TRUST BOARD IN PUBLIC	Date: 28 November 2013 Agenda Item: 4.3
REPORT TITLE:	Board Governance Memorandum
EXECUTIVE SPONSOR:	Gillian Francis-Musanu Director of Corporate Affairs
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REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)	Board Seminars Oct 2012 Jan, June, October 2013

Purpose of the Report and Action Required:		**(√)**
The Board is asked to approve the final draft of the Board Governance Memorandum which forms part of the Board Governance Assurance Framework (BGAF).	**Approval**	√
	Discussion	
	Information	

Summary of Key Issues

There is a requirement for all aspirant Foundation Trusts to complete the Board Governance Memorandum. This is essentially an assessment of the Boards current capacity and capability which is supported by appropriate evidence. This process of self-assessment is then externally validated by an independent assessor.

Over the last year the Board has developed, reviewed and updated its BGAF Action Plan and RAG rated each section. The final outcome of the self-assessment has been transferred onto the attached template and will form part of the submission along with supporting documentary evidence to the independent supplier (Deloitte LLP) for review in December 2013.

Relationship to Trust Corporate Objectives & Assurance Framework:

Objective 4 – Become a sustainable effective organisation

Corporate Impact Assessment:

Legal and regulatory implications	The Trust is required to undertake a process of self-assessment of Board governance as a requirement along the journey to become authorised as a Foundation Trust.
Financial implications	Finance is included in the board case studies
Patient Experience/Engagement	Patient experience and engagement is an essential part of the BGAF self-assessment.
Risk & Performance Management	Risk and performance management is an essential part of the self-assessment process.
NHS Constitution/Equality & Diversity/Communication	Part of the self-assessment process is subject to Equality legislation and communication is also an essential part.

Attachments:

Board Governance Memorandum Template

[Surrey & Sussex Healthcare NHS Trust]

BGM Submission Document

[28th November 2013]

[Planned date to enter TDA approval process for submission to Monitor – September 2014]

Contents

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

Surrey and Sussex Healthcare NHS Trust (SaSH) employs just over 3,500 staff(headcount July 2013), providing a comprehensive range of emergency and non-emergency services to the residents of East Surrey, North-East West Sussex, and South Croydon, including the major towns of Crawley, Horsham, Reigate and Redhill.

Our Trust sits at the heart of a community of half a million people, as well as the thousands of passengers that pass through Gatwick Airport each day. We are responsible for East Surrey Hospital (ESH) in Redhill, where we provide the acute and complex hospital services. In addition, we reach out into the community to provide out-patient, diagnostic and less complex planned services closer to home. We provide services at Dorking and Caterham Dene Hospitals, and Oxted Health Centre, in Surrey, and at Crawley, Horsham and Queen Victoria Hospitals in West Sussex.

The Trust treats in excess of 65,000 in-patients and 245,000 out-patients a year. We also deliver 4,500 babies, administer 4,800 chemotherapy treatments and have 82,000 attendances to our Emergency Department.

The Trust Board has expressed its Vision for the services it will deliver; which is to provide: ***Safe, High Quality Healthcare which puts our Community First.***

Everything we do is underpinned by our Values which are:
Dignity & Respect: we value each person as an individual and will challenge disrespectful and inappropriate behaviour

One Team: we work together and have a 'can do' approach to all that we do recognising that we all add value with equal worth

Compassion: we respond with humanity and kindness and search for things we can do, however small; we do not wait to be asked, because we care

Safety & Quality: we take responsibility for our actions, decisions and behaviours in delivering Safe, High Quality Care

Strategic Objectives

As part of the strategic planning process, the Trust reviews and refines its strategic objectives and linked priorities on an annual basis. The Trust agreed that there would be four strategic objectives which are:

- Objective 1 - Deliver safe, high quality, co-ordinated care
- Objective 2 - Ensure patients are cared for and cared about
- Objective 3 - Work in partnership with our community
- Objective 4 - Become a sustainable effective organisation

Our Clinical Strategy is underpinned by five clinical strategy objectives which in turn feed into the delivery of the Trust's strategic objectives. The primary objective is:

- **Our Business:** Provide core acute services with a focus on emergency and trauma services that allow us to be a clinically and financially sustainable organisation.

