Wirral Community NHS
NHS Foundation Trust

Board of Directors - Terms of Reference

Meeting	Trust Board of Directors		
Date	2 November 2016	**Agenda item**	**12**
Lead Director	Frances Street, Chairman		
Author(s)	Alison Hughes, Trust Board Secretary		

To Approve ☐	**To Note** ☑	**To Assure** ☐

Link to the Board Assurance Framework:

According to these Terms of Reference, the Board of Directors has overall responsibility for ensuring an effective system of risk management and internal control across the Trust. The Board Assurance Framework provides a structure to ensure the effective oversight and mitigation of strategic risks.

Identified risks:

Not applicable.

Financial implications:

Not applicable.

Has an Equality Impact Assessment been completed?	**Yes** ☐	**No** ☑

Does this proposal represent any service improvement or redesign?	**Yes** ☐	**No** ☑

Paper history

Has a committee of the board reviewed this paper?

Submitted to	Date	Brief Summary of Outcome
No previous reporting history.		

Link to strategic objectives - 2014-19 *(please tick those supported by this paper)*			
We will deliver safe and effective patient care	✔	We will further develop and maintain a competent, caring and flexible workforce	✔
We will deliver a positive experience of our services	✔	We will continuously develop the organisation including leadership at every level of the organisation	✔
We will engage effectively with the patients and communities we serve	✔	We will effectively engage with our staff to deliver our strategic objectives	✔
Reducing health inequalities will be integral to all service developments and delivery	✔	We will optimise the use of our resources	✔
We will effectively manage and develop our relationships with our current and new commissioners and stakeholders	✔	The delivery of sustainable clinical services will be supported by corporate services	✔
We will defend and grow our core business	✔	We will effectively manage our finances and fully deliver our efficiency programme	✔
We will lead the delivery of out of hospital integrated care	✔	We will deliver transformation supported by innovation and research	✔
We will deliver to the expectations of our commissioners and demonstrate quality and value	✔		

Wirral Community NHS
NHS Foundation Trust

Board of Directors - Terms of Reference

Purpose

1. This paper provides the Board of Directors with updated Terms of Reference following authorisation as a Foundation Trust from 1 May 2016.

Executive Summary

2. The Terms of Reference describe the purpose and structure of the Board of Directors meetings.

3. The full updated Terms of Reference are included at **appendix 1**.

4. The revisions made are highlighted in red text for ease of review.

5. The Board of Directors is asked to note in particular the proposed e-governance process described in the Terms of Reference.

Board Action

6. The Board is asked to approve the revised Terms of Reference.

Alison Hughes
Trust Board Secretary

19 October 2016

DRAFT Board of Directors - Terms of Reference

Introduction

1. These Terms of Reference outline the constitution and modus operandi of the Board of Directors of Wirral Community NHS Foundation Trust. The Trust has Standing Orders for the practice and procedures of the Board of Directors (Annex 7 of the FT constitution). For the avoidance of doubt, those Standing Orders take precedence over these terms of reference.

2. Every NHS Foundation Trust should be headed by an effective Board of Directors. The Board is collectively responsible for the performance of the NHS Foundation Trust.

Constitution

3. The Constitution of Wirral Community NHS Foundation Trust conforms to the requirements laid down in the National Health Service Act 2006, with a Chair, Executive Directors and Non-Executive Directors as well as the Health and Social Care Act 2012.

4. All Board members have a duty to comply with these terms of reference and commit to participate actively in the work of the Board of Directors.

5. The Board of Directors will function as a corporate decision-making body, considering the key strategic issues facing the trust in carrying out its statutory and other functions. All business shall be conducted in the name of Wirral Community NHS Foundation Trust.

Guiding Principles

6. Directors and staff are expected to observe the Nolan principles of public life of selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

7. The Board of Directors will have due regard to the NHS Leadership Academy 2013 guidance 'The Healthy NHS Board', by undertaking the following:

    - The formulation of strategy
    - Ensuring accountability
    - Shaping a healthy culture

8. The Board of Directors will lead on the promotion of observance by the Trust of the principles of Duty of Candour for healthcare providers.

9. The Board will at all times operate in a manner which accords with agreed Board behaviours.

10. In conducting its business, the Board of Directors will at all times seek to promote its commitment to equality diversity and human rights by the creation of an environment that is inclusive of both our staff and people who use our services including those who have protected characteristics and those who are vulnerable in the community.

Role & Duties

11. The Board of Directors of Wirral Community NHS Foundation Trust has a schedule of matters reserved to the Board. These are set out in Section C of the Corporate Governance Manual - Schedule of Reservation and Delegation.

12. The general duty of the Board of Directors, and of each Director individually, is to act with a view to promoting the success of the organisation so as to maximise the benefits for the members of the trust as a whole and for the public.

