NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board (public)	**Agenda item:**	**SFT 4015**
Date of Meeting:	12 April 2018		

Report Title:	Integrated Governance Framework, Board Standing Orders and Accountability Framework			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				x
Prepared by:	Andy Hyett, Chief Operating Officer David Seabrooke, Head of Corporate Governance			
Executive Sponsor (presenting):	Christine Blanshard, Deputy Chief Executive			
Appendices (list if applicable):	Integrated Governance Framework • Board Committee terms of Reference • Board Committee compositions 2018/19 Board Standing Orders Accountability Framework			

Recommendation:
To approve the updated Integrated Governance Framework, with accompanying terms of reference of board committees To approve updated board committee compositions To approve minor amendments to the Board Standing Orders To approve the updated Accountability Framework 2018/19

Executive Summary:
Integrated Performance Framework The Trust adopted the Integrated Governance Framework in 2017. This sets out the Board's relationship with its committees and outlines the relationship with the clinical directorates and into service areas. It includes a diagram of the committees within the Executive reporting to the Trust Management Committee and summarises the roles of the executive directors. Committee terms of reference and the formal memberships are appended, as described below. **Committee Terms of Reference** The Terms of Reference for the Workforce Committee and the Strategy Committee are new. Others have been revised in line with the new strategy to assign responsibility for the review of areas of the Assurance Framework and to adopt the Trust's new format for these.

The Clinical Governance Committee, Workforce Committee, Strategy Committee, and Finance & Performance Committee reviewed their revised terms of reference at their March meetings.

Committee compositions

The Board committee compositions table sets out proposed memberships of the committees of the board, following recent director appointments and formation of the Strategy Committee. It also identifies the Lead Executive for each committee.

Agendas for board committees are circulated to all board members, with non-members having the option to request the full papers and attend the meeting.

Board Standing Orders

The Standing Orders (meeting procedure rules) for the Board of Directors were last revised in 2013. These have been updated and are brought to Board for re-approval with minor changes detailed in the supporting information.

Accountability Framework

First adopted in 2017, this document provides a framework for how the trust will maintain and manage its performance and focuses on the accountability relationship between the Executive and the management of the five directorates that are subject to performance review meetings. It sets out the required agenda/reporting content, the assessment, rating and support criteria which are outlined in the Single Oversight Framework, issued by NHS Improvement in November 2017, looking at operations, quality, finance, leadership and co-operation with inter-agency initiatives. We will continue to develop the metrics.

Board Assurance Framework – Strategic Priorities	
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	
Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	x

Supporting Information

Board Standing Orders – minor updates

Various - Name changes, e.g. Trust Management Committee, NHS Improvement

16.2 removal of redundant wording: ACCEA and medical appointments are not formal board committee functions; Audit and Remuneration are the only mandatory board committees – others are discretionary.

16.8 Not all committees in practice appoint a vice Chair

25.6 reflects the introduction and role of Workforce Committee and Strategy Committee in relation to the Assurance Framework;

Committee Terms of Reference

In practice, there is a very limited range of formal, standing matters delegated by the Board to its committees and this is reflected as necessary in the terms of reference. The Standing Financial Instructions approved by the Board in February 2018 allocate delegated powers to the Audit Committee and these are included in the Committee's terms of reference.

A provision to enable a committee member to refer a delegated matter coming before a committee to the Trust Board for resolution has been included in the terms of reference for Workforce, Clinical Governance, Strategy and Finance & Performance Committee.

Salisbury
NHS Foundation Trust

INTEGRATED GOVERNANCE FRAMEWORK

April 2018

Contents **Page**

1. INTRODUCTION

Integrated Governance is the means by which 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 ensure the strategic aim of the delivery of "an outstanding experience for every patient", by an organisation that is well managed, cost effective and has a skilled and motivated workforce.

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 particular reference to the provision of quality services.

This document is underpinned by the Accountability Framework which specifies how the performance management systems are structured and tracked, to ensure delivery of the corporate objectives at every level of the organisation focussing across the breadth of quality, operations, finance and workforce.

2. STRATEGIC OBJECTIVES

The Trust's strategic objectives are set out in its 2018-20 strategy. Underpinning delivery of these objectives, there is a business planning process. The corporate goals are:

Local Services - Our aim is to meet the needs of the local population by developing new and improved ways of working which always put the patient at the centre of all that we do.

Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population – more than 11 million across Southern England for the Spinal Centre and over three million for patients across Wessex for burns and plastics, cleft lip and palate, genomics and specialist rehabilitation services.

Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered making a positive contribution to the financial position of the Trust.

Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm.

People - We will make SFT an outstanding place to work where everyone feels valued, supported and engaged and are able to develop as individuals and as

teams'

Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources.

3. SCOPE OF THE FRAMEWORK FOR INTEGRATED GOVERNANCE

Integrated Governance is based on the understanding that all elements of governance are important and they should not be managed in silos. To achieve focused decision-making and deliver strategic objectives, the Board considers all aspects of accountability in the round. This framework sets out the principal strands of governance and describes how Salisbury FT arrangements bring these together.

4 ELEMENTS OF GOVERNANCE

4.1 Corporate Governance

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.

4.2 Financial Governance

Financial governance will be the responsibility of the Board supported by the 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, performance management and strategy overview).

Standing Orders and Standing Financial Instructions

The Trust Constitution, 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. 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.

4.3 Clinical Governance

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

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.

Demonstrating Quality

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 national framework, Information Governance Toolkit, CQC standards and the Trust's performance monitoring framework.

4.4 Risk Management Strategy & Board Assurance Framework

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

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 Directorate 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

The Board will be responsible for the Board Assurance framework, but the Audit Committee will undertake scrutiny and review of the evidence, to provide assurance to the Board, supported by the four assuring committees, Strategy Committee, Clinical Governance Committee and Finance & Performance, Workforce Committee and also the Trust Management Committee

The Board Assurance Framework is reported to the Trust Board at every public meeting, with a detailed review undertaken in advance by the assurance committees.

4.5 The Role of the Trust Board

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

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 and the public 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 to ensure they can undertake their responsibilities effectively and appropriately.

Charitable Trustees

The Trust Board is the corporate trustee of the Salisbury District Hospital Charitable Fund, known as the STARS appeal. Members of the Board meet periodically as the Charitable Trustees 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.

4.6 Annual Governance Statement

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.

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.

5 INTEGRATED GOVERNANCE FRAMEWORK

The following describes the Trust's Integrated Performance Management Framework.

Committee	Membership	Principal Reporting Documents
Level 1: SFT Trust Board		
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 and 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 Directorate Performance Reviews (by exception)
↕		
Level 2 Review of Directorate Management		
Executive Performance Review Meetings	Lead Executives Directorate Management Team HR and Finance Business Partners	Detailed performance dashboard for Directorate Directorate commentary Risk Registers Other issues by exception

Level 3: Directorate management		
Directorate Management Committees	Directorate Management Committee, HR and Finance Business Partners	Directorate performance dashboard Individual dashboards, locally held performance information, and directorate risk register

Level 4: Specialty / Service Line		
Specialty and department review process	Directorate 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

Level 5: Team / Individual		
Ward and clinical area reviews	Specialty Director, and Service Lead, with Ward Sister or equivalent	Ward trigger tools and dashboards, budget review and other specific governance indicators
Individual performance management arrangements (non-medical)	Individual line manager	Agree objectives Appraisal and appraisal documentation

6. 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. A number of meetings and processes support the Board in its role.

Level 1: Assurance Committees of the Board

6.1 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.

6.2 Clinical Governance Committee

The Clinical Governance Committee's terms of reference detail its responsibility in delivering 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.

6.3 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.

6.4 Workforce Committee

The Workforce 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 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;

- Organisational Development and Change Management.

6.5 Strategy Committee

The Strategy Committee provides the Board of Directors with assurance on development and delivery of the Trust's strategy and particularly progress with developing new models of care, many of which will be related to the whole site redevelopment project. It also leads on the development of a digital strategy.

6.6 Level 2 – Review of Directorate Management

Executive Performance Review Meetings are held monthly with the clinical Directorates, consisting of three executive directors and each Directorate Management Committee to review performance across quality, finance, operations, and workforce.

Further detail is given in the Accountability Framework.

Level 3: Directorate Arrangements

6.7 Directorate Clinical Governance Arrangements

The Trust manages the delivery of its services through a directorate structure with each accountable for its contribution to the Trust's strategic objectives and integrated business plan. Authority to act is set out in the Trust's Scheme of Delegation and Accountability Framework as appropriate to each individual post or generic staff group.

There are also specific corporate functions in place to support the Directorates to achieve their objectives and to provide assurance to the Trust Board in its performance management role. These include: finance; human resources; quality; operations, and informatics.

6.8 Directorate Management Committees

Each directorate is led and managed by a Directorate Management Team, made up of the Clinical Director, Directorate Manager and Directorate Senior Nurse.

This Directorate Management Committee is supported by Lead Clinicians, operational managers, and the corporate functions such as HR and Finance. For the Facilities Directorate, this is the Head of Service and General Managers.

The Directorate Management Committee is responsible for providing leadership within the clinical directorates. They ensure the Trust delivers an outstanding experience for every patient, which represents best value and includes working with partner organisations to deliver innovative models of care.

Directorate Management Committees, together with Specialty Leads, have specific roles and responsibilities to ensure that the care and treatment provided to patients meets with the Care Quality Commission's standards.

Each Directorate will have governance arrangements appropriate to their services as set out in the Accountability Framework.

6.9 Level 4: Quality Assurance within Directorates

The Directorates will have in place arrangements for quality governance that is accountable, through the DMC via the Executive Performance Meetings to the executive team.

The scope of matters covered by Directorates will include:

- Development of team/specialty quality goals and measures
- Areas designated for improvement as set out in the Trust's Annual Quality Account
- Achievement of indicators defined in the annual CQUIN payment framework.

Patient Safety:
- Morbidity and mortality reports
- Incident reports and trends including Serious Incident learning
- Learning from claims
- Directorate risk register items
- CAS alerts
- Infection, prevention and control issues

Clinical Effectiveness:
- Compliance with and implementation of national guidelines and standards, including the Care Quality Commission standards, NICE guidance, quality standards and pathways, together with any other statutory framework or set of standards relevant to the services provided by the directorate
- Clinical audits
- Research

Patient Experience:
- Complaints and concerns themes/trends and identified action,
- Patient and Public involvement activity
- Ward-based audits

All of the above to include:
- the monitoring of progress against associated action plans.
- Monitor progress with current quality initiatives.

- Provide a forum for continuous improvement and development.
- The DMC will ensure that clinical specialties have relevant supporting/ parallel working arrangements.

Executive and Committees

6.10 Accounting Officer – Chief Executive

Under the Accounting Officer Memorandum, the Chief Executive is responsible for the stewardship of all the resources entrusted to the Trust. This role also carries extensive delegated authority from the Trust Board for the delivery of the Trust's services.

6.11 Trust Management Committee

The Trust Management Committee (TMC) comprises the Executive Directors, Clinical Directors, Directorate Managers and is the senior Executive committee. The purpose of TMC is to support the Chief Executive in ensuring the delivery of Trust services, meeting required financial, organisational and governance requirements.

The TMC brings together reports from, medicines management, information governance, operations, and health & safety. Further information is set out in the Accountability Framework.

Public accountability

6.12 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 membership to the Trust Board.

Board Appointments

6.13 Nominations Committees

The non-executive directors are appointed by the Council of Governors and a Nominations Committee that is run jointly with the Board oversees the appointments process. Executive Directors are appointed by a committee of the non-executive directors and the Chief Executive. The Chief Executive is appointed by the non-executive directors, and the appointment is subject to approval by the Council of Governors.

7. GOVERNANCE SUPPORT ARRANGEMENTS

Quality Directorate

The Quality Directorate provides trust-wide guidance, facilitation & support for the following elements of the integrated governance agenda, linked to Directorates:

- Collecting and storing evidence to support external assessments and preparing submissions to the CQC and NHS Resolve.
- Monitoring compliance with NICE guidelines and standards, alerts and other national frameworks.
- Producing the Trust's annual Quality Account
- Practice development associated with Patient Safety.
- CQUINs and clinical audit element of the annual contract.
- Risk management, including operational and corporate risk registers.
- Serious, critical and other Incident investigation and reporting.
- Aggregating learning from Incidents, Complaints, PALs, Claims, Mortality Review, Inquests and Rule 43 letters.
- Monitoring and reporting with National Institute of Health Research and clinical Research Network high level objectives'
- Customer Care: Complaints and PALs
- Clinical audit programme
- Mortality review processes
- Administering the CAS process

The Trust's CQC registration is overseen by the Head of Corporate Governance.

8. SUSTAINABILITY & TRANSFORMATION PARTNERSHIP

The Trust is part of the Bath & North East Somerset, Swindon and Wiltshire Sustainability Partnership. Under its emergent plan the agencies that comprise the partnership are working to address five priorities:

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

The Trust Board will receive periodic updates on progress being made through the partnership.

9. MONITORING AND REPORTING PROCESS

The Trust Board monitors the delivery of this framework primarily through reporting to the following committees:

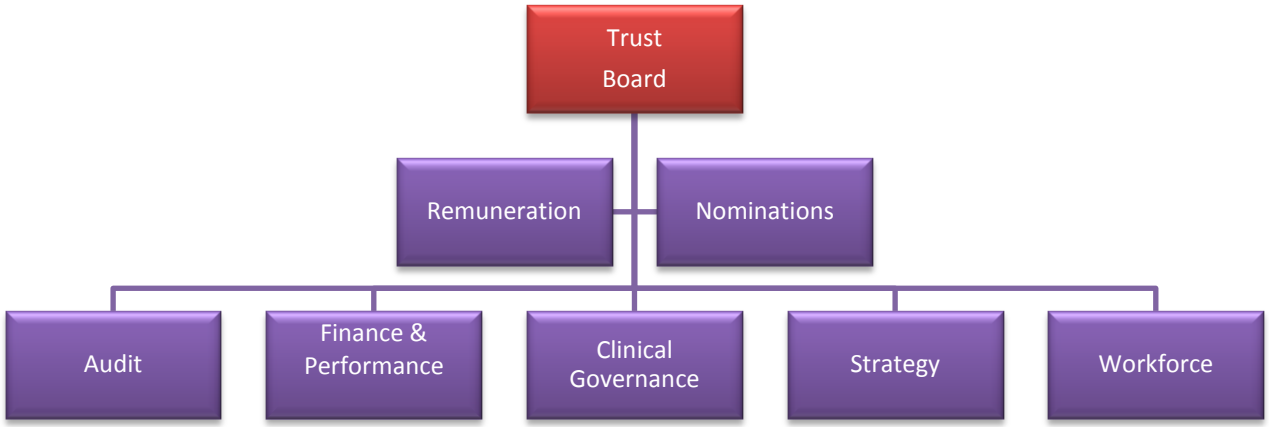
- Audit
- Finance & Performance
- Clinical Governance
- Strategy
- Workforce

In addition, reports will be received from internal and external audit, and other regulatory bodies and their inspections evidenced by integrated reports to provide further assurance directly to Trust Board, such as equalities, infection control or safe working for trainees.