The remaining four objectives are key enablers, these are:

- **Reputation:** Establish an excellent reputation through delivery of local and national expectations, commitment to academic training, research and innovation and becoming an employer of choice.
- **Outcomes:** Deliver good clinical and quality outcomes for our patients by improving patient safety, patient experience and clinical effectiveness.
- **Partnership:** Work with our NHS and commercial partners and engage with our community to deliver appropriate services and models of care and utilise clinical networks to ensure safe and sustainable services.
- **Productivity:** Improve productivity by adopting better ways of working, effective job planning, using intelligent information and benchmarking our performance.

The Trust aims to be the provider and employer of choice for the residents of East Surrey and North West Sussex. To achieve this we want to take advantage of the benefits of becoming a foundation trust. Our hospital is at the heart of our community and developing our plans for patient and public membership means that we can reach out too hard to reach groups, continue to develop our patient focus, clinical quality and responsiveness to ensure we can fully meet the expectations of service users, the local population and Commissioners.

Surrey and Sussex Healthcare NHS Trust is a district general hospital trust with recurring underlying income of £227m. It has no private finance arrangements and a relatively straightforward financial structure.

Modeling shows that the Trust can be realistically positioned to achieve the financial requirements for being a Foundation Trust in 2014/15.Performance against the financial risk rating (FRR) metrics in the forward financial base case plan sees the Trust scoring '4' from 2015/16 onwards. Downside scenarios describe risk that can be managed with achievable mitigation.

In 2013/14 the Trust is delivering its financial targets. The Trust delivered its financial plans in 2012/13 and crept a little ahead of its medium term financial plan with a better underlying financial position.

The Trust provides the following services:

Surgical	Medicine	Women & Children	Clinical Support Services
Breast Surgery	Emergency Care	Maternity	HSDU
Colorectal surgery	Critical Care	Gynaecology	Pathology
Dentistry & Orthodontics (including paediatrics)	Cardiology	Neonatology	Pharmacy
Ear, Nose & Throat	Chemotherapy	Paediatric medicine & surgery	Radiology
General Surgery	Clinical Haematology		Out-patients/Health Records
Gastroenterology/ Endoscopy	Clinical/Medical Oncology		
Ophthalmology	Dermatology		
Oral and Maxillofacial Surgery	Elderly Medicine		
Pain management	Endocrinology		
Trauma & Orthopaedics	End of Life Care		
Urology	General Medicine		
Vascular surgery	Neurology		
	Respiratory		
	Rheumatology		
	Thoracic Medicine		

Care Quality Commission (CQC) inspections in June 2012 resulted in the Trust being registered as “performing”. A subsequent unannounced inspection in February 2013 confirmed that the Trust met all the standards assessed during the visit and the Trust is currently registered without conditions.

On 24th October the CQC published Intelligent Monitoring Reports in line with the changes they are making to the way they inspect and regulate acute hospitals. Surrey and Sussex Healthcare NHS Trust was assessed as being in lowest risk category of Band 6 alongside 37 other Trusts across England.

Our ambitions for the future are inextricably linked to our shared vision and values working as one team to deliver safe high quality care for our patients. Our achievements to date have been rapidly driven by a proactive and competent Board with significant collective business skills and experience vital for transforming

and propelling the Trust to the next phase of its development. Our skilled and competent workforce has been at the heart of a climate of infrastructural and clinical changes that has improved the quality of patient care.

We recognise that our continued success is dependent on on-going investment in our workforce particularly if we are to maintain the strong foundations essential to become a high performing organisation. Leadership development at all levels and has been a key priority for the Trust from the Boardroom to the Ward and frontline staff which strengthens our ability to provide responsive, safe and effective care. However, we are not complacent about the challenges ahead and our workforce strategy and plans for leadership, workforce innovation and clinical skills development will not only ensure we retain our highly skilled workforce but continue to attract the brightest and the best.

