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Leicestershire Partnership NHS Trust

Level 1 Committee Governance

Purpose

To present the outcome of a review of level 1 governance with revised Terms of Reference for the Quality and Safety Committee (QSC), the Finance and Performance Committee (FPC), the People and Culture Committee (PCC) and the Audit and Risk Committee (ARC).

Analysis of the issue

Terms of Reference have been reviewed for the QSC, FPC, PCC and ARC and are appended (A-D respectively), the revisions take account of;

- Routine review ahead of the new financial year, taking into account feedback from the committee chairs and members.
- Feedback from the external review of our governance and leadership arrangements.
- Best practice guidance including the NHSE Insightful Provider Board.
- Lean governance principles.

The key changes include;

- An additional meeting of the QSC in May each year to receive all year end items. This will reduce the number of items being received by the committee throughout the year.
- The QSC ToR has been updated to reflect the enhanced governance arrangements for quality and safety including the introduction of a feeder Safety Forum.
- Updated governance for Freedom To Speak Up (FTSU) following board development discussions. FTSU is primarily routed through the PCC, with any appropriate cross fertilisation to other relevant level 1 committees. In line with HFMA guidance we will also continue to receive an annual report on the arrangements in place for our FTSU processes.
- Ongoing development of dashboards. This reflects our work to increase the data dashboard provision at committees, with a focus on clinical outcomes and triangulation.
- From 1 April, the level 1 committees dates are staggered to allow for the cross fertilisation of feedback between the committees.
- Align the agendas to the BAF. To align assurance received by the committee to the relevant risk areas.

The appended Terms of Reference contain

- A full update for the QSC and FPC. These have been reworked to include reference numbers for key items within the ToR, which allows us to reconcile with the workplans to ensure that we are sighted on all areas of assurance.
- Tracked changes indicate changes following feedback provided by the committees in February 2025
- Tracked changes for the updates to the PCC and ARC ToR.

Decision

Trust Board approval of the revised terms of reference for the QSC, FPC, PCC and ARC.

Appendix A

Leicestershire Partnership NHS Trust
Quality and Safety Committee Terms of Reference 2025/26

Version	2025/26 v1
Executive Lead	Executive Director of Nursing, Allied Health Professionals & Quality
Approved	Quality and Safety Committee February 2025
Ratified	Trust Board *March 2025*
Review Date	Annual Review March 2026

Purpose of Committee

The Quality and Safety Committee ('the Committee' or 'QSC') is a formal level 1 sub-committee of the Leicestershire Partnership NHS Trust's Board of Directors and will exercise its delegated authority in line with the standing orders of the Trust Board and its approved Terms of Reference.

The purpose of the Committee is to support the Trust in achieving its strategic objectives in relation to quality and safety matters, including the goal to achieve 'great outcomes' and our objectives to 'improve access to our services for our local population' and to 'ensure that our services are safe, delivered in partnership with others and continue to innovate to deliver great outcomes for Leicester, Leicestershire and Rutland'.

Duties

The Trust requires patient-to-board line of sight for assurance that there is safe and effective delivery of high-quality care. Emphasis is placed on receiving assurance through data, and from across the three lines of assurance and include patient and staff voice, and feedback from the clinical directorates through the Committee via assurance reports.

The Committee will receive assurance over the following standing items;

Quality and Safety Overview

QS1. The previous month QSC escalation AAA highlight report (each meeting).

QS2. The escalation AAA highlight report from the Accountability Framework Meeting (the 'AFM' is this Trust's performance review forum).

QS3. The escalation AAA highlight report from the Access Delivery Group (the Trust's waiting times review forum).

QS4. Executive Environmental Analysis. An opportunity for Executive Director members of the Committee to provide a verbal update where it is relevant to do so. This item may also include time limited areas on which the committee will be charged to provide assurance to the Board. It may also include any relevant Freedom to Speak up feedback from the PCC.

QS5. Strategic risk on the Board Assurance Framework including any relevant corporate risk on the Corporate Risk Register, relating to quality and safety. To regularly review the Board Assurance Framework (including in-depth review of specific risks) and to ensure that it reflects the assurances for which the Committee has oversight, with risks highlighted being appropriately reflected on the risk

registers. This shall include, but not be limited to the Committee acting in accordance with Board approved 'open' risk appetite and risk tolerance levels when reviewing risks.

QS6. A six-monthly policy compliance report. This will include adherence to review timescales and will spot check compliance against policy monitoring measures.

