Oxford University Hospitals NHS Trust

BGM Submission Document

Planned date to enter DH process 7 January 2013

Contents

	Page
Board context	3
Summary results	6
1. Board composition & commitment	9
2. Board evaluation, development & learning	13
3. Board insight and foresight	18
4. Board engagement and involvement	23
5. Board impact case studies	28

Board context

Board context

This section should set the overall context for the Trust and should include a brief overview of the Trust, together with a summary of the Board's key strategic objectives and how the Trust is performing against them. This overview links into section 3.3 of the Board Memorandum under good practice point 5 which covers the Board's strategic focus. It provides the Board with an opportunity to summarise what is important to the organisation, how it performs against KPIs and what patients think of the services provided.

In this section please provide a brief overview of:

1. Your organisation in terms of income, staff and key services provided;
2. Your organisation's key strategic objectives;
3. Summary of the KPIs the Board uses to track performance against these objectives and how it is currently performing;
4. Summary of the Trust position with regards patient feedback

Oxford University Hospitals NHS Trust (OUH) is an acute teaching hospital trust providing a wide range of general and specialist services from four hospital sites: the Churchill Hospital, John Radcliffe Hospital and Nuffield Orthopaedic Centre in Oxford and the Horton General Hospital in Banbury. It was formed on 1 November 2011 from the integration of the Oxford Radcliffe Hospitals NHS Trust (ORH) and the Nuffield Orthopaedic Centre NHS Trust (NOC). This integration also signalled a stronger collaboration with the University of Oxford through a joint working agreement to increase opportunities to translate strong Oxford-based basic science and healthcare research into new and better NHS treatments.

OUH's aim is to deliver high quality services that exceed patients' expectations, with a vision to deliver excellence and value in patient care, teaching and research within a culture of compassion and integrity.

Since 2010, the Trust's services have been delivered through a clinically-led structure. OUH provides services in more than 90 clinical specialties which are grouped into seven clinically-led divisions. Services are delivered in a range of locations across Oxfordshire and beyond. In 2011/12 the Trust provided:

- 727,448 outpatient consultations and treatments
- 115,671 attendances at its emergency departments
- 76,144 admissions for emergency assessment or treatment
- 98,351 admissions for planned inpatient or day case treatment; and
- delivered 8,650 babies.

The Trust had a turnover of £788m in 2011/12 and fixed assets of £707m. Income for providing NHS patient care services in 2011/12 was £623.3m. The Trust employed 8,772 whole time equivalent (WTE) staff as at 31 March 2012.

The seven clinically-led divisions oversee a small number of clinical directorates:

Division of Neurosciences, Trauma and Specialist Surgery:

- Neurosciences
- Specialist Surgery

Division of Cardiac, Thoracic and Vascular:

- Cardiac medicine
- Cardiac, vascular & thoracic surgery

Division of Children's and Women's services:

- Paediatric medicine, surgery and neonatology
- Women's

Division of Emergency Medicine, Therapies and Ambulatory:

- Emergency medicine and therapies
- Specialist and ambulatory medicine

Division of Surgery and Oncology:

- Oncology
- Surgery
- Renal, transplant and urology

Division of Critical Care, Theatres, Diagnostics and Pharmacy:

- Anaesthetics, critical care and theatres
- Pathology and laboratories
- Radiology and imaging
- Pharmacy

Division of Nuffield Orthopaedic Centre:

- Orthopaedics
- Rehabilitation and rheumatology

The Trust's seven strategic objectives are:

- To be a patient-centred organisation providing high quality and compassionate care whilst promoting a culture of integrity and respect for both patients and staff – "delivering compassionate excellence".
- To become a vigorous, adaptable and successful organisation with strong, well-embedded governance systems and high standards of assurance, building on a successful FT application – "becoming a resilient, flexible and successful organisation".
- To meet the challenges of the current economic climate and changes in the NHS by providing efficient and cost-effective services and better value healthcare – "delivering better value healthcare".
- To provide high quality general acute healthcare services to the population of Oxfordshire including the development of better-integrated provision across the local health and social care economy – "delivering integrated healthcare".
- To provide support and strong leadership to healthcare partners to create sustainable clinical networks together that provide health benefits to the population and to all partners – "supporting sustainable clinical networks".
- To provide high quality specialist and tertiary services to the population of Oxfordshire and beyond as part of extended clinical networks, expanding OUH's

referral base for these services –"delivering excellence in specialist and tertiary care".
- To lead the development of a durable academic health science system with our population, academic, health and social care partners and the life sciences industry and business community to lead and facilitate discovery, innovation and workforce education – "a robust Academic Health Science Network (AHSN)"

As part of its 2011/12 Trust Business Plan the Board agreed a set of corporate objectives under each of the strategic objectives. Progress against each was reported to the Board in July 2012. In summary, good progress has been made against the majority, including:

- OUH being designated as a major Trauma Centre;
- integration of the former ORH and NOC Trusts to form Oxford University Hospitals;
- agreement and implementation of a joint working agreement with the University of Oxford;
- a Satellite Dialysis Unit being established at the Horton General Hospital;
- Phase 1 of an agreed Regional Vascular Surgery development being delivered;
- a clinical network founded that involves all acute hospitals in the Thames Valley and beyond; and
- development, approval and adoption of new Trust values – 'Delivering Compassionate Excellence.'

Where work remains, objectives have been included in the 2012/13 Trust Business Plan.

An integrated performance framework has been developed to monitor key performance indicators across the main areas of Access, Quality, Finance and Workforce. Key national performance standards were met in 2011/12. One area where further progress is required is in reducing delayed transfers of care. At the end of March 2012, the Trust reported 9.65% of its occupied bed days being applicable to delays. Delays are occurring across the health and social care system as a whole and the emphasis is on joint working across organisational boundaries.