The Trust is committed to involving and engaging local people in the development of future services and is already benefitting in this area from the experience and expertise within its user involvement activities.

A Patient Experience Forum has been established for a number for a number of years which is made of 15 lay members who work with the Trust to improve services. This group contributes to Trust projects, surveys, peer reviews and working groups. The Trust will engage further with patients and the public during our FT application by undertaking a public consultation and developing our membership strategy and the establishment of a Council of Governors. Once the Trust has become a foundation trust we will fully implement our membership strategy which will include providing regular member communications and utilise the public and patient governors to represent that population that we serve as well actively participating in providing feedback which will contribute to the development of local services.

Summary results

Summary results

Overview of BGM sections 1 to 3 inclusive

1. Board composition and commitment			
Ref	**Area**	**Self-Assessment rating**	**Any additional notes**
1.1	Board positions and size	Green	
1.2	Balance and calibre of Board members	Amber/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	Amber/Green	
2.3	Board induction, succession and contingency planning	Amber/Green	
2.4	Board member appraisal and personal development	Amber	
3. Board insight and foresight			
3.1	Board performance reporting	Amber	
3.2	Efficiency and Productivity	Green	
3.3	Environmental and strategic focus	Amber/Green	

3.4	Quality of Board papers and timeliness of information	Green	

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	Green	
4.3	Board profile and visibility	Green	
4.4	Future engagement with FT Governors	Amber/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

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

1.1 Board positions and size

GP1. The size of the Board (including voting and non-voting members) Is appropriate for the requirements of the business. **GP2.** All voting and non voting positions are substantively filled. **GP3.** The Board has a Senior Independent Director (SID) in place approved at Trust Board in 2012. **GP4.** The Board has a substantive Director of Corporate Affairs/Company Secretary who has been in post since 1.10.12. **GP5.** It is clear who on the Board is entitled to vote **GP6**. There are 15 members of the Board. 11 members are entitled to vote. Of these 6 are non executive directors (NEDs) (including the chair) and 5 executive directors. 4 directors are non-voting). **GP7.** The terms of office of xx NEDs are staggered so not all are due to for re-appointment within a short space of time.		

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

1.2 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 (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1. Due consideration has been given to the balance of skills, experience and knowledge amongst Board members. **GP2.** In selecting Board members the Chair and CEO have given due consideration to the various qualities that are essential for the person to be effective in their board role. **GP3.** The Board has a blend of NEDs from the public, private and voluntary sectors. **GP4.** Recruitment to Board posts has been in line with the Equality Act 2010. **GP5.** The Board has given consideration to the appointment of at least one NED with a clinical healthcare background and will pursuing appointment in the last quarter of 2014. **GP6.** There is an appropriate balance between members that are new to the Board and those that have served for longer. **GP7.** The majority of the Board are experienced Board members. **GP8.** The Chair of the Board has previous recent experience of successfully leading large and complex organisations. **GP9**. The Chair of the Board has previous non-executive director experience. **GP10.** The Chairman of the Audit Committee is a Chartered Accountant with recent and relevant financial experience.	**GP1**. A talent management and skills audit review is due to be conducted as part of the board development programme during 14/15. **GP5.** The Board is considering the possibility of recruiting a NED with a clinical healthcare background. A draft job description is in place.	

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 (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1. Board members have attendance recorded at all formal Board and sub-Committee meetings. This is presented to the board for review on an annual basis. **GP2.** Board members have discussed and acknowledged the time commitment required for the FT process and Board members have committed to set aside this time. The Trust has an FT project board and an update on progress is reported at each board meeting. **GP3.** The Board has a Code of Conduct contained within the Rules of Procedure which clearly describes the behaviours expected of Board members. Compliance with the code of conduct is monitored by the Chair and reviewed as part of each Board members annual appraisal.	**GP2.** A programme of FT seminars and education sessions have been developed for the Board and the whole board development programme will also include FT preparation modules.	

