Avon and Wiltshire Mental Health Partnership NHS Trust

BGM Submission Document

Entering DH process as per TFA – October 2013

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Board context

Board context

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

In this section please provide a brief overview of:

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

1. Overview

The Avon and Wiltshire Mental Health Partnership NHS Trust is a provider of specialist mental health services in the South West of the Country.

AWP is committed to becoming a leading provider of specialized mental health services, locally, regionally and nationally. We have 3,305 whole time equivalent staff and provide care for over 34,000 patients and service users (12/13). We work continuously to develop our services in line with the needs of patients, service users and carers. We are determined that our services should be consistently high quality and will create a robust and viable business to succeed into the future.

2. Our strategy

Our strategy is about translating our motto 'You matter, we care' and our valued into effective action. We will:

- Consolidate our services so that they are of the highest quality and meet the needs of our communities
- Integrate our services with those of a wide range of other providers through innovative partnerships.
- Expand our business in line with changing demand.

3. **How we are performing**.

   Through the introduction of our Quality Information System, the Board oversees an integrated and rigorous performance management strategy and framework which sets out the full range of statutory targets, duties and indicators required of us by our regulators, commissioners, patients and service users and wider public to judge our performance. Managing performance in this integrated way facilitates a balanced assessment of performance and risk across a number of domains, simultaneously enabling triangulation of information. For the period June 2013, the point at which this assessment is made, the Trust performance is compliant for the Monitor requirements, full CQC compliance and an improving position across all other areas.

4. **Feedback from patients, service users and carers**

TO BE ADDED

Summary results

Summary results

Overview of BGM sections

1. Board composition and commitment			
Ref	**Area**	**Self-Assessment rating**	**Any additional notes**
1.1	Board positions and size	Amber/Green	The Trust meets all of the identified good practice. One red flag identified.
1.2	Balance and calibre of Board members	Amber/Green	The Trust meets the majority of the good practice indicated with two actions to address gaps. No red flags identified.
1.3	Board member commitment	Green	The Trust meets all of the identified good practice. No red flags identified.
2. Board evaluation, development and learning			
2.1	Effective Board-level evaluation	Green	The Trust meets all the good practice indicated.
2.2	Whole Board development programme	Amber/Green	The Trust meets the majority of the good practice indicated with two actions to address gaps. No red flags identified.
2.3	Board induction, succession and contingency planning	Amber/Green	The Trust meets all of the identified good practice with one action to address gaps. No red flags identified.
2.4	Board member appraisal and personal development	Amber/Green	The Trust meets the majority of the good practice indicated with two actions to address gaps. No red flags identified.
3. Board insight and foresight			
3.1	Board performance reporting	Amber/Green	The Trust meets the majority of the good practice indicated with no actions

			to address gaps. One red flag identified.
3.2	Efficiency and Productivity	Amber/Green	The Trust meets the majority of the good practice indicated with two actions to address gaps. No red flags identified.
3.3	Environmental and strategic focus	Green	The Trust meets the majority of the good practice indicated with one action to address gaps. No red flags identified.
3.4	Quality of Board papers and timeliness of information	Amber/Green	The Trust meets the majority of the identified good practice with one action to address gaps. One red flags identified
4. Board engagement and involvement			
4.1	External stakeholders	Amber/Green	The Trust meets the majority of the good practice indicated with one action to address gap. One red flag identified
4.2	Internal stakeholders	Amber/Green	The Trust meets the majority of the good practice indicated with one action to address gap. No red flags identified
4.3	Board profile and visibility	Amber/Green	The Trust meets all of the identified good practice. No red flags identified
4.4	Future engagement with FT Governors	Amber/Green	The Trust meets some of the identified good practice with one action to address gaps. One red flag identified.
5. Board impact case studies			
Key points to highlight			
5.1	Performance issues in the areas of quality		
5.2	Performance issues in the areas of finance		

5.3	Organisational culture change	
5.4	Organisational strategy	

1. Board composition and commitment

Section RAG rating:
Amber/Green

1. Board composition and commitment

1.1 Board positions and size

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 – AWP NHS Foundation Trust Constitution (Subject to Board approval in July) GP1 – Standing Orders GP2 – Integrated Business Plan – Chapter 8 – Board Pen Picture Profiles GP3 - Integrated Business Plan – Chapter 8 - Board of Directors pen profiles GP4 – Job Description for Trust Board Secretary GP5 – Current Standing Orders and AWP NHS Foundation Trust Constitution GP6 - Current Standing Orders and AWP NHS Foundation Trust Constitution GP7 – List of Non Executive Director Appointments		Not applicable

