governors

Views of members are fed to the Trust through the Governors

Governors consult with and inform members about the Trust's strategy and activities

Council of Governors
Chaired by Trust Chair, the Council consists of governors elected by the members (staff and public) and governors appointed by the Trust's key partner organisations (UEA and Local Authority)

The Council appoints the Chair and Non-Executives to sit on the Board of Directors

It must approve appointment of the Trust Chief Executive

Council holds the NEDs to account for the performance of the Board in delivering its duties, ensuring that interests of members and public are served

Approves any significant transactions, mergers, acquisitions, dissolutions etc

Board works with the governors to ensure that the strategy and forward plan has regard to their views

Board of Directors
Includes Chair, Chief Executive, Non - Executive Directors and Executive Directors
The Board of Directors is responsible for all aspects of the operation and performance of the Trust, and for its effective governance.
The Board of Directors is collectively responsible for making decisions and taking actions which legally bind the Trust.

Corporate Assurance

In addition to setting the strategic direction of the organisation, the Board must identify and manage risks and threats to achieving its Strategic Commitments.

The Board must ensure that there are robust systems of accountability that enable it to monitor and manage performance (operational, financial and quality) and the impact on patients and staff and achievement of the Trust's strategy and vision.

This is managed through delegated responsibility to Board committees and relevant Board members. Foundation Trusts are required by statute to have two Board committees - an Audit Committee and a Nominations & Remuneration Committee. The number and remit of other Board committees is determined by the Board, based on strategic priorities and operational requirements relating to quality, finance, performance and workforce.

By delegating responsibilities for seeking assurance in specified areas to its Board Committees, the Board can ensure that there is adequate focus in these areas whilst freeing itself to give appropriate attention to matters of strategy, long-term sustainability and system working.

This section sets out the assurance map of the organisation and describes how information is received by each of the four main assurance committees of the Board, and then onward to the Board itself.

There are summaries for each board committee describing the responsibilities and reporting arrangements

Of note is an embedded committee meeting cycle intended to optimise information flow to the Board:

- Hospital Management Board meets as required (currently weekly), allowing sufficient time for the executive to analyse and summarise the information received from management committees, and escalate key matters for attention of the Board assurance committees
- Board assurance committees meet routinely in the week before the Board meeting.

Board Level Responsibilities for Assurance

As members of a unitary Board, all Board members share collective corporate responsibility for decisions and actions of the Board.

There are however distinct roles for different members of the Board, reflecting their organisational responsibilities and aligned to each of the Board and management committees. Each executive Board member is responsible for leading implementation of strategy in their functional areas and takes principal responsibility for providing accurate, timely and clear information to the Board.

The Chief Executive is designated as the Accounting Officer for the Foundation Trust in accordance with the NHS Act 2006 and NHS Foundation Trust Accounting Officer Memorandum. This means that the Chief Executive has overall responsibility to Parliament for the organisation and management of the Trust, ensuring that it operates in accordance with statutory duties, making efficient and effective use of the Trust's resources, in a way which ensures the proper stewardship of public money and assets.

Quality and Safety Committee

- Dr Pamela Chrispin Non-Executive Director
- Bernard Brett (Interim Medical Director)
- Nancy Fontaine (Chief Nurse)
- Clinical Safety & Effectiveness
- Patient Experience and Engagement

Research and Education Committee

- Non-Executive Directors
- Paul Jones (Chief People Officer)
- Nancy Fontaine (Chief Nurse)
- Bernard Brett (Interim Medical Director)
- Education Governance
- Biomedical Research Centre

People & Culture Committee

- Sandra Dinneen Non-Executive Director
- Paul Jones (Chief People Officer)
- Cultural development
- Workforce Planning
- Staff Experience

Major Projects Assurance Committee

- Tom Spink Non-Executive Director
- Alex Berry (Director of Transformation)
- Simon Hackwell (Director of Strategy & Major Projects)
- Ed Prosser-Snelling (Chief Digital Information Officer)
- Major Projects assurance

Audit Committee

- Julian Foster Non-Executive Director
- Roy Clarke (Chief Finance Officer)
- Nancy Fontaine (Chief Nurse) [Chief Risk Officer]
- Bernard Brett (Interim Medical Director) [Clinical Audit Exec lead]
- Financial systems & governance
- Risk Management

Finance, Investments & Performance Committee

- Tom Spink Non-Executive Director
- Roy Clarke (Chief Finance Officer)
- Chris Cobb (Chief Operating Officer)
- Ed Prosser-Snelling (Chief Digital Information Officer)
- Simon Hackwell (Director of Strategy & Major Projects)
- Operational & financial performance
- Capital planning & estates assurance
- Information governance

Corporate Calendar

Trust Board Of Directors

Routinely meets Monthly – week 1 (unless otherwise agreed or by exception)

N&W Committees in Common

Meets by agreement

Audit Committee

Meets not less than 4 times a year, to meet statutory duties

Nominations & Remuneration Committee

Meets as necessary to fulfil statutory duties, and routinely twice a year

Research & Education Committee

Meets 4-6 x per annum

Quality & Safety Committee

Meets monthly, one week before the Board (i.e. week 4)

People & Culture Committee

Meets monthly, one week before the Board (i.e. week 4)

Finance, Investments & Performance Committee

Meets monthly, one week before the Board (i.e. week 4)

Major Projects Assurance Committee

Meets monthly, one week before the Board (i.e. week 4)

Hospital Management Board meeting as
Quality Programme Board
Meets monthly

Hospital Management Board
Meets as required currently weekly

Hospital Management Board meeting as
Investment Group
Meets as required

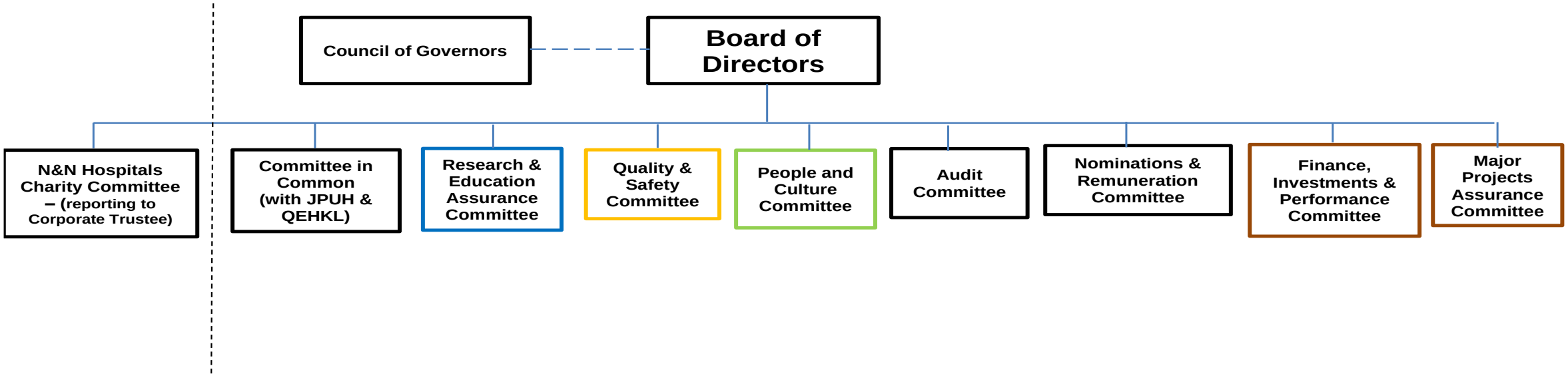
Management Committees reporting to Hospital Management Board
Meet in accordance with their terms of reference – typically monthly – and populate the Integrated Performance report

Divisional Performance Committee
Meets monthly with each Division and reviews the Divisional Performance and Accountability Framework

Divisional Boards report to Divisional Performance Committee
Routinely meet monthly and review divisional and service level data

Foundation Trust Board Reporting Structure

- Leadership of the Foundation Trust is provided by its Board of Directors (a unitary Board with a majority of Non-Executive Directors).
- The Board has established a structure of Board Committees with responsibility to seek assurance on behalf of the Board and/or to exercise specific delegated authority.
- That Committee structure is detailed below:



As at December 2023

FOUNDATION TRUST
BOARD OF DIRECTORS COMMITTEE MEMBERSHIP*
(as at December 2023)

Norfolk and Norwich University Hospitals NHS Foundation Trust

BOARD OF DIRCTORS

Operates as a unitary board – all members are equal – must have a majority of NEDs

Members:

- Non-Executive Directors (including Chairman) (x 8)
- Executive Directors (including Chief Executive) (x 6)

N&W COMMITTEES IN COMMON

Members:

- Chairman
- Chief Executive
- 1 NED
- Director of Strategy & Major Projects

QUALITY & SAFETY COMMITTEE

Members:

- 3-4 NEDs
- Chief Executive
- Medical Director
- Chief Nurse
- Patient Safety Partner

Link Governor observers x 2

PEOPLE & CULTURE COMMITTEE

Members:

- 3 NEDs
- Chief Executive
- Chief People Officer
- Chief Operating Officer
- Chief Nurse
- Medical Director
- Chiefs of Division x 4

Link Governor observers x 2

AUDIT COMMITTEE

Members:
3 NEDs

Link Governor observers x 2

RESEARCH & EDUCATION COMMITTEE

Members:

- 2-3 NEDs
- Medical Director
- Chief Nurse
- Chief People Officer

Link Governor observers x 2

NOMINATIONS & REMUNERATION COMMITTEE

Members:

- All Non-Executive Directors (inc Chairman)
- Chief Executive

FINANCE, INVESTMENTS & PERFORMANCE COMMITTEE

Members:

- 3 NEDs
- Chief Operating Officer
- Chief Executive
- Chief Finance Officer
- Chief People Officer
- Director of Strategy & Major Projects
- Clinical Executive (MD or CN)
- Chief Digital Information Officer
- Director of Transformation

Link Governor observers x 2

MAJOR PROJECTS ASSURANCE COMMITTEE

Members:

- 3 NEDs
- Chief Operating Officer
- Chief Executive
- Chief Finance Officer
- Director of Strategy & Major Projects
- Clinical Executive (MD or CN)
- Chief Digital Information Officer
- Director of Transformation

Link Governor observers x 2

*All committees have the discretion to invite subject specialists and other non-members to attend meetings on a regular or individual basis, to promote the purpose of the committee

S:\Corporate Departments\Legal Services\Foundation Trust Board\Organisational Structure Charts

Key sources of assurance:

Hospital Management Board (HMB)

Meets Weekly | Key Matters Escalated to Assurance Committee – 3rd week

HMB meeting as Quality Programme Board

Meets Monthly | Key Matters Escalated to assurance committee 3rd week

Governance Sub-Boards for:
- Clinical Safety and Effectiveness
- Patient Engagement & Experience

Meets Monthly | Key Matters Escalated to HMB

- **Mental Health& Complex Care**
- **Children's Board**
- **Risk Oversight Committee**
- **Cancer Board**
- **Emergency & Urgent Care Board**

Meets Monthly | Key Matters Escalated to HMB

Other sources of assurance:

- Internal audit reports in relation to clinical quality and patient safety systems
- CQC and other regulatory inspections
- In-patient and other care related surveys
- Integrated Performance Report

Quality & Safety (Q&S) Assurance Committee

Meets Monthly 4th Week | Key Matters Escalated to the Trust Board with Board papers week 4

Trust Board

Meets Monthly 1st Wednesday of month | Receive Board Papers – Week 4

Assurances are provided to the Trust Board on the following key matters:

- Development and implementation of the Trust's Quality Strategy
- Data and trends in patient safety, experience and outcomes, including undertaking necessary "deep dives"
- Appropriateness of the actions taken by management to address the significant concerns or adverse findings highlighted by external bodies in relation to clinical quality
- Development and implementation of action plans arising from both in-patient and other care related surveys with recommendations to the Board as appropriate
- Impact of Quality Impact Assessments of Cost Improvement Programmes on quality, patient safety and wider health and safety requirements arising from clinical practice and procedures
- Effectiveness of the clinical systems in maintaining compliance with the Care Quality Commission (CQC's) Essential Standards of Safety and Quality
- Systems and processes in place in relation to Infection Control and the progress against identified risks to reducing hospital acquired infections
- Appropriateness of the actions taken by management under the Patient Safety Incident Response Framework (PSIRF)
- Appropriateness of the actions taken by management to implement recommendations of internal audit reports relevant to quality and patient safety
- Advise the Board of key strategic risks relating to quality and patient safety and consider plans for mitigation as appropriate

Key: Direct oversight by the committee: ——— Indirect oversight by the assurance committee: - - -

