

Corporate Governance Statement Review

FINAL Assignment Report 2016/17

Liverpool Heart and Chest Hospital NHS Foundation Trust



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1. Introduction and background

All NHS foundation trusts are required on an annual basis to self-certify whether or not they have complied with the relevant Conditions of the NHS provider licence.

As part of the financial year end, Liverpool Heart and Chest Hospital NHS Foundation Trust (the Trust) needs to self-certify annual declarations in respect of the governance arrangements and other licence conditions as follows:

- Governance arrangements Condition FT4
- General Condition G6 – Systems for compliance with licence conditions
- Continuity of Services Condition 7 – Availability of Resources
- Certification on Academic Health Services Centre (AHSC)s and Governance
- Training of Governors

For the purposes of this review the focus has been on arrangements in respect of the governance Condition FT4 only.

In relation to the governance arrangements Condition, the self-certification is a forward looking statement of expectations regarding corporate governance arrangements and requires Boards to confirm:

- compliance with the Condition as at the date of the statement; and
- anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks.

The aim of self-certification is for the Trust to review whether its governance systems achieve the objectives set out in the licence Condition.

In previous years the Trust has been required to self-certify and submit a Corporate Governance Statement (CGS) to Monitor setting out compliance against the 20 individual statements that make up the governance Condition in the provider licence.

NHS Improvement (NHSI) has changed the process for self-certification for 2017. The Board is still required to sign off that it is satisfied with compliance with the governance Condition and make this declaration within 3 months of the year end. However, there is no requirement for trusts to submit the CGS to NHSI. Instead from July 2017 NHSI will audit a selection of providers.

Although the submission process has changed the governance condition in the licence has stayed the same. This means that the Board will need to self-certify compliance with the same 20 individual statements that were in the CGS last year.



2. Objectives, scope and approach

As part of the internal audit plan the Trust asked MIAA to carry out a high level evaluation of the Trust's processes for preparing and assessing compliance with the CGS.

At the time of agreeing the scope and objectives for this review, NHSI had not confirmed the arrangements for the 2017 self-certification and submission. NHSI has now issued guidance which changes the self-certification process but has not prescribed how trusts should carry this out. The guidance makes it clear that the process adopted should ensure that the Board understands clearly whether or not the Trust can confirm compliance.

Having reviewed the NHSI guidance and following discussion with the Trust we have agreed that the original objectives and scope of the review remain relevant. On this basis our approach has been as follows:

- Follow up progress in implementing recommendations from the independent reviews carried out as part of the self-certification process for the CGS in 2015 and 2016 (Appendix A).
- For each of the 20 individual statements that form the governance condition, working with the Trust, to update the evidence base from 2016 to reflect any changes in governance processes or evidence since the last review. The outcome of this is an evidence base that the Trust considers is complete, up to date and accurate (Appendix B).
- Evaluating the adequacy and sufficiency of evidence, focussing on gaps identified previously and any new evidence identified in the evidence base.

We will have taken into account the evidence and findings from the recent CQC Review and the assessment against NHSI Well Led framework which was reported in March 2017.

Our work was completed through discussion with Board members and via a review of the Trust Board and Committee papers and other appropriate supporting documentation provided to us.

A summary of findings including a risk rating for each individual statement based upon the assessment of evidence provided is included in Section 4. These observations are where the areas for improvement are identified which, in turn, creates the proposed recommendations in Section 5 for the Trust to consider. The follow up of previous recommendation is included in Appendix A. More detail on current processes and evidence for each individual statement is included in Appendix B.

Limitations to Scope:

We did not test the reliability or accuracy of the data gathered as part of the review. Assessment of the processes for preparing and assessing compliance with the General Condition G6 – Systems for compliance with licence conditions, Continuity of Services Condition 7 –



Availability of Resources Certification on Academic Health Services Centre (AHSC)s and Governance and Training of Governors is outside the scope of the review.

The review does not provide assurance on whether the Trust is fully compliant against the 20 individual statements that make up the governance Condition in the provider licence. It is ultimately the Board's responsibility to carry out assurance that they are in compliance with the Conditions.

3. Executive Summary

Overview

We found that the Trust has designed and put in place principles, systems and standards of good corporate governance with evidence of effective board and committee structures, reporting lines and performance and risk management systems.

Our review has identified two opportunities for improvement (Section 5) but there are no serious gaps in evidence that require immediate attention before the Board completes the self-certification.

Taking into account the findings from this review the Board can take reasonable assurance that the processes upon which the Trust relies for preparing and assessing compliance with the 20 statements in the governance Condition are appropriately designed and consistently applied.

There continues to be a visible commitment across the whole Board, led by the Chairman and Chief Executive, to the importance of good governance and the absolute requirement to operate in line with the Trust provider licence.

The Trust continues to support the Healthy Liverpool Programme and is working with partners across the Liverpool Health economy to support delivery of the Cheshire and Merseyside (C&M) 5 Year Forward View. The Trust is leading on the redesign of the CVD pathway across the C&M footprint.

The system wide changes are complex and fast moving and the challenges the Trust is facing now and in the period ahead will test the resilience of all aspects of the Trust's governance arrangements. In response to system change and risk the Trust keeps its governance arrangements under review and there have been changes in year to strengthen and enhance those arrangements eg refreshing the NED cohort, changes to executive team members and their portfolios and the setting up of Business Transformation Steering Group (BTSG) to focus on CIP delivery and productivity.

The agreed actions from previous reviews have been implemented or superseded, key developments include an evaluation of the People Committee and divisional structures, embedding change in IM&T governance via the creation of a Digital Healthcare Committee and strengthening PMO leadership and effectiveness.

CQC has assessed the Trust as outstanding overall and in the well led domain. The well led assessment concluded that the Trust is well led with examples of outstanding practice in many areas including governance processes. The Trust has been evaluated as being segment 1 in NHSI's Single Oversight Framework (SOF) assessment. This is defined as being those providers who are lowest risk and who are given maximum autonomy with no potential support needs identified.

The Board has action plans in place to implement the improvement opportunities from the CQC and Well Led assessments. To avoid duplication we have not repeated any of the recommendations from these external assessments in this report and have included one overarching recommendation for the Board to ensure that the learnings from these reviews are implemented on a timely basis.

The Trust has good processes in place to ensure its self-certification process is robust, this includes having regard to the view of governors.

The Audit Committee carry out a quarterly licence review (the most recent one was in March 2017) and provides assurance to the Board that key licensing requirements have been met and to identify any emerging risks that could threaten compliance.

The Board is kept up to date with the internal and external factors that could impact on compliance with the provider licence and self-certification as well as steps being taken to manage the risks. Board members told us that the main risk to compliance in 2017/18 relates to achieving the financial control total and in particular securing agreement from commissioners in Wales to adopt HRG4+. The Board is confident in management's capacity to mitigate risk and deliver the agreed actions within a reasonable timeframe. The Board obtains assurance from the Integrated Performance Committee (IPC) on progress with agreed actions and in relation to compliance with the provider licence. The IPC has provided this assurance to the March 2017 Board in its Annual Report.




4. Ratings assessment and improvement opportunities


Our observations in this section are aligned to each of the individual statements that make up the overall governance condition in the provider licence. These observations are where the areas for improvement are identified which, in turn, creates the proposed recommendations in Section 5 for the Trust to consider/take action in advance of self-certification.



We have included a commentary in Appendix B outlining the main processes and sources of evidence in place for each statement. The Trust has confirmed that the evidence base in Appendix B is complete, up to date and accurate.



To provide consistency we have given each of the Board statements a risk rating in line with the prior year assessments below which are based upon the adequacy of the evidence provided to support the statements.






