St. George's Healthcare NHS Trust

Board Governance Memorandum

Version 1.3 – 21st May 2014

Planned date to enter Monitor process – June 2014

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

The Organisation

St. George's Healthcare NHS Trust (SGH) provides a high quality, comprehensive range of health services from leading edge tertiary and trauma care for 3.4 million people to local community services for the people of Wandsworth. The Trust is the major tertiary provider for south west London and Surrey, and is the only Trust in London which has all specialties on one site.

St George's Hospital is one of the country's leading teaching hospitals with a history dating back to 1733. The organisation has consistently developed its services and moved with the times. Established as the regional teaching hospital and specialist centre for south west London, Surrey and Sussex in the 1980s and 1990s, St George's became an integrated healthcare provider with the acquisition of Community Services Wandsworth in 2010.

The trust is the major centre for tertiary services, including cardiovascular, neurosciences, renal, cancer, and specialised children's services for south west London and Surrey. It is one of four Major Trauma Centres in London, and received 1,524 trauma calls in 2012-13
The trust is a designated Heart Attack Centre, and was the first trust in London to provide primary angioplasty services 24 hours a day
The trust is a designated large Hyper Acute Stroke Unit (HASU), providing an extremely high quality service, and received over 2,000 stroke patients in 2012/13

Quality and patient outcomes match St George's distinguished history. Mortality is consistently and significantly lower than at other trusts[1], the major national audits highlight the clinical quality of services at St George's[2] and the organisation as a whole has been named Dr Foster "Large acute trust of the year."

The trust is well supported by commissioners, GPs and referring hospitals. It has an appropriate population base to sustain the range of services provided. This will be enhanced by population growth, incremental service changes, and formal service reviews such as Better Services, Better Value.

Co-located with St. George's, University of London (SGUL), and with both organisations now in a formal strategic alliance with King's Health Partners, the trust delivers with its partners high quality research and education, which contribute to the healthcare provision of tomorrow.

- Adding together these different elements of the trust's profile the 'whole' of St George's is even greater than the sum of its parts. The organisation is a modern, integrated teaching provider with the staff, facilities, population base, track record for quality and relationships with both commissioners and referrers to take the step up to becoming an NHS Foundation Trust.

In 2012-13, the trust:

- Saw 533,789 outpatients, delivered 4,995 babies, undertook 41,813 elective inpatient and daycase procedures, had 147,018 patients attend A&E, and admitted 44,931 non-elective patients
- Employed 7,254.88 WTE staff (made up of 7,775 staff with some working less than full time)
- Had 1,052 beds from highly intensive to rehabilitation, surgical, medical and community across two hospital sites
- Received income of £636 million and delivered a £3.1m surplus

St. George's – 2022

St. George's Healthcare NHS Trust has a compelling vision for the future. As a highly performing Foundation Trust, St. George's will in 2018/19 be a provider of excellent integrated care and the major provider of tertiary services to south west London, Surrey and beyond. Delivering health care of exceptional quality, the trust will provide a comprehensive range of health services, which patients will choose for their treatment, GPs and other hospitals will choose for their patients and commissioners will choose for their populations.

In addition to providing enhanced cardiovascular, neuroscience, paediatric, and other tertiary services to a population of 3.4 million, the trust will also provide the full range of high quality acute and community health services, integrated where appropriate with social care, which local patients deserve from their local NHS.

[1] SHMI,HSMR reference
[2] MINAP, VSGBI, Sentinel references

As well as delivering exceptional healthcare, St. George's will be leading on and collaborating with other organisations in the development of cutting edge research, and sharing the benefits of that research with other health, social and third sector organisations. Partners in this work will include St. George's University of London, King's Health Partners, and the South London Academic and Health Sciences Network. This research will have both direct benefits in terms of the quality of patient care received by St. George's patients, and indirect benefits in terms of attracting and retaining staff of the highest calibre to come and work at an organisation with a growing reputation in research.

Linked to the delivery of excellent patient care and cutting edge research, the trust, with a leadership role in Health Education South London, the local LETB, will be collaborating with other organisations to teach and develop the health professional workforce of the future.

In delivering this tripartite mission of healthcare delivery, research and education, the trust will put the needs of the patient first, such that the quality of patient care at St. George's is amongst the best in the country. The trust is proud of its record in delivering safe care and excellent clinical outcomes and will work tirelessly to improve the experience of patients and to build on its strengths in safety and outcomes.

St. George's will meet operational targets and deliver robust financial performance that allows the trust to reinvest in its services and estate. For the last six years, the trust has had an improving track record of delivering its financial and operational targets. The Integrated Business Plan (IBP) will seek to demonstrate that, as a thriving Foundation Trust, and through the implementation of the trust strategy and its planned service developments, St. George's is well placed to meet the health needs of the various populations it serves and the clinical, financial, operational and societal challenges that the NHS faces.

Stakeholder Engagement and Patient Feedback
Stakeholder engagement is a key area of focus for the trust as it develops its Foundation Trust application. The trust has developed a comprehensive engagement strategy to support St. George's Foundation Trust application. Stakeholders, including Clinical Commissioning Group leads and local authority representatives, have been involved in the development of the IBP. St. George's proposed governance arrangements, developed between September and December 2012, will seek to create genuine engagement and discussion with Governors and the membership. One of the trust's key tasks will be to grow a genuinely representative membership and then to engage them with the trust's work to ensure that their voice, representing the local community as a whole, is central to decisions taken by the organisation.

