Accountability and Integrated Governance Framework

March 2023

Version	V 1
Author	Fiona McNeight, Director of Integrated Governance Lisa Thomas, Chief Operating Officer

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1. Background

1.1. As part of the Trust Improving Together Programme and review of the operating framework at both Trust, Division and Specialty level and to align to the recently published NHS Oversight Framework, the Trust Accountability Framework, and Integrated Governance Framework ('the framework') have been merged to create one document.

2. Purpose

2.1. The purpose of the Accountability and Integrated Governance Framework is to ensure that Salisbury NHS Foundation Trust has sufficient mechanisms in place to monitor and drive delivery of the Trust's strategic and operational plans during 2022 and beyond. This framework takes account of the Trust's requirement to comply and adopt best practice from the following:

- NHS Oversight Framework (27 June 2022)
- Trust Provider Licence
- Trust Constitution
- NHS Standard Contract
- NHS Code of Governance
- Care Quality Commission

2.2. The framework also takes account of the establishment of the BSW Integrated Care System on 1 July 2022, and new collaborative arrangements at system level. The framework aims to outline proportionate and effective oversight arrangements of Trust-led care within this system.

2.3. The Framework sets out the expectations of the Trust as a whole and as individual divisions. It provides a framework for how the Trust will monitor and manage its own performance within defined governance parameters. In order to achieve its ambitions, the Trust must ensure consistency in its approach to managing and delivering its plans, and that sufficient escalation triggers are in place and the Board is routinely sighted on and involved in the mitigation of key risks.

3. NHS oversight

3.1. This framework will ensure that as an organisation we are pro-active in providing assurance to our regulators. There are five accountability themes which align to the national themes set out in the NHS Oversight Framework.

Theme	Aim
Quality of care, access, and outcomes	To continuously improve care quality, helping to create the safest, highest quality health and care service

Finance and use of resources	For the Trust to balance its finances and improve its productivity
Preventing ill-health and reducing inequalities	To support prevention programmes to help people to stay healthy and support more accurate assessment of health inequalities and unmet needs of the local population
People	To be a responsive and flexible employer and address current workforce pressures
Leadership and capability	To build leadership and improvement capability to deliver sustainable services
Local Strategic priorities	The Trust is part of the ICB and the planning process. The ICB strategy is being refreshed in line with the national timelines.

4. NHS England Monitoring

4.1. NHS England use information to identify where providers are triggering a potential concern in one or more of the five themes (which indicates they are not in segment 1 and may benefit from support) and judgement, based on consistent principles, to determine whether or not they are in breach of licence and, if so, whether the issues are serious or very serious/complex.

4.2. To provide an overview of the level and nature of support required across systems, inform oversight arrangements and target support, all ICBs and Trusts are allocated to one of four segments:

Segment	Description of support needs
1. Maximum autonomy (consistently performing across the 5 oversight themes)	No actual support needs identified across the 5 themes Systems empowered to direct improvement resources
2. Targeted support	Support needed to address specific identified issues
3. Mandated support	Significant support needs against one or more oversight themes
4. Special measures/Mandated intensive Support	Intensive support required to address very serious/complex issues manifesting as critical quality and/or financial concerns

5. Governance

5.1. Integrated Governance is how the Trust Board controls and directs the organisation and its supporting structures, to identify and manage risk and ensure the successful delivery of the organisation's objectives. The framework is designed to support the delivery of our vision to "provide an outstanding experience for our patients, their families and the people who work for and with us" by an organisation that is well managed, cost effective and has a skilled and motivated workforce.

5.2. Salisbury NHS Foundation Trust is committed to operating by the principles of good governance. This framework sets out to describe the system of integrated governance used within the Trust with reference to the provision of quality services.

6. Strategic Priorities

6.1. The Trust's strategic priorities are set out in its 2022-26 strategy. Underpinning delivery of these objectives, there is a business planning process. The strategic aims are:

6.2. In 2022, the Trust launched the Improving Together Programme, which is one of the four strategic priorities that underpin the delivery of the updated Trust Strategy. These priorities, supported by annual breakthrough objectives, will be focusing and guiding how we work within our hospital and as part of an Integrated Care System (ICS).