Quality

Q1. **Escalation AAA Highlight Reports** from the feeder level 2 quality groups which include;

- Q1.1 The Quality Forum
- Q1.2 The Mental Health Act Group
- Q1.3 Transformation and Quality Improvement Group

Q2. **Quality Dashboard**. To include key quality related measures including the priorities in the quality account. There will be an emphasis on clinical outcome metrics and the triangulation of key performance measures.

Q3. **Quality Assurance Report**. This includes regulatory activity, deep dives and inspections. To include as standard any Care Quality Commission core service and mental health act inspections and quality accreditation work delivered by the Quality Regulation and Excellence Group.

Q4. **Quality Improvement Report**. This includes assurance over the planning and significant outcomes from quality improvement and clinical audit activity.

Q5. **Patient Experience and Involvement Report**. This includes outcomes from complaints and compliments; it also includes feedback and involvement activity with patients and carers.

Q6. **Clinical Plan.** Including the outline plan for the coming year and an end of year report on outcomes.

Q7. **Quality Account** annual report in draft.

Q8. **The Mental Health Act Annual Report** including the Hospital Managers Panel Annual Report.

Q9. **Privacy and Dignity** Annual Declaration

Q10. **Research and Development** Annual Report. This includes the planning and significant outcomes from research and development activity.

Q11. **Service visit feedback**. Including any themes or risk issues identified.

Safety

S1. **Escalation AAA Highlight Reports** from the feeder level 2 quality groups which include;

- S1.1 Safety Forum
- S1.2 Safeguarding Group.
- S1.3 Health and Safety Committee. Pinned items include security management, and violence and aggression incidents

S2 **Safety Dashboard**. To include key quality and safety related measures including the priorities in the quality account. There will be an emphasis on clinical outcome metrics and the triangulation of key performance measures.

S3**. Safety** Assurance report. To include PSIRF incident reporting

S4**. Safeguarding** Assurance Report.

S5. **Learning From Deaths** Report. This includes LeDER, CDOP and Coronial feedback.

S6. **Safe and effective staffing** review

S7. **Sexual Safety** Annual Report

S8. **Single Sex Accommodation** Annual Declaration

S9. Infection, Prevention and Control Board Assurance Framework

S10. Controlled Drugs Accountable Officer Annual Report

Risk Based

The escalation AAA highlight reports from feeder groups will ensure pinned items include the following items for update when they are available;

- Hip fractures, falls and dementia
- Palliative and end of life care
- Resuscitation
- Children and Young People
- People with a learning disability and/or with Autism
- LeDer
- Suicide Prevention
- Ligatures
- Pressure Ulcers

The AAA reports also allow for direct escalations relating to any quality and safety related matters. Where alerts are made, the full accompanying papers will be provided in the information folder.

The committee has oversight of policy management via the feeder escalation AAA reports and may request further information where any extensions are granted, or where compliance isn't being met.

In addition, the committee will receive the following (with the full reports provided in the accompanying information pack);

R1. A risk-based approach to **deep dives** where additional information is required

R2. **Quality Summits**

R3. Any **internal audit, clinical audits, quality improvement** and clinical effectiveness projects and arrangements for research and development within the Trust where appropriate to the committee.

R4. The LPT response to any national, regional, system or local (including Group) **third-party reports**; to include public inquiries and prevention of future death reports. Consider learning from assurances and information, including improvement identified through liaison under the Group arrangements with Northamptonshire Healthcare NHS Foundation Trust.

Cross fertilisation

Cross fertilisation will occur in a number of ways, including

- Staggered level 1 committee dates to allow for the transfer of information
- NED attendance across multiple level 1 committees
- Input from Directorate representatives
- AAA reporting methodology
- Deep Dives in joint workshops.

- Oversight of patient and staff voice relating to quality and safety, including staff network feedback and the involvement of people with lived experience, service users, carers and the public via assurance reports received by the committee.

Associated documents

- QSC workplan
- Corporate governance structure chart

Membership

The membership and attendance membership of the Committee is

- Three Non-Executive Directors, of which one will Chair, one will also attend the People and Culture Committee and one will attend the Finance and Performance Committee.
- Director of Nursing, AHP & Quality (Executive Lead)
- Medical Director
- Executive Operational Directors
- Director of Governance and Risk

In attendance

- Head of Health and Safety
- Head of Quality Improvement
- Integrated Care Board Representative
- Relevant Staff Network Chairs
- Wider Directorate Senior Leadership Team attendance

The Chair of the Committee shall be one of the independent Non-Executive Directors selected by the Chair of the Trust Board. In their absence their place will be taken by another independent Non-Executive Director.