Priority ratings		
 High priority	 Medium priority	 Low priority
A serious gap in evidence or no evidence provided for the board statement. Any recommendations in this category would require immediate attention before the Trust can declare compliance	Areas for improvement noted and/or additional evidence needed to provide full assurance over the board statement	Sufficient evidence provided and/or only minor improvements needed to enhance assurance over the board statement



Ref	Board Statement	Risk Rating	Summary of findings
1	The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.		<p>The Trust keeps its governance arrangements under review and has made changes in year to further develop those arrangements. This includes setting up the BTSG to strengthen CIP identification and delivery.</p> <p>The Board confirm compliance with the Code of Governance at its March 2017 meeting.</p> <p>The Board Assurance Framework (BAF) is a key mechanism to prioritise the Board's time and give confidence in the achievement of each strategic objective.</p> <p>The Trust has been included in Segment 1 under the SOF which allows maximum autonomy. The Trust has been rated as outstanding in the CQC assessment.</p> <p>The well led assessment concluded that the Trust is well led with examples of outstanding practice in many areas including governance processes.</p> <p>There is a commitment to pro-active system wide collaboration and leadership and also a recognition at Board level of the potential</p>



Ref	Board Statement	Risk Rating	Summary of findings
			<p>impact of these changes on the Trust's governance arrangements. There is evidence that the Board is reviewing the potential impact of corporate and clinical support service collaboration on the Trust.</p> <p>The observations relating to CQC, well led assessment and SOF segmentation provide evidence for the other statements in the governance conditions but have not been repeated.</p> <p><i>One overarching recommendation relating to timely implementation of the learning actions from the CQC and well-led reviews has been included as Recommendation 1.</i></p>
2	The Board has regard to such guidance on good corporate governance as may be issued by NHSI from time to time.		<p>Guidance from NHSI is disseminated primarily by the Director of Corporate Affairs.</p> <p>The Chief Executive provides a briefing for both the Operational Board and Trust Board that contains an update on any NHSI guidance.</p> <p>There is evidence of action being taken on new initiatives in the year eg adapting reporting to the Board to reflect the requirements of the SOF. Also Learning from Deaths guidance has been shared with the Board and the requirements for mortality reviews and publication of data on 'avoidable' deaths features on the Board development plan for 2017/18.</p>
3	The Board is satisfied that the Trust implements effective board and committee structures.		<p>The governance structure facilitates a clear distinction between assurance (non-executive led) and performance management (executive led).</p> <p>The Audit Committee reported to the April 2017 Board that, based on a review of the annual reports, each Assurance Committee has operated effectively in 2016/17 and in</p>




Ref	Board Statement	Risk Rating	Summary of findings
			<p>accordance with the Terms of Reference delegated by the Board.</p> <p>The Board has approved the People Committee as a standing assurance committee and concluded that the key intended benefits of the People Committee have been realised.</p> <p>The People Committee is updating the People Strategy which will include a revised set of targets that will be more measurable to assess progress with implementing the strategy.</p>
4	The Board is satisfied that the Trust implements clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees.		<p>Each Committee and Group has approved terms of reference setting out clear reporting lines and responsibilities.</p> <p>Committee and Group terms of reference are updated annually.</p> <p>The Corporate Governance Manual (CGM) includes a schedule of decisions reserved for the Board and a scheme of delegation.</p>
5	The Board is satisfied that the Trust implements clear reporting lines and accountabilities throughout its organisation.		<p>The Board and Committee structure is set out in a clear organogram.</p> <p>The Council of Governors are aware of their responsibilities and the level of engagement with the Board of Governors is exemplary.</p> <p>Assurance Committees enable effective challenge of assurances to support delivery of the Trust's strategic objectives and regulatory compliance.</p> <p>The Operational Board is accountable for all aspects of delivery and operational performance and reports routinely to the Board.</p> <p>The divisional structure has been in place since 2016. A key driver for the change was been to improve accountability and clinical engagement and overall the divisions have</p>



Ref	Board Statement	Risk Rating	Summary of findings
			<p>been seen as a success by the Board eg delivering improvements in many key strategic and operational risk areas such as reducing agency spend and improving access targets.</p> <p>In response to recommendations in the well-led review the Trust is strengthening divisional accountabilities via a formal accountability framework which provide clearer definition for the roles and responsibilities of divisions and their business partners.</p> <p>There is an appraisal process in place for all Trust staff and Board members.</p>
6	The Board is satisfied that the Trust effectively implements systems and/or processes to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively.		<p>A key objective of the Integrated Performance Committee (IPC) is to provide the Board with assurances in respect of the Trust's operations in relation to compliance with the licence. The IPC has provided this assurance to the April 2017 Board in its annual assurance statement.</p> <p>Corporate benchmarking information and updates on progress with implementing recommendations from the Carter Review are presented to the BTSG.</p> <p>The Trust maintained a green governance rating from Monitor and a Financial Sustainability Risk Rating of 2 up until 30 September 2016.</p> <p>The Trusts Finance and Use of Resources score for the period ending 31st March 2017 is a 3 overall (on a scale of 1 to 4, with 1 being the lowest risk). This score reflects the relatively low levels of cash impacting on liquidity. Action is being taken to increase cash reserves in 2017/18.</p> <p>The Trust has shared the findings from the Well Led review with NHSI and the Board does</p>



Ref	Board Statement	Risk Rating	Summary of findings
			<p>not expect NHSI to carry out an intervention in the next 12 months.</p> <p>The financial control total for 2017/18 has been agreed with NHSI.</p> <p>The development of SLR and productivity metrics will be a key focus of the IPC committee and the Chief Financial Officer in 2017/18. A timetable for developing SLR reporting and clinical engagement has been shared with the IPC.</p> <p><i>The Board knows it needs to have reliable SLR information eg to assess consultant productivity and identify and deliver cost improvement opportunities. The Board via the IPC should ensure that improvements in SLR are progressing with pace (Recommendation 2).</i></p>
7	The Board is satisfied that the Trust effectively implements systems and/or processes for timely and effective scrutiny and oversight by the Board of the Licensee's operations.		<p>The Board reviews a performance dashboard of metrics designed around the strategic objectives.</p> <p>The IPC Committee provides a verbal BAF key issues report to the Board so that members are fully sighted on key risks in respect of compliance with the licence.</p>
8	The Board is satisfied that the Trust effectively implements systems and/or processes to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators		<p>The Quality Committee is established as an Assurance Committee of the Board in order to provide the Board with assurances in respect of quality governance.</p> <p>The Quality Committee provides a BAF key issues report to the Board so that members are fully sighted on key risks in respect of quality of care.</p> <p>The Trust was awarded outstanding in the CQC inspection. In order to maintain standards the Director of Nursing is leading on implementing the action plan and has</p>


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	of health care professions.		arranged a full mock CQC inspection. There will also be unannounced inspections carried out over the next 12 months.
9	The Board is satisfied that the Trust effectively implements systems and/or processes for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern).		<p>There is evidence that information flows support financial decision making in the Trust eg financial performance is scrutinised at all levels in the Trust; significant investments such as Robotics development require business cases approval from the Board.</p> <p>The IPC and Board scrutinises the annual financial plan and also approve the Long Term Financial Model.</p> <p>The Board receives regular updates in relation to progress with the Trusts financial strategy.</p> <p>The IPC provide assurances to the Board in respect of the Trust's current and forecast performance and its operations in relation to compliance with the licence, regulatory requirements and statutory obligations.</p> <p>The Board formally considers Going Concern on an annual basis.</p>
10	The Board is satisfied that the Trust effectively implements systems and/or processes to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making.		<p>The Board and the Committees have an agreed work plan setting out the cycle of business and what information should be reported at each meeting.</p> <p>Strategic and operational dashboards along with exception reports are presented at each Trust Board and Operational Board meeting.</p> <p>The Board has had input to designing the strategic dashboard so that it considers appropriate information is being analysed and challenged.</p> <p>Board members triangulate the data received at Board with reference to issues or themes</p>

