Chapter 9

Governance
9. Governance

Introduction

9.1. This chapter gives an account of governance arrangements to provide the required assurance to the Board of Directors across a range of key measures and indicators.

9.2. The overall structures and processes in place are outlined, the areas on which the Board requires assurance are defined and specific measures in place to provide this are described.

Council of Governors and membership

9.3. Upon authorisation as a Foundation Trust, the Council of Governors will be responsible for representing the interests of members and stakeholder organisations in the governance of OUH whilst acting in the best interests of the Trust and adhering to its values and code of conduct.

9.4. It will be chaired by the Trust’s chair and has statutory powers to:

- Appoint and, if appropriate, remove the chair;
- Appoint and, if appropriate, remove the other Non-Executive Directors;
- Decide the remuneration and allowances, and the other terms and conditions of office, of the chair and the other Non-Executive directors;
- Approve the appointment of the chief executive;
- Appoint/remove auditors and receive annual accounts and auditors’ reports.
- Consider any changes to the constitution proposed by the Board.
- Consider changes to non-NHS income (to check that there is no adverse effect on NHS services).
- Consider any proposed merger or acquisition.

9.5. The Board of Directors will take into account the views of the Council of Governors in preparing the Trust’s forward plan which must be submitted to Monitor each May.

Constituencies and governors

9.6. The Board agreed a Membership Strategy in January 2012 and updated it in January 2014. This is based on a commitment to:

- build a substantial and representative membership base to take forward the Trust’s Strategy, to support public accountability and local engagement, and to develop a more outward-facing organisation; and
- generate a well-informed, motivated and engaged membership which will help the Trust to be a more responsive organisation with an improved understanding of the needs of its patients and local communities.

9.7. Work continues to develop and sustain an active and engaged membership community which in turn will elect public and staff representatives to form a Council of Governors. As at October 2014, OUH had over 8,300 public members in line with its projected plan for membership growth.

9.8. Public consultation took place in 2012, informing the Trust’s proposed Constitution. Consultation points are summarised in Chapter 3 with decisions made as a result. An updated Constitution was agreed by the Board in January 2014 and an updated Governance Rationale in March 2014. The draft Constitution was updated in September 2014 to take account of the publication by the Foundation Trust Network of new Model Electoral Rules and by Monitor of an updated model Constitution.
9.9. The draft Constitution lists two categories of members:

- **Public members**: members of the general public, patients and carers who live in Oxfordshire and in other geographical areas from which substantial numbers of people come to the Trust for treatment and care.

- **Staff members**: employees of OUH (including those seconded to the Trust’s PFI providers), of the University of Oxford’s Medical Sciences Division and of the Trust’s PFI providers working on the Trust’s sites.

9.10. OUH has not designated a separate membership category for patients, as it expects that within its ‘public’ membership there will be many people who have been patients of the Trust at some time in the past, and/or are carers. Strong support was expressed for the Trust’s proposed governance arrangements during the public consultation.

9.11. Specific steps are being taken to ensure representation from black and minority ethnic, and white non-British communities. Where there are particular ethnic minority groups who seem under-represented in the membership in comparison to their presence in the wider community, every effort is being made to find ways of encouraging members of that particular community to join.

9.12. The Trust hopes that as many members as possible will engage fully with its membership programme and will participate in events, in consultation activities and in elections to the Council of Governors. OUH is drawing on strong existing engagement through work with the local community in Banbury and North Oxfordshire through the Community Partnership Network; patient groups such as the Cancer Patient Panel and Diabetes group; consultative meetings with the local community about how to improve services; regular briefings for stakeholders and feedback from patients, carers and the public through a variety of mechanisms.

9.13. Full membership begins at age 16, which means that anyone eligible to become a member is also eligible to stand for election to the Council of Governors (an important principle of governance). Perpetrators of assault or harassment against Trust staff will not be permitted to join the Trust’s membership.

9.14. In shaping the Trust’s strategic direction, the proposed Council of Governors will have direct representation from the Trust’s public members in geographically-defined constituencies; from its clinical and non-clinical staff classes, including those who hold honorary contracts; and from other nominated representatives as set out below. Governors elected by public members are in the majority, as required by legislation.

9.15. The Trust has engaged actively with both its staff and public members regarding the role of governor and the appointments process, holding a series of information sessions attended by both Executive and Non-Executive Board members and with input from NHS FT governors. Indications from these events are that there will be a significant level of interest in these roles.

9.16. The composition of the proposed Council of Governors is as set out below.

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9.17. The proposed Council of Governors (excluding the Chairman) is made up as shown below.

<table>
<thead>
<tr>
<th>Public constituencies (elected)</th>
<th>Seats</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area served by Cherwell District Council</td>
<td>2</td>
</tr>
<tr>
<td>Area served by Oxford City Council</td>
<td>2</td>
</tr>
<tr>
<td>Area served by South Oxfordshire District Council</td>
<td>2</td>
</tr>
<tr>
<td>Area served by Vale of White Horse District Council</td>
<td>2</td>
</tr>
<tr>
<td>Area served by West Oxfordshire District Council</td>
<td>2</td>
</tr>
<tr>
<td>Northamptonshire and Warwickshire</td>
<td>2</td>
</tr>
<tr>
<td>Buckinghamshire, Berkshire, Gloucestershire and Wiltshire</td>
<td>2</td>
</tr>
<tr>
<td>Rest of England and Wales</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff constituency (elected)</th>
<th>Seats</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical staff</td>
<td>4</td>
</tr>
<tr>
<td>Non-clinical staff</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nominated (Stakeholder) Governors</th>
<th>Seats</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxfordshire County Council</td>
<td>1</td>
</tr>
<tr>
<td>University of Oxford</td>
<td>1</td>
</tr>
<tr>
<td>Oxford Brookes University</td>
<td>1</td>
</tr>
<tr>
<td>Oxford Health NHS FT</td>
<td>1</td>
</tr>
<tr>
<td>Oxfordshire Clinical Commissioning Group</td>
<td>1</td>
</tr>
<tr>
<td>Oxfordshire Local Medical Committee</td>
<td>1</td>
</tr>
<tr>
<td>Specialised Commissioner (nominated by NHS England)</td>
<td>1</td>
</tr>
<tr>
<td>Young person (nominated by Young People’s Executive)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8</strong></td>
</tr>
<tr>
<td><strong>Grand total</strong></td>
<td><strong>29</strong></td>
</tr>
</tbody>
</table>

9.18. The arrangement for public constituencies divides Oxfordshire geographically by District Council areas. It then splits the surrounding counties who send patients to the Trust for general and specialist services into two, taking account of public feedback that the populations of Northamptonshire and Warwickshire also receive a local hospital service from OUH from the Horton General Hospital in Banbury. The constituency for the Rest of England and Wales takes account of the fact that some of the Trust’s specialised services operate on a national basis.

