

# Monitor Corporate Governance Statement Review Assignment Report 2015/16

Liverpool Heart and Chest Hospital NHS Foundation Trust



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## 1. Introduction and background

To comply with the governance conditions of their licence, NHS Foundation Trusts are required to provide a 'Corporate Governance Statement' (CGS) as part of their annual plan submission. The CGS is a forward looking statement of expectations regarding corporate governance arrangements over the next 12 months and requires boards to confirm:

- Compliance with the governance condition at the date of the statement; and
- Forward compliance with the governance condition for the current financial year, specifying (i) any risks to compliance and (ii) any actions proposed to manage such risks.

In 2014, Liverpool Heart and Chest Hospital NHS Foundation Trust (the Trust) submitted a CGS to Monitor stating that they were fully compliant.

The Trust is required to submit its declarations by 30 June 2015 and will need to assess itself against the same 20 individual statements in the CGS as last year.

The Board needs to be satisfied with the controls and assurances in place to support the CGS, and Monitor has informed trusts that **"issues not identified and subsequently arising can be used as evidence of self-certification failure"**

## 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. Our approach focussed on:

- Following up of progress in implementing recommendations from the independent review carried out as part of the self-certification process for the CGS in 2014.
- Working with the Trust to update the evidence base from 2014 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.
- Evaluating the adequacy and sufficiency of evidence, focussing on gaps identified previously and any new evidence identified in the evidence base. We have taken into account the work we have carried out on the Quality Governance Framework earlier in the year.

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

There are other observations around governance that have been raised by external reviews on risk management and the Quality Governance Framework reviews that we recognise but we have not repeated them in this report. Progress in implementing these recommendations is being reported to the Integrated Performance Committee (IPC) and Quality Committee. The Board will need to consider the impact of these as part of the process for signing off the CGS.

#### Limitations to Scope:

We did not test the reliability or accuracy of the data gathered as part of the review.

The review does not provide assurance on whether the Trust is fully compliant against the criteria of Monitor's Corporate Governance Statement. It is ultimately the Board's responsibility to assure itself of compliance with each of the statements in the CGS.

### 3. Executive Summary

#### Key findings

Our testing identified that the Trust has designed and put in place principles, systems and standards of good corporate governance that meet key elements of good practice for corporate governance. The Trust has taken action to implement the recommendations from the CGS review in 2014. We did identify some areas for development in relation to operating effectiveness and how some of the processes and controls are designed and implemented.

Taking into account the issues identified the Board can take reasonable assurance that the processes upon which the organisation relies for preparing and assessing compliance with the CGS are appropriately designed and consistently applied.

It is clear from our discussions with Executives and the Chair that the Board recognises that the main risk to compliance relates to achieving the 18 week (RTT) target from 1 July 2015 (Q2). The Trust has an action plan to return to sustainable compliance with the RTT target from Q2, but the risk of continued patient complexity and acuity, as well as increasing referrals, presents challenges to the Trust.

The Trust has been very open with Monitor regarding the risks to achieving the RTT target in its recent Q4 submission. The Board has had several papers outlining the reasons for the breaches and the plans to deliver the targets on an ongoing basis. The



Board has been assured at its April 2015 Board meeting that the RTT Action plan and forward trajectory will deliver compliance from Q2. The Trust intends to signal to Monitor the risk to compliance with achieving the RTT target and specify the mitigating actions the Trust is taking. The Board will continue to monitor the RTT position prior to submitting the CGS to Monitor.

### Good practice

We identified many areas of good practice during our review:

- There is 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 license.
- The Trust has refreshed its Board Committee structure to strengthen how assurances are reviewed and escalated to the Board of Directors. Each Committee is led by a NED and there is evidence of scrutiny and challenge.
- The current Board composition demonstrates a good mix of skills and experiences. In particular there is good, relevant, clinical expertise in the NED cohort. There is clear evidence of the strength of challenge to the executive on matters of clinical quality and organisational performance.
- The Executive Structure is kept under review and a new position of Director of Strategy and Organisational Development has been created to build capacity and capability for strategic planning.
- We have seen examples of the Board demonstrating a proactive approach to succession planning with recent NED appointments and the Medical Director.
- The culture of the Trust is open and caring with a commitment to reporting harm and error. This is complemented by an aspiration **"to be the best"**. The Board regularly commit resources time and funding to this area.
- There are a number of good initiatives in place to empower staff to deliver quality care such as the Listening into Action programme.
- We saw strong evidence of the Board's commitment to shaping the organisational culture through structured staff and patient engagement.
- 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.
- There is evidence of scrutiny and challenge in both the Integrated Performance Committee and Board regarding the robustness of the RTT Action plan and forward trajectory.



### Follow up

The independent review carried out as part of the self-certification process for the CGS in 2014 made 2 recommendations and highlighted some gaps in evidence – the Trust has taken action and a number of these are complete or progress is being made with the implementation these. A summary of action taken is set out in Appendix A.




The Trust Board is sighted on these initiatives and receives assurances regarding progress from the Board Committees. The Board is confident in management's capacity to deliver the agreed actions within a reasonable timeframe.

Further development is needed in relation to implementing a method for maintaining an easily accessible evidence base that can support not only the CGS but other assessments such as the Well Led Review. The Trust should consider how the work of the Committees might better support assurances concerning this annual declaration for the future and ensure the agendas and work of the committees are driven accordingly.



### Improvement opportunities



We have identified opportunities for enhancing evidence/governance arrangements which the Trust may wish to consider/take action in advance of approving the CGS. We have included a commentary in Appendix B outlining the main processes in place for each statement and the Trust evidence base. The Trust has confirmed that the evidence base in the Appendix 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 2014 assessment (see below) which is 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


In the table below we have summarised the findings and areas for improvement that we have identified from our work along with the priority rating.




Ref	Board Statement	Risk Rating	Summary of findings
1	<b>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.</b>		<p>The Trust keeps its governance arrangements under review and has made changes in year to further develop those arrangements. This includes redesigning the Board Assurance Framework (BAF) to ensure alignment with the Trust's strategic plan; reforming the Board Committee structure; building Board level capacity and capability for strategic planning and updating the approach to risk management.</p> <p>Evidence provided to support this statement includes Board and Committee minutes; Constitution review; Code of Governance compliance review; Quality Governance Framework compliance; annual assurance and Committee reports.</p>
2	<b>The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time</b>		<p>Guidance from Monitor is disseminated primarily by the ADCA. There is evidence of action being taken on new initiatives in the year eg compliance with fit and proper persons requirements.</p> <p>Many of the items highlighted in 1 above are relevant for this statement. Other evidence includes the maintenance of a register of external visits and accreditation; annual Board review of compliance with the provider licence and annual review of Corporate Governance Manual (CGM) with support from MIAA to ensure it is comprehensive and consistent with best practice.</p>
3	<b>The Board is satisfied that the Trust implements effective board and committee structures;</b>		<p>New Board Committees were introduced in 2014 with the focus on assurance. Board members told us that the new structures have been a success and are more in line with good practice principles eg the Chairs, supported by executives, drive the Committee agenda; there is greater clarity of risks facing the Trust and a</p>




Ref	Board Statement	Risk Rating	Summary of findings
			<p>more informed and effective challenge from NED who are requesting assurance reports.</p> <p>A new Operational Board oversees the management of operations/performance in the Trust.</p> <p>Evidence provided for this statement includes: Committee annual assurance reports for the Board; MIAA feedback on the operation of the IPC and Quality Committee; Board approved Committee Structure and ToRs / annual workplans/focus; Board development programme; output from CoG/Board of Directors development day.</p> <p>Board members have participated in a survey on Board effectiveness which will inform further refinement of the Board's processes.</p> <p><i>Effective Committee structures require time to bed in. The Trust recognises this and work has been ongoing to monitor committee effectiveness and full review is due to be done in June 2015 (12 months from new structure approval).</i></p> <p><i>On occasion the Chairs of the Committees provide a verbal update to the Board. The Trust should ensure that the timing of Committees allows for written Chair's reports to Board.</i></p>
4	<b>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.</b>		<p>In addition to evidence for statement 3 there is evidence of the Board member appraisals taking place and an update was provided to the July 2014 Nomination and Remuneration Committees.</p> <p>In addition, each Committee has approved terms of reference setting out clear reporting lines and responsibilities.</p> <p>The CGM includes a schedule of decisions reserved for the Board and a scheme of</p>