The Committee shall be supported administratively by the PA to the Director of Nursing, AHPs and Quality. This includes production of the Committee information pack to be circulated within 7 days prior to the meeting, attend the meetings to take the minutes, keep a record of matters arising and issues to be carried forward and generally provide support to the Chair and members of the Committee.

The agenda will be agreed with the Chair following consultation with the Director of Nursing, AHPs & Quality.

Unless otherwise agreed, notice of each meeting confirming the venue, time, and date together with an agenda and supporting papers will be forwarded to each member of the Committee, and any other person required to attend, no later than 5 working days before the date of the meeting.

The agenda for each meeting will include an item “Declarations of interest in respect of items on the agenda”. Any declarations made will be recorded in the minutes of the meeting.

Minutes of Committee meetings shall be circulated promptly to all members of the Committee.

Quorum

The quorum necessary for the transaction of business shall be three and must include a non-executive Director and clinical executive director. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

Frequency

The Committee shall meet bimonthly (not less than 6 times a year) and at such other times as the Chair of the Committee shall require including consideration of any joint workshops with other Committees. The Committee will be scheduled to align with but not occur on the same day as the PCC and FPC every other month.

The Quality and Safety Committee, People and Culture Committee and the Finance and Performance Committee will hold joint workshops for any key joint agenda items where relevant and will report on recommendations separately.

Members will be expected to attend at least three-quarters (75%) of all meetings.

Annual Review

The Committee shall, at least once a year, review its own performance, constitution, and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Trust Board for approval.

Appendix B

Leicestershire Partnership NHS Trust

Finance and Performance Committee Terms of Reference 2025/26

Version	2025/26 v1
Executive Lead	Director of Finance and Performance
Approved	Finance and Performance Committee February 2025
Ratified	Trust Board *March 2025*
Review Date	Annual Review March 2026

Purpose of Committee

The Finance and Performance Committee ('the Committee' or 'FPC') is a formal level 1 sub-committee of the Leicestershire Partnership NHS Trust's Board of Directors and will exercise its delegated authority in line with the standing orders of the Trust Board and its approved Terms of Reference.

The purpose of the Committee is to support the Trust in achieving its strategic goal to achieve 'great care' and our strategic objectives to 'improve access to our services for our local population' and to 'ensure our organisation delivers great care through careful use of our financial resources, great environments and a resilient organisation'.

As a Committee of the Board of Directors, it is important that the Finance and Performance Committee minimises areas of overlap with the Audit and Risk Committee. Therefore, the following specific areas of responsibility will be excluded from the Finance and Performance Committee Agenda:

- Arrangements in place for securing internal and external audit assurance
- Arrangements for and Subsequent Adoption of Annual Accounts
- Standing Financial Instructions and Scheme of Delegation
- Approval of accounting policies
- Local Counter Fraud Specialist work
- Emergency and Business Continuity Annual Report (6 monthly updates will be provided to the FPC)
- LPT Major incident plan

Duties

The Trust requires patient-to-board line of sight for assurance that there is safe and effective delivery of high-quality care. Emphasis is placed on receiving assurance through data, and from across the three lines of assurance and include patient and staff voice, and feedback from the clinical directorates through the Committee via assurance reports.

The Committee will receive assurance over the following standing items;

Finance and Performance Overview

FP1. The previous month FPC escalation AAA highlight report (each meeting).

FP2. Executive Environmental Analysis. An opportunity for Executive Director members of the Committee to provide a verbal update where it is relevant to do so. This item may also include time limited areas on which the committee will be charged to provide assurance to the Board. It may also

include any relevant Freedom to Speak Up feedback from the PCC, or service visit feedback from the QSC.

FP3. Strategic risk on the Board Assurance Framework including any relevant corporate risk on the Corporate Risk Register, relating to the finance and performance committee. To regularly review the Board Assurance Framework (including in-depth review of specific risks) and to ensure that it reflects the assurances for which the Committee has oversight, with risks highlighted being appropriately reflected on the risk registers. This shall include, but not be limited to the Committee acting in accordance with Board approved 'open' risk appetite and risk tolerance levels when reviewing risks.

FP4. A six-monthly policy compliance report. This will include adherence to review timescales and will spot check compliance against policy monitoring measures.