9.19. OUH staff will be members unless they choose to opt out. Staff constituency proposals are based upon the numbers of staff in each employment group, with the ‘non-clinical’ constituency incorporating staff categorised in the Trust’s Electronic Staff Record as administrative and clerical, estates and ancillary staff; and the ‘clinical’ constituency incorporating allied health professionals, additional clinical services, healthcare scientists, medical and dental, nurses and midwives, and professional and technical staff.

9.20. Staff employed by the Medical Sciences Division of the University of Oxford will be able to opt in as staff members, although staff holding honorary consultant contracts with the Trust will be members of the clinical staff class unless they choose to opt out.
9.21. Staff seconded to the Trust’s PFI providers under retention of employment agreements will be members of the non-clinical staff class unless they choose to opt out, and employees of the Trust’s PFI providers who work on the Trust’s sites will be able to opt in to the non-clinical staff class.

9.22. Stakeholder Governors from Oxfordshire County Council and the University of Oxford will be appointed as required in legislation. The recognition of partnerships within the local health economy is of particular importance, hence the proposed stakeholder governors from Oxfordshire Clinical Commissioning Group, Oxford Brookes University and Oxford Health NHS Foundation Trust. The stakeholder governor from NHS England reflects the scale and importance of the Trust’s specialised services to its wider catchment population and the wider NHS.

Council of Governors and membership support

9.23. OUH has a Membership Office to communicate with its members, to support potential Governors in preparation for the first elections and to support communications with Governors and members following the formation of the Council of Governors.

9.24. The Trust has held a series of workshops for members who might wish to stand as Governors. These have included information about the role of the Council of Governors and the electoral process, as well as input from governors from existing foundation trusts.

9.25. Induction training will be organised for new governors. This will draw on governor training commissioned by the Department of Health from the Foundation Trust Network, with bespoke training on OUH and its Strategy and forward plans. OUH will maintain training arrangements for governors, responding to specific needs as they arise. OUH will consider a mentoring system to support new governors.

9.26. The Council of Governors will be responsible for representing the interests of members and stakeholder organisations in the governance of the Trust. In doing so, it should act in the best interests of the NHS Foundation Trust and should adhere to its values and code of conduct. The Board of Directors will work with potential members of the Council and following elections, governors themselves, to explain the direction and strategy for the organisation, its services, and to highlight in particular the roles and responsibilities of governors towards members and other stakeholders. This will include specific training for governors on the duties and accountabilities of the Council as outlined in the Constitution, including those relating to the appointment of the Chairman and Non–executive Directors.

9.27. Induction for governors will also include the roles and responsibilities of the Board of Directors, and the Trust’s arrangements for governance, performance and risk management.

Membership engagement

9.28. A lively membership programme is an essential part of creating a motivated and engaged membership. The main elements of the membership programme are as follows:

- An annual members’ meeting including presentations on developments likely to be of interest to members and providing an opportunity for members to meet with Trust Governors.

- Members are invited to the Annual General Meeting and to special events such as a Cancer Centre open day and a Heart Centre open day organised by Charitable Funds. Members have also been invited to attend engagement meetings. Any such event organised in OUH is drawn to the attention of members, particularly those who have expressed an interest in attending events.

- Links with the Oxford Biomedical Research Centre support a continuing programme of presentations on areas of clinical innovation, to which members are invited.
• The Trust aims to widen its network of patient groups as it strengthens its arrangements for patient and public involvement. A close link will be maintained with the Trust’s membership through these activities.

• Staff members will be able to participate in all of the above activities in addition to specific staff-related activities.

Staff engagement
9.29. Since January 2012 the Trust has undertaken an extensive programme of employee engagement. The Board agreed the Delivering Compassionate Excellence programme to deliver improvements in the quality of patient care through:

• shared values and standards of behaviours;
• employee reward and recognition; and
• staff development through leadership programmes and induction.²

9.30. Board members are involved in a number of further initiatives including the following:

• Embedding Trust values – the Board agreed Trust values based on feedback from an extensive staff consultation process. These have formed the basis for new appraisal and recruitment processes.

• Listening into Action – workshops have been attended by hundreds of staff from all four hospital sites who are encouraged to take forward their ideas to make changes to improve patient experience, quality and safety.

• Quality priorities – Board members took part in quality workshops and work programmes have been developed at Divisional level on quality improvement in three key areas: patient safety, patient experience, clinical effectiveness and outcomes.

• Leadership events – Board members joined senior managers for two workshops aimed at helping staff connect with the Trust’s vision and five-year integrated business plan.

• Staff recognition awards – annual awards to recognise the success of staff and teams through putting values into action and delivering ‘compassionate excellence’. The awards are presented by Board members.

Internal communications
9.31. Opportunities for staff to feed back and to communicate across the organisation are provided through channels including:

• All-staff briefing sessions led by the Chief Executive and Executive Directors.
• Chief Executive-led senior manager briefing sessions after each Board meeting to disseminate key issues and Board decisions.
• Chief Nurse e-newsletter for nursing teams.
• ‘Listening into Action’ pulse checks – spot surveys with staff groups to gauge the impact of improvement projects and to monitor staff views on working for the Trust.
• Walk rounds of clinical ward areas – these involve Executive and Non-Executive Directors and encourage feedback from staff and patients.

Structures of corporate governance and management
9.32. The overall organisational structure including assurance and management functions is illustrated below. Board committees provide assurance to the Board, seeking information from the Trust Management Executive (TME) as required. Each of the committees with assurance responsibilities report directly to the the Board but they can also seek further more

² Further details are provided in Chapter 8.
detailed assurance from the others. They can also seek assurance from the executive management arm of the organisation.