7. Scope of the Framework for Integrated Governance

7.1. Corporate Governance

7.1.1. The term is used in the NHS to mean the system by which an organisation is directed and controlled, at its most senior levels, to achieve its objectives and meet the necessary standards of accountability, probity and openness. Corporate governance, led by the Trust Board, is about achieving objectives, providing quality services and delivering value for money.

7.1.2. The Constitution sets out the workings of the Foundation Trust – the membership, Council and Board. Appendices to the Constitution include formal procedures for the conduct of meetings and membership elections.

7.1.3. As a Foundation Trust, the organisation is asked to certify annually that it is compliant with the NHS Provider license conditions. The Trust completes an annual self-certification that confirms eligibility to hold an NHS Provider licence and submits this to NHS Improvement/England.

7.2. ***Financial Governance***

7.2.1. Financial governance will be the responsibility of the Board supported by the Audit Committee, (governance, risk management and internal control, internal audit; external audit, other assurance functions, counter fraud, financial reporting and raising concerns) and the Finance & Performance Committee (financial strategy and policies, effective and efficient use of resources, appraise annual budgets, cost improvement plans, financial issue management, performance reporting and management).

7.3. ***Standing Orders and Standing Financial Instructions***

7.3.1. The Trust Standing Orders and Standing Financial Instructions provide the regulatory framework for the financial conduct of the Trust. This includes guidance on delegation limits and procurement rules.

7.4. ***Clinical Governance***

7.4.1. This is a responsibility of the Trust Board, supported by the Clinical Governance Committee for continuously improving the quality of the services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

7.4.2. Clinical governance is the mechanism for understanding and learning, to promote the components that facilitate the delivery of quality care: candour, learning, questioning, a just culture, and excellent leadership for clinicians and services directly involved with patient care.

7.5. ***Demonstrating Quality***

7.5.1. The Integrated Governance Framework will provide evidence to the Trust Board through demonstrating its compliance with the quality and safety standards relevant to an NHS provider organisation. This will include Quality Accounts, Data Security and Protection Toolkit, CQC standards and the Trust's performance monitoring framework.

7.6. ***Continuous Quality Improvement***

7.6.1. Trust Board are responsible for ensuring that a continuous quality improvement approach is adopted and embedded throughout the organisation. This should be evidenced at all levels across the organisation. This approach should be evident

at Trust Board and all Board Committees and at Executive Committees.

7.6.2. The Improving Together Programme is focused on continuous improvement and is supported by the development of a coaching culture. This programme will support staff in undertaking tasks that really add value and empower them to make process changes at a local level. The approach is intended to ensure that everyone has the time, space, and responsibility to be curious about processes, consider how priorities can be achieved and have freedom to test new ways of working. As part of this programme all Trust colleagues will be invited to a modular training programme, which will be rolled out in a phased approach.

7.7. **Risk Management Strategy & Board Assurance Framework**

7.7.1. The Risk Management Strategy and Board Assurance Framework enable the Trust to manage risk at all levels in the organisation.

7.7.2. The key objectives of the risk framework are to:

- Ensure that the Board Assurance Framework is a dynamic Board assurance tool, underpinned by the Corporate and Divisional Risk Registers
- Clearly evidence the control and management of risk to achieve the Trust's strategic aims and objectives.
- Provide assurance that the Trust has an appropriate Assurance Framework in place and adheres to guidance on the Annual Governance Statement.
- Ensure that principal risks to meeting corporate objectives are identified and mitigated to an acceptable level.

7.7.3. The Board will be responsible for the Board Assurance framework, but the Audit Committee will undertake scrutiny and review of the process, to provide assurance to the Board, supported by the three assuring committees: Clinical Governance Committee, Finance & Performance Committee, People and Culture Committee together with the Trust Management Committee.

7.7.4. The Board Assurance Framework is reported to the Trust Board quarterly with a detailed review undertaken in advance by the assurance committees.

8. **The Role of the Trust Board**

8.1. Comprising executive and non-executive directors, the Trust Board will work actively to promote and demonstrate the values and behaviours which underpin integrated governance.