13. The specific duties applicable to the Board of Directors are as follows;

Leadership

- Establish and articulate a clear vision and actively endorse the organisation's values, while ensuring its obligations to governors, patients & carers, the local community and regulators ~~the Secretary of State~~ are understood and met
- Provide entrepreneurial leadership within a framework of prudent and effective controls which enable risk to be assessed and managed
- Take corporate responsibility for all the trust's activity
- Take responsibility for adding value to the organisation by promoting its success through the direction and supervision of its affairs

Strategy

- Establish the organisation's strategic aims, and at least annually take into consideration the view of the Council of Governors, ensuring the necessary financial and human resources are in place for it to meet its priorities and objectives, and reviewing progress and management performance
- Monitor and review management performance to ensure objectives are met
- Develop and maintain an annual business plan and ensure its delivery as a means of driving the strategy of the Trust to meet the expectations of stakeholders
- Ensure that national policies and legislative requirements are effectively addressed and implemented (e.g. Equality Act 2010)

Governance

- Ensure that the highest standards of corporate governance and personal integrity are maintained in the conduct of the Trust's business
- Seek assurance that the systems of governance, risk management and internal controls operating within the Trust are robust and reliable (including reviewing standing orders and standing financial instructions)
- Ensure that the Trust complies with its governance and assurance obligations in the delivery of clinically effective, personal and safe services taking account of patient and carer experiences
- Ensure compliance with the Trust's licence, its constitution, mandatory guidance issued by NHS Improvement, relevant statutory requirements and contractual obligations.
- Ensure the Trust functions effectively, efficiently and economically.

Quality

- Ensure the quality and safety of health care services, education, training and research delivered by the Trust and apply the standards and principles of clinical governance set out by the Department of Health, NHS England, the Care Quality Commission (CQC) and other relevant bodies

Risk Management

- Ensure an effective system of integrated governance, risk management and internal control across the Trust's clinical and corporate activities

- Ensure there are appropriately constituted appointment arrangements for senior positions

Communication

- Ensure an effective communication channel exists between the Trust, it's Council of Governors, members, staff and the local community

- Ensure that Board of Director proceedings and outcomes that are not confidential are communicated publically (via the Trust's website primarily)

- Publish an Annual Report and Accounts, in accordance with national guidance and hold an Annual Members Meeting

Culture

The Board of Directors is responsible for shaping the culture and setting the values, ensuring they are widely communicated and that the behavior of the Board is entirely consistent with those values

Membership and Voting

14. The Chair is responsible for leading the Board of Directors and for ensuring that it successfully discharges its overall responsibilities for the Trust.

15. All Executive and Non-Executive Directors of the Trust are members of the Board of Directors.

~~16. The membership of the Board consists of voting and non-voting members. In addition, representatives from stakeholders groups are invited to attend.~~

Voting members:

- Chairman
- 4 x Non-Executive Directors
- Chief Executive
- Director of Finance and Resources
- Medical Director
- Director of Nursing and Performance

Non-voting members:

- Director of HR & Organisational Development
- Director of Integration & Partnerships
- Director of Business Development & Strategy

17. All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.

18. All questions put to the vote shall, at the discretion of the Chairman, be decided by a show of hands. A paper ballot may be used if a majority of the Board of Directors present and entitled to vote so request. In the event of a tied vote, the Chair can exercise a casting vote.

19. Other senior Managers or Officers may be required to attend by invitation, if deemed by the Board that attendance will contribute to the discussion. However, these senior Managers or Officers will have no voting rights and will not count towards the quorum.

20. The Board will appoint one of the independent Non-Executive Directors to be the Senior Independent Director and Vice-Chair of the Board. The Vice-Chair will take on the Chair's duties if the Chair is absent for any reason.

21. The Trust Board Secretary will act as the Secretary to the Board and will attend to take minutes of the meeting and provide appropriate support to the Chairman and Board members.

22. If a dispute arises at a Committee, a record of the discussion will be taken and escalated to the Board of Directors; votes will always be taken at Board level.

Quorum

23. No business shall be transacted at a meeting unless at least one third of the whole number of voting directors (including the Chairman) are present including at least one Executive Director and one Non-Executive Director.

24. If the Chairman or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest, that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

Frequency of Meetings

25. The Board will meet formally in public on a bi-monthly basis.

26. Board members will be expected to attend at least three quarters of scheduled meetings annually.

27. Matters which are confidential on the grounds of commercial sensitivity or involving personnel issues will be discussed in a separate private session which will not be attended by members of the public. In addition, the Board will hold regular informal development workshops and attend relevant seminars.