All committees receive reports and regular monitoring information as set out in the workstream structures. This covers all principal strands of governance as part of the Trust-wide assurance framework.

Appendix 1: Overview of Committees that report to the Trust Board

Reporting comprises an Escalation Report prepared by the Chairman of the committee and Lead Executive, and is supported by the minutes presented to the Trust Board.



Appendix 2 – Committee structure and executive accountability

Clinical Governance Committee	Finance & Performance Committee
Audit Committee	Workforce Committee
Remuneration Committee	Strategy Committee

Trust Board

Chief Executive

Council of Governors

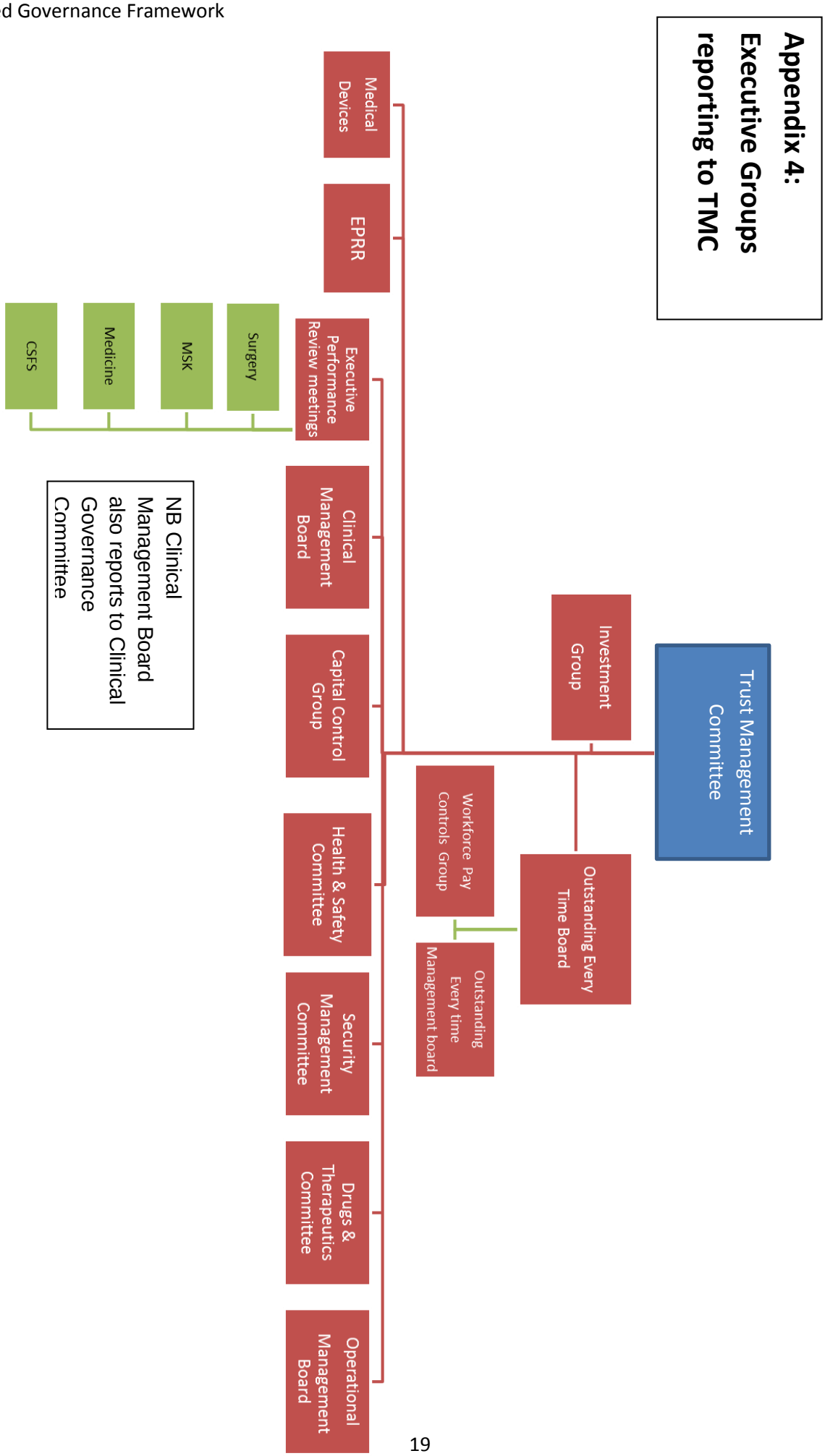
Medical Director	Director of Nursing	Chief Operating Officer	Director of Finance	Director of People & OD	Director of Corporate Development
Themes Professional leadership Responsible Officer (Medical Appraisal) Clinical Effectiveness Caldicott Guardian Mortality reviews Research Medical Education	**Themes** Nursing, Midwifery, Therapy workforce Patient safety Patient experience Risk management Litigation; Customer Care Adult and children's safeguarding DIPC	**Themes** Cost Improvement Operational Performance Facilities Medical Equipment Emergency planning	**Themes** Financial Recovery Plan Contracting Procurement Financial Control Trust-owned companies Capital control	**Themes** Organisational Development Education Equalities Occupational Health Volunteers	**Themes** Informatics Estates Site development Policy planning STP SIRO

Directorate Management Committees			
Medicine	Surgery	Clinical Support & Family Services	Musculo-skeletal

Appendix 3: Board Committee – summary of roles

Committee	Frequency	Principal Functions
Audit Committee	Quarterly	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	9 per year	To provide assurance to the Board on: • Patient Safety • Clinical Effectiveness • Patient Experience
Finance & Performance Committee	Monthly	To provide assurance on and scrutinise high level operational and finance related matters, providing assurance to the Board regarding reported results and compliance with NHS I requirements and in particular: • Financial strategy, policy, management and reporting • management and reporting Performance • Service Improvement and Change Management • Monitoring Cost Improvement Programme • Operational performance • Oversight of commercial holdings

Committee	Frequency	Principal Functions
Remuneration Committee	Six Monthly	The purpose of the Committee is to ensure there is a fair and transparent procedure for developing and maintaining policy on executive remuneration and for setting the remuneration packages of individual Directors. Specifically, the Committee will make decisions, on behalf of the Board, on the appropriate remuneration and terms of service for the Chief Executive, Executive Directors within the remit of the Remuneration Committee, including: • all aspects of salary, including any performance related/bonus elements; • arrangements for termination of employment and other contractual terms; • monitor and evaluate the performance of the Chief Executive and Executive Directors; • succession planning
Strategy Committee	Bi –monthly	• Development of the Trust Strategy • Monitoring of delivery of the trust strategy • Oversight of the One Estate project • Development of new models of care • Development of Digital Strategy
Workforce Committee	Bi-monthly	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
Charitable Trustees	Every four months	The Trust Board is the Corporate Trustee of the Salisbury Foundation Trust Charity and manage the Charitable Funds: • To oversee the investment policy of the Charitable Funds consider applications for funding • To ensure that the duties of trustees of Salisbury NHS Foundation Trusts Charitable Funds are complied with


Appendix 4:
Executive Groups reporting to TMC
Trust Management Committee
Investment Group
Outstanding Every Time Board
Workforce Pay Controls Group
Outstanding Every time Management board
Medical Devices
EPRR
Executive Performance Review meetings
Surgery
MSK
Medicine
CSFS
Clinical Management Board
Capital Control Group
Health & Safety Committee
Security Management Committee
Drugs & Therapeutics Committee
Operational Management Board
NB Clinical Management Board also reports to Clinical Governance Committee

Appendix 5: Accountability of Executive Directors

	Lead for Board Objective
Chief Executive Officer	Delivery of strategic and corporate objectives Working across the wider health and social care system Financial Recovery Plan Accounting Officer for Annual Governance Statement Executive governance arrangements Corporate governance – policies and compliance Board Assurance Framework Wiltshire Health & Care
Chief Operating Officer	Clinical Directorates and Facilities Service delivery; transformation and improvement Change management/CIP programme Performance delivery of directorates Accountable Officer for emergency planning and business continuity Medical Equipment Security Management
Medical Director	Professional leadership – medical Responsible Officer (Medical Appraisal) Clinical Effectiveness Quality Account (joint with DoN) Caldicott Guardian Mortality reviews Clinical audit and effectiveness Medical-legal matters Research and Development Medical Education QIA approval (joint with Director of Nursing) Medicines Management Joint management of the Quality Directorate (with Director of Nursing) Chief Knowledge Officer
Director of Nursing,	Professional lead – nursing, midwifery, therapists Patient Safety Patient Experience Quality Account (joint with MD) Joint management of the Quality Directorate with Medical Director Risk management Infection, prevention and control (DIPC) Safeguarding adults and children Legal Services CQC lead (liaison and reporting) QIA approval (joint with Medical Director) CQUIN and Quality Schedule negotiation
Director of Finance	Financial Recovery Plan Financial planning and performance Financial management and accounting Audit and counter fraud

	Lead for Board Objective
	Performance management Oversight Capital planning and management Commissioning and Contracting Payroll Procurement Charitable Trustees Trust-owned companies and Wholly Owned Subsidiary project
Director of People & Organisational Development	Human resources Health & Safety Learning, Training and development Equality and diversity (staff, patient and public) Corporate Communications Volunteers Chaplaincy Fire Safety Occupational Health Employment law Staff involvement Radiological Protection lead
Director of Corporate Development	Estates Strategy and Management Chief Information Officer Chief Clinical Information Officer Hard Facilities Management Trust Strategy and business planning Information Governance and records management GP relationships Commercial – tenders co-ordination Informatics Sustainability & Transformation Partnership Senior information risk owner (SIRO)

Appendix 6A – Annual review of Committees

In devising their annual reviews, committees are requested to follow the template set out here

1. Conduct of business throughout the year

- Committee membership and any changes
- Frequency of meetings and register of attendances
- Administration arrangements
- Reports to Board

2. Terms of Reference

- Delivery against terms of reference and work programme
- Key decisions or recommendations
- Key risks identified and mitigations
- Key issues managed or escalated to board
- Any changes made, or requested to the Terms of Reference

3. Future plans

- Areas of focus in the coming year

4. Timings of reviews

- Audit and Remuneration committees: April to fit into Annual Report
- Finance & Performance and Strategy – September
- Clinical Governance – October
- Workforce – November

Appendix 6B – Terms of Reference of Board Committees [to be added]

Appendix 7: Version control

Document Title	Integrated Governance Framework			
Date Issued/Approved:	12 April 2018			
Date Valid From:	1 April 2018			
Date Valid To:	28 February 2021			
Directorate / Department responsible (author/owner):	Head of Corporate Governance			
Brief summary of contents	Description of the integrated governance operated within the Trust. It is designed to ensure the delivery of high quality patient focussed care from an organisation that is well managed, cost effective and has a well-trained and motivated work force.			
Executive Director responsible for Policy:	Chief Executive			
Date revised:	20 February 2018			
Approval route (names of committees)/consultation:	Chief Executive in consultation with trust board			
Name and Post Title of additional signatories	Not Required			
Signature of Executive Director giving approval	{Original Copy Signed}			
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet		Intranet Only	x
Document Library Folder/ Folder	Constitution			
Links to key external standards	None			
Related Documents:	None			
Training Need Identified?	No			

Version Control Table

Date	Version No	Summary of Changes	Changes Made by *(Name and Job Title)*
1 March 2017	V1.0	Initial Issue	David Seabrooke Head of Corporate Governance
1 April 2017	V2.0	Completed version	David Seabrooke Head of Corporate Governance
8 August 2017	V 3.0-	Amended Exec responsibilities from away awayday – appendix 4	David Seabrooke Head of Corporate Governance
16 November 2017	V v4.0	Minor amendments to exec responsibilities and introduction of OETB	David Seabrooke Head of Corporate Governance
22 January 2018	V 5.0	Introduction of Trust Management Committee and Strategy Committee	David Seabrooke Head of Corporate Governance
20 February	V 5.1	Minor updates and clarifications; addition of Charitable Trustees	David Seabrooke Head of Corporate Governance
19 March 2018	V5.2	Comments by CEO and DoN Attendance at Strategy C'ttee Removed Exec Oversight of Directorates (previously extracted from Accountability Framework) and individual extract of Terms of Reference of Trust Management Team Proposed removal of committee memberships Added review of committees Added Nominations Committees	David Seabrooke Head of Corporate Governance

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry. This document is only valid on the day of printing

Board Committees 2018/19

NEDs	Nick Marsden	Tania Baker	Michael Marsh	Michael von Bertele	Paul Kemp	Jane Reid	Rachel Credidio	Paul Miller	Governor
Remuneration	Ch	x	x	x	x	x	x	x	-
Audit		x		x	Ch				-
Finance & Performance					x	x	x	Ch	John Mangan
Clinical Governance			Ch			x		x	Jan Sanders
Strategy	x	Ch		x					Chris Horwood
Workforce			x	Ch			x		-
Trust Board	Ch	Vc	x	x	x	x	x	x	Raymond Jack

Execs	Frequency p.a.	Cara Charles-Barks	Christine Blanshard	Lorna Wilkinson	Andy Hyett	Lisa Thomas	Paul Hargreaves	Laurence Arnold
Remuneration	2	A					A	
Audit	5	A				L (A)		
Finance & Performance	12	x			x	L	x	
Clinical Governance	9		L	L	x			
Strategy	6	x	x	or x		x		L
Workforce	6		x	x			L	
Trust Board	12	x	x	x	x	x	x	x

NOTES

Ch = Chair X = member of the committee A = advisor L = member and lead exec

vc = vice chair

Chair and Chief Executive will visit committees that they are not members of. The Audit Committee expects senior representation from departments where internal audit reports are presented.

