Report to: Trust Board 22 July 2012

Title	NHS Foundation Trust update report
Sponsoring Executive Director	Julia Clarke – Director of Compliance and Risk Management
Author(s)	Tony Holt – FT Programme Manager
Purpose	Update on the Trusts progress towards FT authorisation

Executive summary

- The Trust remains broadly on schedule to deliver the key components included within the Tripartite Formal Agreement (TFA) with the SHA and DH
- The Assurance Compliance Unit (ACU) has been issued with the monthly performance monitoring which will be reported to the SHA via the Provider Management Regime (PMR) for the period of June 2012:
  - Financial Risk Rating - **Amber**
  - Governance Risk Rating - **Amber/Red**

  Performance issues continue to be escalated through the PMR framework and discussions are regular and ongoing between the CEO and SHA regarding the Trust's plans to achieve and sustain compliance against all measures within the PMR from July 2012. The Board should note that the ACU has been advised that actions detailed in the Learning Disabilities Strategy will not be fully implemented until December 2012
- FT workstream RAG ratings:
  - Financial Governance - **Amber**
  - Quality Governance – **Green**
  - Business Development - **Amber**
  - Workforce - **Green**
  - Governance - **Green**
- The SHA has notified the Trust that a further period of formal public consultation does not need to be undertaken as the HOSC consider the Trust's continuing and future engagement strategy is sufficient
- HDD stage 1 formally commenced 18 July
- The total FT membership stands at 12,803 members (7344 public and 5459 staff members)
- The FT Project Plan shown at Appendix A
- The FT Risk Log shown at Appendix B – the Finance capacity risk has been increased to from 16 to 20
- A Board Capacity & Capability review was completed earlier in the year and is attached at Appendix C
- A baseline assessment against the Board Governance Assurance Framework (BGAF), was undertaken and has been updated at Appendix D, prior to external validation in October
- Appendix E covers items discussed at the Board Development Day on 16 July 2012

Related SaTH objectives	SaTH Sub-objectives
FS - Financial Strength: We will use our resources wisely and create surpluses to invest in quality	FS1. Develop and implement sustainable clinical strategies
LG - Learning and Growth We will develop our staff and internal processes to sustain our ability to change and improve	LG3. Devolve responsibility and accountability and cooperate with each other

Risk and assurance issues	Risks agreed in Tri-partite Formal Agreement Assurance through monthly Provider Management Report
Equality and diversity issues	None
Legal and regulatory issues	All NHS Trusts must become authorised as NHS Foundation Trusts by April 2014

Action required by the Trust Board

Trust Board Members are asked to:

- **DISCUSS** and **APPROVE** the content of the NHS Foundation Trust update report
- **APPROVE** the Board capacity & capability/BGM action plans deadlines and progress

The Shrewsbury and Telford Hospital NHS

NHS Trust

NHS Foundation Trust Development Programme Summary update report

Report to:	Trust Board
Date:	26 July 2012
Lead:	Julia Clarke
Overall Status:	**AMBER/RED**

| External measures | Provider Management Regime (period of June 2012) | GRR | AMBER/RED | ↔ |
| | | FRR | AMBER | ↑ |

Internal measures

FT Workstreams

Financial Governance	AMBER	↔
Quality Governance	GREEN	↔
Business Development	AMBER	↔
Workforce	GREEN	↔
Governance	GREEN	↔

FT Membership	This month		Last month
Public	7344	↑	7321
Staff	5459	↓	5487

The Shrewsbury and Telford Hospital NHS

NHS Foundation Trust Development Programme Summary update report

Attachment xx

Overview of activity for past month	Performance issues have been escalated through the PMR framework and the most recent discussions between the Trust Board and SHA Board have focused on the delivery of the RTT admitted target, and sustaining the RTT non admitted target. The SHA has requested firm assurance that plans to achieve and sustain both targets are implemented more quickly to ensure all specialities achieve compliance as soon as possible. The Trust has revised its financial plan for 2012/13, profiling a £1.9m surplus (0.6% of turnover) within the latest iteration of the LTFM. Within the revised plan, a deficit budget is forecast to July 2012, where after an in-month surplus is then forecast until the end of the financial year. The forecast FRR for the year is therefore marginally below the authorisable threshold of 3.

The TFA Risk in relation to 'Capacity to manage the impact of consolidation of financial management and operational performance whilst starting the FT pipeline' has been increased to 20 pending the imminent departure of 2/3 of the senior finance team

Milestones included within the TFA for this period relate to the commencement of a Historic Due Diligence (HDD) exercise with our assessment partner Grant Thornton. Stage 1 of the process focuses on financial reporting procedures and a comprehensive response to the information requested by GT was successfully completed by the 6 July deadline. Interviews with Directors and senior managers commenced on 18 July, with analysis and documentation review to follow - the final report and action plan is expected on 8 August.