28. According to the Standing Orders for the Board of Directors, the Chairman may call a meeting of the Board at any time. One third or more members of the Board may request a meeting in writing. If the Chairman refuses, or fails, to call a meeting within seven days of a request being presented, the members signing the requisition may forthwith call a meeting.

Openness

~~29.~~ All formal meetings of the Board will be open to members of the public, staff and governors to observe. Members of the public, staff or governors in attendance will be invited to submit any questions in advance of the meeting to be addressed at the discretion of the Chairman. ~~may not contribute towards the debate of the organisations business.~~

30. The Board will make arrangements for a public notice of the time and place of the meeting, and the public part of the agenda, to be available on the Trust's website three days before the meeting.

Committee Reporting

31. The Board has established Committees with delegated powers contained within agreed terms of reference to carry out business on behalf of the Board. Each of the Committees provide reports and minutes arising from their meetings directly to the Board as outlined below:

- Remuneration Committee (at least one per year)
- Audit Committee (up to 5 meetings per annum)
- Quality & Governance Committee (Monthly)
- Finance & Performance Committee (Monthly)
- Education & Workforce Committee (Monthly)

Review

32. These Terms of Reference shall be reviewed annually by the Board to ensure they are still appropriate.

Board - Chair Approval			
Name:		**Date:**	
Signature:		**Review Date:**	

Appendix 1 - E-governance process

In order to facilitate the Board of Directors undertaking the business required of it, there will on occasion be a need for this to be conducted outside of its scheduled meetings in circumstances where it would not be practical to convene a meeting 'in person'.

In such circumstances the Board of Directors is authorised by its Terms of Reference to conduct business via a process of 'e-governance'. The rules to be observed when conducting business in this manner are as follows;

- The business to be conducted must be set out in formal papers accompanied by the usual cover sheets which clearly set out the nature of the business to be conducted and the proposal which members are being asked to consider.
- The papers will be forwarded by the Trust Secretary via e-mail to all members of the Board of Directors who, subject to their availability, are expected to respond by e-mail to the same distribution list with their views within three working days of receipt of the papers.
- For the conclusion of the Board to be valid, responses must be received from a quorate Board membership and in instances where the approval of the Board of Directors is sought; all such responses should support the proposal.
- In the event that there is not a unanimous agreement of all responding Members, the proposal shall be considered not to be approved.
- The Trust Secretary will summarise the conclusions reached for the agreement of the Chair and this summary will be presented to the next scheduled meeting of the Board following which it will be appended to the minutes of that meeting.

Wirral Community NHS
NHS Foundation Trust

Well Led Framework
Self-assessment Quarterly Review
Quarter 2 01 July - 30 September 2016

Meeting	Trust Board of Directors		
Date	02 November 2016	**Agenda item**	**13**
Lead Director	Sandra Christie, Director of Nursing and Performance		
Author(s)	Sandra Christie, Director of Nursing and Performance Alison Hughes, Trust Board Secretary		

To Approve ☑	**To Note** ☐	**To Assure** ☐

Link to the Board Assurance Framework:
This paper provides assurance on the strategic objectives listed overleaf and on how the QGAF is implemented in practice in the organisation and how the key strategies that support the QGAF are monitored. The paper provides assurance on all the principle risks referenced in the Board Assurance Framework.

Identified risks:
None

Financial implications:
None

Has an Equality Impact Assessment been completed?	**Yes** ☐	**No** ☑

Does this proposal represent any service improvement or redesign?	**Yes** ☑	**No** ☐
A rationalisation of the papers being submitted to the committee for assurance.		

Paper history		
Submitted to	**Date**	**Brief Summary of Outcome**
Trust board	13 January 2016	Quarterly review submitted and approved
	04 May 2016	Quarterly review submitted and approved
	07 September 2016	Quarterly review submitted and approved

Link to strategic objectives - 2014-19 *(please tick those supported by this paper)*			
We will deliver safe and effective patient care	✔	We will further develop and maintain a competent, caring and flexible workforce	✔
We will deliver a positive experience of our services	✔	We will continuously develop the organisation including leadership at every level of the organisation	✔
We will engage effectively with the patients and communities we serve	✔	We will effectively engage with our staff to deliver our strategic objectives	✔
Reducing health inequalities will be integral to all service developments and delivery	✔	We will optimise the use of our resources	✔
We will effectively manage and develop our relationships with our current and new commissioners and stakeholders	✔	The delivery of sustainable clinical services will be supported by corporate services	✔
We will defend and grow our core business	✔	We will effectively manage our finances and fully deliver our efficiency programme	✔
We will lead the delivery of out of hospital integrated care	✔	We will deliver transformation supported by innovation and research	✔
We will deliver to the expectations of our commissioners and demonstrate quality and value	✔		

Wirral Community NHS
NHS Foundation Trust

Well Led Framework
Self-assessment Quarterly Review
Quarter 2 01 July - 30 September 2016

Purpose

1. The purpose of this paper is to present the Well Led self-assessment for quarter 2 to the Board for approval.

Executive Summary

2. In the well led framework guidance, updated from 2014, the regulator at that time, Monitor, aligned the four domains and ten high level questions asked of NHS provider organisations with the CQC's characteristics of 'good' under their well-led domain.