Patient feedback

The Oxford University Hospitals NHS Trust (OUH) is committed to continually developing and improving the provision of care to patients and their carers, ensuring all have an experience that surpasses their expectations. Fundamental to this is using patient's views and stories to help improve service delivery. There are a number of different opportunities for patients and relatives to provide feedback on their experiences which include completing 'Let us know your views' questionnaires, Comments and Suggestions Forms and through contact with the Patient Advice and Liaison Service (PALS).

An overview on patient feedback is reported to the Board within the monthly quality report. The positive feedback reported to the May, June and July 2012 Board indicates that a high proportion of patients would recommend this hospital. In addition the results from the national inpatient and outpatient surveys conducted in 2011 showed that 83% of respondents rated their care as either excellent or very good.

Key themes from complaints are also reported within the monthly quality report. The main areas of concern relate to patient care/experience, delays/waiting times (appointments, admissions discharge and transport), communication and behaviour. The 2011 inpatient and outpatient national surveys indicate that the main areas requiring improvement relate to delays in discharge for inpatients and for outpatients, information on how long they would have to wait in clinics. Each Division reviews complaints and patient experience feedback on a monthly basis in order to improve the quality of the service and experience they offer to patients, carers and relatives. A patient experience framework has recently been developed. It identifies how the OUH will improve the patient experience and bring together a number of existing initiatives into one 'umbrella' framework. A local CQUIN for 2012/13 has been agreed to take forward a project to implement electronic patient feedback.

Summary results

Summary results

Overview of BGM sections 1 to 3 inclusive

Ref	Area	Self-Assessment rating	Any additional notes
1. Board composition and commitment			
1.1	Board positions and size	Green	
1.2	Balance and calibre of Board members	Green	
1.3	Board member commitment	Amber/Green	
2. Board evaluation, development and learning			
2.1	Effective Board-level evaluation	Amber/Green	
2.2	Whole Board development programme	Green	
2.3	Board induction, succession and contingency planning	Amber/Green	
2.4	Board member appraisal and personal development	Amber/Green	
3. Board insight and foresight			
3.1	Board performance reporting	Amber/Red	
3.2	Efficiency and Productivity	Amber/Green	
3.3	Environmental and strategic focus	Green	
3.4	Quality of Board papers and timeliness of information	Amber/Green	

Summary results

Overview of BGM sections 4 to 5 inclusive

4. Board engagement and involvement			
Ref	**Area**	**Self-Assessment rating**	**Any additional notes**
4.1	External stakeholders	Amber/Green	
4.2	Internal stakeholders	Amber/Green	
4.3	Board profile and visibility	Green	
4.4	Future engagement with FT Governors	Green	
5. Board impact case studies			
Key points to highlight			
5.1	Performance issues in the areas of quality		
5.2	Performance issues in the areas of finance		
5.3	Organisational culture change		
5.4	Organisational strategy		

1. Board composition and commitment

Section RAG rating: Green

1. Board composition and commitment

1.1 Board positions and size

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice	Explanation if not complying with good practice
GP1 The size of the Board (including voting and non-voting members) is appropriate for the requirements of the business. ***Ref: 1.1, 1.2, 1.3, 1.4*** **GP2** All voting positions are substantively filled. ***Ref: 1.1, 1.2*** **GP3** The Senior Independent Director is identified (approved at Trust Board on 5th July 2012). ***Ref: 1.6, 1.7*** **GP4** The Board has an experienced interim Company Secretary who commenced post on 2 April 2012. Recruitment for a substantive post holder for Head of Corporate Governance/Company Secretary is underway. ***Ref: 1.9*** **GP5** It is clear who on the Board is entitled to vote. ***Ref: 1.1*** **GP6** There are 17 members of the Board. Thirteen members are entitled to vote. Of these, seven are non executives (including the chair) and 6 are executive directors. ***Ref: 1.1, 1.10, 1.8*** **GP7** Currently the terms of office of a number of NEDs are due to finish at the similar times in 2013. This issue is being addressed by the Board. ***Ref: 1.6***	**GP4 Action plan:** Recruitment for substantive post for Head of Corporate Governance is underway. A substantive Deputy Head of Corporate Governance (ICSA qualified) is in post to provide relevant support to ensure there is no impact on plans for FT authorisation. Completion date: 31st October 2012 Executive Lead: Director of Assurance	**GP7** The Appointments Commission has confirmed that they are unable to amend or extend the terms of office due to their forthcoming disestablishment. As the new NHS Trust Development Authority is not fully operational the issue of changing terms of office cannot be resolved but will be as soon as the Authority is in place. Anticipated timescale September/October 2012. Executive Lead: Director of Assurance

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
None	Not applicable	

Section RAG rating: Green

1. Board composition and commitment

1.2 Balance and calibre of Board members

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice	Explanation if not complying with good practice
GP1 Due consideration has been given to the balance of skills, experience and knowledge amongst Board members ***Ref: 1.12, 2.2*** **GP2** In selecting Board members, the Chair and CEO have given due consideration to various qualities that are essential for the person to be effective in their Board role. ***Ref: 1.2, 1.5, 2.2*** **GP3** There is appropriate NED representation from the public, private and voluntary sectors. ***Ref: 1.2*** **GP4** Recruitment to Board posts has been in line with Equality Act 2010. ***Ref: 1.12*** **GP5** Two NEDs and an Associate Non-executive Director are medically qualified. ***Ref: 1.2*** **GP6** There is an appropriate balance between Board members that are new to the Board and those that have served on the board for longer. ***Ref: 1.7a, 1.11*** **GP7** The majority of the Board are experienced Board members. ***Ref: 1.2, 1.5a, 1.7a*** **GP8** The Chairman of the Board has demonstrable and recent track record of successfully leading a large and complex organisation. ***Ref: 1.2*** **GP9** The Chairman has previous non executive director experience. ***Ref: 1.2*** **GP10** The Chairman of the Audit Committee is a Chartered Accountant with extensive financial and commercial experience. In addition, membership includes another NED who is also a Chartered Accountant with 33 years experience. ***Ref: 1.2***	**GP1, GP2, GP4 Action Plan:** A further critical talent management review will be conducted. This will include review of the knowledge, experiences and skills of Board members to effectively govern the organisation post FT. Completion date: 30th September 2012. Executive Lead: Director of Workforce	

