EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**7 AUGUST 2015**
SUBJECT:	**DELOITTE GOVERNANCE REVIEW UPDATE**
REPORT FROM:	**CHIEF EXECUTIVE OFFICER**
PURPOSE:	**APPROVAL**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

The Trust commissioned Deloitte's to undertake a Board Governance Review in October 2014. All Trust's must undertake this type of review at least every three years under Monitors Risk Assessment Framework. The review aims to ensure that Boards are fully sighted on any governance issues and encourages regular reviews against best practice.

The report was received in late January 2015 and the themes were discussed at the Board of Directors' away-day in February 2015 and an action plan agreed.

The action plan and Well-Led summary document was circulated to Governors and a brief discussion took place at the Council of Governors meeting in March 2015.

Monitor discussed the action plan with the Trust at the March and April Performance Reviews

SUMMARY:

Progress is on-going with a number of actions completed. Where an action is complete it will be "greyed out" if evidence has been provided. Where evidence has not been provided the action remains live.

The Executive Team reviewed the action plan in July 2015, although the Chief Operating Officer and Director of Finance were on leave. They identified a number of actions that needed focus, especially:

- R33: The Trust should review its suite of regular Board reports to increase the level of consistency in presentation across finance, performance and quality and between executive portfolios.
- R34: Trust should look to streamline the volume of material presented to the Board by making more consistent use of exception reporting, dashboards, benchmarking and more focused narrative to guide the reader
- R56: It has been identified that resource will be required to meet this recommendation: Consider extending the clinical leadership development programme to existing registrars at the Trust. The estimated cost is £69,270 for an 18 month period.

These two recommendations suggested a working group approach with NED's and ED's. The Grant Thornton report also recommended a focus on the information.

The recommendations in relation to risk (R36 – R46): Barry Wilding, Nikki Cole, Acting Chief Nurse and the Deputy Director of Patient Safety, Governance and Risk

met to discuss risk. Additional support has been put in place for a 2 month period to provide a focus on risk

Some actions are overdue but these are being addressed and actions are being taken.

RECOMMENDATIONS:

Review the action plan and agree how to take R33 and R34 forward as a Board.

NEXT STEPS:

Continue the quarterly review by the Board but integrate it with the Improvement Plan updates.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

SO1: Deliver excellence in the quality of care and experience of every person, every time they access our services

SO2: Ensure comprehensive communication and engagement with our workforce, patients, carers, members GPs and the public in the planning and delivery of healthcare

LINKS TO BOARD ASSURANCE FRAMEWORK:

All

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:

None

FINANCIAL AND RESOURCE IMPLICATIONS:

Potential cost associated with the delivery of the plan as external support will be required.

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

The Trust is in breach of its licence and provided a number of undertakings to Monitor, one of which was to undertake the Board Governance Review and implement the resultant recommendations. The Trust will remain in breach until this plan is delivered. However, there are other undertakings and therefore coming out of breach is not solely reliant on delivery of the actions.

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES

None

ACTION REQUIRED: **(a) Discuss the progress made in delivering the Board Governance action plan;**
CONSEQUENCES OF NOT TAKING ACTION: Continue to remain in breach of licence.