Key sources of assurance:

Hospital Management Board

Meets Weekly | Key Matters Escalated to Assurance Committee – 3rd Week

Financial Improvement & Productivity Board

Meets Monthly | Key Matters Escalated to

Divisional Performance Committee

Meets Monthly | Key Matters Escalated to

- **Business Case Review Panel**
- **Capital and Estates Committee**
- **Digital Transformation Cmtee**
- **Health & Safety Committee**
- **PFI Liaison Committee**
- **Sustainability Committee**

Meets Monthly | Key Matters Escalated to HMB

Finance, Investments & Performance (FI&P) Assurance Committee

Meets Monthly 4th Week | Key Matters Escalated to the Trust Board with Board papers

Trust Board

Meets Monthly 1st Wednesday of month | Receive Board Papers – Week 4

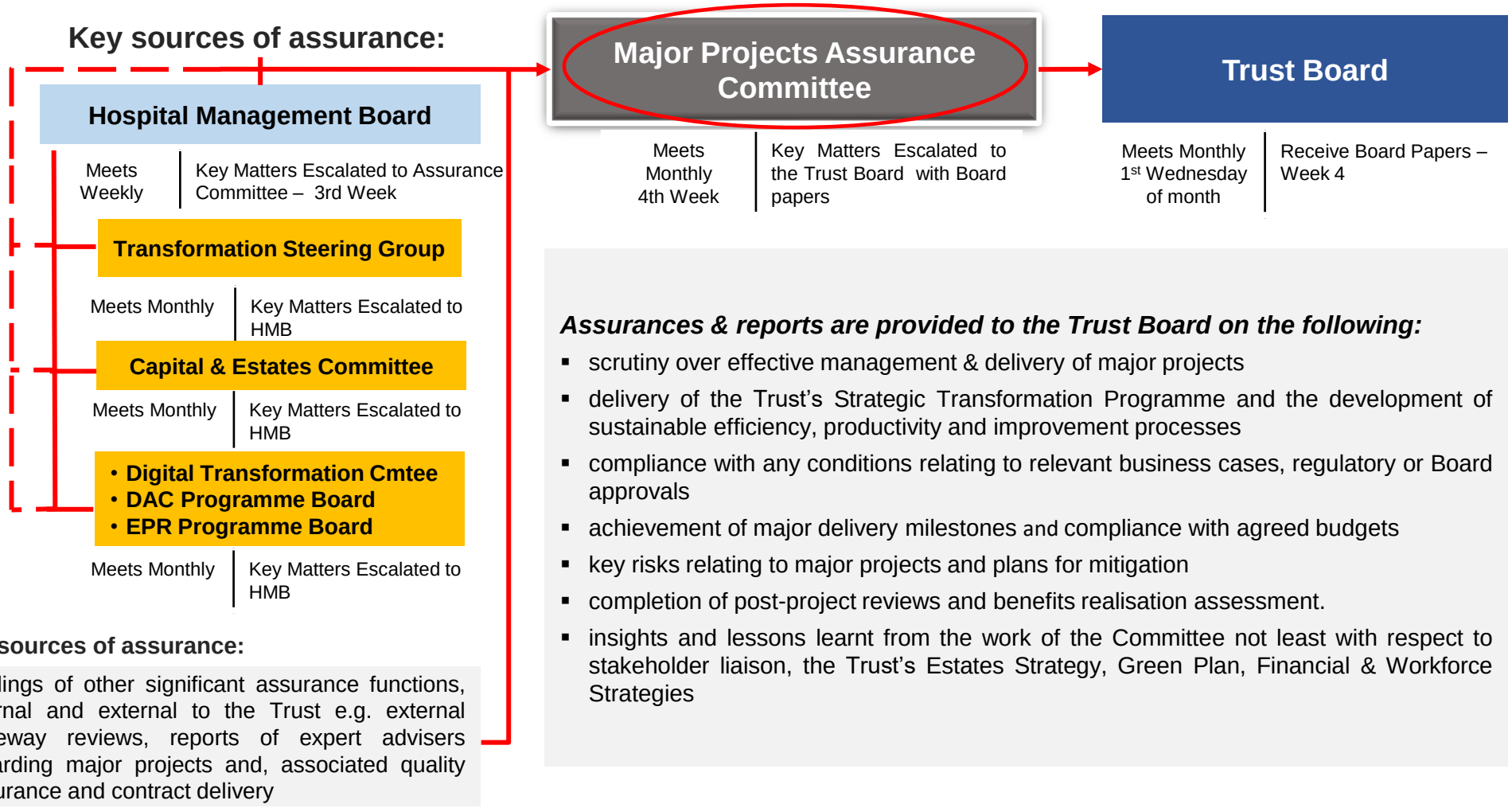
Other sources of assurance:

- Internal audit reports in relation to finance and performance
- Findings from the CQC and other regulatory inspections
- Systems of integrated governance, risk management and internal control
- Results of self-assessments against EPRR, UoR & Premises Assurance
- Integrated Performance Report

Assurances are provided to the Trust Board on the following key matters:

- Development and implementation of the Foundation Trust's financial and performance strategies to ensure delivery of financial and performance targets
- Delivery of the Trust's cost improvement and transformation programmes and the development of efficiency and productivity processes
- Performance against financial and operational performance KPIs by undertaking necessary "deep dives"
- Appropriateness of the investment appraisal of business cases including tracking of benefits realisation, and wider business development opportunities
- Appropriateness of the contracting and planning mechanisms in place with commissioners of healthcare and any financial or operational risks arising from those contracts are identified and mitigated as appropriate
- Scrutiny over rolling capital programme and its delivery
- Advise the Board of key strategic risks relating to financial and operational performance and consider plans for mitigation as appropriate
- Best use of Trust's resources
- Divisional performance
- Management of the Trust's Estate, PFI contract and Premises Assurance
- Structures, processes and responsibilities with regard to Business Continuity and Emergency Preparedness, Resilience & Response
- Identification, monitoring and managing risks associated with Health & Safety

Key: Direct oversight by the committee: ——— Indirect oversight by the assurance committee: - - - -



Other sources of assurance:

- Findings of other significant assurance functions, internal and external to the Trust e.g. external Gateway reviews, reports of expert advisers regarding major projects and, associated quality assurance and contract delivery

Assurances & reports are provided to the Trust Board on the following:

- scrutiny over effective management & delivery of major projects
- delivery of the Trust's Strategic Transformation Programme and the development of sustainable efficiency, productivity and improvement processes
- compliance with any conditions relating to relevant business cases, regulatory or Board approvals
- achievement of major delivery milestones and compliance with agreed budgets
- key risks relating to major projects and plans for mitigation
- completion of post-project reviews and benefits realisation assessment.
- insights and lessons learnt from the work of the Committee not least with respect to stakeholder liaison, the Trust's Estates Strategy, Green Plan, Financial & Workforce Strategies

Key: Direct oversight by the committee: ——— Indirect oversight by the assurance committee: - - -

Key sources of assurance:

Hospital Management Board

Meets Weekly | Key Matters Escalated to Assurance Committee – 3rd Week

Governance Sub-Board for Workforce and Education

Meets Monthly | Key Matters Escalated to HMB

- **Divisional Boards**
- **Divisional Performance Committee**
- **Risk Oversight Committee**
- **Health & Safety Committee**

Meet Monthly | Key Matters Escalated to HMB

People & Culture Assurance Committee

Meets Bi-Monthly 4th Week | Key Matters Escalated to the Trust Board with Board papers

Trust Board

Meets Monthly 1st Wednesday of month | Receive Board Papers – Week 4

Other sources of assurance:

- Reports on the staff survey and other staff engagement data
- Internal audit reports relevant to workforce and organisational development
- Integrated Performance Report metrics

Assurances are provided to the Trust Board on the following key matters:

- Trust strategy and plans on workforce issues including planning, recruitment, retention and deployment of staff to meet current & future service requirements
- Effective oversight and management of risks relating to workforce planning and availability and appropriateness of the actions taken to address these risks
- Effectiveness of the workforce enablers and reward arrangements put in place to drive high performance and quality improvement
- Performance indicators relevant to the remit of the committee
- Trust's compliance with the Public Sector Equality Duty and implementation of its Equality, Inclusion & Belonging Strategy
- Organisational Development to promote the desired culture of caring, efficient, high-quality services delivered within a Trust that is recognised as an employer of choice
- Promotion of staff health and wellbeing in context of ICS People Strategy
- Effectiveness of the action plans that support improvement in staff experience
- Recognition of the link between delivery of high-quality healthcare and sufficient, well-motivated, trained and satisfied staff.

Key: Direct oversight by the committee: ——— Indirect oversight by the assurance committee: - - -

Key sources of assurance:

- **Quality & Safety Committee**
- **Finance, Investments & Performance Committee**
- **People & Culture Committee**
- **Major Projects Assurance Committee**
- Internal Audit Activity

Other sources of assurance:

- External audit
- Over-arching systems of integrated governance, risk management and internal control
- Findings of other significant assurance functions, both internal and external to the Trust, inc clinical audit

Audit Committee

Meets minimum 4 times a year

Key Matters Escalated to the Trust Board with Board papers

Trust Board

Meets Monthly 1st Wednesday of month

Receive Board Papers – Week 4

Assurances are provided to the Trust Board on the following key matters:

- Effectiveness of the Trust's systems of integrated governance, risk management and internal control, that support the achievement of the corporate objectives.
- Effectiveness of the internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Trust Board.
- Independence and objectivity of the external audit activity and the effectiveness of the audit process.
- Findings of other significant assurance functions, both internal and external to the Trust, and the implications to the governance of the organisation.
- Reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
- Integrity of the financial statements of the Trust and any formal announcements relating to its financial performance.
- Other topics as delegated by the Board; including, appointment of outside contractors for financial services, e.g. Internal Audit, Banking, Payroll Services, etc.
- Standing Orders (SOs) and Standing Financial Instructions (SFIs) including use of waivers
- Annual Code of Governance review
- Compliance with the Trust's Conflicts of Interest and Business Conduct Policy

Key:
Direct oversight by the committee: ——— Indirect oversight by the assurance committee: - - -

Key sources of assurance:

Hospital Management Board

Meets Weekly | Key Matters Escalated to Assurance Committee – 3rd Week

Research Oversight Board

Meets Monthly | Matters Escalated to HMB

Workforce & Education Governance Sub-Board (WESB)

Meets Monthly | Matters Escalated to HMB

- **Divisional Boards**
- **Divisional Performance Committee**
- **Risk Oversight Committee**
- **Research Ethics Committee**

Research & Education Assurance Committee

Meets Bi-monthly 3rd Week | Key Matters Escalated to the Trust Board with Board papers

Trust Board

Meets Monthly 1st Wednesday of month | Receive Board Papers – Week 4

Assurances & reports are provided to the Trust Board on the following:

- Development and implementation of the Trust's Education Strategy
- Development and implementation of the Trust's Research Strategy
- Rates of patient participation in research & development of the Trust's capacity & capability as a Bio-Medical Research Centre (BRC)
- Trust's strategy and plans for workforce education, learning and development, and that individual training and development approaches are fit for purpose
- Trust performance in supporting provision of undergraduate & postgraduate education
- Performance indicators relevant to the remit of the Committee
- Investment of Trust funds to support delivery of the Research & Education strategies
- Restoration of the Trust's reputation as an education provider of choice
- Development of the Clinical Research Facility (CRF) in line with NIHR expectations
- Development and visibility of key metrics relating to research and education
- Strengthening the Trust's relationship & collaboration with partners, in Quadram Institute Partners, NRP & UEA Health Partners

Other sources of assurance:

- Surveys on educational experience
- Reports on staff survey and other staff engagement data
- Experience of recruitment & retention of trainees
- Internal audit reports in relation to research & education
- Feedback from research funders & NIHR
- reports received from external sources
- IPR metrics on research & education