Ref	Board Statement	Risk Rating	Summary of findings
			delegation.
5	<b>The Board is satisfied that the Trust implements clear reporting lines and accountabilities throughout its organisation.</b>		<p>In addition to evidence for statement 3, the Executives make key operational decisions and hold divisions to account for their performance at the Operational Board.</p> <p>The Trust has provided performance reports, key issues reports and the minutes from the Operational Board, Committees and the Board. The Board minutes show evidence of challenge and scrutiny.</p> <p>The Executive has reviewed the structures below the Committees to ensure they are fit for purpose and have identified a new divisional structure which is being implemented to improve accountability and clinical engagement.</p> <p><i>In the next 12 months the Trust should review the effectiveness of the divisional structures to ensure they have bedded in and are delivering the improvements expected.</i></p>
6	<b>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.</b>		<p>Evidence presented for this statement includes the External Audit Opinion and the Director of Internal Audit Opinion (<i>both of these currently draft but no major issues are expected</i>). The Trust has maintained a green governance rating from Monitor and a Continuity of Service rating of 4 throughout the year.</p> <p>The Board carried out a review of compliance with the licence conditions at its March 2015 meeting and no major issues were identified. The Board approves each Monitor submission having considered the risks and issues to compliance.</p> <p>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.</p>



Ref	Board Statement	Risk Rating	Summary of findings
			<p>The Board makes use of “soft” intelligence from hospital walkabouts and interaction with governors.</p> <p>Major projects in the year to further improve economy, efficiency and effectiveness of the use of resources include a review of consultant job planning to allow for better alignment to corporate objectives.</p>
7	<b>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.</b>		<p>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.</p> <p>The Board has been kept up to date with 18 week RTT performance. Board papers outline that the Trust has met its contractual requirements and the backlog has resulted primarily from increased activity both elective and non-elective and that cases have had greater complexity/acuity. The Trust is increasing capacity via investment in staff and additional beds. In the short term the Trust has secured capacity via outsourcing to other providers.</p> <p>There is evidence that the IPC has debated the risk in respect of non-compliance for RTT during the year and the Committee Chair has provided assurance to the Board around the robustness of the RTT recovery plan to restore compliance in quarter 2 of 2015/16.</p> <p>Evidence for this statement includes Board strategic and performance dashboards; evidence that the NEDs challenge executives across the whole performance framework.</p> <p><i>The Board has recognised a potential gap in how members are sighted on workforce issues in the Trust and is taking action to strengthen governance arrangements. In the meantime the</i></p>

Ref	Board Statement	Risk Rating	Summary of findings
			<i>Board should satisfy itself that there are appropriate mechanisms and tools in place to cover any gaps in workforce reporting.</i>
8	<b>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 of health care professions.</b>		<p>The evidence to support this statement includes; CQC registration with no conditions; Trust assessed by CQC as (the lowest) risk band 6 in the most recent report (December 2014) ; the Board approved Clinical Quality Improvement Strategy (CQIS); assessment against Monitor's Quality Governance Framework; medical revalidation report and external assurance re quality account indicators.</p> <p>There is evidence that the Trust has taken timely and appropriate action in response to issues raised by CQC inspections eg areas of non-compliance identified by CQC following its inspection of the Critical Care Unit.</p> <p>The Director of Nursing is leading on a project to prepare the Trust for its CQC inspection and the Board is updated on findings and any actions taken to improve compliance with standards.</p>
9	<b>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).</b>		<p>The evidence to support this statement includes the IPC and Board scrutiny of the 2015/16 financial plan prior to approval; IPC assurance role in ToR; Monitor quarterly self-certifications and supporting narrative for the Board; scrutiny of financial risks at IPC; internal audit review of financial systems and controls and external audit opinion refers to the Trust as a going concern.</p>
10	<b>The Board is satisfied that the Trust effectively implements systems and/or processes to obtain and disseminate accurate, comprehensive,</b>		<p>Evidence provided for this statement includes; Board input to designing the strategic dashboard; Board and Committee annual cycle of business (workplans); performance reporting to Board and Committees; senior managers and clinicians attend the Operational Board.</p>

Ref	Board Statement	Risk Rating	Summary of findings
	<b>timely and up to date information for Board and Committee decision-making.</b>		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 Upper GI surgical service.  <i>Further development work is planned for the Board performance summary report to link to updated strategic ambitions.</i>
11	<b>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;</b>		Evidence for this statement include: Board review of compliance with the provider licence during 2014/15; BAF focus on key strategic risks; external Risk Management review and ongoing implementation of action plan; Board dashboards with exception/variance focus and escalations; Monitor quarterly self-certifications and supporting narrative for the Board; monitoring of complaints, survey results and incidents and claims.  <i>The Trust is running the old risk register structure with the intention to roll out the new risk management strategy and risk register and training over the summer. The Board should satisfy itself that the transitional arrangements are robust.</i>
12	<b>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.</b>		Evidence for this statement includes: Board strategy time out; appointment of Director of Strategy; Board strategic vision sessions with external facilitator; External audit opinion; BAF key issues reporting to the Board; Monitor's evaluation of Annual Plan submission; Monitor risk rating; internal review of plans by the IPC; confirm and challenge sessions for the financial plan.  <i>The Trust should consider updating its self assessment of its strategic planning process using Monitors tool or equivalent as a development tool (as opposed to a compliance tool) with full Board engagement.</i>
13	<b>The Board is satisfied that the Trust effectively implements systems</b>		Evidence provided for this statement includes: the Constitution review; CEO reports to the Board; work on Duty of Candour and Fit and

Ref	Board Statement	Risk Rating	Summary of findings
	<b>and/or processes to ensure compliance with all applicable legal requirements.</b>		<p>Proper Persons requirements; mandatory training monitoring; Annual reports eg Health and Safety and Infection Control.</p> <p><i>The Trust improved performance during the year but has not met the targets for mandatory training in 2014/15. This will be an area of focus in 2015/16.</i></p>
<b>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)</b>			
14	<b>That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;</b>		<p>Evidence provided for this statement includes; QGF independent assessment; 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 and work of Nomination and Remuneration Committee.</p> <p><i>There is evidence that board skills are considered on an ongoing basis and for each appointment. The Board might consider the benefit of having a formal Board skills audit, this will be of value for the Well Led Review.</i></p> <p><i>The Corporate and Local Induction and Mandatory Training Policy has passed its review date of August 2014.</i></p>
15	<b>That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;</b>		<p>Evidence provided to support this statement includes: response to Francis, Keogh and Berwick informed clinical priorities in the CQIS; QGF independent assessment; Quality Accounts – priority development process and monitoring; Patient Story for Board meetings; QIA process and CQC Intelligent Monitoring Tool.</p>
16	<b>The collection accurate comprehensive, timely and up to date information on quality of care;</b>		<p>The evidence to support this statement includes: Board monthly quality dashboard; 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</p>