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
None	Not applicable	

Section RAG rating: Amber/Green

1. Board composition and commitment

1.3 Board member commitment

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice	Explanation if not complying with good practice
GP1 Board members have attendance recorded at all formal Board and Committee meetings and at Board events. ***Ref: 1.14, 2.28*** **GP2** Board members have discussed and acknowledged the time commitment required of the FT process. A schedule of attendance at Board Committee meetings where FT is debated and discussed has been maintained. Minutes provided demonstrate discussion of FT agenda items. Board members have also attended a range of seminars and away days to specifically discuss and debate FT authorisation. ***Ref: 1.3, 1.6, 1.14, 2.7, 2.22, 2.24, 2.26, 2.26a, 2.30, 3.1, 3.7*** **GP3** Members of the Board adhere to the Code of Conduct and Code of Accountability in the NHS. The behaviours expected of Board members are aligned to the values of the Trust. Compliance with the codes of conduct are monitored by the Chair and included as part of each executives and NED's annual appraisal. ***Ref: 1.12, 1.12a, 1.13, 1.15***		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments

2. Board evaluation, development and learning

Section RAG rating: Amber/Green

Board evaluation, development and learning

2.1 Effective Board level evaluation

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice	Explanation if not complying with good practice
GP1 Formal evaluations of the Board have been undertaken within the previous 12 months including: • A full independent evaluation of Board effectiveness was completed by Professor Stuart Emslie in November 2011 which has been used to inform the Board Development Programme ***Ref: 2.8, 2.8a*** • The SHA observed a Trust Board meeting in March 2012 ***Ref: 2.9*** • In May 2012, the Board received feedback from KPMG on Board effectiveness as part of mock exercise on historical due diligence ***Ref: 2.10a*** • In April 2012, the Chairman introduced a reflective process following each Board meeting. This included feedback from a member of the public to inform this process. ***Ref: 2.14*** A number of changes/improvements in Board and Committee effectiveness have resulted from these evaluations. ***Ref: 2.3, 2.5, 2.5b, 2.10, 2.12*** **GP2** The Board has had independent evaluations of its effectiveness and committee structure within the last two years by a third party. These have included the following: • An external review was commissioned between May and August 2010 of governance arrangements within the Trust. Part of this included a review of Board effectiveness. This review identified the priority areas as the Trust strategy and Board Committee structure. These were addressed at Board Away day in September 2010 and appropriate actions agreed by the Board in October 2010. ***Ref: 2.1, 2.6, 2.1a and 2.1b*** • In February 2011, the Board conducted a 'Capacity and Capability Assessment' which was reviewed by the South Central SHA. ***Ref 2.2*** • As part of this assessment, the SHA observed the Board in April 2011 and provided feedback ***Ref: 2.4*** • Following this review, a revised Board Development Plan for May to October 2011 was completed ***Ref: 2.5*** • A full independent evaluation of Board effectiveness was completed by Professor Stuart Emslie in November 2011 which was further used to inform the Board Development Programme and the Board then distilled the key themes ***Ref: 2.8, 2.8a*** • The SHA observed Trust Board meetings in March 2012 ***Ref: 2.9*** • In May 2012, the Board received feedback from KPMG on Board effectiveness as part of mock exercise on		

historical due diligence ***Ref: 2.10a*** • Progress against the Board Development Plan which included an action plan, based, in part, on these evaluations, was then presented to the Trust Board in June 2012. ***Ref: 2.5b*** **GP3** The formal evaluations conducted have included a range of evaluation methods. The Board is however, mindful that in this process, it is yet to include the views of other stakeholders such as staff and commissioners. Consideration is being given to this as identified in the action plan below. **GP4** Formal evaluations of the Board have included all dimensions of effectiveness. The external evaluations considered the content of Board and Committee meetings. ***Ref: 2.4, 2.8, 2.9***		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
Linked to GP3 Where the Board has undertaken an evaluation, only the perspectives of Trust Board members were considered and not those outside the Board (eg: staff, commissioners etc).	The Trust will introduce a 360 degree feedback process that will involve staff, commissioners and other key stakeholders in evaluations of the Board. Completion date: 30th September, 2012. Executive Lead: Director of Workforce	