Salisbury NHS Foundation Trust

Workforce Committee Terms of Reference

1. Purpose

1.1. The Committee is established to provide the Board of Directors with assurance on staffing matters, organisational development plans, medical and non-medical training and recruitment.

Date Adopted	April 2018
Review Frequency	Annual
Terms of Reference Drafting	Trust Secretary
Review and Approval	Trust Board
Adoption and ratification	Trust Board

2. Authority

2.1. The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Workforce Committee (the Committee).

2.2. The Committee is a standing committee of the Board of Directors (the Board).

3. Membership and Attendance

Membership

3.1. The Committee shall be appointed by the Board of Directors and shall consist of:

- Three Non-Executive Directors
- Director of People & O.D. (Lead Executive)
- Medical Director
- Director of Nursing

3.2. A Non-Executive Director shall be appointed as Chair of the Committee.

3.3. The designated members of the committee (or nominated deputies) are expected to attend all meetings. The designated Non-Executive Directors are expected to attend 75% of the scheduled committee meetings as a minimum. Attendance will be monitored and non-attendance of more than 2 meetings will be followed up by the chair.

3.4. Each member must nominate a deputy to attend in their place when they are unable to. These nominated deputies will have voting rights and be counted towards the quorum.

Quorum

3.5. Quorum shall be at least half the members being present, including at least one Non-Executive Director member or nominated deputy.

3.6. Any one member of the committee can request that a matter coming before the committee be referred to the Board for decision.

Attendance

3.7. Meetings of the Committee shall normally be attended by:

Deputy Director of HR	Director of Medical Education
Head of Learning and Development	Deputy Director of Nursing
And others by invitation	

4. Roles and Responsibilities (not delegated unless otherwise stated)

4.1. Assigned area of responsibility: to provide the Board of Directors with assurance on staffing matters, organisational development plans, medical and non-medical training and recruitment

4.2. Assurance Framework and Strategy: People (Staffing) – to ensure that the assurance framework is kept under regular review

4.3. The duties of the committee are described in relation to its assigned area of responsibility under the following headings:

4.3.1. Strategy: Development and Review

People Strategy

People aspect of the Clinical Strategy

4.3.2. Assurance Framework: review, update and comment

People (Staffing)

4.3.3. Review of Trust activity in assigned area

- Develop and monitor plans and key performance indicators for workforce matters
- Consider any new initiatives to assist with the organisational development of the Trust and, where appropriate, make recommendations to the Trust Board.
- Review any other related activities which could impact on the reputation of the Trust.
- To receive and discuss any relevant reports e.g. proposing new initiative before their submission to the Trust Board,
- To receive report of the Guardian of Safe Working on the Board's behalf on medical trainees exception reports

4.3.4. Scrutiny of Integrated performance report

Workforce section

4.3.5. Policy monitoring and review

Oversee the development of the Trust's approach to:-

- Organisational Development
- Recruitment & Retention
- Human Resources Management
- Workforce Design
- Learning and Development
- Leadership and Talent Management
- Equality and Diversity
- Staff Wellbeing,
- Health & Safety

4.3.6. **Oversight of implementation of audit recommendations**
As referred by the Audit Committee.

5. Conduct of Business

Administration

5.1. The Head of Corporate Governance shall be Secretary to the Committee

5.2. The Committee shall be supported administratively by the Head of Corporate Governance, whose duties in this respect will include:

- agreement of agendas with Chair and attendees and collation of papers
- taking the minutes
- keeping a record of actions, matters arising and issues to be carried forward
- advising the Committee on pertinent issues/areas
- provision of a highlight report of the key business undertaken to the Board of Directors following each meeting, in the public session where possible.

Frequency

5.3. The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.

5.4. Meetings will be held at least six times per year, with additional meetings where necessary.

Notice of meetings

5.5. An agenda of items to be discussed will be forwarded to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting. Supporting papers will be sent to Committee members and to other attendees as appropriate, at the same time

5.6. In normal circumstances, a minimum notice period of two weeks must be given for any other meetings of the Committee. Emergency meetings can be arranged, at shorter notice, if this is approved and evidenced as such, by the majority of the members of the Committee.

Reporting

5.7. Minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.

5.8. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure or escalation to the full Board. The Committee shall also raise any significant concerns in relation to the business undertaken directly with the Board in a timely manner.

5.9. The Committee will report annually on the performance of its duties as reflected within its Terms of Reference.

5.10. The Committee will receive, for oversight and information, the minutes of the following committees:

- Medical Education and Training Committee
- Workforce Design & Education Group
- Equality and Diversity Steering Group
- Staff Wellbeing Strategic and Action Group
- Nursing, Midwifery and Therapy Workforce Steering Group

6. Review

6.1. These Terms of Reference will be subject to an annual review. The Committee shall conduct an annual self-assessment on the performance of its duties as reflected within its Terms of Reference and report any conclusions and recommendations for change to the Board.

6.2. As part of this assessment, the Committee shall consider whether or not it receives adequate and appropriate support in fulfilment of its role and whether or not its current workload is manageable.

6.3. These terms of reference were approved by the Workforce Committee with amendments on 26 March 2018 and ratified by the Board of Directors on 12 April 2018.

Salisbury NHS Foundation Trust

Clinical Governance Committee

Terms of Reference

1. Purpose

The Committee has the power to act on behalf of the Trust Board. Its purpose is to assure the Trust Board and the Chief Executive that high quality care is provided to patients throughout the Trust.

Date Adopted	April 2018
Review Frequency	Annual
Terms of Reference Drafting	Trust Secretary
Review and Approval	Trust Board
Adoption and ratification	Trust Board

2. Authority

2.1. The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Clinical Governance Committee (the Committee).

2.2. The Committee is a standing committee of the Board of Directors (the Board).

3. Membership and Attendance

Membership

3.1. The Committee shall be appointed by the Board of Directors and shall consist of:

- **Three** Non-Executive Directors
- Medical Director, Director of Nursing (joint Lead executive)
- Chief Operating Officer

3.2. The designated members of the committee (or nominated deputies) are expected to attend all meetings. The designated Non-Executive Directors are expected to attend 75% of the scheduled committee meetings as a minimum. Attendance will be monitored and non-attendance of more than 2 meetings will be followed up by the chair.

3.3. A Non-Executive Director shall be appointed as Chair of the Committee.

3.4. Each member must nominate a deputy to attend in their place when they are unable to. These nominated deputies will have voting rights and be counted towards the quorum.

Quorum

3.5. Quorum shall be at least half the members being present, including at least one Non-Executive Director member or nominated deputy.

3.6. Any one member of the committee can request that a matter coming before the committee be referred to the Board for decision.

Attendance

3.7. Meetings of the Committee shall normally be attended by:

- Any nominated deputy attending in place of a designated Committee member.
- Other Non-Executive Directors and Executive Directors are invited to contact the Chairman in advance if they wish to attend a CGC meeting.
- The Deputy Director of Nursing and Head of Clinical Effectiveness' Personal Assistant will act as Secretary to the Committee.
- Governor observer

4. Roles and Responsibilities (not delegated unless otherwise stated)

4.1. Assigned areas of responsibility:

4.1.1. To provide assurance that high quality care is provided to patients throughout the Trust.

4.1.2. To ensure the Trust delivers and drives the key principles of quality it should assure safe, clinically effective, patient-centred care, identifying where improvements may be required.

4.1.3. Assurance Framework and Strategy: **Care, Innovation**

4.2. The duties of the committee are described in relation to its assigned area of responsibility under the following headings:

4.2.1. Development and Review

Agree the annual quality plan (quality account priorities) and monitor progress**.**

4.2.2. Assurance Framework: review, update and comment

Care, Innovation

4.2.3. Review of Trust activity in assigned area,

Patient Safety:

- Agree the annual sign up to safety plan and monitor progress.
- Ensure risks to patients are minimised through application of a comprehensive risk management system in accordance with the risk management strategy. Including:
- identify areas of significant risk, set priorities and agree actions using the Assurance Framework and risk register process.

- Monitor and review the clinical risks in the Assurance Framework and corporate risk register as per the risk management strategy and policy.
- Assure that there are processes in place that safeguard adults and children within the trust

Clinical Effectiveness / Clinical Outcomes:

- Ensure that care is based on evidence of best practice and national guidance.
- Assure that procedures stipulated by professional regulators or chartered practice (i.e. GMC and NMC) are in place and performed to a satisfactory standard.
- Assure the implementation of all new procedures and technologies according to Trust policies
- Identify and monitor any gaps in the delivery of effective clinical care ensuring progress is made to improve these areas, in all specialties.

Patient Experience:

Assure that the Trust has reliable, real time, up to date information about what it is like to be a patient experiencing care in this hospital, to identify areas for improvement and ensure that these improvements are made. This will be provided through a comprehensive patient experience programme.

Learning:

Ensure the Trust is outward looking and incorporates learning and recommendations from external bodies into practice with mechanisms to monitor their delivery

4.2.4. Scrutiny of Integrated performance report

Monitor the progress of the Trust quality indicators and approve the quality account and assure the Board that the Trust meets the requirement of commissioners and other external regulators.

4.2.5. Policy monitoring and review

Agree the annual patient experience/engagement plan and monitor progress.

Ensure the research programme and governance framework is implemented and monitored.

4.2.6. Oversight of implementation of audit recommendations

As referred by the Audit Committee

5. Conduct of Business

Administration

5.1. The Head of Clinical Effectiveness shall be Secretary to the Committee

5.2. The Committee shall be supported administratively by the Head of Clinical Effectiveness whose duties in this respect will include:

- agreement of agendas with Chair and attendees and collation of papers
- taking the minutes
- keeping a record of actions, matters arising and issues to be carried forward
- advising the Committee on pertinent issues/areas
- provision of a highlight report of the key business undertaken to the Board of Directors following each meeting, in the public session where possible.

Frequency

5.3. The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.

5.4. Meetings will be held at least nine times per year, with additional meetings where necessary.

Notice of meetings

5.5. An agenda of items to be discussed will be forwarded to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting. Supporting papers will be sent to Committee members and to other attendees as appropriate, at the same time

5.6. In normal circumstances, a minimum notice period of two weeks must be given for any other meetings of the Committee. Emergency meetings can be arranged, at shorter notice, if this is approved and evidenced as such, by the majority of the members of the Committee.

Reporting

5.7. Minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.

5.8. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure or escalation to the full Board. The Committee shall also raise any significant concerns in relation to the business undertaken directly with the Board in a timely manner.

5.9. The Committee will report annually on the performance of its duties as reflected within its Terms of Reference.

5.10. Reporting arrangements into the Committee from Sub-Committees

The following groups and committees report to the Clinical Governance Committee:

- Clinical Management Board (Minutes and raising concerns)
- Infection Prevention and Control Committee (Minutes and raising concerns)
- Information Governance Steering Group (Minutes and raising concerns)
- Clinical Risk Group (Minutes and raising concerns)
- Children and Young People's Quality & Safety Board (Minutes and raising concerns)

- Integrated Safeguarding Committee (Minutes and raising concerns) NB: quarterly reports presented to the CGC.
- Care Quality Commission Steering group (minutes and raising concerns)
- Organ Donation Committee (minutes and annual report)

6. Review

6.1. These Terms of Reference will be subject to an annual review. The Committee shall conduct an annual self-assessment on the performance of its duties as reflected within its Terms of Reference and report any conclusions and recommendations for change to the Board.

6.2. As part of this assessment, the Committee shall consider whether or not it receives adequate and appropriate support in fulfilment of its role and whether or not its current workload is manageable.

6.3. These terms of reference were approved by the Clinical Governance Committee with amendments on 22 March 2018 and ratified by the Board of Directors on 12 April 2018.

Salisbury NHS Foundation Trust

Finance & Performance Committee

Terms of Reference

1. Purpose

1.1. The Committee is established to provide the Board of Directors with assurance on the trust's finances, its operational performance and its commercial holdings.

Date Adopted	April 2018
Review Frequency	Annual
Terms of Reference Drafting	Head of Corporate Governance
Review and Approval	Finance & Performance Committee
Adoption and ratification	Trust Board

2. Authority

2.1. The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Finance & Performance Committee (the Committee).

2.2. The Committee may take any legal or other professional advice with regard to the financial performance of the Trust as necessary.

2.3. The Committee is a standing committee of the Board of Directors (the Board).

3. Membership and Attendance

Membership

3.1. The Committee shall be appointed by the Board of Directors and shall consist of:

- **four** non-Executive Directors
- Director of Finance (Lead Executive)
- Chief Executive
- Chief Operating Officer
- Director of People & O.D.

3.2. A Non-Executive Director shall be appointed as Chair of the Committee.

3.3. The designated members of the committee (or nominated deputies) are expected to attend all meetings. The designated Non-Executive Directors are expected to attend 75% of the scheduled committee meetings as a minimum. Attendance will be monitored and non-attendance of more than 2 meetings will be followed up by the chair.

3.4. Each member may nominate a deputy to attend in their place when they are unable to. These nominated deputies will have voting rights and be counted towards the quorum.

Quorum

3.5. Quorum shall be at least half the members being present, including at least one Non-Executive Director member.

3.6. Any one member of the committee can request that a matter coming before the committee be referred to the Board for decision.

Attendance

3.7. Meetings of the Committee shall normally be attended by:

- Core members defined in para 3.1 above
- Financial Controller, Deputy Director of Finance
- Other directors and other staff by invitation
- Governor observer

4. Roles and Responsibilities (not delegated, unless otherwise stated)

4.1. Assigned area of responsibility:

4.1.1. The committee is responsible to the Trust Board for monitoring the Trust's financial position, its operational performance and the operation of the Trust's commercial holdings

4.1.2. Assurance Framework and Corporate Strategy: **Resources, Local Services, Specialist Services**

4.2. The duties of the committee are described in relation to its assigned area of responsibility under the following headings:

4.2.1. Development and Review

- Agree revenue and capital financial plans, budgets, income generation programmes and financial monitoring reports
- To scrutinise the Financial Recovery Plan
- Consider any new financial initiatives/formation of companies to assist with the business development of the Trust and, where appropriate, make recommendations to the Trust Board.