We continue to periodically communicate our progress towards FT, together with associated the risks and issues, to all stakeholders via, HEC, ODG and TNCC in addition to staff and public member newsletters, the intranet and public website. The next Stakeholder Conference is scheduled for Thursday 13 September 2012 at PRH.

A process for CIP QIAs was agreed at the BDD on 16 July |
| **Key issues/ items for forthcoming period:** | ▪ Further to the baseline self assessment of the Board Governance Memorandum (BGM), an action plan has been constructed to address areas of development. Mandatory independent assessment against the Board Governance Assurance Framework (BGAF) by Ernst & Young (EY) will commence in October 2012

▪ Evidence collection and validation by Board members continues apace to assure the Quality Governance Framework (QGF) prior to independent assessment in October 2012

▪ A revised LTFM is required by 17 August

▪ Estates, IT, Clinical Service and Workforce Strategies are required as strong drafts for BDD on 3 September and to submit to relevant SHA Department for sign-off prior to Board approval |
| **Policy and guidance update** | ▪ In June, Monitor published an updated *Model Core Constitution* to reflect legislative changes to be implemented by the Health and Social Care Act 2012, at a date yet to be determined. Changes have been tracked so amendments can easily be seen at a glance. Some presentational amendments have also been made, most notably to insert the Notes to the Model Core Constitution as footnotes. Monitor decided to publish the new constitution now - ahead of the formal commencement of the relevant sections of the 2012 Act - to meet high levels of interest expressed in seeing a revised document and to help trust boards of directors and councils of governors to prepare for the new legal arrangements. Therefore, note that this revised constitution for guidance purposes, although the Trust's draft Constitution has been updated to reflect these changes. The revised document is available from the Monitor website here: http://www.monitor-nhsft.gov.uk/sites/default/files/Model%20Core%20Constitution%20with%20HSC%20Act%202012%20amendments%20June%202012%20(2).docx

▪ On 12 June, Monitor published a *Best practice guide for boards of directors* which identifies the key factors for establishing strong director-governor interaction within foundation trusts. Aimed at existing and aspirant FTs, the document sets out best practice from foundation trusts rated by peers and other stakeholder groups as being strong in the area of director-governor interaction. The document is available from the Monitor website here: http://www.monitor-nhsft.gov.uk/sites/default/files/Monitor%20-%20Director%20govenor%20interaction%20report%20June%202012_0.pdf

▪ On 19 June, Monitor published *Strategic Options for Costing*. Monitor commissioned PwC to identify |