3. By well led, regulators mean that the leadership, management and governance of the organisation ensure the delivery of sustainable high quality person-centred care, support learning and innovation, and promote an open and fair culture.

4. The well led self-assessment takes the place of the Board Governance Assurance Framework (BGAF) self-assessment and the Quality Governance Assessment Framework (QGAF) self-assessment.

5. The well-led framework is not just a tool for trusts to use in preparing for the foundation trust assessment process; it is a tool for all NHS trusts to use to develop and improve their capacity and capability. Trusts carrying out leadership and governance reviews as part of their on-going development will be expected to use the well-led framework.

6. The well led framework is based on four different domains to review how well a board is operating:

   - Strategy and planning - how well is the board setting direction for the organisation?
   - Capability and culture - is the board taking steps to ensure it has the appropriate experience and ability, now and into the future, and can it positively shape the organisation's culture to deliver care in a safe and sustainable way?
   - Process and structures - do reporting lines and accountabilities support the effective oversight of the organisation?
   - Measurement - does the board receive appropriate, robust and timely information and does this support the leadership of the trust?

Table 1: The four domains of the well-led framework for governance reviews

Strategy and planning	Capability and culture	Process and structures	Measurement
Does the board have a credible strategy to provide quality, sustainable services to patients and is there a robust plan to deliver? Is the board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?	Does the board have the skills and capability to lead the organisation? Does the board shape an open, transparent and quality-focused culture? Does the board support continuous learning and development across the organisation?	Are there clear roles and accountabilities in relation to board governance (including quality governance?) Are there clearly defined, well-understood processes for escalating and resolving issues and managing performance? Does the board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?	Is appropriate information on organisational and operational performance being analysed and challenged? Is the board assured of the robustness of information?

7. If delivered effectively, assessment against this framework should provide boards with assurance over the effective oversight of the care provided throughout their trust.

8. The four domains have ten underpinning questions for boards to use to self- assess themselves against to establish if they are well led:

Strategy and Planning	Capability and culture	Process and structures	Measurement
Q1 Does the board have a credible strategy to provide quality, sustainable services to patients and is there a robust plan to deliver?	Q3 Does the board have the skills and capability to lead the organisation?	Q6 Are there clear roles and accountabilities in relation to board governance (including quality governance)?	Q9 Is appropriate information on organisational and operational performance being analysed and challenged?
Q2 Is the board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?	Q4 Does the board shape an open, transparent and quality-focused culture?	Q7 Are there clearly defined, well-understood processes for escalating and resolving issues and managing performance?	Q10 Is the board assured of the robustness of information?
	Q5 Does the board support continuous learning and development across the organisation?	Q8 Does the board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?	

Well Led and NHS Improvements (NHSI) Single Oversight Framework

9. The Single Oversight Framework was published on 30 September 2016.

10. The Single Oversight Framework is designed to help NHS providers attain, and maintain, Care Quality Commission ratings of 'Good' or 'Outstanding'. The Framework doesn't give a performance assessment in its own right.

11. The framework applies from 1 October 2016, replacing the Monitor 'Risk Assessment Framework' and the NHS Trust Development Authority 'Accountability Framework'.

12. The framework will help NHSI identify NHS providers' potential support needs across five themes:

    - Quality of care
    - Finance and use of resources
    - Operational performance
    - Strategic change
    - Leadership and improvement capability (**well-led**): building on the joint CQC and NHS Improvement well-led framework, NHSI will develop a shared system view with CQC of what good governance and leadership look like, including organisations' ability to learn and improve.

13. Under Well Led NHSI expect providers to demonstrate three main characteristics: effective boards and governance, continuous improvement capability and effective use of data.

14. NHSI will draw on the existing well-led framework and associated tools to identify any potential support needs concerning the governance and leadership of a provider. They will use several information sources to oversee provider leadership as used previously by Monitor and TDA, including:

    - Information from third parties
    - Staff/patient surveys
    - Organisational metrics
    - Information on agency spend
    - Delivering Workforce Race Equality Standards (WRES)
    - CQC 'well-led' assessments.

15. They are working with CQC to consider how the current shared well-led framework needs to evolve to better reflect continuous improvement capability.

16. As NHSI develop the well-led framework they will build on this approach to identifying support needs under all aspects of this Well Led theme, including potentially culture and engagement, particularly through working with CQC. They will also look to incorporate the principles and findings of the National Leadership Development and Improvement Board.