8.2. It will ensure a balanced focus on all aspects of its business. Further to this:

- The Integrated Governance Framework ensures the Board and its committees are structured effectively and properly constituted.
- The Board will ensure it promotes a culture where patients are at the centre; staff learn from experience; and the Trust engages with patients, the public

and partners to develop services in the future.

- Board business cycles will be clearly set out with actions implemented.
- The Board will ensure codes of conduct are upheld and the public service values of accountability, probity and openness in the conduct of business are maintained.
- Board members will receive appropriate induction and ongoing training and development to ensure they can undertake their responsibilities effectively and appropriately.

9. Charitable Trustees

9.1. The Trust Board is the corporate trustee of the Salisbury District Hospital Charitable Fund, known as the STARS appeal. Members of the Board meet quarterly as the Charitable Funds Committee to oversee the work of the charity, decide how charitable money should be used to support the hospital, manage its investments and the reporting requirements to the Charity Commission. The Terms of Reference can be found in Appendix 3.

10. Annual Governance Statement

10.1. The Annual Governance Statement (AGS) is produced and signed off by the Accounting Officer having regard to the model template and following discussion at the Audit Committee and comment from the auditors on the effectiveness of the Trust's internal controls. This is supported by the Board Assurance Framework and the underpinning Trust risk management arrangements.

10.2. Any significant weaknesses identified in the Trust's internal control mechanisms are highlighted in the AGS, together with the actions necessary to address the issues reported on.

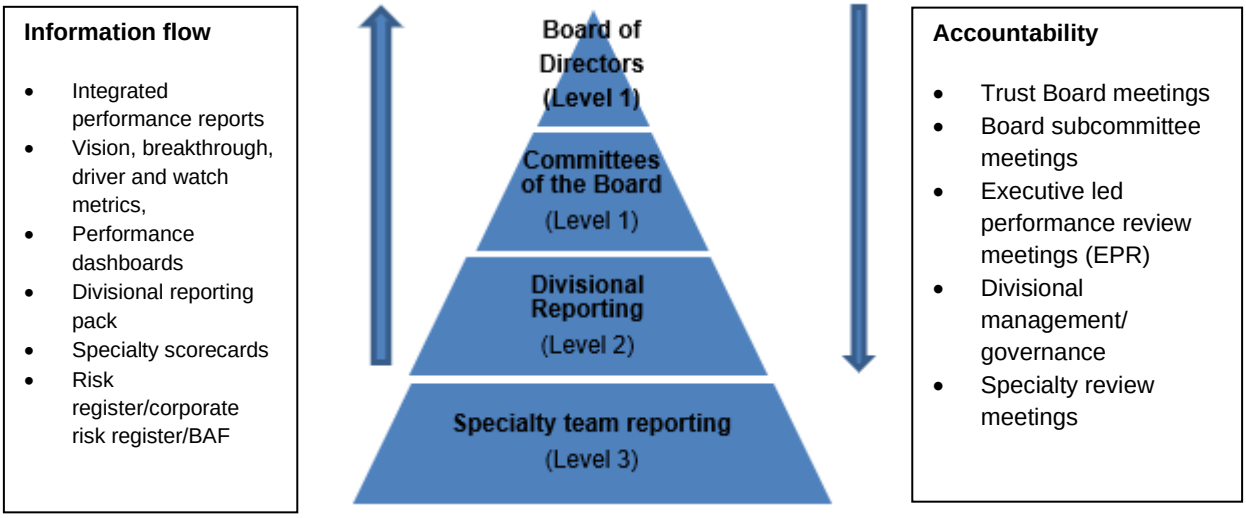
11. Internal performance Framework

11.1. The internal governance framework has two main overarching aims and is the underpinning structure to enable:

- Supporting continuous improvement to deliver the Trust's Vision.
- The Trust to show accountability for its performance from Board all the way through to clinical specialities/wards (quality/finance/performance and workforce).

11.2. The measurement of performance is directly linked to achieving the Trust strategy (2022-26), to ensure we plan and embed new ways of working alongside achieving tangible progress for our ambitions and aims.