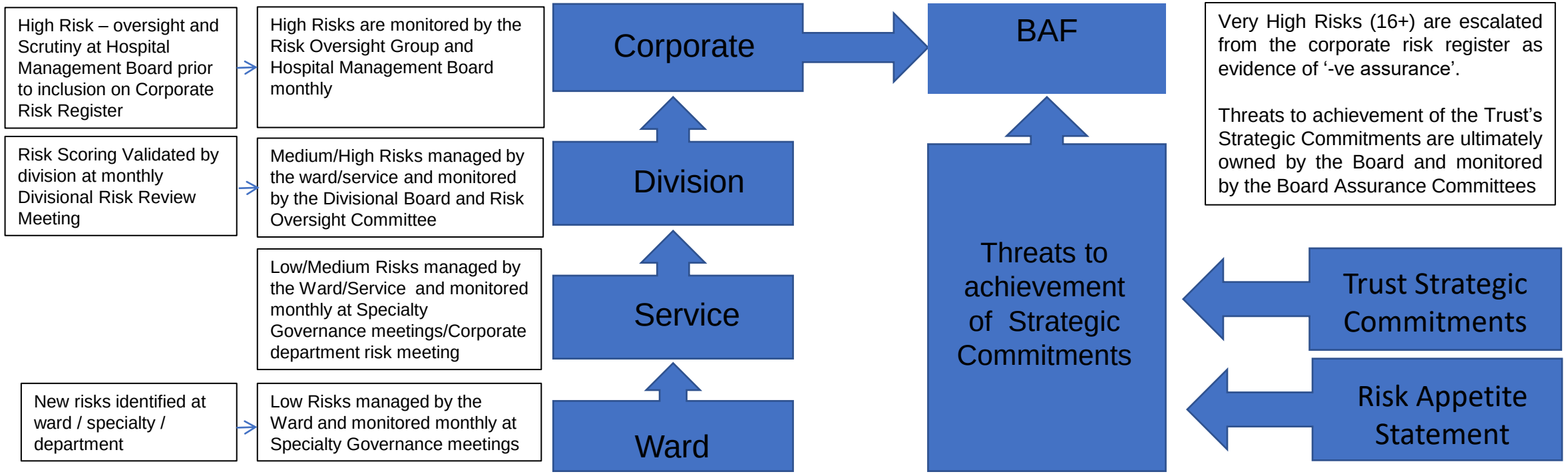
Key:
Direct oversight by the committee: ——— Indirect oversight by the assurance committee: - - -

Risk Management

The Board is responsible for ensuring that the Trust has appropriate processes for risk identification and risk management in place to deliver its strategic plans and comply with the registration and licensing requirements of key regulators. This includes systematically assessing and managing risks at all levels from ward to Board.

Risk Management is the process of identifying, assessing, analysing and managing all potential risks. Decisions made within the Trust should take into account potential risks that could directly or indirectly affect patient care.

Board Assurance Framework: This is a document that sets out the Strategic Commitments, identified threats to achievement of each, along with associated controls in place and evidence available on their operation. One of the sources of information for the BAF is the Corporate Risk Register. The BAF provides an overall 'heat map' summary of areas of threat affecting achievement of the Trust.Strategy.



Risk Appetite

Risk appetite refers to the amount of risk that the Board is prepared to accept, tolerate, or be exposed to in pursuit of its Strategic Commitments. The higher the appetite, the greater the autonomy that is granted to the risk owner before the threshold is crossed for escalating issues to the Board; the lower the appetite the greater the control that the Board will wish to exercise over its management

Risk Appetite Statement 2023 – approved by Trust Board 07.12.22
Defines the types and aggregate levels of risk that an organisation is willing to accept in pursuit of Strategic Commitments

REGULATORY REQUIREMENT

We have a **LOW** risk appetite for risks relating to legal and regulatory requirements. The Trust will actively seek to reduce all risks to compliance with these requirements. This covers all forms of regulation including Health and Safety, Care Quality Commission, Fire etc.

Risks that threaten our compliance with these requirements will not be deemed acceptable until the risk is reduced to a score of 1-4. There would be little room for tolerance of such risks.

NATIONAL STANDARDS AND KPIs

We have a **MODERATE** risk appetite for risks related to compliance with national standards and KPIs. This means that we expect all services to comply with nationally mandated standards and targets as measured through KPIs, however, these risks need to be balanced with those relating to safety, and the Trust's financial sustainability.

Risks that threaten our compliance with these requirements will not be deemed acceptable until the risk is reduced to a score of 5-8. There would be some room for tolerance of such risks, where there is clear reasoning for maintaining a higher than desired risk position, in order to maintain a low risk profile in other domains.

FINANCE / VALUE FOR MONEY

We have a **LOW** risk appetite for financial risks which may affect the Trust's statutory requirements and achievement of the Control Total. This means that the Trust is only prepared to accept the possibility of very limited financial loss and only if it is essential; value for money is the primary concern.

Risks that threaten the Trust's financial sustainability will not be deemed acceptable until the risk score is reduced to 1-4. There would be some room for tolerance of such risks, where there is clear reasoning for maintaining a higher than desired risk position, in order to maintain a low risk profile in other domains, or to deliver greater returns / benefit. In these instances, clear executive level decision making will be required and challenged if longstanding.

Risk Appetite

Risk appetite refers to the amount of risk that the Board is prepared to accept, tolerate, or be exposed to in pursuit of its Strategic Commitments. The higher the appetite, the greater the autonomy that is granted to the risk owner before the threshold is crossed for escalating issues to the Board; the lower the appetite the greater the control that the Board will wish to exercise over its management

Risk Appetite Statement 2023 – approved by Trust Board 07.12.22
Defines the types and aggregate levels of risk that an organisation is willing to accept in pursuit of Strategic Commitments

PATIENT SAFETY

We have a **LOW** risk appetite for risks which compromise the safety of patients. This means that we expect services to be delivered safely with robust control measures in place to minimise risk to patients. Healthcare is inherently risky, and therefore a higher level of risk may need to be tolerated in some circumstances.
The organisation does not actively seek to take risk that compromise safety, however, there will be times where, in extremis, higher risk strategies may need to be employed in order to maintain safety for the greatest number of patients.

Risks that threaten patient safety will not be deemed acceptable until the risk score is reduced to 1-4. There would be little room for tolerance of such risks, however, in extremis, tolerance of such risks may need to be increased in the short term. In these instances, clear executive level decision making will be required and challenged if longstanding.

QUALITY – OUTCOMES

We have a **LOW** risk appetite for risks that compromise the delivery of outcomes for our patients. This means that we expect services to be delivered effectively, and service developments will not adversely affect the expected outcomes for patients
.
Not all aspects are within the Trust's control (examples include ED four-hour access waiting times and referral to treatment).

The Trust proactively reviews available local and national outcome data and measures. The trust responds robustly to CUSUM mortality alerts in order to identify any learning and actions to reduce the risks identified through the investigation of an alert to patients in the outlier diagnosis group. Where risks are identified, improvement work will be undertaken to support improved outcomes. There will be times where one risk to patient outcomes will need to be balanced with others.

Risks that threaten patient outcomes will not be deemed acceptable until the risk is reduced to a score of 1-4. There would be little room for tolerance of such risks.

Risk Appetite

Risk appetite refers to the amount of risk that the Board is prepared to accept, tolerate, or be exposed to in pursuit of its Strategic Commitments. The higher the appetite, the greater the autonomy that is granted to the risk owner before the threshold is crossed for escalating issues to the Board; the lower the appetite the greater the control that the Board will wish to exercise over its management

Risk Appetite Statement 2023 – approved by Trust Board 07.12.22
Defines the types and aggregate levels of risk that an organisation is willing to accept in pursuit of Strategic Commitments

WORKFORCE - TRANSFORMATION

We have a **MODERATE** risk appetite for transformational workforce risks. This means that we expect services to be delivered safely and effectively, whilst implementing initiatives that support transformational change, and ensuring the organisation remains a safe place to work.

Risks outside of the desired appetite are not tolerated without clear executive level discussion and rationale and are challenged if longstanding. There would be some room for tolerance of such risks, where there is clear reasoning for maintaining a higher than desired risk position, in order to maintain a low risk profile in other domains. As the organisation has a desire to pursue transformation, there is an expectation that some risk will be taken in order to realise potential benefits.

QUALITY – EXPERIENCE

We have a **MODERATE** appetite for risks which may affect the experience of our services users. This means that we expect patients and visitors to receive a positive experience whilst interacting with the organisation, whether as a patient, client, visitor or other service user (as measured through the Friends and Family Test, levels of complaints and compliments, etc.). However, there will be times where safety will be prioritised over experience.

Risks that threaten our compliance with these requirements will not be deemed acceptable until the risk is reduced to a score of 5-8. There would be some room for tolerance of such risks, where there is clear reasoning for maintaining a higher than desired risk position, in order to maintain a low risk profile in other domains, as the organisation has a desire to improve patient experience.

Risk Appetite

Risk appetite refers to the amount of risk that the Board is prepared to accept, tolerate, or be exposed to in pursuit of its Strategic Commitments. The higher the appetite, the greater the autonomy that is granted to the risk owner before the threshold is crossed for escalating issues to the Board; the lower the appetite the greater the control that the Board will wish to exercise over its management

Risk Appetite Statement 2023 – approved by Trust Board 07.12.22
Defines the types and aggregate levels of risk that an organisation is willing to accept in pursuit of Strategic Commitments

REPUTATION

We have a **MODERATE** risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the Trust. This means that the Trust will only undertake activities and events where there is little chance of any significant repercussion for the organisation should there be a failure.

Risks that threaten our reputation will not be deemed acceptable until the risk is reduced to a score of 5-8. There would be some room for tolerance of such risks, where there is clear reasoning for maintaining a higher than desired risk position, in order to maintain a low risk profile in other domains. The organisation at times may wish to take some risk in order to enhance its reputation.

TECHNOLOGY AND INNOVATION

We have a **HIGH** risk appetite for the use of technology and innovation of service delivery. This means that the Trust supports and actively encourages innovation, with demonstration of commensurate improvements in management control and productivity.

Systems / technology developments will be used routinely to enable operational delivery. This of course is in context of compliance to delivering clinically safe, secure, available, resilient systems and architecture. Our high risk appetite for technology and innovation does not mean we will accept risks that compromise the security of data or our networks (see below).

The organisation may at times feel the level of risk being taken (and in turn the potential benefit) is too low and so the trust may wish to take greater risk in order to deliver innovation.

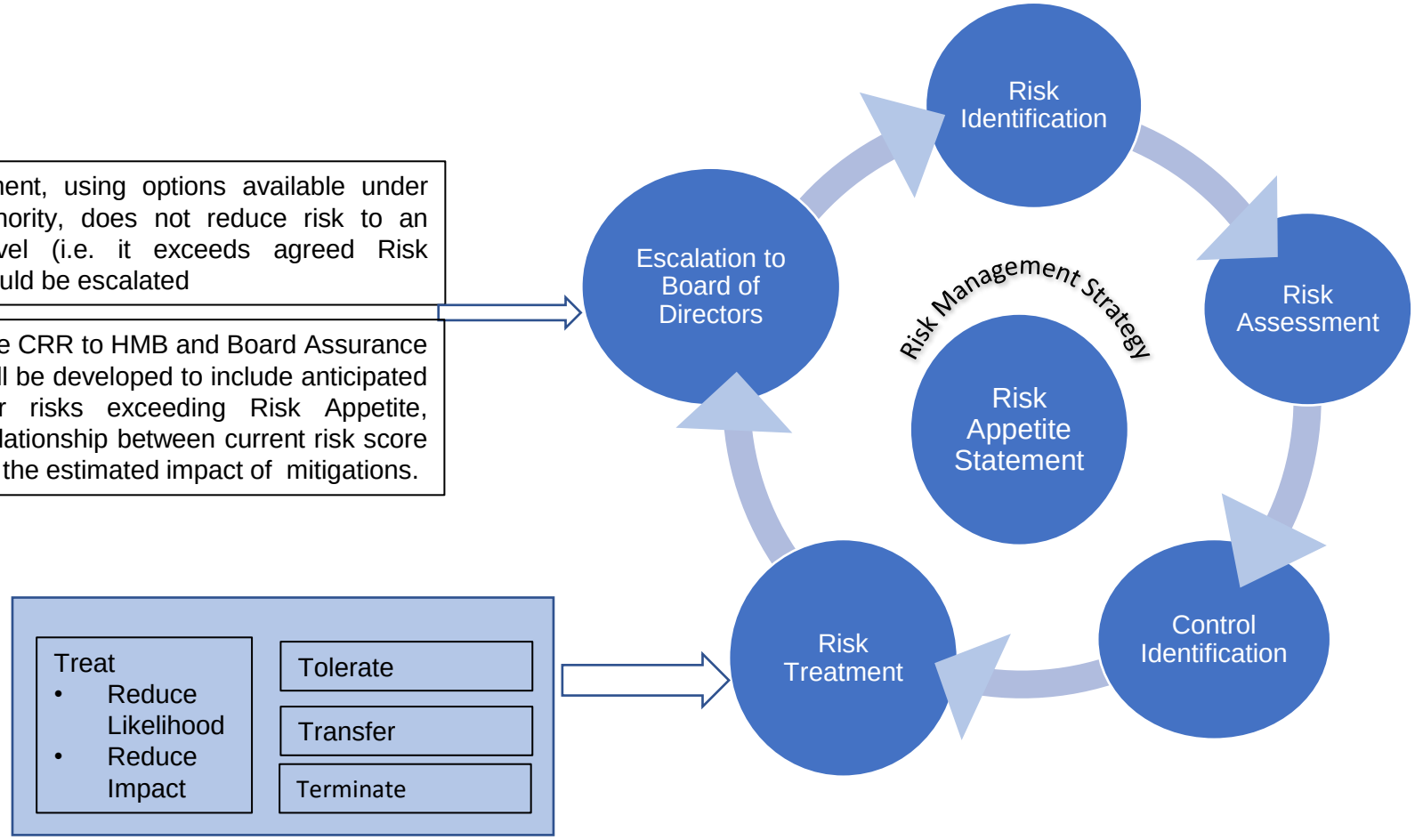
DATA AND CYBER SECURITY

We have a **LOW** risk appetite in relation to data and cyber security risks where we expect to invest in order to protect our digital network and underlying data and application systems from breaches. Since the risks of cyber security are many and change each day, we also commit to detailed plans for the eventuality that our systems are breached.