Well Led Self -Assessment Quarter 1

17. The self-assessment process is an important step in setting the Well Led Framework starting point for the trust.

18. Trusts should assess themselves to:

    - Provide insight to the NHS foundation trust and the independent reviewer about how the trust gauges its own leadership and governance performance
    - Shape the emphasis and scope of the future external review, identifying areas within the four domains for extra attention or other areas outside the 'core' scope of the framework.

19. The self-assessment questions are rated using a colour-coded (RAG) system. The good practice examples linked to the 10 questions have been used as a guide to make a judgement about the RAG rating for each question.

20. While a nominated trust lead or team may co-ordinate the self-assessment and other aspects of the review, the self-assessment should be completed and signed-off by the full board.

21. The Director of Nursing and Performance has worked with the trust board secretary and their staff to gather the information and the evidence against each question and to present their findings and initial conclusions to the board for discussion and challenge in a dashboard **appendix 1**.

22. The underpinning evidence that is the basis for this self-assessment will be circulated to board members in a separate paper.

23. The self-assessment will be reviewed and updated and presented to the board for further scrutiny and challenge quarterly and be updated to reflect any new developments in the Well Led framework.

24. This will ensure the board can shape the emphasis and scope of the future external review and identifying areas within the four domains for extra attention with the trusts work streams. These reviews will also be informed by NHSI's approach to well led and the development of the Single Oversight Framework.

Board action

25. The board is asked to approve the quarter 2 self-assessment of the Well Led Framework.

Sandra Christie,
Director of Nursing and Performance

Alison Hughes
Trust Board Secretary

20 October 2016

Appendix 1. Well Led Framework Self- Assessment

Well Led Framework Self-Assessment Quarter Two 2016

The well led framework is based on four our different domains to review how well a board is operating:

- Strategy and planning - how well is the board setting direction for the organisation?
- Capability and culture - is the board taking steps to ensure it has the appropriate experience and ability, now and into the future, and can it positively shape the organisation's culture to deliver care in a safe and sustainable way?
- Process and structures - do reporting lines and accountabilities support the effective oversight of the organisation?
- Measurement - does the board receive appropriate, robust and timely information and does this support the leadership of the trust?

Risk Ratings Explained:

Risk rating (or other means of assessment)	Definition	Evidence
Green	Meets or exceeds expectations	Many elements of good practice and there are no major omissions
Amber-green	Partially meets expectations, but confident in management's capacity to deliver green performance within a reasonable timeframe	Some elements of good practice, no major omissions and robust action plans to address perceived gaps with proven track record of delivery
Amber-red	Partially meets expectations, but with some concerns on capacity to deliver within a reasonable timeframe	Some elements of good practice, some minor omissions. Action plans to address perceived gaps are in early stage of development with limited evidence of track record of delivery
Red	Does not meet expectations	Major omission in quality governance identified. Significant volume of action plans required and concerns about management's capacity to deliver

Strategy and Planning	Capability and culture	Process and structures	Measurement
Q1 Does the board have a credible strategy to provide quality, sustainable services to patients and is there a robust plan to deliver?	Q3 Does the board have the skills and capability to lead the organisation?	Q6 Are there clear roles and accountabilities in relation to board governance (including quality governance)?	Q9 Is appropriate information on organisational and operational performance being analysed and challenged?
Q2 Is the board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?	Q4 Does the board shape an open, transparent and quality-focused culture?	Q7 Are there clearly defined, well-understood processes for escalating and resolving issues and managing performance?	Q10 Is the board assured of the robustness of information?
	Q5 Does the board support continuous learning and development across the organisation?	Q8 Does the board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?	

Appendix 1. Well Led Framework Self- Assessment

Well Led Framework Self-Assessment Quarter 2 2016

The well led framework is based on four our different domains to review how well a board is operating:

- Strategy and planning - how well is the board setting direction for the organisation?
- Capability and culture - is the board taking steps to ensure it has the appropriate experience and ability, now and into the future, and can it positively shape the organisation's culture to deliver care in a safe and sustainable way?
- Process and structures - do reporting lines and accountabilities support the effective oversight of the organisation?
- Measurement - does the board receive appropriate, robust and timely information and does this support the leadership of the trust?