Section RAG rating: Green

Board evaluation, development and learning

2.2 Whole Board Development Programme

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 The Board has a formal development programme that has continuously evolved. The programme in place, was initially agreed in May 2011. This approach has been reviewed and revised following evaluations as outlined in section 2.1. In particular, feedback from the evaluations of Professor Stuart Emslie, SHA and KPMG informed the programme to ensure alignment with FT requirements. The Board Development Plan includes actions to support the Trust's FT application, opportunities to reflect on the effectiveness of the Board and its supporting governance arrangements. ***Ref: 2.4, 2.5, 2,5b, 2.8, 2.8a, 2.9, 2.10, 2.10a*** **GP2** Board members have an appreciation of how they will be regulated as an NHS FT and the role of the Board and NEDs in an FT environment. ***Ref: 2.4, 2.5a, 2.7, 2.11, 2.11a, 2.24, 2.26, 2.26a, 2.30*** **GP3** The Board is engaged in the development of the Integrated Business Plan and the Long Term Financial Model. It has also been engaged in self-assessing the Trust's quality governance arrangements. ***Ref: 2.13, 2.15, 2.31, 2.32, 4.31, 4.32, 4.33*** **GP4** The development programme includes time for executives to reflect upon the effectiveness of the Board. ***Ref:2.5, 2.5b, 2.9, 2.10, 2.10a, 2.11, 2.11a, 2.24*** **GP5** Time is 'protected' for undertaking this programme. ***Ref: 2.11, 2.11a, 2.24*** **GP6** The Board has begun to consider the potential development needs of the Board post authorisation. A programme of seminars has been developed to support this and this will be further developed as outlined in the attached action plan. ***Ref: 2.7***	**GP6 Action Plan:** GP6 (i) See Action Plan in section 1.2 relating to the critical skills review that will be undertaken. Completion date: 30th September 2012. Executive Lead: Director of Workforce GP6 (ii) This review will include consideration of the potential development needs of the Board post authorisation. Completion date: 30th September 2012. Executive lead: Director of Workforce	

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
None	Not applicable	

Section RAG rating: Amber/Green

Board evaluation, development and learning

2.3 Board induction, succession and contingency planning

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 All members of the Board are appropriately inducted into their role as a Board member. ***Ref:2.20, 2.23, 2.23a*** **GP2** Induction for Board members is conducted on a timely basis. ***Ref: 2.20, 2.23*** **GP3** New Board members have received a comprehensive corporate induction. ***Ref: 2.20, 2.23, 2.23a*** **GP4** Deputy positions for the Chair and CEO have been formally designated and minuted. ***Ref: 2.17, 2.18, 2.19, 2.22, 2.25*** **GP5** The Board has considered the skills it requires to govern the organisation effectively in the future and there are demonstrable plans in place for all key Board positions. ***Ref: 1.2, 2.25***	**GP5 Action Plan:** A process to build on the existing programme for top leaders is being developed. This includes contingency planning for executive director positions. This process will be part of the critical talent management review outlined in action plan 1.2 (GP1, GP2, GP4). Completion date: 30th September Executive Lead: Director of Workforce	

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
Linked to GP5(ii) NED appointment terms are not sufficiently staggered.	A number of existing NEDs are due to finish their term of office at the same time. This issue is being addressed by the Chief Executive Officer and Chair. The Appointments Commission has confirmed that they are unable to amend or extend the terms of office due to their forthcoming disestablishment. As the NHS Trust Development Authority is not fully operational, the issue of changing terms of office cannot be resolved but will be as soon as Authority is in place. Completion date: 31st October 2012 (depending on new TDA capacity). Executive Lead: Chief Executive Officer and Director of Workforce.	

Section RAG rating: Amber/Green

Board composition and commitment

2.4 Board member appraisal and personal development

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 Chair and NEDs are appraised annually in line with Appointments Commission guidelines. The CEO is appraised annually by Chair and Executives are appraised annually by CEO. Performance against objectives is reviewed by the Remuneration and Appointments Committee. ***Ref: 1.13, 2.21, 2.21a, 2.27, 2.27a, 2.27b, 2.27c, 2.27d*** **GP2** There will be a comprehensive appraisal process in place to evaluate the effectiveness of the Chair of the Board that is led by the Senior Independent Director. **GP3** Each Board member (including each Executive Director) has objectives specific to their Board role that are reviewed on an annual basis. These are included in the appraisal process. In advance of the visit, an example of one executives objectives has been provided. ***Ref: 2.27e*** **GP4** All Executives have personal development plans as part of the appraisal process. ***Ref:2.27, 2.27a*** **GP5** There are processes in place to ensure the development of Executive Directors as Corporate Directors as part of their personal development plans and the Board development programme as evidenced in section 2.1. ***Ref: 2.5, 2.27e*** **GP6** As a result of the appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board level. ***Ref: 2.9, 2.21, 2.21a, 2.27*** **GP7** The involvement of Governors in the Chair and NED appraisal process, once the Trust is an FT, is currently under consideration.	**GP1 Action Plan:** A review of the appraisal and personal development processes to be conducted. This will include introduction of 360 degree feedback process. Changes will apply to 2012/13 performance review process. Completion date: 30th September 2012. Executive Lead: Director of Workforce. **GP2 Action Plan:** The appraisal process for the Chair of the Board is being developed. Completion date: 31st December 2012. Executive Lead: Director of Workforce. **GP7 Action Plan:** A process is being developed for the involvement of governors in the NED and Chair appraisal post FT authorisation. Completion date: 31st December Executive Lead:	**Comment on GP2**: SID appointment was confirmed at 5th July Board meeting. This will be evidenced once the appraisal of the Chairman has taken place.

	Director of Workforce.	

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
None	Not applicable	

3. Board insight and foresight

Section RAG rating: Amber/Red

Board insight and foresight

3.1 Board Performance Reporting

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)		Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 The Board has debated and agreed a set of quality and financial metrics outside the national and regionally agreed metrics. ***Ref: 1.6, 3.31a, 3.32, 3.35*** **GP2** Performance reports are provided in the key domains: Finance, Quality, Operational which comply with best practice. The Integrated Performance Report has been running in shadow form as part of the development process. This will be presented next to the Board in September. ***Ref: 3.2, 3.3, 3,5 3.31a, 3.31b, 3.32*** **GP3** Key committee minutes are provided and are reported to the Board by the non-executive chair of that committee. ***Ref: 3.1, 3.6, 3.7, 3.8, 3.9, 3.12*** **GP4** The Board regularly discusses the key risks facing the Trust and plans to manage or mitigate them. ***Ref 3.1, 3.2, 3.3, 3.4, 3.5, 3.6, 3.7, 3.8, 3.13, 3.34*** **GP5** An action log is taken at Board meetings and progress against actions is actively monitored. ***Ref:3.9, 3.10***			
Red Flags	**Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)**		**Notes/ comments**
Linked to GP4 The Board does not receive 12 month rolling cash flow forecast information	This forecast information is being developed alongside the Long Term Financial Model (LFTM). Completion date: 31st October 2012. Executive Lead: Director of Finance and Procurement.		