How the Board's Risk Appetite should be applied

If Risk Treatment, using options available under delegated authority, does not reduce risk to an acceptable level (i.e. it exceeds agreed Risk Appetite) it should be escalated

Reporting of the CRR to HMB and Board Assurance Committees will be developed to include anticipated trajectories for risks exceeding Risk Appetite, showing the relationship between current risk score and target with the estimated impact of mitigations.



All the Board Assurance Committees have a role in Risk Management

BAF
Each Strategic Threat on the BAF is linked to an identified Executive

High risks (16+) on the Corporate Risk Register are assigned to Board Assurance Committees.

Each High Risk is linked to:
- a designated **Executive Risk Owner;** and
- one or more **Management Committees**

Board of Directors

Audit Committee

Board Assurance Committees
- Quality and Safety Committee
- Finance, Investments and Performance Committee
- People and Culture Committee
- Audit Committee
- Major Projects Assurance Committee
- Research and Education Committee

Risk Owners

The **Board** is collectively responsible for setting strategy and ensuring good stewardship and direction.

The **Audit Committee** provides advice to the Board of Directors on the operation of the Trust's governance processes, risk management and internal control systems within the Trust.

Having reviewed the evidence provided by the risk owners, the **assurance committee** provides assurance to the Board of Directors that the high-level risks within their remit are being mitigated effectively and that the BAF entry reflects the most recent information about strategic threats and relevant controls.

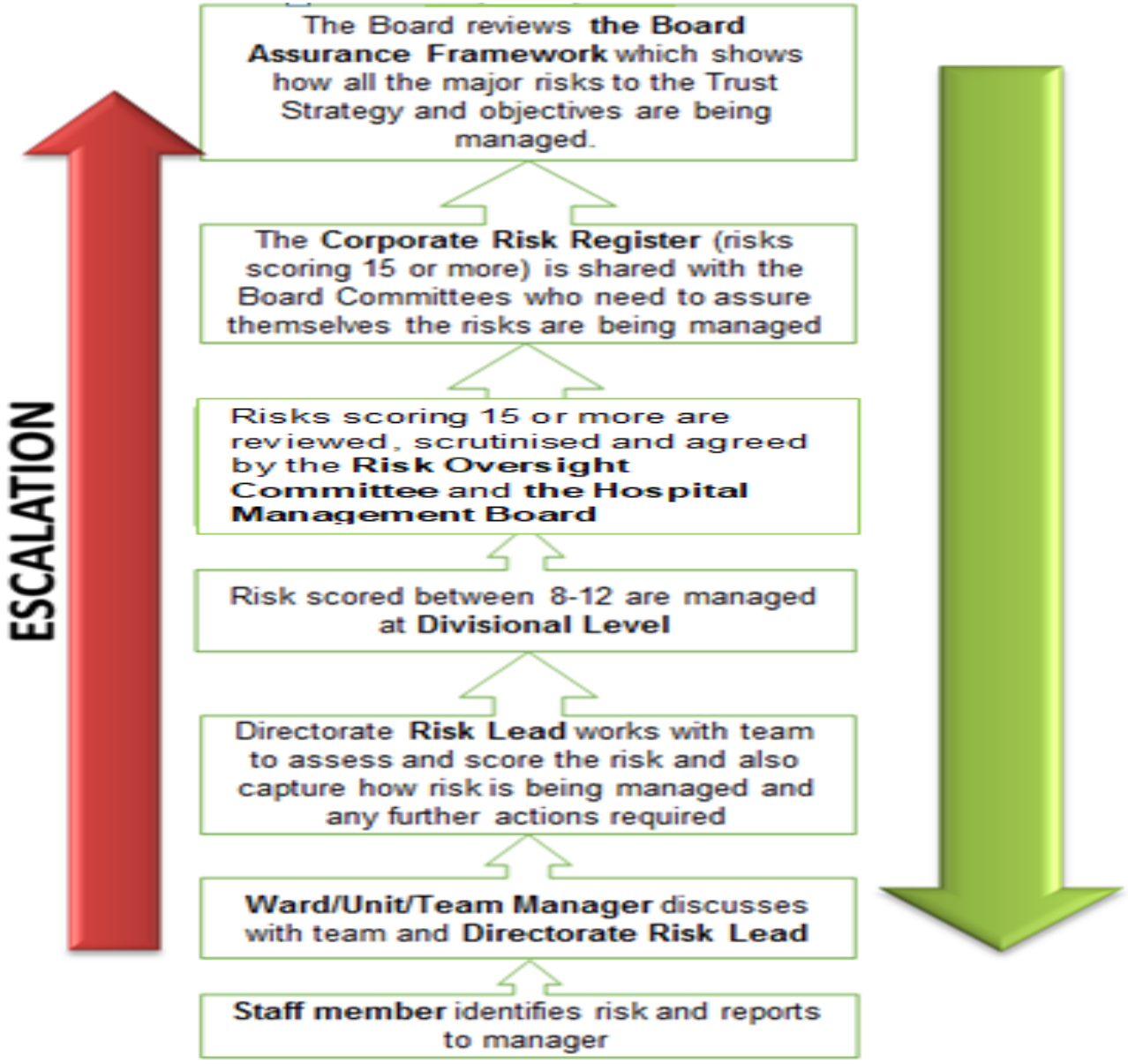
Risk owners provide assurances to the assurance committee overseeing the risks within their remit that processes and controls are effective. Performance information and action plans will provide evidence that mitigating actions are effective in reducing risk to acceptable levels.

Board Assurance Framework

Corporate Risk Register

Divisional Risk Management Exception Reports

Directorate, Service & Ward Risk Management Reports

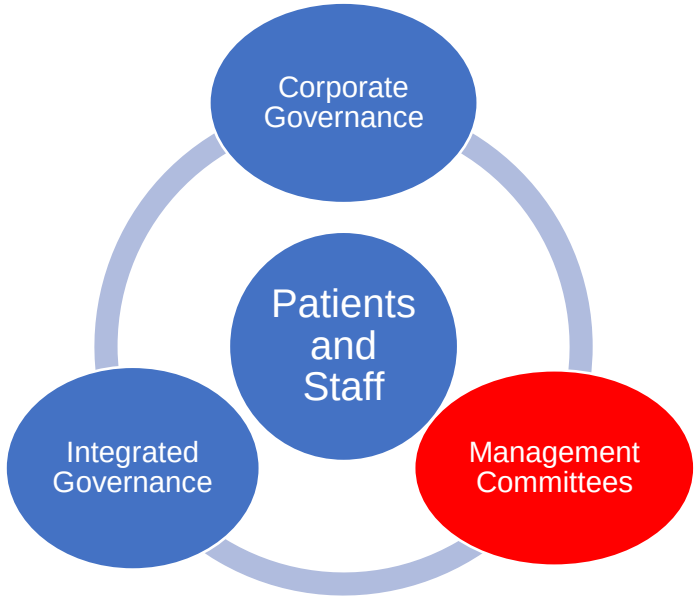


Section 2 - Management Committees

This section describes the corporate management functions led by the Chief Executive

Overseen by the Hospital Management Board, the management committees coordinate the tactical plans for key areas, including the organisation's compliance with the core objectives of the Board. The Committees include:

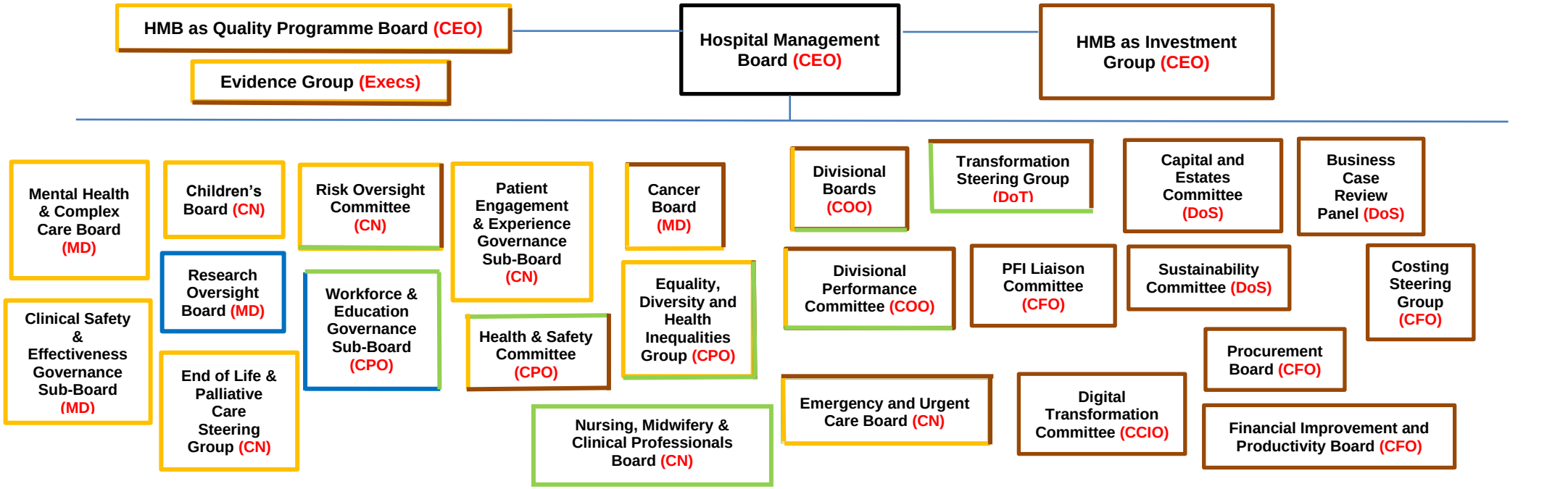
- Governance Sub-Boards for
  - Clinical Safety and Effectiveness
  - Patient Engagement and Experience
  - Workforce and Education
- Divisional Performance Committee
- Financial Improvement and Productivity Board
- Risk Oversight Committee
- Research Oversight Board
- Children's Board
- Cancer Board
- Mental Health & Complex Care Board
- Health & Safety Committee
- Digital Transformation Committee
- Emergency and Urgent Care Board
- Transformation Steering Group



The structure and reporting relationships of the management committees of the Trust are determined by the Chief Executive, in line with the needs of the organisation and ensuring that appropriate assurance and escalation arrangements are in place for the delivery of the Trust's Strategic Commitments. Beneath each of the reporting committees is another layer of specialty groups focused on particular areas of activity in the Trust.