Performance Management
The trust has reviewed its management and governance arrangements to prepare for Foundation Trust status, including changes to the board and executive team, a revised board sub-committee structure and a revised management structure and performance framework have also been put in place to embed clinical leadership within the trust. Clinical leadership is seen as central to the delivery of a successful St. George's, and the new structure, implemented in 2012, has more fully and clearly outlined the clinical leadership role and the trust's expectations of this. A Divisional governance review has been undertaken to assess how embedded the revised structure now is, and to identify further areas where organisational development input is required.

The trust has strong risk management and governance arrangements, with a comprehensive committee structure that supports the flow of

information from board to ward and ward to board. With the introduction of a new performance management framework, comprehensive performance reporting is in place within Clinical Divisions and information flows up through the corporate structures to the board. Performance reporting includes clinical and patient experience measures as well as financial and workforce indicators.

Summary of Key Performance Indicators presented at Trust Board
The Board receives a series of performance reports at each meeting, including quality, finance, operational, workforce and risk.

Summary results

Ref	Area	Self-Assessment rating	Deloitte rating December 2012
1. Board composition and commitment			
1.1	Board positions and size	Amber / Green	Amber / Green
1.2	Balance and calibre of Board members	Amber / Green	Amber / Green
1.3	Board member commitment	Green	Green
2. Board evaluation, development and learning			
2.1	Effective Board-level evaluation	Amber / Green	Amber / Red
2.2	Whole Board development programme	Green	Amber / Green
2.3	Board induction, succession and contingency planning	Green	Amber / Red
2.4	Board member appraisal and personal development	Amber / Green	Amber / Green
3. Board insight and foresight			
3.1	Board performance reporting	Amber / Green	Amber / Green
3.2	Efficiency and Productivity	Green	Amber / Green
3.3	Environmental and strategic focus	Green	Green
3.4	Quality of Board papers and timeliness of information	Green	Amber / Green
4. Board engagement and involvement			

Ref	Area	Self-Assessment rating	Deloitte rating December 2012
4.1	External stakeholders	Green	Amber / Green
4.2	Internal stakeholders	Green	Green
4.3	Board profile and visibility	Green	Green
4.4	Future engagement with FT Governors	Green	Amber / Green

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1. Board composition and commitment

1. Board composition and commitment (Guidance)

1.1 Board positions and size

Red Flag	Good Practice
• The Chair and/or CEO are currently interim or the position(s) vacant. • There has been a high turnover in Board membership in the previous two years (i.e. 50% or more of the Board are new compared to two years ago). • The number of people who routinely attend Board meetings is unwieldy	• The size of the Board (including voting and non-voting members of the Board) is appropriate for the requirements of the business. • All voting positions are substantively filled. • The Board has a Senior Independent Director (SID) in place. • The Board has a Foundation Trust Secretary (or equivalent) in place. • It is clear who on the Board is entitled to vote. • At least half the Board of Directors, excluding the Chair, comprise NEDs determined by the Board to be independent (refer A3.2 and C2.2 in the Monitor NHS Foundation Trust Code of Governance). • Where necessary, the appointment term of NEDs is staggered so they are not all due for re- appointment or leave the Board within a short space of time.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Biographical information on each member of the Board. • The Board's structure. • Job Descriptions/ Role Specifications for FT Secretary, SID, and NEDs. • Evidence of potential conflicts of interest of Board members being declared and managed.

Section RAG rating:
Amber / Green

1. Board composition and commitment (Assessment)

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 (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
• Declaration / Register of interests • Trust Secretary in post • Corporate Governance Manual developed which includes Board structure and composition, terms of reference for Board and subcommittees • Biographies of Board published on website • Executive director appointment dates and succession plans in place • SID appointed as well as deputy chair • Board skills audit completed • Clear succession planning in place for non-executive and executive directors • Associate NED appointed with commercial experience.	• New Director of Estates and Facilities appointed to take up post in June 2014; interim director in post • Chief Nurse appointed who will take up post on 4th June 2014. • Interim Director of Delivery and Improvement in post; substantive appointment made on 16th May (new post) – start date to be confirmed.	

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
None		

1. Board composition and commitment (Guidance)

1.2 Balance and calibre of Board members

Red Flag	Good Practice
• There are no NEDs with a recent and relevant financial background. • There is no NED with current or recent (i.e. within the previous 2 years) experience in the private/ commercial sector. • The majority of Board members are in their first Board position. • The majority of Board members are new to the organisation (i.e. within their first 18 months)	• The Board can clearly explain why the current balance of skills, experience and knowledge amongst Board members is appropriate to effectively govern the Trust over the next 5 years. In particular, this includes consideration of the value that each NED will provide in helping the Board to effectively oversee the implementation of the Trust's IBP. • 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 (e.g. effective at working in teams, independence of thought, well developed political/ influencing skills, sound judgement, ability to build trusting and respectful relationships, ability to listen first and then assert their view). • The Board has an appropriate blend of NEDs from the public, private and voluntary sectors. • The Board has given due consideration to the diversity of its composition in terms of the protected characteristic groups in the Equality Act 2010. • There is at least one NED with a clinical healthcare background (e.g. a doctor, nurse or allied health professional who is not conflicted). • There is an appropriate balance between Board members (both Executive and NEDs) that are new to the Board (i.e. within their first 18 months) and those that have served on the Board for longer. • The majority of the Board are experienced Board members. • The Chair of the Board has a demonstrable and recent track record of successfully leading a large and complex organisation, preferably in a regulated environment. • The Chair of the Board has previous non-executive experience. • At least one member of the Audit Committee has recent and relevant financial experience.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Biographical information on each member of the Board. • The Board's structure. • Board skills audit. • Board and Committee Terms of Office for NEDs. • • Example NED role descriptions.