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	

2. Board evaluation, development and learning

Board evaluation, development and learning

Section RAG rating:

Amber/Green

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 (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1. Informal independent evaluation of the Board was undertaken in April 2012. As part of the formal Board development programme an evaluation of the Board was undertaken in July/Aug 2013 as the first stage. This included board, staff and stakeholder surveys, focus group, Board and committee observations, document review and 1:1 Board interviews. A workshop to review the results took place in September 2013. A number of changes/developments have taken place as a result; some of which are currently being implemented. **GP2.** The Board has had an independent evaluation of its effectiveness and committee structure in July/August 2013 by a 3rd party that has a good track record in undertaking Board effectiveness evaluations. **GP3.** In undertaking the formal evaluation, the Board has used an approach that includes various evaluation methods including the perspective of a representative sample of staff and key external stakeholders on whether or not they perceive the Board to be effective. **GP4.** The focus of the evaluation considered: The knowledge, experience and skills required to govern the organisation, how effectively meetings are chaired, the effectiveness of challenge provided by Board members, role clarity between the Chair and CEO, the balance of the board agenda and the quality of relationships between board members.	**GP1**. Phase one of the board development programme has taken place with phase two due to commence in January 2014.	

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

2.2 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 development programme in place which seeks to address the findings of the Board evaluation and includes: Understanding what FT status means, development specific to the Trusts FT application and reflecting on the effectiveness of the Board and its supporting governance arrangements. **GP2.** The Board has an understanding of what FT status means, 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. **GP3.** The Board is engaged in the development of the IBP and the LTFM and self-assessing the Trusts quality governance arrangements using Monitor's Quality Governance Framework. **GP4.** The development programme includes time for the Board to reflect on its effectiveness, the focus and balance of Board time, the quality and value of the Boards contribution, the effectiveness of Board sub-committees and the assurance process. **GP5.** A development programme is in place which has protected time for undertaking this process and is well attended. **GP6.** The Board will begin to consider and scope the potential development needs of the Board post authorisation. A programme of seminars will be developed to cater for these needs.	**GP6.** Plans will be developed to scope the development needs of the Board post authorisation. By Feb 14.	

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. **GP2.** Induction for Board members is conducted on a timely basis. **GP3.** New Board members have received a comprehensive corporate induction. **GP4**. Deputy positions for the Chair and CEO have been formally designated and minuted. **GP5.** The Board has considered the skills it requires to govern the organisation effectively in the future. NED appointments are staggered. There is a need for succession plans for executive directors.	GP5. Development of Board succession plans for the executive.	

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

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. The Chair and NEDs are appraised annually in line with the TDA guidelines. The CEO is appraised annually by the Chair and Executives are appraised annually by the CEO. Performance against objectives is reviewed by the Remuneration Committee. **GP2.** There is a comprehensive appraisal process in place to evaluate the effectiveness of the Chair by 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 and are included in the appraisal process. **GP4.** All Executives have personal development plans as part of the appraisal process. **GP5.** There are processes in place to ensure the development of Executive Directors as Corporate Directors as part of their development plans and the Board development programme. **GP6**. As a result of the appraisal and personal development programme, Board members can evidence improvements that they have made in the quality of their contribution at Board level. **GP7**. A plan to ensure the involvement of Governors in the Chair and NED appraisal process will be undertaken prior to the Trust being authorised as an FT.	**GP3.** 360degree feedback process and developing the top team will be included as part of the board development programme. **GP7**. An action plan to ensure the involvement of Governors in the Chair and NED appraisal process will be developed prior to the Trust being authorised as an FT. July 2014	

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

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 performance, quality and financial metrics that are relevant to the Board given the context within which it is operating. **GP2.** The Board receives a fully integrated monthly performance report which includes the following domains, access, outcomes, quality governance, workforce and finance. **GP3.** Key committee minutes are provided and reported to the Board by the non-executive chair of that committee. **GP4**. The Board regularly discusses the key risks facing the Trust and plans to manage or mitigate them. **GP5**. An action log is taken at Board meetings and progress against actions is actively monitored and reported to the Board.	**GP2**. Action is being taken to give greater focus on service lines, triangulated information and escalation of divisional issues to the Board. **GP2**. Further triangulation of key quality information (complaints, incidents, claims, etc) is being developed for reporting to the Board.	