Management Board
Reporting and Accountability Structure

Norfolk and Norwich University Hospitals NHS Foundation Trust



As at December 2023

Information Flow and Reporting

Trust Board

Board Assurance Committees

- Quality & Safety
- People & Culture
- Research & Education
- Finance, Investments & Performance
- Audit Committee
- Major Projects Assurance

Quality Programme Board

Hospital Management Board

Management Committees

Governance sub-groups for
- Clinical Safety & Effectiveness
- Patient Engagement & Experience
- Workforce & Education

- Research Oversight Board
- Divisional Performance Committee
- Financial Improvement & Productivity Board
- Capital & Estates Committee
- Digital Transformation Committee
- Risk Oversight Group
- Health & Safety Committee

Management Information

Integrated Performance Report

- ED Performance
- Patient Flow
- RTT Performance
- Diagnostics
- Cancer standards
- Stroke & Cardiology
- Mortality
- Infection Control
- Patient Safety
- Patient Experience
- Workforce
- Safer Staffing
- Appraisal & Mandatory Training
- Sickness & Turnover
- Finance & Use of Resources
- Cost Improvement Programme

Divisional Performance Committee

Divisional Performance & Accountability Framework

Divisional Boards receive management information on
- Financial Performance
- Operational Performance
- Patient Safety & Experience
- Clinical Effectiveness
- Incident reporting/adverse events
- Workforce
- Productivity

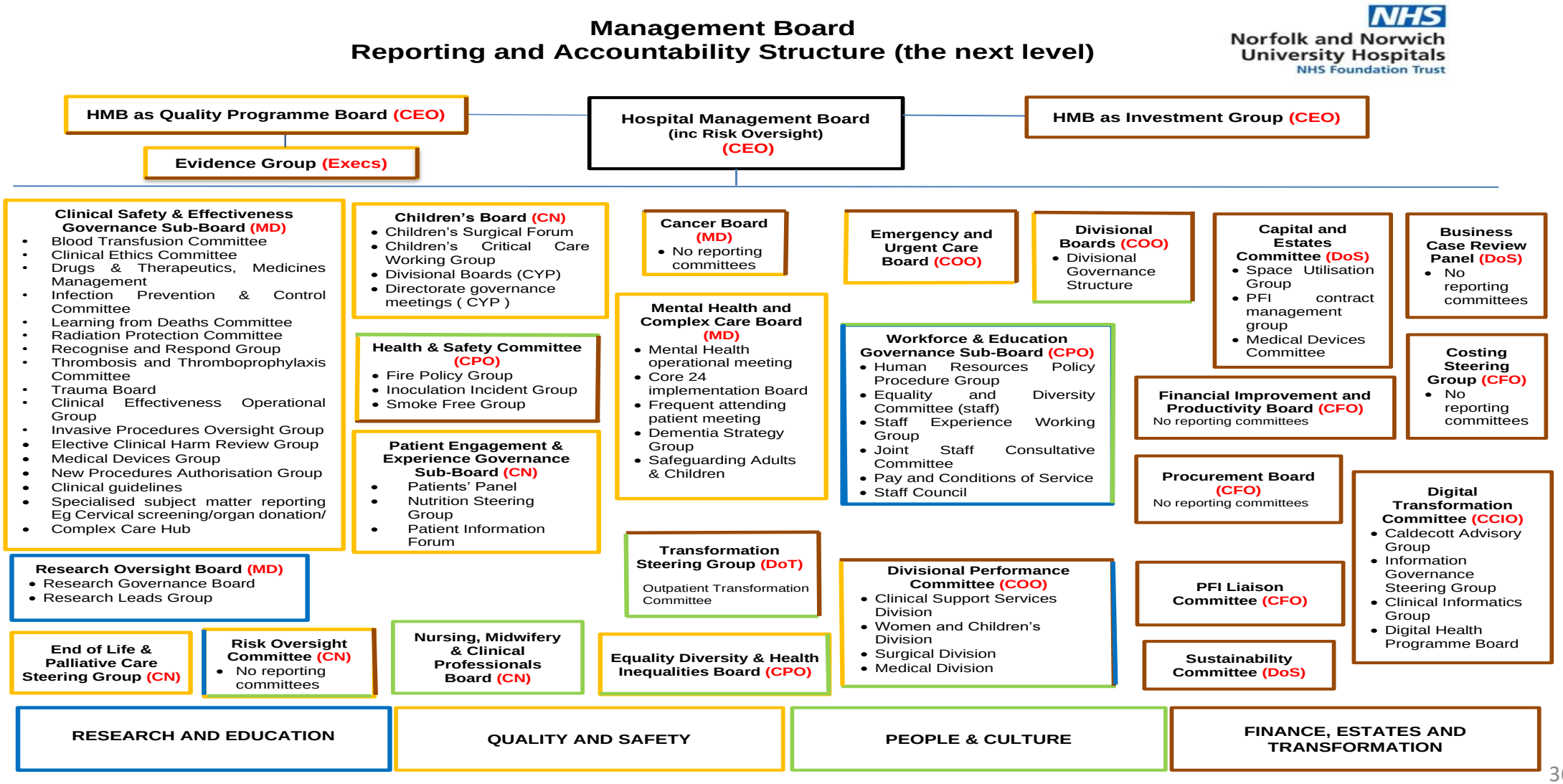
Flow of Information

- Management and divisional reports are provided to the Hospital Management Board
- Each Management Committee reviews risks relating to its remit and has an annual workplan and calendar for reporting that aligns to the quality and compliance requirements of the organisation
- Management information aligns to the Committees' ToRs, for example the Governance sub-board for Clinical Safety & Effectiveness will receive management information against mortality, incident reporting, NICE, GIRFT, clinical audit, etc
- Oversight of Divisional performance is provided by the Divisional Performance Committee that is led by the Chief Operating Officer

Escalation of Risk and Performance Issues

Management Committees -the next layer down

(Groups that report to the Committees that report to the Hospital Management Board)



As at December 2023

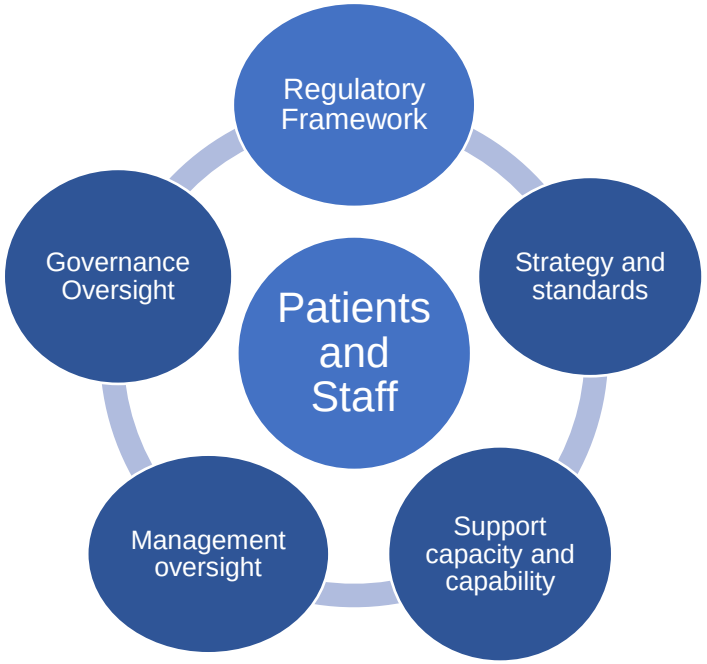
Section 3 - Integrated Governance

The NHS uses the term “integrated governance” to refer to systems, processes and behaviours by which trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of service and in which they relate to patients and carers, the wider community and other stakeholders.

Good governance is about having a framework to ensure that we:

- Provide our patients with safe and effective care and our staff with a safe and supportive work environment
- Have effective structures, systems and processes in place to ensure we meet regulatory standards and our strategic vision, commitments and goals
- Have the capacity and capability, in terms of knowledge, skills and resources to deliver those objectives
- Are critically evaluating what we do and ensuring that we continually improve the ways we work; and
- Are transparent in how we report our performance and are accountable for our work.

The Trust has in place a consistent framework for integrated governance across all of its governance themes – clinical, financial, workforce, research, information, education and divisional.



Integrated Governance – Executive Leadership

Each stream within our system of integrated governance is led by a Senior Risk Owner and supported by appropriate teams and management information aiding our corporate and divisional delivery

- Clinical Governance – led by the Chief Nurse and Medical Director
- Financial Governance – led by the Chief Financial Officer
- Information Governance – led by the Chief Digital Information Officer
- Research Governance – led by the Medical Director
- Workforce Governance – led by the Chief People Officer
- Education Governance – led by the Chief People Officer, Chief Nurse & Medical Director
- Performance & Divisional Governance – led by the Chief Operating Officer

Integrated Governance

Integrated Governance includes the following key activities, which are reported organisationally in the Integrated Performance Report and, where relevant by division in the divisional performance reports and Divisional Performance & Accountability Framework.

As well as the individual responsibilities of the senior risk owners for these areas, the Board is collectively responsible for the system of integrated governance, risk management and internal control in its entirety. With executive directors as senior risk owners and non-executive director members of assurance committees overseeing the identified risks in the BAF, when the Board comes together, it takes a collective view on the inter-connectedness of these activities against the context of its agreed risk appetite statement

Finance and Use of Resources

- Income and Expenditure account
- Income analysis
- Pay costs
- CIP analysis
- Capital Expenditure
- Statement of Financial Position

Information Governance

- Incident reporting
- Data breaches
- Information Governance mandatory training compliance
- Cyber attacks

Operational Performance

- ED performance
- 12 hour breaches
- Ambulance handovers
- Bed occupancy
- Average length of stay
- Boarding
- RTT performance
- Diagnostic performance
- Cancer faster diagnosis
- Cancer 62 day
- Stroke
- Cardiology

Workforce and Education

- Substantive vacancies (WTE)
- Care hours per patient day (CHPPD)
- Sickness absence
- Staff turnover
- Medical & Non-medical appraisals
- Mandatory training compliance
- Use of temporary & agency staff

Research

- Number of live projects
- Commercial studies
- Non-commercial studies
- Patient participation in research
- Publications

Clinical Governance (see next page)

Clinical Governance

Clinical Governance includes the following key activities, which are reported by division through divisional performance reports and organisationally in the Integrated Performance Report as appropriate.

Patient Safety

- Patient Safety Incident Response Framework (PSIRF)
- Incident Reporting
- Duty of Candour
- Risk assessments (patients)
- Mortality and Morbidity reviews
- Reporting on Measures of Essential Care (including Falls, pressure ulcers, VTEs, UTIs, Care Hours per Patient)
- Claims activity
- Safeguarding
- Infection Prevention and Control
- Mental Health
- Learning from Deaths

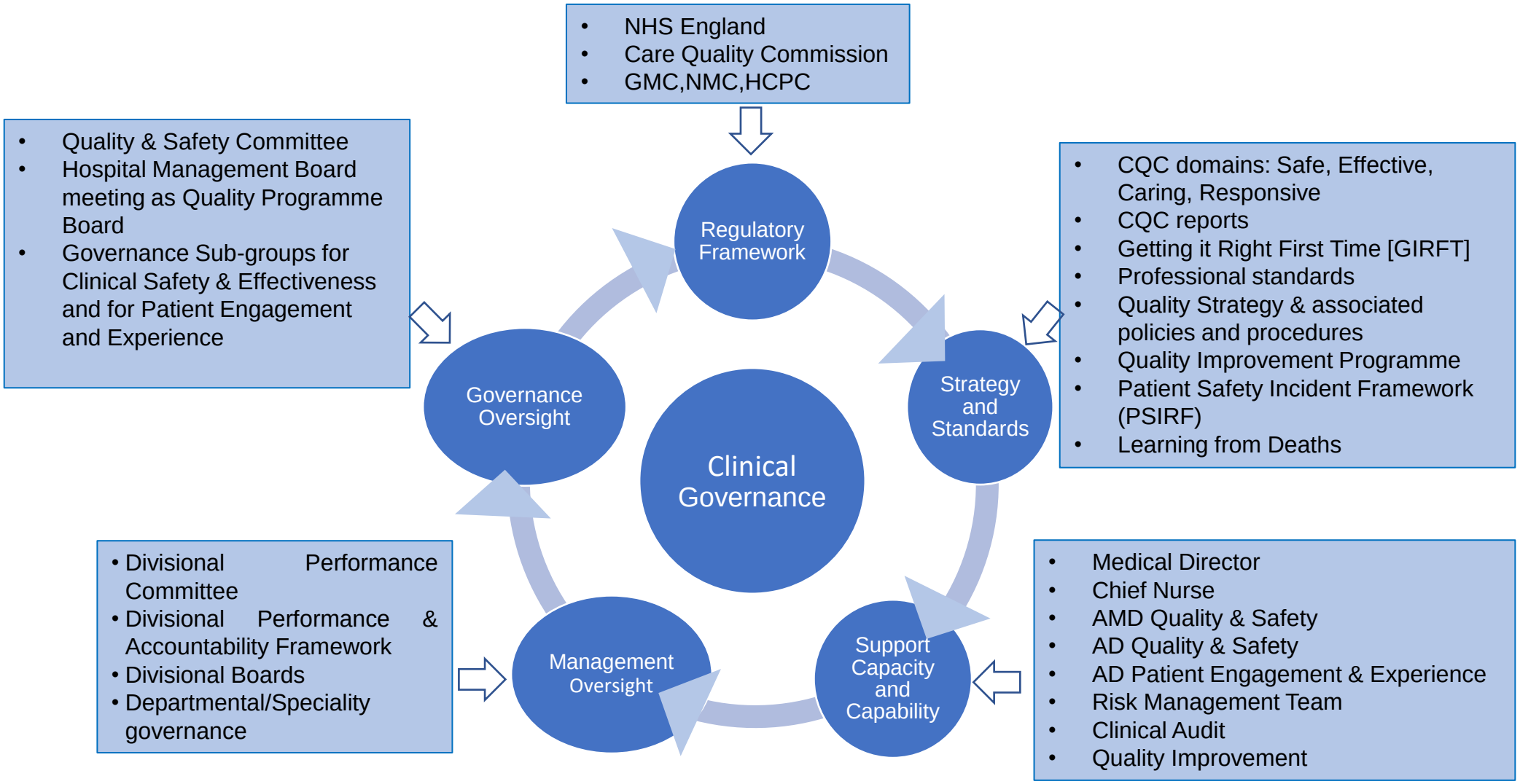
Patient Experience

- Friends and Family tests (including reporting levels and response rates)
- Complaints
- Patient Advice Liaison Service (PALS) contacts
- Patient Surveys and audits
- Patient User Groups
- Patient Information
- PLACE environmental surveys
- Compliments