4.2.2. Assurance Framework: review, update and comment

Act as an Assurance Committee of the Trust's business and finance risks via the Assurance Framework and Risk Registers which will be presented to the Committee bi-monthly

4.2.3. Review of Trust activity in assigned area

- Monitor the financial performances of the Trust against the detailed plans, taking such remedial action as considered necessary
- Approve any other financial information prior to submission to any accountable authority or regulator
- Review any financial activity which impact on the performance or reputation of the Trust.

4.2.4. Scrutiny of Integrated Performance Report

To scrutinise the monthly financial report and the operations report

4.2.5. Policy monitoring and review

- To receive assurance from the Outstanding Every Time Board on the delivery of the Financial Recovery Plan
- Approve the development of financial reporting in line with the NHS Foundation Trust Financial Regime
- Monitor the activities and performance of the Trust's subsidiaries

4.2.6. Oversight of implementation of audit recommendations

As referred by Audit Committee

5. Conduct of Business

Administration

5.1. The Head of Corporate Governance shall be Secretary to the Committee

5.2. The Committee shall be supported administratively by the Head of Corporate Governance, whose duties in this respect will include:

- agreement of agendas with Chair and attendees and collation of papers
- taking the minutes
- keeping a record of actions, matters arising and issues to be carried forward
- advising the Committee on pertinent issues/areas
- provision of a highlight report of the key business undertaken to the Board of Directors following each meeting, in the public session where possible.

Frequency

5.3. The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.

5.4. Meetings will be held at least twelve times per year, with additional meetings where necessary.

Notice of meetings

5.5. An agenda of items to be discussed will be forwarded to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting. Supporting papers will be sent to Committee members and to other attendees as appropriate, at the same time

5.6. In normal circumstances, a minimum notice period of two weeks must be given for any other meetings of the Committee. Emergency meetings can be arranged, at shorter notice, if this is approved and evidenced as such, by the majority of the members of the Committee.

Reporting

5.7. Minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.

5.8. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure or escalation to the full Board. The Committee shall also raise any significant concerns in relation to the business undertaken directly with the Board in a timely manner.

5.9. The Committee will report annually on the performance of its duties as reflected within its Terms of Reference.

6. Review

6.1. These Terms of Reference will be subject to an annual review. The Committee shall conduct an annual self-assessment on the performance of its duties as reflected within its Terms of Reference and report any conclusions and recommendations for change to the Board.

6.2. As part of this assessment, the Committee shall consider whether or not it receives adequate and appropriate support in fulfilment of its role and whether or not its current workload is manageable.

6.3. These terms of reference were reviewed at the June 2016 meeting of the committee and were unchanged. They were approved in a revised format by the Board on 12 April 2018.

Salisbury NHS Foundation Trust

Audit Committee Terms of Reference

1) Purpose

The Committee will provide the Trust Board with a means of Independent and objective review of financial and operational systems, and compliance with law, guidance and codes of conduct.

Date Adopted	April 2018
Review Frequency	Annual
Terms of Reference Drafting	Head of Corporate Governance
Review and Approval	Audit Committee – 18 September 2017
Adoption and ratification of changes	Board of Directors – 12 April 2018

2) Authority

a) The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Audit Committee

b) The Committee is a standing committee of the Board of Directors (the Board).

c) 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 any such employee will be directed to co-operate with any request made by the Committee.

d) 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 or expertise.

3) Membership and Attendance

Membership

a) The Committee shall be appointed by the Board of Directors and shall consist of three Non-Executive Directors

b) A Non-Executive Director shall be appointed as Chair of the Committee.

Quorum

c) Two members of the Committee
d) In the absence of the Chair of the Committee, the Secretary will invite one of the other Committee members to chair the meeting.

Attendance

e) Meetings of the Committee shall normally be attended by:

- The Director of Finance, or her nominated Deputy, will normally be in attendance.
- Representatives from the External (Appointed) Auditors and Internal Auditors will normally be in attendance.
- The Chief Executive
- The Head of Corporate Governance will act as Secretary to the Committee and will normally be in attendance
- Others by invitation – this may include executive sponsors in the case of audit reports

4) Roles and Responsibilities (not delegated unless otherwise stated)

a) Strategy and Assurance Framework - Assigned area of responsibility:

i) The Committee will provide the Trust Board with an Independent and objective review of financial and operational systems, and compliance with law, guidance and codes of conduct

ii) Assurance Framework – overview of the operation of the review and updating process carried on by the Board and its committees

iii) Corporate Strategy – not applicable

b) The duties of the committee are described in relation to its assigned area of responsibility under the following headings:

i) Strategy: Development and Review

(1) Discuss the external audit plan with the External Auditor before the audit commences and the extent of the reliance to be placed on the work of internal audit.
(2) Agree the annual work plan for the Local Counter Fraud Specialist (LCFS) and receive a progress report at each meeting.
(3) Review the Internal Audit Strategy and Plan ensuring sufficient time is being allocated to verify that suitable and effective systems for Risk Management and controls assurance are in place.
(4) Review proposed changes to the Standing Orders and the Standing Financial Instructions.
(5) Set investment policy; oversee all investment transactions. Approve treasury policy. **(delegated by SFI 11.3.2)**
(6) Approve short term investment vehicle **(delegated by SFI 11.3.4.)**

ii) Assurance Framework: review, update and comment

Review the relevant elements of the Assurance Framework and the Risk Registers on a half-yearly basis.

iii) Review of Trust activity

(1) Review the annual report of the Head of Internal Audit and ensure the content satisfies the requirements of the Trust's Annual Governance Statement signed annually by the Chief Executive as the Trust's Accounting Officer.

(2) Monitor the policies for ensuring compliance with relevant regulatory, legal and Code of Conduct requirements.

(3) Review accounting policies.

(4) Receive a report at each meeting from the Head of Internal Audit on audit reports completed and Management's response. Unless there are significant issues this will not normally include full copies of audit reports, but these will be available to any committee member on request.

(5) Review the External Auditor's annual management letter and the Trust's response.

(6) Discuss privately with the External Auditor any problems and reservations arising from work undertaken and any matters the External Auditor may wish to raise.

(7) Examine the circumstances associated with each occasion when Standing Orders are formally waived and receive reports on any non-compliance with standing orders or standing financial instructions.

(8) Review the scope of internal control arrangements while recognising that the responsibility for such control remains an Executive duty.

(9) Review the schedules of losses and compensations and make recommendations to the Trust Board as necessary.

(10) Review the draft annual financial statements before submission to the Trust Board, focusing in particular on:

- Any changes in accounting policies and practices
- Major judgmental areas
- Value for Money considerations
- Significant adjustments arising from the audit
- The going concern basis
- Compliance with accounting standards

(11) Ensure that an external auditor is appointed in compliance with

the constitution and that they comply with the Audit Code. Ensure that the Council of Governors are aware as appropriate. **(delegated by SFI 2.3)**

(12) Consider the contents of any report involving the Trust issued by the Public Accounts Committee or the Comptroller and Auditor General and review management's proposed response before presentation to the Trust Board for agreement.

(13) Referring action or ratification of any non-compliance with SFIs. Also need to be disclosed to the DOF. **(delegated by SFI 1.1.8)**

iv) Scrutiny of Integrated performance report

The committee may receive audit reports on data quality factors supporting the information presented.

v) Monitoring and review

i) Oversight of implementation of audit recommendations
ii) Review of Management's proposed response, before presentation to the Trust Board for agreement.

5) Conduct of Business

Administration

a) The Head of Corporate Governance shall be Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chairman and Committee members.

b) The Committee shall be supported administratively by the Head of Corporate Governance, whose duties in this respect will include:

- agreement of agendas with Chair and attendees and collation of papers
- taking the minutes
- keeping a record of actions, matters arising and issues to be carried forward
- advising the Committee on pertinent issues/areas
- provision of a highlight report of the key business undertaken to the Board of Directors following each meeting, in the public session where possible.

Frequency

c) The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.

d) Meetings will be held at least quarterly, an additional meeting to review the draft annual report and accounts, with additional meetings where necessary.

Notice of meetings

e) An agenda of items to be discussed will be forwarded to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting. Supporting papers will be sent to Committee members and to other attendees as appropriate, at the same time.

f) In normal circumstances, a minimum notice period of two weeks must be given for any other meetings of the Committee. Emergency meetings can be arranged, at shorter notice, if this is approved and evidenced as such, by the majority of the members of the Committee.

Reporting

g) Minutes of Committee meetings will be recorded, reported to the Trust Board and will normally be confirmed as accurate at the next meeting of the Committee.

h) The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board. The Committee shall also raise any significant concerns in relation to the business undertaken directly with the Board in a timely manner.

i) The Committee will report annually on the performance of its duties as reflected within its Terms of Reference.

6) Review

a) These Terms of Reference will be subject to an annual review. The Committee shall conduct an annual self-assessment on the performance of its duties as reflected within its Terms of Reference and report any conclusions and recommendations for change to the Board.
b) As part of this assessment, the Committee shall consider whether or not it receives adequate and appropriate support in fulfilment of its role and whether or not its current workload is manageable.
c) These Terms of Reference were last reviewed and approved by the Audit Committee on 11 July 2016 and 18 September 2017.
d) The terms of reference were the subject of consultation with the Council of Governors on 12 May 2014.

Salisbury NHS Foundation Trust

Strategy Committee Terms of Reference

1. Purpose

1.1. The Committee is established to provide the Board of Directors with assurance on development of the Trust strategy and particularly progress with developing new models of care, many of which will be related to the whole site redevelopment project.

Date Adopted	March 2018
Review Frequency	Annual
Terms of Reference Drafting	Director of Corporate Development
Review and Approval	Strategy Committee
Adoption and ratification	Board of Directors

2. Authority

2.1. The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Strategy Committee ("the Committee").

2.2. The Committee is a standing committee of the Board of Directors (the Board).

3. Membership and Attendance

Membership

3.1. The Committee shall be appointed by the Board of Directors and shall consist of:

- 2 Non-Executive Directors
- Chief Executive Officer
- Director of Corporate Development
- Director of Finance
- Director of Nursing / Medical Director

3.2. A Non-Executive Director shall be appointed Chair of the Committee.

3.3. Two clinical members of staff shall be invited to be in attendance

3.4. Each member must nominate a deputy to attend in their place when they are unable to. These deputies will have voting rights.

Quorum

3.5. Quorum shall be at least half the members being present, including at least one Non-Executive Director.

3.6. Any one member of the committee can request that a matter coming before the committee be referred to the Board for decision.

4. Roles and Responsibilities (not delegated unless otherwise stated)

4.1. The duties of the Committee can be described as follows:

4.1.1. Strategy Development:

- To oversee the development of the Trust strategy, embracing all matters of long-term, medium-term and short-term planning. To ensure the alignment of all aspects of the Trust's strategy and planning, in relation to operational, financial, technical and human resource planning
- To consider the impact of major external changes and the possible impact on the organisation's strategy, including the impact of STP-wide developments
- To monitor strategic risks and assess the degree to which the strategy needs to be adapted to address those risks

4.1.2. Monitoring of Delivery of the Strategy

- To consider performance against agreed plans KPIs and on a three times a year provide feedback to the Board of Directors on the effectiveness of strategy implementation in meeting the Trust's objectives, linked to presentation of the Board Assurance Framework.

4.1.3. Review of Major Projects

- To oversee the development of major schemes, linking in with the Finance & Performance Committee and the Outstanding Every Time Board on the transformational aspects of such projects, and advise the Board on progress with those schemes. The projects to include:
  - The Salisbury campus programme and how the site can be adapted to facilitate a major clinical transformation programme and to bring on site a range of services and industries from different sectors
  - The development of new models of care taking forward opportunities to transform how services are provided and delivering services which are more integrated with other health and care providers in line with the Trust strategy
  - Development of the Trust's Digital Strategy and subsequent monitoring of delivery against the strategy

5. Conduct of Business

Administration

5.1. The Head of Corporate Governance shall be Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chairman and Committee members.

5.2. The Committee shall be supported administratively by the Head of Corporate Governance, whose duties in this respect will include:

- agreement of agendas with Chair and attendees and collation of papers
- taking the minutes
- keeping a record of matters arising and issues to be carried forward
- advising the Committee on pertinent issues/areas
- provision of a highlight report of the key business undertaken to the Board of Directors following each meeting, in the public session where possible.

Frequency

5.3. The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. Meetings will be held at least six times per year, with additional meetings where necessary.

Notice of meetings

5.4. An agenda of items to be discussed will be forwarded to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting. Supporting papers will be sent to Committee members and to other attendees as appropriate, at the same time.

5.5. In normal circumstances, a minimum notice period of two weeks must be given for any other meetings of the Committee. Emergency meetings can be arranged, at shorter notice, if this is approved and evidenced as such, by the majority of the members of the Committee.

Reporting

5.6. Formal minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.

5.7. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board. The Committee shall also raise any significant concerns in relation to the business undertaken directly with the Board in a timely manner.

5.8. The Committee will report to the Board of Directors annually on the performance of its duties as reflected within its Terms of Reference.

5.9. The Committee will report to the Board of Directors after six months on its effectiveness in meeting responsibilities as reflected within this Terms of Reference.

6. Review

6.1. These Terms of Reference will be subject to an annual review. The Committee shall conduct an annual self-assessment on the performance of its duties as reflected within its Terms of Reference and report any conclusions and recommendations for change to the Board.