**Governance structure**

*Board Assurance*

- Audit Committee
- Finance and Performance Committee
- Quality Committee
- Remuneration and Appointments Committee

*Executive Management*

- Trust Management Executive
  - Clinical Governance
  - Education and Training
  - Health Informatics
  - Public Health
  - Transformation
  - Cost Improvement
  - Health and Safety
  - Performance
  - Research and Development
  - Workforce

*Divisional Performance*

- Children's and Women's Services
- Clinical Support Services
- Medicine, Rehabilitation and Cardiac
- Neurosciences, Orthopaedics, Trauma and Specialist Surgery
- Surgery and Oncology
9.33. At least one Non-Executive Director is a member of both the Finance and Performance Committee and Quality Committee, supporting the assurance functions of the two committees being coordinated where these relate to associated aspects of Trust business.

**Board of Directors**

9.34. The Board of Directors provides leadership on strategy, on the development of policy and on systems of internal control.

9.35. With new Non-Executive Directors appointed by the Council of Governors from the date of authorisation as an NHS Foundation Trust (and current Non-Executive Directors to be confirmed in post for the remainder of their terms by the Council at that point), the Board of Directors as a whole is responsible for the quality and safety of healthcare services, education, training and research delivered by the Trust and for applying the principles and standards of clinical governance set out by the Department of Health, the Care Quality Commission and other relevant NHS bodies.

9.36. Prior to authorisation, it is accountable to the Secretary of State through the NHS Trust Development Authority.

9.37. Having effective Board meetings and committees of the Board is a key part of an effective governance structure and OUH has, as part of its preparation for Foundation Trust status, reviewed its arrangements to ensure that organisational governance is compliant with best practice and supports the objectives of the Trust. This work has included both a review of the Board and its committees and the composition of the Board itself.

9.38. Account has been taken of the Board Governance Assurance Framework and Quality Governance Framework for Aspirant Foundation Trusts.

9.39. The Board’s role is largely strategic and supervisory, having as its key functions to:

- set strategic direction, define objectives and agree plans for the Trust
- monitor performance and ensure corrective action is taken where necessary
- ensure financial stewardship
- ensure high standards of corporate and clinical governance
- appoint, appraise and remunerate executives
- ensure dialogue with external bodies and the local community.

9.40. The work and functioning of the Board is supported by Standing Orders, Standing Financial Instructions, and a Scheme of Reservation and Delegation to the Board.

9.41. The Remuneration and Appointments Committee considered the composition of the Board as part of the development of governance arrangements for Foundation Trust status, drawing on guidance from Monitor’s Code of Governance and the principles that:

- the Board should not be so large as to be unwieldy; and
- sufficient skills and experience are present, appropriate to the size of the business.

9.42. The Board has the following membership (with * denoting a voting Board member):

| Chairman* | Chief Executive* |
| Six Non-Executive Directors* | Chief Nurse* |
| Associate Non-Executive Director | Director of Clinical Services* |
| | Director of Finance and Procurement* |
| | Medical Director* |
| | Director of Assurance |
| | Director of Development and the Estate |
9.43. In common with authorised Foundation Trusts, OUH’s draft Constitution refers to the voting Directors as shown above following the date of authorisation.

**Divisions and corporate functions**

9.44. The Trust’s clinical services are grouped into five clinical Divisions, as shown in Chapter 2. These are accountable for the day-to-day management, delivery and governance of services within their areas, in line with Trust strategies, policies and procedures. Each Division is headed by a Divisional Director, a practising clinician who is supported by a Divisional Nurse/Divisional Governance and Professional Lead and General Manager.

9.45. The five Divisions and their clinical directorates operate with Divisional Management Executives (DMEs) which meet monthly and comprise clinical and managerial members. The Divisional teams include senior staff from Human Resources and Finance (senior business partners) who are accountable to the Divisional Director whilst their professional accountability remains with the relevant executive director.

9.46. Overall structures and processes of assurance, governance and risk management are developed and overseen by the relevant corporate directorate: Assurance, Clinical Services, Development and Estate, Finance and Procurement, Medical, Nursing, Planning and Information or Organisational Development and Workforce.

**Board Committee structure**

9.47. The Board operates with the support of committees. In preparation for assessment against Board Governance and Quality Governance requirements for Foundation Trust applicants, the Board undertook a review of the Board and its sub-committees using the following principles:

- the need for committees to strengthen the overall governance arrangements of the Trust and support the Board in the achievement of the Trust’s strategic aims and objectives;
- the requirement for a committee structure that strengthens the role of the Board in strategic decision making and that supports the Non-Executive Directors in scrutiny and challenge of executive management actions;
- maximising the value of the input from Non-Executive Directors, given their limited time and providing clarity around their role as non-executive members of the Board;
- supporting the Board in fulfilling its role, given the nature and magnitude of the Trust’s wider agenda, to support background development work and to perform scrutiny in more detail than is possible at Board meetings.

9.48. The following areas were covered during the review:

- statutory duties and good practice guidance;
- balance of committee membership and culture of challenge and scrutiny;
- scope and breadth of committee remits and gaps; and
- preparation and nature of committee papers, scheduling and support arrangements.

9.49. The Board agreed to revise its committees to create the structure shown below. The Finance and Performance Committee was established to focus on the overview and scrutiny of all aspects of performance reporting and the development and determination of financial strategy and plans. The introduction of this committee allowed the Audit Committee to focus on its responsibilities and duties as outlined in the DH Audit Committee Handbook and Monitor’s Code of Governance.
9.50. The Board’s committee structure is shown below.

Committees

Audit Committee

9.51. The Audit Committee is responsible for providing assurance to the Board of Directors on the Trust’s system of internal control by means of independent and objective review of financial and corporate governance and risk management arrangements, including compliance with laws, guidance, and regulations governing the NHS.

9.52. The role of the Audit Committee takes account of the DH Audit Committee Handbook, Monitor’s Code of Governance and other key guidance.

9.53. The Audit Committee will:

- obtain assurance from independent Internal Audit, External Audit and Counter Fraud activities;
- ensure standards are set and compliance with them is monitored in non financial, non clinical areas that fall within the remit of the Committee;
- monitor corporate governance issues such as compliance with NHS regulations, Codes of Conduct, and the maintenance of Register of Interests; and
- monitor and provide oversight of systems of internal control including the Board Assurance Framework and the Risk Register.

9.54. The Committee will receive assurances on the arrangements in place to manage clinical and related risks from the Quality Committee as outlined below.