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			<p>picked up through other channels of information eg walkabouts.</p> <p>The well led assessment reported that the Trust is ahead of many organisations in relation to data quality.</p>
11	The Board is satisfied that the Trust effectively implements systems and/or processes to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence.		<p>Board members have a consistent understanding of the top risks to the Trust. There is a clear route for escalating risks from "ward to Board".</p> <p>Work has been ongoing to further develop risk management arrangements in the Trust via the continued roll out of DATIX. A decision has been taken to maintain Athena as the Trust risk register as the risk register element of DATIX does not fully meet the Trust's requirements. This decision on whether to retain Athena will be reviewed annually.</p> <p>Each year the Executive Team undertake a proactive risk analysis to ensure all major risks have been considered for inclusion on the corporate risk register (CRR). From this exercise two new risks were identified and included in the 2017/18 CRR relating to medication safety and employee motivation.</p>
12	The Board is satisfied that the Trust effectively implements systems and/or processes to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery.		<p>There is a very well structured planning process to develop and approve both the operational plan and the strategy built upon regular engagement with internal and external stakeholders.</p> <p>In advance of updating plans each year, the Board has a horizon scanning/ strategic vision session with external facilitator.</p> <p>The Board receives an integrated performance report (IPR) at every meeting and exception reports with action plans are provided for any areas which are off target. The IPR report is</p>

Ref	Board Statement	Risk Rating	Summary of findings
			<p>supplemented with issues raised by the Assurance Committees, reports from Operational Board and 'softer' intelligence gained from walkabouts and observation.</p> <p>The Trust meets with NHSI and performance against plans is discussed and actions agreed.</p>
13	The Board is satisfied that the Trust effectively implements systems and/or processes to ensure compliance with all applicable legal requirements.		<p>The CEO/Chair have overall responsibility for legal compliance and will update the Board with any relevant requirements via the CEO briefing eg Learning from Deaths.</p> <p>The Board will be updated on requirements as they emerge either at formal Board meetings or at Away Days.</p> <p>The BAF is a tool for monitoring regulatory and legal compliance and risks to delivery of strategic plans.</p>
The Board is satisfied that the systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure (14-19)			
14	That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided.		<p>The Director of Nursing is the lead Director responsible for quality and together with the Medical Director they are responsible for all clinical and quality governance.</p> <p>There is a NED with direct clinical experience to facilitate clinical challenge at the Board. This NED has resigned and there is a recruitment campaign underway for a replacement.</p>
15	That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations.		<p>The Quality Strategy has recently been updated and sets out the priorities for 2017-20. Improving the quality, safety and experience of care for patients and families remains a key strategic objective for the Trust.</p> <p>The Quality Impact Assessment (QIA) process has been developed to ensure that appropriate steps are in place to safeguard</p>

Ref	Board Statement	Risk Rating	Summary of findings
			quality whilst delivering significant changes to service delivery.
16	The collection accurate comprehensive, timely and up to date information on quality of care.		<p>The Chief Executive hosts a daily safety huddle where staff can raise any concerns regarding staffing or safety.</p> <p>Other initiatives include the Trust's 'Sign Up to Safety' campaign which has resulted in a 35% improvement in incident reporting.</p> <p>Systems are in place to review and monitor performance and quality of care through performance dashboards at ward, service, divisional and Board level with a wide range of information available across the Trust.</p> <p>The Executive Team review key quality indicators at its weekly meetings eg harms report which includes information on pressure ulcers, falls and other safety data.</p>
17	That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care.		<p>Quality is an agenda item for each Board and the meetings usually start with a patient story.</p> <p>The Quality Committee provides assurance to the Board on all aspects of quality including delivery, governance and clinical risk management.</p> <p>A dashboard of Key Performance Indicators is reviewed monthly by the Board to ensure delivery of the five strategic objectives. The dashboard triangulates information on activity delivery and capacity levels, workforce engagement, patient safety and experience and financial performance.</p> <p>Any issues that arise between Quality Committee meetings are reported directly to the Board eg never events.</p> <p>There have been three serious clinical incidents reported to the Board in 2016/17</p>

Ref	Board Statement	Risk Rating	Summary of findings
			including two never events. The Trust carried out immediate investigations into these incidents and exercised its duty of candour to all involved patients, along with a formal apology from the Chief Executive. Organisational learning plans have been put in place.
18	That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources.		<p>The Trust engages with patients, staff and stakeholders in a number of ways eg via executive, NED and Governor walkabouts, listening into action program and patient and family listening events.</p> <p>For the eighth time in 10 years, patients rated the Trust as the best hospital in the country for 'overall patient care' in the Care Quality Commission's National Inpatient Survey.</p> <p>The National NHS Staff Survey 2016 scored the Trust as the best hospital to work and receive treatment.</p> <p>Surgeon of the day/week has been introduced on the back of stakeholder feedback.</p>
19	That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		<p>Board members understand their ultimate accountability for quality. Levels of delegation are in place and monitored with appropriate Board and Committee oversight.</p> <p>There are several ways in which staff can report quality issues, including the daily safety huddle, accessible to all staff and led by the Chief Executive, The Speak Out Safely campaign, 'HALT' process and appointment of a Freedom to Speak Up Guardian.</p> <p>The corporate risk register is populated with quality issues captured in Divisional Registers.</p> <p>All risks with a score over 15 are reported to the Board.</p>

Ref	Board Statement	Risk Rating	Summary of findings
			The Trust has implemented an Organisational Learning Policy, providing the opportunity for all to learn, together with follow up of improvements to ensure sustainability. The Organisational Learning strategy is relatively new and has not yet had the chance to become embedded. A key initiative for the Board is to ensure there is shared learning across the Trust in 2017/18.
20	The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.		<p>The Trust has made significant progress with the people development agenda via the establishment of a People Committee which monitors progress in implementing the People Strategy.</p> <p>The People Strategy will be updated in 2017/18 to reflect the workforce challenges facing the Trust – this includes the impact of shortage of staff in key areas</p> <p>Ward staffing is managed on a daily basis to ensure patient safety and quality of care levels are maintained.</p> <p>A number of the workforce targets have been assessed as amber at the end of March 2017.</p>

A summary the areas for improvement are set out in the next section.



5. Action plan

No	Recommendation	Response, person responsible and date of action
1	<p>Agreed CQC and Well led action plans- follow up</p> <p>The Trust should ensure that the plans put in place to reflect the learnings from these assessments are implemented on a timely basis</p>	<p>The Board is scheduled to review the Well led recommendations in July 2017 and the CQC action plan in September 2017.</p> <p>Well led: Lucy Lavan – Director of Corporate Affairs</p> <p>CQC: Sue Pemberton – Director of Nursing and Quality</p>
2	<p>SLR implementation</p> <p>The Board knows it needs to have reliable SLR information eg to assess consultant productivity and identify and deliver cost improvement opportunities. The Board via the IPC should ensure that improvements in SLR are progressing with pace.</p>	<p>SLR work is ongoing and a focus of IPC review throughout 2017/18.</p> <p>Claire Wilson – Chief Finance Officer</p>

Appendix A: Follow up – status of recommendations from the independent CGS review in 2016

No	Recommendation	Update May 2017 Status
1	<p>Agreed Action Plans – follow up</p> <p>The Trust should ensure that the action plan to address the findings from the independent CGS review in 2015 is updated and that revised actions and timescales are met for partially implemented recommendations. These relate to:</p> <ul style="list-style-type: none"> • Effectiveness of divisional structures • Effectiveness of the People Committee • Roll out of DATIX and embedding of risk management across the Trust • Formal Board skills audit • Assessing data quality for new Board indicators. 	<p>Implemented</p> <p>A more formal evaluation of the effectiveness of divisional structures has been considered as part of the Well Led Review.</p> <p>The divisions have been successful in delivering a number of improvements. The next challenge for the divisions is to broaden their focus and be accountable for performance across all aspects of the Trust's business.</p> <p>In response the Trust is developing an accountability framework that sets out the arrangements for devolved leadership and communicates the parameters by which performance will be assessed.</p> <p>The People Committee effectiveness considered as part of the Well Led Review and via an internal assessment. The Board recognises the positive impact of and has agreed that the People Committee will continue into 2017/18. The focus on people and learning and development is a priority for the Trust.</p> <p>Risk management is now embedded and DATIX implemented with the exception of the risk register as the Trust has decided to retain Athena for the next 12 months.</p>

