



South Eastern Health  
and Social Care Trust

## Annual Report on Risk Management As at 31 March 2018

<b>Policy Profile</b>	
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<b>Approval Profile</b>	
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<b>Governance Assurance Committee:</b>	13 June 2018
<b>Trust Board:</b>	21 June 2018

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# Annual Report on Risk Management as at 31 March 2018

## 1.0 Introduction

This is a report on the Trust's Risk Management System from the 1 April 2017 to 31 March 2018. It is based on the criteria within the Risk Management Controls Assurance Standard issued by the Department of Health, Social Services & Public Safety (DHSSPS) in April 2003 and annually thereafter. Criterion 6 of the standard specifies, "an annual report is produced for the Board to demonstrate the risk management system's continuing suitability and effectiveness in satisfying the organisation's risk management policy and strategy".

The Trust is required to meet substantive compliance (75-99%) with this standard, which should be subjected to independent verification on a yearly basis. Internal Audit carries out this function on behalf of the Trust. The audit took place week beginning 5 March 2018. The Trust achieved substantive compliance (93%) in this standard and this was verified by Internal Audit in their report received on 28 March 2018. The score decreased by 1% (94%) from 2016/17 due to a limited assurance report from Internal Audit in respect of the Fire Safety Issues.

## 2.0 Requirements of the Risk Management Controls Assurance Standard

The purpose of the Risk Management Controls Assurance standard is to ensure that all HPSS bodies have the basic building blocks in place for managing risk through development and implementation of a comprehensive risk management system. This standard, together with the Governance and Financial Management Standards, provides the basis for statutory reporting for the Statement on Internal Control as set out by the Department of Finance and Personnel in DAO (DFP) 05/01 and DAO (DFP) 25/03. All three core standards are required to achieve substantive compliance.

Risk management should be recognised within an organisation as an integral part of good practice and should be part of the organisation's culture. It should be integrated into its philosophy, practices and business plans, and not be viewed or practiced as a separate programme. When this is achieved, risk management becomes the business of everyone in the organisation.

In July 2003, the Department of Health (formerly the DHSSPS) mandated that all HPSS Trusts should adopt a common risk management system based on the Australia/New Zealand standard. This standard defines a set of generic principles for establishing a risk management system in any organisation. The standard has been licensed for the HPSS and the full standard has been made available to all HPSS bodies, which are encouraged to make good use of the information and guidance contained in AS/NZS 4360:2004.

During the year, DoH advised all HSC Trusts, that with effect from 30 June 2018 Trusts could no longer use the afore-mentioned standard on the basis that the licence expired. Alternative arrangements and models for risk management are currently being explored by HSC Trusts and it is anticipated that one model for all HSC Trusts, Health & Social Care Board and Public Health Agency will be agreed for use with effect from 30 June 2018.

### **3.0 Governance arrangements within the South Eastern H&SC Trust**

During 2017/18, the Trust continued to embed the governance arrangements as approved by the Trust Board at its meeting on 24 March 2010 (and subsequent amendments thereafter). The basis for governance within the Trust is an integrated governance model, linking financial governance, risk management (including organisational controls), and clinical and social care governance. An overarching Governance Assurance Committee supported by two main sub committees – Corporate Control & Safety, Quality Improvement & Innovation Committee operated throughout the year and this is illustrated in the extant structures, dated April 2016; updated July 2017 and are included at Appendix 1.

In July 2017, the Trust reviewed and updated its Governance Infrastructure. The Informatics Programme Board was stood down and a proposal to create a new E-Health Sub Committee was approved by Corporate Control in July 2017. The Terms of Reference for the new E-Health Programme Sub Committee were approved by Corporate Control Committee at its meeting on the 19 January 2018.

### **4.0 Risk Management & Governance Directorate – Update**

The Risk Management & Governance Directorate is managed by the Assistant Director, Risk Management & Governance and is part of the wider Human Resources & Corporate Affairs Directorate. The out workings of an internal restructuring were finalised in 2017/18 to improve/assist in creating an infrastructure that was fit for purpose in order to deliver the increasing complexity associated with the Risk Management & Governance agenda.

The work of the Directorate continued to be supported by Dr Ann Hamilton, Clinical Risk Director and Mr Brendan Mullen, Associate Risk Director.

During the year, the Directorate continued to carry out a significant amount of corporate work and its main activity was to support the operational Directorates, continued embedding of Risk Management within the organisation, and further implementation of the Governance and Risk Management infrastructure.

### **5.0 Risk Management Strategy**

The Trust developed its third Risk Management Strategy 2014 – 2017 in April 2014 which was subsequently approved by the Trust Board at its meeting on 25 June 2014. The document sets out the strategic direction for the management of all types of risk – clinical, non-clinical and organisational, for the period 2014 – 2017.

The strategy provides a framework for the continued development of risk management systems and processes building on already established risk management and governance structures in the former legacy organisations. It forms part of a series of strategies and systems for improving and strengthening practices and governance arrangements so that safe and high quality health and social care are provided to all that need them. The strategy is updated on an annual basis each year and was last reviewed in December 2017.

A proposal was submitted to Governance Assurance Committee on 10 January 2018 (original date – 20 December 2017) to extend three key documents (Board Assurance Framework, Risk Management Strategy and Governance Strategy) to 30 June 2018 pending clarification on the future replacement for Controls Assurance and the AS/NZS Standard.

## **6.0 Activities of the Corporate Control Committee and its sub committees – 2017/18**

The Trust's Corporate Control Committee was formally established in April 2011 and meets on a quarterly basis. During 2017/18, the committee met on four occasions in line with its terms of reference. It is chaired by the Chief Executive supported by the Director of Human Resources & Corporate Affairs (Lead Director for Governance) as Vice Chairman.

The role of the Committee is to be the overarching strategic committee responsible to the Governance Assurance Committee on all matters pertaining to integrated governance issues ie, Financial Governance, Corporate Governance (including Risk Management and Organisational Controls). Clinical and Social Care Governance remains within the responsibility of the Safety and Quality Committee. It supports the governance and risk management accountability arrangements within the organisation and ensures that all significant risks are properly considered and communicated to the Governance Assurance Committee and/or the Trust Board, as appropriate.