9.55. Full membership of the Audit Committee is limited to Non-Executive Directors and two of the Non-Executive Directors have recent and relevant financial experience. A non-executive member is also a member of the Quality Committee ensuring the link in relation to internal controls and the management of risks with a specific and potential risk on all aspects of quality. A non-executive member is also a member of the Finance and Performance Committee ensuring the link to the detailed work of this Committee is maintained.

9.56. The Committee identifies areas in which it wishes to undertake a ‘deep dive’ to gain greater assurance in order to fulfil its duty in internal control. A forward plan of deep dives is maintained, with flexibility to amend as risks are identified and reviewed.

9.57. The Audit Committee meets at least five times per year and at each meeting its members also meet privately with the Trust’s internal and external auditors.

9.58. A covering report is taken to the following public meeting of the Board by the Chairman of the Committee, highlighting the key issues discussed, decisions taken, risks identified, future business and any issues referred to other Committees.

9.59. An Annual Report on the work and performance of the Committee is provided to the Board.

9.60. A mid-year review also takes place considering the effectiveness of the Committee and an annual review is reported to the Board prior to the production of the Annual Governance Statement.
Finance and Performance Committee

9.61. The Finance and Performance Committee is responsible for performance reporting including specific oversight of financial performance and delivery against planned budgets, risks related to finance and performance (as identified from the Corporate Risk Register), CIP targets whilst improving patient safety, experience, clinical effectiveness and outcomes, corporate financial policy, management and reporting, and quality.

9.62. It is chaired by a Non-Executive Director (also a member of the Audit Committee) and includes three additional non-executive members, the Chief Executive, the Director of Finance and Procurement, the Medical Director, the Director of Clinical Services and the Director of Development and the Estate.

9.63. The Committee meets at least six times per year.

9.64. A covering report is taken to the following public meeting of the Board by the Chairman of the Committee, highlighting the key issues discussed, decisions taken, risks identified, future business and any issues referred to other Committees.

9.65. An Annual Report on the work and performance of the Committee is provided to the Board.

9.66. A mid-year review also takes place considering the effectiveness of the Committee and an annual review is reported to the Board prior to the production of the Annual Governance Statement.

Quality Committee

9.67. The Quality Committee is responsible for providing the Board with assurance on the standards of quality safety for clinical care and on clinical governance and risk management systems.

9.68. As part of the assurance process on the management of clinical risks, the Quality Committee provides assurance to the Audit Committee at least twice per year on the systems in place through review of non-financial risks on the Corporate Risk Register, Board Assurance Framework and Quality Governance Framework and specifically in relation to the development and completion of the Annual Governance Statement.

9.69. The Committee oversees monitoring of the Trust’s compliance with CQC Essential Standards of Quality and Safety and ensures, through work with the Audit Committee, that systems for the management of risks to quality are robust and that assurance upon them can be provided to the Board.

9.70. The Committee is made up of four Non-Executive Directors, the Chief Executive, the Medical Director, the Chief Nurse, the Director of Clinical Services, the Director of Assurance and the Director of Workforce and is chaired by a Non-Executive Director. The Director of Planning and Information attends to discharge responsibilities regarding information governance as the Trust’s Senior Information Risk Owner (SIRO).

9.71. The Quality Committee meets at least six times per year.

9.72. A covering report is taken to the following public meeting of the Board by the Chairman of the Committee, highlighting the key issues discussed, decisions taken, risks identified, future business and any issues referred to other Committees.

9.73. An Annual Report on the work and performance of the Committee is provided to the Board.

9.74. A mid-year review also takes place considering the effectiveness of the Committee and an annual review is reported to the Board prior to the production of the Annual Governance Statement.

Remuneration and Appointments Committee

9.75. Boards are required to have a Remuneration and Appointments Committee which determines policy on executive remuneration, approves contracts of employment for executive directors
and agrees arrangements for termination of contracts, ensuring that appropriate performance management arrangements are in place for Executive Directors, working with the Chief Executive to relate performance judgements to pay.

9.76. Membership of the Committee is limited to the Chairman and Non-Executive Directors, with the Chief Executive and Director of Workforce in attendance for part of the meetings.

9.77. The Committee meets at least twice per year.

9.78. A covering report (which highlights the key issues discussed, decisions taken, risks identified, future business and any issues referred to other Committees) is taken to the following public meeting of the Board by the Chairman of the Committee.

**Trust management arrangements**

9.79. Trust Management Executive (TME) is the executive management decision-making body for the Trust. It is chaired by the Chief Executive and consists of the Trust’s Executive Directors, Divisional Directors and the University of Oxford Medical Sciences Division’s Associate Head of Division (Clinical Affairs).

9.80. TME has a remit to:

- support the Board in setting and delivering the strategic direction for the Trust within the overall context of the university hospital and its partners within the local academic and health and social care system by contributing options for strategic direction, ensuring the integrated and effective delivery of the Trust’s agreed Strategy and fulfilment of its duties, standards, targets and other obligations;
- oversee the Trust’s management of risk in all aspects of the delivery of its services;
- ensure that there is always appropriate integration, connection and liaison between individual clinical services, between clinical and corporate functions and between strategic and operational matters: all within the Trust and between all the Trust’s partners;
- support individual directors to deliver their delegated responsibilities by providing a forum for briefing, exchange of information, mutual support, resolution of issues and achievement of agreement;
- ensure the fullest clinical contribution to determining the strategic direction and operational delivery; and
- approve policies within the delegated authority from the Board of Directors.

9.81. TME has sub-committees as shown on page 225. These report to it by means of a covering report and minutes.

9.82. Its sub-committees support TME to monitor:

- the effectiveness of clinical governance processes related to patient safety, experience, clinical effectiveness and outcomes and ensure that appropriate actions are taken, as advised by the Clinical Governance Committee;
- the development and delivery of cost improvement plans, as advised by the Cost Improvement Committee;
- the delivery of the Trust’s Education and Training Strategy and plans, as advised by the Education and Training Committee;
- arrangements in place to meet Health and Safety requirements, as advised by the Health and Safety Committee;
- the delivery of the Trust’s Information Management and Technology Strategy and plans, as advised by the Health Informatics Committee;
• delivery of the Trust’s service activity and financial objectives and agree actions, allocate responsibilities, and ensure delivery where necessary to deliver the Trust’s objectives or other obligations, as advised by the Performance Review Committee;
• the delivery of the Trust’s Public Health Strategy through the Public Health Steering Committee;
• the delivery of the Trust’s Research and Development Strategy and plans, as advised by the Research and Development Committee;
• delivery of sustainable service changes to assist Divisions to increase efficiency, improve patient safety and be innovative in the way services are delivered via the Transformation Steering Group;
• the delivery of the Trust’s Workforce Strategy and plans, as advised by the Workforce Committee.