Ref	Board Statement	Risk Rating	Summary of findings
			<p>an RCA process; enhanced RTT reporting in response to compliance issues.</p> <p>The Chief Executive hosts a daily safety huddle where staff can raise any concerns regarding staffing or safety.</p>
17	<b>That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;</b>		<p>Evidence provided includes: system for scoring data quality (bronze, silver and gold); PbR clinical coding and other external coding audits indicate high level of coding accuracy; External assurance (re Quality Account); CQC Intelligent Monitoring Tool; Annual Plan; internal audit reviews of data quality.</p> <p><i>Data quality focus is increasing however there has been a delay in implementing the data quality policy and process.</i></p>
18	<b>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;</b>		<p>Evidence includes: stakeholder engagement and involvement in developing quality priorities; Membership and Patient and Family Engagement Strategies; staff involvement in the mutual research project; Board members, clinicians and managers involved in the Healthy Liverpool Project and sub-forums; updates on partnership working with acute trusts included in the CEO update to the Board; Friends and Family test results; patient and staff surveys along with action plans for improvement areas; Board walk rounds; COG-independent and influencing agenda.</p> <p><i>Stakeholder management is a key strategic objective for 2015/16. The Trust should consider preparing a stakeholder engagement strategy and management plan to bring together all the current initiatives. A more visible and co-ordinated approach is likely to be of value for the Well Led Review</i></p>
19	<b>That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for</b>		<p>Evidence includes: Quality Committee driving scrutiny of Trust's performance on key quality metrics; Executive job descriptions and annual objectives; incidents, divisional and ward dashboards; monitors displaying staffing levels in all wards; risk registers are supported and</p>

Ref	Board Statement	Risk Rating	Summary of findings
	<b>escalating and resolving quality issues including escalating them to the Board where appropriate.</b>		<p>fed by quality issues captured in Divisional registers; top 10 risks reported to the Board; culture survey and response to issues highlighted for action; a clinician led Mortality review Group looks at all deaths, major harms and cardiac arrests; Incident Reporting Including Investigation and Root Cause Analysis Procedures</p> <p>The Trust is introducing a new Nursing Assessment &amp; Accreditation System and has set a goal of all wards achieving ECS status by 2017.</p>
20	<b>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.</b>		<p>Evidence provided for this statement include: Board assurances on nurse staffing and monitoring of nursing numbers; commitment to introduce Listening into Action; current Board composition; minutes of Nomination and Remuneration Committee meetings; Board approval of composition; mandatory training compliance – monitored by Board; Appraisal compliance monitored by Board.</p> <p><i>The Trust has reconfigured its HR support function and is now on with a major people development agenda. Work is ongoing to update the HR policy in respect of recruitment and retention. Also the Trust has noted the need for a people strategy which represents a gap in evidence. There are a number of red rated workforce indicators eg turnover, sickness absence and both mandatory training and appraisals targets have not been met. There are risks around the sufficiency of the evidence to provide assurance.</i></p>

A summary of the gaps in evidence and areas for improvement are set out in the next section.





## 4. Action plan

Following the Board's confirmation of the findings and the actions identified, the action plan will be updated in response to these findings.

No	Recommendation	Response, person responsible and date of action
1	The Trust should ensure that the action plan to address the findings from the independent CGS review in 2014 is updated and that revised actions/timescales are met (see Appendix A).	
2	As part of the review of Committee effectiveness planned for June 2015 the Board should consider whether the timing of Committees can be changed so that there is time for the Chairs to provide a written rather than verbal Chair's report for the Board.  Improvements identified from the Committee effectiveness review should be actioned on a timely basis.	
3	In the next 12 months the Trust should review the effectiveness of the divisional structures to ensure they have bedded in and are delivering the improvements expected.	
4	The Trust should ensure that the actions planned to strengthen governance arrangements for workforce are progressed on a timely basis. In the meantime the Board should satisfy itself that there are appropriate mechanisms and tools in place to cover any gaps in workforce reporting.	
5	The Board metrics should be kept under review to ensure the dashboards reflect any updated strategic ambitions.	
6	In running with the old risk register structure until the new risk management strategy and risk register and training are rolled out the Board should satisfy itself that the transitional arrangements are robust.	



No	Recommendation	Response, person responsible and date of action
7	The Trust should consider updating its self assessment of its strategic planning process using Monitors tool or equivalent as a development tool (as opposed to a compliance tool) with full Board engagement.	
8	The Trust should ensure that systems are in place to support compliance with the mandatory training target in 2015/16 and beyond.	
9	The Board should consider the benefit of having a formal Board skills audit.	
10	The Corporate and Local Induction and Mandatory Training Policy has passed its review date of August 2014 and should be reviewed and updated.	
11	The Trust should ensure that the revised timescales for finalising and implementing the revised data quality policy and process are met.	
12	Given stakeholder management is a key strategic objective for 2015/16, the Trust should consider preparing a stakeholder engagement strategy and management plan to bring together all the current initiatives.	
13	The People strategy needs to be finalised as a priority along with communication and implementation plans.	
14	The Trust should ensure that systems are in place to support compliance with all the Board level workforce targets eg turnover, sickness absence and appraisals in 2015/16 and beyond.	

## Appendix A: Follow up – independent review of CGS 2014

No	Recommendation or gap Person responsible and date of action	Update April 2015
1	<p><b>Compilation of evidence</b></p> <p>The Trust has not yet designed a method for compiling the evidence required to support the statements. There is a risk that relevant evidence may be missed which in turn compromises the effectiveness of the evidence base. There is also a risk that evidence identified may not be available for review. Evidence must be available for it to be considered to support the statements.</p> <p>We recommend that the Trust considers the completeness of the current suite of evidence identified. Evidence should be stored to ensure it is accessible and where necessary available for update.</p> <p>Lucy Lavan June 14 Board</p>	<p><b>Partially implemented</b></p> <p>Capacity pressures in the executive support team has meant that Trust has been unable to fully implement this recommendation.</p> <p>Having evaluated the risk of not implementing this recommendation the Trust considers it has other processes which mean that evidence is readily accessible. Board and Committee workplans are set up at the start of the year with reference to provider licence requirements and there are no major gaps in evidence.</p> <p>The Trust will revisit this recommendation and look for a method for maintaining an easily accessible evidence base that can support not only the CGS but other assessments such as the Well Led Review.</p>
2	<p><b>Risk register</b></p> <p>The corporate risk register is one of the documents provided by the Trust as evidence to support the statements. Within the register there are out of date risks and assurances. This represents a risk to the integrity of the assurance offered by the document over the Trust's risk management arrangements. The Trust should review its risk management arrangements and refresh the risk register during the next year. This will provide assurance over the Trust's risk management arrangements and potentially identify areas where they can be strengthened.</p> <p>Sue Pemberton June 14 Board</p>	<p><b>Partially implemented</b></p> <p>Following an external review the Board has agreed an action plan which is being implemented. Actions taken:</p> <ul style="list-style-type: none"> <li>• Responsibility for risk is now with Director of Research and Informatics</li> <li>• Risk appetite statement now agreed by the Board</li> <li>• The revised risk management policy is going to the May Audit Committee then to Board for approval</li> <li>• The Trust has reverted to 5X5 matrix for scoring risk</li> <li>• Top 10 operational risks now go to the Board.</li> </ul> <p>Once the risk register format is finalised</p>

No	Recommendation or gap Person responsible and date of action	Update April 2015
		it will be rolled out across the Trust along with updated training.
3	Register of External Visits to be updated and maintained with 6 monthly reviews by Audit Committee  Lucy Lavan July 14 Audit Committee	<b>Actioned</b>
4	Audit Committee Terms of Reference to be reviewed  David Jago / Lucy Lavan June 14 Audit Committee and then Board	<b>Actioned</b>
5	Outcome of Executive Team appraisals for 2013/14 to be reported to Nominations & Remuneration Committee  Jane Tomkinson June 14 Nom & Rem Comm	<b>Actioned</b> 2014/15 executive appraisals due May 2015 and will be reported to the July Nominations & Remuneration Committee
6	Board to consider and confirm its requirements in relation to internal and external validation of the Trust's annual plan submission for future years.  David Jago / Debbie Fryer During 2014/15	<b>Partially implemented</b> The Trust believes they are not at the stage where the assumptions in the plan need external assessment beyond the Monitor review. A strategic dashboard for all objectives seen is presented at each Board meeting. During the year the Board has had external commentators challenge strategy and plans.  The Trust will keep this requirement under review.
7	Board skills audit to be included in terms of reference for 2014/15 external Board governance review.  Chairman Nov 14	<b>Partially implemented</b> Board skills are considered on an ongoing basis and for each appointment.  The Trust will keep this requirement under review.