The Committee's responsibility also includes the organisation-wide co-ordination and prioritisation of risk management issues and overseeing the work of any specialist risk management groups. The committee's terms of reference are included at Appendix 2.

For ease of reference, the sub committees aligned to the Corporate Control Committee during 2017/18 are listed below:-

- Decontamination
- Emergency Planning & Service Continuity
- E-Health Programme (approved in July 2017)
- Environmental Cleanliness
- Environmental/Waste Management
- Fleet & Transport
- Fire Safety
- Food Safety
- Health & Safety
- Information Governance
- Lessons Learnt
- Medical Devices & Equipment
- Organisation and Workforce Development
- Radiation & MRI Protection
- Security

As at 31 March 2018, 15 sub committees were fully operational. The E-health Sub Committee was established in July 2017; Terms of Reference endorsed by

Corporate Control meeting on 19 January 2018. Each operational sub committee had approved terms of reference and an annual action plan<sup>1</sup> based on the key priorities for its respective work area. Progress reports were submitted to the committee on a quarterly basis. The end of year position reports on the action plans for 2017/18 were submitted to the Corporate Control Committee on 18 April 2018; the action plans for 2018/19 were also submitted to this meeting for endorsement.

## **7.0 Corporate and Directorate Risk Registers**

In order to develop and be aware of its risk profile and to identify the key areas for investment in risk reduction/management, the Trust developed a new framework for risk registers which was presented to, and approved by, the Executive Management Team on 12 February 2008 (updated on an annual basis, last updated in May 2017).

The Corporate Risk Register for 2017/18 was presented to, and approved by, the Trust Board at its meeting on 22 June 2017. Regular progress reports on the Corporate and Directorate Risk Registers were made to the Corporate Control and Governance Committees respectively during 2017/18. The end of year position report for 2017/18 will be incorporated into the Board Assurance and Corporate Risk Register Report which will be presented to the Trust Board at its meeting on 21 June 2018.

## **8.0 Corporate Control Committee Programme of Work/Action Plan – 2017/18**

The Committee has a Programme of Work (Appendix 3) which dictates the activities discussed at each meeting. This is complemented by a detailed Action Plan (Appendix 4) which outlines the objectives that the Committee wish to achieve during the year.

The action plan was primarily focused on the key actions arising out of the baseline assessments of the Risk Management Controls Assurance Standards (addressed in detail in section 10.0 below) to ensure continued substantive compliance with the standard viz:-

- Maintenance of sub committee structure aligned to the Corporate Control Committee;
- Review of terms of reference for committee and its effectiveness;
- Further embedding of SET Governance Strategy;
- Directorate Management Plans (incorporating Governance issues);
- Development of an Annual Risk Management Report;
- Annual review of the Board Assurance Framework;
- Annual Review of the Risk Management Strategy;
- Continued implementation of the Controls Assurance Programme;
- Continued implementation of the Corporate and Directorate Risk Registers; and
- Key Performance Indicators.

13 out of 13 (100%) objectives were achieved during 2017/18.

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<sup>1</sup> Action plan currently being developed for new E-Health Sub Committee

The Action Plan for the Corporate Control Committee for 2017/18 was developed and approved by the Committee at its meeting on 25 January 2017 for endorsement by the Governance Assurance Committee at its meeting on 15 March 2017. The Terms of Reference and Programme of Work for the Corporate Control Committee were reviewed in April 2017 (approved 19 April 2017) and again during March 2018 and approved by the Committee at its meeting on 18 April 2018. There were no significant changes to the documents.

## 9.0 Board Assurance Framework

During 2017/18, the Trust continued to implement the out workings of the Board Assurance Framework approved by the Trust Board at its meeting on 24 June 2014. It is subject to annual review in December each year (last review December 2017). The work of the Governance Assurance, Corporate Control and the Safety, Quality Improvement & Innovation Committees continued to be embedded in the organisation and all Committees discharged their duties during the year in line with their agreed terms of reference and programmes of work. As mentioned above, a proposal was submitted to the Governance Assurance Committee on 10 January 2018 (original date – 20 December 2017) to extend documents (Board Assurance Framework, Risk Management Strategy and Governance Strategy) to 30 June 2018 pending clarification on the future replacement for Controls Assurance and the AS/NZS Standard.

## 10.0 Baseline assessments of the Risk Management Controls Assurance Standard – 2017/18

The internal Controls Assurance Programme required that two baseline assessments be completed during the current year for all extant controls assurance standards. However for 2017/18 this was reduced to one on the basis that the programme would cease on 31 March 2018. For 2017/18, the date for submission of the baseline assessment was 31 January 2018. A detailed action plan was developed in April 2017 to ensure substantive compliance with the standard was maintained and, where possible, to improve the scoring on the previous year. The result of the baseline is listed below at Figure 1. It should be noted that the mechanism for scoring is extremely subjective and based on the opinion of the assessor/s. The score is formulated by adding the scores for each criteria and then dividing them by the total number of criterion (average score).

Figure 1 - Results of the baseline assessment – 31 January 2018

Criterion	Trust Score 2017/18	Trust Score 2016/17
1 – Board Accountability	98%	98%
2 – Organisation wide risk management processes	98%	98%
3 – Organisation wide accountability	85%	98%
4 – Adverse Incidents	88%	85%
5 – Complaints and Claims	98%	95%
6 – Risk Management Processes	98%	98%
7 – Business Continuity Management	85%	85%
8 – Capability	88%	88%
9 – Independent Assurance	98%	98%
<b>Total score</b>	<b>93%</b>	<b>94%</b>

The baseline assessment for 2017/18 was submitted by the due date of 31 January 2018 to the Project Manager. The Trust's self-assessment score = 93%; internal audit score = 93% = substantive range (75%-99%). The internal audit score (93%) will be submitted to the DOH on 8 May 2018. The decrease in score in criteria 3 – Organisation wide accountability primarily related to findings in the Fire Safety Audit (limited assurance) which cited difficulties by the Fire Safety Committee in reporting key issues to Corporate Control, Governance Assurance Committee and ultimately Trust Board. This matter was immediately rectified.