9.83. Each Board meeting receives a report from the Chief Executive on business conducted by TME since the previous Board meeting.

Governance processes

Risk management

9.84. The Board of Directors is the accountable body for risk and is responsible for ensuring that the Trust has effective systems for identifying and controlling all risks, whether clinical, financial or organisational.

9.85. The Trust’s Risk Management Strategy defines the system of internal controls in relation to the management of risk and sets out accountabilities and reporting arrangements to the Board of Directors for risk management within the Trust. Operational responsibility for the implementation of risk management is delegated to TME. Assurance on risk management activities is monitored via the Board of Directors and its committees.

9.86. The Risk Management Strategy and supporting toolkit for staff set out the key responsibilities for managing risk within the organisation, including ways in which risk is identified, evaluated, controlled and escalated where necessary. The diagram below summarises the risk management process.

The Risk Cycle

9.87. Risk management is a core component of the job descriptions of senior managers within the Trust.
9.88. A range of risk management training is provided to staff and there are policies in place which describe the roles and responsibilities in relation to the identification, management and control of risk. All relevant risk policies are available to staff via the Trust intranet.

9.89. The risk management system includes both proactive and reactive processes to support embedding it in day-to-day activities. The Trust learns from good practice though a range of mechanisms including clinical supervision, reflective practice, individual and peer reviews, performance management, continuing professional development, clinical audit and application of evidence-based practice.

9.90. The Trust uses proactive processes of risk assessment and risk registers to identify and evaluate potential risks that may affect achievement of organisational objectives. A risk scoring matrix is used to ensure a consistent approach is taken to assessing and responding to clinical and non-clinical risks and incidents. This relates to the Trust’s appetite for risk with clear processes for the management and monitoring of proactive risk assessments defined within the Risk Management Strategy and supporting procedures.

9.91. On a reactive level, the Trust learns from events where things have not gone well. All staff are responsible for responding to incidents, hazards, complaints and near misses in accordance with the appropriate policies. All serious incidents requiring investigation (SIRIs) and serious risks are reported to the Board of Directors via the established committee and reporting structures.

9.92. Risk management by the Board is underpinned by a number of interlocking systems of control. The Board reviews risk through the following related activities:
   - the Corporate Risk Register;
   - the Board Assurance Framework;
   - the Annual Governance Statement; and
   - tailored reports from Executive Directors.

9.93. Local management teams, via clinical governance groups, are responsible for developing and maintaining local risk registers and overseeing the management of adverse incidents. Management teams are responsible for the review of risk action plans and ensuring they are implemented through the business planning process and other established routes.

9.94. Trust-wide risk processes are monitored and reviewed by Trust Management Executive and subject to independent overview by the Audit Committee. Specific elements are monitored by the Clinical Governance Committee, the Quality Committee and the Finance and Performance Committee. The Board reviews the Corporate Risk Register at least twice per year.

9.95. The Board has recognised the need for a consistent approach to three interlinking strategies for risk management, quality and assurance. These strategies, agreed in July 2012, have been developed and publicised in a coordinated fashion. They represent a development in the Trust’s risk, quality and assurance processes and a means to support continuous quality improvement.

9.96. The Risk Management Strategy and its supporting Toolkit set out the way in which risks are escalated and de-escalated from ward to Board level. The Strategy also outlines the high-level process used by the Board to consider the Trust’s risk appetite and risk tolerance levels. The Board has accepted that it does not have the same appetite and tolerance levels for all risks and has agreed that a tolerance level will be set of each of its strategic risks as part of an annual review of the Corporate Risk Register and Board Assurance Framework.

9.97. Further assurance on the effectiveness of risk management has been received with the achievement of compliance with the Risk Management Standards of the NHS Litigation Authority (NHSLA) at level one for acute and maternity services in September and November
2011 respectively. Level two for maternity services was subsequently achieved in November 2013.

Audit

9.98. OUH’s External Auditor is Ernst & Young LLP.

9.99. The Trust’s Internal Audit service is provided by KPMG LLP, who also provide a Counter Fraud service to the Trust.

9.100. Audit opinions for 2011/12, 2012/13 and 2013/14 are shown below. In each case the Annual Audit Letter was received by the Trust and action taken to address recommendations.


<table>
<thead>
<tr>
<th>External Audit (from Annual Audit Letter 2011/12)</th>
<th>Unqualified opinion on the accounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Audit (Head of Internal Audit Opinion, April 2013)</td>
<td>Satisfactory Assurance given that there is a generally sound system of internal control in place</td>
</tr>
<tr>
<td>External Audit (from Annual Audit Letter 2012/13)</td>
<td>Unqualified opinion on the accounts and value for money conclusion</td>
</tr>
<tr>
<td>Internal Audit (Head of Internal Audit Opinion, April 2014)</td>
<td>‘Substantial’ assurance can be given that there is a generally sound system of internal control on key financial and management processes. These are designed to meet the Trust’s objectives, and controls are generally being applied consistently</td>
</tr>
<tr>
<td>External Audit (from Annual Audit Letter 2013/14)</td>
<td>Unqualified opinion on the accounts and value for money conclusion</td>
</tr>
<tr>
<td>Key internal audit findings in 2013/14</td>
<td>The outcome of Internal Audit reports issued in 2013/14 is set out in the table below</td>
</tr>
</tbody>
</table>

9.102. The latest Head of Internal Audit Opinion, notified to the Audit Committee in May 2014, stated that:

“The Trust has in place a Board Assurance Framework (BAF) that has been presented to the Board throughout the year and the Trust has risk management arrangements in place designed to ensure that risks are reviewed and challenged.

The Trust has extensively reviewed and refined its BAF and risk management arrangements in 2013/14. The Trust has established a sound Corporate Risk Register [and] is continuing to further develop the risk processes at Divisional, Directorate and Clinical Service Unit level.