6.2. As part of this assessment, the Committee shall consider whether or not it receives adequate and appropriate support in fulfilment of its role and whether or not its current workload is manageable.

standing orders

Made under paragraph 35 of The Constitution

CONTENTS

SALISBURY NHS FOUNDATION TRUST

TRUST STANDING ORDERS

INTRODUCTION

i. As set out in the Constitution, the Board of Directors of the Trust shall comprise a Chairman, and up to fourteen other Directors. The number of Executive Directors shall not exceed the number of Non-Executive Directors. The Chairman and Non-Executives are appointed by the Council of Governors who also approve the appointment of the Chief Executive.

ii The Executive Directors shall as a minimum comprise the Chief Executive and Director of Finance by virtue of the posts they hold, together with a qualified nurse or midwife and a qualified doctor or dentist

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iii. These Standing Orders incorporate the Standing Financial Instructions (SFIs) and Scheme of Delegation of the Trust which are included within this document. **Failure to comply with Standing Orders and SFIs is a disciplinary matter which, could result in dismissal**.

iv. Any expression to which a meaning is given in the Health Service Acts, Statutory Instruments or in the Financial Directions made under the Acts shall have the same meaning in these instructions. Where there is any question regarding the legality of a proposed transaction legal advice should be sought via the Chief Executive, or Head of Corporate Governance.

v. Salisbury NHS Foundation Trust has been established in accordance with the National Health Act 2006, hereinafter referred to as 'the Act'.

vi. In these Standing Orders, unless the context of the statement requires otherwise:

* The male gender shall be deemed to include the female gender and vice versa and reference to the singular shall be deemed to include the plural and vice versa

* The term '~~Monitor'~~ NHS ~~refers~~Improvement refers to the Independent Regulator of Foundation Trusts as laid down in the Act.

* The term 'Trust' denotes 'Salisbury NHS Foundation Trust'

* The Foundation Trust is established through the Licence, issued by Monitor and these determine the responsibilities and activities of the Trust.

* The Foundation Trust has a 'Constitution' which establishes roles and responsibilities of the Trust and its Directors, Governors, and Members.

* The term 'Chairman' refers to the formal post of Chairman of the Trust Board and who is also the Chairman of the Council of Governors, however in the context of meetings the term Chairman is also used to denote the individual chairing the meeting. The term Chairman is used to denote both male and female.

* 'Members' are those people from trust's staff, patients or the general public who have chosen to join the membership register of the Trust.

* The term 'Trust Board' or 'Board' refers to the Chairman, Non-Executive Directors and Executive Directors. The Chairman and Non-Executive Directors are appointed by the Council of Governors who also approve the appointment of the Chief Executive.

* The term 'Chief Executive' means the chief officer of the Trust as appointed from time to time by the Board and approved by the Council of Governors. The Chief Executive is the 'Accounting Officer' of the Trust.

* The term 'Director of Finance' means the chief financial officer of the Trust, as appointed from time to time by the Board. The actual title of the post may include other responsibilities.

* The term 'Director' shall be used in the context of this document to refer only to members of the Trust Board and shall be deemed to include Executive Directors, Non-Executive Directors and the Chairman.

* The term Executive Director shall incorporate the Chief Executive, Director of Finance, Director of Nursing, Medical Director, Director of ~~Human Resources~~ People & Organisational Development, and Chief Operating Officer.

* The term '~~Joint Board of Directors~~' 'Trust Management Committee' denotes the top level executive group in the Trust and consists of Executive Directors of the Trust Board together with Clinical Directors and other senior staff as decided by the Chief Executive.

* The 'Capital Control Group', is a sub-group of the Trust Management Committee' ~~Joint Board of Directors~~ and acts on behalf of the Joint Board of Directors in respect of capital.

* The term 'Head of Corporate Governance' refers to a specific post within the Trust responsible for servicing the Board and its Committees as specified by the Board from time to time. The post reports to the Chief Executive.

* 'Estates Development Manager' refers to the individual appointed from time to time to be professionally responsible for estates matters of the Trust.

* 'General Manager - Estates Technical Services' refers to the individual appointed from time to time to be professionally responsible for works maintenance and development in the Trust.

* The term 'Budget' means an approved allocation of resources (expressed in financial and manpower terms where appropriate) for the purpose of achieving specific objectives over a defined period of time.

* References to husband and wife shall be deemed to include those who are not married but are living together as spouses or partners.

vii. This document and its references are available on the Trust's web site or directly from the Head of Corporate Governance, or Director of Finance. Personnel Policies are available from the Director People & Organisational Development of ~~Human Resources~~~~People & O.D.~~

viii. All new staff will be made aware of the Standing Orders and Standing Financial Instructions and their availability as part of the Trust's induction process.

I. MEETINGS

(Constitution paragraph 34)

1 CALLING MEETINGS

1.1 The Chairman may call a meeting of the Trust Board at any time.

1.2 A requisition for an extraordinary meeting to be called, signed by at least one third of the existing number of Trust Board Directors, may be presented to the Chairman who shall call a meeting. If the Chairman shall not call a meeting within seven days after such requisition shall have been presented to him, the Directors presenting the requisition may, forthwith, call a meeting.

1.3 Ordinary meetings of the Trust Board shall be held at regular intervals in public and at such times and places as the Board may determine. There shall be a private section of such meetings where confidential matters may be discussed amongst Board Directors.

1.4 The Trust Board shall determine a date prior to 31 October each year for an Annual General Meeting with members, held in public, at which the audited accounts of the previous financial year and the Annual Report are presented.

2 NOTICE OF MEETINGS

(Constitution paragraph 34)

2.1 Before each meeting of the Trust Board, a notice of the meeting, specifying the business proposed to be transacted thereat, shall be delivered to every Director, or sent by post to the usual place of residence of such Director, or such other address as he shall require, so as to be available to such Director at least five clear days before the meeting, providing that:

a. want of service of such notice on any Director shall not affect the validity of a meeting.

b. in the case of a meeting called by Directors in default of the Chairman, the notice shall be signed by those Directors and no business shall be determined at the meeting other than that specified in the notice.

2.2 Notice of intention to hold a meeting of the Trust Board in public shall be posted on the Trust's website and circulated to the governors

2.3 In the case of the Annual General Meeting, members will be notified not less than 14 days prior to the date of the meeting. The notification shall state:

a. the time, date and location of the meeting
b. that the Annual Report and Accounts of the Trust will be presented at the meeting

3. ELECTION OF VICE-CHAIRMAN AND SENIOR INDEPENDENT DIRECTOR

(Constitution paragraph 30)

3.1 Any Director so elected may at any time resign from the office of Vice-Chairman by giving notice in writing to the Chairman, and the Directors of the Trust shall thereupon elect another of their Non-Executive Directors as Vice-Chairman in accordance with the provisions of this Standing Order.

4. CHAIRMAN OF MEETING

4.1 At any meeting of the Trust Board the Chairman if present, shall preside. If the Chairman is absent from the meeting, the Vice-Chairman if present, will preside. If the Chairman and Vice-Chairman are absent, another Non-Executive Director as the Directors present shall choose, shall preside at that meeting.

5. RECORD OF ATTENDANCE

5.1 The names of Directors present at a Trust Board meeting shall be recorded, and where such attendance is not for the full meeting the point at which they arrive or leave will be noted.

5.2 It is expected that Directors will make every effort to attend meetings and the Chairman will hold a record of attendance. Where a Director is not able to attend it is expected that the Director will advise the Chairman in advance. Where a Director has not been able to attend regularly and without good reason, such as ill health, then the Chairman will discuss with that Director their status within the Board.

6. QUORUM

6.1 No business shall be transacted at a Trust Board meeting unless at least **four** Directors (being two Non-Executive Directors and two Executive Directors), are present.

7. NOTICE OF MOTIONS

7.1 The Chairman shall routinely construct the agenda for meetings following discussion with the Chief Executive and the Board Secretary, and having taken into account matters raised with him by Directors.

7.2 Where a Director desires to formally have a matter raised with a view to a resolution being passed, he shall send a notice of the motion at least ten working days before the meeting to the Chairman. The Chairman shall insert in the agenda for the next meeting all notices so received subject to the same being in order.

7.3 Any motion, whether moved at the meeting or of which written notice has been given beforehand, may be withdrawn without notice.

7.4 Directors shall have the right to report to the Board as a standing agenda item.

8. NOTICE OF MOTIONS

8.1 The mover of a motion shall have a right to reply at the close of any discussion on the motion or any amendment thereto.

8.2 When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

a. an amendment to the motion

b. the adjournment of the discussion or the meeting

c. that the meeting proceed to the next business

d. the appointment of an ad hoc committee to deal with a specific item of business

e. that the question be now put

f. a motion resolving to exclude the public (including the press).

8.3 Whenever an amendment is proposed to an original motion, then unless the Board shall decide to the contrary no second amendment shall be proposed until the first amendment is resolved.

8.4 On the seconding of a motion, the Chairman, if he is of the opinion that the question before the Board has been sufficiently discussed, shall put the motion to the vote.

8.5 A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Trust Board.

9. MOTION TO RESCIND A RESOLUTION

9.1 Notice of a motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Director who gives it and also the signature of two other Directors. When any such motion has been considered and dismissed by the Trust it shall not be competent for any Director other than the Chairman to propose a motion to the same effect within six months.

10. CLOSURE MOTIONS

10.1 If a motion under Paragraph 8.2b, 8.2c or 8.2e, is proposed and seconded the Chairman shall proceed as follows:

a. On a motion to adjourn the debate or the meeting (Paragraph 8.2b) the Chairman shall decide whether in his opinion the original matter before the meeting has been discussed sufficiently. If he is of the opinion that such matter has not been discussed sufficiently, and that it is not reasonably possible to do so on that occasion, he shall put the adjournment motion to the vote without giving the mover of the motion his right of reply on that occasion.

b. On a motion to proceed to the next business (Paragraph 8.2c) the Chairman shall decide whether in his opinion the matter raised has been discussed sufficiently and if so will give the mover of the original motion a right of reply following which the motion to proceed to the next business will be put to the vote.

c. On a motion that the question be put (Paragraph 8.2e) the Chairman shall decide whether in his opinion the matter has been discussed sufficiently and if he is of the view that it has, he will put to the vote the motion that the question be put. If the motion is passed then the mover of the original motion shall be given a right of reply before putting the motion itself to the vote.

11. CHAIRMAN'S RULING

11.1 The decision of the Chairman of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and his interpretation of the Standing Orders, shall be final (except in the case of an error of law or mistake of fact). In his interpretation he may be advised by the Chief Executive or Director of Finance, and in the case of Standing Financial Instructions by the Director of Finance.

12. VOTING

12.1 Every question at a meeting shall be determined by a majority of the votes of Directors present and voting on the question and, in the case of an equality of votes, the Chairman of the meeting shall have a second or casting vote.

12.2 All questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by show of hands provided that, upon any question the Chairman of the meeting may direct, or it may be proposed, seconded and carried that a secret vote be taken by paper ballot.

12.3 If at least one third of the Directors so request, the voting (save in the case of a secret ballot) on any question may be recorded so as to show how each Director present voted or did not vote.

12.4 If a Director so requests, his vote shall be recorded by name.

12.5 In no circumstances may an absent Director vote by proxy. However the views of an absent Director may be conveyed in writing to the Chairman who will inform the Board of the views expressed.

13. MINUTES

13.1 The Chairman of a meeting shall ensure that the minutes of the proceedings of the meeting shall be drawn up and when approved entered in a book kept for that purpose. Such minutes shall record details of any person who is excluded from the discussion of an issue and the reason.

(Constitution paragraph 34.2)

13.2 The minutes of a Board meeting shall be distributed to Directors and Governors within fifteen working days of that meeting and will be in draft form until approved by the Trust Board at its next meeting, upon which event the Chairman of that meeting will sign the minute book for correctness.

13.3 No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate.

13.4 Where inaccuracies are identified in the minutes these will be corrected at the Board meeting to which the minutes are submitted and the amendments reported to a subsequent Board meeting in order to be ratified. The minute book may be signed subject to ratification of any changes. Where the amendments are purely of a typographical nature the minutes may be signed after correction by the Chairman and such changes need not be represented to the Board.

13.5 Members of staff and the public may have access to the minutes of the public session of the Board, and the minutes will be posted on the Trust's website. However where discussions have been held in confidence or cover matters of a confidential nature the minutes arising shall be treated in confidence and may only be viewed by Directors and Governors

14. ADMISSION TO TRUST BOARD MEETINGS

14.1 Except where the Trust Board shall, by formal resolution otherwise decide, the first part of all regular business meetings of the Trust Board shall be open to the press and the general public.

14.2 The attendance at the private section of Board meetings by personnel other than Directors is at the discretion of the Chairman.

15. INTEREST OF DIRECTORS IN CONTRACTS AND OTHER MATTERS

(Constitution paragraph 36)

15.1 In the interests of openness and transparency Directors shall disclose memberships of all organisations, clubs or societies to which they belong, and these shall be held in the register of Directors' Interests.

II. COMMITTEES AND SUB-COMMITTEES

16. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

16.1 The Trust Board may appoint committees of the Trust consisting wholly or partly of the Chairman and Directors of the Trust or wholly of persons who are not Directors of the Trust.

16.2 The Trust Board will establish committees in respect of; Audit, ~~Clinical Governance, Finance~~, ~~Senior Medical Appointments (ad hoc), Local ACCEA Awards Committee, Staff Appeals (ad hoc),~~ and Remuneration and other committees as it deems appropriate and having regard to guidanmce and good practice. ~~The Local ACCEA Awards Committee shall be chaired by the Chief Executive.~~ Each committee will be chaired by a Non-Executive Director and terms of reference and membership of such committees will be reviewed annually and approved by the Board). The minutes of these committees shall be routinely presented to the Board for information and ratification if necessary.

16.3 A committee appointed under Paragraph 16.1 may, subject to such directions as may be given by the Trust Board, appoint sub-committees consisting partly of members of the committee (whether or not they are Directors of the Trust) together with persons who are not members of the committee.

16.4 Members of committees or sub-committees who are not Directors or employees of the Trust may claim expenses and subsistence payments, and may be remunerated if so approved by the Board.

16.5 The Standing Orders of the Trust as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Trust. Any such alteration should be recorded in committee minutes.

16.6 A member of a committee or sub-committee, including co-opted members, shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Trust or shall otherwise have concluded action on that matter.

16.7 A Director of the Trust or member of a committee shall not disclose any matter reported to the Trust or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Trust or committee shall resolve that it is confidential.

16.8 Where there is more than one Non-Executive Director on a committee the Chairman of the Trust Board shall determine the chairman of the committee. ~~Every committee shall, unless its terms of reference provide otherwise, at its first meeting, before proceeding to any other business, elect a Vice-Chairman for the year.~~

16.9 The Head of Corporate Governance shall summon any committee to meet on the request of its Chairman, or the Trust Board, or on the written request of at least one third of the members of the committee.

17. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS

17.1 The Trust Board may make arrangements for the exercise, on its behalf, of any of its functions by a committee, sub-committee or joint committee appointed by virtue of Paragraph 16.1 or 16.2 or by a senior employee of the Trust, in each case subject to such restrictions and conditions as the Trust Board thinks fit.

17.2 The Trust shall approve corporate governance arrangements which will oversee the exercise of the functions of the Board and ensure all activities are conducted legally and in accordance with approved Standing Orders. Such duties may be assigned to an existing Executive Director or a non-Director appointment may be made. The Head of Corporate Governance will report to the Chairman on matters pertaining to the Board, and to the Chief Executive in respect of executive functions.

III. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

(Constitution paragraph 47)

18. CUSTODY OF SEAL

18.1 The common seal of the Trust shall be kept by the Chairman in a safe place.

19. SEALING OF DOCUMENTS

19.1 The seal of the Trust shall not be fixed to any document unless the sealing has been authorised by a resolution of the Trust Board or where the Board has delegated its powers in that behalf to an Executive Director.

19.2 The seal shall be attested by two authorised Directors, one of whom must be a Non-Executive Director and the other must be an Executive Director.

19.3 The seal shall be affixed on documents as advised by the Trust's legal advisers and provides additional legal protection under certain circumstances. Usually this will include:

* conveyancing estate for sale, transfer, or purchase
* licences executed or signed as a deed
* leases for three years or more
* appointments under major building contracts such as architects, design consultants, clerk of works, and main contractors

20. REGISTER OF SEALING

20.1 An entry of every sealing of a document shall be made, consecutively numbered in a register to be maintained for this purpose by the Head of Corporate Governance and signed by the persons who have attested the seal and such Register shall be kept by the Head of Corporate Governance in a safe place.

20.2 A summary of entries in the Register of Sealing shall be submitted to the Trust Board at its next meeting.

IV. APPOINTMENT OF DIRECTORS

21. [not used]

22. DIRECTORS
(Constitution paragraph 31)

22.1 A Board nominations committee (Ad-hoc committee) shall be established for the appointment of the Chief Executive and will be convened with terms of reference as determined by the Chairman and Non-Executive Directors. The appointment of the Chief Executive requires the approval of the Council of Governors.

22.2 For the appointment of Executive Directors the Chief Executive and Chairman shall determine the appropriate committee membership and process.

22.3 Executive Directors apart from the Chief Executive and the Director of Finance may be removed from their Directorship of the Trust without being removed from their post of employment if, in the view of the Chairman, Non-Executive Directors and the Chief Executive, it is not in the interests of the Trust for them to continue as a Director.

22.4 The Chairman and Non-Executive Directors are appointed for a fixed period of time, the details of which shall be held in a register by the Head of Corporate Governance. Renewal or appointment of new Non-Executive Directors shall be effected in accordance with the Trust's Constitution.

V. APPOINTMENT OF STAFF

23. CANVASSING OF, AND RECOMMENDATION BY, DIRECTORS

23.1 Canvassing of Directors of the Trust or of any committee of the Trust, directly or indirectly, for any appointment under the Trust shall disqualify the candidate for such appointment. The purport of this paragraph of this Standing Order shall be included in any form of application or otherwise brought to the attention of the candidates.

23.2 An Executive or Non-Executive Director of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for an appointment. However Paragraphs 23.1 and 23.2 shall not preclude a Director from giving a written testimonial of a candidate's ability, experience or character for submission to the Trust.

24. RELATIVES OF DIRECTORS OR SENIOR EMPLOYEES

24.1 Candidates for any appointment under the Trust shall, when making application, disclose, in writing to the Trust, any relationship to any Director or the holder of any senior office under the Trust, of which they are aware. Deliberate failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/her liable to instant dismissal.

24.2 Every Director of the Trust shall disclose to the Trust at the earliest possible time any relationship between himself/herself and a candidate of whose candidature he is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made in respect of senior management appointments.

24.3 Relationships to which this order applies are these:

a. where two people may not be married but are living together as spouses or partners.

b. where either of the two persons concerned or the spouse of either of them is the son or daughter or grandson or granddaughter or brother or sister or nephew or niece of the person concerned or of the spouse of that other person.

VIII. MANAGEMENT OF RISK

25. MANAGEMENT OF RISK ARRANGEMENTS

25.1 The Chief Executive shall ensure that there are proper procedures for the identification of risk and the assessment of the likelihood and impact of such risks.

25.2 Identified risks shall be recorded in Departmental risk registers across the Trust and shall include measures to minimise risks and actions to be taken to address them should they arise.

25.3 Principal risks shall be assessed and agreed by the Board.

25.4 The Board shall approve an Assurance Framework to assess and manage the principal risks associated with achieving the organisation's objectives. The Assurance Framework shall incorporate measures to ensure that the Trust complies with its Authorisation and allows the Board to agree the annual Statement of Internal Control.

25.5 Each principal risk has an identified local risk manager who is responsible for managing and reporting on the overall risk. The identified local risk manager is normally an Executive Director.

25.6 Assurance Committees will assure the Trust Board that each principal risk is being monitored, gaps in controls identified, and processes put into to place to minimise the risk to the organisation. The designated Assurance Committees of the Trust Board are: the Audit Committee, the Clinical Governance Committee, Workforce Committee the Finance & Performance Committee, and the Strategy Committee.

25.7 It is the responsibility of the Assurance Committees to report to the Trust Board, ~~on a quarterly basis~~ any new risks identified, or gaps in assurance/control, as well as positive assurances. If a significant risk to the Trust's service delivery or gap in control/assurance is identified then this must be reported immediately via the Executive Directors.

25.8 The Board shall approve, and maintain up to date, a Risk Management Strategy which shall address risks associated with: clinical standards and safety, service performance, finance, physical environment, employment, and the work undertaken for the Trust by third parties.

25.9 The Audit Committee will monitor the overall Assurance Framework process.

VIX. MISCELLANEOUS

26. SUSPENSION OF STANDING ORDERS

26.1 Except where this would contravene any statutory provision or any direction made by the Secretary of State any one or more of the Standing Orders may be suspended at any meeting, provided that at least two thirds of the appointed Directors of the Trust are present and that a majority of those present vote in favour of suspension and that the majority of non-Executives present also vote in favour of suspension.

27. VARIATION AND AMENDMENT OF STANDING ORDERS

27.1 These Standing Orders shall be amended only if;

a. a notice of motion under Paragraph 7 has been given; and

b. a majority of the Trust's appointed Directors present and choosing to vote on the matter are in favour of amendment; and

c. a majority of the Trust's non-Executives present are in favour of the amendment; and

d. at least two thirds of the Trust's appointed Directors are present; and

e. the variations proposed do not contravene a statutory provision or direction made by the Secretary of State.

28. DISTRIBUTION OF STANDING ORDERS

28.1 The Head of Corporate Governance shall ensure that a copy of the Standing Orders are provided to each Director of the Trust and appropriate other employees and immediately following any time when revised Standing Orders are approved by the Board. ~~Receipt of Standing Orders and amendments should be duly signed for to confirm they have been read and understood~~.

28.2 A copy of the Standing Orders and SFIs shall be available on the Trust's web site.

29. SIGNATURE OF DOCUMENTS

29.1 Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, or if the Trust shall have given the necessary authority to some other person for the purpose of such proceedings, be signed by the Chief Executive or by any other officer duly authorised by him for this purpose. Original signed contracts will be held by the Estates Department for building contracts. The Procurement Department will maintain a database for all other contracts including details of where the original documentation is held, who is responsible for its maintenance and the renewal date.

30. STANDING FINANCIAL INSTRUCTIONS

30.1 Standing Financial Instructions adopted by the Trust shall have effect as if incorporated in these Standing Orders and the Constitution.

31. [NOT USED]

32. URGENT DECISIONS

32.1 Where an urgent decision is required between Board meetings in respect of a matter which would normally be considered by the Board, the Chief Executive will be empowered to take action on behalf of the Trust, provided that he consults with the Chairman or in his absence the Vice Chairman and such other Directors as he is able to contact before taking action.

32.2 In the absence of the Chief Executive the Chairman may act in the capacity of Chief Executive for the purpose of actioning an urgent matter or the Chairman may appoint an acting Chief Executive for a period of time.

32.3 Where a decision normally reserved to the Board is taken by the Chairman or Chief Executive due to urgency, such decision shall be reported to the Trust Board at its first meeting afterwards.

33. PROVISION OF DOCUMENTATION

33.1 A Director shall be entitled to receive upon request a copy of any document to which the Trust is a party subject to constraints of confidentiality and any personal interests that a Director may have in such documentation.

34. INTERPRETATION OF STANDING ORDERS

34.1 The Chairman of the Trust shall be the final authority in the interpretation of Standing Orders, on which he may be advised by the Chief Executive, Director of Finance and Head of Corporate Governance, or in the case of Standing Financial Instructions by the Director of Finance.

Salisbury
NHS Foundation Trust

Accountability Framework

2018/19

CONTENTS

PURPOSE

The purpose of the Accountability 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 2018/19 and beyond.

The Accountability Framework pulls together, in one place, the Trust's business as usual performance, including delivery against its contracts and transformational programmes including Cost Improvement Plans (CIP) and Quality, Innovation, Productivity and Prevention (QIPP) plans and Commissions for Quality and Innovation (CQUIN) schemes.

The Accountability Framework sets out the expectations of the Trust as a whole and as individual directorates. It provides a framework for how the Trust will monitor and manage its own performance. 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.

The Accountability Framework has been designed to align as closely as possible with the NHS Improvement Single Oversight Framework November 2017. This framework reflects the requirements of the Care Quality Commission (CQC), Financial sustainability/stability, performance management and improvement capability. It will ensure that as an organisation we are pro-active in providing assurance to our regulators.

There are five themes to the Accountability Framework (these match the themes defined in the Single Oversight Framework November 2017), each set out below:

Theme	Aim
Quality of care (safe, effective, caring, responsive)	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
Operational performance	To maintain and improve performance against core standards
Strategic change	To ensure every area has a clinically, operationally and financially sustainable pattern of care
Leadership and improvement capability (well-led)	To build leadership and improvement capability to deliver sustainable services

PERFORMANCE FRAMEWORK

The performance function will oversee the delivery of all elements of Trust performance throughout the year, including service performance and quality of care, linked to the delivery of the Trust's Transformational and Financial plans. No one element of the Trust's business plan can be assessed in isolation.

The Performance Framework sets out the metrics that each directorate will be held accountable against, these metrics will be taken from the Trust's Operational Plan, individual directorate plans and will include all national and contractual requirements.

The dashboard is based on the five themes that will be used as part of the overall assessment of performance at a directorate and organisational level.

To mirror the Single Oversight Framework the Trust is using the segmentation methodology and for each theme there will be an assessment:

Segment	Description of support needs
1 Maximum autonomy	No actual support needs identified across the 5 themes
2 Targetted support	Support needed in one or more of the 5 themes
3 Mandated support	Significant support needs
4 Special measures	Very serious/complex issues

Below is the summary of the five themes with the information used and the triggers that will highlight issues or concerns.

Theme	Information used	Triggers
Quality of care (safe, effective, caring, responsive)	• CQC information • Quality information • 7 day services	• CQC rating of 'inadequate' or 'requires improvement' in overall rating, or against any of the key questions for - 'Safe' - 'Caring' - 'Effective' - 'Responsive' • CQC warning notices relating to the directorates' core areas • Any other material concerns identified through, or relevant to, CQC's monitoring process, such as civil or criminal cases raised or raising concerns information • Concerns arising from trends in Quality Indicators • Failure to deliver against agreed commitments regarding the four priority standards for seven- day hospital services • Any other material concerns about a providers quality of care arising from intelligence gathered
Finance and use of resources	• A monthly finance score (Trust level) • A use of resources assessment (where available) • Other relevant information on financial performance, operational productivity and whether a directorate is making optimal use of its resources	• Poor levels of overall financial performance, such as monthly finance score of 4 or 3 (at Trust level) • A use of resources rating of 'inadequate' or 'requires improvement' (at Trust level) • Any other material concerns about a directorate's finances or use of resources
Operational performance	• NHS Constitution standards • A&E waiting times • Referral to treatment times • Cancer treatment times	• Failure to meet any operational performance standard for at least two consecutive months • Other factors (eg a significant deterioration in a single month or multiple potential support needs across standards and/or other themes) indicate the need to get involved before two months have elapsed • Any other material concerns about a directorates's operational performance

Strategic change	• Extent to which directorates and departments are working with partners to address local challenges and to improve services for patients • Directorate's contribution to developing, agreeing and delivering the objectives of sustainability and transformation partnerships (STPs) • Nature of directorate's relationships with local partners, their role in any agreed service transformation plans and how far these plans have been implemented	• Material concerns about support for the local transformation agenda, including (where relevant) new care models and devolution
Leadership and improvement capability (well-led)	**Effective Boards and Governance:** • CQC well led inspections and outcomes of developmental well-led reviews where these generate material concerns relating to directorates • Information from third parties eg Healthwatch, MPs, complaints, whistleblowers, coroners' reports • Staff/patient surveys • Level of directorate management team turnover • Organisational health indicators • Delivering Workforce Race Equality Standards (WRES) **Continuous improvement capability:** • Assessments of learning, improvement and innovation within well-led reviews undertaken by CQC or in developmental reviews using the well-led framework **Use of data:** • Adoption of measurement-for-improvement approach	• CQC 'inadequate' or 'requires improvement' assessment against 'well-led' in relevant core areas • Concerns arising from trends in directorate health indicators • Other material concerns about a directorate's governance, leadership and improvement capability

Quality of Care

The following metrics will constitute the metrics that the Trust will use to establish the quality of care provided by the Trust.