Finance

F1 The escalation AAA highlight report from the Capital Management Group

F2. Finance Report. To include any related procurement updates, and capital plan development & delivery.

F3. Patient level costings pre and post submission reports

Business

B1. Business Pipeline Report. To ensure an appropriate and robust response is in place for contracting, and that the Trust has timely and accurate costing and activity information to support the process. To also review regularly the Trust's performance against tender bids, both successful and unsuccessful.

B2. To oversee and approve under delegated limits the investment appraisal of business cases and wider business development opportunities where relevant and appropriate.

Performance and Data

P1. The escalation AAA highlight report from the Accountability Framework Meeting (the 'AFM' is this Trust's performance review forum).

P2. The escalation AAA highlight report from the Data Privacy and Data Quality Group to provide assurance that there is an effective data quality system in place.

P3. The escalation AAA highlight report from the IM&T Group

P4. The escalation AAA highlight report from the Transformation and QI committee.

P5. Finance and Performance Dashboard. Gain assurance over required standards, and the mitigation of risk of any substandard performance, including compliance with regulatory requirements within the remit of the Committee. To include further assurance reports relating to any finance and performance measures of concern. Have joint oversight of areas in common with other committees such as waiting times (overseen with a quality and safety lens at the Quality and Safety Committee).

P6. Lead Provider Collaborative Performance Measures quarterly

P7. Data Security and Protection Toolkit- annual return to NHS Digital (to include Registration Authority sign off)

P8. Caldicott Guardian Report

P9. Hosted Service Annual Report from the Leicestershire Health Informatics Service. To review the

performance, business plans and value-added contribution from our hosted service.

P10. Cyber Security Management Annual Report

P11. Digital Transformation Plan

P12. EPRR 6 monthly update

Estates, Sustainability and Partnerships

ES1. The escalation AAA highlight report from the Estates and Medical Equipment Group

ES2. The escalation AAA highlight report from the Commissioning and Collaborative Group

ES3. Estates Plan, including close down report from previous year and draft for year ahead.

ES4. Facilities management 6 monthly update, to also ensure the arrangements and performance of the facilities management services are adequate and monitored regularly throughout the financial year.

ES5. Green Plan – development and delivery.

ES6. Sustainability, assurance relating to the sustainability agenda which is broader than the green plan, and is aligned to the CQC well led quality statement.

ES7. PLACE Audit

ES8. Premises Assurance Model

Risk Based

The escalation AAA highlight reports from feeder groups will ensure pinned items include the following items for update when they are available;

- EPRR standards

The AAA reports also allow for direct escalations relating to any finance and performance related matters. Where alerts are made, the full accompanying papers may be provided in the information folder where it is appropriate to do so.

The committee has oversight of policy management via the feeder escalation AAA reports and may request further information where any extensions are granted, or where compliance isn't being met.

In addition, the committee will receive the following (with the full reports provided in the accompanying information pack);

R1. A risk-based approach to **deep dives** where additional information is required

R2. Any **internal audit, clinical audits, quality improvement** and clinical effectiveness projects and arrangements for research and development within the Trust where appropriate to the committee.

R3. The LPT response to any national, regional, system or local (including Group) **third-party reports**. To consider learning from assurances and information, including improvement identified through liaison under the Group arrangements with Northamptonshire Healthcare NHS Foundation Trust.

Cross fertilisation

Cross fertilisation will occur in a number of ways, including

- Staggered level 1 committee dates to allow for the transfer of information
- NED attendance across multiple level 1 committees
- Input from Directorate representatives
- AAA reporting methodology

- Deep Dives in joint workshops.
- Oversight of patient and staff voice relating to finance and performance via assurance reports received by the committee.

Associated documents

- FPC workplan
- Corporate governance structure chart

Membership

The membership and attendance membership of the Committee is

- Three Non-Executive Directors, of which one will Chair, one will also attend the People and Culture Committee and one will attend the Quality and Safety Committee.
- Director of Finance and Performance (Executive Lead)
- Director of Strategy and Partnerships
- Chief Finance Officer
- Director of Governance and Risk

In attendance

- Operational Directors (CHS, DMH and FYPCLD)
- Wider Senior Leadership Team attendance.

The Chair of the Committee shall be one of the independent Non-Executive Directors selected by the Chair of the Trust Board. In their absence their place will be taken by another independent Non-Executive Director.