Further work is needed to continue to refine and embed the Trust’s risk management arrangements to help to ensure that at a local level, risks are fully understood, clearly documented and evidenced, and that appropriate actions are taken in a timely manner to address those risks. Trust officers recognise these opportunities and action is being taken to achieve them.

The areas for improvement that we have highlighted will strengthen the process currently in place, although do not hinder our ability to issue an overall substantial assurance opinion. We will follow up recommendations raised during 2014-15.”
9.103. Internal Audit reports issued in 2013/14 gave the following opinions regarding the level of assurance:

<table>
<thead>
<tr>
<th>Audit Area</th>
<th>OUH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Management</td>
<td>significant</td>
</tr>
<tr>
<td>Recruitment and appraisal</td>
<td>significant</td>
</tr>
<tr>
<td>Employee satisfaction &amp; experience</td>
<td>significant</td>
</tr>
<tr>
<td>Performance management</td>
<td>significant</td>
</tr>
<tr>
<td>Service line management</td>
<td>significant</td>
</tr>
<tr>
<td>Information Governance Toolkit (follow-up)</td>
<td>significant</td>
</tr>
<tr>
<td>Procurement</td>
<td>significant</td>
</tr>
<tr>
<td>NICE guidance</td>
<td>significant</td>
</tr>
<tr>
<td>Safeguarding</td>
<td>significant</td>
</tr>
<tr>
<td>Clinical records</td>
<td>significant</td>
</tr>
<tr>
<td>Data quality / Key Performance Indicators</td>
<td>significant</td>
</tr>
<tr>
<td>BAF and risk management</td>
<td>significant</td>
</tr>
<tr>
<td>Cost improvement &amp; QIPP</td>
<td>significant</td>
</tr>
<tr>
<td>Responding to Francis II</td>
<td>significant</td>
</tr>
<tr>
<td>Complaints &amp; PALS</td>
<td>significant</td>
</tr>
<tr>
<td>Junior doctors’ rotas</td>
<td>limited</td>
</tr>
</tbody>
</table>

9.104. Internal Audit reports are received throughout the year and agreed with management. The Audit Committee is rigorous in its follow-up of outstanding recommendations: any high or medium priority recommendations which are overdue are followed up with a monthly report to the Executive team and regular reports to the Committee.

9.105. An Annual Quality Account, with a strong focus on clinical audit and effectiveness, is prepared, reviewed by Internal Audit, and agreed by the Board. This reflects the Board’s annual quality priorities (as informed by the Quality Strategy) and drives the development of clinical audit plans within the Trust.

**Assurance model**

9.106. The Trust has an Assurance Strategy setting out long term aims in relation to the assurance that the organisation can gain on the delivery of its strategic objectives. This process is set out in diagrammatic form below.

A model for structured assurance. [Source: Health Care Standards Unit]
9.107 The Trust receives a range of assurance from mechanisms such as monitoring of compliance by the Care Quality Commission on Essential Standards of Quality and Safety; NHSLA assessments; NICE and National Patient Safety Agency metrics.

9.108 The Trust uses three levels of assurance:
- Level 1: management or operational assurance, for example reports to Board meetings.
- Level 2: oversight functions, for example reports from the Audit Committee.
- Level 3: independent review, for example CQC inspection.

9.109 The three levels reflect the independence of the body providing the assurance with independent review having a higher value than internal management provided assurance. The organisation maintains an evidence-based approach to assurance and the quality and credibility of evidence is assessed to identify and redress any gaps that may exist. Not all assurance is in written form. Some types of assurance are in the form of oral reports or derived from discussions while others are derived from observation, for example board walk rounds.

9.110 In addition to the levels given above the value of assurance received is based on several factors, such as the time that has elapsed since the assurance was obtained and its durability. Some sources of assurance last indefinitely but diminish in relevance over time, for example annual accounts. Others are snapshots in time and need to be current to be of value, for example a clinical audit report. Not all sources of assurance are completely relevant: they may cover only part of a service or be only partially aligned to a particular objective. Some sources of assurance are more reliable than others, while the independence of the source will also affect its value.

9.111 The various mechanisms and tools described in the Assurance Strategy not only enable the assurance information produced to be assessed in terms of value, but also enable any identified gaps in assurance to be reported at an appropriate level and addressed when considered necessary.
Specific Assurance Arrangements

9.112. The sections below provide examples to illustrate the assurance arrangements for a set of key standards, benchmarks and processes. These are by no means exhaustive.

Quality

9.113. The Trust’s Quality Strategy, agreed by the Board in July 2012 and updated in September 2013, sets an ambitious five-year quality vision for the organisation. Ten measurable strategic quality goals are grouped into three domains: patients’ safety, patients’ experience and clinical effectiveness. The Trust has set itself the objective of being one of the safest providers of hospital care, in the top 10% of hospitals for patient and staff experience and providing clinical services that have clinical outcomes in the top 10% nationally. The Quality goals are shown in the diagram overleaf.

9.114. Each clinical service is expected to set annual quality priorities aligned to the Trust’s strategic quality objectives. The Board sets annual quality priorities for the Trust, drawing these from locally set priorities and incorporating national standards and commissioner requirements.

9.115. The agreed priorities form a framework for Divisional and service level quality priorities. These are developed through discussion with clinicians, including nursing and medical staff taking into account incidents, risks, complaints and feedback.

9.116. OUH also uses locally-commissioned and national peer reviews to inform its work. During 2013, it reviewed care for patients undergoing surgery and participated in the national peer review of cancer services.

9.117. Progress against quality objectives is reviewed locally through Divisional Executive meetings. Overall delivery of the Strategy is monitored through the Trust’s committee structure.

9.118. The Quality Committee is responsible for providing the Board with overall assurance on clinical governance systems and standards of quality and safety. Its minutes are seen by the Trust Board, accompanied by the Committee Chair’s report. The Medical Director and Chief Nurse also provide topic-specific quality reports on relevant issues to the Trust Board at each of its public meetings. A Quality Account is produced on an annual basis as part of the Trust’s Annual Report.

9.119. A range of quality metrics form part of the Integrated Performance Report to the Board and Divisional performance against relevant standards is monitored via the performance review cycle described above.
9.120. The Clinical Governance Committee monitors the effectiveness of clinical governance processes related to patient safety, experience, clinical effectiveness and outcomes and ensures that appropriate actions are taken. It provides a closer scrutiny on these issues than is possible via Divisional performance reviews and, with all Divisions represented, can support consistency of approach across the organisation.

