Salisbury
NHS Foundation Trust

# Accountability Framework

# 2019/2020

**March 2019**

Salisbury NHS Foundation Trust

**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<br>Maximum autonomy | No actual support needs identified across the 5 themes |
| 2<br>Targetted support | Support needed in one or more of the 5 themes |
| 3<br>Mandated support | Significant support needs |
| 4<br>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<br>• Quality information<br>• 7 day services | • CQC rating of 'inadequate' or 'requires improvement' in overall rating, or against any of the key questions for<br>- 'Safe'<br>- 'Caring'<br>- 'Effective'<br>- 'Responsive'<br>• CQC warning notices relating to the directorates' core areas<br>• Any other material concerns identified through, or relevant to, CQC's monitoring process, such as civil or criminal cases raised or raising concerns information<br>• Concerns arising from trends in Quality Indicators<br>• Failure to deliver against agreed commitments regarding the four priority standards for seven- day hospital services<br>• 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)<br>• A use of resources assessment (where available)<br>• 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)<br>• A use of resources rating of 'inadequate' or 'requires improvement' (at Trust level)<br>• Any other material concerns about a directorate's finances or use of resources |
| Operational performance | - NHS Constitution standards<br>• A&E waiting times<br>• Referral to treatment times<br>• Cancer treatment times | • Failure to meet any operational performance standard for at least two consecutive months<br>• 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<br>• 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<br>• Directorate's contribution to developing, agreeing and delivering the objectives of sustainability and transformation partnerships (STPs)<br>• 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:**<br>• CQC well led inspections and outcomes of developmental well-led reviews where these generate material concerns relating to directorates<br>• Information from third parties eg Healthwatch, MPs, complaints, whistleblowers, coroners' reports<br>• Staff/patient surveys<br>• Level of directorate management team turnover<br>• Organisational health indicators<br>• Delivering Workforce Race Equality Standards (WRES)<br>**Continuous improvement capability:**<br>• Assessments of learning, improvement and innovation within well-led reviews undertaken by CQC or in developmental reviews using the well-led framework<br>**Use of data:**<br>• Adoption of measurement-for-improvement approach | • CQC 'inadequate' or 'requires improvement' assessment against 'well-led' in relevant core areas<br>• Concerns arising from trends in directorate health indicators<br>• 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 |
|---|---|---|---|---|
| | 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) |
| | Serious Incidents count | Safe | Monthly | StEIS |
| | 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 |
| | 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 |

| | | | | |
|---|---|---|---|---|
| | MSSA bacteraemias | Safe | Monthly<br>12 month rolling | PHE |
| | E Coli bacteraemias | Safe | Monthly<br>12 month rolling | PHE |
| | Total number of deaths & total number of admissions | Safe | Monthly<br>12 month rolling | Local |

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

**Workforce Metrics (organisational health indicators)**

| | Measure | Type | Frequency | Source |
|---|---|---|---|---|
| * | Staff sickness | Organisational Health | Monthly/Quarterly | HSCIC (publicly available) |
| * | Staff turnover | Organisational Health | Monthly/Quarterly | HSCIC (publicly available) |
| | Proportion of Temporary Staff | Organisational Health | Quarterly | FT return |

*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 | |
| a) Urgent GP referral for suspected cancer | | 85% |
| b) NHS cancer screening service referral | | 90% |
| Maximum 6-week wait for diagnostic procedures | Monthly | 99% |
| Dementia assessment and referral: the number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours: | Quarterly | |
| a) Who have a diagnosis of dementia or delirium or to whom case finding is applied | | 90% |
| b) Who, if identified as potentially having dementia or delirium, are appropriately assessed and | | 90% |
| c) Where the outcome was positive or inconclusive, are referred on to specialist services | | 90% |

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<br>- Pre-procedure elective bed days<br>- Emergency readmissions (30days)<br>- 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<br>• Sickness absence rate<br>• Pay cost per weighted activity unit (WAU)<br>• Doctors cost per WAU<br>• Nurses cost per WAU<br>• 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<br>• 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<br>• Finance cost per £100 million turnover<br>• Human resources cost per £100 million turnover<br>• Procurement Process Efficiency and Price Performance Score<br>• Estates cost per square metre |
| Finance | How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients? | • Capital service capacity<br>• Liquidity (days)<br>• Income and expenditure margin<br>• Distance from financial plan<br>• 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<br><br>CQC warning notices, fines, civil or criminal actions and information on other relevant matters |
| Finance and use of resources | Monthly returns | Annual operational plans<br><br>Information relating to Use of Resources (UoR) assessments | One-off financial events (eg sudden drops in income/ increases in costs)<br>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<br>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]<br><br>Organisational health indicators<br>- staff absenteeism<br>- staff churn<br>- board vacancies | Staff and patient surveys<br><br>Third-party information with governance implications[2] | Findings of well-led reviews and developmental well-led reviews<br><br>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.<br>Maximum autonomy and lowest level of oversight appropriate.<br>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**<br><br>**+ 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**<br><br>**Targeted**<br><br>**+ 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**<br><br>**Targeted**<br><br>**+ 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.

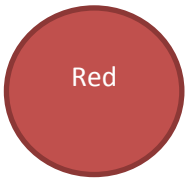
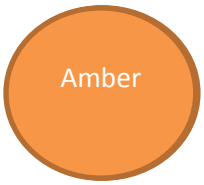
RAG ratings will be routinely reported to the Trust Management Committee to ensure that appropriate scrutiny is given to the most significant areas of risk.

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

## CORPORATE DEPARTMENTS

The Trust has a well-established process for monitoring the performance of clinical areas against financial metrics, operational delivery and quality KPIs through the well established Executive Performance Reviews. Historically, there has been no formal structure to oversee the performance of the corporate services which presents a risk to delivery of the CIP programme and the Trust's strategic objectives.

In order to address this, a new programme of Executive Performance Reviews for corporate areas was initiated in 2018. These provide a bi-annual review of the corporate functions and an opportunity to hold the Head of Service or nominated deputy to account for performance within the relevant corporate area. These reviews are Executive led by those not responsible for delivery of that corporate service.

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 2019/20 | | | |
| **Date Issued/Approved:** | 4 April 2019 | | | |
| **Date Valid From:** | 4 April 2019 | | | |
| **Date Valid To:** | 31 March 2020 | | | |
| **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/ Director of Corporate Governance | | | |
| **Date revised:** | March 2019 | | | |
| **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} | | | |
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| **Document Library Folder/ Folder** | Standing Financial Instructions & Orders | | | |
| **Links to key external standards** | • NHS Improvement Single Oversight Framework November 2017<br>• 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 – presented to Board. Approved with need to further update key metrics | Andy Hyett, Chief Operating Officer |
| 22/05/18 | V2.6 | Final document – updated key quality of care and operational performance metrics for presentation to Finance & Performance Committee | Andy Hyett, Chief Operating Officer |
| 04/04/19 | V2.7 | Draft document – presented to Board. Approved with no further changes. | Andy Hyett, Chief Operating Officer |

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