No	Recommendation	Update May 2017 Status
		<p>The Risk Management and Corporate Governance Committee membership and scope have been updated in response to recommendations from the Well Led Review.</p> <p>There is a Board succession plan in place and the Chairman is satisfied with the current arrangements where skills assessments are carried out as part of NED appointments eg the Trust has recognised that there is a need for a NED with experience of large scale organisational change.</p> <p>The Well Led Review confirmed that the Board is provided with an assessment of data quality for Board level indicators. A recent Internal Audit Review provided significant assurance in this area.</p>
2	<p>Committee Effectiveness</p> <p>We note that the volume of papers to the Committees has increased over the last year and this is likely due to preparation for the CQC inspection. Now that the inspection is complete it would be good practice, for all assurance committees, to revisit the size of agendas and the balance between access to operational detail and the practicality of needing to develop a good understanding of the Trust and how it is functioning</p>	<p>Implemented</p> <p>Each Committee has carried out an effectiveness review at the end of 2016/17 and prepared an annual report setting out how it has met its terms of reference in the year.</p> <p>Action has been taken to streamline committees and examples of changes includes the introduction of starred items to indicate the item is for information.</p>
3	<p>IM&T Governance</p> <p>The Trust should ensure that there are appropriate reporting and governance arrangements for IM&T and clinical systems in line with the agreed responses to the</p>	<p>Implemented</p> <p>Progress with implementing agreed actions and embedding change for IM&T governance has been considered as part of the Well Led Review.</p>

No	Recommendation	Update May 2017 Status
	external EPR Review and make sure that the changes are embedded across the organisation on a timely basis.	<p>Roles and responsibilities have been updated. The Trust has set up a Digital Healthcare Committee that meets bi-monthly and reports to the Operational Board.</p> <p>There is a work plan for the Committee and membership includes clinicians.</p>
4	<p>PMO leadership and effectiveness</p> <p>Given the financial position of the Trust, the Board knows that it needs to strengthen the PMO approach to CIP delivery in 2016/17 and ensure effective PMO leadership. The Board through IPC should ensure that improvements in the PMO function are progressing with pace.</p>	<p>Implemented</p> <p>There is a PMO team in place with clear leadership arrangements and reporting lines in place.</p> <p>The focus in 2016/17 has been on implementing an effective framework and processes. The PMO is providing project management for a number of large schemes and supporting other schemes as necessary eg coaching role.</p> <p>The PMO provides support for the BTSG and is an important source of assurance for the CFO.</p> <p>Going forward the focus will be on embedding the processes in the Trust and for the PMO to have a more strategic and transformational role eg in back office consolidation.</p> <p>The IPC monitors progress with implementing change in the PMO function.</p>



Appendix B – CGS statement - current processes/arrangements and evidence

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
1	<p>The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.</p> <p><i>Note: the comments in the processes/arrangements and evidence/assurance columns apply to other criteria in this table.</i></p>	<ul style="list-style-type: none"> The Board of Directors has established governance policies that reflect the principles of the NHS Foundation Trust Code of Governance including a Corporate Governance Manual which is reviewed and updated annually. The Board receives assurance each year in relation to compliance with The Board has had a Well Led Review in 2016/17 where no significant issues were identified. The Trust has been included in Segment 1 under the NHSI SOF which allows maximum autonomy. The Trust has been rated as outstanding in the CQC assessment. The Board confirm compliance with NHSI Code of Governance at its March 2017 meeting. The draft 2016/17 Annual Governance Statement, which outlines the Trust's governance arrangements, is considered in principle by the Audit Committee. The AGS includes details of any gaps in control and mitigating actions. The Internal Audit "Opinion Statement" for 2016/17 provides 'significant assurance' that there is a generally a sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. Where gaps were identified, action plans are in place. Work is ongoing to provide the External audit opinion. At this stage no issues raised which might indicate a qualified opinion <i>Final opinion due May 2017.</i> At the April 2017 Board meeting the Board received Annual Assurance Committee Reports from: <ul style="list-style-type: none"> Audit Committee Integrated Performance Committee 	<ul style="list-style-type: none"> Corporate Governance section of the Annual Report outlining Code of Governance Compliance. CQC assessment Well led assessment report Draft Annual Governance Statements Board papers and minutes Corporate Governance Review and revised governance structures BAF key issues and review of BAF process External Audit Opinion – annual report and quality accounts Audit Committee minutes Director of Internal Audit Opinion Board walk arounds Mandatory training compliance monitored by the Board Appraisal compliance monitored by the Board. Risk Management Focus Board papers and minutes

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
		<ul style="list-style-type: none"> ○ Quality Committee ○ People Committee. • In each case the Board has been given assurance that the Committees have operated effectively in 2016/17 and discharged their terms of reference. • The Audit Committee approves the detailed programme of work for Internal Audit. This included a range of key risks identified through discussion with management and executives and a review of the Trust's Board Assurance Framework (BAF). • The Board receives a BAF issues document and copies of minutes following each Committee meeting. • The Trust has a strategy in place and the Board is aware of key risks and mitigating actions via the risk register BAF. • A formal review is undertaken by the Board on a quarterly basis, but the BAF is updated following every Board meeting, after consideration of new assurances and any new emerging or escalating risks. • The operation of the BAF is supported by the BAF Policy which sets out roles and responsibilities of the Board, Committees and individuals and provides templates for Board reporting to enable assurances provided and new risks to be linked directly to the BAF to aid the Board in keeping the BAF relevant and up to date. • Timely information on all key areas of performance is provided to the Board along with exception reports where the Trust is not meeting targets. The Board uses information/performance management to drive improvements. • The organisational appetite for risk has been set by the Board, and is embedded in the risk register structures. This results in the acceptance of risks when appetite thresholds are reached or exceeded. • Outside of the formal committee meetings, the Board has other mechanisms to gather early warning intelligence from patients and 	<ul style="list-style-type: none"> • Nominations and Remuneration Committee papers and minutes. • Constitution Review – annual report on compliance to the Board. • Annual Committee Assurance Statements • Board meetings and strategic planning days • Strategic and operational dashboards for each Board meeting. • Board walk around – paper to private Board • CoG minutes • CoG and Board joint development day • Provider Licence checklist • Operational Board papers and minutes • Integrated Performance committee papers and minutes • Quality Committee papers and minutes

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
		<p>staff e.g. via Board formal and informal walk-around. These methods help the Board members triangulate the hard facts and data reported at the Board and in Committees with what they are hearing and observing around the Trust.</p> <ul style="list-style-type: none"> • There is publication and discussion of Board minutes at Council of Governor (COG) meetings supported by a 'highlight' report of issues which the Board have highlighted for the attention of the COG. • CoG and Board work together to develop strategy plans and improve ways of working. • Incorporating within the internal audit programme an annual review of the sufficiency and quality of evidence brought to the Board and its Committees throughout the year to support the corporate governance statement (this report). 	
2	The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time	<ul style="list-style-type: none"> • The Board relies mainly on the Director of Corporate Affairs to seek, find, analyse and communicate the impact of corporate governance guidance on the Trust eg impact of the SOF. • The Chief Executive provides an update to the Board each month as required. • Guidance issued by NHSI is considered by the relevant Board Sub-Committees, the Trust Board and the Council of Governors. • Evidence that issues impacting on the Board are brought to its attention and action taken to ensure compliance. • The auditors provide updates relating to emerging issues and changes to the Audit Committee and the executives at the request of the Audit Committee will provide an assurance paper noting the Trust's responses to the challenge questions relating to the emerging issues and developments highlighted by the external auditors. • Compliance with guidance issued by NHSI is tested via relevant external reviews eg Well Led assessment 	<ul style="list-style-type: none"> • Evidence of corporate governance guidance being shared via Board papers. • Assurance Committee papers and minutes. • Register of external visits, reviews and inspections.