No	Recommendation or gap Person responsible and date of action	Update April 2015
8	Succession plan for Executive Team to be considered annually by Nominations & Remuneration Committee  Jane Tomkinson June 14 Nom & Rem Comm	<b>Actioned</b>  The succession plans for both Executives and NEDs will be updated to reflect recent changes and considered by the July Committees.
9	Recruitment & Retention Policy to be reviewed and updated  Tracy Boustead May 14 Workforce Committee	<b>Partially implemented</b> There are plans to review and update this policy as part of the update of the people strategy.  The Workforce Committee is no longer functioning. The Board is currently considering the need for a separate workforce assurance committee to oversee the implementation of the various people and OD initiatives.
10	Data quality policy / strategy to be developed and adopted  Mark Jackson June 14 Board	<b>Partially implemented</b> Work is underway. A Data Quality policy will be presented to the Board in July.  An approach has been agreed and c55% of board level indicators have been assessed for data quality. This assessment will be included in the May Board reports.  Capacity issues in the IT team have impacted on achieving the original timescales.  The Trust is mindful of key individuals who represent "single point of failures" should they be absent or leave the organisation.



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

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
1	<p><b>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.</b></p> <p><b>Executive Sign off – ADCA</b></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"> <li>The Board has developed its Board structures and built Board level capacity for strategic planning and organisational development.</li> <li>The Trust has a strategy in place and the Board is aware of key risks and mitigating actions via the risk register and Board Assurance Framework (BAF). At the start of 2014/15 the Board Assurance Framework (BAF) was redesigned to ensure alignment to the Trust's new 5 year strategic plan and new governance arrangements The Framework incorporates and provides an evidence base of compliance against a number of objectives.</li> <li>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.</li> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>BAF</li> <li>BAF policy</li> <li>Board papers and minutes</li> <li>Nominations and Remuneration Committee papers and minutes.</li> </ul>
		<ul style="list-style-type: none"> <li>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.</li> <li>The Board gets assurance over the data quality for certain indicators.</li> <li>The Trust Board considers, the information held by the CQC about the Trust which is contained within the CQC Intelligent Monitoring Reports.</li> <li>Trust Board obtains the findings from stakeholder surveys eg patient and staff surveys.</li> <li>The CQC Intelligent Monitoring Tool is considered by both the Quality Committee and the Board.</li> </ul>	<ul style="list-style-type: none"> <li>Board meetings and strategic planning days</li> <li>Strategic and operational dashboards for each Board meeting.</li> <li>Internal Audit has reviewed data quality in respect of 2 indicators RTT admitted and 62 day cancer waits and provided significant assurance</li> <li>Board papers and minutes</li> </ul>

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
			<ul style="list-style-type: none"> <li>CQC Intelligent Monitoring Tool</li> </ul>
		<ul style="list-style-type: none"> <li>During 2014/15 the Trust has commissioned relevant external reviews of its governance arrangements including reviews by MIAA of quality governance and committee operation and by PM of risk management. Where these reports contain action plans, the implementation of recommendations is being monitored by Board Committees.</li> </ul>	<ul style="list-style-type: none"> <li>External risk register</li> <li>Quality Committee and IPC minutes</li> </ul>
		<ul style="list-style-type: none"> <li>The draft 2014/15 Annual Governance Statement, which outlines the Trust's governance arrangements, was considered in principle by the Audit Committee in March 2014.</li> <li>The AGS includes details of any gaps in control and mitigating actions.</li> <li>The Internal Audit draft 'Opinion Statement' for 2014/15, provides <b>'significant assurance'</b> 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. <i>Final opinion due May 2015</i></li> <li>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 2015</i>.</li> </ul>	<ul style="list-style-type: none"> <li>Draft AGS</li> <li>Audit Committee minutes</li> <li>HoIA opinion</li> <li>External Audit Opinion</li> </ul>
		<ul style="list-style-type: none"> <li>Outside of the formal committee meetings, the Board has other mechanisms to gather early warning intelligence from patients and 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</li> </ul>	<ul style="list-style-type: none"> <li>Board walk around – paper to April 2015 private Board</li> <li>CoG minutes</li> <li>CoG and Board joint development day</li> </ul>

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
		<p>and in Committees with what they are hearing and observing around the Trust.</p> <ul style="list-style-type: none"> <li>• There is publication of and discussion of Board minutes at Council of Governor meetings supported by a 'highlight' report of issues which the Board have highlighted for the attention of the Council of Governors.</li> <li>• CoG and Board work together to develop strategy plans and improve ways of working.</li> </ul>	
		<ul style="list-style-type: none"> <li>• The Board receives a BAF issues document and copies of minutes following each Committee meeting.</li> <li>• At the April 2015 Board meeting the Board received Annual Assurance Committee Reports from: <ul style="list-style-type: none"> <li>○ Audit Committee</li> <li>○ Integrated Performance Committee</li> <li>○ Quality Committee</li> </ul> </li> <li>• In each case the Board has been given assurance that the Committees have operated effectively in 2014/15 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.</li> <li>• An annual review of the Trust's compliance with Monitor's Code of Governance is undertaken. A formal refresh of the review of the Code of Governance was undertaken during 2014 to reflect changes to the Code.</li> <li>• The Constitution was last revised in July 2014 and the changes approved by both the Board and the CoG</li> </ul>	<ul style="list-style-type: none"> <li>• BAF key issues</li> <li>• Annual assurance committee reports</li> <li>• Audit Committee papers and minutes</li> <li>• Internal Audit Annual Plan</li> <li>• Board papers March 2015</li> <li>• Board minutes July 2014</li> <li>• CoG minutes July 2014</li> </ul>



Ref	Board statement	Process/arrangement in place at the Trust	Evidence
2	<p><b>The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time</b></p> <p><b>Executive Sign off – ADCA</b></p>	<ul style="list-style-type: none"> <li>• The Board relies mainly on the ADCA to seek, find, analyse and communicate the impact of corporate governance guidance on the Trust.</li> <li>• The Chief Executive provides an update to the Board each month as required.</li> <li>• Guidance issued by Monitor is considered by the relevant Board Sub-Committees, the Trust Board and the Council of Governors.</li> <li>• Evidence that issues impacting on the Board are brought to its attention and action taken to ensure compliance eg fit and proper person</li> <li>• Trust has a timeline for carrying out Monitors Well Led review in 2016</li> <li>• 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.</li> <li>• Compliance with guidance issued by Monitor is tested via relevant external reviews e.g. Internal Audit review of quality governance framework.</li> <li>• 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.</li> <li>• During 2014 the Manual has been reviewed and updated to ensure compliance with current legislation and regulatory requirements; and to reflect the changes to the governance arrangements and Committee structure that the Board approved at its last meeting in May 2014.</li> <li>• Mersey Internal Audit Agency supported the review of the Manual to ensure that it is comprehensive and consistent with best practice</li> <li>• The Audit Committee reviewed the Governance Manual at its meeting on 17th June 2014 and made a recommendation to the Board in respect of approval and adoption of the Manual.</li> </ul>	<ul style="list-style-type: none"> <li>• Evidence of corporate governance guidance being shared via Board papers.</li> <li>• Assurance Committee papers and minutes.</li> <li>• March 2015 Audit Committee – paper from executives no major omissions noted</li> <li>• Register of external visits, reviews and inspections.</li> <li>• MIAA review of the QGF</li> <li>• The changes to the governance structures have been approved by the Board.</li> <li>• The updated Corporate Governance Manual approved by the Board at its June 2014 meeting.</li> <li>• Audit Committee papers for June 2014.</li> </ul>