Risk Ratings Explained:

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Red	Does not meet expectations	Major omission in quality governance identified. Significant volume of action plans required and concerns about management's capacity to deliver

Strategy and Planning

No.	Question	Priority rating	Explanation of self-assessment rating	How is the board assured – evidence for assessment	What are the principal actions/areas for discussion with your independent review team
1.	Does the board have a credible strategy to provide high quality, sustainable services to patients and is there a robust plan to deliver?	**Green**	At the end of 2013/14 the trust undertook a significant review and refresh of its 5 year strategy to ensure the strategy; • Set out a clear vision for the future with 16 key strategic objectives across 4 priority areas; our patients and community, our services, our staff and our sustainability • Is supported by a number of ambitious, measurable 2 year goals • Improved quality, patient safety and experience • Has a focus on research and innovation • Emphasised the trusts role in system wide leadership • Provided flexibility to enable the trust to continually adapt and learn • Is shared with and understood by staff The Integrated Business Plan (IBP) describes how this strategy will be achieved and is refreshed annually as part of the business planning cycle based on the trusts vision, commissioning intentions and national and local priorities. This plan has been shared with staff at the annual planning	**Internal** Integrated performance report reported to board (bi-monthly) Chief Executives report to board (bi-monthly) Healthy Wirral(integration) reports to board (bi-monthly) Quality strategy approved at board (annual) Quality dashboard reviewed by board (bi-monthly) Quality issues escalated to QGC from IPG in quality report Quality report reported to QGC (monthly) Quality issues escalated to board from QGC in chairs briefing Resilience Group minutes to QGC (quarterly) Patient Story paper reported to board (bi-monthly) Quality Strategy assurance report to QGC (quarterly) Quality Account presented to board and audit committee (annual) Commercial and Business Development report presented to board (bi-monthly) Commercial Strategy updates presented to FPC (quarterly) Well Led Framework self –assessment presented to board (quarterly) Healthy Wirral paper presented to board (bi-monthly)	2016 Action areas: • Review patient safety priorities Lead Deputy Director of Nursing – complete • Review Well Led self-assessment quarterly Lead Director of Nursing and Performance (boards in May, September, January) • Plan external review of Well Led self-assessment lead Trust Board Secretary (dates set) • Introduce Yellow Fin software to improve top to team sharing of quality goals and progress lead Head of Business Intelligence (December 2016) • Develop service specific quality goals Senior Leadership Team (March 2017) • Deliver a business planning session for each division to cascade vision and strategy for quality, performance, finance and human resources Senior Leadership team (30 September 2016) • Review CIP QIA process - Lead Deputy Director of Nursing (30 December 2016) • Review quality improvement infrastructure and support for staff – lead Director of Nursing and Performance (30 September 2016) • Review trust strategy, vision and values

			briefings attended by over 700 staff. The IBP is underpinned by strategies which are monitored by the sub-committee of the board to ensure that the strategy is being delivered and which include: • The quality strategy • The patient safety strategy • The patient experience and engagement strategy • The safeguarding strategy • The clinical effectiveness Strategy • The Human Resources Strategy • Equality, Diversity and Human Rights Strategy • Clinical Strategy • Nursing Strategy • IMT Strategy • Business Intelligence Strategy • Commercial Strategy • Estates Strategy • Procurement Strategy • Information Governance Strategy All strategies are aligned to the strategic objectives of the trust and have underpinning policies and a workforce plan to guide operational delivery. The 2 year goals are available to view on staff zone.	CQC fundamental standards report to QGC (quarterly) Revised Quality Strategy and quality goals presented to board for approval Quality account approved at Audit Committee following consultation Quality account presented to Council of Governors 13/07/2016 Divisional plans on a page reviewed Individual objectives linked to organisations strategy and quality/patient safety priorities as part of appraisal process Annual reports reviewed and approved at board/sub committees : • Safeguarding • Medication Optimisation • Risk • Information Governance • SIRO Information Governance Strategy 2016-2019 approved CQC action plan closed **External** External QGAF assessment: September 2012 October 2012 December 2012 July 2013 Monitor review of QGAF August 2014 Care Quality Commission (CQC) comprehensive inspection September 2014 rated as Good for Well Led	

			The Wirral Joint Strategic Needs Assessment (JSNA) is a key resource for the trust to support the strategic planning process. . The maturity of the organisation can be seen in its approach to growth and its learning and reflection e.g. • A Commercial Framework Assessment flow chart, toolkit and model have been developed and reasons for pursuing or not pursing business are tracked • a learning from experience process has been developed for al successful and unsuccessful bids and the learning used to improve the process • the CEOs report focused on horizon scanning, political awareness and strategy The stakeholder analysis is updated following new contracts being awarded A new CEO has been appointed and their portfolio repositioned to reflect the need for key senior stakeholder relationship management and political awareness Delivery is focused on the vision and strategy of the organisation at all levels: • board • divisions • individual	CQC action plan implementation monitored monthly by TDA at IDM meetings Quality Account supporting statements from key stakeholders TDA assurance of annual plan Information Governance Assurance Review 2015/16 MIAA Report gives high assurance	