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
		<ul style="list-style-type: none"> The Corporate Governance Manual comprises all the key documents, policies and procedures that together provide a regulatory framework for the business conduct of the Foundation Trust eg the Scheme of Reservation and Delegation. 	
3	The Board is satisfied that the Trust implements:		
	(a) Effective board and committee structures	<ul style="list-style-type: none"> The Board has an Annual Business Cycle each year that links to the BAF and allocates responsibility across the Executive Team. There is a Board approved Committee Structure and terms of reference, annual workplans. The Operational Board is accountable for all aspects of delivery and operational performance and reports routinely to the Board of Directors. The Annual Report identifies key members of the Board and notes chairperson and members for Nominations, Audit and Remuneration Committees. Each Board Committee reports directly to the Board of Directors with NED input. A NED Chairs each of the Board Committees. The Executive has reviewed the structures below the Committees to ensure they are fit for purpose and implemented a new divisional structure. Each Committee has undertaken a review of its effectiveness in delivering its terms of reference and this is reported to the Board. The Audit Committee has a responsibility to review and seek assurance that the Board's Committees are operating effectively and considers this as part of its review of the AGS. The Board has designated four full days during the year to work on strategic planning and development. The Board routinely undertakes an informal evaluation of the Board at the end of every Board meeting and a summary of the feedback from 	<ul style="list-style-type: none"> Annual Report disclosures Board composition Implementation of approved changes to the governance structures. Annual Reports of assurance committees and review of terms of reference Board papers and minutes Board development plan Board and Committee annual cycle of business (workplans) Annual CGM compliance review Board led Committee effectiveness review

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
		Directors is recorded in the minutes of the meeting.	
	b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees;	<ul style="list-style-type: none"> • The Trust Corporate Governance Manual (CGM) included a schedule of decisions reserved for the Board and a scheme of delegation. • Division of responsibility between the Chair and CEO set out in in the CGM and agreed by the Board. • The Board has a formal Schedule of Matters Reserved for Board Decisions and a Scheme of Delegation. • The Annual Report to describe how Board and CoG operate, including a summary of types of decision to be taken by each and which are delegated to executive management. • The CGM, including the Scheme of Delegation is updated and approved annually by the Audit Committee. • Composition of the CoG is set out in Constitution. • The CoG hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors. • All Directors received an annual appraisal and have personal development plans. • The Chairman's appraisal is led by the Senior Independent Director and follows a process approved by the Council of Governors that involves all governors and directors having the opportunity to input relevant feedback. • Commissioning external reviews to provide an assessment of governance arrangements. 	<ul style="list-style-type: none"> • Corporate Governance Manual • Annual review of CGM by Audit Committee • Annual Report • Constitution • CoG papers and minutes • Nominations and Remuneration Committee papers and Minutes • Board member appraisals & personal development plans • Audit Committee papers and minutes.
	(c) Clear reporting lines and accountabilities throughout its organisation.	<ul style="list-style-type: none"> • The Annual Performance reports are provided to committees and the Board – the Board rely on committees functioning properly and providing appropriate information to the Board. • There are many mechanisms for engaging with staff and sharing key messages eg Big Conversation • Board members attend the quarterly CoG meetings and NEDs present reports on a cyclical basis of the work of the Board's assurance 	<ul style="list-style-type: none"> • Strategic and operational dashboards • Board and Committee papers and minutes • Staff communication / involvement eg you said we did/team brief

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
		<p>committees. A report from the Audit Committee is provided at each meeting.</p> <ul style="list-style-type: none"> • The Chair meets with the COG quarterly to update the governors on news and feedback on any matters they wish to raise. • There is a CoG Engagement Policy in place which outlines mechanisms for engagement between the CoG and the Trust Board. • Members provide feedback to the Trust through the bi-annual survey. • Action is being taken to further strengthen divisional accountabilities and the role of business partners via a formal accountability framework, 	<ul style="list-style-type: none"> • Big Conversation Roadshows • CoG papers and minutes. • Corporate hotboards • Listening into Action • Weekly Bulletins
4	The Board is satisfied that the Trust effectively implements systems and/or processes		
	4a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively.	<ul style="list-style-type: none"> • The operational plan is approved by the Board and submitted to NHSI. The plan, including forward projections, is monitored in detail by the Integrated Performance Committee. • The operational planning process is through Divisional structures • A Business Transformation Steering Group, chaired by the Chief Financial Officer has been established to oversee CIP performance. • The Board itself reviews a report on financial performance provided by the Chief Finance Officer including key performance indicators and NHSI metrics at each Board meeting. • All cost improvement plans are risk assessed for deliverability and potential impact on patient safety through an Executive led review process. The outcome of this assessment is reported to the Integrated Performance Committee and Board of Directors as part of the sign off of annual plans. • A key objective of the IPC is to provide the Board with assurances in respect of the Trust's operations in relation to compliance with the licence. The IPC has provided this assurance to the April Board in its annual assurance statement. 	<ul style="list-style-type: none"> • Operational Plan • Operational Board papers and minutes • Monthly Board report on activity and income, agency trajectory, CIP delivery • IPC Minutes • IPC ToR and annual effectiveness review • Board reports • The Audit Committee minutes • Board reporting of finance and performance • There is evidence that the Board considers Provider Licence compliance in the Board papers. • External Audit Opinion

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
		<ul style="list-style-type: none"> • The Board approves each NHSI submission having considered the risks and issues to compliance. • The Trust was issued with its provider licence on 1 April 2013 and the Board of Directors undertook a review of compliance with the licence conditions in March 2014 and introduced a process for quarterly review by the Audit Committee using a checklist of key licence requirements – the most recent one was in March 2017. • Directors individually and collectively have responsibility for reporting to and providing assurance to the Trust Board on the controls in place to mitigate risks to compliance with the Trust's Licence. • NEDs are encouraged to challenge executives across the whole framework, not just in their own area of expertise. • The scope of the external auditors work covers the requirement of the Trust to have proper arrangements for securing economy, efficiency and effectiveness of the use of resources. • The AGS contains a description on the economy, efficiency and effectiveness of the use of resources. • The Trust's resources are managed within the framework set by the Governance Manual, which includes Standing Financial Instructions. Financial governance arrangements are supported by internal and external audit to ensure economic, efficient and effective use of resources. • Outside of the Boardroom, the Directors conduct regular walkabouts to meet informally with staff and patients and to triangulate data received in relation to patient safety and quality of care. • The Trust has established an independent Programme Management Office. • To improve efficiency the Trust uses benchmarking data provided by the National Cardiothoracic Benchmarking Collaborative (NCBC) to 	<ul style="list-style-type: none"> • Board walkabouts • BAF key issues reports from the IPC • HOIA opinion • Annual Report and AGS • CGM • Annual Plan review • Board Report from walkabouts – key themes • Trust Going Concern Review • March 2017 Audit Committee papers

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
		<p>measure comparative length of stay and opportunities to remove unwarranted variation via improved utilisation of the bed base.</p> <ul style="list-style-type: none"> • The IPC is the lead assurance Committee responsible for monitoring the implementation of the Carter review recommendations. • Assurance on the adherence with the new national People Strategy is led by the People Committee. • A timetable for developing SLR reporting and clinical engagement has been shared with the IPC. The IPC is responsible for monitoring progress against the plan. 	
	4b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations	<ul style="list-style-type: none"> • A comprehensive review of compliance with the provider licence is undertaken annually and reported to the Audit Committee; this is supplemented by use of a quarterly checklist to provide assurance that key licensing requirements have been met and to flag up emerging risks that could threaten future compliance. • The dashboards included within the Board papers link to licence conditions. The reports provide a RAG rating to highlight areas of concern. • NEDs are encouraged to challenge executives across the whole framework, not just in their own area of expertise. • The Board is provided with the latest information available at their meetings. • The Board considers each quarterly self certification prior to submission to NHSI. • The IPC Committee provides a BAF key issues report to the Board so that members are fully sighted on key risks in respect of compliance with the licence. • The internal audit workplan is agreed annually. • Governor involvement via the safety and patient experience Council of Governors sub-group • Friends and Family, survey, patient feedback loops 	<ul style="list-style-type: none"> • The Board minutes show evidence of challenge and scrutiny. • Board dashboards • IPC assurance and reports, • Monitor quarterly submissions • Audit Committee minutes and papers (March 2017) • Internal Audit Annual Plan