Ref	Deloitte Recommendation	Priority given by Deloitte	High level action	Action taken to date	Outcome expected following action implementation	Person responsible	Timeline for completion of action	Assurance
			Senior Leadership					
R1	The interim Chief Executive should initiate an executive development programme aimed at team building and behaviours as part of a wider Board development programme (see R10).	Medium priority	A development programme will be brought to the April / May 2015 BoD for review and will include; • Quarterly workshops • Review of induction • Consideration of using an external development consultancy for a longer term programme	5/5/15 meeting took place with agreement to sign up to the top level plan provided by Hay.	Executive Team working more cohesively	CEO / DoHR + NED RemCom	End of April 2015 and on-going	Development programme compiled with key dated milestones and signed-off by the CEO Each milestone completed Regular exec 360 review to ensure improvement. (NB Baseline for is Deloitte Survey)
R2	The executive team should arrange a discussion forum with divisional leaders to clarify respective roles, responsibilities and behaviours and to agree the appropriate balance of executive oversight and divisional autonomy.	High priority	A discussion forum involving the current executive team and the divisional leaders will take place as soon as can be arranged. The outputs will be reviewed, amended as appropriate and then taken forward by the Interim Chief Executive and this team. Joint Executive and Divisional team workshops will be held on key issues e.g. strategy, throughout the year. Appointments in diaries to meet Medical and Divisional Directors. Executive Away Day Team Building in April.	**June 2015** First meeting took place 29 May 2015 which looked at governance; roles; learning from incidents. Work will continue on scheduling further discussion forums. Divisional Medical Directors and Divisional Heads Of Nursing will attend Managament Board to ensure all are involved in decision making. In addition the CEO will undertake a management structure review and make recommendations by the end of December 2015	Closer working between Exec Team and Divisional Leadership. Divisional leaders will be able to articulate their roles, responsiblities and the behaviours expected. An agreed Performance Framework in place which all understand and abide by.	CEO	From May 2015 - on-going	Discussion Forum held by agreed date Forums as planned attended by all key members Roles and responsibilities agreed and 'signed up to' Agreed joint meetings in existence and being attended All key objectives to come from Board and link exec and Divisional leads Staff Pulse surveys to check achievements as appropriate (baseline Deloitte review / re-run relevant questions). 360 review for execs and Divisional leads to check that all are satisfied with approach, and that the team is integrating (baseline is Deloitte review)
R3	The Board development programme (see R11) should include a focus on listening skills and individual coaching should be made available where development areas are identified.	Medium priority	CEO and Chair to develop a programme for NEDs and EDs which will include listening skills and individual coaching.	Chair in place 11/5/15; discussions with DoHR already started. **June 2015** DoHR has produced a first draft of a development plan for the Chair to consider.	Constructive feed back is perceived as positive in enabling better discussion and solutions	Chair / CEO	Following appointment of Cair	Covered by some questions in the Deloitte review - will re-run within the year.
R4	The interim Chief Executive should put in place an internal stakeholder engagement plan, as part of a wider stakeholder plan (see R12). This plan should be aimed at enhancing the internal engagement for all Executive Directors.	Medium priority	Development of a plan to focus on how the Executive Team engage and communicate internally - using the work currently being undertaken by Hay to inform this. Consideration of commissioning externally. Update the current Communications Strategy.	Communications plan in place (requires update) Shadowing by Executive Team **June 2015:** External consultancy assisting in the development of a communications plan.	Staff perceive a high level of engagement from the Executive and Divisional leadership teams and drive staff engagement. Ensure the Trust is removed from Special Measures and complete te consultation on strategic direction that secures clinical and financial stability	CEO/DHR with ED input	To commence April 2015 - will take 3 months	Internal stakeholders listed and fully understood by exec and divisions Purpose of internal engagement plan agreed by exec and divisions and linked to culture change programme agreed Internal stakeholder plan written with key milestones and linked to culture change programme Each exec to be personally linked in engagement plan Trust communications strategy developed and implemented
R5	The interim Chief Executive should hold a summit with senior leaders from commissioners to agree ways of enhancing the quality of future interactions between Executives and local commissioners.	High priority	Interim Chief Executive will meet with CCG leaders and establish effective working relationships. Arrange B2B / Summit	Has met Clinical Chairs and Accountable Officers. In addition has spoken to NHS England regional office. AO's meeting regularly. July B2B in place. CEO also attends Whole Health Economy Federation meetings	CCG leaders and Trust Board members describe a good working relationship	CEO / Chair	on Appointment of Chair	Regular self assessment by Trust Board re healthiness of relationships and plans to improve partnership working (Deloitte review questions) Regular joint meetings agreed
R6	The Board should recruit an interim Chief Executive who is external to the organisation as soon as possible. This individual should have a successful track record in 'turning around' NHS organisations from a staff engagement and cultural perspective. Given the nature of the issues we have described and the criticality of needing to show positive progress in a number of areas, it may be necessary for this interim to be at the Trust for the medium term (e.g. 12 months).	High priority	Recruit an Interim CEO	Chris Bown in place, met over 1000 staff in first 4 weeks. Anecdotal feedback is good. Comms working up additional opportunities.	Bring stability and cohesiveness to the Executive Team	Chair / CEO	Completed	Audit to check that the interim CEO is recognised within the Trust as part of preparation for CQC revisit (site based teams) Comms opportunities to introduce himself and also give key messages including use of press
R7	The substantive Trust CEO should be recruited externally to the organisation.	Medium priority	A timeline and job specification will be developed and agreed with the Nominations Committee to ensure that the substantive recruitment process is in place.	June 2015: CEO candidate pack agreed at NomCom 25 June 2014	Clear leadership in place for the Executive Team	DoHR / NomCom	Sep-15	Recruitment strategy and process in place and will be taken forward in September 2015 for appointment to start Feb 2016