			The trust values and behaviours linked to strategy and strategic goals and part of appraisal process or all staff The board has addressed the lack the capacity to identify and pursue new business opportunities through restructure of the PMO and recruitment of a Director for Strategy and Business Development Annual planning sessions for staff have been held to ensure all staff aware of strategic plan A Board development session on strategic development using the Monitor tool kit has been held There is a PESTLE analysis of the strategy in the IBP The trust has described the Healthy Wirral programme and its strategic ambition in relation to New Models of Care in the IBP The trust is hosting a Director of Integration post for the Healthy Wirral programme which ensures it is integral to all developments and a leader and key partner in Healthy Wirral. The trust is a co-opted member of the local health and wellbeing board and the local authorities Families and Well Being Policy and Performance Committee. The Healthy Wirral programme is overseen by the Wirral Partners board with strategic oversight from the health and wellbeing board. The four work streams under the Healthy Wirral programme are:		

			• systems resilience • population health • Joint commissioning • integrated provision The trust is represented at the Wirral Partners board and all key groups As part of the Healthy Wirral programme the trust submitted its IBP to key stakeholders and has been part of the wider public consultation on the system strategy for the future. The Strategy memorandum has been completed The Well Led memorandum has been completed. The trust uses Service Line Reporting, and has plans to deliver regular SLR reporting to all areas of the organisation during 2015/16. The next step in this journey is the implementation of services benchmarking action plans The divisional structure has been revised to ensure we can deliver the strategic plan, including a focus on children's series and transition Training has been provided for the Senior Leadership team (SLT) on commercial awareness by the Wirral Chamber of Commerce		

			The divisions have three year plans on a page which link directly to the IBP and the strategic objectives Contract monitoring meetings are held monthly with all contract partners Board to Board meetings with CCG and key local partners are held The IBP reflects CCG and key local stakeholder priorities and jour priorities are very aligned to the system priorities The trust is a key partner at the System Resilience Group for the local health and social care economy The trust has an increasing reputation for flexible out of hospital health and well- being delivery within both the local health and social care economy and wider e.g. • Healthy Wirral and Better Care Fund investment • 0 – 19 Cheshire East • Prison health in Liverpool Public and patient engagement is used to re-design pathways e.g. • The Continence Service undertook a consultation process re change to continence wear supplier last year.		

			• The Dietetics service undertook a service evaluation in families with children receiving parental infant feeding care. The trust continues be compliant with the Care Quality Commission (CQC) registration, regulations, standards and inspections (maintaining a rating of 'Good') and with Monitor's Quality Governance requirements. All of the 'must dos' in the CQC comprehensive inspection action plan have been implemented The Quality strategy is reviewed and refreshed annually The Trust wide Quality goals refreshed annually The Quality dashboard on the web based Prodecapo system has been developed The Quality dashboard is included in the Integrated performance report A Quarterly quality strategy assurance report has been developed The Quality strategy communication and action plans for each quality goal are in place A Quality goals leaflet is shared with all staff The Well Led Framework self - assessment has been completed The Divisional plans on a page linked to strategic objectives		

No.	Question	Priority rating	Explanation of self-assessment rating	How is the board assured – evidence for assessment	What are the principal actions/areas for discussion with your independent review team
2.	Is the board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?	**Green**	The trust has a strong safety culture which is underpinned by incident reporting, investigation and learning within an established assurance framework that ensures continuous monitoring and triangulation of intelligence. The risk assessment model links to the trusts strategic objectives and ensures the board is sighted on all risks to its strategic plan. The Board Assurance Framework (BAF) records the principle risks which could impact on the trust achieving its strategic objectives and has been reviewed and revised following the QGAF review last year. The BAF is the key document for ensuring there is sufficient evidence to inform the Annual Governance Statement. The Risk Strategy has been reviewed to reflect a revised risk and risk escalation which links to the BAF following the QGAF review last year A quality escalation framework linked to the QGAF was taken to all sub committees of the board during June to ensure all strategies where being reported on and the board was sighted on all risks to the quality,	Integrated performance report reported to board (bi-monthly) Quality strategy approved at board (annual) Quality dashboard reviewed by board (bi-monthly) IPRR to board (bi-monthly) Quality report reported to QGC (monthly) Risk Report presented to QGC (monthly) BAF presented to board (bi- monthly) Annual Governance Statement approved at Audit Committee and Board. Patient Story paper reported to board (bi-monthly) Well Led self-assessment approved by board (quarterly) Quality Strategy assurance report to QGC (quarterly) Quality Account presented to board and audit committee (annual) 2015/16 - CIP process - awaiting outcome Frequency of meetings and agendas for divisional risk and governance groups reviewed as part of restructure to ensure fit for purpose Quality and CIP dashboard on ProDeCapo reflects new divisional structure Sign up to safety action plan incorporated into patient safety strategy Capsticks report into LCH reviewed and recommendations made to QGC National Raising Concerns Guidance reviewed, recommendations made to QGC and internal policy reviewed and approved at QGC Harm Free Care Collaborative 2016/17	Action areas: • Report on CIP quality dashboard at QGC - Lead Deputy Director of Nursing (30 December 2016) • Continue to implement Sign Up To Safety action plan as part of 2016/17 quality priorities Lead Deputy Director of Nursing (30 March 2017) • Introduce Clinical Governance Assurance Group as sub group to Quality Governance Committee - Lead Deputy Director of Nursing (30 September 2016) • Continue to develop the quality improvement methodology in the organisation and the triangulation of indicators at QGC - Lead Deputy Director of Nursing (31 March 2017)