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
		<ul style="list-style-type: none"> Clinical audit plan covering local and national audits. The Audit Committee considers the effectiveness of the work of the clinical audit team. 	
	<p>4c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;</p>	<ul style="list-style-type: none"> The Quality Committee is established as an Assurance Committee of the Board of Directors in order to provide the Board with assurances in respect of quality governance. All data within the Quality report is reviewed by the Quality Committee as part of a quality dashboard and is derived from a 3 Year Quality Improvement Strategy, approved by the Board of Directors. The Quality Committee consider those risks that are relevant to their ToR and report to the Board following each Committee meeting. This process provides the Board with assurances on the operation of controls for all major risks and provides a mechanism for the Board to routinely update the BAF. There is governor local stakeholders (including, patients, commissioners), Healthwatch and the local authority and Board engagement in priority setting in the Quality Accounts. A Board approved Organisational Learning Strategy has been implemented – this focuses on how the Trust learns from all available information and feedback about services; this sharing learning and good practice is monitored through the Quality Committee and communicated widely across the Trust through Divisional Governance structures. Implementation of the Quality Strategy and Organisational Learning Strategy supports delivery of the Trust's key objective to provide high quality and safe care. The Clinical Audit Plan is aligned with priorities and testing of compliance 	<ul style="list-style-type: none"> CQC assessment Quality Accounts Annual Report Clinical Audit Plan Organisational Learning Strategy Quality Committee assurance and reports, CQC registration with no conditions Board papers and minutes Board approved Clinical Quality Improvement Strategy (CQIS); medical revalidation report external assurance re quality account indicators Audit Committee approval of Internal Audit plan alignment of clinical audit plan with Trust priorities Board dashboards link to healthcare standards. BAF Quality Committee annual assurance report.

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
		<ul style="list-style-type: none"> There is evidence that the Trust has taken timely and appropriate action in response to issues raised by CQC inspections eg whistleblowing. The Director of Nursing led on a project to prepare the Trust in preparing for its CQC inspection and the Board was updated on findings and any actions taken to improve compliance with standards. 	
	4d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern)	<ul style="list-style-type: none"> The Integrated Performance Committee is established as an Assurance Committee of the Board of Directors in order to provide the Board with assurances in respect of the Trust's current and forecast performance and its operations in relation to compliance with the licence, regulatory requirements and statutory obligations. It is a Non-Executive Committee. Trust has developed a Long Term Financial Model (LTFM) An independent PMO has a key role in supporting divisions in delivering the financial plans. As part of preparing the Annual Report the Board considers the expectation that the Trust has adequate resources to continue its operations for the foreseeable future. The external auditor includes a view on the Trust as a going concern as part of its opinion. Working within the new clinical leadership structure the Trust has developed a financial plan for 2016/17 based on demand and capacity modelling working with the divisional leadership teams. Key to the delivery of this plan will be addressing the current workforce capacity constraints. Workforce plans have been developed to support this. The Audit Committee reviews the effectiveness of internal control through delivery of the internal audit plan and the financial systems reviews carried out. NHSI has not raised any concerns regarding going concern in its feedback on the 2017/18 operating plan submission. 	<ul style="list-style-type: none"> IPC and Board scrutiny of the 2017/16 financial plan prior to approval IPC assurance role in TofR Monitor quarterly self-certifications and supporting narrative for the Board Scrutiny of financial risks at IPC Annual plan LTFM Director of Internal Audit Opinion Internal audit review of financial systems and control External audit opinion refers to the Trust as a going concern.

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
	4e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making	<ul style="list-style-type: none"> The Board and the Committees have an agreed work plan setting out the cycle of business and what information should be reported at each meeting. The Board has had input to designing the strategic dashboard so that it considers appropriate information is being analysed and challenged. Strategic and operational dashboards are RAG rated and presented at each Board meeting. A summary of key issues and recommendations is provided for in Board papers. Papers are circulated to Board members (and committee members) prior to the meeting to support decision making. Each Board meeting starts with a patient story and cover patient experiences that are both positive and where things have not gone well to set the tone for the meeting. There is a BAF policy and reporting template and compliance with these has been re-inforced during the year. The Trust is exploring joint working with a number of Trusts and there is evidence that performance reports and information to support decision making is provided to the Board eg tendering of respiratory services. Benchmarking work has commenced but requires broader roll out. The Business Intelligence Committee meets on a monthly and is charged with identifying and discussing potential data quality issues which need to be addressed and actioned accordingly. 	<ul style="list-style-type: none"> Annual Plan Board and Committee annual cycle of business (workplans) Dashboard reporting to Board and Committees Business Intelligence Committee ToFR. Patient Stories BAF
	4f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the	<ul style="list-style-type: none"> A monitoring process for on-going review of compliance with the Provider Licence by the Audit Committee has been in place throughout the year. A key objective of the IPC is to provide the Board with assurances in respect of the Trust's current and forecast performance and its operations in relation to compliance with the licence. The BAF focus on key strategic risks. 	<ul style="list-style-type: none"> Audit Committee review of compliance with the provider licence BAF focus on key strategic risks Annual Report

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
	Conditions of its Licence	<ul style="list-style-type: none"> • In accord with the Risk Management Policy, risks scoring 15 or more are presented to the Board along with mitigating actions. • The Audit Committee provides the Board of Directors with an independent and objective review of its risk management system. • Responsibility for risk management has been delegated to the Director of Research & Informatics, who acts as the Chief Risk Officer. • During 2015/16 the Chief Risk Officer led the development and implementation of an enterprise-wide risk management strategy which has resulted in improvements to the risk management process, including the introduction of a new risk management policy electronification and integration of the risk registers and risk management training for all levels of the organisation. This new approach is work in progress and has been embedded during 2016/17. • The Executive team carry out an annual proactive risk analysis to ensure all possible risks likely to affect the Trust are considered. • When things do go wrong, staff are encouraged to report incidents, whether or not there was any consequence, in order that opportunity for learning can be captured. • Risk management training is delivered via corporate and local induction programmes for new staff and thereafter by participation in mandatory training. 	<ul style="list-style-type: none"> • Annual Plan and business planning process • Board dashboards with exception/variance focus and escalations • CEO briefing to the Board • Monitoring of complaints, survey results, incidents and claims • Director walkabouts to triangulate intelligence obtained at the Board • Monitoring of complaints and incidents.
	4g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on	<ul style="list-style-type: none"> • The Board approves the Trust's strategic and operational plans, taking into account the views of Governors and other stakeholders. • The Board has retained ownership of strategic development and there are 4 days assigned to strategic development within the Board's annual calendar. • Completion of external Strategic Options Report. • Responsibility for business planning now with the CFO which is independent of the operations function. • Board strategic vision sessions with external facilitator 	<ul style="list-style-type: none"> • Board strategy time out; • Board papers and minutes • Operational plan meetings • Director of Internal Audit Opinion; • BAF key issues reporting to the Board; • NHSI evaluation of Annual Plan submission;

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
	such plans and their delivery	<ul style="list-style-type: none"> Structured planning approach to develop and approve the operational plan and strategy. All cost improvement plans are risk assessed for deliverability and potential impact on patient safety through an Executive led review process. The outcome of this assessment is reported to the integrated Performance Committee and Board of Directors as part of the Executive Sign off of annual plans. The IPC has a role in challenging and reviewing plans and providing an update to the Board on assurances and risks. In relation to oversight of the Trust's performance, the Board receives an integrated performance report at every meeting and exception reports with action plans are provided for any areas which are off target. The IPR report is supplemented with issues raised by the Assurance Committees, reports from Operational Board and 'softer' intelligence gained from walkabouts and observation. The Board frequently receives presentations from clinical and non-clinical leaders to enable it to focus on key areas for development and learning. The Board Assurance Framework (BAF) is used as a tool to prioritise the Board's time through documentation of the principal risks to strategic objectives and regulatory compliance, identification of controls and assurances and actions needed to address any gaps. There is a clear process for regularly reviewing and updating the BAF and the BAF drives the Board's agenda and business cycle. All Board and Committee papers are referenced to the BAF to enable any changes in risks or gaps in assurance to be highlighted. Each of the Assurance Committees reports on BAF key issues to the Board and this informs regular review of the BAF. 	<ul style="list-style-type: none"> NHSI Segment Rating; Internal review of plans by the IPC