Section RAG rating:
Amber / Green

1. Board composition and commitment (Assessment)

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
• Balance of skills assessed when considering NED vacancies – Board skills audit completed August 2013 • Consideration given to qualities required by Board • Diversity of Board – 3/6 NEDs female, 1/1 Associate NED female, 4/9 Directors female • 2 NEDs clinical background (Medical School Principal and previous President of Royal College of Anaesthetists) • Balance in seniority of Board members – 4x NEDs more than 18 months 6 Directors more than 18 months • Majority of Board are experienced Board members and have experience of other boards • Skills and experience of Chair – with relevant NED experience (Kingston) • Audit Committee Chair and 2 other members with financial experience • Associate NED with commercial (marketing) experience appointed March 2014 • Annual appraisals of both non-executive and executive directors • Balance and calibre of Board independently evaluated by Deloitte and NTDA as part of FT preparation		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
None		

1. Board composition and commitment (Guidance)

1.3 Board member commitment

Red Flag	Good Practice
• There is a record of Board and Committee meetings not being quorate. • There is regular non-attendance by one or more Board members at Board or Committee meetings. • Attendance at one or more Committees is inconsistent (i.e. the same Board members do not consistently attend the same Committee meetings). • There is evidence of Board members not behaving consistently with the behaviours expected of them and this remaining unresolved.	• Board members have a good attendance record at all formal Board and Committee meetings and at Board events (e.g. workshops; quality walks etc). • The Board has discussed the time commitment required of the FT process and Board members have committed to set aside this time. • The Board has an explicit 'Code of Conduct' which clearly describes the behaviours expected of Board members. These behaviours are aligned to the values of the Trust and the 7 Nolan Principles of Public Life. Compliance with the code is routinely monitored by the Chair and included as part of each Board member's annual appraisal.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board attendance record. • Attendance at Sub-Committee meetings. • Induction programme.

Section RAG rating:
Green

1. Board composition and commitment (Assessment)

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
• Membership of Board sub-committees by NEDs reviewed to ensure this fits with the balance of skills among the NEDs • Attendance at Board and subcommittees monitored and discussed at NED appraisal • All Board sub-committees are chaired by a NED • NED induction programme in place • FT programme and time commitment discussed on an ongoing basis • Trust values published • Code of Conduct for Board members – adopted by board annually. Included in Governance Manual.	• Board training record needs to be formalized (July 2014). • Compliance with the code of conduct to be included as part of each Board member's annual appraisal (April 2015)	

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
None		

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2. Board evaluation, development and learning

2. Board evaluation, development and learning (Guidance)

2.1 Effective Board level evaluation

Red Flag	Good Practice
• No formal Board evaluation has been undertaken within the last 12 months. • The Board has not undertaken an independent evaluation of its effectiveness within the last 2 years. • Where the Board has undertaken an evaluation, only the perspectives of Trust Board members were considered and not those outside the Board (e.g. staff, commissioners etc). • Where the Board has undertaken an evaluation, only one evaluation method was used (e.g. only a survey of Board members was undertaken).	• Formal evaluations of the Board and Committees have been undertaken within the previous 12 months consistent with the NHS Foundation Trust Code of Governance. The Board can clearly identify a number of changes/ improvements in Board and Committee effectiveness as a result of the formal evaluations that have been undertaken. 2. The Board has had an independent evaluation of its effectiveness and committee structure within the last 2 years by a 3rd party that has a good track record in undertaking Board effectiveness evaluations. • In undertaking its formal evaluation, the Board has used an approach that includes various evaluation methods. In particular, the Board has considered the perspective of a representative sample of staff and key external stakeholders (e.g. commissioners and/or patients) on whether or not they perceive the Board to be effective. • The focus of the evaluation included traditional 'hard' (e.g. Board information, governance structure) and 'soft' dimensions of effectiveness. In the case of the latter, the evaluation considered as a minimum: ▪ The knowledge, experience and skills required to effectively govern the organisation and whether or not the Board's membership currently has this; ▪ How effectively meetings of the Board are chaired; ▪ The effectiveness of challenge provided by Board members; ▪ Role clarity between the Chair and CEO, Executive Directors and NEDs, between the Board and management and between the Board and its various sub-committees; ▪ Whether the Board's agenda is appropriately balanced between: strategy and current performance; finance and quality; making decisions and noting/ receiving information; matters internal to the organisation and external considerations; and business conducted at public board meetings and that done in confidential session. ▪ The quality of relationships between Board members, including the Chair and CEO. In particular, whether or not any one Board member has a tendency to dominate Board discussions and the level of mutual trust and respect between members.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Report on the outcomes of the most recent Board evaluation and examples of changes/ improvements made in the • Board and Committees as a result of an evaluation. • The Board Scheme of Delegation/ Reservation of Powers.