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R8	The Chief Executive should reduce the overall frequency of his contributions at Board and Committee meetings.	Medium priority	Contributions at Board meetings (including spread of contributions, relevant challenge and how to ensure scrutiny) will be included in the Board Development Programme – linked to R3	Interim Chief Executive appointed	All Board members engage effectively with the discussion / decision making	Chair / CEO / DoHR	End of May 2015	Completed
R9	The Chair should actively encourage other Board Members to increase the quality and frequency of their Board level contributions.	Medium priority	See R8	Chair in place 11/5/15; discussions with DoHR already started. **June 2015:** Draft development plan produced and being discussed.	All Board members engage effectively with the discussion / decision making	Chair / CEO / DoHR	End of May 2015	Board development undertaken when new Chair in place, incuding review of Board behaviour at Board meetings At end of each Board meeting review performance using values and behaviours
R10	The frequency and quality of scrutiny needs to be improved materially, through refreshing the Non-Executive cohort and through focused development.	High priority	See R8 / R14 / R15	Chair in place 11/5/15; discussions with DoHR already started. 2 new NEDs joining in May 2015. **June 2015:** Draft development plan produced and being discussed.	All Board members engage effectively with the discussion / decision making	Chair / CEO / DoHR	Dec-15	NED refresh to be considered as terms of office expire. Set of reflective questions developed to ask at Board (eg is there a subject that we are still not assured about: what further action is required to assure us) At end of each Board meeting there is a review against the Trusts values and behaviours Board development undertaken Board review in one years time - using Deloitte questions
R11	The Chair should develop a comprehensive Board development programme, timed to coincide with the arrival of new Executives and Non Executives, aimed at team building and influencing behaviours.	Medium priority	A Non-Executive Director recruitment initiative is underway to address the two immediate vacancies. Once these appointments are in place, the Chair will ensure that an individually focussed and collective development programme is initiated – see R8 and R3	Chair in place 11/5/15; discussions with DoHR already started. **June 2015:** Draft development plan produced and being discussed.	Board members describe good working relationship with other Board members whilst encouraging constructive challenge	Chair	on Appointment of Chair	New Chair has worked with iterim CEO and a Board development programme is comisioned as soon as appointed, which encompasses the work already being undertaken in the culture change programme
R12	The Trust should develop a Board stakeholder engagement plan and ensure that all Non Executives have an active role to play in its delivery.	Medium priority	See R4 Review Clinical Strategy / Communications Strategy and Stakeholder Map to develop a stakeholder engagement plan which includes NED's as well as ED's and ensures a review of time commitment for NEDs	1. Engagement Plan is in place in relation to the Clinical Strategy. 2. Executive Patient Safety Visits 3. 6 monthly B2B with Commissioners	Staff and External Stakeholders report increased engagement with NEDs	CEO / DHR and Execs and NEDs + incoming Chair	Commence work April 2015 - will take around 3months	R4 expanded to include a plan for all stakeholders NEDs role identified in the plan Governors role identified in the plan Stakeholder engagement plan links with culture change programme Regular Board to Board meetings agreed
R13	The Chair should create opportunities for Non Executives to present at Council of Governor meetings and also incorporate Non Executives in the governor induction programme.	Medium priority	Chairman working with Lead Governor to discuss opportunities. Incoming chair will be updated on progress so that the work continues.	NEDs presented reports at May CoG. Induction being reviewed. Governance session to be held and include NEDs	Governors report higher levels of interaction with NEDs	Chair	May-15	NEDs given a clear statement of responsibility at governors meetings Governors induction includes NEDs Review success in 6 months time with Lead Governor, Chair and SID
R14	The Council of Governors should give due consideration to the timing of replacement Non-Executive Directors to ensure they are appropriately staggered over the next 12-24 months.	Medium priority	Produce timeline to ensure that NEDs appointments are staggered over the next 12-24 months	The Council of Governors Nominations Committee has met to discuss and agree the strategy for staggering the new NED appointments over the next 12-24 months. Plan is in place	Board refresh is a smooth process and the challenging agenda is met	Chair	Completed	Written plan for recruitment / refresh of NEDs and staggering (which is already in place) developed with governors.
R15	We recommend that the Council of Governors appoint new Non-Executive Directors with organisational development, clinical and strategic transformation backgrounds.	Medium priority	The job specifications for the NED roles include the need for specific expertise.	Appointed Chair amd NEDs with these skills.	Refresh of NEDs will ensure good spread of knowledge and experience	DoHR / NomCom	Completed	Included in job specifications - completed.
R16	The Council of Governors should appoint a Chair from outside the Trust, once the term of the current Chair comes to an end in September 2015.	High priority	The Chair has decided to stand down in April 2015 and recruitment is underway.	Chair appointed	New Chair will be in place	Deputy Chair / NomCom	April - May 2015	Plan required if unable to appoint Clear local induction programme for successsful applicant developed
R17	The Council of Governors should strongly consider using a specialist recruitment agency to ensure that applicants to the Non-Executive Director vacancies are of sufficient high quality.	Medium priority	The Council of Governors has appointed Odgers to lead the recruitment process.	Recruitment agency appointed	Specialist external support in recruiting high quality NEDs	DoHR / Deputy Chair / NomCom	Completed	Achieved
R18	Ensure strategies are developed with full engagement with staff and key stakeholders. In particular, ensure that adjoining strategies (e.g. workforce, estates, communications strategies) receive the same engagement.	Medium priority	See R4 and 12 'Great Place to Work' and 'Clinical Engagement Strategy' in place to address this in the interim. Longer term engagement strategy to be developed so thay all strategies ensure good engagement	1. Clinical Strategy Engagement Programme in place 2. Great Place to Work - engagement initiative in place	Staff are able to articulate the Trusts strategies	DoHR / DoS&CP	end of July 2015 - testing of effectiveness over 12-18 months	See R4 and R12 All strategies and programmes which require engagement with should have staff and others identified In all strategy reports there is a section to show how staff and others have been engaged since the last report (including members of staff who have attended engagement events) Culture change programme includes learning in involving others in strategy development and implementation
BOARD PROCESSES AND SYSTEMS								