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
There has been a high turnover in board membership in the previous two years e.g. 50% or more of the Board are new compared to two years ago).	The Board is now reaching full complement (Peter Greensmith has resigned and the TDA Appointments Team are leading a campaign to replace him) following a series of changes. The Board appointments are staggered to ensure that there will not be a situation in the future when a number of Non-Executive Directors retire at the same time.	None

1. Board composition and commitment

Section RAG rating: **Amber/Green**

1.2 Balance and calibre of Board members

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 – IBP Chapter 8 Board of Director pen portrait profiles GP2,3 & 4– Executive Director and Non-Executive Director applications and interview process GP5 – Appointment of Associate NED with clinical experience GP3 & 6-10 - Integrated Business Plan – Chapter 8 - Board of Directors pen profiles	• Document skills mix analysis – Company Secretary – July 2013 • The appointment of a further Accountant in the latest recruitment campaign for a new NED.	

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

Section RAG rating:
Green

1. Board composition and commitment

1.3 Board member commitment

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 – Board member attendance matrix GP2 – Discussed at Board meeting and Seminar (see June minutes) GP2 – Engagement of Keith Pople and Beechcroft LLP to support application process. GP3 – Annual adoption of the Nolan principles - see Constitution. GP3 – Board Concordat developed	None identified	Not applicable

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

2. Board evaluation, development and learning

Section RAG rating:
Green

2. Board evaluation, development and learning

2.1 Effective Board level evaluation

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1,2,3,4 – Beechcroft Independent Board Evaluation Report and next stage report as planned GP 1,2,3,4 - Monthly Board Evaluation of performance at Board.		

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

Section RAG rating:
Amber/Green

Board evaluation, development and learning

2.2 Whole Board Development Programme

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 – Board Annual Cycle of Business and combined development planner GP2 – Board 'reading room' of information to support development GP3 – Self assessment and sign off of Board Governance Memorandum and Quality Governance Memorandum. FT Steering Group combining ED and NEDs. Regular reports to the Trust Board. GP4 – Board Annual Cycle of Business and combined development planner GP5 – Board Annual Cycle of Business and combined development planner	• Arrange Board seminar on regulation of FTs and the role of Board, NEDs & Governors in FT – Company Secretary – July 2013; • Consider development needs of Board post authorisation and include in development planner – Trust Board Secretary – August 2013	

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

Section RAG rating: **Amber/Green**

Board evaluation, development and learning

2.3 Board induction, succession and contingency planning

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 – Board of Directors Induction checklist GP2 - Board of Directors Induction examples for Peaches Golding GP3 – Attendance at Corporate Induction GP4 - Integrated Business Plan – Chapter9	Succession Plan to be further developed and considered by Remuneration Committee – Company Secretary August 2013	All Executive and Non-Executive Director appointments are externally advertised following Trust Development Authority Guidance. This ensures that, both the Trust and the TDA reviews the skills and experience needs of the Trust and the Board, ensuring a fresh

		perspective can be brought into the Board.

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

Board composition and commitment

Section RAG rating: **Amber/Green**

2.4 Board member appraisal and personal development

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 – Chief Executive and Chairman Appraisal of all Board members and appraisal plan for 2013/14 GP2 – Appraisal process for Chair with SID GP3 – Appraisal process for EDs and NEDs	• Check all Board members have specific objective related to their Board role – Chief Executive – July 2013 • Capture evidence of improvements following appraisal and PDP – Chief	AWP is embarking on a programme of organisational development which features a renewed approach to leadership and development. The Board development programme will be refined through this process to ensure it reflects

GP4 – PDPs for all Executive Directors and NEDs & skills analysis GP5 – Oxford Executive Leadership Programme for Executive Team GP6 – Board minutes evidencing challenge GP7 – Appraisal process for Chair with SID	Executive – July 2013	best practice and shared purpose. NEDs and EDs attend national events and networking opportunities for FTs.

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

3. Board insight and foresight

Section RAG rating:
Amber/Green

Board insight and foresight

3.1 Board Performance Reporting

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 – Quality Information System (Trust Board oversight of its development during 2013) GP2(1, 2, 3, 4, 5,6) - Monthly Quality and Performance Reports to Trust Board; GP3 – Trust Board Committee Chair verbal reports to the Board and Minutes of Committees to Board. GP4 – Trust wide Risk Register and risks identified in Board reports. GP5 - Trust Board Action list updated at each meeting.	Further triangulation of key quality information by Locality and Team, when available via the Quality Information System – Director of Business Development.	