Section RAG rating:
Amber / Green

2. Board evaluation, development and learning (Assessment)

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
• Evaluation of Board and Committees – annual survey of effectiveness and proposals for changes to Board March 2014 • Board skills audit completed by Deloitte August 2013 • Independent evaluation of Trust Board and key sub-committees undertaken by NHSL and the NTDA during 2012 and 2013, with independent observation of meetings • BGAF assessment undertaken by Deloitte December 2012 • Executive to Executive (January 2014) and Board to Board meeting (March 2014) with the NTDA to assess Board knowledge and function • Scheme of delegation/ Reservation of Powers • Chairman 360 appraisal completed March 2014 • Board development programme in place • Internal review of divisional governance arrangements completed and action plan agreed	• Develop an annual assessment process going forward for the Board and sub-committees to include external evaluation and quantitative as well as qualitative indicators (September 2014) • Implement recommendations from divisional governance review (September 2014) • Plan an external review of divisional governance arrangements (April 2015)	

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
None		

2. Board evaluation, development and learning (Guidance)

2.2 Whole Board development programme

Red Flag	Good Practice

• The Board does not currently have a Board development programme in place.
• The Board Development Programme is not aligned to helping the Board achieve FT status.
	• The Board has a programme of development in place. The programme seeks to directly address the findings of the Board's annual evaluation (see previous section) and contains the following elements: understanding what FT status means; development specific to the Trust's FT application; and reflecting on the effectiveness of the Board and its supporting governance arrangements.
	• Understanding 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.
	• Development specific to the Trust's FT application **–** the Board is or has been engaged in the development of the IBP and LTFM and self-assessing the Trust's quality governance arrangements against Monitor's Quality Governance Framework.
	• Reflecting on the effectiveness of the Board and its supporting governance arrangements -The development programme includes time for the Board as a whole to reflect upon, and where necessary improve:
	  • The focus and balance of Board time;
	  • The quality and value of the Board's contribution and added value to the AFT;
	  • How the Board responded to any service or financial failures;
	  • Whether the Board's subcommittees are operating effectively and providing sufficient assurances to the Board;
	  • The robustness of the Trust's risk management processes;
	  • The reliability, validity and comprehensiveness of information received by the Board.
	• Time is 'protected' for undertaking this programme and it is well attended.
	• The Board has considered, at a high-level, the potential development needs of the Board post authorisation as an FT.

Examples of evidence that could be submitted to support the Board's RAG rating.	• The Board Development Programme. • Attendance record at the Board Development Programme.

Section RAG rating: Green

2. Board evaluation, development and learning (Assessment)

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
• A formal Board development programme is in place which is based on a Board skills audit • Monthly board development sessions for all board members with notes produced. • Board development sessions currently focused on FT preparation and have included IBP, LTFM and key assumptions, development of the key strategies, data quality and assurance. • Sessions have included other topics in past 12 months – including safeguarding training, risk management, quality (e.g. Francis and Clwyd reports). • There is in addition a Board strategy seminar every second month	• The Board development programme reviewed in April 2014 to ensure that it continues to meet the needs of both individual Board members and the Board as a whole in preparing for FT status – programme for next 12 months to be confirmed (June 2014)	

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
None		

2. Board evaluation, development and learning (Guidance)

2.3 Board induction, succession and contingency planning

Red Flag	Good Practice
• There is no formal induction for new members of the Board. • Deputy Chair and Deputy CEO positions have not been • formally designated and noted • in Board minutes. • NED appointment terms are not sufficiently staggered.	• All members of the Board, both Executive and Non-Executive, are appropriately inducted into their role as a Board member. Induction is tailored to the individual Director and includes access to external training courses where appropriate. As a minimum, it includes an introduction to the role of the Board, the role expectations of NEDs and Executive Directors, and the statutory duties of Board members in FTs. • Induction for Board members is conducted on a timely basis. • Where Board members are new to the organisation, they have received a comprehensive corporate induction which includes an overview of the services provided by the Trust, the organisation's structure, Trust values and meetings with key leaders. • Deputy positions for the Chair and CEO have been formally designated and minuted. • 5. The Board has considered the skills it requires to govern the organisation effectively in the future and the implications of key Board-level leaders leaving the organisation. Accordingly, there are demonstrable succession plans in place for all key Board positions (Executive and Non Executive) notwithstanding the requirement to market test applicants and, where appropriate, recruit externally.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Succession plans. • Sample induction programmes.