The main strands of performance reporting within SFT are:



12. **Board of Directors**

The Board of Directors has overall responsibility for the implementation of the Integrated Governance Framework. The Board is required to ensure that the Trust remains at all times compliant with Monitor's Provider License and has regard to the NHS Constitution.

12.1. Accountability

Level 1: SFT Trust Board		
Committee	**Membership**	**Principal Reporting Documents**
Trust Board	All directors	Corporate Strategy. Other principal strategies – e.g. People, Quality, I.T, & Estates. Budget & Capital Programme Annual reports on Health & safety, Information Governance, Risk Management. Performance Reports – quality, workforce, operations, finance. Board Committee supporting information. Customer Care and Legal Reports.
Board Committees	Non-Executive Directors, CEO Lead Executives	Presentation on key performance information, including detailed information and actions on any key business targets currently being failed. Scrutiny of the Trust's commercial holdings. Scrutiny and assurance regarding risks and adequacy of actions. Escalation actions from Divisional Performance Reviews (by exception).

12.2. Information

12.2.1. The Trust's Integrated Performance Report (IPR), using a balanced scorecard approach, provides a summary of the core critical indicators for SFT. The reporting focuses on the key metrics aligned to the areas prioritised for improvement in year (breakthrough objectives and Driver metrics), monitoring progress of improvement. The report also contains "Watch" metrics, those metrics aligned to the statutory and contractual reporting requirements to ensure Board oversight and focus.

12.2.2. The IPR is issued to the Board of Directors monthly, highlighting key areas of success or concern and actions being taken to address the issues. Performance is also visually displayed in the form of tables and charts which show historic performance and trends via the use of SPC.

12.3. **Committees of the Board**

12.3.1. There are several board assurance committees. An outline of each committee responsibilities and core functions are set out in Appendix 1 and the overall Trust Committee Assurance Map in Appendix 2.

- Audit Committee
- Clinical Governance Committee
- Finance & Performance Committee
- People and Culture Committee
- Renumeration and Nomination committee

12.3.2. The individual Board Committees received the IPR and BAF relevant to the committee topic alongside a programme of more regular deep dives with additional information for assurance.

12.3.3. All committee terms of reference can be found in appendix 3.

12.3.4. Each committee will undertake an annual review of their performance against the terms of reference. The template can be found in Appendix 4.

13. **Divisional Reporting**

13.1. ***Accountability***

13.1.1. The Divisional Performance Reporting process is focused on monitoring operational performance, finance, quality, and workforce metrics aligned to the Trust breakthrough objectives.

13.1.2. The objective of the Divisional Performance Reviews is to review the performance of each Division in relation to an agreed suite of key metrics, ensuring both compliance and continual improvement. The reviews will also provide a forum for Divisions to discuss issues and challenges facing services with Executive Directors

and agree solutions in partnership as well as an opportunity to share and celebrate success and good practice.

13.1.3. There will be a clear and consistent schedule of Divisional Performance Reviews agreed at the start of each new financial year.

Level 2: Review of Divisional Management		
Committee	**Membership**	**Principal Reporting Documents**
Executive Performance Review Meetings	Lead Executives Divisional Management Team HR and Finance Business Partners	Detailed performance dashboard for Division Division commentary Risk Registers Other issues by exception

14. ***Information***

The key information follows a similar format to the Board report, it contains performance, workforce, finance, and quality improvement targets disaggregated to Divisional level. The reporting packs focus on the breakthrough and driver metrics aligning the delivery of the Trust strategy with key in year improvement targets. The purpose is to provide an insight into the contribution of individual divisions to performance of the business-critical indicators, as well as furnishing the divisions with performance data more specific to their area of activity through watch metrics.

15. **Divisional Management**

15.1. ***Accountability***

The Divisional management teams have Divisional Management committees with a wider group of staff (finance, business intelligence and Workforce Business partners) to ensure oversight of all the specialities the Division covers. There are two key monthly meetings to ensure robust governance is in place, the Divisional management Team meeting, and the Divisional clinical governance meeting. Key risks are taken from the specialty reporting and discussed in both forums to mitigate risk to delivery/performance or quality impacts.