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
3	<p><b>The Board is satisfied that the Trust implements:</b></p> <p><b>(a) Effective board and committee structures</b></p> <p><b>Executive Sign off – CEO/ADCA</b></p>	<ul style="list-style-type: none"> <li>• The Trust is headed by an experienced Board of Directors which is collectively responsible for the performance of the Trust.</li> <li>• The new committee structure and Board assurance process arrangements have been evaluated internally.</li> <li>• MIAA have observed the new Assurance Committees (Quality Committee and Integrated Performance Committee) in action and provided assurance reports on their findings and recommendations.</li> <li>• The Annual Report identifies key members of the Board (incl SID) and notes chairperson and members for Nominations, Audit and Remuneration Committees.</li> <li>• Each Board Committee reports directly to the Board of Directors with NED input. A NED Chairs each of the Board Committees.</li> <li>• A new Operational Board was introduced in 2014/15 and this has facilitated a much clearer distinction between operational performance management and accountability (Executive-led) and assurance (Non-Executive led).</li> <li>• The Executive has reviewed the structures below the Committees to ensure they are fit for purpose and have identified a new divisional structure which is being implemented.</li> <li>• Each Committee has undertaken a review of its effectiveness in delivering its terms of reference and this is reported to the Board.</li> <li>• 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.</li> <li>• Board members have participated in a survey on Board effectiveness which will inform further refinement of the Board's processes.</li> <li>• The Board has designated four full days during the year to work on strategic planning and development.</li> <li>• There is a program of Board Development days.</li> </ul>	<ul style="list-style-type: none"> <li>• Annual Report disclosures</li> <li>• Board composition</li> <li>• Implementation of approved changes to the governance structures.</li> <li>• Annual Reports of assurance committees and review of terms of reference</li> <li>• Board papers and minutes</li> <li>• Board development plan</li> <li>• Board and Committee annual cycle of business (workplans)</li> <li>• MIAA report on Committee observations</li> <li>• Annual CGM compliance review</li> </ul>

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
		<ul style="list-style-type: none"> <li>The Board of Directors also undertake an annual self assessment of compliance with Monitor's Code of Governance.</li> <li>The Board routinely undertakes an informal evaluation of the Board at the end of every Board meeting and a summary of the feedback from Directors is recorded in the minutes of the meeting.</li> </ul> <p>There is a Corporate Timetable in place which includes details of the (routine) matters requiring reporting to the Trust Board.</p>	
	<p><b>b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees;</b></p> <p><b>Executive Sign off – CEO/ADCA</b></p>	<ul style="list-style-type: none"> <li>The Trust Corporate Governance Manual (CGM) included a schedule of decisions reserved for the Board and a scheme of delegation.</li> <li>Division of responsibility between the Chair and CEO set out in the CGM and agreed by Board.</li> <li>The Board has a formal Schedule of Matters Reserved for Board Decisions and a Scheme of Delegation.</li> <li>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.</li> <li>The CGM, including the Scheme of Delegation is updated and approved annually by the Audit Committee.</li> <li>Composition of CoG is set out in constitution last reviewed 2013.</li> <li>The CoG hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors.</li> <li>All Directors received an individual appraisal in 2014/15. In the case of the Chief Executive, this was led by the Chairman; for the executive directors, the process was led by the Chief Executive; and for the Non-Executives by the Chairman. The Chairman's appraisal was led by the Senior Independent Director and followed a process approved by the Council of Governors that involved all governors and directors having the opportunity to input relevant feedback.</li> </ul>	<ul style="list-style-type: none"> <li>Corporate Governance Manual</li> <li>Annual review of CGM by Audit Committee</li> <li>Annual Report</li> <li>Constitution</li> <li>CoG papers and minutes</li> <li>Nominations and Remuneration Committee papers and Minutes</li> <li>Board member appraisals &amp; personal development plans</li> <li>Audit Committee papers and minutes.</li> </ul>
	<b>(c) Clear reporting lines and</b>	<ul style="list-style-type: none"> <li>Performance reports are provided to committees and the Board – the Board rely on committees functioning properly and providing appropriate</li> </ul>	<ul style="list-style-type: none"> <li>Strategic and operational dashboards</li> </ul>

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
	<p><b>accountabilities throughout its organisation.</b></p> <p><b>Executive Sign off – CEO/ADCA</b></p>	<p>information to the Board.</p> <ul style="list-style-type: none"> <li>• There are many mechanisms for engaging with staff and sharing key messages eg A 'Your Chance to Shine' campaign was launched in January 2015 and is designed to engage staff in all areas in identifying and showcasing their own achievements, whilst also celebrating the innovation and service improvement implemented in their areas.</li> <li>• The team brief approach to encourage staff involvement was further embedded in 2014/15, with parts of team brief being delivered by staff from across the organisation. 'Majoring on the Minor, gives individual teams the opportunity to showcase quality and service improvements in their area and share best practice.</li> <li>• Board members attend the quarterly CoG meetings and NEDs present reports on a cyclical basis of the work of the Board's assurance committees. A report from the Audit Committee is provided at each meeting.</li> <li>• The Chair meets with the COG quarterly to update the governors on news and feedback on any matters they wish to raise.</li> <li>• There is a CoG Engagement Policy in place which outlines mechanisms for engagement between the CoG and the Trust Board.</li> <li>• Members provide feedback to the Trust through the bi-annual survey.</li> </ul>	<ul style="list-style-type: none"> <li>• Board and Committee papers and minutes</li> <li>• Staff communication / involvement eg you said we did/team brief</li> <li>• Your Chance to Shine campaign.</li> <li>• CoG papers and minutes.</li> <li>•</li> </ul>

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
4	<b>The Board is satisfied that the Trust effectively implements systems and/or processes</b>		
	<p><b>4a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively.</b></p> <p><b>Executive Sign off – Chief Financial Officer</b></p>	<ul style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>The checklist is maintained by the relevant accountable Executive Directors and reported to the Audit Committee to provide assurance that the Trust is compliant with key licence conditions.</li> <li>NEDs are encouraged to challenge executives across the whole framework, not just in their own area of expertise.</li> <li>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.</li> <li>The AGS contains a description on the economy, efficiency and effectiveness of the use of resources.</li> <li>Major projects in the year to further improve economy, efficiency and effectiveness of the use of resources include a review of consultant job planning to allow for better alignment to corporate objectives.</li> <li>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.</li> <li>The Board makes use of "soft" intelligence from hospital walkabouts and</li> </ul>	<ul style="list-style-type: none"> <li>The Audit Committee considered the provider licence checklist at its March 2015 meeting and no major issues were noted.</li> <li>Board reporting of finance and performance</li> <li>There is evidence that the Board considers Provider Licence compliance in the Board papers.</li> <li>External Audit Opinion</li> <li>Board walkabouts</li> <li>IPC ToR and annual effectiveness review</li> <li>BAF key issues reports from the IPC</li> <li>HOIA opinion</li> <li>Monitor quarterly submissions</li> <li>Annual Report and AGS</li> <li>CQC Intelligent Monitoring Tool</li> <li>CGM</li> <li>Annual Plan review</li> </ul>

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
		<p>interaction with governors.</p> <ul style="list-style-type: none"> <li>The Board approves each Monitor submission having considered the risks and issues to compliance.</li> <li>The Trust has maintained a green governance rating from Monitor and a Continuity of Service rating of 4 throughout the year.</li> <li>The financial plan is developed through a process of 'confirm and challenge' meetings with divisions and departments to ensure best use of resources.</li> <li>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.</li> </ul>	
	<p><b>4b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations</b></p> <p><b>Executive Sign off – Chief Operating Officer</b></p>	<ul style="list-style-type: none"> <li>The dashboards included within the Board papers link to licence conditions. The reports provide a RAG rating to highlight areas of concern.</li> <li>NEDs are encouraged to challenge executives across the whole framework, not just in their own area of expertise.</li> <li>The Board is provided with the latest information available at their meetings.</li> <li>The Board considers each quarterly self certification prior to submission to Monitor.</li> <li>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.</li> <li>There is evidence that the IPC has debated the risk in respect of non-compliance for RTT during the year and the Committee Chair has provide assurance to the Board around the robustness of the RTT recovery plan to restore compliance in quarter 2 of 2015/16.</li> </ul>	<ul style="list-style-type: none"> <li>The Board minutes show evidence of challenge and scrutiny.</li> <li>Board dashboards</li> <li>IPC assurance and reports,</li> <li>Monitor quarterly submissions</li> </ul>
	<b>4c) To ensure</b>	<ul style="list-style-type: none"> <li>Areas of non-compliance were identified by CQC following its inspection</li> </ul>	<ul style="list-style-type: none"> <li>Quality Committee</li> </ul>