The Committee shall be supported administratively by the PA to the Director of Finance and Performance. This includes the production of the Committee information pack to be circulated within 7 days prior to the meeting, attend the meetings to take the minutes, keep a record of matters arsing and issues to be carried forward and generally provide support to the Chair and members of the Committee.

The agenda will be agreed with the Chair following consultation with the Director of Finance and Performance.

Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda and supporting papers will be forwarded to each member of the Committee, and any other person required to attend, no later than 5 working days before the date of the meeting.

The agenda for each meeting will include an item “Declarations of interest in respect of items on the agenda”. Any declarations made will be recorded in the minutes of the meeting.

Minutes of Committee meetings shall be circulated promptly to all members of the Committee.

Quorum

The quorum necessary for the transaction of business shall be three and must include a Non-executive Director and an Executive Director. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

Frequency

The Committee shall meet bimonthly (not less than 6 times a year) and at such other times as the Chair of the Committee shall require including consideration of any joint workshops with other Committees. The Committee will be scheduled to align with but not occur on the same day as the PCC and QSC every other month.

The Finance and Performance Committee, Quality and Safety Committee, and the People and Culture Committee will hold joint workshops for any key joint agenda items where relevant and will report on recommendations separately.

Members will be expected to attend at least three-quarters (75%) of all meetings.

Annual Review

The Committee shall, at least once a year, review its own performance, constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Trust Board for approval.

Appendix C

Leicestershire Partnership NHS Trust
People and Culture Committee Terms of Reference 2025/26

Version	2025/26 v1
Executive Lead	Director of Human Resources & Organisational Development
Approved	People and Culture Committee February 2025
Ratified	Trust Board *March 2025*
Review Date	Annual Review March 2026

Purpose of Committee

The People and Culture Committee ('the Committee') is a formal level 1 sub-committee of the Leicestershire Partnership NHS Trust's Board of Directors and will exercise its delegated authority in line with the standing orders of the Trust Board and its approved Terms of Reference.

The purpose of the Committee is to support the Trust in achieving its strategic objective 'to be a great place to work' and 'to support our staff to deliver high quality compassionate care and well-being'. The Committee has oversight of assurance that our workforce is fit for purpose and responds to changing healthcare needs.

Duties

The Committee will oversee the delivery of the Trust's strategic aims for people and culture, and delivery of key underpinning strategies and plans and will have oversight of the following;

Risk

To regularly review the Board Assurance Framework (including in-depth review of specific risks) and to ensure that it reflects the assurances for which the Committee has oversight, with risks highlighted being appropriately reflected on the risk registers. This shall include, but not be limited to the Committee acting in accordance with Board approved 'open' risk appetite and risk tolerance levels when reviewing risks.

Escalations

Maintaining oversight of the business of the Workforce Group and its associated group sub-structure through the receipt of regular update reports; review the AAA escalation report from the workforce group and receive updates on any areas of concern and risk including action plans or unresolved matters/concerns or areas of performance for escalation to the Board. To include oversight of workforce group approval of policies and policy compliance.

Escalation of issues to other committees where relevant.

Workforce Strategies

Provide assurance to the Board that the Trust has appropriate and effective workforce recourse strategies and transformation plans in place relating to LPT's people including;

- The People Plan.

- Delivery of the Long Term Workforce Plan
- The workforce and agency reduction plan; workforce planning & redesign that utilises skills mixing and new roles to support productivity, efficiency, and long-term sustainability of the workforce; attraction and retention, recruitment and representation.
- To consider any relevant CQC and NHS Improvement workforce standards.

Data

Receive and reviewing information and data relating to workforce. Measures will be based on the recommended range of indicators outlined by the insightful provider board guidance.

Staff Voice

- Staff stories
- Oversight of activity relating to staff engagement, health and wellbeing and staff side feedback.
- Feedback from relevant staff networks and change leaders
- Analysis and oversight of action in response to staff survey
- Whistleblowing and FTSU including consideration and triangulation with other relevant information.
- Exit interviews

Organisational Development

- Oversight of organisational development, culture, equality diversity and inclusion, leadership and management and appraisals.
- Growing our own, talent management, apprenticeships, widening participation and adding social value through employment opportunities.
- Training and education. Receive reporting relating to changes in Professional Education and Essential Core Skills training. Monitor the provision of training and development and implementation of solutions which deliver a skilled, flexible modernised workforce improving productivity, performance and reducing health inequalities.