15.2. ***Information***

The Divisions have access to Power BI with a range of dashboards to support quality/performance/finance and workforce metrics (specialty/divisional/specific resource metrics e.g., Theatres/outpatients). These are used to underpin performance at specialty level.

Committee	**Membership**	**Principal Reporting Documents**
Divisional Management Committees	Divisional Management Committee,	Divisional performance dashboard Individual dashboards, locally held performance information, and divisional risk register.

Committee	**Membership**	**Principal Reporting Documents**
	HR and Finance Business Partners	
Divisional Governance Committees		Team/specialty goals and measures Improvement as set out in the Trust's Quality/performance/finance and workforce objectives

15.3. ***Specialty Reporting***

Level 4: Specialty / Service Line		
Committee	**Membership**	**Principal Reporting Documents**
Specialty and department review process	Divisional Management Committee, HR and Finance Business Partners, Specialty Director, Service Lead and Senior Sister	Specialty-level performance dashboard Individual dashboards, locally held performance information, Risk assessment and mitigation

15.4. **Escalation**

There are a range of scenario's where additional support may be required in response to performance not matching expected levels or particular issues that require greater oversight. These could range from non-delivery of key quality, performance, and finance metrics at Divisional level, to team or individual workforce issues which require greater focus and support. There are a range of interventions that may be deployed at any one time to address remedial issues, these include:

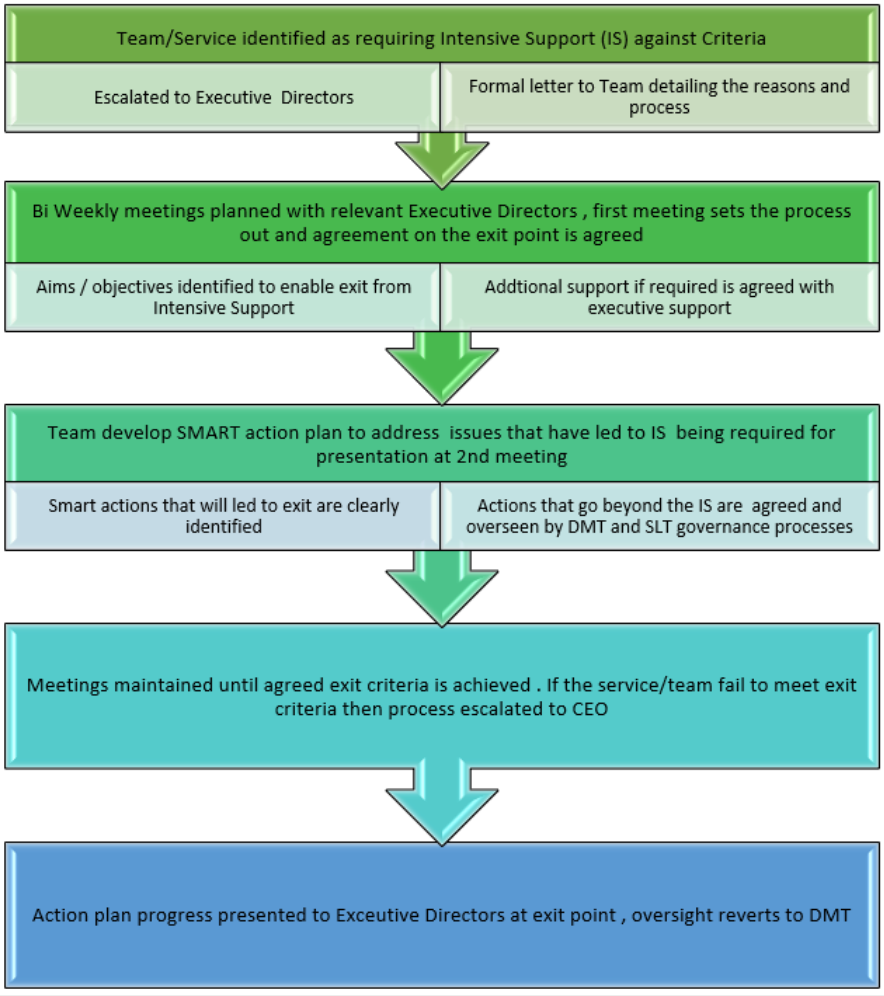
Stage	**Intervention**
Enhanced diagnostic	• Ensure root cause analysis addressed • Remedial action plans in place • Utilisation of improving together tools (Go See, Improvement Huddles, A3 thinking)
Enhanced Oversight	• Increased reporting • Consideration of external/peer review • Comprehensive action plans with clear metrics for improvement.
Intensive Support	• Bespoke mandated support • Executive oversight •
	• Meeting with CEO regularly • Capacity and Capability review