A summary of the **key initiatives implemented during the year** to achieve substantive compliance with the standard is outlined below. These include the key action points arising from the action plan. For ease of reference the description of the criterion is also included.

**10.1 Criterion one – Accountability: *Board level responsibility for risk management is clearly defined and there are clear lines of accountability for managing risk throughout the organisation leading to the Board***

Implementation of the three year Risk Management Strategy, 2014-2017 continued during 2017/18. This incorporates both clinical and non-clinical risk issues, responsibilities for staff at all levels and continued implementation and use of the organisation-wide risk matrix based on the AS/NZS standard 4360:2004. The Trust continued to roll out the HSC Regional Risk Matrix for use by HSC Trusts, HSCB and the Public Health Agency. In addition, the quarterly reporting mechanism from the Corporate Control Committee to the Governance Assurance Committee and the Governance Assurance Committee to the Trust Board continued to ensure the recording and reporting of significant risk issues to the Board on a continuous basis.

**10.2 Criterion two – Organisation-wide risk management processes: *The organisation's senior management has defined and documented its strategy for managing risks, including objectives for, and its commitment to, risk management. The risk management strategy is relevant to the organisation's strategic context and its goals, objectives and the nature of its business. Management ensures that the strategy is understood, implemented and maintained at all levels of the organisation***

The Corporate Risk Register for 2017/18 was presented to, and approved by, the Trust Board on 22 June 2017. This was supplemented by the production of Directorate Risk Registers for 2017/18 which were submitted to, and considered by, the Corporate Control Committee on a quarterly basis during the year at its meeting held on 19 July 2017.

**10.3 Criterion three – Organisation-wide accountability: *A committee structure is in place, which supports the risk management accountability arrangements within the organisation and ensures that all significant risks are properly considered and communicated to the board***

In July 2017, a revised Governance Infrastructure (low level structures only) was presented to, and approved by, the Corporate Control Committee with effect from July 2017. This related to the establishment of a new E-Health Sub Committee.

**10.4 Criterion four – Management of Incident Reporting:** *An agreed process for reporting, managing, analysing and learning from adverse incidents is in place, in accordance with HPSS guidance*

Revised Trust Incident policies and procedures were developed and issued December 2016. In September 2016, the Trust delivered bespoke training sessions in respect of Incident Management and Complaints as detailed below:-

- Two-day level 2 Root Cause Analysis training was held on 25 and 26 April 2017;
- Significant Event Audit training (held in April 2017 and March 2018) which helped equip Directorate staff in undertaking Level 1 Serious Adverse Incident reports (Significant Event Audits) including engagement with service users; and
- Effective Written Responses to Complaints Training (March 2018) which focused on providing staff investigating complaints, with effective response writing skills.

**10.5 Criterion five – Complaints and Claims:** *An agreed process for reporting, managing, analysing and learning from complaints and claims is in place, in accordance with HSC guidance*

During 2017/18, the Trust continued to operate the HSC Complaints Procedure which was launched on 1 April 2009. A range of training programmes for all levels of staff was prepared and rolled out during the year (see 10.4 above).

**10.6 Criterion six – Risk Management Processes:** *A risk management process, based on the requirements of AS/NZS 4360:1999 and covering all risks, is embedded throughout the organisation at all levels, including the board, with key indicators being used to demonstrate performance. The whole system of risk management is continuously monitored and reviewed by management and the board in order to learn and make improvements to the system*

This criterion is covered under criteria 1 to 9.

**10.7 Criterion seven – Business Continuity Management:** *Business Continuity Management plans aligned to the International Standard on Business Continuity Management Systems (ISO 22301) are in place that can be activated in order to protect and maintain essential services, to a pre-defined level, through a business disruption*

The Trust has a range of major incident and business continuity plans in place which are tested on a regular basis. These are supported by Directorate Incident Response Plans. During the year, extant Business Impact Analysis Plans for Directorates were reviewed and updated. The Trust participated in a Mass Casualty exercise in December 2017 organised by the Health & Social Care Board. A debrief report was completed and submitted to the Emergency Preparedness & Business Continuity Sub Committee on 5 March 2018. During November/December 2017, preparation began for a Table Top Exercise to test the Trust's business

continuity arrangements in respect of a Cyber attack. The date for this exercise is 23 April 2018.

**10.8 Criterion eight – Capability: *All employees, including members of the board, clinicians, managers, bank, locum and agency staff, together with, where relevant, contractors and volunteers are provided with appropriate risk management training***

During 2017/18, a range of training initiatives were provided and the full detail of these is reflected in the baseline assessment of this standard and section 11.0 below. The main focus on training during the year was on Induction, Risk Assessment, Corporate and Directorate Risk Registers, Complaints (in terms of drafting written responses) and Root Cause Analysis (Significant Event Audit – Level 1 and Level 2).

**10.9 Criterion nine – Independent Assurance: *The board receives independent assurance(s) that a risk management system is in place that meets the requirements of this standard***

In compliance with the controls assurance programme, the Trust was audited by Internal Audit in respect of the following standards as directed by the DoH, which included the Risk Management Standard.

- Financial Management (core standard);
- Governance (core standard);
- Risk Management (core standard) – deferred to accommodate a full Fire Safety Audit at the request of the DoH; and
- Fire Safety.