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
	<p><b>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;</b></p> <p><b>Executive Sign off – Director of Nursing and Quality / Medical Director</b></p>	<p>of the Critical Care Unit during the year. Action has been taken to address those concerns and a recent re-inspection has stated that the standards were achieved and the Trust was compliant.</p> <ul style="list-style-type: none"> <li>• The CQC intelligent monitoring report for December 2014 places LHCH in Band 6 – the lowest risk band.</li> <li>• The response to Francis, Keogh and Berwick informed clinical priorities in the CQIS</li> <li>• 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. It is a Non-Executive Committee.</li> <li>• There is evidence that the Trust has taken timely and appropriate action in response to issues raised by CQC inspections eg whistleblowing.</li> <li>• The Director of Nursing is leading on a project to prepare the Trust in preparing for its CQC inspection and the Board is updated on findings and any actions taken to improve compliance with standards.</li> <li>• 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.</li> </ul>	<p>assurance and reports,</p> <ul style="list-style-type: none"> <li>• CQC registration with no conditions</li> <li>• Board papers and minutes</li> <li>• CQC reports</li> <li>• Board approved Clinical Quality Improvement Strategy (CQIS);</li> <li>• Assessment against Monitor's Quality Governance Framework;</li> <li>• medical revalidation report</li> <li>• external assurance re quality account indicators</li> <li>• Audit Committee approval of Internal Audit plan</li> <li>• alignment of clinical audit plan with Trust priorities</li> <li>• Board dashboards link to healthcare standards.</li> <li>• BAF</li> <li>• Quality Committee annual assurance report.</li> </ul>
	<p><b>4d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to</b></p>	<ul style="list-style-type: none"> <li>• The April Board received the final financial plans for 2015/16 – the report set out the key risks, opportunities and areas of uncertainty for example the CIP gap is reported as £1.04m. The plan is for a £0.3m deficit which will allow the Trust to maintain its COSRR of 3 during 2015/16. The plan has been approved subject to some minor refinements.</li> <li>• The Integrated Performance Committee is established as an Assurance Committee of the Board of Directors in order to provide the Board with</li> </ul>	<ul style="list-style-type: none"> <li>• IPC and Board scrutiny of the 2015/16 financial plan prior to approval</li> <li>• IPC assurance role in ToFR</li> <li>• Monitor quarterly self-certifications and supporting narrative for the</li> </ul>

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
	<p><b>ensure the Licensee's ability to continue as a going concern)</b></p> <p><b>Executive Sign off – Chief Financial Officer</b></p>	<p>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.</p> <ul style="list-style-type: none"> <li>• An independent PMO has been introduced during the year and will have a key role in supporting divisions in delivering the financial plans.</li> <li>• 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.</li> <li>• The external auditor includes a view on the Trust as a going concern as part of its opinion.</li> <li>• The Audit Committee reviews the effectiveness of internal control through delivery of the internal audit plan and the financial systems reviews carried out.</li> <li>• The Board considers any impact on the Continuity of Service (CoS) rating prior to approving the quarterly submission to Monitor.</li> </ul>	<p>Board</p> <ul style="list-style-type: none"> <li>• CIP performance and PMO control/independence</li> <li>• Scrutiny of financial risks at IPC</li> <li>• Annual plan</li> <li>• Director of Internal Audit Opinion</li> <li>• Internal audit review of financial systems and control</li> <li>• External audit opinion refers to the Trust as a going concern.</li> </ul>
	<p><b>4e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making</b></p> <p><b>Executive Sign off – ADCA</b></p>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• The Board has had input to designing the strategic dashboard so that it is considers appropriate information is being analysed and challenged.</li> <li>• Committees are well supported with papers being sent out on time. There is a BAF policy and reporting template and compliance with these have been re-inforced during the year.</li> <li>• 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 Upper GI surgical service.</li> <li>• 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.</li> </ul>	<ul style="list-style-type: none"> <li>• Annual Plan</li> <li>• Board and Committee annual cycle of business (workplans)</li> <li>• Benchmarking;</li> <li>• Dashboard reporting to Board and Committees</li> <li>• Senior managers and clinicians attend the Operational Board</li> <li>• Business Intelligence Committee ToFR.</li> </ul>
	<b>4f) To identify and</b>	<ul style="list-style-type: none"> <li>• The Board undertook a review of compliance with the provider licence in</li> </ul>	<ul style="list-style-type: none"> <li>• Board review of compliance</li> </ul>



Ref	Board statement	Process/arrangement in place at the Trust	Evidence
	<p><b>manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence</b></p> <p><b>Executive Sign off – Director of Research and Informatics</b></p>	<p>2013/14 and this was been refreshed in 2014/15.</p> <ul style="list-style-type: none"> <li>• A monitoring process for on-going review by the Audit Committee has been in place throughout the year.</li> <li>• 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.</li> </ul>	<p>with the provider licence during 2014/15;</p> <ul style="list-style-type: none"> <li>• BAF focus on key strategic risks</li> <li>• Annual Plan and business planning process</li> <li>• Risk Management review and ongoing implementation of action plan</li> <li>• Board dashboards with exception/variance focus and escalations</li> <li>• Monitor quarterly self-certifications and supporting narrative for the Board</li> <li>• Monitoring of complaints, survey results, incidents and claims</li> <li>• Director walkabouts to triangulate intelligence obtained at the Board</li> </ul>
	<p><b>4g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate</b></p>	<ul style="list-style-type: none"> <li>• The Board has held two strategic vision sessions with a senior NHS consultant to obtain external assurance on the plans and direction.</li> <li>• The Board has retained ownership of strategic development and there are 4 days assigned to strategic development within the Board's annual calendar.</li> <li>• The Board has strengthened capacity and capability through the appointment of a new executive director with responsibility for</li> </ul>	<ul style="list-style-type: none"> <li>• Board strategy time out;</li> <li>• Appointment of Director of Strategy;</li> <li>• Board strategic vision sessions with external facilitator;</li> <li>• Director of Internal Audit</li> </ul>

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
	<b>external assurance on such plans and their delivery</b>  <b>Executive Sign off – Chief Financial Officer</b>	<p>Strategy and Organisational Development.</p> <ul style="list-style-type: none"> <li>The financial plan is developed through a process of 'confirm and challenge' meetings with divisions to ensure best use of resources.</li> <li>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.</li> <li>Monitor's review in October 2014 of the Trust's 5 year plan assessed the Trust strategy as "green" and did not highlight any "undue concerns".</li> <li>The IPC has a role in challenging and reviewing plans and providing an update to the Board on assurances and risks.</li> </ul>	<p>Opinion;</p> <ul style="list-style-type: none"> <li>CQC Intelligent Monitoring Tool;</li> <li>External audit opinion;</li> <li>BAF key issues reporting to the Board;</li> <li>Monitor's evaluation of Annual Plan submission;</li> <li>Monitor risk rating;</li> <li>Internal review of plans by the IPC</li> <li>Confirm and challenge Sessions for the financial plan.</li> </ul>
	<b>4h) To ensure compliance with all applicable legal requirements.</b>  <b>Executive Sign off – Chief Financial Officer</b>	<ul style="list-style-type: none"> <li>The Board Assurance Framework has been refreshed in 2014/15 to add greater value to the work of the Board as a tool for monitoring regulatory and legal compliance and risks to delivery of strategic plans.</li> <li>The CEO/Chair have overall responsibility for legal compliance and will update the Board with any relevant requirements eg in relation to Duty of Candour and Fit and proper Persons requirements.</li> <li>Each Board member will inform the Board of the legal requirements relating to their area.</li> <li>The Board will be updated on requirements as they emerge either at formal Board meetings or at Away Days.</li> <li>The Board receives compliance reports during the year eg on health and safety and fire safety.</li> <li>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 /</li> </ul>	<ul style="list-style-type: none"> <li>Constitution review;</li> <li>CEO reports to the Board;</li> <li>Work on Duty of Candour and Fit and Proper Persons requirements;</li> <li>Mandatory training monitoring;</li> <li>Annual reports eg Health and Safety and Infection Control</li> <li>Board metrics</li> <li>Internal Audit and Counter Fraud workplan focus</li> <li>Standards of Business Conduct; Register of</li> </ul>