NHS Foundation Trust Development Programme Summary update report
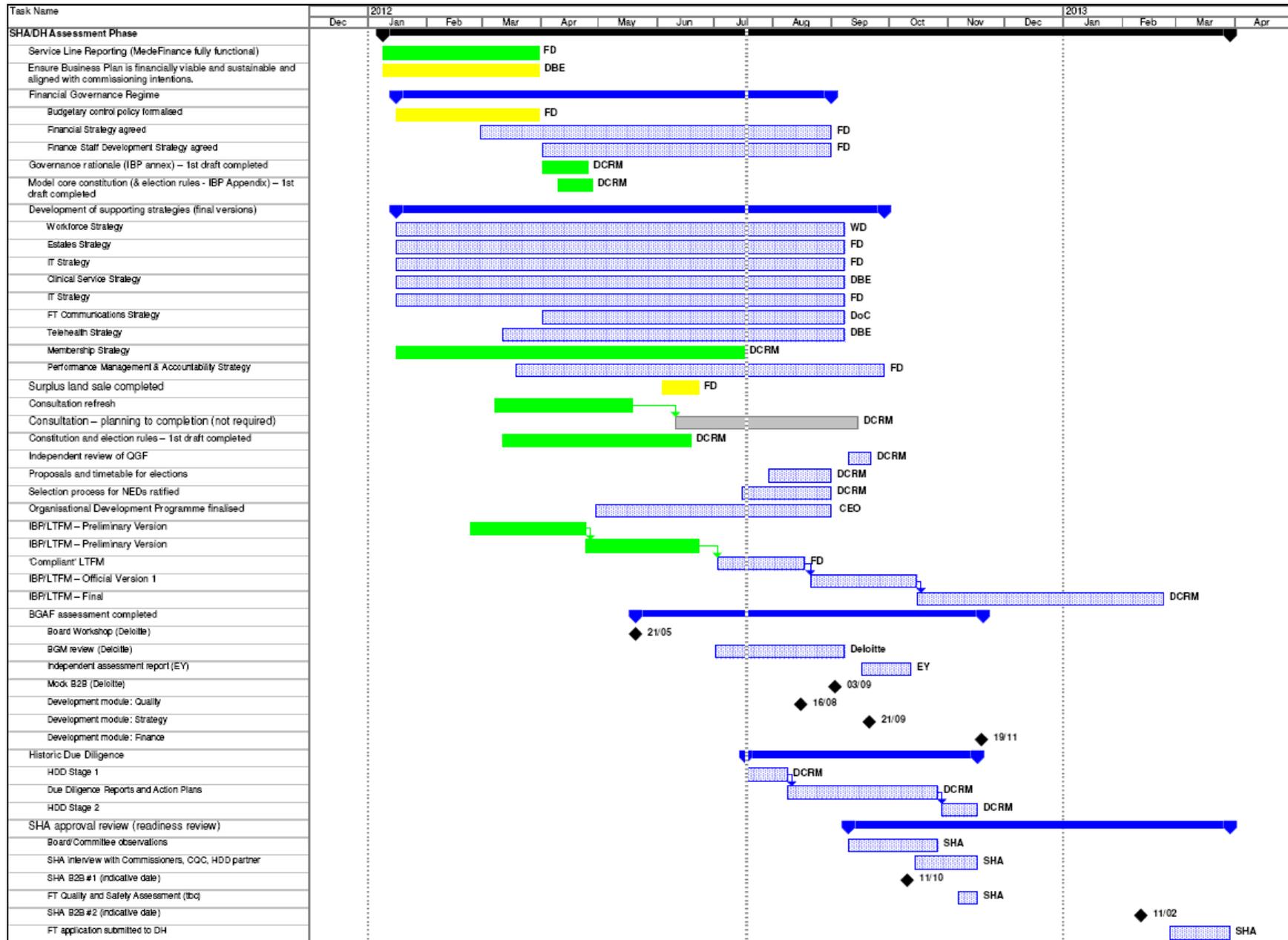
	and assess options to improve the cost data from acute providers that is used to set prices. PwC's recommendation, based on this assessment, is that Monitor should collect patient-level cost data from providers that can meet a mandated cost allocation methodology and assurance requirements. The full document is available from the Monitor website here: http://www.monitor-nhsft.gov.uk/sites/default/files/Strategic%20options%20for%20costing%20(full%20report)%20-%20190612_0.pdf ■ On 28 June, Monitor published two independent reports by its internal auditor KPMG, *Learning and Implications from Peterborough and Stamford NHS Foundation Trust (FT)* and *Learning and Implications from University Hospitals Morecambe Bay NHS Foundation Trust (FT)*. Monitor is already applying the lessons learned to its assessment and compliance frameworks and will also be consulting on two adjustments (see below) to the assessment framework based on recommendations in the Morecambe Bay report. Management responses to both reports are available from the Monitor website: http://www.monitor-nhsft.gov.uk/home/browse-category/reports-nhs-foundation-trusts/reports-following-regulatory-action/management-re-0 http://www.monitor-nhsft.gov.uk/home/browse-category/reports-nhs-foundation-trusts/reports-following-regulatory-action/management-re
	■ Linked to the above publications (28 June), Monitor has launched an 8-week consultation on its proposals to make changes to Monitor's sections of the publication *Applying for NHS Foundation Trust Status: Guide for Applicants ('the Guide')*, following a recent internal audit review into the events at University Hospitals Morecambe Bay NHS Foundation Trust. Monitor is keen to hear views on the detail of the proposals, with responses invited to consultation@monitor-nhsft.gov.uk. In light of the small number of areas for consultation, the consultation period will run for eight weeks, closing at 5pm on 5 September 2012. Monitor is aiming to publish an amended Guide for Applicants in autumn 2012. This consultation document sets out proposals to make changes to Monitor's sections of the Guide. The changes are being proposed following a recent internal audit review into the events at Morecambe Bay NHSFT. This consultation includes the following proposals: 1. Introducing the ability for Monitor to require applicant trusts to commission external reviews into service performance or governance arrangements in cases where there is insufficient evidence to conclude that the level of concern is within the tolerance for authorisation; *and* 2. The requirement for applicants to submit a letter of representation at the end of Monitor's assessment process which certifies that they have provided all relevant information to Monitor in their submissions The full consultation document is available from the Monitor website here: http://www.monitor-nhsft.gov.uk/sites/default/files/Assessment%20Consultation%20-%20July%202012.pdf The consultation response form is available from the Monitor website here: http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=6361 ■ The Secretary of State has asked Monitor to carry out an independent review of matters that may be affecting the ability of providers of NHS-funded services to participate fully in providing them. The purpose of the Fair Playing Field review is to examine whether there are matters that mean not all NHS-funded health care providers operate on an equal footing. Interested respondents are invited to provide initial submissions to fairplayingfield@monitor-nhsft.gov.uk by 6 July 2012. Stakeholder events are planned to follow in July, August and September. The review will report to the Secretary of State for Health in early 2013 and he will subsequently present a report to Parliament by 27 March 2013. More details can be found on the Monitor website here: http://www.monitor-nhsft.gov.uk/monitors-new-role/fair-playing-field-%E2%80%93-the-benefit-patients
FT authorisations and applicants	There are currently 144 NHS Foundation Trusts of which 41 are mental health trusts, and 4 are Ambulance trusts. The most recent Trust to receive FT authorisation was: ■ Royal Free London NHS Foundation Trust (1 April 2012) 59% of all acute and specialist Trusts have now been authorised as FTs.