East Kent Hospitals NHS Foundation Trust
Board Governance Review

Ref	Deloitte Recommendation	Priority given by Deloitte	High level action	Action taken to date	Outcome expected following action implementation	Person responsible	Timeline for completion of action	Assurance
R19	The Board should review progress on a monthly basis in relation to the various initiatives underway to address organisational cultural change and improve staff engagement.	High priority	From the February Board of Directors meetings onwards, progress on the culture / engagement programme will be included as a specific item on the meeting agenda	Update provided at February 2015 away day but metrics need to be agreed.	Board is aware of progress and the impact that the changes are having.	DoHR	Mar-15	Culture change written report to monthly Improvement Board includes progress Also part of monthly Improvement Plan report to Board
R20	Consider creating a dedicated Workforce/Human Resources committee within the assurance structure	Medium priority	Agreed in principle and will form part of the work outlined in R21	Terms of reference approved by BoD; meeting will be scheduled for June 2015 to be chaired by Richard Earland. **June 2015:** Committee met for the first time in June 2015 and will meet monthly.	Board receive assurance in relation to workforce plans and issues	DoHR	By July 2015	Workforce committee in place with appropriate membership Clear strategy and implementation plan identified Actions in plan acheievd KPIs for improvement identified and monitired (eg vacancy rates)
R21	Consider whether operational performance should be formally covered in detail in one of the existing Board Committees, either FIC, Quality or a new Workforce Committee.	Medium priority	Review of Committee Structure (various people will lead): • Map agendas to ensure flow of information through the correct route (from Divisional level up and use PWC work to ensure below Division committees are effective) • Review of frequency of meetings • Alignment with EPRs and Divisional Boards • Consideration of resource implications • Review of Terms of Reference	Paper to Management Board 20/5 and to Board 21/5 on bullets 2 & 3. Once agreed flows to be mapped and ToRs produced. **June 2015:** Management Board and thereafter the Board of Directors approved the changes, implementation started. Grant Thornton review may inform	Clear governance structure that supports the work of the Board. Assurance is provided in a timely manner	CNDQ (supported by TS)	end of July 2015 for review and recommendations. Implementation will take 2 months and embedding will take 12 months	Governance reviewed and improved in light of the PWC Governance review: Terms of Reference in place to make it clear where performance is covered; effectiveness reviewed through annual effectiveness survey.
R22	Ensure that operations is sufficiently represented to cover the agenda for Board committee meetings where operational performance is presented.	Medium priority	See R 21	Paper to Management Board 20/5 and to Board 21/5 on bullets 2 & 3. Once agreed flows to be mapped and ToRs produced. **June 2015:** Board of Directors now receives a more detailed report on performance against the national standards along with updates on action plans.	Clear governance structure that supports the work of the Board. Assurance is provided in a timely manner	CNDQ (supported by TS)	end of July 2015 for review and recommendations. Implementation will take 2 months and embedding will take 12 months	There is a comprehensive operations report to the Board (or committees) with evidence of challenge and review of recovery plans. Where operational information is discussed COO (or Divisional Directors) will be invited to attend.
R23	Change the Quality Committee meeting frequency from quarterly to either monthly or six-weekly.	Medium priority	Agreed to move this to monthly following the scheduled April 2015 meeting. Link to R21 and consider resource implications prior to implementation.	Meetings rescheduled to make this meeting monthly	Clear governance structure that supports the work of the Board. Assurance is provided in a timely manner	CNDQ / TS	May-15	Quality Committee meets every month Clear agenda linked to other quality committtees Report to Board
R24	Ensure all Committees use action trackers with clear timescales and ownership for delivery.	Medium priority	All Board Committees use the agreed action tracker. Chairs to ensure that actions have appropriate due by dates.	Action trackers are in use, training to be provided to ensure actions are dated	To ensure clear action tracking	NED Chairs	Apr-15	Audit of all committee reports and identify any non compliance Non compliant committees made compliant
R25	Review the agenda of the Finance and Investment Committee to ensure that it is focused on assurance rather than operational detail.	Medium priority	See R21	Paper to Management Board 20/5 and to Board 21/5 on bullets 2 & 3. Once agreed flows to be mapped and ToRs produced. **June 2015:** Governance review by Grant Thornton will inform the FIC ToRs and agenda going forward. Report expected w/c 20/7.	Clear governance structure that supports the work of the Board. Assurance is provided in a timely manner	DoF / TS	end of July 2015 for review and recommendations. Implementation will take 2 months and embedding will take 12 months	Operational review is provided for review in similar manner as finace report Links with finance to be identified in reports (see R21) interlinks with activity to be shown
R26	Ensure chairmanship of the Quality Committee is handed over to another Non Executive at the earliest opportunity.	Medium priority	Current Chair to discuss with NEDs to agree new Chair of QC	Chris Corrigan to Chair from May 2015 and then to form part of the review by the new Chair	Adherence with best practice - Trust Chair should not Chair a committee	Chair	from May 2015	New NED Chair in place
R27	Consider the relationship between the Quality Committee and divisional leadership teams and whether the Terms of Reference should be amended to include representation from the Divisions	Medium priority	See R21	Early discussions held, further work to be undertaken with divisions. DMD's to attend. **June 2015:** DMD's will attend at least every 4 months to update on clinical audit, review of terms of reference in July 2015 will discuss membership further.	More clinical and divisional input into assurance around quality to the Board.	CNDQ / COO / TS	Jun-15	Reviewed terms of reference signed-off by Board showing the membership.
R28	The process for managing interdependencies, information flows and assurance mapping between Board committees should be clarified and communicated to all Board Members.	Medium priority	Map information flows from Executive led committees through Board Committee and up to Board.	Paper to Management Board 20/5 and to Board 21/5 on bullets 2 & 3. Once agreed flows to be mapped and ToRs produced. **June 2015:** in process will be completed by the end of July 2015	Ensure that there is no duplication or gaps in reporting to the Board.	TS	end of July 2015 for review and recommendations. Implementation will take 2 months	Information flow map produced and reviewed Review map quaterly against actual performance and address any breakdown