External and national workforce developments and best practice learning

- Learning from the Group arrangement including joint people and culture programmes such as 'Together Against Racism'.
- Consider reports on national and local surveys and benchmarking activity including the staff survey and GMC survey, monitoring the implementation of actions agreed to be taken to address areas of concern identified.
- To receive and review relevant reports of or relating to the LLR integrated care system where relevant.
- Internal learning and themes from internal HR reviews, exit interviews and employment tribunals. Learning from any relevant audit findings and quality improvement work.

Mandated/Statutory requirements

- To oversee and monitor progress against national NHS England workforce standards and reporting including the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).
- To review the Trust's Equality and Diversity Monitoring Report.
- To review the Gender Pay Gap Report.
- To review the annual consultant revalidation report.
- Nurses and AHPs revalidation report

- Seek assurances on behalf of the Board that arrangements are sufficient and effective in respect to the Guardianship of Safe Working Hours.
- Receive the Safe and Effective Staffing Review six monthly report]
- Fit and proper persons test

Membership and Secretary

The members and in attendance membership of the Committee is as follows

The following will be members of the Committee

- Three Non-Executive Directors, one of which will be the Chair, one will hold the board champion 'wellbeing guardian' role and one will hold the board champion 'disciplinaries' role.
- Director of HR and OD (Executive Lead)
- Directorate Directors
- Director of Nursing, AHPs and Quality
- Medical Director
- Director of Governance and Risk
- Staff-side Lead

In attendance

- Deputy Director of HR and OD
- Head of Operational HR
- Head of Equality, Diversity and Inclusion
- Head of Education and Training
- Associate Director of communication and culture
- Head of OD
- HWB Lead
- Relevant Staff Network Chairs
- FTSU Guardian
- Wider senior leadership team attendance

The Chair of the Committee shall be one of the independent Non-Executive Directors selected by the Chair of the Trust Board. In their absence their place will be taken by another independent Non-Executive Director. NED attendance will provide cross cover with both the Quality Assurance Committee and the Finance and Performance Committee.

The Committee shall be supported administratively by the PA to the Director of Human Resources and Organisational Development. This includes production of the Committee information pack and papers to be circulated within 7 days prior to the meeting, attend the meetings to take the minutes, keep a record of matters arising and issues to be carried forward and generally provide support to the Chair and members of the Committee.

The agenda will be agreed with the Chair following consultation with the Director of HR and OD.

Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda and supporting papers will be forwarded to each member of the Committee, and any other person required to attend, no later than 5 working days before the date of the meeting.

The agenda for each meeting will include an item 'Declarations of interest in respect of items on the agenda'. Any declarations made will be recorded in the minutes of the meeting.

Minutes of Committee meetings shall be circulated promptly to all members of the Committee.

Quorum

The quorum necessary for the transaction of business shall be three and must include a Non-executive Director and a Director of HR and OD or Deputy. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

Frequency

The Committee shall meet bimonthly (not less than 6 times a year) and at such other times as the Chair of the Committee shall require, with the addition of any joint committee workshops. Members will be expected to attend at least three-quarters (75%) of all meetings.

Annual Review

The Committee shall, at least once a year, review its own performance, constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Trust Board for approval.

Appendix D

Leicestershire Partnership NHS Trust
Audit and Risk Committee Terms of Reference 2025/26

Version	2025/26 v1
Executive Lead	Director of Finance and Performance
Approved	Audit and Risk Committee March 2025
Ratified	Trust Board *March 2025*
Review Date	Annual Review March 2026

1. Constitution

The Board hereby resolves to establish a committee of the Board to be known as the Audit and Risk Committee ('the Committee'). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

2. Membership

The Committee shall be appointed by the Board from amongst its independent, non-executive directors and shall consist of not less than three members. A quorum shall be two of the three independent members. One of the members will be appointed chair of the Committee by the Board. The Chair of the Trust itself shall not be a member of the Committee.

The membership will include:

- Three independent Non-executive Directors.