The Shrewsbury and Telford Hospital NHS

NHS Trust

NHS Foundation Trust Development Programme Summary update report

	Monitor states that the following Trusts have received Secretary of State approval to apply for NHSFT status: • Devon Partnership NHS Trust • Leicestershire Partnership NHS Trust • Royal Liverpool and Broadgreen University Hospitals NHS Trust • The Royal Wolverhampton Hospitals NHS Trust • Manchester Mental Health and Social Care Trust • East of England Ambulance Service NHS Trust • West Midlands Ambulance Service NHS Trust • Dudley and Walsall Mental Health Partnership NHS Trust • Western Sussex Hospitals NHS Trust
Summary: Board Development Day 16 July 2012	The Trust leadership team was invited to the morning session where the following items were discussed: • **The immediate challenges ahead** - Steve Peak • **Clinical Strategy & Business Developments*** - Debbie Vogler • **Foundation Trust journey and what we will look like** - Julia Clarke • **Committee structure – what do you think?** - Julia Clarke The afternoon session was for Board members only and covered: • **Quality Impact Assessments and CIPs* -** Rajinder Biran/Julia Clarke • **Committee Structure -** John Davies • **SHA Feedback and HDD interviews -** Julia Clarke ***For further information please see Appendix E** **DATE OF NEXT MEETING**: 3 September 2012

Appendix A – FT Project Plan

Task Name	Dec	2012 Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2013 Jan	Feb	Mar	Apr
SHA/DH Assessment Phase																	
Service Line Reporting (MedeFinance fully functional)		FD															
Ensure Business Plan is financially viable and sustainable and aligned with commissioning intentions.		DBE															
Financial Governance Regime																	
Budgetary control policy formalised		FD															
Financial Strategy agreed									FD								
Finance Staff Development Strategy agreed									FD								
Governance rationale (IBP annex) – 1st draft completed				DCRM													
Model core constitution (& election rules - IBP Appendix) – 1st draft completed				DCRM													
Development of supporting strategies (final versions)																	
Workforce Strategy									WD								
Estates Strategy									FD								
IT Strategy									FD								
Clinical Service Strategy									DBE								
IT Strategy									FD								
FT Communications Strategy									DoC								
Telehealth Strategy									DBE								
Membership Strategy							DCRM										
Performance Management & Accountability Strategy									FD								
Surplus land sale completed						FD											
Consultation refresh																	
Consultation – planning to completion (not required)							DCRM										
Constitution and election rules – 1st draft completed					DCRM												
Independent review of QGF									DCRM								
Proposals and timetable for elections								DCRM									
Selection process for NEDs ratified								DCRM									
Organisational Development Programme finalised								CEO									
IBP/LTFM – Preliminary Version																	
IBP/LTFM – Preliminary Version																	
'Compliant' LTFM							FD										
IBP/LTFM – Official Version 1																	
IBP/LTFM – Final											DCRM						
BGAF assessment completed																	
Board Workshop (Deloitte)						21/05											
BGM review (Deloitte)								Deloitte									
Independent assessment report (EY)									EY								
Mock B2B (Deloitte)									03/09								
Development module: Quality								16/08									
Development module: Strategy									21/09								
Development module: Finance											19/11						
Historic Due Diligence																	
HDD Stage 1								DCRM									
Due Diligence Reports and Action Plans									DCRM								
HDD Stage 2									DCRM								
SHA approval review (readiness review)																	
Board/Committee observations									SHA								
SHA interview with Commissioners, CQC, HDD partner									SHA								
SHA B2B #1 (indicative date)								11/10									
FT Quality and Safety Assessment (tbc)										SHA							
SHA B2B #2 (indicative date)													11/02				
FT application submitted to DH														SHA			