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R29	Review the Terms of Reference of the Quality Assurance Board in light of the creation of the Quality Committee to ensure that there is no duplication and that there are clear information and assurance flows.	Medium priority	See R21	Paper to Management Board 20/5 and to Board 21/5 to approve the creation of one quality focussed committee. **June 2015:** This is in review but the current plan is for the Patient Safety Board, Patient Experience Group (new), Clinical Audit and Effectiveness Committee and NICE Implementation Committee to feed directly into Quality Committee , removing a alyer of governance not require and taking the information through in a more timely way.	Clear governance structure that supports the work of the Board. Assurance is provided in a timely manner	CNDQ / TS	end of July 2015 for review and recommendations. Implementation will take 2 months	PWC report and plan is actioned imediately See R23 TMB has been considered
R30	Evaluate the effectiveness of the Clinical Advisory Board following the recent changes in structure and focus, including the links with other key operational committees.	Medium priority	See R21 and PWC report Action 12	Paper to Management Board 20/5 and to Board 21/5 to approve the creation of one quality focussed committee. June 2015: This is in review but the current plan is for the Patient Safety Board, Patient Experience Group (new), Clinical Audit and Effectiveness Committee and NICE Implementation Committee to feed directly into Quality Committee , removing a alyer of governance not require and taking the information through in a more timely way.	Clear governance structure that supports the work of the Board. Assurance is provided in a timely manner	CEO / MD /TS/ CNDQ / DoS&CP	May-15	As above / Completed
R31	The Trust should align its reporting of performance information to ensure that the information is being presented in a consistent format at Board and committee meetings.	Medium priority	Review the presentation of financial information (Corporate Performance Report) and performance information (key national performance targets). To ensure specifically that KNPT's are discussed at Board Committee level. Links with R28 and R32	Paper to Management Board 20/5 and to Board 21/5 to approve principles for reporting and consistency in reporting. **June 2015:** Grant Thornton work will include a complete refresh of our trust/committee reports. Divisional EPRs now in new format.	All Board and Divisional Leaders are clear on what is presented to each meeting and how it is to be presented.	RE /DoF / TS	Jun-15	Reporting styles reviewed Discussed and agreed through Board development New reporting style implemented There is no unneccessary duplication of reports Review success through Board review in one year (using Deloitte Review relevant questions)
R32	The Trust should ensure that Board meetings receive more granular detail in relation to divisional financial performance and the efficiency programme, particularly in the light of current financial challenges.	Medium priority	More comprehensive finance paper to Board to ensure greater focus on divisional financial performance and delivery of the efficiency programme. Define what Board wants to see to ensure Board awareness and discussion.	Financial Recovery Group set up (first mtg 20/5) to focus on financial performance and CIPs. Will support reporting to FIC. **June 2015:** Grant Thornton undertaking financial governance review which will inform this action in terms of the level of detail.	Clarity on the detail that should be provided at Committee and Board level	FIC Chair / DoF	Jun-15	Review other Trust Board Finance reports A suitable report is identified for EKHUFT and implemented Board minutes to evidence consideration of divisional performance review
R33	The Trust should review its suite of regular Board reports to increase the level of consistency in presentation across finance, performance and quality and between executive portfolios.	Medium priority	NED and ED task and finish group to review suite of reports including the type of report required and detail to be provided (link to R 31 and R32)	Action to come from BoD meeting on 21/5 following approval of some changes.	Using consistent reporting can reduce errors - especially for data.	ED / NED Group	Jul-15	See R31
R34	Trust should look to streamline the volume of material presented to the Board by making more consistent use of exception reporting, dashboards, benchmarking and more focused narrative to guide the reader	Medium priority	See R32 / 33 / 34	Paper to Management Board 20/5 and to Board 21/5 to approve principles for reporting and consistency in reporting.	Board should become more effective and focussed.	ED / NED Group	Jul-15	See R31/R33, developed through Board development work ; and Review other high performing Boards' reports undertaken
R35	Develop a workforce report that includes workforce and organisational development KPIs to be presented regularly to the Board or a relevant committee.	High priority	Director of HR is currently developing a workforce report to include OD KPI's and this will be presented to Board / Workforce Committee.	KPI's developed, report to May 2015 BoD	Ensure the Board is sighted on issues around workforce	DoHR	May-15	Link to R20 Workforce indicators included in the Corporate Performance Report which helps the Board assure iself that workforce issues are understod and being managed.