9.121. It is the Trust’s policy that all deaths that occur on Trust premises should be reviewed. In some specialties, where death is a common occurrence, some reviews may be undertaken by the responsible consultant using the authorised ‘screening form’. Where a formal review takes place, this is led by a senior clinician not directly involved in the patient’s care, and undertaken in a multi-disciplinary environment. The process is managed through the Clinical Outcomes Review Group.

9.122. The outcomes of the reviews are threefold: to estimate the frequency of deaths that may have been preventable; to identify learning points and actions to be taken locally and potentially in other areas across the Trust; and to share good practice.

9.123. Divisions are held to account for the mortality review process through quarterly reports to the Clinical Governance Committee. These reports are designed to provide a quantitative
overview of the mortality review process and a narrative on learning with pan-Trust applicability.

9.124. The concept of ‘risk summits’ at OUH has been established alongside the peer review programme following publication of the Francis and Berwick Reports, and the Keogh Reviews earlier in the year and it is proposed that risk summits will continue going forward on approximately a quarterly basis.

9.125. Risk summits have been held regarding the care of patients with pneumonia and of inpatients with diabetes. These summits have led to developments in staffing and access to specialist care for patients with these conditions across the Trust’s services and sites.

9.126. Monthly Divisional reports are provided to the Clinical Governance Committee. These include assessments of compliance with CQC standards and an analysis of Dr Foster outcome measures. Trends in complaints and incidents as well as lessons from individual instances are tracked to inform progress and future strategy, along with relevant alerts from Dr Foster and the Central Alerting System (CAS). OUH also uses NICE reports and the clinical audit process to proactively explore opportunities for quality improvements. The Clinical Governance Committee reports to the Trust Management Executive on a monthly basis and escalates issues of concern where necessary.

9.127. Regular clinical audit reports go to the Clinical Audit Committee (a subcommittee of the Clinical Governance Committee) for assurance and the outcomes are reported to the Board’s Quality Committee.

9.128. A Trust-wide Clinical Governance team sets out and monitors clinical governance arrangements and is supported by a frontline team of clinical governance and risk practitioners who are allocated to each Division and support activity to deliver the Trust’s vision on quality.

9.129. The Trust has had an external assessment against Monitor’s Quality Governance Framework and reassessments against the relevant standards will continue to be made as required and included in its internal audit programme.

9.130. The Trust’s patient experience survey comprises four programmes coordinated by a Patient Experience Steering Committee, chaired by the Chief Nurse and co-chaired by a patient leader. Local and national benchmarking has taken place to ensure that OUH is in line with latest national and local best practice in patient, carer and staff experience.

9.131. The four programmes are:

- Patient Experience and Insight. Use of the Friends and Family Test with proactive use of real-time feedback for inpatient and outpatient services.
- Patient Stories. The development of patient stories as an approach for learning, personal and professional reflection, sharing excellence and examining poor practice.
- Compassionate Care. Driving compassion as the core component of patient and carer experience, supported by an OUH compassionate care charter co-produced with patients, families and staff.
- Patient Leaders. Transforming the working relationship of patients and carers with staff, providing training to enable patients to develop a more strategic approach to working with staff.

9.132. Executive and Non-Executive Directors undertake regular quality walk rounds which are included in Board reports and example patient stories are presented to the Board. Both provide opportunities to triangulate other quality information with the realities of current patient experience.

Performance Management Framework
9.133. The *NHS Foundation Trust Code of Governance* states that:

“At least annually and in a timely manner, the board of directors should set out clearly its financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust’s business and operations, including clinical outcome data, to allow members and Governors to evaluate its performance. Further requirements are included in the *NHS Foundation Trust Annual Reporting Manual.*”

9.134. Monitor’s Risk Assessment Framework specifies indicators used to judge the performance of FTs. Financial indicators are reported to the Board in its Finance reports. Indicators which contribute to the Governance Risk Rating are included within the Board’s Integrated Performance Report (IPR). These are shown in the table below.

<table>
<thead>
<tr>
<th>Metric</th>
<th>Indicator</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 week referral to treatment</td>
<td>Incomplete pathway</td>
<td>92%</td>
</tr>
<tr>
<td></td>
<td>Admitted pathway</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>Admitted specialties</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Non-admitted pathway</td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td>Non-admitted specialties</td>
<td>0</td>
</tr>
<tr>
<td>Accident &amp; Emergency</td>
<td>Maximum waiting time of four hours from</td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td>admission, transfer or discharge</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td>62 day referral to treatment</td>
<td>85%</td>
</tr>
<tr>
<td></td>
<td>62 day screening referral to treatment</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>31 day first treatment</td>
<td>96%</td>
</tr>
<tr>
<td></td>
<td>31 day subsequent - chemotherapy</td>
<td>98%</td>
</tr>
<tr>
<td></td>
<td>31 day subsequent - surgery</td>
<td>94%</td>
</tr>
<tr>
<td></td>
<td>31 day subsequent - radiotherapy</td>
<td>94%</td>
</tr>
<tr>
<td></td>
<td>Cancer 2 week wait</td>
<td>93%</td>
</tr>
<tr>
<td></td>
<td>Breast symptomatic 2 week wait</td>
<td>93%</td>
</tr>
<tr>
<td>Clostridium Difficile</td>
<td>Incidence against threshold</td>
<td></td>
</tr>
</tbody>
</table>

9.135. The IPR at Trust level is built up from equivalent analysis at Divisional and directorate level. It is therefore possible to ‘drill down’ into the analysis to review performance within individual areas. The IPR at Divisional level receives evaluation and scrutiny via Divisional performance reviews.

9.136. The Board reviews monthly performance reports covering financial, activity and quality performance data. These include key relevant national priority and regulatory indicators, including Commissioning for Quality and Innovation (CQUIN) targets with additional reports devoted to patient safety, patient experience, clinical effectiveness and outcomes. A monthly qualitative summary is supplemented by more detailed exception reports on any areas of adverse performance.