Appendix B - Risk Log

Risk description	Commentary	Date entered	Owner	Mitigating action taken	LxC*	Residual score	Status
Failure to deliver improved financial position – including working capital and CIPs	Need to ensure QIPP income not understated and LHE deliver QIPP plans.	TFA	FD	SLR introduced aligned to new Centre structure with monitoring of performance. CIP plans identified to deliver savings to achieve operating surpluses. Dedicated Programme Management Office established to track performance of CIP delivery.	3x5	15	OPEN
Failure to deliver service performance improvements	Working with LHE 19 projects to improve quality and delivery	TFA	DoO	Performance management arrangements in place with escalation procedure	3x5	15	OPEN
Capacity to manage the impact of consolidation of financial management and operational performance whilst starting the FT pipeline	Notice given of two Assistant Directors of Finance are imminently leaving the organisation	TFA	FD	Project approach with robust measurable programmes in place and creation of Programme Management Office to ensure deadlines are delivered. Management and clinical restructure completed. Additional senior staff in post. Restructure of Finance Directorate in progress	4x5	20	OPEN
Failure to deliver improvements to quality and safety	Working with LHE 19 projects to improve quality and delivery	TFA	DQS	Quality Improvement Strategy being drawn up with clear action plan monitored through Quality & Safety Committee. Additional focus on improving patient safety and patient experience. Embedding LIPS across organisation. Trust McKinsey benchmark shows as top quartile performance. Recent improvements in GRR	2x5	10	OPEN
Lack of support and engagement from external stakeholders.	Current changing landscape of LHE makes engagement more difficult	18.1.12	Chairman	Inaugural Stakeholder conference held on the 10 May 2012 – to be held quarterly. Next event scheduled for Sept 2012	2x4	8	OPEN

Risk description	Commentary	Date entered	Owner	Mitigating action taken	LxC*	Residual score	Status
Failure to deliver reconfiguration of services	Key risks noted at Trust Board 1) Communication of 2) Workforce training 3) Managing transition /implementation	TFA	DoT	Full public consultation and ongoing engagement with patients and clinicians and clear project management arrangements and plan in place. Approved by Trust Board 16/4/12. Programme Board established under DoT for implementation stage. FBC with SHA for approval	1x5	5	OPEN
Engagement and understanding of FT amongst staff is not achieved		20.2.12	WD	Learning support being developed 'FT so what' to ensure organisations understanding.	2x2	4	OPEN
Available time and resource to conduct public consultation if required		26.1.12	DCRM	SHA and HOSC agreed further formal consultation not required	3x2		Closed
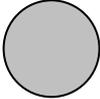
Appendix C: Board Capacity & Capability (Chantrey Vellacott) Action Plan – outstanding actions

This action plan was initially issued in November 2011. From the 75 recommendations within the original report, 6 remain outstanding, which are listed below:
A working action plan is available to view here: X:\Foundation Trust\Board Development\CC action plan\Action plans\CC RAG rating.xls

Lead	CV Ref	Recommendations	Agreed Action	RAG	Due date	Progress
Julia Clarke Director of Compliance and Risk	61	The Board should implement the action plans arising from this review ensuring that issues are fully addressed within agreed timescales	The Board Capacity and Capability Assessment Report (CVDFK) was received by the Trust in September 2011, and this action plan approved in November 2011. Progress against the Action Plan will be undertaken by the FT Project Board on a regular basis.	Amber		In progress
Julia Clarke Director of Compliance and Risk	75	Board cycle of business should allow for performance and effectiveness self-review on a fully inclusive basis.	New annual cycle of business - completed Feb 2012 (DV)	Amber	Sep-12	To be completed as part of Deloitte review to BDD Jul 2012
Victoria Maher Workforce Director	28	Board directors should ensure that they have a full understanding and approval, and have adequate reporting in respect of the implementation plans associated with the delivery of the Trust's workforce strategy.	New Workforce Director to deliver Workforce Strategy and then progress as part of Board development programme	Amber	Sep-12	To finalised Sept 2012
Neil Nisbet Finance Director	55	The performance and accountability framework should be framed to promote the move from verbal assurance to evidence based issues identification and resolution.	Need to develop Performance and Accountability Framework.	Amber	Sep-12	Full information set in place on a monthly basis and Centre Performance Reviews operating on a monthly basis. Formal performance and accountability framework being developed by Steve Peak.
Victoria Maher Workforce Director	29	Board directors should ensure that they are able to articulate a service/business rationale for its future workforce requirements.	Progress as part of Board development programme	Amber	Sep-12	To finalised Sept 2012
John Davies Chairman	65	Board needs to position itself and structure its business to achieve an appropriate balance between its current operational management focus and its aspiration to develop a more strategic governance focus.	Agreed as part of the Board Observation as per SOM.	Amber	Ongoing	Ongoing