Stage	Intervention
CEO escalation	• Identification of any longer term structural and strategic issues which must be addressed.

15.4.1. The decision to escalate a division may be made on the basis of significant underperformance against multiple metrics; however, it may also be as a result of just one core area of underperformance which presents a significant risk to the overall delivery of the Trust's plan. The decision to escalate will be taken by the Trust's Executive Directors at the Executive Performance Review meetings

15.5. **Intensive Support**

Intensive Support is a process that can be implemented for one or more reasons where there is concern or indication that care within a ward/department may have fallen below acceptable standards. These may include a cluster of incidents e.g., pressure ulcers, falls, SIIs. HCAIs, failure to submit/pass infection prevention audits, increased volume/severity of complaints, increased staff sickness/vacancy levels.



15.5.1. The focus of the meetings is to ensure actions are being taken promptly, required improvements are being made and that the actions prioritise the key areas of concern. The meetings will also enable the Executives to identify and action any additional support or help required, to ensure standards can be improved and sustained. At any stage of escalation, all parties will agree the criteria that must be met for the Division to exit any mandated support. Specific arrangements will need to be agreed in each situation to ensure appropriate governance and oversight.

16. **Corporate Departments**

This will be reviewed once content of EPR agreed.

Additional information to support the Governance process is provided in the attached appendices.

17. **Public Accountability**

17.1. **Council of Governors**

The Council of Governors comprises Public, Staff and Appointed governors and has a number of responsibilities to hold the Trust Board to account through the Non-Executive Directors, to appoint and remunerate the non-Executives, to appoint the Trust's auditor (in conjunction with the Audit Committee). It has an essential role in representing the views of the Foundation Trust membership to the Trust Board.

18. Collaborative Working and Partnerships

The Trust is part of the Bath & Northeast Somerset, Swindon, and Wiltshire Integrated Care System (BSW ICS). This allows partners to take collective responsibility for the health and wellbeing of the population across the region. The agencies that comprise the partnership are working to address five priorities:

- Create locality-based integrated teams supporting primary care
- Shift the focus of care from treatment to prevention and proactive care
- We will develop an efficient infrastructure to support new care models
- Establish a flexible and collaborative approach to workforce
- Enable better collaboration between acute providers

18.1. Statutory component parts of an ICS are an Integrated Care Board (ICB) and an Integrated Care Partnership (ICP). The ICB is a statutory NHS body that bring partner organisations together in a new collaborative way with common purpose; and will bring the NHS together locally to improve population health and establish shared strategic priorities within the NHS, connecting to partnership arrangements at system and place. The Trust Board receives a monthly update on system working through the Chief executive report, outlining the activities at system level in BSW and the impact and involvement of the Trust.

18.2. As part of the move towards more collaborative working the Trust is also part of the Acute Hospital Alliance (AHA) with Great Western Hospital and Royal United Hospitals (RUH) Bath NHS Foundation Trusts. The AHA is focused on improving clinical services and closing the gaps in relation to health and care inequalities and finance to benefit the population of BSW. The local place-based Wiltshire Integrated Care Alliance is also a clear focus for the executive team and clinical leaders.