All four standards achieved substantive compliance. Internal Audit's last audit of Risk Management was undertaken during January 2017. The outcome of the audit is highlighted below:-

*“Internal Audit can provide **satisfactory assurance** on the system of internal control over risk management. 1 Priority 1 weakness was identified; 1 Priority 2 weakness and 1 Priority 3 weakness were also identified”.*

**11.0 Risk Management Training and Education Programmes**

During the year the following range of courses were delivered by staff within the Risk Management & Governance Directorate:-

- Risk Management Induction – a general induction to Risk Management;
- H&S Induction – a general induction to Health & Safety (e-learning);
- Risk Assessment – how to undertake general risk assessments;
- Corporate Risk Registers – how to create a corporate risk register;
- Directorate Risk Registers – how to create a Directorate Risk Register;
- Foundation Training – Junior Doctors;
- Consent, Risk Management & Records Management – Medical Staff;
- Complaints Training – face to face and e-learning;
- Securing Records;
- Serious Adverse Incident training – RCA and Significant Event Audits;
- Incident Reporting and Management;
- Emergency Planning and Business Continuity Awareness training; and

- Other bespoke training to professional staff groups.

Four major training programmes were delivered during 2017/18:-

- Level 2 – two day Root Cause Analysis Training (April 2017);
- Significant Event Audit training (April 2017 and March 2018) which helped equip Directorate staff in undertaking Level 1 Serious Adverse Incident reports (Significant Event Audits) including engagement with service users;
- Effective Written Responses to Complaints Training (March 2018) which focused on providing staff investigating complaints, with effective response writing skills; and
- Regional Incident Grading Workshop – 27 March 2018.

Additionally, other training such as infection control, waste, security was also provided by specialist advisers who work outside the remit of the Risk Management & Governance Directorate.

## **12.0 Summary and Conclusion**

This report provides a brief overview of developments within Risk Management during 2017/18 based on the criteria outlined in the Controls Assurance standard for Risk Management. It provides an annual report for the Board to demonstrate the risk management system's continuing suitability and effectiveness in satisfying the organisation's risk management policy and strategy.

The baseline assessment of the standard, verified by Internal Audit, in their report received on 28 March 2018 confirmed the Trust achieved 93% (substantive compliance – 75%-99%) with the standard.

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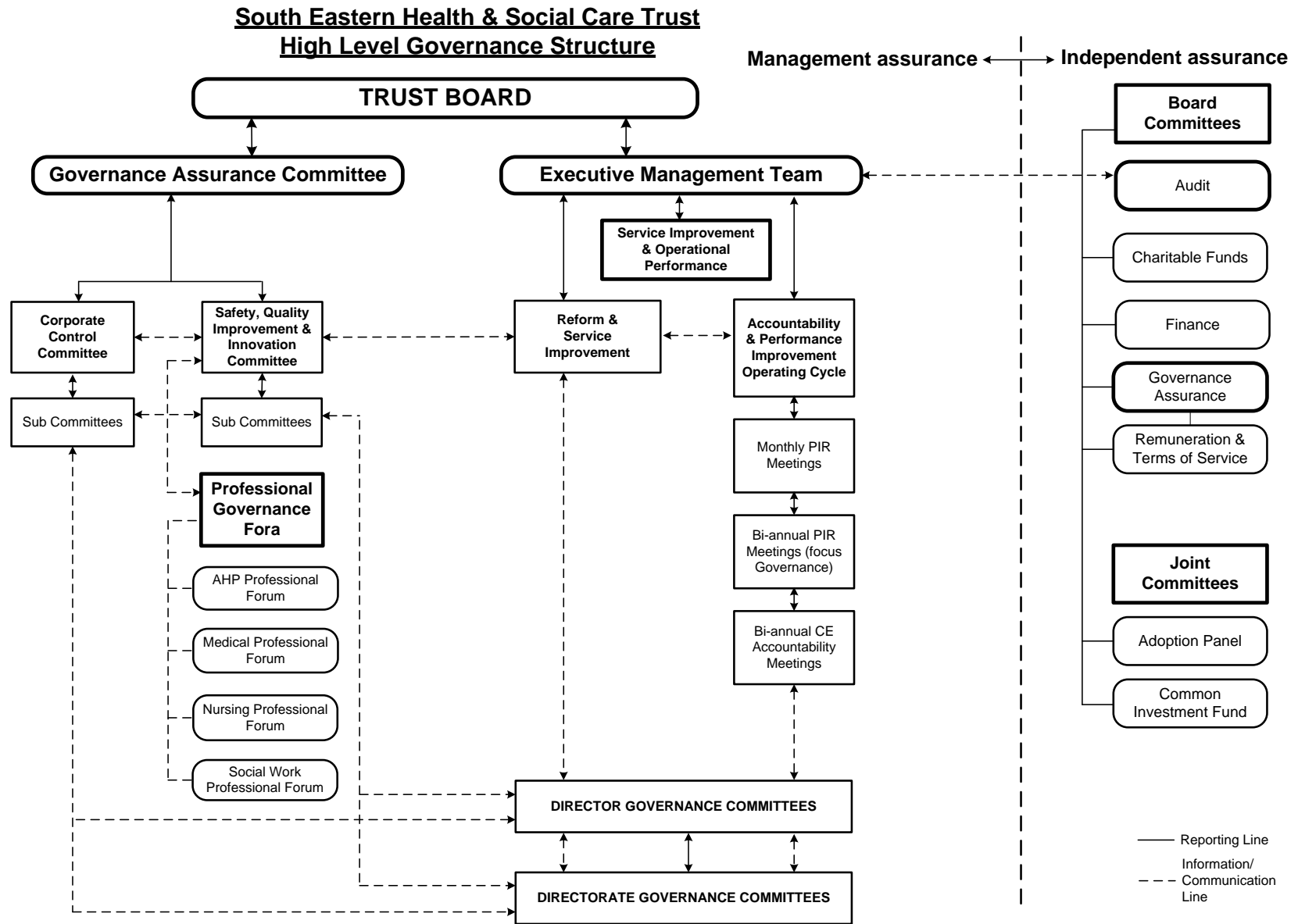
**Irene Low**  
**Assistant Director: Risk Management & Governance**

**16 April 2018**

# Appendices

Appendix 1 – High and low level Governance Structure – 2017/18 (April 2016; updated July 2017)
Appendix 2 – Terms of Reference – Corporate Control Committee (dated April 2017)
Appendix 3 – Programme of work – Corporate Control Committee (2017/18)
Appendix 4 – Action Plan for the Corporate Control Committee – 2017/18 (with status report as at 31 March 2018)