Appendix D (i): Board Governance Memorandum Action Plan – current status

A baseline assessment against the criteria set out in the Board Governance Assurance Framework (BGAF) in March 2012. The RAG rating against each element and the current status is set out below:

Ref	BGAF Summary	Initial Self-Assessment rating	Current Self-Assessment rating
1. Board composition and commitment			
1.1	Board positions and size	RED	GREEN
1.2	Balance and calibre of Board members	GREEN	GREEN
1.3	Board member commitment	GREEN	GREEN
2. Board evaluation, development and learning			
2.1	Effective Board-level evaluation	AMBER / RED	GREEN
2.2	Whole Board development programme	AMBER / RED	AMBER
2.3	Board induction, succession and contingency planning	RED	AMBER
2.4	Board member appraisal and personal development	RED	AMBER
3. Board insight and foresight			
3.1	Board performance reporting	RED	AMBER / RED
3.2	Efficiency and Productivity	RED	AMBER / RED
3.3	Environmental and strategic focus	RED	AMBER
3.4	Quality of Board papers and timeliness of information	AMBER/GREEN	GREEN
4. Board engagement and involvement			
4.1	External stakeholders	RED	AMBER/GREEN
4.2	Internal stakeholders	RED	AMBER
4.3	Board profile and visibility	GREEN	GREEN
4.4	Future engagement with FT Governors	GREEN	GREEN

Appendix D (ii) BGM action plan – outstanding actions

Lead	BGM Element	BGAF *Red Flag*	Action	Current Status RAG	Due date	Progress
Julia Clarke Director of Compliance and Risk	2.1 Effective Board level evaluation		External stakeholder view on Board effectiveness to be undertaken by Deloitte as part of Board Development Programme	AMBER	Sep-12	
Julia Clarke Director of Compliance and Risk	2.1 Effective Board level evaluation		- Independent review of Committees to be undertaken by Deloitte	AMBER	Sep -12	Committee structure discussed at Board Development Day July - new structure formalised based on Deloitte recommendations
Vicky Morris Director of Quality and Safety	2.2 Whole Board Development Programme		- Delivery of BGAF Development Module: Quality	AMBER	Dec-12	
Debbie Vogler Strategy / Progress on Plan	2.2 Whole Board Development Programme		- Delivery of BGAF Development Module: Strategy	RED	Jan-13	Work plan priorities for the Strategy Team require reviewing, to be agreed by the CEO. To review whether the development module is a project for the Strategy team for this year.
Neil Nisbet Finance Director	2.2 Whole Board Development Programme		- Delivery of BGAF Development Module: Finance	AMBER	Nov-12	Framework agreed with Remuneration Committee in June 2012. Plans to be finalised in Oct-12.
John Davies Chairman	2.3 Board induction, succession and contingency planning		- Formally designate and minute Deputy CEO	AMBER	Dec-12	Sep-12
Victoria Maher Workforce Director	2.3 Board induction, succession and contingency planning		- Formalise Board induction process/policy	AMBER	Sep-12	Development and Training (Mary Beales) formalising policy for completion in August.
Victoria Maher Workforce Director	2.3 Board induction, succession and contingency planning		- Formal succession plans/policy in place	AMBER	Sep-12	Succession Planning: NEDs succession plan being developed by Chairman; Executives by new CEO.
Victoria Maher Workforce Director	2.4 Board member appraisal and personal development		- Develop process of formal appraisal feedback at Board level	AMBER	Sep-12	Framework agreed with Remuneration Committee at June 2012.
Victoria Maher Workforce Director	2.4 Board member appraisal and personal development		- Formalise process for CEO to feedback appraisal of EDs to Chair	AMBER	Sep-12	Framework agreed with Remuneration Committee at June 2012.