Ref	Deloitte Recommendation	Priority given by Deloitte	High level action	Action taken to date	Outcome expected following action implementation	Person responsible	Timeline for completion of action	Assurance
R36	Develop a detailed risk appetite statement and then align practices to manage risk within the boundaries set by the statement.	Medium priority	Review of risk appetite statement to be undertaken to underpin how the Board and its Committees discuss the Corporate Risks and balance the risks accordingly	Discussions have taken place between CEO / CNO to ensure the Risk Management Strategy clearly sets out the level at which risks should be escalated. Chair keen to have some Board training. Risk workshop to be planned.	Provide a realistic statement of risk appetite to be rolled out across the Trust	CNDQ to lead joint work	Jul-15	R36- R42 This suite has much more work to be done linking to the PWC report. Key outcomes: Risk appetite agreed Risk Management committee with appropriate membership Risk Management training in place for all staff and assessment of take-up, effectiveness etc. Considered by Workforce Committee abd assurance to Board. Risk Register supported by system and used from'ward to board' Board understands and uses corporate risk register All risks intergrated Trust has reviewed where risk management sits Risk management properly resourced All points in CQC and PWC report dealt with
R37	Conduct risk management training for all current and future Board Members, focusing on the NHS environment and Trust context. The training should focus on an effective risk management process with emphasis on risk treatment, how to make decisions about risk and using risk appetite.	Medium priority	Review the risk management training for Board (including the Divisional teams) to ensure they receive regular training with a focus on effective risk management, the treatment of risk and making decisions about the risk.	Risk workshop to be planned now that Chair in place (11/5/15)	Adherence with best practice - the Board should have regular risk management trainng	CNDQ	Jul-15	***See Above***
R38	Implement a risk register database system that is less labour intensive and enables greater interrogation of risk to support decision making and enable better escalation of risk.	High priority	review of options around risk register database systems for consideration with executive colleagues and the new Interim Chief Executive with a view to taking a clear proposal to the April Board of Directors meeting	Pilot running. Minor tweaks before rolling out.	Provide a system which is efficient, not prone to manual error and allows easy manipulation of data	CNDQ	Apr-15	***See Above***
R39	Undertake an audit of risk escalation processes, particularly the effectiveness of decision making following the escalation of risk.	Medium priority	Commission an audit of risk escalation processes with a focus on the effectiveness of decision making following the escalation of risk	Internal Audit to plan an audit to test this.	Better understanding of issues around escalation and decision making around risk and improved adherence to process.	CNDQ	schedule audit June 2015	***See Above***
R40	Ensure all staff receive regular training on risk management, particularly in relation to the application of registers.	High priority	develop a way forward to ensure all staff receive regular risk management training (coupled with appropriate measurement metrics)	Risk training package being costed.	All staff to understand the application of risk registers	CNDQ / DoHR	Apr-15	***See Above***
R41	Develop a trust-wide assurance and escalation framework that will enable staff to consistently apply risk management practices across the Trust.	Medium priority	Update the RM Strategy to make the guidance on risk escalation more explicit and communicate this to staff involved in risk management along with a reminder as to how to score risks. Consider providing a trigger score above which risks must be escalated and leave professional judgement to escalate lower scoring risks if appropriate. (PWC 18)	Review of RM Strategy underway and training being developed.	Risk evaluation and scoring better understood and used to escalate to divisional and corproate level for discussion	CNDQ	Jun-15	***See Above***
R42	The BAF should explicitly outline when a risk was reviewed by the Board or a Committee, what actions emerged from that review and what progress has been made against the action.	Medium priority	The BAF was under development when first reviewed by Deloitte. The BAF does show details of the risk as well as the actions taken or actions that need to be taken (including dates of review)	Completed - Internal Audit provided clean bill of health to BAF. Risks should be clearly managed on the CRR and links only required from the BAF	Clarity over the management of risks of the BAF	TS	Completed	Internal Audit of BAF - awaiting outcome.
R43	Ensure that the proposed Quality Impact Assessment process for CIP schemes is: • developed in conjunction with clinical teams; • includes a requirement for clinical lead sign off for each quality impact assessment; and • includes reference to quality indicators to allow tracking post implementation.	Medium priority	There is a process already in place. The CIP programme for 2015/16 is to be signed off by MD and CNDQ. The process will be reviewed in line with the action.	Review of quality assurance of CIPs to be reviewed by Quality Committee in April 2015	More clinical engagement in the quality assurance process.	MD / CNDQ	Jul-15	QIA process agreed Evidence of QIA process having been undertaken and reported to FIC and Board
R44	Ensure there is greater focus on the value of reporting incidents and near-misses and providing shared feedback to all relevant staff.	Medium priority	CQC Action Plan M05 / KF11	Grand Round presentations on each site on the learning from Sis. Medical Director / Associate Medical Director for Patient Safety to brief Junior Doctors on learning from Sis.	Increase in the number of incidents and the number of staff reporting feed back and learning from incidents	CNDQ	Jun-15	Reporting increases per plan Evidence in Board quality report of learning from incidents etc. Examples of learning reported to Board
R45	Address the lack of clinical engagement with clinical audit as a tool for risk mitigation and assurance.	Medium priority	CQC Action Plan M23 / KF15	Quality Committee has asked Divisional Medical Directors to clarify obstacles to clinical audit processes. Clinical Leads to be invited to attend QC to discuss audit. **June 2015:** NICE Implementation Committee set up.	Clinical audit is used effectively by Divisions to improve outcomes	MD	March 2015 - on-going	Clinical audit has higher profile in quality committee including divisional plans and performance against them Consequence agreed for incompleted audits, or audit recommendations not acted upon