Version control

Document Title	**Integrated Governance and Accountability Framework 2022/23**			
Date Issued/Approved:	TBC 4th May 2023			
Date Valid From:	May 2023			
Date Valid To:	April 2024			
Division / Department responsible (author/owner):	Chief Operating Officer			
Executive Director responsible for Policy:	Chief Operating Officer			
Date revised:	March 2023			
Approval route (names of committees)/consultation:	Chief Operating Officer in consultation with Trust Board			
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet	x	Intranet Only	
Related Documents	Listed Appendices			

Version Control Table

Date	Version No.	Summary of Changes	Changes made by (name and job title)
18/03/22	**V1**	**Draft document – joint Integrated Governance and Accountability Framework**	**Lisa Thomas, Chief Operating Officer** **Fiona McNeight, Director of Integrated Governance** **Kylie Nye, Head of Corporate Governance**

Appendix 1: Board Committees

BOARD COMMITTEES

The Board's purpose is to govern effectively and in doing so build patient, public and stakeholder confidence that sustained, quality services are delivered. Several meetings and processes support the Board in its role.

Level 1: Assurance Committees of the Board

Audit Committee

The Audit Committee's terms of reference detail its role in providing assurance by independently and objectively monitoring and reviewing the Trust's processes of integrated governance, risk management, assurance, and internal control and, where appropriate, to require the Executive to instigate actions necessary to mitigate gaps.

The Committee fulfils its governance and accounting responsibilities by consideration of the integrity, completeness and clarity of annual accounts and the risks and controls around its management.

The Committee adopts a risk-based approach, but this does not, however, preclude the Committee from investigating, any specific matter relevant to their purpose.

Principal functions:

To oversee the governance and management of risk and internal control including the provision of the following:

- Governance
- Risk Management
- Internal Audit
- External Audit
- Other Assurance Functions
- Counter Fraud
- Financial Reporting
- Raising Concerns

Clinical Governance Committee

The Clinical Governance Committee's terms of reference detail its responsibility in providing assurance of the Trust's clinical governance and the quality agenda i.e. patient safety, clinical effectiveness, and patient experience.

The Committee reviews the Quality Account and agrees priorities for the forthcoming year and monitoring of the current year.

The Committee provides assurance to the Board, through ensuring the supporting processes

are embedded and the Trust wide groups promote learning, best practice and compliance with all relevant statutory duties.

Principal functions:

To provide assurance to the Board on:

- Patient Safety
- Clinical Effectiveness
- Patient Experience
- Service Improvement and Change Management
- Continuous Quality Improvement

Finance & Performance Committee

The Finance & Performance Committee provides assurance to the Board that the finance and performance of the Trust is meeting its targets and proposes mitigating strategies as required. It will do this through continual review of financial, risk and performance issues. The Committee has delegated powers to scrutinise, on behalf of the Board, all high-level operational matters and finance related matters, providing assurance regarding reported results and compliance with NHS Improvement requirements.

Principal functions:
To provide assurance on and scrutinise high level operational and finance related matters, providing assurance to the Board regarding reported results and compliance with NHSI requirements and in particular:

- Financial strategy, policy, management, and reporting
- Management and reporting Performance
- Monitoring Cost Improvement Programmes
- Operational performance

People and Culture Committee

The People and Culture Committee has responsibility for the delivery and assurance of the People Strategy. In addition, it has responsibility for:

- ensuring the mechanisms are in place to support the development of compassionate and inclusive leadership capacity and capability within the Trust
- the development and design of the workforce, to ensure that the Trust has productive staff, with the skills, competencies, and information to meet the required contractual obligations
- the mechanisms of improving how the Trust engages with its workforce so that they are motivated to do the best they can for the organisation and for the communities the Trust serves.
- That Organisational Development and Change Management are deployed well to maximise the opportunities of improvement and shape the Trust culture
- Continuous Quality Improvement methodology is readily made available, the skills reinforced and this way of working actively promoted

Principal functions:

To provide assurance on:

- Workforce Effectiveness Programme
- HR Strategy
- Scrutiny of Workforce Performance
- Organisational Development
- Policies and Procedures
- Key workforce KPIs
- Compliance with employment legislation
- Educational and professional development
- Recruitment and retention
- Staff engagement
- Change Management
- Occupational therapy and counselling services
- Service Improvement and Change Management