Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	16
Date of Meeting:	04 April 2019		

Report Title:	Integrated Governance Framework			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				X
Prepared by:	Fiona McNeight, Director of Corporate Governance			
Executive Sponsor (presenting):				
Appendices (list if applicable):	Integrated Governance Framework – March 2019			

Recommendation:
The Trust Board is asked to approve the revised Integrated Governance Framework, March 2019

Executive Summary:
Following a review of the Trust's Integrated Governance Framework a number of minor changes have been made to bring the document up to date. The attached contains tracked changes to enable Board members to easily identify the revisions that have been made. Amendments include: • Recognition of changes to Board level Committees including the establishment of the Subsidiary Governance Committee and the Charitable Funds Committee • Incorporation of the role of the new Directorate Governance Committees • Re-presentation of some aspects of the document's content to remove duplication between the main body of the document and its appendices • Combining information from two appendices into one to form a new appendix 1 providing an overview of the Committees which report to Board with a summary of their roles • Minor adjustments to reflect current working terminology

Board Assurance Framework – Strategic Priorities	Select as applicable
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	☒

Salisbury
NHS Foundation Trust

INTEGRATED GOVERNANCE FRAMEWORK

~~April 2018~~
March 2019

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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 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 the 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, Data Security and Protection Toolkit,~~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 fivefour assuring committees;, Strategy Committee, Clinical Governance Committee, and Finance & Performance Committee,, Workforce Committee and Subsidiary Governance Committee and also the Trust Management Committee.

The Board Assurance Framework is reported to the Trust Board at every quarterly public meetings, 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 and partners to develop services in the future.
- Board business cycles will be clearly set out with actions implemented.
- The Board will ensure codes of conduct are upheld and the public service values of accountability, probity and openness in the conduct of business are maintained.
- Board members will receive appropriate induction and ongoing training and development to ensure they can undertake their responsibilities effectively and appropriately.

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~~ quarterly as the Charitable ~~Trustees~~ Funds Committee to oversee the work of the charity, decide how charitable money should be used to support the hospital, manage its investments and the reporting requirements to the Charity Commission.

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
Directorate Governance Committees		Team/specialty goals and measures Improvement as set out in the Trust's Annual Quality Account Annual CQUIN indicators Patient Safety Clinical Effectiveness Patient Experience
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.

Principal functions:

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

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

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.

Principal functions:

To provide assurance to the Board on:

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

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.

Principal functions:

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

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

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.

Principal functions:

To provide assurance on:

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

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.

Principal functions:

- 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

6.6 Subsidiary Governance Committee

The Subsidiary Governance Committee was established late 2018 to provide assurance to the Board of Directors on the appropriate management of the Trust's wholly owned subsidiary companies and where the Trust has a shareholding or interest in a company. Meetings commenced in early 2019.

Principal Functions:

- Oversight of the subsidiary level risk profile and exposure
- Ensuring a governance framework and structure for oversight of any related company/entity

6.7 Remuneration Committee

The purpose of the Remuneration 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

6.~~8~~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~~ Team to review performance across quality, finance, operations, and workforce. The reviews have been extended in early 2019 to include Corporate Functions.

Further detail is given in the Accountability Framework.

Level 3: Directorate Arrangements

6.~~7~~9 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~~10 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.

6.11~~9~~ Level 4: Quality Assurance within Directorates

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

Directorate Governance Committees will be held monthly. Standard Terms of Reference can be found in Appendix 6.

The scope of matters covered by Directorate Governance Committee agendas 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
- Information Governance

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

6.120 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.

6.131 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 (see appendix 3). Further information and Terms of Reference are ~~is~~ set out in the Accountability Framework.

Public accountability

6.142 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

6.153 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~~Regulation 28 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

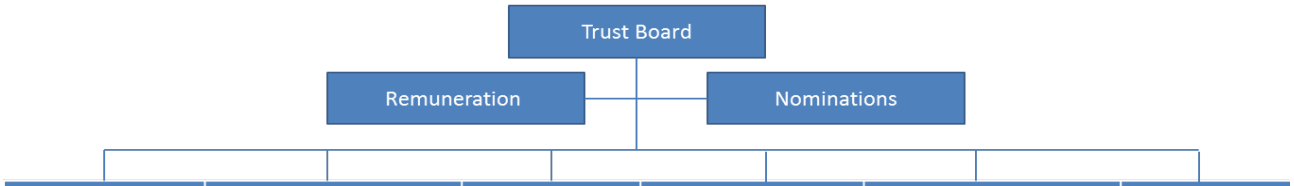
The Trust Board monitors the delivery of this framework primarily through report~~sing~~ to the Board from the following committees:

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

In addition, reports will be received from internal and external audit, and other regulatory bodies to provide independent assurance to the Board. ~~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~~ each Committee's workplan. This covers all principal strands of governance as part of the Trust-wide assurance framework.