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
		<p>members and staff via the Trust's Intranet and Internet.</p> <ul style="list-style-type: none"> <li>The Trust has refreshed its Values and Behaviours to ensure they are more aligned to its vision to '<b>be the best</b>' and to the core values of the NHS Constitution.</li> <li>Heads of Department are updated about legal changes via corporate communications and training will be provided if needed.</li> </ul>	<p>Interests</p> <ul style="list-style-type: none"> <li>CQC Intelligent Monitoring Tool</li> <li>BAF key issues reports from Assurance Committees</li> <li>Medical Revalidation reports.</li> </ul>
5	<p><b>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:</b></p>		
	<p><b>5a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;</b></p> <p><b>Executive Sign off – CEO</b></p>	<ul style="list-style-type: none"> <li>The Board takes an active leadership role on quality. Feedback from the QGAF review indicated that Board members are very knowledgeable about quality and there is good engagement and challenge from the NEDs.</li> <li>The commitment to providing high quality care is expressed in a number of documents including <i>Quality Improvement Strategy</i>.</li> <li>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.</li> <li>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</li> <li>The 2014/15 Board Development Plan has had an emphasis on quality and safety and the Board has accessed the AQuA programme to support its leadership development work. As a result of this learning the Board has strengthened a number of its processes eg the new strategic and</li> </ul>	<ul style="list-style-type: none"> <li>QGF independent assessment</li> <li>NED led Quality Committee</li> <li>Board development plan</li> <li>Outcome of appraisals;</li> <li>Details of training undertaken by NEDs and executives</li> <li>Corporate and Local Induction and Mandatory Training Policy (check if up to date);</li> <li>Board succession plan</li> <li>Pre-employment checks; contractual conditions regarding other employment</li> <li>Board composition and work of Nomination and Remuneration Committee</li> </ul>

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
		<ul style="list-style-type: none"> <li>operational dashboard.</li> <li>The Corporate and Local Induction Policy and Mandatory Training Policy sets out the responsibilities of the Board and executive team.</li> <li>There is a succession plan for each Board director.</li> <li>Each board member has an annual appraisal and a training programme.</li> </ul>	<ul style="list-style-type: none"> <li>NED with relevant clinical background.</li> </ul>
	<p><b>5b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;</b></p> <p><b>Executive Sign off – Director of Nursing and Quality / Medical Director</b></p>	<ul style="list-style-type: none"> <li>The completed Quality Governance Framework review includes evidence demonstrating how quality drives the Trust's strategy.</li> <li>CQIA was approved by the Board in January 15 and is monitored via the Quality Committee.</li> <li>Monitor's review in October 2014 of the Trust's 5 year plan assessed the Trust strategy as "green" and did not highlight any "undue concerns."</li> <li>The Trust has self-assessed its strategic planning using Monitor's strategic planning self-assessment tool in February 2014 and identified a number of actions</li> <li>Where risks have been identified there is evidence that action has been taken to mitigate risks to quality eg pressure sores, falls, never events and CQC reports.</li> <li>A paper to the May 2014 Board outlined proposed governance developments to ensure safe delivery of the CIP.</li> <li>The Executive Team decide as a group which CIP initiatives to take forward and the Medical Director and Nursing Director have the final mandate to sign these off.</li> </ul>	<ul style="list-style-type: none"> <li>Response to Francis, Keogh and Berwick informed clinical priorities in the CQIS;</li> <li>QGF independent assessment;</li> <li>Quality Accounts – priority development process and monitoring;</li> <li>Patient Story for Board meetings</li> <li>QIA process</li> <li>CQC Intelligent Monitoring Tool.</li> </ul>
	<p><b>5c) The collection of accurate, comprehensive, timely and up to date information on quality of care;</b></p> <p><b>Executive Sign off –</b></p>	<ul style="list-style-type: none"> <li>The Chief Executive hosts a daily safety huddle where staff have the opportunity to raise any concerns eg staffing or safety.</li> <li>The Board receives a report at each meeting setting out planned vs actual nurse staffing for each ward.</li> <li>AQuA provides information on key areas of activity to support CQUINs.</li> <li>The Executive Team review key quality indicators at its weekly meetings eg harms report which includes information on pressure ulcers, falls and</li> </ul>	<ul style="list-style-type: none"> <li>Board monthly quality dashboard;</li> <li>Board reports on nursing safe staffing at each meeting</li> <li>IG toolkit compliance reporting</li> </ul>

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
	<b>Director of Nursing and Quality</b>	<p>other safety data.</p> <ul style="list-style-type: none"> <li>The Board agreed to sign up to safety actions at the January Board. The Safety Improvement Plan has two main areas of focus and progress with implementing the actions will be monitored by the Patient Safety Group. This is in the early stages of implementation</li> <li>The Quality Committee has a role in ensuring the Trust collects appropriate information on the quality of care.</li> </ul>	<ul style="list-style-type: none"> <li>CQUIN performance reports</li> <li>Quality Committee meeting minutes</li> <li>Complaints, claims and incidents report</li> <li>SUI reporting to Board and through committees supported by an RCA process</li> <li>Enhanced RTT reporting in response to compliance issues.</li> <li>Sign up to safety</li> </ul>
	<p><b>5d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;</b></p> <p><b>Executive Sign off – Director of Nursing and Quality / Medical Director</b></p>	<ul style="list-style-type: none"> <li>The Board gets a strategic dashboard which provides a headline update against the main quality goals. A review of the dashboard has only recently taken place with significant input from the Board.</li> <li>There is also a more detailed performance summary which includes for example Monitor requirements.</li> <li>Performance reports are backed up by exception reports where appropriate eg VTE and falls.</li> <li>Qualitative descriptions and commentary are included to support performance.</li> <li>Incidents, complaints and claims are included within a separate integrated report Information is examined by the Board who challenge the Executives about exceptions.</li> <li>The Trust has a system for scoring data (gold, silver and bronze) dependent on the perceived quality of that data. The Trust is in the process of implementing an "Improving Data Quality Action Plan".</li> <li>Information governance is managed through the BAF process which</li> </ul>	<ul style="list-style-type: none"> <li>External assurance on the Quality Account – due end May</li> <li>CQC Intelligent Monitoring Tool</li> <li>Strategic and Operational Dashboards</li> <li>Board and Committee meeting minutes</li> <li>Complaints, claims and incidents reports</li> <li>IG toolkit compliance</li> <li>PbR and clinical coding audits</li> </ul>