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

3.2 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 Board is assured that there is a robust process for prospectively assessing any risks to care quality and the potential subsequent impact on the wider health and social care community of implementing CIPs. The process required Medical Director and Chief Nurse sign-off to all CIPs to ensure that patient safety is not compromised. **GP2**. The Board can provide examples of CIPs that have been rejected or modified due to their potential impact on patient safety. GP3. The Board receives regular reports on financial performance which are RAG rated and includes progress on savings programme. The Finance and Workforce Board sub-committee (FWC) also receives regular financial information and provides updates to the Board. **GP4.** There is a process in place to monitor the ongoing risks to care quality for each scheme once a scheme has been implemented by reviewing KPI trends. These indicators are reviewed at the monthly divisional performance management meetings. Post implementation reviews are conducted by the FWC on major schemes		

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 (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1. The Chief Executive presents a report to every Board meeting detailing important changes or issues in the external environment. The impact on strategic direction is debated and updates are made to the Trusts Board Assurance Framework where necessary. **GP2.** The Board reviews lessons learnt from incidents and enquiries and has considered the impact upon its self. Actions arising are progressed as part of the serious incident process. **GP3.** The Board has in the past conducted an external stakeholder mapping exercise to inform the development of the IBP. **GP4.** In developing the IBP the Board has explored market opportunities and threats in relation to the services it provides. This will continue to be updated as the IBP is refreshed. **GP5.** The Board has an agreed set of corporate objectives that enable the board to monitor progress against implementing its vision and strategy for the Trust. Performance against objectives is reviewed at divisional performance meetings with the Executive Team and progress is reported to the Board through the Integrated Performance Report. **GP6**. The Board's annual planning programme of work sets time for the consideration of the LTFM including risks and downside scenario planning. **GP7**. Strategic risks to the Trust are actively monitored though the Board Assurance Framework.		

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

3.4 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 has actively considered the timing of Board and committee meetings. **GP2.** A timetable for sending out papers to members is in place and adhered to. **GP3**. Each paper has a clear front sheet and clearly states what the Board is being asked to do. GP4. Board members have access to in-month flash reports to demonstrate performance. **GP5.** Board papers outline the decisions that Executive Directors have made or propose. Business Cases provided to the Board show options, rationale for choice including the degree of scrutiny that the proposal has already been through. **GP6.** Through the Audit Committee the Board receives updates on data quality (e.g. Information Governance Toolkit scores). These updates include internal assurance reports which are underpinned by a programme of clinical and internal/audit to test the controls in place. **GP7.** The Board requests and receives a range of reports on data quality of performance metrics including: Reports to Audit Committee on clinical audit Reports to Safety & Quality Committee Reports to the Board on Safeguarding		

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	

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. The Board will be developing a comprehensive stakeholder engagement plan as part of its overarching communication strategy which will clearly describe the Trusts key and emerging external stakeholder. **GP2**. A variety of methods are used by the Trust to enable the Board and senior management teams to listen to the views of patients, carers, commissioners and the wider public including hard to reach groups. **GP3.** The Integrated Business Plan will detail stakeholder engagement in preparing the 5 year strategy including input from commissioners. **GP4**. The Board will ensure that various communications methods will be deployed to ensure that key stakeholders understand the messages in the IBP and will ensure hard to reach groups will be contacted. **GP5**. The Trust meets regularly with its commissioners as part of formal performance review meetings and the Local Transformation Board and has developed constructive and effective relationships with its key stakeholders including lead commissioners.	**GP1 Action Plan.** Development of stakeholder engagement plan as part of communication strategy.	