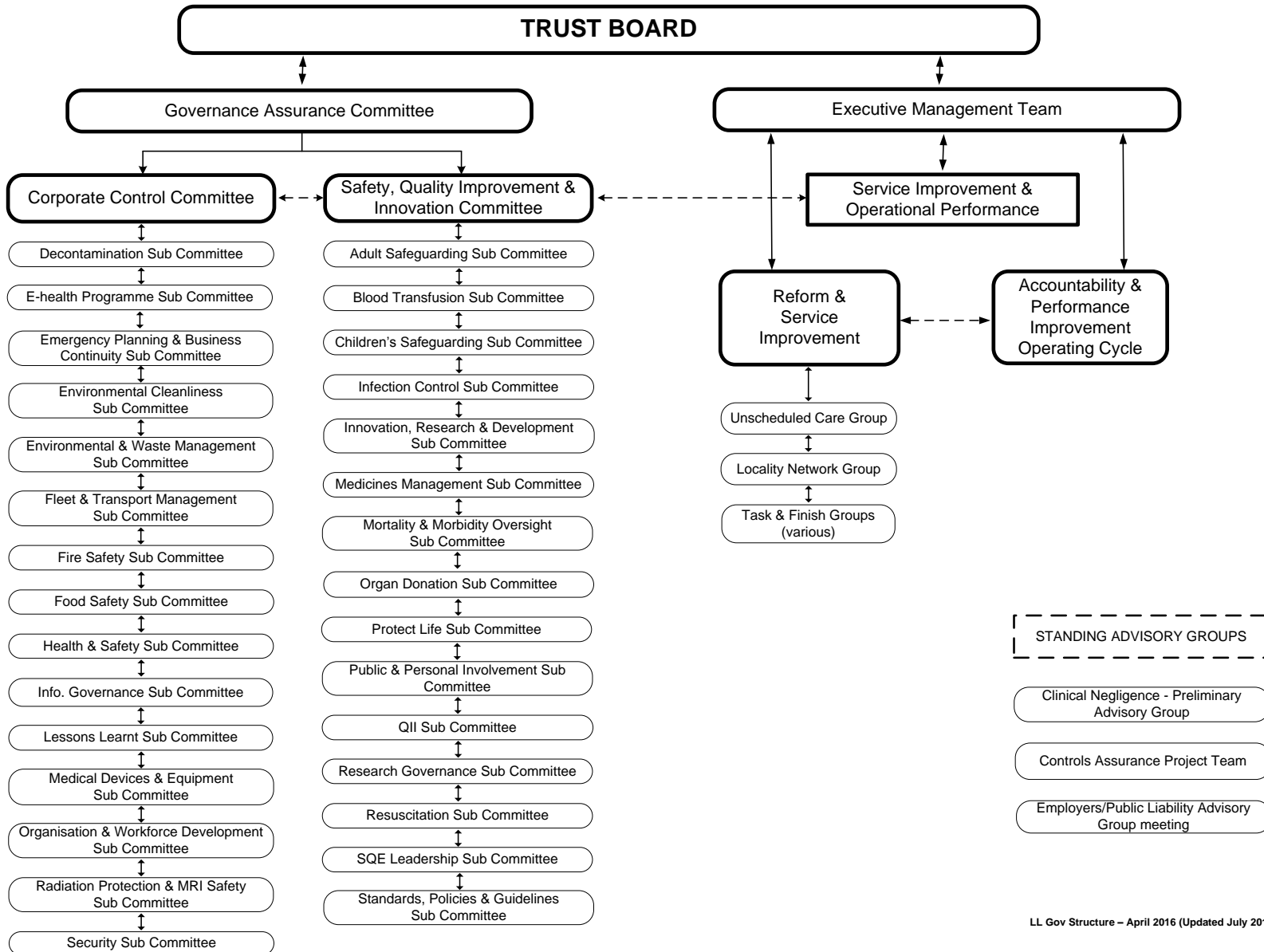
Appendix 1 – High and Low Level Governance Structures 2017/18 (April 2016; updated July 2017)



High Level Gov Structure – April 2016 (Updated July 2017)

# SOUTH EASTERN HEALTH & SOCIAL CARE TRUST

## Lower Level Sub Committee Structure



LL Gov Structure – April 2016 (Updated July 2017)



South Eastern Health  
and Social Care Trust

# Corporate Control Committee Terms of Reference

**Date:** April 2017  
**Version:** Version 1.0  
**Review Date:** April 2018

TOR – Corporate Control -- wef April 2017

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## 1.0 Constitution

The Governance Assurance Committee hereby resolves to establish a sub committee to be known as Corporate Control Committee (the Committee).

## 2.0 Membership of the Committee

Membership of the Committee shall be as follows:

- The Executive Management Team (x 9);
- Two Non-Executive Directors (x2) ;
- Clinical Risk Director;
- Assistant Director of Risk Management & Governance (Joint operational leads for Governance);
- Assistant Director: Financial Services
- Assistant Director: Safe & Effective Care (Joint operational leads for Governance)
- Assistant Director, Social Work Regulation, Improvement and Audit (Joint operational leads for Governance);

In attendance:

Litigation Services & Systems Manager  
Head of Risk Management & Advisory Services

The Chief Executive shall be the Chairman of the Committee and he shall be supported in this role by a Vice Chairman who shall be the lead Director for Governance.

## 3.0 Quorum

A quorum shall be one third (5) of the members of the committee (16).

## 4.0 Frequency of Meetings

The committee shall meet on a quarterly basis.

## 5.0 Authority

The Committee is authorised by the Governance Assurance Committee to undertake any activity within its terms of reference. In particular, it may seek advice from whatever source it deems to be appropriate in order to fulfil its function.

## 6.0 Role and Responsibilities of the Committee

The **role of the Committee** is to be the overarching strategic committee responsible to the Governance Assurance Committee on all matters pertaining to integrated governance issues ie, Financial Governance, Corporate Governance (including Risk Management and Organisational Controls) . Clinical and Social Care Governance is the responsibility of the Safety and Quality Committee.