Section RAG rating: Amber/Green

Board insight and foresight

3.2 Efficiency and Productivity

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 The process for considering the impact on care quality and assessing the risk of implementation of CIP plans has been considered by the Trust Management Executive and assurance provided to the Board on 5th July 2012. All CIP plans have a completed risk assessment and quality impact assessment template submitted using a predefined template. The CIP template facilitates a structured consideration of the key aspects of the financial and non-financial aspects of the CIP including risks to delivery of the CIP and must be signed off as recommended by the Divisional Director. Divisional Directors in the Clinical Management Structure are expected to ensure that CIP plans submitted for consideration by the Medical Director, Chief Nurse and Director of Clinical Services do not have an adverse impact on patient safety. ***Ref: 1.6, 3.11, 3.11a, 3.43, 4.19*** **GP2** There are examples of where CIPS are rejected at Divisional level. Similarly at corporate level some initiatives have not been progressed due to likely impact on quality. Mitigation plans and review of quality measures are expected to be in place in order to minimize any potential impact on quality. ***Ref: 3.28, 3.43, 3.44, 3.45, 3.46*** **GP3** The Board receives regular report on financial performance which includes progress on the savings programme. A review including the risk of non-achievement is carried out on a weekly basis for the Director of Finance and Director of Clinical Services. ***Ref: 3.3, 3.9, 3.29, 3.33*** **GP4** There is a process in place to monitor the on-going risks to care quality for each scheme once a scheme has been implemented, by reviewing KPI trends. These indicators will be reviewed monthly at the Performance Compact meetings ***Ref: 3.1, 3.11, 3.40***	**GP3 Action Plan** Future finance reports will include (by exception) information on other organisations. Completion date: 30th September 2012. Executive Lead: Director of Finance & Procurement.	

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
None	Not applicable	

Section RAG rating: Green

Board insight and foresight

3.3 Environmental and strategic focus

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice	Explanation if not complying with good practice
GP1 Chief Executive's presents a report to the Board detailing any important changes or issues in the external environment. The impact on strategic direction is debated and updates are made to the Trust's Board Assurance Framework. ***Ref: 1.6, 3.6, 3.7, 3.13, 3.15, 3.17, 3.21, 3.36*** **GP2** The Board reviews lessons learnt from enquiries and has considered the impact upon itself. Actions are captured and progress is followed up. ***Ref: 3.47, 3.48, 3.41*** **GP3** The Board has conducted an external stakeholder mapping exercise to inform the IBP. ***Ref:3.16, 3.42*** **GP4** In developing the IBP, the Board explored market opportunities and threats in relation to the services it provides. Risks relating to this were discussed. Board Away Days included review of environmental and external issues likely to impact on strategy development, financial plan and quality etc. ***Ref: 3.16, 2.7, 2.24, 2.30*** **GP5** The Board has agreed a set of corporate objectives and associated KPI's that enable the Board to monitor progress against implementing its vision and strategy for the Trust. Performance against these objectives are reviewed at monthly and quarterly individual divisional performance compact meetings with the Executive team. Progress is reported to the Board. ***Ref: 3.18, 3.40*** **GP6** The Board's annual programme of work sets aside time for the Board to consider risks and downside scenario planning. ***Ref:2.29, 3.16*** **GP7** Strategic risks to the Trust are actively monitored through the Board Assurance Framework. ***Ref: 3.6, 3.7, 3.13, 3.15, 3.17, 3.19, 3.21, 3.36***	**GP1 Action plan:** To strengthen this process, this has been incorporated into the existing worksteam on BAF and risk registers as part of the implementation of the revised risk strategy approved by the Board in 31st July 2012. Completion date: 30th November 2012. Executive Lead: Director of Assurance **GP5 Action Plan:** Divisional reports will be collated into a comprehensive update report and reported quarterly to the Board. Completion date: 31st December 2012. Executive Lead: Director of Strategy & Planning	

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
None	Not applicable	

Section RAG rating:

Amber/Green

Board insight and foresight

3.4 Quality of Boards papers and timeliness of information

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 The Board can demonstrate that it actively considers the timing of the Board and committee meetings. ***Ref: 3.20*** **GP2** A timetable for sending out papers to members is adhered to. **GP3** Each paper clearly states what the Board is being asked to do. ***Ref:3.22*** **GP4** Board members have access to in-month flash reports to demonstrate performance. ***Ref:3.23*** **GP5** Board papers outlined the decisions that Executive Directors have made or propose. Business Cases provided to the Board show options, rationale for choice and that they have been scrutinised. ***Ref: 3.6, 3.7, 3.9, 3.14, 3.24*** **GP6** The Board and Audit Committee do receive some regular data quality updates and reports. However, these are not a scheduled basis. ***Ref: 3.19*** **GP7** Board requests and receives a range of reports on data quality of performance metrics ***Ref: 3.25, 3.26, 3.38*** including: • Reports to Audit Committee on neurosciences coding (Indicators underpinned by these data were rated "green" but concern raised by clinician with NED • Clinical coding task and finish group SHMI/HSMR audit • Programme of external and internal data quality audits reported to Audit Committee Data quality strategy report • EPR reports to Audit Committee and Trust Board.		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments