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

4.2 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. The Trust uses a variety of methods to listen to and engage staff including a staff engagement strategy. During 2013 we have been working with GE Healthcare in engaging, developing and transforming clinical leaders as part of organisational development in additional to regular all staff and senior leaders meetings. Executives and NEDs also do quality walks with the opportunity to speak and listen to staff. **GP2**. Staff have and continue to be involved in the development of the strategy for the Trust. A wide range of staff have also been involved in developing the new goals and values of the Trust. **GP3.** The Trust uses of variety of ways to ensure that staff understand the Trusts key priorities and how they contribute as individual staff members to delivering these priorities. **GP4.** The Trust uses various ways to celebrate services that have an excellent reputation and acknowledge staff that have made an outstanding contribution to patient care. **GP6.** There are processes in place to ensure all staff are informed about major risks that might impact on patients, staff and the Trust's reputation. **GP7.** The Board can demonstrate that clinicians play a key role in management and decision making within the Trust.		

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 (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1. There are a number of events and meetings that enable NEDs to engage with staff. **GP2.** There are a number of meetings and events that increase the profile of key Board members, in particular the Chair and CEO amongst external stakeholders. **GP3.** Board members attend and/or present at high profile events. **GP4.** As part of the programme of Quality walks, NEDs have the opportunity to meet patients and carers. **GP5**. The Board ensures that decision making is transparent.		

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 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 developed a plan to form a Council of Governors which is representative of the staff and community served by the Trust and partner organisations. The Board has considered the size of the Council of Governors to ensure it is not unwieldy and how the Council will be structured in order to discharge its statutory duties. **GP2.** There is a statement in place that sets out the roles and responsibilities of the Council of Governors and how these are distinct from, but complementary to the roles and responsibilities of the Board. **GP3.** Robust plans are being developed to elect, induct and develop governors once the Trust is authorised. **GP4.** Plans are being developed to show how the Board will communicate with and engage governors, in particular, in the area of strategy development, service change and quality issues. **GP5.** The Board has a Membership strategy that describes the number of members required, how that target will be reached, how the Trust will ensure that its membership is representative and how membership will be maintained. **GP6.** The Board has a strategy for engaging and consulting with its membership.	**GP3**. Action Plan being developed to elect, induct and develop governors once the Trust is authorised. **GP4.** Plans are being developed to show how the Board will communicate with and engage governors.	

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: Improving Patient Experience
Brief description of issue	Real-time patient and carer feedback that go beyond the annual patient survey allowing the Trust to use more granular and direct feedback about departments and services which the Trust can use to triangulate with other qualitative forms of feedback will be used to improve quality of services and the experience of patients.
Outline Board's understanding of the issue and how it arrived at this	The results of our 2012 inpatient survey showed a significant improvement in patient views about their treatment and experience compared to the 2011 survey. In 2011 we were in the bottom 20% of trusts for six out of the ten categories. In 2012 we scored in the same range as the majority of trusts for all ten categories. However, the Board wanted to go beyond the general feedback about services and be able to drill down to understand the experience of patients at the level of services, departments and wards.
Outline the challenge / scrutiny process involved	After analyzing services provided by a range of providers, a pilot was undertaken with a leading provider of customer satisfaction for corporate organisations where patients are asked as they leave hospital or soon after to answer 20 questions about their stay in hospital or use of a department of services. The impact of the pilot was reviewed and following its success the pilot the programme was rolled out in phases to specific wards and departments and branded "Your Care Matters"
Outline how the issue was resolved	"Your Care Matters" enables our wards, departments and individual members of staff the opportunity to receive personal feedback that allows the Trust to make specific improvements to the service, environment and quality of service or celebrate when staff have made a real difference to a patient's experience. This programme gives much more detailed information than the annual patient surveys and has supported the implementation of development of the Friends and Family Test and allows the Board to hear the voice of the patient giving real-time feedback about services.
Summarise the key learning points	Today, patients have the opportunity to voice their concerns or praise the treatment they receive in the NHS like never before. National websites like NHS Choices and Patient Opinion provide feedback and we continue to use both sources as a means of improving our services. We have a 'live-feed' from the Patient Opinion site on the homepage of our website so patients can see what others are saying about our services. However, the implementation of 'Your Care Matters' patient feedback mechanism gives the Board

	significant insight to the views of patients about services and the opportunity to make changes that will have a direct impact on improving quality of services and the experience of patients.
Summarise the key improvements made to the Trust's governance arrangements directly as a result of the above	Your care matters enables the organisation to be more responsive to the needs of patients. Triangulated with other forms of feedback such as Patient Opinion, Patient surveys and complaints put the Trust in a very strong position.