	Measure	Type	Frequency	Source
*	Staff sickness	Organisational Health	Monthly/Quarterly	HSCIC (publicly available)
*	Staff turnover	Organisational Health	Monthly/Quarterly	HSCIC (publicly available)
*	Executive team turnover	Organisational Health	Monthly	FT return/O&E
*	NHS Staff Survey	Organisational Health	Annual	CQC (publicly available)
	Proportion of Temporary Staff	Organisational Health	Quarterly	FT return
	Aggressive Cost Reduction Plans	Organisational Health	Quarterly	FT return
	Written Complaints - rate	Caring	Quarterly	HSCIC (publicly available)
	Staff Friends and Family Test Percentage Recommended - Care	Caring	Quarterly	NHSE (publicly available)
	Never events	Safe	Monthly	NHSE (publicly available)
	Never events - incidence rate	Safe	Monthly	NHSE (publicly available)
	Serious Incidents rate	Safe	Monthly	StEIS
	National Reporting and Learning System (NRLS) medication errors: Percentage of harmful events	Safe	Monthly (1)	NRLS (publicly available)
	Proportion of reported patient safety incidents that are harmful (moderate or above)	Safe	Monthly	NRLS (publicly available)
	Potential under-reporting of patient safety incidents	Safe	Monthly	NRLS (publicly available)
	Central Alerting System (CAS) alerts outstanding	Safe	Monthly	NRLS (publicly available)
	Mixed Sex Accommodation Breaches	Caring	Monthly	NHSE (publicly available)
	Inpatient Scores from Friends and Family Test - % positive	Caring	Monthly	NHSE (publicly available)
	A&E Scores from Friends and Family Test - % positive	Caring	Monthly	NHSE (publicly available)
	Emergency c-section rate	Safe	Monthly	HES
	CQC Inpatient Survey	Organisational Health	Annual	CQC (publicly available)

	Maternity Scores from Friends and Family Test - % positive	Caring	Monthly	NHSE (publicly available)
	Percentage of Harm Free Care	Safe	Monthly	NHSE (publicly available)
	Percentage of new harms	Safe	Monthly	NHSE (publicly available)
	VTE Risk Assessment	Safe	Quarterly	NHSE (publicly available)
*	*Clostridium Difficile* - variance from plan	Safe	Monthly	PHE (publicly available)
	Clostridium Difficile - infection rate	Safe	Monthly	PHE (publicly available)
*	MRSA bacteraemias	Safe	Monthly	PHE (publicly available)
	Hospital Standardised Mortality Ratio (DFI)	Effective	Quarterly	DFI
	Hospital Standardised Mortality Ratio - Weekend (DFI)	Effective	Quarterly	DFI
	Summary Hospital Mortality Indicator	Effective	Quarterly	HSCIC (publicly available)
	Emergency re-admissions within 30 days following an elective or emergency spell at the Provider	Effective	Monthly	HES

The Quality of Care is underpinned by the production of performance packs to provide the Executive Directors (via Executive Performance Review Meetings) and ultimately the Board with a clear line of sight on current performance. The information available is reviewed and amended annually to ensure it captures all required metrics.

*Well Led performance indicators

Operational Performance

Standard	Frequency	Standard
Acute and specialist providers		
A&E maximum waiting time of 4 hours from arrival to admission/transfer/discharge	Monthly	95%
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	Monthly	92%
All cancers – maximum 62-day wait for first treatment from:	Monthly	85%

- Urgent GP referral for suspected cancer - NHS cancer screening service referral		90%
Maximum 6-week wait for diagnostic procedures	Monthly	99%

Monthly performance packs will be produced which outline current performance against plan or set targets. Directorates will be expected to respond to any concerns or risks highlighted within the performance reports to the Executive Performance Review meetings. Any additional assurance sought by way of recovery plans or increased monitoring of specific measures will be overseen by the performance function and monitored through the weekly performance meeting.

Financial Performance

The financial metrics show the Trust's financial sustainability, efficiency and controls relating to high profile policy imperatives such as agency staffing, capital expenditure and the overall financial performance of the Trust.

The scoring mechanism for the metrics mirror the Single Oversight framework and scoring from 4 (poorest) to 1 (best). A score of 3 or 4 will trigger a concern with NHS Improvement and trigger potential or mandated support.

Trust Level Finance Metrics

Area	Metric	Definition
Financial sustainability	Capital service capacity	Degree to which the provider's generated income covers its financial obligations
	Liquidity (days)	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown
Financial efficiency	Income and expenditure (I&E) margin	I&E surplus or deficit / total revenue
Financial controls	Distance from financial plan	Year-to-date actual I&E margin (surplus/deficit) in comparison to Year-to-date plan I&E margin (surplus/deficit) on a control total basis

	Agency spend	Distance from provider's cap

Directorate level finance metrics

Metric	Considerations
Revenue	Spend versus budget for pay and non pay
Income	Income in line with contracts and production plan
Cost Improvement Plans	Delivery against cost improvement trajectories and plans

Use of Resources Assessments

NHS Improvement's Use of Resources assessments aim to understand how effectively trusts are using their resources to provide high quality, efficient and sustainable care for patients. NHS Improvement will do this by assessing how well trusts are meeting financial controls, how financially sustainable they are and how efficiently they use their workforce, clinical and operational services to deliver high quality care for patients. NHS Improvement will introduce Use of Resources assessments alongside the CQC's new inspection approach from autumn 2017.

Use of resources area	Key lines of enquiry (KLOEs)	Initial metrics
Clinical services	How well is the trust using its resources to provide clinical services that operate as productively as possible and thereby maximise patient benefit?	• Pre-procedure non-elective bed days • Pre-procedure elective bed days • Emergency readmissions (30days) • Did not attend (DNA) rate
People	How effectively is the trust using its workforce to maximise patient benefit and provide high quality care?	• Staff retention rate • Sickness absence rate • Pay cost per weighted activity unit (WAU) • Doctors cost per WAU • Nurses cost per WAU • Allied health professionals cost per WAU (community adjusted)
Clinical support services	How effectively is the trust using its clinical support services to deliver high quality, sustainable services for patients?	• Top 10 medicines – percentage delivery of savings target • Overall cost per test
Corporate services, procurement, estates and facilities	How effectively is the trust managing its corporate services, procurement, estates and facilities to maximise productivity to the benefit of patients?	• Non-pay cost per WAU • Finance cost per £100 million turnover • Human resources cost per £100 million turnover • Procurement Process Efficiency and Price Performance Score • Estates cost per square metre
Finance	How effectively is the trust managing its financial resources to deliver high quality, sustainable services for	• Capital service capacity • Liquidity (days)

	patients?	• Income and expenditure margin • Distance from financial plan • Agency spend

NHS IMPROVEMENT MONITORING

NHS Improvement 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.

Summary of information requirements for monitoring

	In-year	Annual/ less frequently	By exception[1]
Quality of care	In-year quality information to identify any areas for improvement (see Appendix 1)	Annual quality information	Results of CQC inspections CQC warning notices, fines, civil or criminal actions and information on other relevant matters
Finance and use of resources	Monthly returns	Annual operational plans Information relating to Use of Resources (UoR) assessments	One-off financial events (eg sudden drops in income/ increases in costs) Transactions/mergers
Operational performance	Quarterly/monthly/weekly operational performance information (see Appendix 3)		Any sudden and unforeseen factors driving a significant failure to deliver
Strategic change	Delivery of sustainability and transformation plans Progress of any new care models, devolution plans	Sustainability and transformation plans	Any sudden and unforeseen factors driving a significant failure to deliver
Leadership and improvement capability	Third-party information with governance implications[2] Organisational health indicators - staff absenteeism - staff churn - board vacancies	Staff and patient surveys Third-party information with governance implications[2]	Findings of well-led reviews and developmental well-led reviews Third-party information with governance implications[2]

[1] Providers are also expected to notify NHS Improvement of any other material changes in performance or risks that fall outside routine monitoring

[2] eg reports from quality surveillance groups (QSGs), General Medical council, ombudsman, CCGs, Healthwatch England, NHS Digital, auditors, Health and Safety Executive, patient groups, complaints, whistleblowers, medical Royal Colleges

Support needs and segment descriptions

The support offered by NHS Improvement will be Trust specific but is defined below:

Description of support needs	Level of support offered	Segment
No actual support needs identified across our five themes. Maximum autonomy and lowest level of oversight appropriate. Expectation that provider will support providers in other segments.	**Universal**	**1 (Maximum autonomy)**
Support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS trusts) and/or NHS Improvement considers formal action is not needed.	**Universal** **+ Targeted** support as agreed with the provider to address issues identified and help move the provider to Segment 1	**2 (Targeted support)**
The provider has significant support needs and is in actual or suspected breach of the licence (or equivalent for NHS trusts), but is not in special measures.	**Universal** **Targeted** **+ Mandated** support as determined by NHS Improvement to address specific issues and help move the provider to segment 2 or 1	**3 Mandated support)**
The provider is in actual or suspected breach of its licence (or equivalent for NHS trusts) with very serious/complex issues that mean it is in special measures.	**Universal** **Targeted** **+ Mandated** support as determined by NHS Improvement to minimise the time the provider is in special measures	**4 (Special measures)**

LOCAL ASSESSMENT CRITERIA

Directorates will be assigned an overall RAG rating based on performance against the domains of quality, operational , financial and workforce performance as well as delivery of the directorate's operational plan.

Overall Performance Ratings and Oversight Model

Individual domain ratings will then be aggregated to provide an overall rating for the directorates. The proposed criteria for the overall ratings are shown in the overall performance ratings and oversight model on page 14. The criteria for assigning the overall RAG rating is not limited to the reasons shown, discretionary decisions regarding ratings may be made in agreement at the Executive Performance Review Meetings should they feel that either increased or lesser scrutiny would be more appropriate.

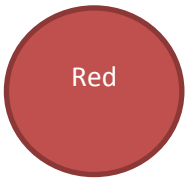
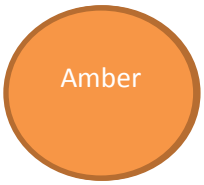
RAG ratings will be routinely reported to the Trust Management Committee to ensure that appropriate scrutiny is given to the most significant areas of risk.

The 'Overall Performance Ratings and Oversight model' below sets out how the Trust Board, Finance and Performance Committee, Trust Management Committee, and the Executive Performance Review Meetings will hold directorates to account for delivery in a consistent and transparent way. The oversight arrangements are directly linked to the Performance Framework, as outlined above.

The overall directorate rating will determine the regularity of performance review meetings and other escalation meetings. These Directorate Performance Review meetings will take place routinely, however for those directorates rated red or amber that require additional intervention of support, increased oversight will be established.

Preparatory work for each of these meetings will be required and the Information Team will work to standardise the documentation as much as possible. This will ensure consistency in the way in which performance is reviewed across the organisation and will align reporting requirements across multiple meetings. This will minimise the amount of time taken by directorates assessing data, re-focussing efforts on ensuring sufficient plans are in place to address areas of under-performance.

Overall Performance Ratings and Oversight Model:

RAG rating	Definitions	Oversight requirement
	• 3 or more domains are rated red • 2 or more domains are rated red and considerable risks to other areas of performance have been identified • Directorate is forecasting significant variances to plan at year end and there is not sufficient confidence in recovery trajectories	➢ Weekly performance challenge meetings ➢ Weekly submission of recovery trajectories and progress ➢ Bi-weekly transformational plan review meetings ➢ Presentation of recovery plan at Trust Management Committee and monthly update on recovery ➢ Further assurance to the Finance & Performance Committee may be required ➢ Dedicated project support as relevant
	• 1 or more domain is rated red • 3 or more domains are rated amber • 2 or more domains are rated amber and risks to other areas of performance have been identified • Directorate is forecasting moderate variance to plan at year end, however there is confidence in recovery trajectories	➢ Weekly submission of recovery trajectories and progress ➢ Bi-weekly performance challenge meetings ➢ Monthly Executive Performance Review meetings ➢ Dedicated project support as relevant
	• No more than 2 domains are rated amber, which indicates small variance to plan • There are no significant risks to delivery identified • Robust recovery trajectories are in place for any variance to plan	➢ Monthly Executive Performance Review meetings ➢ Agreement regarding resource and support required to enable delivery

ESCALATION

The overall RAG rating for each directorate will act as the trigger for any additional support or escalation. For directorates who are rated 'Amber' or 'Red' and/or have failed to deliver any improvements for a sustained period of time, additional interventions may be enacted to support the return of performance to acceptable levels.

The decision to escalate a directorate 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.

Additional interventions will range from putting in place a support package for a particular area of performance, such as peer review, Intensive Support Team (e.g. ECIST support for Emergency Care) supported by the Project Management Office (PMO) where applicable. More serious measures, such as removal of delegated directorate budgets, should there be significant deterioration in performance which does not appear recoverable will also exist, though it is expected that such measures would only be implemented in extreme circumstances.

GOVERNANCE

Throughout this document the term Directorates is used to describe the following clinical and corporate directorates;

- Surgery
- Musculo Skeletal Services
- Medicine
- Clinical Support and Family Services
- Facilities Directorate

Monthly Executive Performance Review meetings will take place with each of the above Directorates. Once in Quarters 1 and 3, Executive Performance Review meetings will be Chaired by the CEO. All Directorates will receive a RAG rating and escalation will be the same for Directorates as outlined on page 14.