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
		<ul style="list-style-type: none"> The Trust has consistently achieved an internal audit opinion of 'significant assurance' in relation to its BAF processes and this has again been confirmed for 2016/17. The Trust supports the Healthy Liverpool Programme and is working with partners across the Liverpool Health economy to support delivery of the Cheshire and Merseyside (C&M) 5 Year Forward View. The Trust is leading on the redesign of the CVD pathway across C&M footprint. 	
	4h) To ensure compliance with all applicable legal requirements.	<ul style="list-style-type: none"> The BAF is a tool for monitoring regulatory and legal compliance and risks to delivery of strategic plans. The Trust has an agreed Constitution and corresponding suite of governing documents. There is a mandatory approved training programme. Compliance monitoring is carried out by the People Committee and Board. The CEO/Chair have overall responsibility for legal compliance and will update the Board with any relevant requirements. Each Board member will inform the Board of the legal requirements relating to their area. The Board will be updated on requirements as they emerge either at formal Board meetings or at Away Days. The Board receives compliance reports during the year eg on emergency planning and health and safety and fire safety. An assessment of the Trust's compliance with the provisions of the NHS Constitution has previously been undertaken and has been reported to the Trust Board. The NHS Constitution is made available to patients / members and staff via the Trust's Intranet and Internet. Heads of Department are updated about legal changes via corporate communications and training will be provided if needed. The Audit Committee approves and monitors the annual Counter Fraud plan. 	<ul style="list-style-type: none"> Constitution review; CEO reports to the Board; Mandatory training monitoring; Annual reports eg Health and Safety and Infection Control Board metrics Internal Audit and Counter Fraud workplan focus Standards of Business Conduct; Register of Interests BAF key issues reports from Assurance Committees Medical Revalidation reports

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
5	The Board is satisfied that the systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:		
	5a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;	<ul style="list-style-type: none"> The Director of Nursing is the lead Director responsible for quality and together with the Medical Director they are responsible for all clinical and quality governance. There is a NED with direct clinical experience to facilitate clinical challenge at the Board. Board development days consider quality training for all the Board. Revised governance structure has led to greater NED involvement in key areas including quality. The Quality Committee provides the Board with an independent and objective review of quality governance. The priority for the Committee is to review and scrutinise assurances that the Trust's strategic priorities for quality improvement are identified, implemented and monitored The Corporate and Local Induction Policy and Mandatory Training Policy sets out the responsibilities of the Board and executive team. There is a succession plan for each Board director and that includes plans for the Board members that lead on quality. Each board member has an annual appraisal and a training programme. 	<ul style="list-style-type: none"> NED led Quality Committee Board development plan Outcome of appraisals; Details of training undertaken by NEDs and executives Corporate and Local Induction and Mandatory Training Policy Board succession plan Pre-employment checks; contractual conditions regarding other employment Board composition and work of Nomination and Remuneration Committee NED with relevant clinical background.
	5b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;	<ul style="list-style-type: none"> The Trust has a Quality Strategy setting out priorities for 2017-20 which includes patient and family experience, key quality and safety awareness improvements. The Trust has agreed key quality priorities with the wider stakeholder group for the year. The Quality Accounts set out the priority areas, development processes and monitoring. There is a Patient Story at the start of each Board meeting 	<ul style="list-style-type: none"> CQIS Quality Accounts – priority development process and monitoring; Patient Story for Board meetings QIA process

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
		<ul style="list-style-type: none"> The Trust has participated in the Speak out Safely and Sign up to Safety campaign and has developed key objectives to support this. The Trust has been conducting mortality reviews for the past six years and is well placed to respond to the directive issued by Sir Bruce Keogh asking all Trusts to undertake a self-assessment of avoidable mortality and publish avoidable deaths. The Trust has two key approaches to quality improvement which are the 'Listening into Action' methodology and the "Plan Do Study Act" to understand the effectiveness of the change considered. The quality priorities are agreed with the leadership teams after full engagement with patients and stakeholders. The Trust governance systems monitor the quality priorities with reporting through Divisional Governance meetings to the Quality Committee. This committee reports to the Board. The Quality Impact Assessment process has been developed to ensure that appropriate steps are in place to safeguard quality whilst delivering significant changes to service delivery. The Medical Director, Director of Nursing & Quality and Head of Nursing (Corporate) are all responsible for signing off the QIA document for all clinical schemes/projects. The Programme Management Office (PMO) monitors the schemes through monthly highlight reports to provide assurance that there is no compromise to quality and safety The Trust was ranked 'Outstanding' – one of only 18 trusts in the country – in the Department of Health's new 'Learning from Mistakes League' when it was published in March 2016. 	<ul style="list-style-type: none"> Mortality Reviews Quality Committee papers and minutes QIA process
	5c) The collection of accurate, comprehensive, timely and up to date	<ul style="list-style-type: none"> The Chief Executive hosts a daily safety huddle where staff have the opportunity to raise any concerns eg staffing or safety. The Board receives a report at each meeting setting out planned vs actual nurse staffing for each ward. 	<ul style="list-style-type: none"> Board monthly quality dashboard;

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
	information on quality of care;	<ul style="list-style-type: none"> The Executive Team review key quality indicators at its weekly meetings eg harms report which includes information on pressure ulcers, falls and other safety data. The Quality Committee has a role in ensuring the Trust collects appropriate information on the quality of care. The Trust's focus on safety across the organisation has resulted in LHCH being part of the national Sign up to Safety campaign which is in its third and final year The Trust signed up to the Nursing Times campaign in 2014 and has implemented confidential ways in which its staff can speak out. The Trust has also initiated the Freedom to Speak up Guardian and has implemented Staff Guardians in many areas across the organisation. Patients and families are encouraged to escalate their concerns when they are concerned about care provision There have been three serious incidents reported to the Board in 2016/17 including two never events. The Trust carried out immediate investigations into these incidents and exercised its duty of candour to all involved patients, along with a formal apology from the Chief Executive. Full route cause analysis is carried out and organisational learning plans were immediately put in place. 	<ul style="list-style-type: none"> Board reports on nursing safe staffing at each meeting IG toolkit compliance reporting CQUIN performance reports Quality Committee meeting minutes Complaints, claims and incidents report SUI reporting to Board and through committees supported by an RCA process Sign up to safety
	5d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;	<ul style="list-style-type: none"> A dashboard of Key Performance Indicators is reviewed monthly by the Board to ensure delivery of the five strategic objectives. The dashboard triangulates information on activity delivery and capacity levels, workforce engagement, patient safety and experience and financial performance. This information is cascaded throughout the organisation at Divisional level and through team brief. The Board receives a monthly Board Assurance Framework (BAF) key issues report from each Assurance Committee regularly. 	<ul style="list-style-type: none"> External assurance on the Quality Account – due end May BAF Strategic and Operational Dashboards Board and Committee meeting minutes

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
		<ul style="list-style-type: none"> • There is also a more detailed performance summary which includes for example Monitor requirements. • Performance reports are backed up by exception reports where appropriate eg VTE and falls. • Qualitative descriptions and commentary are included to support performance. • Incidents, complaints and claims are included within a separate integrated report Information is examined by the Board who challenge the Executives about exceptions. • The Trust has a system for scoring data (gold, silver and bronze) dependent on the perceived quality of that data. • Information governance is managed through the BAF process which includes Executive accountability and a performance monitoring process via the Information Management and Technology Programme Board. • The Trust's Information Governance Toolkit submission is reviewed by independent auditors and for has received a significant assurance opinion for the 2016/17 submission. • The Board receives other reports in the year which include information on the quality of care eg CQC reports. • Internal audit has reviewed data quality and provided a significant assurance rating. 	<ul style="list-style-type: none"> • Complaints, claims and incidents reports • IG toolkit compliance
	5e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as	<ul style="list-style-type: none"> • Stakeholder management is a key strategic objective in 2016/17 and 2017/18 regular updates on partnership working are reported to Board via CEO's report • Internal and external stakeholders have been involved in developing the strategic and operational plan. • Membership and Patient and Family Engagement Strategies are in place 	<ul style="list-style-type: none"> • Board CEO reports • Board update on LHP • Annual plan • Quality Account Priorities 2016/17 • Membership Strategy • PFE strategy • Annual report