5. Board impact case studies

5.2 Case Study 2

Performance issues in the area of finance	Title: Sign off a “capped” 2012/13 Acute Services Contract Sign off a “capped” 2012/13 Acute Services Contract
Brief description of issue	A pan-Sussex arrangement brokered by the SHA CEO to limit risk had led to a formal Contract that capped payments by CCGs to Trusts, while also agreeing to the provision of £19.0m of transitional support to the Trust as part of a 2 year recovery plan. To further complicate the position the Board needed to sign off the Tripartite Formal Agreement describing the Trust’s FT journey, and which although it didn’t need a PCT signature, needed their support. The key decision was that the Board needed to confirm whether the Trust should sign the Contract at its meeting on 26 April 2012, but it also needed to set out what else it wanted the Trust to provide further assurance about minimising financial risk.
Outline Board’s understanding of the issue and how it arrived at this	Briefing and reporting, including at additional extraordinary Board meetings, between January and April had kept the Board appraised. However, the speed [and nature] of the process had meant that it was difficult to ensure the Board were fully up to speed at all points.
Outline the challenge / scrutiny process involved	The Board were uncomfortable at the level of risk being set against the Trust, ostensibly in return for agreement to a recovery plan (that had been through process). The scrutiny around the budget and recovery plan had been significant (the CFO had provided extensive and comprehensive papers at earlier meetings and the board had spent some time going through). The challenge was around the process that had led to this point and to secure the information necessary to weigh up the position so that a clear Board decision could be made and the discussion was about the strategy from here.
Outline how the issue was resolved	The decision was reached through a coherent discussion about the pro’s and con’s, taking into account the “political” (small “p”) climate and intelligence from the CEO and the Chair. The meeting was managed to a) obtain full owned consensus and b) be practical about follow-on action. The decision was to sign, noting that an appendix included in the contract provided some, but incomplete, protection and the main ongoing mitigation was that the Trust needed to articulate its “financial distress” [part of the wording] clearly and effectively early on.

Summarise the key learning points	This is, perhaps, one of the best examples of the Board acting as a Unitary Board in the last 2 years. The process included good grounding in the context (the previous effort that had allowed the Board to understand the financial budget and recovery plan) and a difficult, but well managed Board meeting that involved all members contributing and agreeing the output jointly. The particular nuance was the “politics”, where intelligence and counsel from the CEO and Chair added a flavour which was essential to mix in.
Summarise the key improvements made to the Trust’s governance arrangements directly as a result of the above	Subtle, but important: 1) Part of the driver for the partnership report presented to the Finance and Workforce Committee in its Part 2 session allows for commercial but also NHS “political” issues to be communicated/discussed with NEDs; 2) Acceptance of the need (when justified) for flexibility by the Board about additional Board meetings – we use extraordinary meetings to discuss money and contractual aspects.

5. Board impact case studies

5.3 Case Study 3

Organisational culture change	Title: Developing Clinical Leadership
Brief description of area of focus	Along the path towards authorisation as a Foundation Trust SaSH recognised the need to become a more clinically-led organisation. Our efforts thus far have not resulted in any material change in the day to day practical leadership of the Trust.
Outline reasons / rationale for why the Board wanted to focus on this area	A new clinician-led structure is in place, but behaviours and support structures to enable a more devolved form of management are still emerging, and are essential to shifting to a more accountable, clinically-led culture with earned autonomy. The Board was conscious that a relatively small proportion of the Clinical workforce appear to be fully engaged in the leadership agenda and there is limited succession planning.
Outline the Board was assured that the plan/(s) in place were robust and realistic	Working with the NHS Leadership Academy the Trust underwent a robust selection process for a suitable organisation to develop and lead the programme in partnership with the trust. GE Healthcare was selected to lead the programme. The goals and outcomes of the programme are to help SaSH realise its ambition of successful achievement of FT status and become a clinically led organisation by: • Promoting a continued upward trajectory toward a highly engaged workforce, committed to each other and their patients • Shaping an environment and devolving accountability for clinical leaders who drive strategy formation and deliver service change • Encouraging and enabling the emergence of behaviours and more mature support structures, that will enable this more devolved management • Understanding and demonstrating behaviours that are congruent with values across the organisation at all levels • Developing an executive team culture that allows for timely development review and implementation of engagement strategies • Developing shared understanding and commitment between the executives and clinical leaders.
Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture	Organisations with engaged staff deliver better patient experience, fewer errors, lower infection and mortality rates, stronger financial management, higher staff morale and motivation and less absenteeism and stress. Alignment and improved understanding across the Leadership team supports the Foundation Trust application process and improves the organisation's results. Clinical Leadership will aid in executing this business case, while values, goals and objectives, project