Linked to GP6 The Board does not routinely receive assurances in relation to Data Quality or where reports are received, they have highlighted material concerns in the quality of data reporting.	A process is in place to ensure that quarterly data quality updates will be added to Integrated Performance Report. Completion date: 30th September 2012. Executive Lead: Director of Clinical Services The data quality rating system for Integrated Performance Report is currently being refined Completion date: 31st October 2012. Executive Lead: Director of Clinical Services	

4. Board engagement and involvement

Section RAG rating: Amber/Green

Board engagement and involvement

4.1 External Stakeholders

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 IBP and annual report show stakeholder engagement plans plus evidence of commissioner, GP and other engagement messages. The External Stakeholder Engagement Plan describes the key existing and emerging stakeholders and tailored methods used for involvement. ***Ref: 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.38, 4.39*** **GP2** A variety of methods are used including OUH news, available in translated versions, to enable the Board and senior management to listen to the views of patients, carers, commissioners and the wider public including hard to reach groups. There is a programme of Quality Walkrounds that are undertaken by executives and NED's. These enable a further opportunity for Board Executives to directly receive feedback from patients, relatives and carers. ***4.10, 4.20, 4.21, 4.21a, 5.22, 4.23, 4.40, 4,36, 4.36a,*** **GP3** The Integrated Business Plan includes details of stakeholder engagement in preparing the 5 year strategy. This included input from commissioners ***Ref: 3.16, 4.7*** **GP4** The Board has ensured that various communication methods will be deployed to ensure that key external stakeholders understand the messages in the IBP and will ensure that all identified hard to reach groups will be specifically contacted as part of the Trust consultation programme. There have been Health and Wellbeing Board engagement and links to IBP ***Ref:3.16, 4.9, 4.36*** **GP5** The Trust meets regularly with its commissioners as part of formal performance review meetings. These review meetings provide an opportunity for constructive discussion and agreement. ***Ref: 4.43, 4.44. 4.45***	**GP2 Action plan:** Following specific engagement activity (twice yearly), the Board will ensure that the Quality Committee receives a report detailing how the organisation will respond to the feedback received and to the feedback from 'hard to reach groups'. Completion date: 30th September 2012, Executive Lead: Chief Nurse **GP4 Action plan:** A programme of work is being developed to ensure that identified 'hard to reach' groups are contacted with regard to consultation and ongoing comment on Trust engagement. Completion date: 12th October 2012. Executive Lead: Chief Nurse	

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
None	Not applicable	

Board engagement and involvement

Section RAG rating: Amber/Green

4.2 Internal Stakeholders

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 A comprehensive staff engagement strategy has been agreed entitled 'Delivering Compassionate Excellence'. The Trust is participating in the national 'Listening into Action Programme' which involves pioneering staff conversations and feedback mechanisms. Full staff survey (11,000 staff) has been undertaken in 2011. Executive Quality Walkrounds regularly take place whereby executives have the opportunity to listen to staff views and respond. ***Ref: 4.12, 4.13, 4.20, 4.21, 4.21a, 4.22, 4.36b, 4.37, 4.41, 4.46*** **GP2** Staff have been involved in the development of the strategy for the Trust. New NHS Trust Values agreed following extensive consultation with staff and patients. ***Ref: 3.16, 4.36b*** **GP3** The Board ensures that staff understand the key priorities and how they contribute as individual staff members ***Ref: 4.14, 4.41, 4.36b*** **GP4** Various ways are used to celebrate services. The new staff recognition scheme has been approved by Trust Board and will be launched in August 2012. ***Ref: 4.13*** **GP5** The Board has communicated a clear set of values/behaviours and how staff that do not behave consistent with these values will be managed. Work is underway with Health Foundation on Values Based Recruitment. ***Ref: 4.13, 4.14, 4.41*** **GP6** There are processes in place to ensure staff are informed about major risks ***Ref: 3.15, 3.17, 3.21, 4.14, 4.16a, 4.16b*** **GP7** The Board can demonstrate that clinicians play a key role in management and decision-making within the Trust. The Trust has 7 divisions and each is led by a divisional director who is a clinician, a divisional general manager and a divisional nurse. These senior managers attend a range of committees including the Trust Management Executive. ***Ref:4.17, 4.19, 4.42***	**GP5 Action Plan:** A programme of work is being conducted to ensure that Trust values are incorporated into the recruitment process, the appraisal process and our performance management procedures. Completion date: 31st December 2012. Executive Lead: Director of Workforce.	

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments

None	Not applicable	

Section RAG rating: Green

Board engagement and involvement

4.3 Board profile and visibility

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice	Explanation if not complying with good practice
GP1 There is a structured programme of events/meetings that enable NEDs to engage with staff. ***Ref: 4.1, 4.12, 4.20, 4.21, 4.22, 2.23*** **GP2** There is a structured programme of meetings that increase the profile of key Board members. This includes joint working agreement with the University of Oxford. ***Ref: 4.21, 4.22 ,4.23, 4.24, 4.25, 4.35*** **GP3** Board members attend and/or present at high profile events including ***Ref: 4.6, 4.14, 4.20, 4.23, 4.35*** • FT consultation and plan public meetings with NEDs and Board • Chair and Chief Exec. meetings with senior external stakeholders (e.g. MPs, Local Authority leaders) • Formal and informal meetings between NEDs and PCT NEDs • Programme of NED/Executive Safety Walkabouts • NED attendance at Chief Executive Briefings • NEDs/Executive attendance at patient engagement events. *Please note: Further evidence will be available through the interview process* **GP4** NEDs routinely meet patients and carers ***Ref: 4.12, 4.20, 4.23*** **GP5** The Board ensures that its decision-making is transparent ***Ref: 4.27***		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
None	Not applicable	