Lead	BGM Element	BGAF Red Flag	Action	Current Status RAG	Due date	Progress
Victoria Maher Workforce Director	2.4 Board member appraisal and personal development		- Formalise appraisal process for Chair led by the Senior Independent Director	AMBER	Sep-12	Formal process to be agreed
Victoria Maher Workforce Director	2.4 Board member appraisal and personal development		- Formalise process for each Board member (BM) to ensure objectives are reviewed on an annual basis by the Chair	GREEN	Sep-12	Framework agreed with Remuneration Committee in June 2012. Plans to be finalised in Sep 12.
Victoria Maher Workforce Director	2.4 Board member appraisal and personal development		Formalise process for Personal Development Plans of each BM to be reviewed to ensure inclusion of FT-specific elements	AMBER	Sep-12	Framework agreed with Remuneration Committee in June 2012. Plans to be finalised in Sep 12.
Victoria Maher Workforce Director	2.4 Board member appraisal and personal development		Evidence of clear link between BM appraisals and contributions at Board	AMBER	Sep-12	
Julia Clarke Director of Compliance and Risk	2.4 Board member appraisal and personal development		Formalised plan to involve Governors in the Chair and NED appraisal process -in Constitution	AMBER	Jul-12	Results shared at Board in April 2012 with plan to address employment experience at SaTH. Quarterly Workforce Reports will ensure regular assurance to Board.
Neil Nisbet Finance Director	3.1 Board Performance Reporting	🚩	Inclusion of 12 month rolling cash flow forecast in finance report	AMBER	Jul-12	Plan to have this contained within July Board paper.
Neil Nisbet Finance Director	3.1 Board Performance Reporting	🚩	- All Board requirements to be met in new IPR - Present new IPR to May F&P Committee	RED	Sep-12	Revised IPR document approved at May 2012 Finance & Performance Committee meeting. SPR introduced at June Board. Further development still required.
Neil Nisbet Finance Director	3.2 Efficiency and Productivity	🚩	Formalise process for performance information on CIPs and QIPP to be routinely reported to Board	AMBER	Sep-12	CIP performance presented to Finance & Performance Committee on a monthly basis. CIP reported to Board separately Jun 2012 onwards. LHE QIPP plan to be agreed - Local Health Economy has re-established QIPP Board to commence from 1st August 2012.
Vicky Morris Director of Quality and Safety	3.2 Efficiency and Productivity	🚩	Formalise process to prospectively assess the risks to care quality presented by CIPs	AMBER	Jul-12	Prospective QIA process formalised/agreed - QIA process presented at Board Development Day July to be formally agreed at Trust Board.

Lead	BGM Element	BGAF Red Flag	Action	Current Status RAG	Due date	Progress
Vicky Morris Director of Quality and Safety	3.2 Efficiency and Productivity		- Formalise process of sign-off of QIAs by DoO/MD/DQS	AMBER	Jul-12	Prospective QIA process formalised/agreed - QIA process presented at Board Development Day July to be formally agreed at Trust Board.
Vicky Morris Director of Quality and Safety	3.2 Efficiency and Productivity		- Evidence of examples of rejected CIPs due to negative QIA	AMBER	Jul-12	
Neil Nisbet Finance Director	3.2 Efficiency and Productivity		- Formalise regular report to Board on how other organisations are performing against QIPP	AMBER	Jul-12	Local Health Economy has re-established QIPP Board to commence from 1st August 2012.
Vicky Morris Director of Quality and Safety	3.2 Efficiency and Productivity		- Evidence of examples of reshaping or changes to projects (inc audit) due to negative QIA	AMBER	Jul-12	
Vicky Morris Director of Quality and Safety	3.2 Efficiency and Productivity		- Formalise process for monitoring ongoing risks to care quality for each CIP scheme post implementation	AMBER	Jul-12	Prospective QIA process formalised/agreed - QIA process presented at Board Development Day July to be formally agreed at Trust Board.
Neil Nisbet Finance Director	3.2 Efficiency and Productivity		- Formalise routine reporting of health economy QIPP schemes to Board	AMBER	Jul-12	Local Health Economy has re-established QIPP Board to commence from 1st August 2012.
Debbie Vogler Strategy / Progress on Plan	3.3 Environmental and strategic focus		Formalise process for Board to review progress towards delivering its strategy and downside scenario planning. Ensure Formal Board level review of achievement of strategy is be included in Board business cycle	AMBER	Sep-12	1. SMART objectives for Annual Corporate Plan to Trust Board for August 2012. 2. First review of performance against plan - September Trust Board.
Adrian Osborne Communications Director	4.1 External Stakeholders		- FT Communications Plan and Overarching Strategy to be formalised	AMBER	Jul-12	
Julia Clarke Director of Compliance and Risk	4.1 External Stakeholders		- Ensure views of hard to reach groups have been obtained	AMBER	Sep-12	FT Membership & Engagement Manager to address from July 2012 (following Maternity leave). Included in membership strategy – presented to Board July 2012

Lead	BGM Element	BGAF *Red Flag*	Action	Current Status RAG	Due date	Progress
Victoria Maher Workforce Director	4.2 Internal stakeholders		The latest Trust staff survey results are poor - evidence Board is assured that recommendations from LIA fully implemented. 'Colour of Change' courses introduced.	AMBER	Oct-12	Results shared at Board in April 2012 with plan to address employment experience at SaTH. Quarterly Workforce Reports will ensure regular assurance to board.
Vicky Morris Director of Quality and Safety	4.2 Internal stakeholders		Evidence Board is assured that recommendations from QIS have been fully implemented	AMBER	Oct-12	
Adrian Osborne Communications Director	4.2 Internal stakeholders		- Internal engagement / communications strategy formalised	AMBER	Oct-12	_

Appendix D (iii) – Board impact case studies and Development Modules

a) Four **Board impact case studies**, each one led by a Director with expertise in each specific subject area, are scheduled to be delivered to the Board at the **September Board Development session**.