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
	appropriate views and information from these sources;	<ul style="list-style-type: none"> • A CoG working group on Membership and Communications has been established and supports the implementation of the Membership Strategy • Annual Report describes how public interests are represented • Governor involvement in Patient and Family Experience Strategy • Staff governors are involved in mutual research project • All members of the Board regularly attend Council of Governor meetings (quarterly) and Non-Executive Directors present reports on a cyclical basis of the work of the Board's Assurance Committees. A report from the Audit Committee is provided at every meeting of the Council of Governors. • The Trust also organises an annual development day for governors at which part of the time is allocated to joint working with Directors. • The Trust has an established Partnership Forum which is established as a Sub-Committee of the HR & Education Group to provide a forum for partnership working between management and joint staff side on matters relating to staff employed by the Trust. • Executives, clinicians and managers engage proactively in the STP • Regular stakeholder meetings take place with local acute trusts and the amount of partnership work and the number of joint appointments have increased. • The Board makes use of "soft" intelligence from hospital walkabouts and interaction with governors. 	<ul style="list-style-type: none"> • Staff involvement in the mutual research project • Friends and Family test results • Patient and staff surveys along with action plans for improvement areas; • Board walk rounds;
	5f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for	<ul style="list-style-type: none"> • The Director of Nursing and the Medical Director are responsible for all aspects of clinical and quality governance. • Quality governance is embedded within the Divisional structures, with monthly reporting to the Operational Board, where quality performance is reviewed. Cross-organisational quality initiatives are monitored and managed through a combined divisional quality 	<ul style="list-style-type: none"> • Quality Committee driving scrutiny of Trust's performance on key quality metrics • Executive job descriptions and annual objectives

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
	escalating and resolving quality issues including escalating them to the Board where appropriate.	<p>governance meeting. The Quality Committee receives assurances on progress with all of the Trust's quality initiatives.</p> <ul style="list-style-type: none"> • The corporate risk register is populated with quality issues captured in Divisional Registers. • The Clinical Quality Committee is the forum where individuals are held to account for quality performance. Action plans are identified and monitored at this forum. The Committee reports to the Operations Board and issues flagged up to the Quality Committee and Board if needed. • There is consultant led care at Trust and an escalation framework in place. • The Trust has implemented an organisational learning policy, Key features associated with this include reporting improvements as a consequence of experiences to the Operational Board, thereby providing the opportunity for all to learn, together with robust follow up of improvements to ensure sustainability. • The Quality Committee and Board review complaints, incidents and legal claims. • A clinician led Mortality review Group looks at all deaths, major harms and cardiac arrests. • Serious Untoward Incidents (SUIs) are tracked in the Quality Committee. • The recently revised and approved risk management strategy outlines the Trust process and approach to risk management, including escalation from departments to the Board. • Significant work has been undertaken to change and embed the culture with regard to the escalation of key quality issues. • Where there are particular concerns the Board will receive assurances direct from managers and monitor the implementation of action plans. 	<ul style="list-style-type: none"> • Divisional and ward dashboards • Monitors displaying staffing levels in all wards; • Top scoring divisional risks reported to the Board • Sign up to safety campaign • Speak out safely initiative • Daily safety huddle • Big conversations led by executives • Culture survey and response to issues highlighted for action.

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
		<ul style="list-style-type: none"> • Risk registers are supported and fed by quality issues captured in Divisional registers. • The Trust operates the Nursing Assessment & Accreditation System The HALT initiative was launched in February 2016 and staff have been supported to use this to prevent patient safety incidents occurring. Halt is used by all staff within wards and departments and they are encouraged to do so by the Executive Team. 	
6	The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure	<ul style="list-style-type: none"> • The current Board composition demonstrates a good mix of skills and experiences to lead the organisation. The organisation has the benefit of being well led by an experienced Chairman, knowledgeable of the health systems. • Recent appointments reflects the Board's assessment of the skills required and involves Non-Executives, CoG and external assessors as appropriate. • The NEDs bring a range of complementary skills and backgrounds, including; clinical, finance, law, research and human resources. NEDS have good grasp of their responsibility in holding the organisation to account for delivery of the strategy. 	<ul style="list-style-type: none"> • CFO appointment • Fit and proper persons self declarations for Board and CoG • Minutes of N&R Committee • Board profiles • HR policies and procedures • Executive job descriptions • Annual Report • Outcome of appraisals • N&R Committee minutes

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
	compliance with the conditions of its NHS provider licence.	<ul style="list-style-type: none"> The Executive Structure is kept under review. The Chief Executive has restructured executive portfolios during the year. The Annual Report details each director's area of expertise and includes a statement about Board's balance, completeness and appropriateness to the requirements of the FT. Recruitment processes are in place to address Executive Director appointments which are made in a timely fashion with Deputies (or equivalent) acting up as required during any delay between the Executive Director leaving and new appointee taking up the position. Succession planning review is considered by the Nominations and Remuneration Committee. HR policies and procedures have been updated and are accessible on the updated Trust intranet. The recruitment and selection policy has been developed taking into account current legislation, guidelines and existing Trust policies and the NHS Employment Check Standards There is an established process in place for individual performance review and objective setting for each Trust employee on at least an annual basis. Mechanisms are in place to assess the performance of Directors, through the Performance Review process, and to identify training needs where appropriate. Each Director has in place a personal development plan. The outputs of annual appraisals are reported to the CoG (for Chair and NEDs). Directors' objectives and performance considered annually by the Nominations and Remuneration Committee. The Trust continues to review the capacity and skills required to meet the organisation's need. A 5 year Medical Workforce Strategy has been developed which will complement the Divisional Workforce Plans Staff are encouraged to report concerns on staffing numbers at the daily safety huddle and action is taken to ensure safe staffing levels. 	<ul style="list-style-type: none"> CEO report to the board Board assurances on nurse staffing and monitoring of nursing numbers Workforce indicators included the Board dashboards. Medical Revalidation Report

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
		<ul style="list-style-type: none"> • The revised divisional structure and support functions has been implemented with the aim of ensuring the Trust has in place personnel reporting to the Board and Corporate sub structures who are both sufficient in number and appropriately qualified. • A programme of professional and personal development for the divisional leaders is underway. • The Trust reviews its nurse staffing levels every six months using evidence based tools to ensure the right staffing numbers are in place and publishes its staffing levels on a monthly basis. This is supplemented by a monthly review of ward staffing levels • Action has been taken to reduce the reliance on agency staff and improve recruitment and retention for nurses in particular. 	

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Report Distribution

Name	Title	Report Distribution
Lucy Lavan	Associate Director of Corporate Affairs	PDF Draft and Final
Claire Wilson	Chief Financial Officer	PDF Final
Mark Jackson	Director of Research and Informatics	PDF Final
Jane Tomkinson	Chief Executive	PDF Final

Discussion meeting held with

Name	Title	Date
Lucy Lavan	Associate Director of Corporate Affairs	20 April 2017
Jo Twist	Director of HR	27 April 2017
Mark Jackson	Director of Research and Informatics	27 April 2017
Claire Wilson	Chief Financial Officer	4 May 2017



Review Completion

Name	Planned Date	Actual Date
Fieldwork Starts	20/04/2017	20/04/2017
Discussion Document to Client	15/05/2017	11/05/17
Responses by Client	17/05/2017	
Final Report	18/05/2017	

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Acknowledgement and Further Information

MIAA would like to thank all staff for their co-operation and assistance in completing this review.



This report has been prepared as commissioned by the organisation, and is for your sole use. If you have any queries regarding this review please contact the Audit Manager. To discuss any other issues then please contact the Director.