In attendance there will be the following officers from the Trust:

- Director of Finance and Performance will hold executive responsibility for the meeting
- Director of Corporate Governance

Others in attendance will include:

- Director 360 Assurance (Internal Audit)
- Client Manager 360 Assurance (Internal Audit)
- Principal Anti-crime specialist 360 Assurance (Counter Fraud)
- Partner KPMG (External Audit)
- The Trust's accountable officer (annual)

3. Attendance at meetings

- The Director of Finance and appropriate internal and external audit representatives shall normally attend meetings.
- The counter fraud specialist (LCFS) will attend a minimum of two committee meetings a year.
- The accountable officer should be invited to attend meetings and should discuss at least annually with the audit committee the process for assurance that supports the governance statement. They should also attend when the committee considers the draft annual governance statement and the annual report and accounts.
- Other executive directors/ managers should be invited to attend, particularly when the committee is discussing areas of risk or operation that are the responsibility of that director/ manager.
- Representatives from other organisations (for example, the NHS Counter Fraud Authority (NHSCFA)) and other individuals may be invited to attend on occasion, by invitation.

- The PA to the Director of Finance shall be secretary to the committee and shall attend to take minutes of the meeting and provide appropriate support to the chair and committee members.
- At least once a year the Committee Chair should meet privately with the internal auditors, external auditors and LCFS either separately or together. Additional meetings may be scheduled to discuss specific issues if required.

4. Access

The head of internal audit and representative of external audit have a right of direct access to the chair of the committee. This also extends to the local counter fraud specialist, as well as the security management specialist.

5. Frequency of meetings

The committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. A benchmark of four to five meetings per annum (with a possible additional meeting to specifically review the annual report and accounts) at appropriate times in the reporting and audit cycle is suggested. The chair of the committee, board, accountable/ accounting officer, external auditors or head of internal audit may request an additional meeting if they consider that one is necessary.

To assist in the management of business over the year an annual workplan will be maintained, capturing the main items of business at each scheduled meeting.

6. Authority

The committee is authorised by the board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, and all employees are directed to cooperate with any request made by the committee. The committee is authorised by the board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise, if it considers this necessary.

7. Responsibilities

The committee's duties/ responsibilities can be categorised as follows:

Governance, risk management and internal control

The Committee shall review the adequacy and effectiveness of the system of governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the committee will review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the board
- the underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications, including the NHS Code of Governance and NHS Provider licence
- the policies and procedures for all work related to counter fraud, bribery and corruption as required by the NHSCFA.

In carrying out this work the committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

As part of its integrated approach, the committee will have effective relationships with other key committees (for example, the quality committee, or equivalent) so that it understands processes and linkages. However, these other committees must not usurp the committee's role.

Internal audit

The committee shall ensure that there is an effective internal audit function that meets the Global Internal Audit Standards 2024 and provides appropriate independent assurance to the committee, accountable/ accounting officer and board. This will be achieved by:

- considering the provision of the internal audit service and the costs involved
- reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework
- considering the major findings of internal audit work (and management's response), and ensuring coordination between the internal and external auditors to optimise the use of audit resources
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- monitoring the effectiveness of internal audit and carrying out an annual review.

External audit

The committee shall review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the board when appropriate)
- discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
- discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee
- reviewing all external audit reports, including the report to those charged with governance (before its submission to the board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
- ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

Other assurance functions

The committee shall review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisation. These may include, but will not be limited to, any reviews by Department of

Health and Social Care arm's length bodies or regulators/ inspectors (for example, the Care Quality Commission, NHS Resolution) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies).

In addition, the committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the audit committee's own areas of responsibility. In particular, this will include any committees covering safety/ quality, for which assurance from clinical audit can be assessed, and risk management.

Following guidance from NHSEI in December 2021, the Board has approved an allocation of Non-Executive Director Champion roles and has appointed a Senior Independent Director. The champion role for security management (counter fraud) has been aligned to the Chair of the ARC, with the ARC being the responsible Committee.

In addition, the guidance recommended that a further 11 key themes should be overseen through committee structures. The one which applies to the Audit and Risk Committee is Emergency Preparedness.

Counter fraud

The committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas.

With regards to the local counter fraud specialist it will review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports.

Management

The committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control. The committee may also request specific reports from individual functions within the organisation (for example, compliance reviews or accreditation reports).

Financial reporting

The committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

The committee should ensure that the systems for financial reporting to the board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

The committee shall review the annual report and financial statements before submission to the board, or on behalf of the board where appropriate delegated authority is place, focusing particularly on:

- the wording in the annual governance statement and other disclosures relevant to the terms of reference of the committee
- changes in, and compliance with, accounting policies, practices and estimation techniques
- unadjusted misstatements in the financial statements
- significant judgements in preparation of the financial statements
- significant adjustments resulting from the audit

- letters of representation
- explanations for significant variances.