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
Performance Failures were brought to the attention of the Board by an external party	The Quality Information System provides a robust system of ward to board assurance around seven key quality themes, one of which is CQC compliance. Through its implementation since April 2013, the Board has been sighted on potential 'hot' areas (such as the Bristol Intensive Teams) and have been able to highlight to CQC prior to inspections, the likely areas of concern to be found.	As the Quality Information System is further iterated and embedded, Board Committees will use the data to further scrutinize the effectiveness of process and systems of control and quality of delivery.

Section RAG rating:
Amber/Green

Board insight and foresight

3.2 Efficiency and Productivity

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 – Quality Impact Assessments of all Cost Improvement Plans reviewed in detail by Quality and Standards Committee. GP3 – Finance reports to Trust Board GP4 - – Quality Assessment of QIPP Projects – Quality and Standards Committee	• Identify examples of projects rejected or significant modified due to their potential impact on patient safety earlier in the process of identifying CIP projects – Medical Director and Director of Nursing July 2013 • Expand Finance Report to include examples of how other Trusts are performing against efficiency schemes – Director of Finance July 2013.	Projects which are likely to adversely impact on patient safety are 'reviewed out' at an early stage in the CIP process.

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

Section RAG rating:
Green

Board insight and foresight

3.3 Environmental and strategic focus

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 – Monthly Chief Executive report to Trust Board GP2 – Enquiry reports reviewed by Trust Board and Assurance Committees include Francis Report GP3 –Integrated Business Plan GP4 –Integrated Business Plan & Trust Board Seminar to consider market analysis GP5 – Integrated Business Plan GP6 – Trust Board Annual Cycle of Business and incorporated Development Planner GP7 – Board Assurance Framework reports to Trust Board.		

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

None identified	Not applicable	

Section RAG rating:
Amber/Green

Board insight and foresight

3.4 Quality of Boards papers and timeliness of information

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 and 2 – Trust Board Annual Cycle of Business and Committee reporting matrix GP2 – Trust Board meeting dates including timetable of distribution GP3 - Trust Board Report Template GP4 – All Directors can access real time performance information via the Quality Information System on their Ipads. GP5 - Trust Board Summary Sheet (Reference to previous reports) GP5 – Example of board report. GP6 – Wiltshire Report on Data Quality GP7 – Examples of Non-Executive challenge to presented data.	A seminar session on data quality to be added to the Board Development Programme – Company Secretary July 2013 (COMPLETE)	

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

Where reports are received they have highlighted material concerns in the quality of data reporting.	The ‘Wiltshire Report’ investigated allegations of poor data quality in relation to data entry of patient information. The report identified areas where practice could be improved, and these have been actioned. The investigation has since been closed as the review team were satisfied with the progress made.	

4. Board engagement and involvement

Section RAG rating:
Amber/Green

Board engagement and involvement

4.1 External Stakeholders

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 – Communications and Engagement Plan GP2 – Trust wide Engagement Steering Group Terms of Reference GP2 - Community Engagement Strategy, GP2 - Board Meetings in clinical settings, GP2 - member events attending by the Chair. GP3 – Vision and Values events GP3 – Member Consultation feedback GP4 – Feedback from Commissioner Convergence GP5 – CPMG meeting minutes.	• Develop an engagement plan to further engage stakeholders with the Trust's IBP – Director of Business Development August 2013	

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
The Trust has received adverse negative publicity in relation to the services it provides in the last 12 months.	Many public sector organisations receive negative publicity on a fairly regular basis. Mental Health Trusts, as providers of services for high risk patients, are more susceptible to this. As a Trust we work hard to be open and transparent and have developed good relationships with the press and media. We are open in relation to our serious incidents of harm (via the public board report) and account to our patients and commissioners. By way of example, the Trust has received negative publicity in relation to service failings relating to inquests into deaths of patients or service users within the previous 3 years. The Trust has a good and open relationship with the media, and proactively engages with the press in relation to publicity, offering an open and transparent approach to negative issues.	