Board impact case studies			
5.1	Performance issues in the areas of quality	AF	Never Events
5.2	Performance issues in the areas of finance	NN	CIP or capital
5.3	Organisational culture change	VMa	Devolution & Cooperation
5.4	Organisational strategy	DV	Reconfiguration

b) Standardised **development modules** are to be delivered to the Trust Board through our development partner Deloitte and have been scheduled to the timetable below.
The development modules are available to view here: X:\Foundation Trust\Board Development\BGAF\BGAF Development Modules

	STATUS/ACTION	LEAD	Nov-12	Dec-12	Jan-13
Whole Board Development Programme	- BGAF Development Module: Quality	DQS		▉	
	- BGAF Development Module: Strategy	DBE			▉
	- BGAF Development Module: Finance	FD	▉		

Appendix E (i) – summary of the key projects and priorities that were discussed at Board Development session 23 July 2012

Key Service Developments for the Trust in 2012/13
- Reconfiguration of Acute Surgery and Women and Children's services
- Expansion and development on Cancer Services
- Development of Cardiology Services
- Pathology Reconfiguration
- Repatriation of Market Share
- Private Practice

Appendix E (ii) – detailed steps of Quality Impact Assessment process as discussed at Board Development session 23 July 2012

Programme Management QIA process for Enabling and CIP projects
- Reviewed and ratified by the Sath Board on the 16 July 2012 BDD - Improvements to process incorporated and finalised at the request of the Trust Lead: - Director of Nursing on the 17 July 2012

Phase 1	
Step	**Action**
1	Scheme Identified
1.1	Scheme evidences progress to Stage 2 of the pipeline gateway review of the state of readiness
1.2	Quality Impact Assessment is initiated

Phase 2	
Step	**Action**
2	PMO workbook risks & Issues tab completed
2.1	Risks/issues identified which impact Patient: - 1) Experience 2) Safety 3) Clinical outcomes
2.1.1	A discussion is held with the Chief Nurse and Medical Director to agree the risk score and interim action for mitigation
2.1.2	A QIA is conducted with: - - Clinical input and sign off - Director of Operation's sign off
2.1.3	The QIA is emailed in electronic form to the PMO, and a paper copy with full signatures scanned back to the PMO
2.1.4	The PMO forwards the QIA and workbook (to access the risks and issues tab) through to the Chief Nurse (Director of Q&S) for review and action alongside the Medical Director
2.1.5	If any risk scores over 15 after mitigation, the project team add this to their service level risk register and present it to the Risk Management Executive for review, and entry onto the Corporate Risk Register
2.1.6	Go to Stage 3
2.2	No risks are identified which impact Patient: - 1) Experience 2) Safety 3) Clinical outcomes
2.2.1	A QIA null return is signed by the Clinical Lead and Director Of Operation's with a full review of the risks and issues tab
2.2.3	The QIA is emailed in electronic form to the PMO, and a paper copy with full signatures scanned back to the PMO
2.2.4	See step 2.1.4 and 2.1.5, 2.1.6

Phase 3	
Step	**Action**
3	A clinical review is undertaken led by the Chief Nurse (Director of Q&S) and supported by the Medical Director
3.1	Sustaining Operational Change: - The Chief Nurse and Medical Director ensure a critique of the QIA is undertaken, with support from the Q&S Committee as appropriate
3.1.2	Review and Analysis: - Review dates for QIA are set in advance and communicated trust wide
3.1.3	Recommendation and Feedback: - Within 30 days from the review the feedback is shared with the Project teams and PMO The standard pro forma template to be used
3.1.4	Measuring and Monitoring: - The Project take action to address feedback The PMO monitor and provide assurance that action is being progressed
3.2	A referral to the Q&S Committee is made where the impact to clinical outcomes, patient safety and experience outweighs the benefits realisation of the PMO scheme
3.3	The Q&S ratify the decision to progress the risk. Treat, Tolerate, Transfer, Modify or Reject
3.4	The action is acted on and owned by the project team
3.5	The schemes are reviewed monthly by the project team, if a new quality risk is identified the stages from step 2.1 are followed through
3.6	- Board receives a quarterly Quality Report in the private board - A summary outcome of the progress made with QIA's will be communicated - Key outcomes which require significant board discussions will be attached as an appendixes