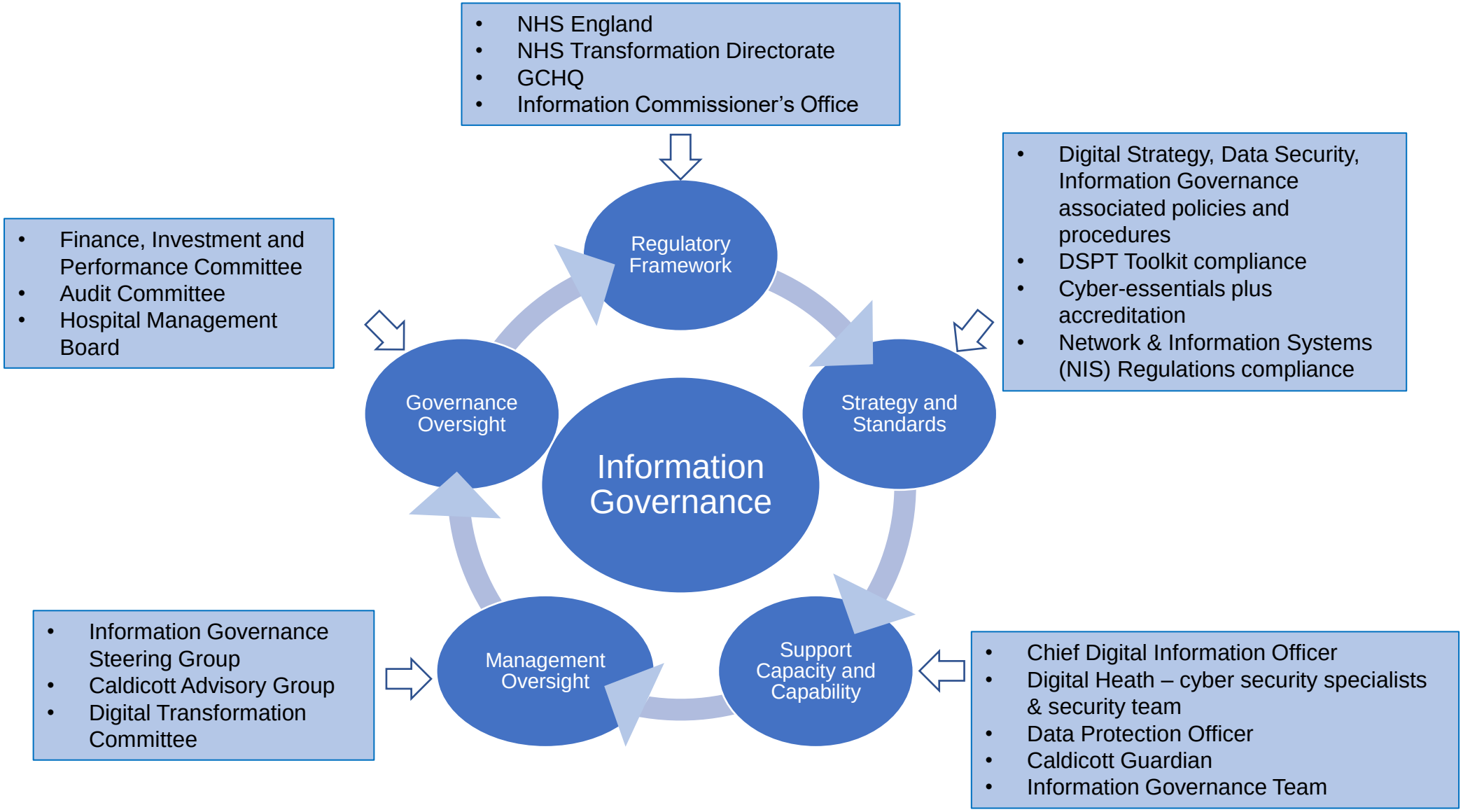
Clinical Effectiveness

- National and local clinical audits
- Implementation of evidence based clinical standards
- Patient Reported Outcome Measures (PROMs)
- Quality improvement projects (including Sepsis, Deteriorating Patient)
- Adherence to national guidance (eg NICE and Royal Colleges)
- GIRFT
- National Accreditation Processes
- Right care
- Screening Programmes
- National data returns (eg.SSNAP, MBRRACE, NCEPOD etc)

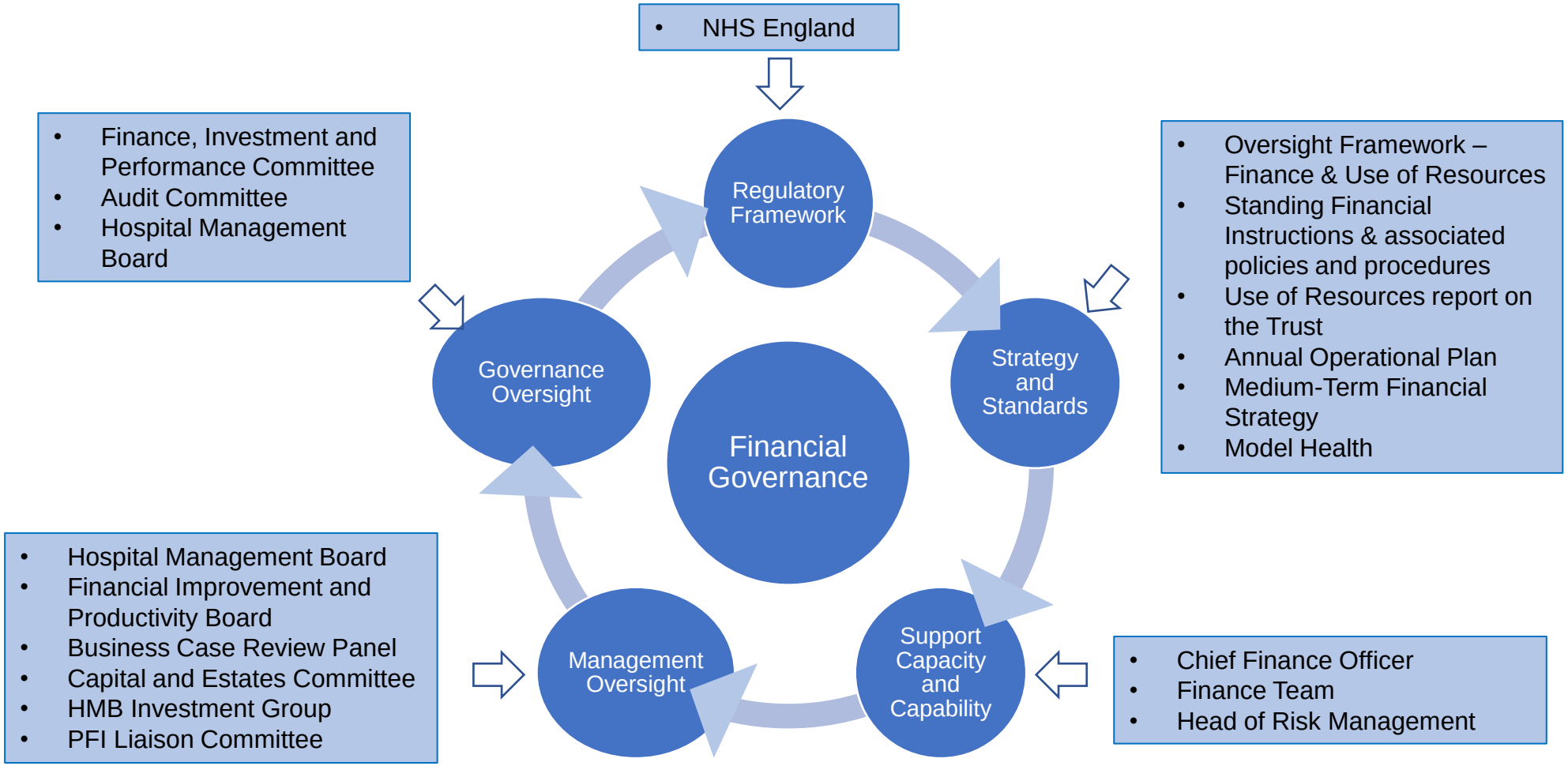
Clinical Governance – Executive leads: Chief Nurse and Medical Director



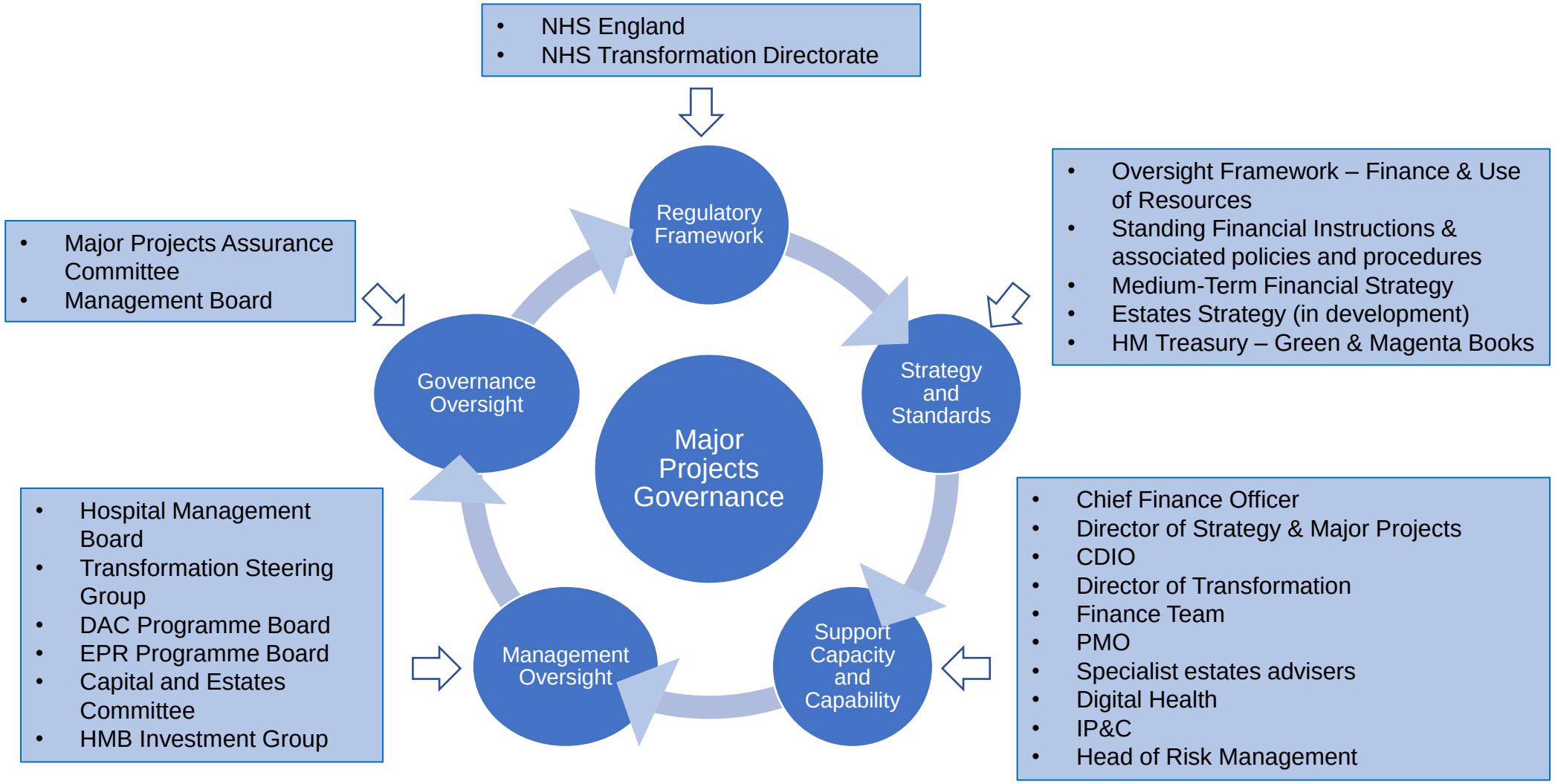
Information Governance – Executive Lead: Chief Clinical Information Officer