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
		<p>includes Executive accountability and a performance monitoring process via the Information Management and Technology Programme Board.</p> <ul style="list-style-type: none"> <li>• The Trust's Information Governance Toolkit submission is reviewed by independent auditors and for has received a significant assurance opinion for the 2014/15 submission.</li> <li>• The Board receives other reports in the year which include information on the quality of care eg CQC reports.</li> <li>• PbR clinical coding and other external coding audits indicate high level of coding accuracy;</li> </ul>	
	<p><b>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 appropriate views and information from these sources;</b></p> <p><b>Executive Sign off – Director of Nursing and Quality / Medical Director</b></p>	<ul style="list-style-type: none"> <li>• Stakeholder management is a key strategic objective in 2014/15 – regular updates on partnership working are reported to Board via CEO's report</li> <li>• Internal and external stakeholders have been involved in developing the strategic and operational plan.</li> <li>• Membership and Patient and Family Engagement Strategies are in place</li> <li>• A CoG working group on Membership and Communications has been established and supports the implementation of the Membership Strategy</li> <li>• Annual Report describes how public interests are represented</li> <li>• Governor involvement in Patient and Family Experience Strategy</li> <li>• Staff governors are involved in mutual research project</li> <li>• Executives, clinicians and managers engage proactively in Healthy Liverpool Project and its sub-forums.</li> <li>• The Trust has engaged with stakeholders on the development of strategies such as the quality strategy and the cardiology strategy.</li> <li>• LHCH has a voice both regionally and locally on forums such as Clinical networks.</li> <li>• Regular stakeholder meetings take place with local acute trusts and the amount of partnership work and the number of joint appointments have increased.</li> <li>• The Board makes use of "soft" intelligence from hospital walkabouts and</li> </ul>	<ul style="list-style-type: none"> <li>• Board CEO reports</li> <li>• Board update on LHP</li> <li>• Annual plan</li> <li>• Quality Account Priorities 2015/16</li> <li>• Membership Strategy</li> <li>• PFE strategy</li> <li>• Annual report</li> <li>• Staff involvement in the mutual research project</li> <li>• Friends and Family test results</li> <li>• Patient and staff surveys along with action plans for improvement areas;</li> <li>• Board walk rounds;</li> </ul>

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
		interaction with governors.	
	<p><b>5f) 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.</b></p> <p><b>Executive Sign off – Director of Nursing and Quality / Medical Director</b></p>	<ul style="list-style-type: none"> <li>• The Director of Nursing and the Medical Director are responsible for all clinical and quality governance.</li> <li>• 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.</li> <li>• There is consultant led care at Trust and an escalation framework in place.</li> <li>• The Quality Committee and Board review complaints, incidents and legal claims.</li> <li>• A clinician led Mortality review Group looks at all deaths, major harms and cardiac arrests.</li> <li>• Serious Untoward Incidents (SUIs) are tracked in the Quality Committee.</li> <li>• The recently revised and approved risk management strategy outlines the Trust process and approach to risk management, including escalation from departments to the Board.</li> <li>• Significant work has been undertaken to change and embed the culture with regard to the escalation of key quality issues.</li> <li>• Work is ongoing to promote the risk management policy and roll out training on the new risk scoring etc across the Trust.</li> <li>• Where there are particular concerns the Board will receive assurances direct from managers and monitor the implementation of action plans eg response to CQC's concerns raised on medicines management discussed at the July 2014 Board meeting.</li> <li>• The CQC has confirmed the elevated risk relating to whistle-blowing has now been closed following re-inspection. This indicates that the Trust has taken timely and appropriate action in response to issues raised on inspection.</li> <li>• Risk registers are supported and fed by quality issues captured in</li> </ul>	<ul style="list-style-type: none"> <li>• Quality Committee driving scrutiny of Trust's performance on key quality metrics</li> <li>• Executive job descriptions and annual objectives</li> <li>• Divisional and ward dashboards</li> <li>• Monitors displaying staffing levels in all wards;</li> <li>• Top 10 risks reported to the Board</li> <li>• Sign up to safety campaign</li> <li>• Speak out safely initiative</li> <li>• Daily safety huddle</li> <li>• Big conversations led by executives</li> <li>• Culture survey and response to issues highlighted for action.</li> </ul>

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
		<p>Divisional registers.</p> <ul style="list-style-type: none"> <li>The Trust is introducing a new Nursing Assessment &amp; Accreditation System and has set a goal of all wards achieving ECS status by 2017.</li> </ul>	
6	<p><b>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.</b></p> <p><b>Executive Sign off - CEO / Director of Strategy and Organisational Development</b></p>	<ul style="list-style-type: none"> <li>The current Board composition demonstrates a good mix of skills and experiences to lead the organisation. Recent appointments reflects the Board's assessment of the skills required and involves Non-Executives, CoG and external assessors as appropriate. Most recent appointment has been for the Medical Director and two NEDs including Chair of Audit Committee.</li> <li>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.</li> <li>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.</li> <li>New Medical Director appointed within a timeframe that allows for full induction and handover.</li> <li>A succession planning review is considered by Nominations and Remuneration Committee.</li> <li>Board considered the implications of Fit and Proper Persons requirements at the January Board and agreed an action plan to ensure compliance.</li> <li>The composition of the Board is well balanced. The organisation has the benefit of being well led by an experienced Chairman, knowledgeable of the health systems.</li> <li>The Non-executives 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.</li> <li>The Executive Structure is kept under review. The Chief Executive has</li> </ul>	<ul style="list-style-type: none"> <li>Medical Director appointment</li> <li>Fit and proper persons self declarations for Board and CoG</li> <li>Minutes of N&amp;R Committee</li> <li>Board profiles</li> <li>HR policies and procedures</li> <li>Executive job descriptions</li> <li>Annual Report</li> </ul>



Ref	Board statement	Process/arrangement in place at the Trust	Evidence
		<p>restructured executive portfolios during the year eg moving responsibility for quality from the Medical Director to the Director of Nursing Services.</p> <ul style="list-style-type: none"> <li>• There is an established process in place for individual performance review and objective setting for each Director on at least an annual basis.</li> <li>• 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.</li> <li>• For 2014/15 appraisals and going forward, the Chair's input into executive appraisal process has been formalised such that every executive is appraised specifically in relation to their role on the Board- any individual development needs to be agreed with CEO for inclusion in PDPs.</li> <li>• 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.</li> </ul>	<ul style="list-style-type: none"> <li>• Outcome of appraisals</li> <li>• N&amp;R Committee minutes</li> </ul>

Ref	Board statement	Process/arrangement in place at the Trust	Evidence
		<ul style="list-style-type: none"> <li>The Trust continues to review the capacity and skills required to meet the organisation's need.</li> <li>The Executive team through the Operational Board agreed to implement a revised management business model across the Trust. The key aspects of the business model included the: <ul style="list-style-type: none"> <li>Refresh the composition of the divisional structure;</li> <li>Increase in clinical leadership and decision making;</li> <li>Realignment of corporate support functions.</li> </ul> </li> <li>This revised structure should ensure the Trust has in place personnel reporting to the Board and Corporate sub structures who are both sufficient in number and appropriately qualified.</li> <li>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.</li> <li>The medical revalidation report for 2013/14 was presented to the January 2015 Board. The Medical Director provided assurance that there were no significant risks with the revalidation process within the Trust.</li> </ul>	<ul style="list-style-type: none"> <li>CEO report to the board</li> <li>Board assurances on nurse staffing and monitoring of nursing numbers</li> <li>Workforce indicators included the Board dashboards.</li> <li>Medical Revalidation Report</li> </ul>

## Report Distribution

Name	Title	Report Distribution
Lucy Lavan	Associate Director of Corporate Affairs	PDF
David Jago	Chief Financial Officer	PDF
Mark Jackson	Director of Research and Informatics	PDF
Jane Tomkinson	Chief Executive	PDF

## Discussion meeting held with

Name	Title	Date
Lucy Lavan	Associate Director of Corporate Affairs	07/05/15 and 13/05/15

## Review Completion

Name	Planned Date	Actual Date
Fieldwork Starts	13/04/2015	13/04/2015
Discussion Document to Client	11/05/2015	12/05/2015
Responses by Client	14/05/2015	13/05/2015
Final Report	18/05/2015	14/05/2015



## Review prepared on behalf of MIAA by

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