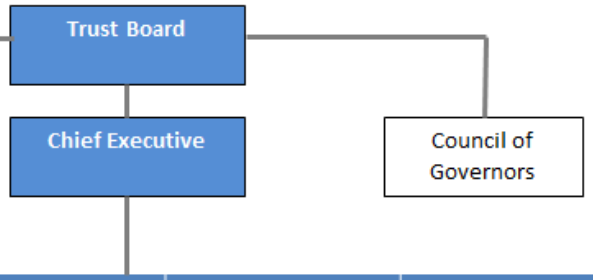
Appendix 1: Overview of Committees that report to Trust Board



Audit	Finance & Performance	Clinical Governance	Strategy	Workforce	Subsidiary Governance
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	To provide assurance and scrutinise high level operational and finance related matters, providing assurance to Board regarding reported results and compliance with NHSI requirements, in particular: -financial strategy, policy, management and reporting -Performance management and reporting -service improvement and change management -monitoring cost improvement programme -Operational performance	To provide assurance on: -Patient safety -Clinical effectiveness -Patient experience -Service improvement and change management	To provide 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: -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	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 & professional development -Recruitment & retention -Staff engagement -Change management -Occupational therapy & counselling services -Service improvement and change	To provide assurance on the appropriate management of the Trust's wholly owned subsidiary companies and where the Trust has a shareholdin or interest in a company: -Oversight of the subsidiary level ri profile and exposure -Ensuring a governance framework and structure for oversight of any related company/entity

Committee 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 accountability of direct reports to Chief Executive



Medical Director (Executive)	Director of Nursing (Executive)	Chief Operating Officer (Executive)	Director of Finance (Executive)	Director of People & OD (Executive)	Director of Transformation	Director of Corporate Governance
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** Operation Performance Facilities Medical Equipment Emergency planning	**Themes** Financial Recovery Plan Contracting Procurement Financial Control Trust-owned companies Capital control Site development	**Themes** Organisational development Education Equalities Occupational Health Volunteers	**Themes** Cost improvement planning Informatics Information governance Policy planning SIRO	**Themes** Corporate Governance Well-Led Board Assurance Framework Board and Committee business and standards Integrated Governance Framework Foundation Trust Governors and members function

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

Note: Executive Directors are Board level positions

Appendix ~~5~~2 continued: Accountability of Direct Reports to the Chief Executive

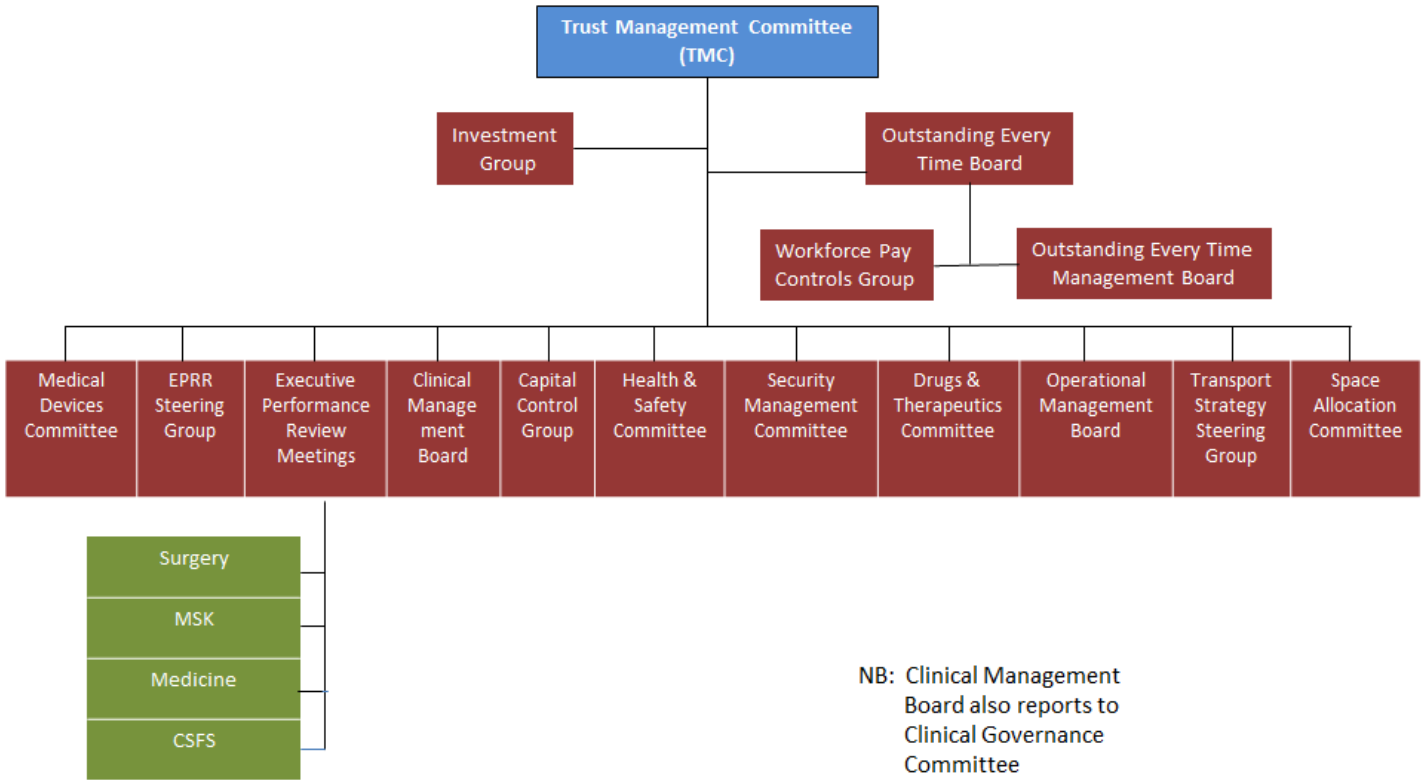
Note: Executive Directors are Board level positions