It will support the governance and risk management accountability arrangements within the organisation and ensure that all significant risks are properly considered and communicated to the Governance Assurance Committee and/or the Trust Board, as appropriate.

### **Governance responsibilities**

- To provide assurance to the Governance Assurance Committee that the key building blocks of integrated governance - Financial Governance, Corporate Governance including Risk Management are being effectively and appropriately managed. Clinical & Social Care - Governance is the responsibility of the Safety & Quality Committee.
- To ensure that key priorities relating to Governance are delivered through a performance management and accountability framework;
- To be responsible for the strategic management of the Trust's integrated Governance agenda, incorporating Financial Governance, Corporate Governance (including Risk Management and organisational controls).
- To develop and implement an integrated Governance strategy supported by annual governance plans at Strategic and Director/Directorate levels;
- To prepare and submit regular reports to the Governance Assurance Committee, as required, on the activities and outcomes of the Corporate Control Committee including the work of related sub committees;
- To receive for endorsement the annual programmes of work for the Corporate Control Sub Committees;
- To consider and prepare the risk management section of the Trust's Annual Statement of Internal Control and any Risk Management Statements for inclusion in the Trust's Annual Report;
- To develop and implement an Assurance Framework for the Trust ensuring that all significant risks that impact on the achievement of the Trust's principal objectives have been identified, recorded, actioned and entered on to the Corporate Risk Register, as appropriate;
- To receive regular reports on the operation of the Trust's Risk Registers (both Corporate and - Directorate) ensuring that regular reports are made to the Governance Assurance Committee and/or Trust Board;
- To ensure compliance with the achievement of the Controls Assurance programme and any other similar initiatives for eg, ISO and HQS programmes in accordance with agreed work plans;
- To ensure appropriate linkages are in place with the Safety & Quality, Financial Management and Operational and Performance Management strands of the governance structure to ensure that the risk and safety/quality programmes work in unison;

## **Risk Management Responsibilities**

- To provide the Governance Assurance Committee with assurances that the Trust has appropriate arrangements for effective internal control, and for the identification and management of risk.
- To implement and maintain a strategic framework within which the Trust can develop a dynamic risk management system including relevant policies, procedures and guidelines for clinical and non-clinical risks;
- To produce an annual risk management programme of work for endorsement by the Governance Assurance Committee;
- To establish and maintain a framework of sub committees reporting to the Corporate Control Committee in order to ensure key risk management priorities are being addressed;
- To be responsible for the organisation-wide co-ordination and prioritisation of risk management issues and overseeing the work of any specialist risk management groups;
- To receive annual action plans and regular reports for all sub committees reporting to the Corporate Control Committee in order to ensure key governance and risk management priorities are being addressed;
- To act as a filter mechanism for risk issues from Directorate level risk registers for entry onto the Corporate Risk Register;
- To lead on the implementation and monitoring of relevant risk management standards in order to ensure the delivery of high quality, evidence based care for eg, Controls Assurance;
- To determine priority areas for the audit programme in respect of governance and risk management activities based on both clinical and non clinical risk programmes; and
- To receive regular management information on complaints, incidents and litigation cases to ensure that the Trust has the necessary controls in place to manage each area and review trends, as appropriate.

## **7.0 Operational arrangements for meetings**

### **7.1 Administrative support to the committee**

The Committee shall be supported administratively by the Assistant Director: Risk Management & Governance, whose duties in this respect will include:

- Preparation and issue of agenda on behalf of the Chairman;
- Collation and distribution of papers sufficiently in advance of each meeting to facilitate their full consideration and discussion at the meeting;

- Ensuring appropriate arrangements are in place for the servicing of the committee including the taking of minutes and keeping a record of matters arising and issues to be carried forward.
- Advising the Committee on pertinent issues.

## **7.2 Conduct of meeting**

All questions arising will be decided by a simple majority of those present. In the case of equal votes, the Chair will have a casting vote. It is intended that meetings will not last more than 2 hours.

## **7.3 Agenda items and papers for meetings**

Agenda items should be submitted to the Assistant Director: Risk Management & Governance 10 days in advance of the meeting. He/she will agree the content of the agenda prior to issue with the chairman of the group.

The Assistant Director: Risk Management & Governance will issue the agenda/papers for the meeting approximately 7 days in advance of the meeting.

Should an item need to be raised on the day, this can be covered under Any Other Business, subject to there being available time for discussion. If separate papers require circulation, these should, wherever possible, be issued with the agenda. This is intended to enable the members to have the opportunity to read information in advance.

## **7.4 Minutes of meetings**

The Assistant Director: Risk Management & Governance (or nominee) will provide the secretariat for the meeting. Minutes of meetings will be produced and agreed with the chair prior to issue. These will be circulated as soon as possible after the meeting listing topics discussed, actions agreed and individuals responsible for undertaking those actions.

## **7.5 Sub Committee Reporting Arrangements**

The Committee will oversee the work of all specialist risk management sub committees and will endorse their terms of reference and annual programmes of work. The Committee will receive the minutes of all sub committee meetings and quarterly reports detailing progress reports on work plans.

## **7.6 Review of terms of reference**

The Committee will review its terms of reference on an annual basis. The Governance Assurance Committee should endorse these.

## **8.0 Reporting**

The minutes of the Committee shall be formally recorded and distributed to the members of the Committee and presented to the next Governance Assurance Committee meeting, for information and noting. Regular reports from the Corporate Control Committee will be submitted to the Governance Assurance Committee as per the agreed reporting mechanism.