2. Board evaluation, development and learning (Assessment)

Section RAG rating:
Green

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
• Consideration by Board as to skills requirements – changes in board membership • Induction program developed for all new board members, supported by induction checklist • Induction documentation includes intro to trust, structures • Formal induction process in place for new Board members and included in Governance manual • Deputy Chair and Deputy CEO both formally designated • Succession plans in place for exec and non-exec directors • Terms of office for non-exec directors recorded and sufficiently staggered		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
None		

2. Board evaluation, development and learning (Guidance)

2.4 Board member appraisal and personal development

Red Flag	Good Practice
• There is not a robust performance appraisal process in place at Board level that evaluates the Board contributions of every member of the Board (including Executive Directors) on an annual basis and documents the process of formal feedback being given and received. • Individual Board members have not received any formal training or professional development relating to their Board role.	• The effectiveness of each Board member's contribution to the Board, including the Board contribution of Executive Directors, is formally evaluated on an annual basis by the Chair (in the case of Executive Directors, this appraisal may form part of a wider annual appraisal process and therefore fed back via the CEO). The evaluation process includes consideration of the perspectives of other Board members on the quality of an individual's contribution (i.e. 360 degree appraisal) and how they have performed against their objectives. • There is a comprehensive appraisal process in place to evaluate the effectiveness of the Chair of the Board that is led by the Senior Independent Director. • Each Board member (including each Executive Director) has objectives specific to their Board role that are • reviewed on an annual basis by the Chair. • Each Board member has a Personal Development Plan that is directly relevant to the successful delivery of their Board role. In particular, each Board member has reflected upon their personal development needs in relation to helping the Trust successfully achieve FT authorisation and, where appropriate, has included these needs within their Personal Development Plan. • There are processes in place to ensure the development of Executive Directors as Corporate Directors. • As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level. • The involvement of Governors in the Chair and NED appraisal process once the Trust is an FT has been considered.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Performance appraisal process used by the Board. • Sample Personal Development Plans. • Sample Board member objectives. • Evidence of attendance at training events and conferences. • Board minutes that evidence Executive Directors contributing outside their functional role and challenging other Executive Directors.

Section RAG rating:
Amber / Green

2. Board composition and commitment (Assessment)

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
• Annual appraisals in place for EDs and NEDs, with summary of ED appraisals presented to Noms and Rems committee • Chairman input into ED appraisals to cover ED performance as a board member • NEDs are appraised re contribution to Board • Board members given opportunity to attend conferences etc. • Executive appraisals review performance as a board member, with input from the Chair • Executive director personal development plans and objectives • Appraisal process in place for chairman, led by SID and informed by 360 degree appraisal. Appraisal meeting also with TDA.	• Systematic collation of attendance at conferences / training etc (July 2014). • 360 degree appraisals to be conducted for all board members (April 2015)	

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
None		

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3. Board insight and foresight

3. Board insight and foresight (Guidance)

3.1 Board performance reporting

Red Flag	Good Practice

• Significant unplanned variances in performance have occurred
• Performance failures were brought to the Board's attention by an external party and/or not in a timely manner.
• Finance and Quality reports are considered in isolation from one another.
• The Board does not receive 12 month rolling cash flow forecast information.
• The Board only receives minutes of Committee meetings and does not tend to discuss them.
• The Board does not have an action log.
• Key risks are not reported / escalated up to the Trust Board.
	• The Board has debated and agreed a set of quality and financial metrics outside the national and regionally agreed metrics that are relevant to the Board given the context within which it is operating and what it is trying to achieve.
	• The Board receives a performance report which includes:
	  ○ A fully integrated performance dashboard which enables the Board to consider the performance of the Trust against a range of metrics including quality, performance, activity and finance and enables links to be made (e.g. financial variances are linked to activity);
	  ○ Variances from plan are clearly highlighted and explained;
	  ○ Key trends and findings are outlined and commented on;
	  ○ Future performance is projected with associated risks and mitigations provided where appropriate (e.g. forecast outturn);
	  ○ Key quality information is triangulated (e.g. complaints, claims, incidents, Rule 43 issues, key HR metrics, and audit findings) so that Board members can accurately describe where problematic service lines are;
	  ○ Benchmarking of performance to comparable organisations is included where possible;
	  ○ Supporting performance detail is broken down by Service Line so members can understand which services are high and low performing from a financial and quality perspective.
	• The Board receives a brief verbal update on key issues arising from each Committee meeting from the relevant Chair. This is supported by a written summary of key items discussed by the Committee and decisions made.
	• The Board regularly discusses the key risks facing the AFT and plans to manage or mitigate them.
	• An action log is taken at Board meetings. Accountable individuals and challenging / demanding timelines are assigned. Progress against actions is actively monitored. Slips in timelines are clearly identifiable through the action log and individuals are held to account.

Examples of evidence that could be submitted to support the Board's RAG rating.	• Board Performance Report. • Board Action Log. • Example Board agendas and minutes highlighting sub-committee discussions by the Board.

Section RAG rating:
Amber / Green

3. Board insight and foresight (Assessment)

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
• Board receives a suite of interrelated performance reports at each meeting, including quality, performance, finance, workforce and risk. • Board agreed objectives and metrics • Board performance report includes dashboard across domains, variances vs. plan, narrative report explains trends and variances • Rotating programme of divisional / service line presentation • Reports from each sub-committee are presented at each board meeting – both verbal update and minutes provided for information • Board action log in place, with matters arising reviewed at each meeting.	• Regular NEDs briefing by the CEO in between meetings to keep NEDs updated on key issues (June 2014) • As well as reports from each sub-committee, each sub-committee to present an annual workplan and report, summarising key topics being considered and to be considered by that committee (July 2014) • Implement agreed changes to board governance following discussion at board meeting on 29th May (June 2014)	