Board engagement and involvement

Section RAG rating: Amber/Green

4.2 Internal Stakeholders

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 – Our Voice Magazine GP1 – Open Staff Meetings (with the CEO) GP1 – Emails from the Chair to staff GP1 – Staff membership GP1 – Weekly roundup to triumvirates GP1 – Suggestion box/email inbox to the CEO GP2 – Vision and Values events for staff GP2 – Involvement of Locality Management Teams in IBP GP3 – Ourspace sharing key issues. GP4 – Staff award ceremony GP4 – Chief Executive's 'champagne moments' in the CEO report to the Board GP6 – Red top alerts GP7(a) – Clinical conferences GP7 – Professional Council GP7 – Clinician Engagement Strategy	• Develop a plan to ensure that all members of staff have a clear understanding of the Trust's strategic approach and shared purpose – Director of Development – August 2013	An organisational development programme has been commissioned and which will work to ensure that staff can sign up to the shared purpose of the Trust.

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

Section RAG rating:
Amber/Green

Board engagement and involvement

4.3 Board profile and visibility

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 – Public Board meetings and lunch GP1 – Listening sessions at Employee Engagement and Strategy Committee GP1 – Quality Improvement Visits GP2 – Meetings with local MPs GP2 – Meetings with local Councils and Commissioners GP3 – Presentations to Conferences GP3 – Attendance at Wiltshire Health & Wellbeing Board GP4 – Service Users and Carer Steering Group GP4 – Quality Improvement visits inc NEDs GP4 – Trust Board meetings in public inc lunch with public GP5 – Public Trust Board meetings with almost all business in public GP5 – Minutes and papers published on the Trust website	• Reinstate summary board minutes of private board sessions – Company Secretary July 2013	

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

Section RAG rating:
Amber/Green

Board composition and commitment

4.4 Future engagement with FT Governors

Evidence of compliance with good practice (Please reference any supporting documentation below and attach with your submission)	Action Plans to achieve good practice (Please reference Actions Plans below and attach with your submission)	Explanation if not complying with good practice
GP1 – FT Constitution GP2 - FT Constitution GP3 – Election Plan for Governors GP3 - Proposed L&D Governor Training Programme GP5 – Membership Strategy GP6 – Membership Strategy	• Develop governor communication and engagement plan – Company Secretary – July 2013	

Red Flags	Action plans to remove the Red Flag(s) or mitigate the risk presented by the Red Flag(s)	Notes/ comments
The Board has not yet considered how best to communicate with and engage with the Council of Governors	• Governor communication and engagement; Company Secretary – August 2013	

5. Board impact case studies

5. Board impact case studies

5.1 Case Study 1

Performance Issues in the area of Finance	Title: Achievement of CIPs
Brief description of issue	The Board became concerned that the Trust was showing a non-achievement of CIPs and wanted to understand if the Trust was at risk, or if the non-achievement related to inappropriate phasing of predicted savings.
Outline Board's understanding of the issue and how it arrived at this	The need to develop and deliver CIP schemes worth circa £45M is a key component of Trusts five year Integrated Business Plan (IBP) and also of the Trust's Operating (Annual) Plans. For example the 2013/14 Operating (Annual) Plan, including CIP plans, was signed off by the Trust Board on 27 March 2013 and the most recent IBP was signed off on 29 May 2013. CIP schemes for 2013/14 had previously been reviewed and approved internally at Trust Senior Management Team and Finance & Planning (F&P) Committee.
Outline the challenge / scrutiny process involved	○ The management responsibility to development and implement CIP's rest with the Executive Team (ET) and the Senior Management Team (SMT) ○ The opportunity for the Board to scrutinise and challenge the Trust's performance in delivering the CIP programme, together with the associated risk lies principally with the F&P Committee, a subcommittee of the Board which has the responsibility for giving assurance to the Board on all financial and business planning issues. The F&P Committee receives finance reports on a monthly basis, containing detailed information on CIP performance, including details on and reasons for non performing schemes. In recognition of the importance of monitoring the delivery of CIPs, from Month 3, 2013/14 a separate CIP report is provided to the committee, complementing the