	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
Chief Operating Officer (Executive Director)	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 Estates Hard Facilities Management
Medical Director (Executive Director)	Professional leadership – medical Responsible Officer (Medical Appraisal) Clinical Effectiveness Quality Account (joint with Director of Nursing) 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 (Executive Director)	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 (Executive Director)	Financial Recovery Plan Financial planning and performance Financial management and accounting Audit and counter fraud Performance management Oversight Capital planning and management Commissioning and Contracting Payroll Procurement Charitable Trustees Trust-owned companies and Wholly Owned Subsidiary project Wiltshire Health & Care Estate strategy and management Trust Strategy and business planning GP relationships Commercial – tenders co-ordination
Director of People & Organisational Development (Executive Director)	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~~ Transformation	~~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)
Director of Corporate Governance	Corporate Governance Well-Led Board Assurance Framework Board and Committee business and standards Integrated Governance Framework Foundation Trust Governors and members function

Appendix 3: Executive Groups reporting to Trust Management Committee (TMC)



NB: Clinical Management Board also reports to Clinical Governance Committee

Appendix ~~6A~~ 4 – 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~~ for 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~~

Committees to review their effectiveness in Quarter 1 each year.

A report providing an overview of the outcomes of this process will be presented to the Board at their meeting in public in August each year.

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Appendix 5 ~~6B~~ – Terms of Reference of Board Committees [to be added]

Appendix 6 – Standard Terms of Reference of Directorate Governance Committees

??? DIRECTORATE GOVERNANCE COMMITTEE
Terms of Reference

1. Constitution

Directorate Governance Committees are established to form part of the Directorate assurance function in conjunction with the Directorate Management Committees. The Governance Committees have no executive powers, other than those specifically delegated in these terms of reference.

The **???** Directorate comprises of the following Specialties insert specialties below relevant to Directorate:

- Urgent Care.
- Medicine.
- Older Persons Medicine.etc

2. Purpose

The purpose of the Directorate Governance Committee is to ensure effective governance and quality assurance to support the organisational structure and corporate objectives; hence promoting a positive and responsible culture, and one which supports continuous quality improvement.

The Committee is responsible for the local delivery of the Trust's Corporate Objectives, ensuring that local standards are met and concerns and risks that have been identified locally are effectively managed.

The Committee will take into account Care Quality Commission (CQC) Fundamental Standards, national best practice guidelines, including National Strategies and associated improvement strategies, NICE guidance and NPSA guidance.

The Committee will also consider the implications arising out of national reports and enquiries relevant to the Directorate, including the National Confidential Enquiries and will consider the outcomes of the national audit programme co-ordinated by the Healthcare Quality Improvement Partnership (HQIP).

The above will provide assurance that the risks associated with the Directorate activities are appropriately managed and that there is continuous quality improvement.

3. Objectives

To ensure effective governance arrangements by:

- Developing, implementing and monitoring a Directorate Quality Improvement Plan (QIP) to address actions arising from incidents, complaints, patient feedback, audit and other quality intelligence. The aim of the plan is to drive quality improvement across the Directorate.
- Monitoring and ensuring compliance with the complaints process, including oversight of compliance with response deadlines and quality of the complaint response.
- Monitoring and ensuring compliance with the incident process, including oversight of compliance with timely review and closure of incidents including the mandated timeframes for investigation and report completion. In addition, ensuring reports are of high quality and address any concerns raised by patients, carers and families.
- Ensuring compliance with the Duty of Candour requirements with meaningful engagement with patients, carers and families when dealing with complaints and incidents.