Additional information to support the Governance process is provided in the attached Appendices;

- Appendix 1 – Directorates to Board flow chart
- Appendix 2 - Trust Management Committee Terms of Reference
- Appendix 3 - Directorate Management Committee Terms of Reference
- Appendix 4 – Executive Performance Meeting Agenda
- Appendix 5 – Directorate Management Committee Agenda

Version control

Document Title	Accountability Framework 2018/19			
Date Issued/Approved:	12 April 2018			
Date Valid From:	12 April 2018			
Date Valid To:	31 March 2019			
Directorate / Department responsible (author/owner):	Chief Operating Officer			
Brief summary of contents	This document provides a framework for how the Trust will maintain and manage its performance and focuses on the accountability relationship between the Executive and the management of the five directorates that are subject to performance review meetings.			
Executive Director responsible for Policy:	Chief Operating Officer			
Date revised:	March 2018			
Approval route (names of committees)/consultation:	Chief Operating Officer in consultation with Trust Board			
Name and Post Title of additional signatories	Not Required			
Signature of Executive Director giving approval	{Original Copy Signed}			
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet		Intranet Only	x
Document Library Folder/ Folder	Standing Financial Instructions & Orders			
Links to key external standards	• NHS Improvement Single Oversight Framework November 2017 • NHS Improvement and Care Quality Commission Use of Resources: Assessment Framework August 2017			

Related Documents	Integrated Governance Framework April 2018
Training Need Identified?	No

version Control Table

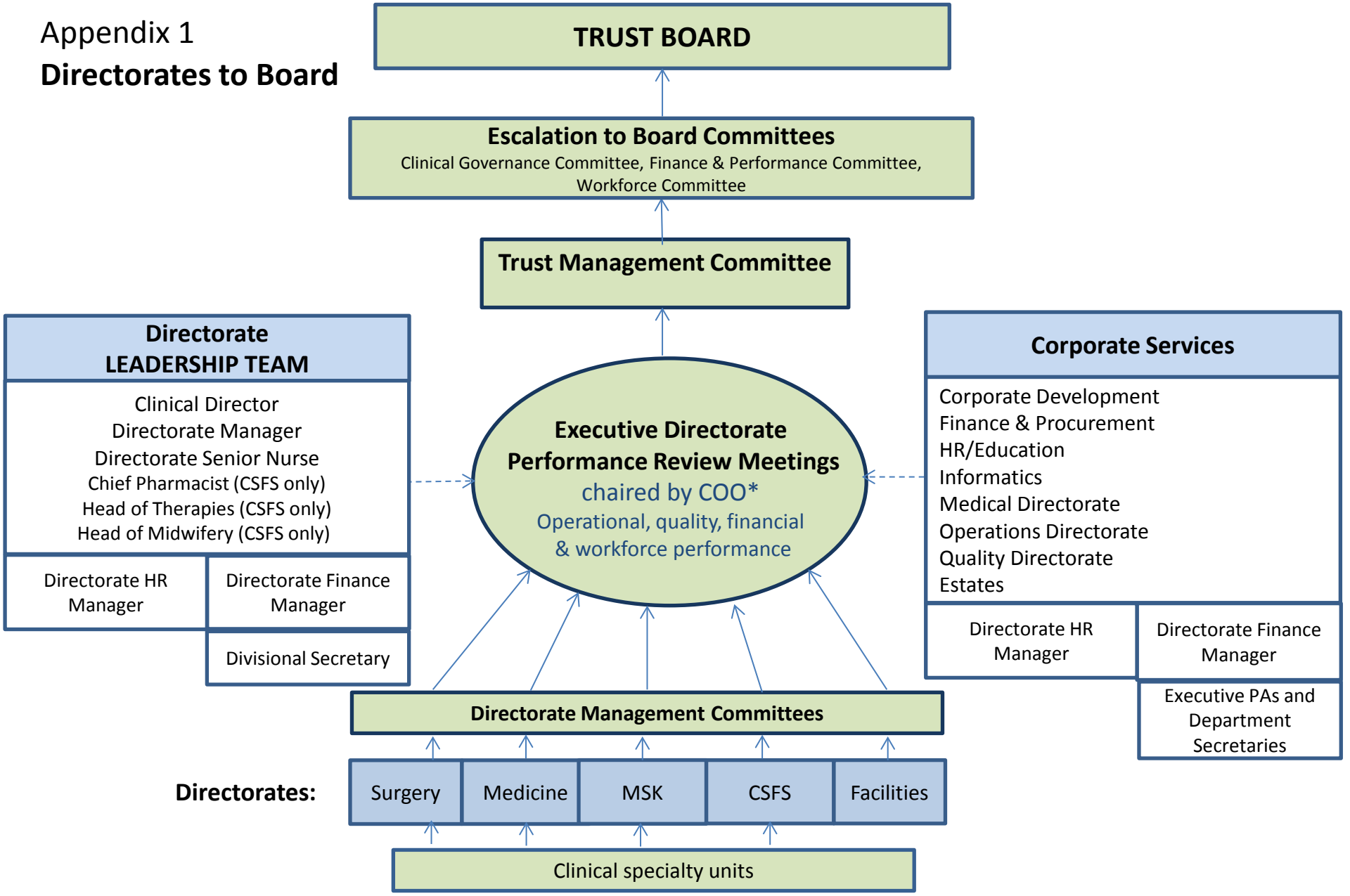
Date	Version No	Summary of Changes	Changes Made by *(Name and Job Title)*
03/02/18	V1.0	Draft document	Andy Hyett, Chief Operating Officer
28/02/18	V1.1	Draft document	Andy Hyett, Chief Operating Officer
15/03/18	V1.2	Final version	Andy Hyett, Chief Operating Officer
15/03/18	V2.1	Draft annual review of document updated to reflect NHS Improvement Single Oversight Framework November 2017	Andy Hyett, Chief Operating Officer
29/03/18	V2.2	Ongoing annual review of document, including updates to document appendices	Andy Hyett, Chief Operating Officer
04/04/18	V2.3	Ongoing annual review of document, including incorporation of key lines of enquiry from CQC & NHSI Use of Resources Assessment Framework August 2017	Andy Hyett, Chief Operating Officer
05/04/18	V2.4	Ongoing annual review of document and supporting appendices	Andy Hyett, Chief Operating Officer
09/04/18	V2.5	Draft document	Andy Hyett, Chief Operating Officer

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry. This document is only valid on the day of printing

Appendix 1

Directorates to Board



* Executive Directorate Performance Review meetings attended by Chief Operating Officer, Director of Finance, Director of Nursing, Medical Director, Director of Organisational Development and People to provide support, oversight and challenge to the directorate leadership team regarding delivery against all requirements in preparation for providing assurance to the Trust Management Committee

APPENDIX 2

Trust Management Committee
Terms of Reference

1. Purpose

1.1. This Committee is established by Chief Executive as the senior executive committee of Salisbury Foundation Trust.

Date Adopted	21 February 2018
Review Frequency	Annual
Terms of Reference Drafting	Head of Corporate Governance
Review and Approval	Joint Board of Directors
Adoption and ratification	Joint Board of Directors

2. Authority

2.1. The Chief Executive has established an Executive Committee to be known as the Trust Management Committee (TMC).

2.2. The Trust Management Committee is accountable to the Board of Directors through the Chief Executive for the operational management of the Trust and the delivery of objectives agreed by the Board of Directors.

3. Membership and Attendance

Membership

3.1. The Committee shall be appointed by the Chief Executive and shall consist of:

Chief Executive (Chair)
Chief Operating Officer
Director of Finance
Director of Nursing
Director of Corporate Development
Director of People & Organisation Development
Head of Facilities
Head of Communications (in attendance)
Medical Director
Clinical Director – Surgery
Clinical Director - Medicine
Clinical Director – Musculo- Skeletal
Clinical Director – Clinical Support & Family Services
Representative of each DMC:
Surgery
Medicine
Musculo- Skeletal
Clinical Support & Family Services

3.2. Clinical Directorates will be represented by the Clinical Director and also the as appropriate the Directorate Manager or Directorate Senior Nurse.

3.3. Each Clinical Director or Executive member may nominate a deputy to attend in their place when they are unable to attend.

Quorum

3.4. Quorum shall be at least **half** the members, or their nominated deputies being present.

4. Roles and Responsibilities

4.1. The Trust Management Committee is the senior Executive Committee.

4.2. It will support the development of the Trust Annual Plan, including policy direction and revenue and capital finance; it plays a key role in developing and implementing the overall strategy of the Trust.

4.3. It is the formal route to support the Chief Executive in effectively discharging his/her responsibilities as Accounting Officer.

4.4. It will determine new clinical procedures and major significant changes of practice or to establishments

4.5. The Committee's terms of reference:

4.5.1. To provide a corporate view on Trust-wide issues of current concern;

4.5.2. To scrutinise key reports in draft prior to submission to the Board of Directors;

4.5.3. To scrutinise the annual revenue estimates and capital programme, prior to Board of Directors' approval;

4.5.4. require regular review of the allocated section of the Assurance Framework and Corporate Risk register;

4.5.5. to ratify as necessary procedural documents, approved by OMB or CMB;

4.5.6. to determine car parking charges

Business Cases and new procedures

4.5.7. to determine business cases for new clinical posts which entail additional income and activity, following consideration by the Trust Investment Committee and within delegated authority;

4.5.8. to determine business cases and service developments which require investment of £25,000 or above, following consideration by the Trust Investment Committee; to ensure that approved cases are reviewed after 12 months

4.5.9. to determine Expanded Practice Protocols;

4.6. The monthly Integrated Performance Report will be circulated for information only.

5. Conduct of Business

Administration

5.1. The Head of Corporate Governance shall be Secretary to the Committee and he or his representative shall attend to take minutes of the meeting and provide appropriate support to the Chairman and Committee members.

5.2. The Committee shall be supported administratively by the Head of Corporate Governance or Deputy, whose duties in this respect will include:

- agreement of agendas with the Chair
- taking the minutes
- keeping a record of actions, matters arising and issues to be carried forward
- advising the Committee on pertinent issues/areas

Frequency

5.3. The meeting will be monthly.

Reporting

5.4. Minutes of meetings of the Committee will be recorded and will normally be confirmed as accurate at the next meeting of the Committee.

5.5. The committee will report to the Trust Board via the CEO's report.

5.6. The Committee shall also raise any significant concerns in relation to the business undertaken directly with the Trust Board in a timely manner.

5.7. The committee will receive minutes and escalation reports from:

5.7.1. Executive Performance Review Meetings

5.7.2. Outstanding Every Time Board

5.7.3. Operational Management Board

5.7.4. Clinical Management Board

5.7.5. Health & Safety Committee

5.7.6. Drugs & Therapeutics Committee – quarterly update report

5.7.7. Security Management Committee

5.7.8. Capital Control Group

5.7.9. Emergency Preparedness, Resilience and Response Steering Group

5.7.10. Transport Strategy Steering Group

5.7.11. Medical Devices Committee

6. Review

6.1. These Terms of Reference will be subject to an annual review. The Committee shall conduct an annual self-assessment on the performance of its duties as reflected within its Terms of Reference.

Appendix 3

DIRECTORATE MANAGEMENT COMMITTEE
TERMS OF REFERENCE

1. Formation of this Committee

The Directorate Management Committees role is to consider key strategic and managerial issues within the Directorate and to ensure that performance is in line with agreed objectives.

2. Role

The Directorate will function as a decision making body in line with its delegated authority. It will provide effective and proactive leadership to the Directorate and ensure that robust governance arrangements are in place and high quality care is consistently delivered. It will provide information and assurances to the Board via meetings with the Chief Operating Officer (COO).

3. Membership of the Directorate Management Committee

The committee shall be comprised of Directorate members as follows:

- Clinical Director (CD)
- Directorate Manager (DM)
- Directorate Senior Nurse (DSN)
- Chief Pharmacist (CSFS only)
- Head of Therapies (MSK only)
- Head of Midwifery (CSFS only)
- Directorate Finance Manager
- Directorate Human Resources Manager
- Speciality Lead Clinicians
- Ward Sisters
- Heads of departments

It is expected that all members will attend at least 75% of meetings of the committee. An annual attendance report will be submitted to the COO for information and action as required.

4. Chair of the Directorate Management Committee

The chair of the Directorate Management Committee shall be the Clinical Director, with the Directorate General Manager adopting the role of Vice Chair.

5. Quorum

The quorum shall be the chair or vice chair, and at least 50% of the other representation.

6. Meetings

The Directorate Management Committee shall meet monthly. The chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

7. Attendance at meetings

Other employees may be invited to attend by the chair, particularly when the Committee is discussing an issue that is the responsibility of that employee.

8. Notice of meetings

Meetings of the committee shall be called at the request of the chair. Notice of each meeting, including an agenda and supporting papers shall be forwarded to each member of the committee not less than five working days before the date of the meeting.

9. Agenda and action points

The agenda and action points of all meetings of the board shall be produced in the standard agreed format of the Trust and kept by the Directorate Administration Team.

10. Reporting arrangements

The Directorate Management Committee has a direct reporting line to the Trust Management Committee. Assurance responsibility is delegated to the Chief Operating officer who along with the Medical Director, Director of Nursing, Director of Finance and Director of Organisational Development & People will meet with the Directorate Management team in line with the Accountability Framework.

11. Responsibilities of the Directorate Management Committee

The Directorate Management Committee is responsible for providing information and assurances to the COO that the Directorate is safely managing all issues relating to the strategic objectives of the Directorate and the Trust. In addition it has responsibility to:

11.1 based on the Trust strategy and emerging risks develop an annual directorate operational plan to form part of the Trust's operational plan

11.2 identify any risks which may prevent the achievement of the work plan and ensure that they are assessed, placed on the Directorate Risk Register and the action plan is monitored

11.3 evaluate its own membership and performance on at least an annual basis

11.4 provide assurance to the Trust Board via meetings with COO and other executive Directors as outlined in the Accountability Framework

11.5 review and monitor the Directorate against its Operating Plan

11.6 review and monitor the Quality Metrics on at least a quarterly basis.

11.7 escalate any significant issues that impact on the corporate objectives

12. Administration

The Committee shall be supported administratively by the Directorate Administration Team who will agree the agenda with the chair, produce all necessary papers, produce and distribute minutes and action points, and generally provide support to the chair and members of the Committee.

Appendix 4

Executive Performance Review Meeting

Agenda

1. Welcome and apologies
2. Minutes of the last meeting
3. Action log review
4. Performance Overview
5. Data dashboards
6. Quality performance
    a) Performance against quality metrics and incidents
    b) Complaint/incident themes and learning
    c) Patient Safety
    d) Quality issues for escalation
7. Operational performance
    a) Performance against metrics
    b) Operational performance issues for escalation
8. Financial performance
    a) Financial performance overview
    b) Financial performance issues for escalation
9. Workforce performance
    a) Workforce metrics
    b) Workforce issues for escalation
10. Performance against Directorate Operational Plan
11. Risk Register Review
12. Key issues for escalation and RAG rating
13. Actions

Appendix 5

Directorate Management Committee

AGENDA

1. Minutes of the last meeting / Matters Arising

2. Update Report from Clinical Director/Directorate Manager

3. Quality Performance
    - Performance against quality Metrics
    - Complaint/incident themes and learning
    - Clinical Governance

4. Operational Performance
    - Performance against metrics

5. Workforce Performance
    - Performance against metrics
    - Identified hotspots and actions required

6. Financial Performance
    - Revenue position
    - CIPs
    - Income

7. Departmental headline issues

8. Risk Register Review

9. Items for escalation

10. Any Other Business

11. Date of Next Meeting