9.137. The selection of appropriate metrics is subject to regular review, with changes in definitions or strategic priorities reflected in the selection. The Finance and Performance Committee’s

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3 *NHS Foundation Trust Code of Governance*, Monitor, December 2013, paragraph C.1.3
forward plan incorporates an annual review of IPR metrics, tied to the annual business planning process.

9.138. The IPR is backed up by reports reviewed by Board Committees such as the Quality Committee, directorates and individual services, with some analysis available at individual practitioner level.

9.139. The Divisional performance review process is shown below. Monthly performance meetings take place with each Division and are led by the Director of Finance and Procurement.

9.140. At quarterly Divisional performance meetings, quality, activity, finance and workforce indicators are reviewed in detail by the executive team and actions agreed to mitigate emerging risks and to manage performance. These meetings provide an opportunity for Divisions to explain performance and for corporate functions to offer support where required.

**Performance Review Process**

9.141. As shown below, the Integrated Performance Report fulfils management and assurance functions. It is reviewed by TME to ensure that appropriate management action is taken where required and by Board committees for assurance purposes.

9.142. The Finance and Performance Committee reviews the IPR in its entirety and the quality and patient experience metrics within it are considered by the Quality Committee.
Strategy and Business Planning

9.143. The Trust’s vision and values have been translated into strategic objectives as shown in Chapter 3. To enable their delivery a series of supporting strategies has been developed.

9.144. The strategic objectives and supporting strategies have been further translated into individual Divisional, directorate and clinical service unit-level objectives. Risks to the delivery of objectives have been considered at each level and, where relevant, included in the appropriate risk register. Objectives then form an integral part of business plans developed across the Trust.

9.145. The diagram overleaf shows schematically how the Trust’s overall vision is cascaded and translated into detailed operational planning and actions at the level of Divisions, services and individuals so as to ensure that these are coherent and congruent with the organisation’s overall goals.

Vision into actions

9.146. An example of this process in action is the development and approval of individual business cases.

9.147. Business cases are progressed and approved through the process shown below, providing assurance that they receive an appropriate level of scrutiny in relation to the level of resource and capital to be committed and that the Board and TME have opportunity to test their consistency with OUH’s overall Strategy.

9.148. Once approved, the respective risks are managed and implementation of plans to achieve the relevant objectives is monitored through the Trust’s executive management.
9.149. Until FT authorisation, approval of schemes above the delegated limit for NHS Trusts must be sought from the NHS Trust Development Authority.
Financial Controls and Reporting including Cost Improvement Programme

9.150. Detailed monthly financial reports are provided for all Divisions and their directorates. These reports are brought together for review by TME and the Board.

9.151. Finance reports to the Board include an assessment of the Trust’s performance against Monitor’s Continuity of Services Risk Rating. The elements that make up the rating are visible to the Board to enable review of performance over time.

9.152. Board reports on finance include the Statement of Comprehensive Income (Income & Expenditure Account); Statement of Financial Position (Balance Sheet); Statement of Cashflows; Financial Risk Rating; Analysis of Income by Commissioner; Analysis of the Capital Programme; Analysis of the Savings Programme; and Risks.

9.153. Controls on expenditure are in place through Standing Orders, Standing Financial Instructions and Budgetary rules.
9.154. OUH recognises that it must deliver cost improvements whilst providing safe and effective clinical care. It has an approach to the development and implementation of its Cost Improvement Programme\textsuperscript{4} that includes an important assurance and oversight role for its Quality Committee. This approach is shown below.

**Cost Improvement Programme (CIP) Governance Framework**

\[\text{Diagram of Cost Improvement Programme (CIP) Governance Framework}\]


9.156. Articulated through the IM&T Strategy is the need for appropriate governance arrangements that function in accordance with governance and assurance arrangements for the Trust as a whole. These are needed to ensure that the organisation moves in a common corporate direction and adheres to common inter-operability, technical and data standards. Without them, systems cannot work together and information cannot be shared.

9.157. OUH recognises the importance of adhering to corporate standards and of ensuring future system compatibility and will put in place appropriate arrangements to deliver this, working through its Health Informatics Committee, reporting to the Trust Management Executive.

**Workforce**

\textsuperscript{4}See also description of the Trust’s Transformation Programme in Chapter 3.
9.158. Workforce metrics to be monitored are determined with Divisions and reviewed by the Workforce Committee and Trust Management Executive (which includes Divisional Directors) to inform the Workforce Plan.

9.159. The Workforce Plan supports and is consistent with the Integrated Business Plan and Long Term Financial Model agreed by the Trust Board. Workforce Key Performance Indicators (KPIs) are set and monitored at Trust and Divisional level. KPIs encompass pay expenditure, temporary workforce expenditure, sickness absence rates, turnover rates, compliance with statutory and mandatory training requirements and appraisal rates.

9.160. The Finance and Performance Committee reviews progress against the Workforce Strategy and plan twice a year. It reviews the Integrated Performance Report (including workforce metrics) on a monthly basis.

9.161. The Quality Committee triangulates information from Quarterly Reviews at Divisional level, relevant KPIs from the Workforce Committee and CQC outcome data from the Clinical Governance Committee and carries out a review of workforce assurance three times a year. As noted above, at least one non-executive is a member of both committees to ensure that complementary activities are considered.

9.162. The Audit Committee provides annual review of Human Resources governance through the audit cycle.

9.163. Strategic risks to the workforce plan are identified in the Integrated Business Plan and monitored as part of the Board Assurance Framework and Corporate Risk Register, which are routinely reviewed by the Trust Board.

9.164. Risks specific to Divisions are identified and monitored via Divisional risk registers, reviewed at Quarterly Performance Meetings and escalated in accordance with the Board Assurance Framework.

9.165. Medical revalidation requirements are managed via an implementation group reporting to the Workforce Committee. Activities in relation to trade unions are reported within the Joint Staff Consultation and Negotiating Committee and Local Negotiating Committee of the BMA and supplied to the Workforce Committee.

Conclusion

9.166. The Board and its committees have arrangements in place to enable them to drive strategy and oversee the Trust’s operational management.


9.168. Specific processes are in place to scrutinise all aspects of performance of the clinical Divisions as well as the development of risk registers, cost improvement plans and business cases that link back to the trust’s strategic objectives.

9.169. Arrangements are also in place to ensure that key information and metrics are reported to the Board and appropriate committees, with appropriate frequency and to a consistent standard to enable all committees to discharge their duties as set out in the relevant terms of reference.