System for raising concerns

The committee shall review the effectiveness of the arrangements in place for allowing staff (and contractors) to raise (in confidence) concerns about possible improprieties in any area of the organisation (financial, clinical, safety or workforce matters) and ensure that any such concerns are investigated proportionately and independently, and in line with the relevant policies. This will be done annually. Regular oversight of themes from our Freedom to Speak Up activity is taken through our People and Culture Committee.

Governance regulatory compliance

The committee shall review the organisation's reporting on compliance with the *NHS Provider Licence and* the *NHS code of governance*. The committee shall satisfy itself that the organisation's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

Auditor Panel

Panel membership comprises two non-Executive members and the Director of Finance. A nominated non-Executive is to act as Chair of the Audit Panel.

The Deputy Director of Finance shall normally attend the meetings.

One Non-Executive Director and the Director of Finance need to attend for quoracy.

The Panel is to conduct an appropriate LPT procurement process, as outlined in section 9 of the Trust's Standing Financial Instructions (SFIs) for the appointment of external auditors.

The Panel is to recommend to the Trust Board the appointment of external auditors.

The Panel is to ensure:

- Contract arrangements (i.e., procurement and the selection of external auditors) are appropriate.
- The relationship and communications with the external auditors are professional
- Conflicts of interest are effectively dealt with.
- It is also important that the Auditor Panel is alert to the possibility of conflicts of interest – for example, if non-audit services work is awarded to the external audit provider, how will the Auditor Panel ensure that the auditors' independence is maintained?

If the Trust Board asks the Panel, it must advise on any proposal to enter into a liability limitation agreement with audit firms (this would be considered as part of the procurement process).

The Trust Board can determine to remove any member of the Auditor Panel including the Chair. The Chair of the Trust Board would need to re-consider the membership of the Committee in the case of a Non-executive Panel member being removed.

The Panel shall provide update reports to the Committee and to the Trust Board.

8. Behaviours and conduct

Trust values

Members will be expected to conduct business in line with the trust values and objectives. Members of, and those attending, the committee shall behave in accordance with the trust's constitution, standing orders, and standards of business conduct policy.

Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

9. Accountability and reporting

The committee shall report to the board on how it discharges its responsibilities.

The minutes of the committee's meetings shall be formally recorded by the secretary and the AAA assurance report will be made available for the board. The chair of the committee shall draw to the attention of the board any issues that require disclosure to the full board, or require executive action.

The committee will report to the board at least annually on its work in support of the annual governance statement, specifically commenting on the:

- fitness for purpose of the assurance framework
- completeness and 'embeddedness' of risk management in the organisation
- effectiveness of governance arrangements
- appropriateness of the evidence that shows that the organisation is fulfilling regulatory requirements relating to its existence as a functioning business.

This annual report should also describe how the committee has fulfilled its terms of reference and give details of any significant issues that the committee considered in relation to the financial statements and how they were addressed.

An annual committee effectiveness evaluation will be undertaken and reported to the committee and the board.

The audit committee will review these terms of reference, at least annually as part of the annual committee effectiveness review and recommend any changes to the board.

10. Secretariat and administration

The committee shall be supported administratively by its secretary. Their duties in this respect will include:

- agreement of agendas with the chair and attendees
- preparation, collation and circulation of papers in good time
- ensuring that those invited to each meeting attend
- taking the minutes and helping the chair to prepare reports to the board
- Support the Chair in draft the AAA escalation and assurance report for the board
- keeping a record of matters arising and issues to be carried forward
- arranging meetings for the chair: for example, with the internal/ external auditors or local counter fraud specialists
- maintaining records of members' appointments and renewal dates and so on
- advising the committee on pertinent issues/ areas of interest/ policy developments
- ensuring that action points are taken forward between meetings
- ensuring that committee members receive the development and training they need.

11. Review

The committee will review its effectiveness at least annually.

These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the board for approval.

Governance Table

For Board and Board Committees:	Trust Board 25 March 2025	
Paper sponsored by:	Kate Dyer, Director of Governance and Risk	
Paper authored by:	Kate Dyer, Director of Governance and Risk	
Date submitted:	13 March 2025	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	QSC, FPC, PCC February 2025 ARC March 2025	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:	NA	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Monthly	
LPT strategic alignment:	Great Health Outcomes	Yes
	Great Care	Yes
	Great Place to Work	Yes
	Part of the Community	Yes
CRR/BAF considerations:	List risk number and title of risk	--
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Confirmed	
Equality considerations:	None	