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
None		

3. Board insight and foresight (Guidance)

3.2 Efficiency and Productivity

Red Flag	Good Practice
• The Board does not receive performance information relating to progress against CIPs and QIPP targets and plans. • There is no process currently in place to prospectively assess the risk(s) to care quality presented by CIPs.	• The Board is assured that there is a robust process for prospectively assessing the risk(s) to care quality and the potential knock-on impact on the wider health and social care community of implementing CIPs. This process requires the Medical, Nursing and Operations Directors to all sign – off each major CIP to ensure that patient safety is not compromised. • The Board can provide examples of CIPs that have been rejected or significantly modified due to their potential impact on patient safety. • The Board receives information on all major CIPs / QIPP plans on a regular basis, including how other organisations in the local health economy are performing against QIPP. Schemes are allocated to lead Directors and are RAG rated to highlight where performance is not in line with plan. The risk(s) to non –achievement of each major CIP is clearly stated and contingency measures are articulated. • There is a process in place to monitor the ongoing risks to care quality for each scheme once a scheme has been implemented, including a programme of formal post implementation reviews. Change(s) to working practice(s) due to major CIPs are supported by a programme of organisation development.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Quality assurance process for signing – off and monitoring CIPs. • Examples of CIPs that have been rejected on the basis of quality. • Board reporting pack that documents CIP progress. • Example post implementation review.

Section RAG rating: Green

3. Board insight and foresight (Assessment)

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
• Board receives report on CIP programme – via the finance report. Detailed report is also presented monthly to the Finance and Performance Committee. • Governance processes in place to risk assess CIPs and monitor risk. • Examples of where CIPs rejected due to quality impact • Board reporting on major CIPs / schemes. • Improvement programme with executive sponsors for individual workstreams. • Documented process re. sign-off of CIPs and assessment of quality impact. Improvement Board and Clinical Governance Group. PIDs include quality and equality impact assessment. • Regular reporting to the Board on both the Improvement Programme and major CIP schemes, including more detailed sessions as part of the Board Development Programme/ Board Strategy Seminars	• Need to implement formal post-implementation reviews for major CIP schemes, to include successful delivery of objectives and any unintended impact.	

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
None		

3. Board insight and foresight (Guidance)

3.3 Environmental and strategic focus

Red Flag	Good Practice
• The Board does not receive an update on developments within the external environment at each Board meeting. • The Board's annual programme of work does not set aside time for the Board to consider environmental and strategic risks to the Trust and downside scenario planning. • The Board does not formally review progress towards delivering its strategy.	• The CEO presents a report to every Board detailing important changes or issues in the external environment (e.g. policy changes, quality and financial risks in the health economy, PBR new tariffs etc.). The impact on strategic direction is debated and, where relevant, updates are made to the Trust's risk registers and BAF. • The Board has reviewed lessons learned from enquires and has considered the impact upon themselves. Actions arising from this exercise are captured and progress is followed up. • The Board has conducted or updated an external stakeholder mapping exercise, market analysis and/or PESTELI analysis within the last year to inform the development of the IBP. • In developing the IBP, the Board as a whole has explored market opportunities and threats in relation to the services it provides, discussed its appetite for risk and has considered various alternative futures (e.g. scenario planning). • The Board has agreed a set of corporate objectives and associated KPIs/ milestones that enable the Board to monitor progress against implementing its vision and strategy for the Trust. Performance against these corporate objectives and KPIs/ milestones are reported to the Board on a quarterly basis. • The Board's annual programme of work sets aside time for the Board to consider environmental and strategic risks to the Trust and downside scenario planning (e.g. the risks presented by PBR, commissioning intentions and efficiency requirements). Specifically, the Board can demonstrate that it has sufficiently discussed the downside scenarios that underpin the LTFM, including key mitigation plans and trigger points for deploying these plans. • Strategic risks to the Trust are actively monitored through the Board Assurance Framework (BAF).
Examples of evidence that could be submitted to support the Board's RAG rating.	• CEO report. • Evidence of the Board reviewing lessons learnt in relation to enquiries. • Outcomes of an external stakeholder mapping exercise. • Corporate objectives and associated KPIs/ milestones and how these are monitored. • Board Annual programme of work. • BAF.

Section RAG rating:
Green

3. Board insight and foresight (Assessment)

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
• CEO report to each public meeting outlining changes in external environment and strategic development e.g. SWL commissioning collaborative (previously *Better Services, Better Value*, academic development, SWL Pathology) • Board review of external enquiries (e.g. Francis report, Clwyd report) • Stakeholders map and market assessment in IBP (chapter 4) • Corporate strategy includes assessment of opportunities / threats and alternative options • Agreed set of objectives • Board strategy sessions every other month to develop strategy, including risks and scenario planning downsides. • Presentation of key risks from BAF via Risk and Compliance Report • Trust stakeholder map refreshed and included within the Corporate Governance Manual		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
None		