Ref	Deloitte Recommendation	Priority given by Deloitte	High level action	Action taken to date	Outcome expected following action implementation	Person responsible	Timeline for completion of action	Assurance
R46	Ensure all consultants receive annual feedback on complaints, claims and incidents and improve mechanisms for holding to account.	Medium priority	Review system to allow feedback to be provided at a consultant level	Clinical Outcomes framework agreed at Clinical Advisory Board May 2015	Consultants received feedback at revalidation to allow them to improve their performance	MD / CNDQ	Jul-15	Numbers of consultants successfully revalidated and appraised reported to Board in Workforce report
ORGANISATIONAL EFFECTIVENESS								
R47	Re-launch the divisional structure, with appropriate communications and refreshed Terms of Reference, which firmly establishes the authority of the triumvirate as collective leadership of the division.	High priority	Re-launch of the Divisional Structure building on the outputs from action on recommendation R2 and clarifying the leadership of the divisions to be taken forward as an early priority by the Interim Chief Executive.	Awayday to agree this 29 May 2015 - see PWC review actions. In addition the CEO will undertake a management structure review and make recommendations by the end of December 2015	Clarity of roles / purpose for Divisional Teams	CEO / CNDQ / COO / MD	Jul-15	Paper written describing agreed Divisional structure; roles and responsibilities; relationship with exec; clarity of middle management and so on. Plan written for Divisional refresh and implemented Development programme for tripartate and other key members of the Divisions implemented Relationship between Sites and Divisions reviewed and changes made
R48	Formally include the Divisional Directors in the weekly executive management team meetings and have a member in attendance at all Board meetings with a rolling programme of presentations on divisional performance from the triumvirate.	Medium priority	Formalise the terms of reference of Integrated Audit and Governance Committee and Finance and Investment Committee to show how the Divisions feed in in terms of presentations on divisional performance (notably to Joint FIC /IAGC meetings). Involvement of Divisions in Board, Board Committees, and Executive Committees to be reviewed as part of the Committee review – see R21	As above: Divisional Directors will be invited to attend EMT's / Boards / Committees when relevant discussions are to be held to ensure effective use of their time. **June 2015:** Divisional Medical Director and Divisional Heads of Nursing are now members of Management Board.	To ensure the Divisional Triumvirates have a voice within the Executive Team	CEO	End of May 2015	Attendance by which members of Divisional triumverate at which Trust meetings agreed, in conjuntion with exec and divisional leadership, linked to R2 New meeting attendance implemented
R49	The effectiveness of Executive Performance Review meetings should be significantly enhanced through a combination of: • Introducing mandatory meetings between the divisional leadership teams and the executive team (monthly or bi-monthly) • Changing the emphasis of the meetings to ensure an equal balance between scrutinising divisional performance across quality, performance, finance and workforce and providing support to the divisional teams in tackling issues or in developing initiatives.	Medium priority	Review of EPRs to be undertaken to enhance the effectiveness: Also PWC Action Plan 13: Review the performance management policy and ensure that regular EPRs are planned to involve the whole executive team and 14: Minutes to be taken in addition to action notes	Paper to MB 20/5 and BoD 21/5 which would ensure all EPRs are attended by Exec team and divisional teams. Agenda to cover all elements and escalation proposed. **June 2015:** Management Board approved the restructure of EPR's in May 2015, the first of the new style meetings too place on 22 July 2015	Regular and effective EPR's are embedded	Lead by DoF - all EDs to discuss	end of June 2015	New format agreed with Exec and divisions linked to R2 Audit attendance and consistency of meeting dates Performance information produced in an integrated manner and in time for Divisions to prepare for reviews Performance information available to speciality level Balanced scorecard reviewed and time for other discussion given
R50	The Trust should facilitate one or more workshops with a selection of support function leads and divisional operational leads to consider scope for improving the effectiveness of central support for the divisions.	Medium priority	PWC Action 11: Review of Divisional governance teams in terms of roles, responsibilities, structure and processes. Identify ways in which the corporate team can support the development of the divisional teams	EMT / Divisional Team away-day to review governance roles and their linkage with corporate teams.	Divisional governance teams feel confident in their roles and supported by the corporate team	COO	May-15	Links to R2 and PWC report PWC report actioned
R51	The Trust should review its organisational structure to ensure that all divisional and specialty leadership responsibilities are organised, and are being applied, on a cross-site basis where practical.	Medium priority	PWC Action 10: Review current specialty clinical governance meetings and ensure they are following the guidance developed, meetings are minuted, have an administrator responsible, with good clinical engagement	EMT / Divisional Team away-day to review speciality governance meetings and consistency of agendas amd minuting etc	Specialty teams have a better awareness of their governance responsibilities and have the time and resource to carry out those responsibilities	COO / MD / CNDQ	May-15	PWC report actioned
R52	The Trust should consider the feasibility of increasing the frequency of rotating senior clinicians across sites.	Medium priority	Medical Director to consider the feasibility of rotating senior clinicians across sites	Review of job planning being undertaken with support from HR.	To make every effort to avoid silo working and to ensure specialisites are not fragmented and safe rotas maintained	MD	Jul-15	Medical Director and CEO with Divisions and other medical leads have considered benefits and oportunities for greater across site working. Develop and implement plans if agreed
R53	The Trust should introduce the triumvirate leadership model at the specialty level to mirror the divisional level arrangements.	Medium priority	See R 47	Awayday to agree this 29 May 2015 - see PWC review actions	Clarity of roles / purpose for Divisional Teams	CEO / CNDQ / COO / MD	Jul-15	Included in implementation plan for Divisional refresh Development given to Speciality level triumverate
R54	Review the scope for increasing joint working across Divisions to ensure that interdependencies are fully considered, including the potential for formally tasking a Divisional Director with responsibility for managing interdependencies across the Divisions.	Medium priority	Links to 47. Map of interdependencies already in place to be reviewed to increase joint working. Consider and recommend who should manage the interdependencies.	Map is being developed	Sharing of learning happens across sites and divisions	COO	Jun-15	Divisions have developed the map with the COO Divisional and exec development achieved (to include interdependancy understanding) Understanding of the importance of interdependancies agreed throughout theTrust (included in leadership development work) This work has been linked to a review of site leadership in relation to divisional leadership
R55	Consider the need to further strengthen the clinical leadership development programme in light of medical engagement issues at the Trust and ensure that time is protected from operational duties for key clinical leaders to attend.	Medium priority	Programmes in place for non-clinical staff. Need to evidence the effectiveness of the clinical leadership programmes and take learnings to improve the programmes. Consider how to protect time for staff to attend the leadership programmes	Leadership programmes are in place, a review of what works well needs to be undertaken	Staff report that they are given the time to attend leadership development programmes	MD / CNDQ / DoHR	Jun-15	The Clinical leadership programme has been reviewed in light of the Divisional, site and speciality work undertaken. The Trust has considered all leadership development together, so that it works as one programme This has been linked to the culture change programme