	information provided in the main Finance report. ○ The opportunity for the Board to scrutinise and challenge the impact on quality of delivering the savings in the 2013/14 CIP programme lies with the completion of a Quality Impact Assessment (QIA) by the Project Lead for each scheme and the subsequent review of these QIAs by Trust Senior Management Team, Quality & Standards Committee & the Trust Board. This process was undertaken for each scheme in March 2013 and the exercise is in the process of being rerun, as there has been significant senior management change since March as the Trust has restructured into a locality based service delivery mode and many CIP schemes now have new Leads.
Outline how the issue was resolved	The issue for 2013/14 has not yet been resolved as we are in the early part of the financial year. However the F&P Committee and Board will be sighted on CIP schemes not delivering and will be challenging the Executive Team to identify and deliver the requisite replacement schemes. Additionally a Programme Management Office (PMO) is being introduced from August 2013 to help strengthen performance managements arrangements .
Summarise the key learning points	○ Business planning process to work more effectively producing better savings plans, starting earlier and engaging fully with LDU management. ○ Would have benefitted from earlier set up of the (PMO) and the performance management role it performs ○ Given the importance of delivering the CIP savings programme a dedicated CIP report, complimenting the information provided in the main Finance report, could have been introduced earlier.
Summarise the key improvements made to the Trust's governance arrangements directly as a result of the above	○ The quality impact of CIPs is now monitored and understood. ○ The new PMO will strengthen performance management arrangements. ○ CIP performance now reported in separate report, reflecting the importance of successful delivery of savings

5. Board impact case studies

5.2 Case Study 2

Performance issues in the area of quality	Title: Introduction of web incident reporting
Brief description of issue	The Trust used a dedicated risk management system (Ulysses) to record details of its incidents. Staff would complete a 4 page paper incident report form, and then pass it to their manager for review. Once completed, the form would be posted to centrally based administrative staff for data entry. Although The Trust had mooted the use of web reporting since 2006, competing priorities on the IM&T workplan triumphed in securing the necessary resources. Thereafter, the introduction of the Trust's current patient information system, RiO, became the overarching IT priority. The externally commissioned Sutherland report: *Review of governance and management arrangements at Avon and Wiltshire Mental Health Partnership NHS Trust on behalf of NHS South of England (January 2012)* provided a wake-up call to the Trust on its antiquated incident reporting procedures. This report was critical that the Trust's reporting arrangements made it one of the poorest performing Trusts in England for the speed of reporting incidents to the National Reporting and Learning System (NRLS). It also expressed concern that there were no plans to integrate the new incident system with the RIO clinical record. The implementation of web reporting became a key priority of the Fit for the Future plan, developed to respond to the Sutherland report.

Outline Board's understanding of the issue and how it arrived at this	The Trust Board had long desired web reporting but the Sutherland report helped it to reflect that it had been somewhat passive in addressing the issue. The Board had been provided with assurance that the speed with which incidents were reported to the NRLS was as fast as possible, given the paper and postage constraints. The Nurse Director had also authorised additional clerical resource to ensure the very timely entry of data from the paper forms. Aside from the timeliness of reporting, the Trust Board was content with other aspects of NRLS reporting. There were also two associated contextual factors that informed the Trust Board's prioritisation of web reporting: • External reporting requirements of serious untoward incidents changed and incrementally increased from approximately 2008. Board attention was on the quality of investigations and learning, rather than the reporting methods per se. • Prior to the introduction of RiO, the IT literacy skills of staff were deemed to be extremely weak, with a significant cohort of front line staff never logging onto a computer. The RiO implementation transformed staff's IT skills.
Outline the challenge / scrutiny process involved	The Fit for the Future (FFtF) Implementation Plan was approved by Board on 25 July 2012 and was subject to monthly scrutiny. Relevant Board Sub-Committees also reported monthly to Board on progress. Additionally, the Audit and Risk Committee commissioned Internal Audit to independently assess evidence of progress against the FFtF. Fieldwork for this audit was conducted during the first week of September 2012, with pleasing results reported to the Audit and Risk Committee on 25 September 2012.

	At the September 2012 Board meeting, the Board were briefed on the feasibility of pursuing electronic incident reporting integration with the RiO clinical record. This explained that there were significant technical, contractual and legal barriers to integration, such that the Board agreed not to pursue this objective further.
Outline how the issue was resolved	To take the web reporting project forward a small project team was assembled, encompassing expertise from the incident team and IM&T. The Trust's existing expert on the Ulysses system was seconded to lead the project implementation and his post backfilled. Limiting data entry by staff to an essential minimum dataset was seen as crucial to the success of the project. To that end, longstanding issues relating to data feeds from ESR and RiO required technical solutions, with the former being extremely problematic. The web form was carefully designed and was subject to extensive in-house testing. This identified the need for system changes that required system changes by the Supplier. The Project Board considered that in the interests of protecting existing high standards of data quality (that were judged externally), it should delay the pilot to allow for system changes. The web system was piloted across several wards at Callington Road. The pilot was extremely successful, and implementation followed immediately thereafter. In October 2012, the Trust-wide Management Group received a report on the progress of the web project. This report highlighted two significant constraints to the project: • The system will continue to be aligned with the ESR management structures. The constraints of the control processes within the Trust to deal with aligning systems to reflect organisational change is outside the scope of this project.