## **Membership of the Committee – April 2017**

Mr H McCaughey, Chief Executive  
Mrs M Weir, Director of Human Resources & Corporate Affairs  
Mr S McGoran, Director of Hospital Services  
Ms N Patterson, Director of Primary Care & Older People and Executive Director of Nursing  
Mrs B Mongan, Director of Adult Services & Prison Healthcare  
Mr C Martyn, Medical Director  
Mr N Guckian, Director of Finance & Estates  
Mr B Whittle, Director of Children's Services & Executive Director of Social Work  
Ms R Coulter, Director of Planning, Performance & Informatics

Mr N Brady, Non-Executive Director  
Mr M Mawhinney, Non-Executive Director

Miss I Low, Assistant Director, Risk Management & Governance  
Dr A Hamilton, Clinical Risk Director  
Mrs B Campbell, Assistant Director, Social Work, Regulation Improvement & Audit  
Mrs L Kelly, Assistant Director, Safe & Effective Care  
Mr M Schubert, Acting Assistant Director, Financial Services (wef 1/8/2016); Brian Grimley  
wef August 2017

### **In attendance:**

Mrs J McAtamney, Head of Litigation Services & Systems Manager  
Mrs V Walker, Head of Risk Management Advisory Services

## Appendix 3 – Programme of Work for the Corporate Control Committee: 2017/18



### Corporate Control Committee: Programme of Work





Month	Corporate Control Meeting	Corporate Control Committee work outside meeting
<b>January</b>	Corporate and Directorate Risk Registers Controls Assurance Programme Directorate Reports – by exception Quarterly reports from sub committees Issues referred from sub committees Prepare draft action plan for incoming year Review and update of Assurance Framework Review and update of Risk Management Strategy Review and update of Governance Strategy	Input into draft internal audit plan in terms of Governance issues
<b>February</b>		
<b>March</b>		Submit January minutes to March GAC
<b>April</b>	Closure of Corporate Control Action plan for extant year Approval of Corporate Control programme of work for incoming year Closure of action plans for Corporate Control Sub Committees for extant year Approval of work plans for Corporate Control sub committees for incoming year Corporate and Directorate Risk Registers Controls Assurance Programme Directorate Reports – by exception Issues referred from sub committees Report on Sealed Documents Consider the committee's own effectiveness in its work Review and update, as required, Committee's terms of reference and programme of work	Draft sections for Governance Statement Draft Annual Risk Management Report
<b>May</b>		
<b>June</b>		Submit April minutes to June Governance Assurance Committee (GAC)
<b>July</b>	Corporate and Directorate Risk Registers Controls Assurance Programme Directorate Reports – by exception Quarterly reports from sub committees Issues referred from sub committees Update report - Family Engagement - SAls	
<b>August</b>		
<b>September</b>		Input to the Mid-Year Assurance Statement Submit July minutes to Sept GAC
<b>October</b>	Corporate and Directorate Risk Registers Controls Assurance Programme Directorate Reports – by exception Quarterly reports from sub committees Issues referred from sub committees Report on Sealed Documents Report from the Procurement Board	
<b>November</b>		
<b>December</b>		Submit October minutes to the December GAC





Appendix 4 – Corporate Control Committee: 2017/18 (including status report as at 31 March 2018)



South Eastern Health & Social Care Trust






Corporate Control Committee Action Plan 2017/2018




**CORPORATE CONTROL COMMITTEE ACTION PLAN – 2017/2018**

No.	Topic Area/ Objective	Baseline Position as at 1 April 2017	Action Planned	Action Achieved/Outcome As at 31 March 2018	Target Date By whom	Status
1.	Corporate Control Committee Action Plan	Corporate Control Action Plan for 2016/17 developed and approved by Governance Assurance Committee (GAC) on 16 March 2016	Develop draft action plan for 2017/2018 for approval by GAC at its meeting on 15 March 2017	Draft action plan endorsed at GAC at meeting held on 15/3/17	CC Committee 1 April 2017	
2.	Maintenance/ Development of the Corporate Control Committee's Sub Committees	Closure of 2015/2016 action plans and updated TOR signed off by Corporate Control Committee – 20/4/16. 2016/2017 action plans approved – 20/4/16	Write to all sub committee chairpersons seeking (i) closure of 2016/2017 action plans (ii) updated terms of reference and (iii) action plans for 2017/2018 by 31 March 2017	Position report on action plans as at 31/3/17 compiled and presented to CC Committee at its meeting on 19/4/17. Position report on TORs as at 31/3/17 compiled and presented to CC Committee at its meeting on 19/4/17. Position report on 2017/18 action plans compiled and presented to CC Committee at its meeting on 19/4/17.	I Low 30 April 2017	
3.	Review of terms of reference for committee and consider the effectiveness of the committee	TOR and Programme of Work last reviewed and updated (20/4/16) by committee on 20/4/16. Paper on review of effectiveness approved at 20/4/16 meeting.	Review committee's TOR, POW and effectiveness and present in report format to the Committee	Revised TOR and POW and Report on Effectiveness for CC Committee compiled and list for discussion and approval at CC meeting to be held on 19/4/17.	CC Committee 30 April 2017	
4.	Governance Strategy and Action Plan	Revised Governance Strategy 2012-2015 approved by Trust Board on 25/6/14	Strategy due for full 3 year revision during 2017/18  Arrange re-audit of implementation of strategy in 4 <sup>th</sup> quarter IA programme 2017/18	Reported at CC on 17/1/18 that the GAC had agreed on 10/1/18 that the BAF, RM Strategy and Governance Strategy should be extended to 30/6/18 to accommodate the proposed changes to the AS/NZ standard and the alternative assurance models for Controls Assurance.	I Low/L Kelly/ B Campbell 31 Oct 2017 R – 31/3/18	