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R56	Consider extending the clinical leadership development programme to existing registrars at the Trust.	Medium priority	An analysis of the benefits and feasibility of extending the clinical leadership development programme to registrars will be undertaken.	**June 2015:** Extending the clinical leadership to Registrars is a great idea but the Trust is unable to afford this. The plan was to join the RCP initiative but this would costs an ST5 salary for 18 months	Development of the next generation of clinicians	MD	Jul-15	As above
R57	Consider the need to allocate additional time to the Divisional Medical Directors and Clinical Leads to allow appropriate time to fulfil the responsibilities of the role. For example, 5-6 PAs for Divisional Medical Directors and 2-3 PAs for Clinical Leads. Ensure that this time is ring-fenced from other clinical commitments.	Medium priority	MD to review the time allocated to the Divisional Medical Directors and Clinical Leads to fulfil their additional responsibilities. Analysis will take into account any national developments. Proposed changes to be agreed with the Interim CEO	HR support provided to review job planning which will go towards the solution. Faculty of Medical Leadership and Management to inform this.	More engagement in the leadership elements of the role	MD	Jul-15	Link to R54 CEO, MD and other exec have considered medical leadership alongside other clinical leadership work Any agreements have been achieved
R58	Develop a standardised agenda, reporting template and Terms of Reference for Divisional Boards which is consistent with the format used at the Executive Performance Reviews.	Medium priority	In consultation with the Divisional teams devise standard agenda's, reporting templates and Terms of Reference for Divisional Board. Maintain consistency with the templates used at Executive Performance Reviews. Links to 49	Paper to MB 20/5 and BoD 21/5 which would ensure consistency in reporting templates. EMT / Divisional Team awayday to sign-off aToRs and agendas.	Consistency in reporting so that information can be consolidated as it moves up the Trust	COO / TS	end of June 2015 for tools to be in place - up to 6 months to embed.	Standardised agenda etc has been produced, and implemented. Execs to attend in a rota base to ensure compliance and consistency
R59	Develop a standardised agenda, reporting template and Terms of Reference for specialty boards which mirror the format used at the divisional boards.	Medium priority	See R58	Discussions are underway with Divisions	Consistency in reporting so that information can be consolidated as it moves up the Trust	COO / TS	end of June 2015 for tools to be in place - up to 6 months to embed.	Standardised agendas etc produced, Divisions have implemented throughout all specialities. Execs and Divisional leads attend in a rota base to ensure consistency
	KEY							
	CEO - Chief Executive Officer							
	CNDQ - Chief Nurse and Director of Quality							
	COO - Chief Operating Officer							
	DoF - Director of Finance							
	DoHR - Director of Human Resources							
	DoS&CP - Director of Strategy and Capital Planning							
	MD - Medical Director							
	Deputy Chair - Jonathan Spencer							
	RE - Richard Earland							
	NEDs- Non-Executive Directors							
	ED - Executive Director							
	TS - Trust Secretary							
	NomCom - Nominations Committee							
	IAGC - Integrated Audit Committee							
	FIC - Finance and Investment Committee							