	• The minimal funding for this project means that it is aiming to go live with the web incident form only, not the additionally available functionality. Roll-out of the system commenced in November 2012 and was completed by June 2013. Staff response to this system has been universally positive.
Summarise the key learning points	The following learning has been identified from this work: • To document the rationale for decisions in relation to the prioritisation of IM&T resources. • An organisation perceived to be in trouble is poorly placed to challenge recommendations from externally commissioned reports, even if they are known not to be viable, ie, the RiO integration. • That use of IM&T is saturating many people's lives both at work and at home, such that staff skills levels are continually accelerating. • The Ulysses system had been well maintained and was in good order to be expanded for web reporting. • That it is possible to implement a good quality IT product with minimal dedicated support – a 1.0 wte band 6 position plus senior manager and IT oversight - in less than a year. Earlier estimates of resource requirements were far in excess of this. • Extensive testing of the web form and the decision to await Supplier modifications before go live proved wise. Staff were given an IT product that worked effectively from day one and alleviated their administrative burdens. • The decision that the ESR structure issues were outside the remit of this project was probably the correct decision at that time. This issue, however,

	continues to haunt the Trust. • Despite the intention to only go live with the basic web functionality, already further use is being made of the system to aid staff. A good quality system will help dictate change.
Summarise the key improvements made to the Trust's governance arrangements directly as a result of the above	The key governance improvements that have been made in respect of this work: • The Trust now has established two groups (Clinical Systems Group and Business Systems Group) to deliberate IM&T challenges and priorities. • The Trust expects substantial improvements in the timeliness of its reporting to be shown in the next publication of NRLS data. • There is now complete alignment of all of the Trust's external reporting arrangements for serious untoward incidents (STEIS/NRLS/SIRS/CQC). • There was wise engagement of Internal Audit in providing the Board with assurance. The Board continues to use this model of independent verification. • Commissioners and the Area Teams continue to take a keen interest in the Trust's incident reporting arrangements and this ongoing scrutiny is welcomed.

5. Board impact case studies

5.3 Case Study 3

Organisational culture change	Title: New leadership team for the Trust
Brief description of area of focus	Following the publication of the Sutherland Report, the Board chose to change the leadership team of the Trust with a view to enabling a new cultural approach. At the same time the Board oversaw implementation of the 'Fit for the Future' Programme aimed at achieving significant change in the organisation's approach to patients and service users, clinicians and governance
Outline reasons / rationale for why the Board wanted to focus on this area	It became clear to the Board that the existing leadership team were unable to achieve the level of change required to transform the quality of the services provided by the Trust and restore stakeholder confidence. The Non-Executive Directors lost confidence in the leadership team and, with support from the SHA (at the time), required an immediate change of CEO and Chair. Following the immediate appointment of an Interim CEO and Chair, the Interim Chair (now substantively appointed) commissioned an independent review of executive team composition and effectiveness. This report has informed the revised executive team now in place. Executive appointments have been made and portfolios significantly revised
Outline the Board was assured that the plan/(s) in place were robust and realistic	The Board appointed an Interim Chief Executive and set out a clear mandate for the level of change required. The change required was documented in the 'Fit for the Future' programme plan. The plan identified areas of improvement which would be implemented in the short, medium, and longer term. Changes included executive level appointments. The Board monitored the robustness of the development of the Fit for the Future Programme through its Board meetings and through Board Committees. Each Board Committee had oversight responsibility for specific elements of programme

	implementation.
Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture	The Trust Board received a regular progress report on 'Fit for the Future' programme at each Board meeting. Board Committees scrutinised achievement of actions at their respective meetings. Committee Chairs reported to Board, by means of exception, on areas where achievement was falling behind. The programme was formally closed in April 2013 and remaining actions incorporated into the Integrated Quality Plan. The Board invited the original review team back in June 2013 to reassess the Trust and the review team found the Trust to have made significant improvements in all areas.