No.	Topic Area/ Objective	Baseline Position as at 1 April 2017	Action Planned	Action Achieved/Outcome As at 31 March 2018	Target Date By whom	Status
5.	Directorate Management Plans incorporating Governance issues	Directorate Management Plans now corporate Governance/SQE priorities.  PIR meetings and Mid and End of Year Accountability meetings to include Governance/SQE issues	All Directors to ensure their Directorate Management Plan/s includes a relevant section on Governance issues.  Review the extant arrangements for Governance/SQE within the Operating Cycle framework and make recommendations for improvement, as required	Draft Directorate Management Plans include section on Governance issues.  Arrangements operated satisfactorily in-year. However, Miss Low will link with Mrs Moore and provided feedback in terms of the Governance section in the light of the experience of the Mid-Year meetings.	All Directors 31 May 2017  Irene Low in conjunction with L Kelly, B Campbell and H Moore  31 Dec 2017	  
6.	Risk Management Annual Report	Risk Management Report for 2015/2016 submitted for approval to Corporate Control Committee on 20/4/16, GAC 15/6/16 and Trust Board 22/6/16	Prepare draft Annual Risk Management Report for 2016/2017 and submit to CC Committee on 19/4/17 and Trust Board on 24/5/17	Draft report to be presented to and approved by CC committee at meeting on 19/4/17. Will be submitted to Trust Board on 31 May 2017. Completed.	I Low 31 May 2017	
7.	Board Assurance Framework	A new 3 year Board Assurance Framework for 2015-2017 was developed and approved by GAC on 17/6/14 and endorsed by Trust Board on 25/6/14. Last scheduled review was Dec 2016 (annual basis) - no changes required	Develop a new 3 year Board Assurance Framework for review on an annual basis.	Reported at CC on 17/1/18 that the GAC had agreed on 10/1/8 that the BAF, RM Strategy and Governance Strategy should be extended to 30/6/18 to accommodate the proposed changes to the AS/NZ standard and the alternative assurance models for Controls Assurance.	I Low 31 Oct 2017 R – 31/3/18	


No.	Topic Area/ Objective	Baseline Position as at 1 April 2017	Action Planned	Action Achieved/Outcome As at 31 March 2018	Target Date By whom	Status
8.	Risk Management Strategy	A new 3 year Risk Management Strategy 2015-2017 was developed and approved by GAC on 17/6/14 and endorsed by Trust Board on 25/6/14. Last scheduled review was Dec 2014 (annual basis) - no changes required	Develop a new Risk Management Strategy for review on an annual basis.	Reported at CC on 17/1/18 that the GAC had agreed on 10/1/18 that the BAF, RM Strategy and Governance Strategy should be extended to 30/6/18 to accommodate the proposed changes to the AS/NZ standard and the alternative assurance models for Controls Assurance.	I Low 31 Oct 2017 R – 31/3/18	
9.	Risk Management Controls Assurance	Baseline assessments for 2016/2017 completed and action plans prepared.	Undertake in year baseline assessments for the Risk Management Controls Assurance Standard in accordance with the Project Timetable to ensure continued substantive compliance by 31 March 2018 (1 <sup>st</sup> – Nov 2017 and 2 <sup>nd</sup> – March 2018)	Project Team agreed to do one baseline assessment (as opposed to two) on the basis that the CA Programme will cease on 31/3/18. Due date = 31 January 2018.  All 22/22 baseline assessments received – 21/22 reporting substantive compliance (Medical Devices = moderate compliance).	I Low 30 Nov 2017 31 Mar 2018	


No.	Topic Area/ Objective	Baseline Position as at 1 April 2017	Action Planned	Action Achieved/Outcome As at 31 March 2018	Target Date By whom	Status
10.	Corporate and Directorate Risk Registers	CRR and DRR closed off for 2016/2017 in March 2017  New CRR and DRR developed in Feb/March 2017  Review and update the framework for Corporate and Directorate Risk Registers (annual basis). Last review – May 2016	Regular progress reports on CRR and DRR to be submitted to the committee for consideration on a quarterly basis.  CRR to be submitted to the Governance Assurance Committee in June 2017  DRR to be submitted to the Corporate Control Committee in April 2017  Review and update extant version of framework for Corporate/Directorate Risk Registers	Final update position on 2016/17 CRRs and DRRs requested and input to Datix as at 31/3/17  Draft CRR report e presented to GAC on 21/6/17 and then Trust Board for approval at meeting on 22/6/17 (draft CRRs in preparation)  2017/18 DRRs currently being compiled and will be presented to July 2017 meeting.  Completed – no significant changes to the framework.	I Low Quarterly Basis wef 1/4/17  I Low 30/6/17  I Low 31/7/17  I Low 30 Aug 2017	      
11.	Develop KPIs capable of showing improvements in management of risk and/or providing early warning of risk (RM & Governance CA requirement)	Documented KPIs for Risk Management & Governance for 2016/2017 reported to committee on a quarterly basis during year  Draft 2017/2018 KPIs to be approved by CC Committee on 20/4/17	Develop KPIs for Risk Management and Governance for 2017/2018 capable of showing improvements in management of risk and/or providing early warning of risk for discussion at Corporate Control Committee.	Draft KPIs developed for approval at CC committee meeting to be held on 19/4/17	I Low 30 April 2017	


No.	Topic Area/ Objective	Baseline Position as at 1 April 2017	Action Planned	Action Achieved/Outcome As at 31 March 2018	Target Date By whom	Status
12.	Report on Sealed Documents	Bi-annual reports on Sealed Documents submitted to CC Committee, for information purposes, in September and March	Arrange for submission of bi-annual report (Sept and March) on Sealed Documents to be prepared and submitted to the CC Committee.	Report on Sealed documents (Jan to Mar 2017) to be presented to CC committee at meeting on 19/4/17  Report on Sealed documents (Jan to Mar 2017) to be presented to CC committee at meeting on 18/10/17	I Low 30 Sept 2017 31 Mar 2018	  
13.	Governance Infrastructure	Governance Infrastructure last reviewed in January 2016 and operational wef 1/4/16.	Review and update the Governance infrastructure diagrams in the light of any changes that develop during the year and best practice guidance/documents.	Last review was January 2016. Changes operational from April 2016. Proposals for further revision to Governance infrastructure to be discussed at meeting on 19/7/17/  New proposals approved at meeting held on 19/7/17 and will be implemented forthwith	I Low in conjunction with relevant parties 31 Mar 2018	

### Symbols used to indicate achievability status

 **Achievable** – on course to achieve target

 **Doubtful** – Effort required/behind schedule in achieving target

 **Not Achievable** – Target not achievable or serious concern/major effort required to achieve target

 **Achieved** – Target achieved