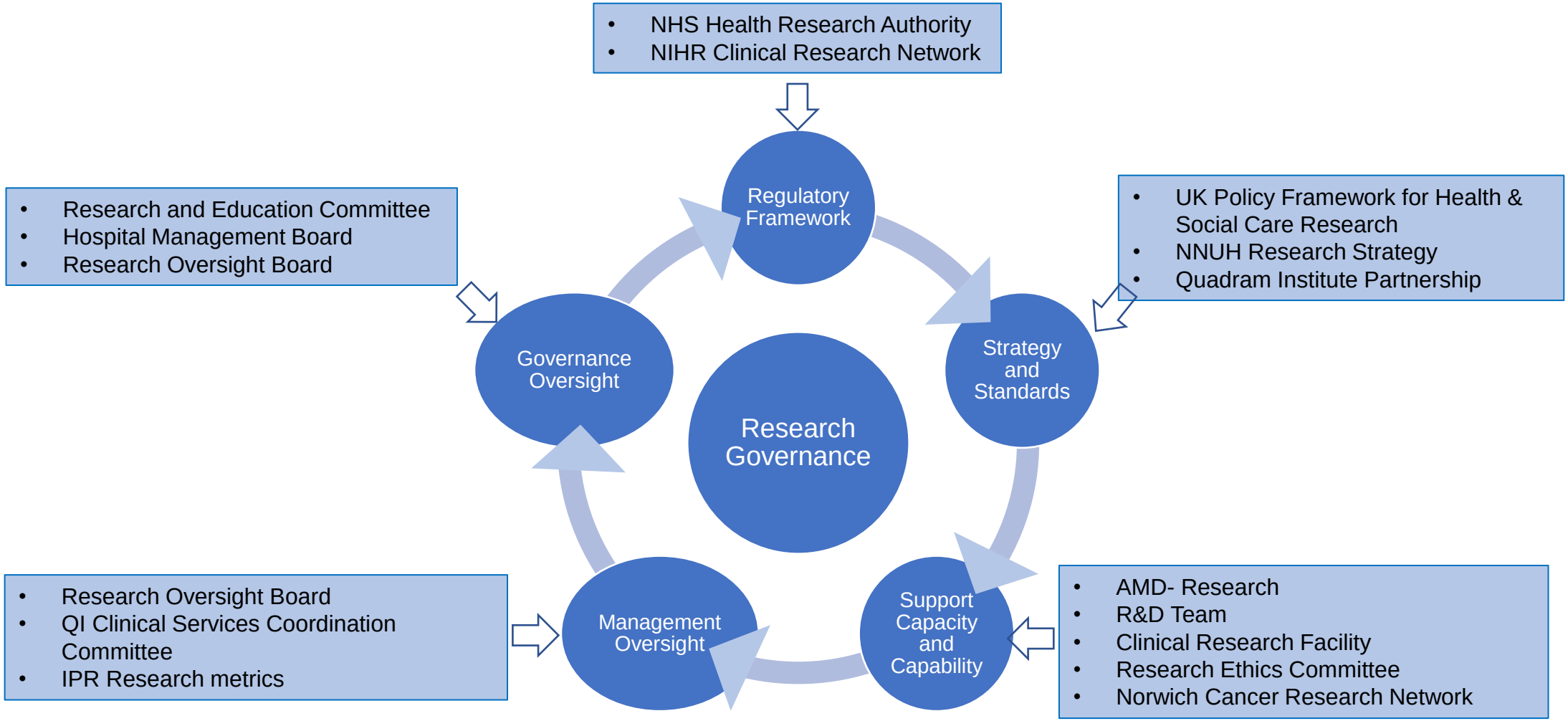
Financial Governance – Executive Lead: Chief Finance Officer



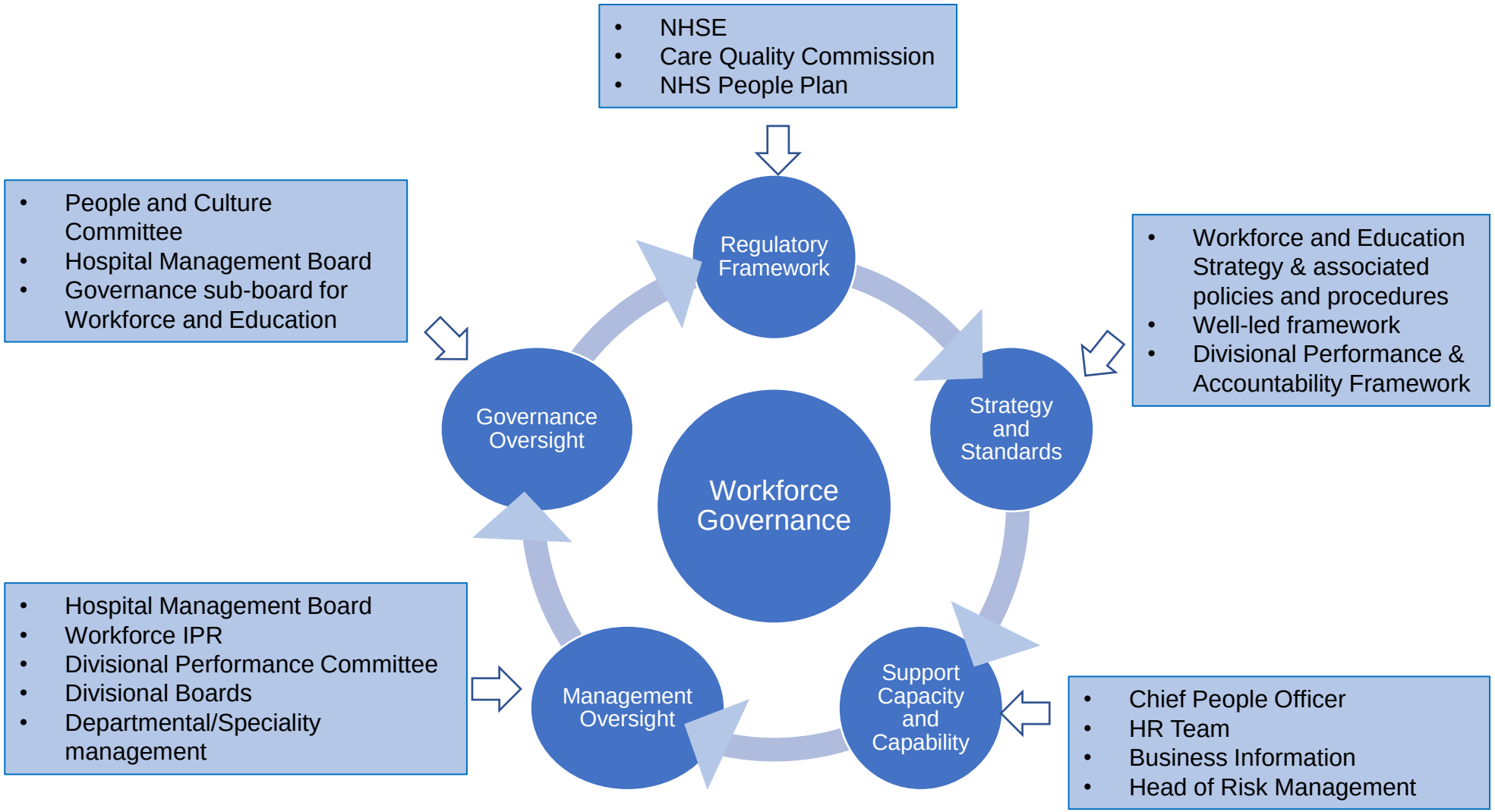
Major Projects Governance – Executive Lead: as per individual projects



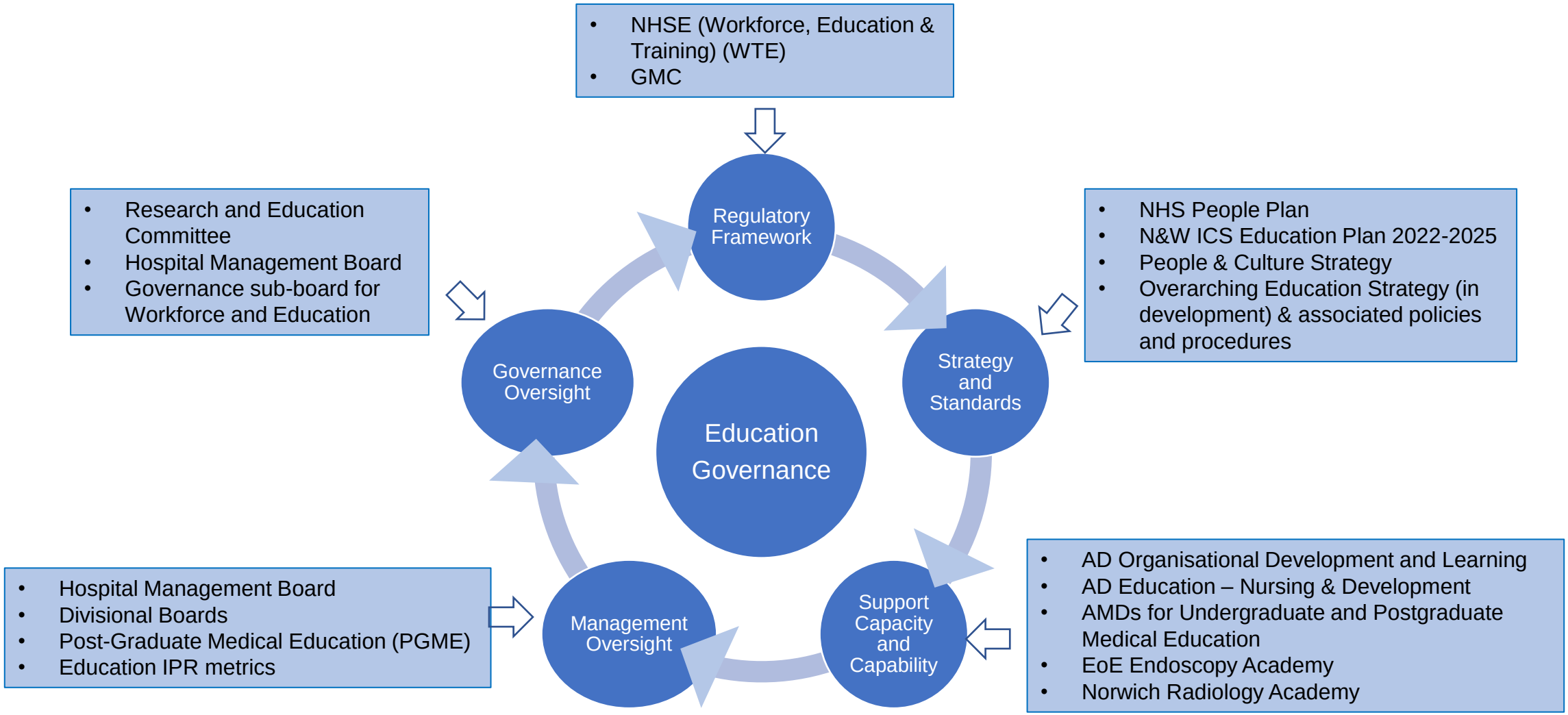
Research Governance – Executive Lead: Medical Director