Section RAG rating: Green

Board composition and commitment

4.4 Future engagement with FT Governors

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 The Board has a plan in place to form and manage the Council of Governors. A draft constitution has been developed for Board review in June 2012, prior to public consultation. ***Ref: 4.28a, 4.28a, 4.29, 4.30*** **GP2** The roles and responsibilities of the Council of Governors been outlined and considered by the Trust Board. ***Ref: 4.28a, 4.28a, 4.30*** **GP3** There are robust plans in place to elect, induct and develop governors once the Trust is authorised ***Ref: 4.29, 4.30*** **GP4** There are robust plans in place to show how the Board will communicate with and engage governors ***Ref: 4.29*** **GP5** The Board has a Membership Strategy which was agreed by the Board in January 2012. The Strategy sets out work to develop the Trust's membership and to communicate with members. The roles of members and benefits of membership are also referred to in the consultation document. ***Ref : 4.29, 4.1, 4.34*** **GP6** The Membership Strategy is being used as the basis of the public consultation document ***Ref:4.1, 4.29***	**Comment on GP3** : Training and induction programmes are to be developed in autumn 2012, with elections to the Council anticipated in February 2013. Executive lead: Director of Planning and Information	

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
None	Not applicable	

5. Board impact case studies

5. Board impact case studies

5.1 Case Study 1

Performance Issues in the area of quality	Title: Dignity and Nutrition Case Study
Brief description of issue	Following two reports that identified issues with standards of care for older people in hospitals, the Secretary of State for Health requested that the Care Quality Commission undertook a programme of work. A series of unannounced inspections initially in 100 NHS acute Trusts were conducted to review compliance against two of the Essential Standards for Quality and Safety. The two standards were related to Outcome 1 (Dignity) and Outcome 5 (Meeting nutritional needs). The project was called the DANI (Dignity and Nutrition Inspection) Programme. The John Radcliffe Hospital was inspected in May 2011 and was subject to improvement action on Outcome 1 and compliance action on Outcome 5. The CQC found that "on the whole staff were kind and respectful to patients" and that "patients felt their privacy was respected". However, the CQC recommended that improvements were made in order to maintain this in terms of information provision and timeliness of some interventions and to take improvement action to improve the systems of recording aspects of nutritional care and nutritional assessments, and to ensure that the support to patients to eat and drink was always provided in an appropriate and timely way. Following a programme of action the Trust was re-inspected in November 2011 and judged to be compliant with both standards.
Outline Board's understanding of the issue and how it arrived at this	Trust Board was briefed at the earliest opportunity (on 19th May 2011) prior to the arrival of the initial report. The Chief Nurse explained the requirements of the Essential Standards and outlined the verbal feedback and with the Medical Director, professionally advised the Board of the potential impact on patients and on the assessment of compliance. The Board considered the initial draft of the report (prior to following factual accuracy assessment) The Board then considered the final report and the action in (September 2011)
Outline the challenge / scrutiny process involved	The Chief Nurse led a programme of internal inspections (over 150 visits including out of hours and weekend visits) involving senior nurses and executive colleagues including the Chief Executive to look at each essential standard in practice. A number of the Non-Executive Directors also joined and observed the inspections. The documentary evidence of compliance was reviewed by the Medical Director, Chief Nurse and Director of Assurance.

Outline how the issue was resolved	The inspection programme was supported by an intense action plan which included meetings with Ward Sister/Charge Nurse, Matron, General Manager and Divisional Nurse. Nursing Standards have been refreshed and issued to all nursing staff and the Inspection Programme continues as a business as usual with spot checks from the corporate nursing team. The CQC conducted a follow up visit at the end of November 2011 to check that the actions had been addressed and recorded full compliance in meeting these standards.
Summarise the key learning points	Organisational understanding of assurance was weak and Board assurance of the quality of care did not adequately provide assurance of input measures such as the process of care. Nursing staff were focused on the delivery of care and some documentation fell short of the standard required.
Summarise the key improvements made to the Trust's governance arrangements directly as a result of the above	In addition to the programme of quality improvement described above the Trust supported the development of an evidence based assurance system (Heath Assure). An Assurance Strategy has also been developed to give direction to the importance of assurance as a discipline for all staff.

Section RAG rating: Green

5. Board impact case studies

5.2 Case Study 2

Performance issues in the area of finance	Title: Delivery of Additional CIPs in 2011/2
Brief description of issue	Development of additional CIP programme for 2011/2 after operational demand challenges encountered.
Outline Board's understanding of the issue and how it arrived at this	The Trust Board approved a 2011/2 Cost Improvement Programme as part of the budget setting process for 2011/2 in March 2011. At month 2 it became evident that a number of schemes were likely to be impeded by emerging operational pressures. The Board in private session on 7 July received a report on this (minute TBC94/11 applies).
Outline the challenge / scrutiny process involved	At its meeting on 7 July 2011 the Board requested that Trust Management team deliver details of options to deliver a remedial programme at the Board in Committee meeting on 21 July. These options had already been considered by the TME and the CIP executive sub-group. A presentation of the likely options was provided to Board in committee on 21 July. Implementation of the remedial programme, in particular the MARs proposal, was further considered at Board in committee in September 2011 and private Board meeting on 6 October (minutes TBC116/11 and TBC117/11 apply).
Outline how the issue was resolved	A range of additional savings proposals were delivered. Whilst the operational issues were delivered by management through the TME and CIP Executive, the Board requested and received a granular understanding of the remedial programme. The Board also received regular reports on the cause of the challenge, in particular the operational demand issues faced by the Trust.
Summarise the key learning points	1. Early notification of the issue 2. Granular explanation of the root causes and "triangulation" of the issue 3. Granular understanding of the key decisions and the processes used internally by management to determine the response. 4. A requirement for additional Board committee time to scrutinise these issues ; this occurred at a time of significant change in the organisation (NOC merger, EPR implementation etc.) and the urgent requirement for this issue to be addressed could, in other circumstances, "crowd out" Board discussions on other matters.
Summarise the key improvements made to the Trust's governance arrangements directly as a result of the above	The development of the Finance and Performance Committee will enable additional time to be devoted to complex interdependent performance issues such as this. Additional reporting of CIP challenges and a "continuous" CIP programme will also mitigate these risks.