5. Board impact case studies

5.4 Case Study 4

Organisational Strategy	Title: Shaping the Vision of the Trust
Brief description of area of focus	The Board's vision is for AWP to become a quality focused, sustainable foundation trust and to be a leading provider of specialist mental health services. The Board believes this will be delivered by devolving decision making closer to the front line; increasing clinical leadership and engagement; and working openly and transparently in partnerships with staff, service user, carers and the local health communities in which we work. In pursuit of this, the Board switched from a Trust wide strategic business unit management structure to a devolved locality based approach, led by a three person team consisting of a clinical director, managing director and a head of profession and practice. In addition to establishing clear locality management arrangements, the Board wanted to reduce the layers of decision making, increase the local clinical voice and establish a more effective 'ward to board' reporting line. In implementing this approach, the Board not only implemented its 'Fit for the Future' programme of organisational change but it also developed a new clinician engagement strategy and new strategic objectives (Consolidate, Integrate and Expand), supported by a motto and new values.
Outline reasons / rationale for why the Board wanted to focus on this area	The Board wanted to set out internally and externally a clear direction of travel that not only avoided the failures of the past but responded to the challenges facing the health and social care community and positioned AWP as a local, clinically led, patient and recovery focused partner in the delivery of specialist mental health services. It wanted to ensure decision making reflected clinical and local priorities and it wanted to maximise the resource available to the front line. In establishing a new management structure, the Board wanted to strengthen the Trust's involvement in the local communities of care, empower local clinicians to engage with their opposite numbers; increase understanding and engagement with local communities and to begin to change the perception of the Trust in the eyes of GPs and commissioners, as well as service users and staff. It also wanted to improve staff management and local accountability as well as empowering staff

	on the frontline to address issues of quality and performance openly and honestly. By being open and transparent, internally and externally, in all communications, The Board sought to improve engagement, especially with staff, service users and commissioners.
Outline the Board was assured that the plan/(s) in place were robust and realistic	In making the transition in management structure, a detailed plan was prepared to ensure that robust arrangements were put in place to ensure all operational issues were dealt with and that none fell through any transitional gap. Detailed reporting arrangements were put in place to secure the change rapidly and safely, with regular progress reports being made to the Board and its committees, providing opportunities for questioning and challenge. The process was overseen by both the Executive team and the then Trust wide management group with any problems being highlighted to Board members. Actions were also monitored by the Board via the Fit for the Future programme. Board members heard directly from local clinicians and from its clinical leadership group, professional council and as a result of rotating its meetings around the Trust, met staff and service users who could also raise issues via public questioning. The Board undertook a proactive communications approach, ensuring that key steps were shared in advance with stakeholders, internally and externally, thus ensuring all those interested in the work of the Trust could challenge any variations between words and actions. Each role in the management structure had clear responsibilities and accountabilities and appointments were made by a transparent process which involved local commissioners, service users and carers, staff and Board members. This ensured those leading the localities were in tune with the ambitions of the Board.
Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture	The Board and its committees have received regular reports on implementation and on progress being made. They have heard at first hand from the leadership teams in Board committees and feedback from commissioners was received by the chair and chief executive in their regular meetings with their opposite number in PCTs and more recently CCGs. Positive feedback has also been received from service users, carers and staff. The local leadership teams are showing they are accountable for activity in their localities and have established more positive links with stakeholders. The impact of the changes can be seen in improved relationships and more active involvement in the local communities of care, success in tendering for new business. Ward to Board reporting on quality issues was strengthened via the introduction of IQ.

	The Trust is at an early stage in the process and the impact of the changes will continue to be monitored in the months ahead. The second Sue Sutherland report did give some positive indications that the changes desired by the Board were being seen in the organization.
Specifically explain how the NEDs were involved	NEDs were involved in debating and improving the new management structure, maintaining pressure to act at pace and by encouraging greater direct contact with the Board. They ensure appropriate consultation and/or engagement internally and externally. NEDs have actively engaged with the new clinical leaders in the Trust, inputted into the development of the IQ system and by their actions supported the open and transparent approach of the Trust. They have publicly backed and supported the changes being made and contributed their expertise into the shaping and implementation of the changes. Through quality improvement visits they have also been able to engage with staff at first hand on the impact of the changes. By holding the overwhelming work of the Board in open session, hearing complaints presentations at their meetings and encouraging open dialogue they have set an example for the Trust to follow.