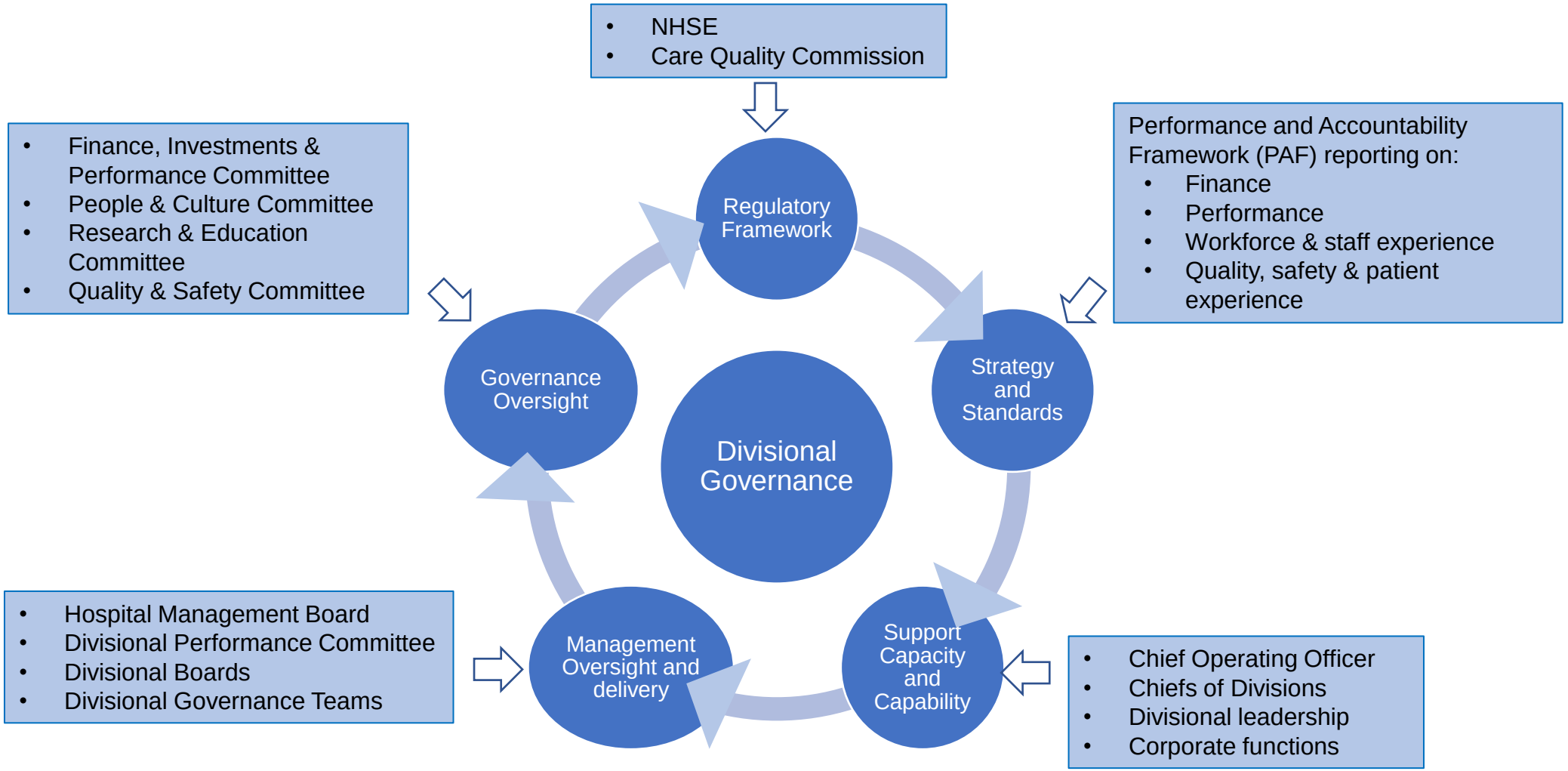
Workforce Governance – Executive Lead: Chief People Officer



Education Governance – Executive Leads: CPO, MD & CN



Divisional Governance - Executive Lead: Chief Operating Officer



Divisional Governance – Overview

The Trust uses a divisional structure to ensure that its services are clinically-led, with the Divisions having effective ownership of divisional culture and operational, financial and quality performance of their services. This section illustrates the way in which management of governance is devolved into the four divisions by the following structures.

- **Triumvirate Leadership**
  The triumvirate leadership model ensures medical, nursing/AHP and operational management of each division

- Each division has a **divisional board,** supported by central support services. Each Board is responsible for its performance and culture – quality, safety, contractual, financial and people – monitored through the Divisional Performance and Accountability Framework.

- Each divisional board is chaired by a **Chief of Division** who will be the clinical leader of the division. The board includes HR and Finance partners who will have a dual reporting role. The Chief of Division reports to the Chief Operating Officer although they retain a professional accountability to their professional lead who will be either the Chief Nurse or Medical Director

- Each division is supported by **embedded governance and management** functions.

- The Governance function is set within the divisional board so that it provides all the required quality data to support the identification of emerging risks, management of patient safety and patient experience and ensuring that clinical delivery groups are delivering clinically effective services and cultures in line with Trust values

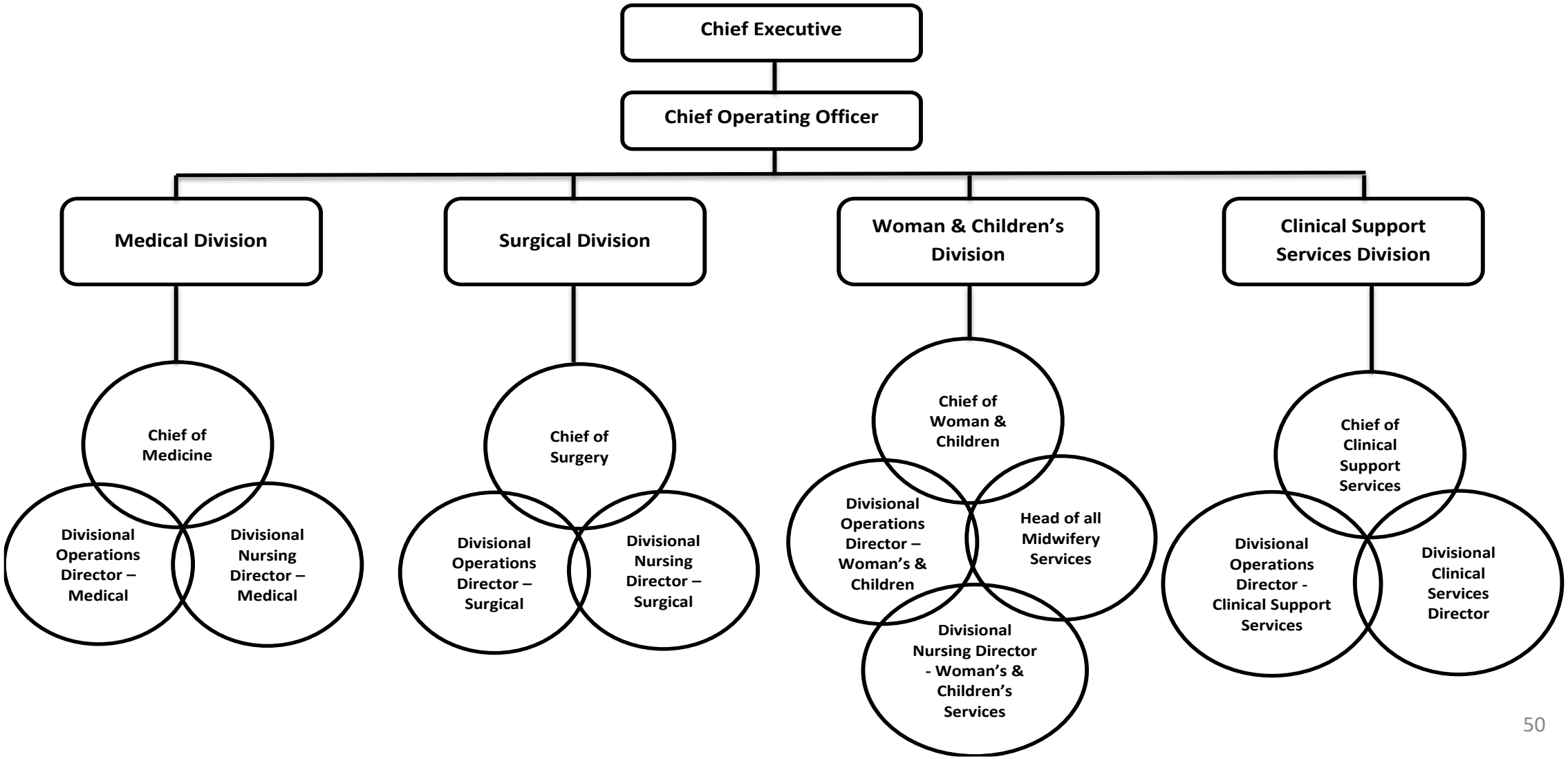
- **Divisional accountability** is to the Hospital Management Board through the **Divisional Performance Committee.**

- The divisional **Performance & Accountability Framework:**
  - demonstrates accountability for quality of clinical outcomes, operational performance and financial budget management
  - measures improvement and compliance with national and professional standards and tracking performance against national and local targets
  - records, reports and escalates risks
  - monitors and evaluates actions to reduce risks, improve quality and sustain improvement
  - evidences quality improvement activity, including innovation and the delivery of excellence

Our Vision
The best care for every patient

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Our Divisional Structure



Section 4 - Charity Governance

- Executive Lead: Company Secretary

Norfolk & Norwich Hospitals Charity

The Norfolk and Norwich Hospitals Charity is registered with the Charity Commission (registration number 1048170). By securing donations, legacies and sponsorship, the Charity is able to provides support for additional equipment and projects above and beyond what is available through normal NHS funding. Ultimately the Charity is overseen by the Board of Directors, acting on behalf of the Foundation Trust as a **Corporate Trustee.**

The Charity Commission has issued guidance which is relevant to charities associated with third parties such as NHS bodies https://www.gov.uk/guidance/guidance-for-charities-with-a-connection-to-a-non-charity.

The guidance sets out six principles:

i. Recognise the risks – relationships with non-charities can benefit charities, but the risks of any particular relationship must be assessed and appropriate steps taken to manage risks.

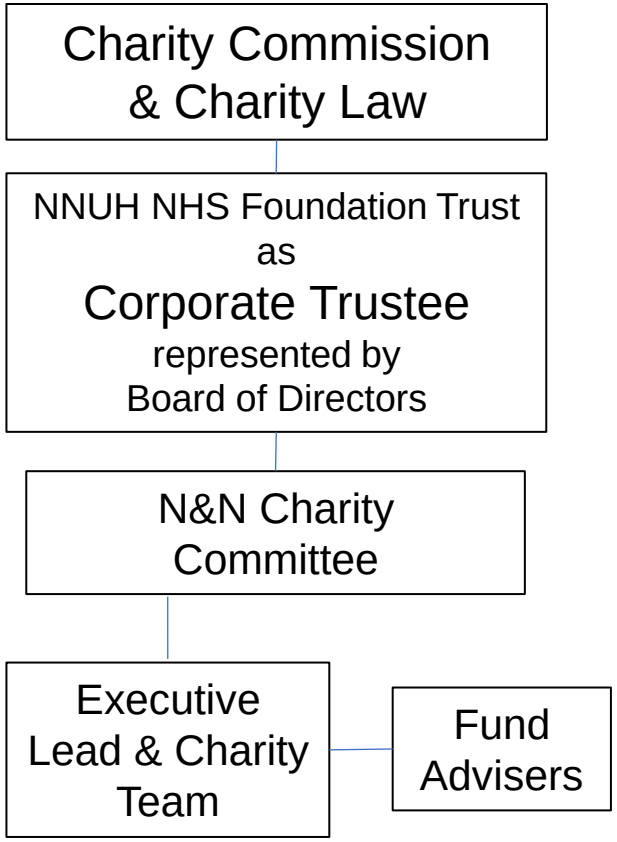
ii. Do not further non-charitable purposes – for a charity to be charitable **all charitable funds must be applied exclusively for charitable purposes**.

iii. Operate independently – a charity must remain independent of any non-charitable organisation with which it has a close connection. **The trustees must act in the best interests of the charity alone**.

iv. Avoid unauthorised personal benefit and address conflicts of interest – The guidance notes that any personal benefit from a charity must be appropriately authorised in advance and any conflict of interest must be appropriately managed.

v. Maintain your charity's separate identity – The guidance states that **charity trustees have a legal obligation "to keep it [*the charity*] distinct from any connected organisation".** The guidance is particularly concerned with the extent to which a charity might share its identity with a non-charitable organisation, and the potential risks of sharing an identity.

vi. Protect your charity - A key duty of charity trustees is to safeguard the assets of their charity (including its reputation).



It is therefore crucial that there should be clear segregation and distinction between the funds and interests of the Charity and those of its host Foundation Trust. The Charity has separate accounts and governance from the Foundation Trust, with separate lines of decision-making and reporting. An established N&N Charity Committee oversees the Charity's – investments policy, budget setting and long-term plans., in accordance with the Charity's Strategy (2023-27) - ***Supporting Better Care*** **.**