5. Board impact case studies

5.3 Case Study 3

Organisational culture change	Title: WHO Surgical Checklist
Brief description of area of focus	A programme of work was implemented to improve full compliance with the WHO Surgical Safety Checklist across the Trust.
Outline reasons / rationale for why the Board wanted to focus on this area	The occurrence of two Never Events involving retained swabs in theatres within a time period of three months prompted a focus upon compliance with the WHO Surgical Safety Checklist. The Board recognised that whilst the WHO Surgical Safety Checklist may not in itself have prevented these adverse clinical incidents, attitudes towards the Checklist and performance in relation to it were likely to provide an important insight into wider safety culture and leadership in the theatre environment.
Outline the Board was assured that the plan/(s) in place were robust and realistic	The WHO Checklist, when followed correctly, is proven to reduce harm events such as retained swabs, therefore this was clearly an initiative the Board would endorse. The profile of the WHO Surgical Safety Checklist was heightened following the Never Events. A variety of methods were used to remind staff that compliance with the WHO Surgical Safety Checklist was an expectation of the Trust as employer, and not an optional part of working life in theatres. Specific elements of the work plan included: ▪ Discussion at Trust Management Executive ▪ Letters sent jointly by the Medical Director, Chief Nurse and Director of Clinical Services to all surgeons and anaesthetists reminding them of their obligations ▪ Large scale educational events with anaesthetists, theatre staff and surgeons (approximately 500 staff attended and heard powerful presentations developed and delivered by their peers - Executives attended these sessions to visibly demonstrate their engagement and leadership on the issue but struck a good balance between the 'top down' and 'bottom up' approach) ▪ Agreement of ground rules in relation to the use of the Checklist (specifically documentation and responsibilities) ▪ A rapid programme of spot audits to assess completion of the Checklist with personalised letters from the Executive team to those who had not been fully compliant copied to line managers (significant improvement demonstrated) ▪ Review of variants of the WHO Checklist in use and some standardisation ▪ Agreement of a revised programme of observational audit in order to move from spot checks to more formative and holistic

	assessment of safety performance ▪ Non-Executive Directors were briefed by the Executive in relation to the Never Events and this work with the WHO Checklist. Executives played a very visible leadership role.
Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture	A report to the Quality Committee in June 2012 updated the Board on recent compliance levels with completion of the WHO Surgical Safety Checklist. Medical records relating to 1,876 relevant interventions were examined within the Divisions to assess for the presence and completeness of the WHO Surgical Safety Checklist, in four separate rounds of spot checks. In late May 2012, fully completed checklists were found in respect of 87% of relevant interventions. The checklist was absent in just 2% of cases (7%, 11% and 5% in earlier rounds). Actions are ongoing to maintain and improve compliance with completion of the checklist including a commissioned external review of safety cultures in OUH theatres.

5. Board impact case studies

5.4 Case Study 4

Organisational strategy	**Title:** Relocation of Head and Neck Cancer Services
Brief description of area of focus	Relocation of Head and Neck Cancer Services from the West Wing of the John Radcliffe Hospital to the specialist Churchill Hospital Cancer Centre.
Outline reasons / rationale for why the Board wanted to focus on this area	This service transfer had been a component of the original business case for the PFI development on the Churchill site. However, through the Trust's operational management and planning processes, clinical governance, operational and financial concerns were raised. The Board, therefore, suspended the transfer of services in July 2011 and decided to undertake a review of both the strategic and the operational dimensions of the planned development.
Outline the Board was assured that the plan/(s) in place were robust and realistic	The Board's review took the form of an options appraisal exercise. The review included an extensive consultation exercise involving patients, patient representative groups, members of the public, staff, the Cancer Network, commissioners, other providers and the University. The identified options were appraised for overall strategic fit with the Trust's wider strategy and the strategies for cancer services in general and for head and neck cancer services in particular. The options were also judged against clinical governance, operational and financial criteria. In addition, the Board identified three specific issues on which it required specific further evidence/assurance. These related to the position of key external stakeholders on different aspects of the review.
Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture	The Board received the output of the options appraisal exercise. This included an evaluation of the identified options against the relevant criteria. The Board received the views of the key clinical and academic leaders of cancer services within the Trust and the University on the strategic fit of the three options. The Board considered the outcome of the consultation exercise and the views of the internal and external stakeholders. The Board also received the additional evidence/assurance on the three specific issues it had identified as requiring resolution before a final decision could be made.
Specifically explain how the NEDs were involved	The NEDS were involved in the original decision to review the plans (which was taken at a Trust Board). The review was considered and debated by the NEDs at both formal and informal Board meetings and workshops. At these meetings updates on the review were given, the key issues were debated and evidence was taken. The Chairman met and communicated with patient representatives. The outputs of the review were considered at a Trust Board meeting which made the decision on which of the options to adopt.