- Providing oversight of risk management across the Directorate. This will include ensuring the Directorate risk register is current, regularly reviewed, that risks are appropriately graded and actions are appropriate to mitigate the risk in line with the Risk Management Strategy and Policy.
- Ensuring development of monitoring systems to provide the committee that activity is being carried out appropriately.
- Ensuring compliance with the Information Governance Compliance requirements.
- Development of a risk based, annual clinical audit plan and providing an annual audit report.
- Triangulation of all quality intelligence (related to safety, experience and outcomes) to understand the functioning of the Directorate in respect of the quality of care and outcome for patients.
- Receiving regular reports from Specialties to obtain assurance of effective governance, audit and risk management.
- Sharing learning from quality intelligence across the Directorate, and organisation as appropriate, through a variety of methods to ensure all staff are communicated with effectively to support sustainable change.
- Any points for escalation will be through the Executive Performance Reviews.
- Promoting a just and open culture where continuous quality improvement is encouraged and internal scrutiny is seen as an integral and seamless component in the delivery of healthcare.
- Monitoring Directorate compliance with all local and national quality standards, including the CQC fundamental standards, ensuring that all deficits are addressed.
- Encouraging user involvement in service improvement and planning at all levels.
- Supporting the Directorate as required in the review and development of the action plan for the National Staff Survey.
- Monitoring learning and development reports in order to provide assurances that Directorate staff have the right knowledge, experience, qualifications and skills to support care delivery e.g. APDR, Essential Skills Training compliance.
- Acting as a discussion forum to challenge the existing practice in the light of evidence-based medicine or clinical effectiveness data as it is presented to the committee.
- Undertaking the role in approval of new policies and guidelines within the Directorate as appropriate/required.
- Receiving and act on reports as required from the CQC, Confidential Enquiries and any other National reports and also any relevant local reports.
- Assessing benchmark or audit data and recommending action with regard to changing clinical practice and improving value for money.
- Provide assurance reports to other Committees as required.

4. Authority

The committee will investigate or approve any activity within the Terms of Reference. Items for escalation will be through the Directorate Management Committee and subsequently via the Executive Performance Reviews.

It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request for such information.

5. Membership

The Committee shall consist of the following members:

Need to discuss and identify Chair and Vice Chair and add any Directorate specific attendees

- Clinical Director
- Directorate Senior Nurse
- Directorate Manager
- Senior representation for each specialty

Other members may be co-opted on to the committee as required, either for additional work or for the purpose of communication or presentation.

6. Attendance

Attendance is required by members at 75% of meetings. Members are requested to nominate a deputy to attend who is appropriately briefed to participate in the meeting.

A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members.

7. Administration

The committee will be appropriately supported with an administration function to ensure effective management of the committee.

Accurate minutes will be recorded and maintained in accordance with Information Governance requirements.

8. Meetings

Meetings will be held on a monthly basis. The length of the meeting will be determined by Directorate requirements; however, should be a minimum of 2 hours to address the objectives effectively.

9. Reporting

The Committee will provide escalation points through the Executive performance Reviews.

10. Quorum

A quorum is determined as being one third of the members (or nominated deputies) in attendance but must include the Chair or Vice-Chair.

11. Review

The Terms of Reference shall be reviewed on an annual basis and ratified by the Clinical Quality Committee.

ToRs agreed by:		**Date of agreement:**	
ToRs ratified by:		**Date of ratification:**	
Review date:			

Appendix 7: Version control

Document Title	Integrated Governance Framework			
Date Issued/Approved:	~~12 April 2018~~ 4 April 2019			
Date Valid From:	~~1 April 2018~~ 5 April 2019			
Date Valid To:	~~28 February 2021~~ 31 March 2021			
Directorate / Department responsible (author/owner):	~~Head~~ Director 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~~ March 2019			
Approval route (names of committees)/consultation:	~~Chief Executive in consultation with trust board~~ Trust Board April 2019			
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~~ Well-Led Framework
Related Documents:	~~None~~ Accountability Framework Constitution Standing Orders Standing Financial Instructions Scheme of Delegation
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	David Seabrooke Head of Corporate Governance

		Reference of Trust Management Team Proposed removal of committee memberships Added review of committees Added Nominations Committees	
26 March 2019	V6.0	Document updated to reflect changes to Board Committees including introduction of a Subsidiary Governance Committee, update to accountabilities of direct reports to the chief executive and condensing of content to remove duplication	Fiona McNeight Director of Corporate Governance

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