	management and change leadership are enablers to Clinical Leadership. The Executive team, clinical chiefs, clinical leaders and a wide range of staff have developed goals, values and behaviours which are due to be embedded in the organisation and will deliver the desired changes in culture. The long term outcomes post-implementation & integration have been identified as: • Improved engagement scores on staff survey • Improved scores on GE Leadership capability assessment • Better patient experience • Better patient outcomes

5. Board impact case studies

5.4 Case Study 4

Organisational strategy	Title: Joint Working to Reduce Non-elective Activity
Brief description of area of focus	The winter bed strategy is to ensure that sufficient bed capacity is in place to support delivery of high quality care over the winter period through the internal Urgent care and Patient Flow programme and the work under the direction of the local transformation board to commission community beds.
Outline reasons / rationale for why the Board wanted to focus on this area	The Trusts proposed future bed strategy for achieving a reasonable level of bed occupancy whilst having sufficient capacity to manage peak demand. Insufficient bed capacity would result in bed occupancy consistently above the 90% recommended level which in turn impacts adversely patient experience. Right size speciality bed base to support patient flow and quality of care • Flex capacity to meet peak winter demand and dedicated decant capacity • Support effective management of Infections • Support growth of elective and patient activity Bed Modelling showed a winter shortfall of 140 beds • This was partly mitigated by internal efficiencies of 30-35 beds being managed through the Operational Improvement Programme • Without further action this leaves a net deficit of 105 – 110 beds

Outline the Board was assured that the plan/(s) in place were robust and realistic	Extensive external discussions and negotiation by the Chief Executive and Chief Operating Officer with key stakeholders (commissioners, community providers, social care and other providers) with the Local Transformation Board. Discussion took place at the July and August private board meetings where a bed strategy and capacity plan with a number of options were presented to give ongoing assurance to the Board which included SaSH main urgent care actions: • Operational improvement programme is extensive and brings in real 7 day medical cover, electronic work management and a new model for the site team, with more senior nursing management. • Emergency Department: direct admitting rights, new see & treat, eliminate triage; • Medical Rotas: Expanded junior doctors rota in place, consultant 7 day rotas for autumn, AMU rota changes (more availability) • Site management: New model for site team (senior nurse now in post, remaining structure by October), revised protocols (including streaming to specialist beds) • Patient management: professional standards fully implemented (EDD, rounding, MDT activity etc), protocol based pathways with standard management plans, screening tool (extended stay warning), patient transport availability. • Electronic work management: electronic bed management system • Clinical support services: 7 day therapies (funded, being implemented), 7 day availability of diagnostics, phlebotomist working and TTO efficiency. • Develop integrated health services across our community with our partners. The Community beds are also to provide sub-acute care in the Community and reducing acute beds. This in turn will help release funding that enables our partners to invest in local services closer to home
Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture	Evidence of significantly improved joint planning and co-operation by key partners along with confirmation that the phased provision of community assured the board that the plan is being implemented and will deliver reduced non-elective activity and improve patient flow.
Specifically explain how the NEDs were involved	The plans were presented by the Executive and their robustness was tested and challenged by the Board. Following the first report presented in July, the NEDs requested that a range of options be brought back to the board and that regular updates on progress be given and reported to the board on a monthly basis.