3. Board insight and foresight (Guidance)

3.4 Quality of Board papers and timeliness of information

Red Flag	Good Practice
• Reports are regularly tabled on the day of the Board meeting and members do not have the opportunity to review or read prior to the meeting. • Board discussions are focused on understanding the Board papers as opposed to making decisions. • 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.	• The Board can demonstrate that it has actively considered the timing of Board and committee meetings and the presentation of Board and committee papers in relation to month and year end procedures and key dates (e.g. submissions to CQC) to ensure that information presented is as up-to-date as possible and that the Board is reviewing information and making decisions at the right time. • A timetable for sending out papers to members is in place and adhered to. • Each paper clearly states what the Board is being asked to do (e.g. noting, approving, decision, discussion). • Board members have access to in-month flash reports to demonstrate performance against key metrics and there is a defined procedure for bringing significant issues to the Board's attention outside of formal monthly meetings. • Board papers outline the decisions or proposals that Executive Directors have made or propose. This is supported, where appropriate, by: an appraisal of the relevant alternative options; the rationale for choosing the preferred option; and a clear outline of the process undertaken to arrive at the preferred option, including the degree of scrutiny that the paper has already been through. • The Board is routinely provided with data quality updates (e.g. Information Governance Toolkit scores). These updates include external assurance reports that data quality is being upheld in practice and are underpinned by a programme of clinical and/or internal audit to test the controls that are in place. • The Board can provide examples of where it has explored the underlying data quality of performance metrics that have been RAG rated green.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board meeting timetable. • Process for submitting and issuing Board papers. • In-month flash reports. • Sample Board papers. • Data Quality updates.

Section RAG rating: Green

3. Board insight and foresight (Assessment)

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
• Timetable for preparation of board agendas and papers and circulation in place – quality of papers and timeliness of papers for committees reviewed annually though effectiveness reviews. • At the end of each board meeting there is an evaluation of the effectiveness of that meeting • Front sheet for papers used to summarise purpose of paper, route gone through to develop proposals and executive summary used to outline proposals • In-month performance reporting to Executive Management Team and Board sub-committees (Finance, Performance & Investment and Quality & Risk Committee) • Reports on Information Governance Toolkit via the Risk and Compliance report to Board • Regular update from Audit Committee to alert to assurances received re data quality • Timing of Board and sub-committees reviewed and amended in 2012, and reviewed subsequently annually via the committee effectiveness reviews.	• Implementation of regular NEDs briefing by CEO to update NEDs on key issues between meetings (June 2014)	

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
None		

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4. Board engagement and involvement

4. Board engagement and involvement (Guidance)

4.1 External stakeholders

Red Flag	Good Practice
• The development of the IBP and LTFM has only involved the Board and a limited number of Trust staff. • The Trust has poor relationships with its commissioners. • The Trust's latest patient survey results are poor. • The Trust has received adverse negative publicity in relation to the services it provides in the last 12 months.	• The Board has an External Stakeholder Engagement Plan that clearly describes the Trust's key existing and emerging external stakeholders, their relative priority and the tailored methods used to involve each stakeholder group (stakeholders include PCT Cluster, Clinical Commissioning Groups, Local Authorities and Wellbeing Boards). • A variety of methods are used by the Trust 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 like non-English speakers and service users with a learning disability. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice. • The Board can evidence how key external stakeholder groups (e.g. patients, carers, commissioners and MPs) have been engaged in the development of their 5 year strategy for the Trust and provide examples of where their views have been included and not included in the IBP. • The Board has ensured that various communication methods have been deployed to ensure that key external stakeholders understand the key messages within the IBP (e.g. campaigns in community vantage points, shopping centres, leisure centres; close links with academic institutions and schools; visits to 'hard to reach 'groups etc.). • The Trust has constructive and effective relationships with its key stakeholders, especially Lead Commissioners.
Examples of evidence that could be submitted to support the Board's RAG rating.	• External Stakeholder Engagement Plan. • Organisational/ management structure. • Clinical Commissioning Group Strategy. • Description of disputes with Commissioners and how they have been resolved.

Section RAG rating: Green

4. Board engagement and involvement (Assessment)

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
• FT Stakeholder Steering Group in place to ensure external input into IBP / LTFM and development of strategies, including CCG leads. • Various methods in place for feedback from stakeholders – membership events, Patient Reference Group, HOSC and HWB, Healthwatch, MPs CEO blog • Evidence of work with commissioners (Clinical Quality Review Meeting, contract negotiations etc.) • Patient groups (ICE etc) involvement in service improvement / planning • Consultation process re key strategies – stakeholders involved • External stakeholder engagement plan agreed by Board as part of the Communications Strategy and implementation plan. This includes feedback mechanisms for various stakeholder groups.		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
Adverse negative publicity in last 12 months - negative publicity following unannounced CQC inspection January 2013	Actions in that report now addressed and CQC (CIH) inspection in February 2014 rated trust as 'good' overall, with positive publicity from CQC.	

4. Board engagement and involvement (Guidance)

4.2 Internal stakeholders

Red Flag	Good Practice
• The Trust's latest staff survey results are poor. • There are unresolved staff issues that are significant (e.g. the Board or individual Board members have received 'votes of no confidence' by the clinical community, the Trust does not have productive relationships with staff side/ trade unions etc.). • There are significant unresolved quality issues.	• A variety of methods are used by the Trust to enable the Board and senior management to listen to the views of staff, including 'hard to reach' groups like night staff and weekend workers. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice. • The Board can evidence how staff have been engaged in the development of their 5 year strategy for the Trust and provide examples of where their views have been included and not included in the IBP. • The Board ensures that staff understand the Trust's key priorities and how they contribute as individual staff members to delivering these priorities. • The Trust uses various ways to celebrate services that have an excellent reputation and acknowledge staff who have made an outstanding contribution to patient care and the running of the Trust. • The Board has communicated a clear set of values/ behaviours and how staff that do not behave consistent with these values will be managed. Examples can be provided of how management have responded to staff that have not behaved consistent with the Trust's stated values/ behaviours. • There are processes in place to ensure that staff are informed about major risks that might impact on patients, staff and the Trust's reputation and understand their personal responsibilities in relation to minimising and managing these key risks. • The Board can demonstrate that clinicians play a key role in management and decision-making within the Trust.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Internal engagement or communications strategy/ plan. • Organisational values. • Dignity at Work policy.

Section RAG rating: Green

4. 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
• Board agreed values disseminated to staff through induction and staff communications. • Acknowledgment of staff that demonstrate values – staff awards at AGM, values awards. • Summary business plan disseminated to staff • Clinicians play key role in management – Divisional Chair role, terms of reference of EMT, and eCMB • Variety of mechanisms in place to communicate with staff – eCMB, leadership forums, open staff meetings, eGazette, team briefings • Staff engaged in corporate strategy – extended attendance at Board strategy sessions and engagement with staff groups • Action plan in response to staff survey – particular focus on bullying and harassment • Internal engagement plan included in the Communications Strategy • Regular staff forum focusing on quality and patient safety in place • The Trust has a Dignity at Work policy • Listening into Action programme now into second year – repeating 'Big Conversations' as well as targeted conversations with staff groups / disciplines. 20 individual teams working on LiA projects. • Staff newsletter introduced May 2014	• Implementation of formal staff briefing system – 'Core Brief' (September 2014) • Review effectiveness of staff forums to support implementation of core brief (September 2014)	

• Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
None		

4. Board engagement and involvement (Guidance)

4.3 Board profile and visibility

Red Flag	Good Practice
• With the exception of Board meetings held in public, there are no formal processes in place to raise the profile and visibility of the Board. • Attendance by Board members is poor at events/ meetings that enable the Board to engage with staff (e.g. quality/ leadership walks; staff awards, drop in sessions).	• There is a structured programme of events/ meetings that enable NEDs to engage with staff (e.g. quality/ leadership walks; staff awards, drop-in sessions) that is well attended by Board members and has led to improvements being made. • There is a structured programme of meetings and events that increase the profile of key Board members, in particular, the Chair and CEO, amongst external stakeholders. • Board members attend and/or present at high profile events. • NEDs routinely meet patients and carers. • The Board ensures that its decision-making is transparent. There are processes in place that enable stakeholders to easily find out how and why key decisions have been made by the Board without reverting to freedom of information requests.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board programme of events/ quality walkabouts with evidence of improvements made. • Active participation at high-profile events. • Evidence that Board minutes are publicly available and summary reports are provided from private Board meetings.

Section RAG rating: Green

4. Board engagement and involvement (Assessment)

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
• Open and transparent decision-making – e.g. public board meetings, public consultation over neuro-rehabilitation and board meeting attendance. Board papers available on website. • Additional high profile events – annual open day and AGM, staff awards evening. Chair / NED attendance at high profile openings / visits • Quality inspections programme, including NEDs and EDs • Extended membership at board strategy sessions • Chairs attendance at department meetings and walkabouts • Regular meetings for MPs with Chair and CEO, plus MP briefing in place • CEO regular attendance at HOSC meetings • Membership events – 'Meet the Chair / CEO session' • 'Board to Board' and joint executive meetings with SGUL • Chair and CEO membership of external bodies / committees • Board meetings now held in QMH as well as St. George's	• Raise profile of board members and senior management within community services, as recommended by CQC – execs and NEDs to take part in community quality inspections (September 2014).	

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
None		

4. Board engagement and involvement (Guidance)

4.4 Future engagement with FT Governors

Red Flag	Good Practice
• The Board has not yet considered the roles and responsibilities of the Council of Governors. • The Board has not yet considered how best to communicate with and engage the Council of Governors. • The Board has not yet considered how to elect, induct and develop governors.	• The Board has a plan in place 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. • 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. The statement also considers the role of specific groups of governors (e.g. staff governors) and how they will be used to best effect. • There are robust plans in place to elect, induct and develop governors once the Trust is authorised. • There are robust plans in place to show how the Board will communicate with and engage governors, in particular, in the areas of strategy development, service change and quality issues. • 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 the membership will be maintained going forward. • The Board has a strategy for engaging with its membership, including describing the kinds of issues it will consult with members on and how the views of hard-to-reach groups in the community will be represented.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Council of Governors Development Plan. • Membership Recruitment Strategy. • Membership Engagement Strategy. • Statement on the roles and responsibilities of the Council of Governors. • Governor election timetable and plan.

Section RAG rating: Green

4. Board composition and commitment (Assessment)

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
• Membership strategy in place and plan for engagement – 12,500 public members at present • Governance rationale and constitution developed, including roles and responsibilities of Council of Governors • Public consultation on proposed governance arrangements completed April 2013 • Election of Governors process commence 2 June – results due to be announced 28th July 2014 • Induction programme developed for new governors and resources identified to ensure continued support for governors. •		

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
None		