			sustainability and delivery of its strategic plan. A revised QGAF score of 2.5 was approved at board in August. The QGAF score and action plan has been reviewed quarterly by the board. An overall rating Green against the corporate governance elements of the well led framework. The following reports have been produced for board and board sub committees: • Annual Risk report • Monthly risk report The monthly risk report ensures the board is sighted on all risks facing the organisation and now includes CIP risks The BAF and risk processes are all managed through the web based Datix system and link together A Risk health score for the organisation has been introduced to ensure staff are focused on risk assessment and review. All incidents are reported through the Datix web based incident reporting system which supports reporting and escalation of incidents in real time.	Annual Plan approved Health & Safety Annual Report approved CQC strategy 2016 reviewed and Internal self- assessment process revised **External** External QGAF assessment: September 2012 October 2012 December 2012 July 2013 Monitor review of QGAF August 2014 Care Quality Commission (CQC) comprehensive inspection 4 September	

			The risk register is the main source of all identified risks that present a risk to the strategic plan and objectives and is derived from: • Incident and near miss reporting • Investigations • Claims • Complaints • Concerns • Patient experience • Inspection reports • External agency feedback • Financial loss • Compliance with regulatory requirements • Business planning • Project reviews • Operations risks • Audit findings Risks are assessed and escalated following the risk management policy. The trust has safe staffing escalation policy. Staffing risks are reported through the daitx incident reporting system and directly escalated to the Director of Nursing and Performance. Staffing is reported monthly to the EWC and staffing incidents are triangulated with shift fill rates in the patient safety dashboard. The trust reviews a range of workforce KPIs to monitor workforce performance and risks		

			including: • Staff in post • Workforce diversity • Temporary staffing • Absence • Employee relations There is a robust vacancy management process in place that includes scrutiny of temporary and agency spends. The trust has consistently delivered on income and expenditure targets (I and E), CIPs, public sector payment targets, cash and external financing targets and capital expenditure limits. The trust long term financial model (LTFM) includes a planned achievement of a 4 on the Monitor Continuity of Service (CoS) rating for each of the next 5 years. The trust has used the Monitor LTFM underpinned by local and national assumptions to forecast the income and expenditure position, balance sheet and cash flow for the next 5 years. This demonstrates an increasing operating surplus by year 3. The commissioner requested services are identified in the standard contract with commissioners. A CIP policy has been developed and approved based on the best practice described by Monitor and the Audit		

			Commission. . All clinical CIPs have an identified clinical lead who completes the quality impact assessment All CIPs are quality impact assessed reviewed and signed off by the Medical Director and Director of Nursing and Performance Board CIP QIA paper includes CIP Schemes which have been modified or rejected where quality concerns have been raised Quality indicators are built into CIP PIDs Examples of underpinning evidence to support CIP schemes are requested e.g. capacity and demand work The trust has a good track record of implementing CIP schemes without impacting on quality e.g. safeguarding restructure, productivity in WICs, Sexual Health Management redesign Benchmarking exercises have been undertake as part of BMEG Risks identified in CIP PIDs link to the risk register Risk training for staff has been reviewed The trust uses a root cause analysis (RCA) approach to		

			incident investigation for significant, high risk incidents which cause patient harm and a Situation, Background, Assessment and Recommendation (SBAR) approach for moderate risk incidents. Revised Serious Incident Framework investigations should be completed within a deadline of 60 days. CCG policy complied with for investigation Final report quality assured by Governance and Patient Safety lead Final report approved by Director of Nursing and performance/Medical Director All RCA and SBAR investigations have an action plan which results in improvements. Action plan approved/monitored by QGC Board informed in minutes of QGC/briefing from QGC chair Duty of Candour reported in Patient safety incidents are reported monthly to NHS England via the national reporting and learning system (NRLS) and to the CQC as required A new Resilience Group has been introduced and the Business Continuity policy reviewed. Francis, Keogh and Berwick reports reviewed for trends and		

			learning points for the organisation and reported to board Care Quality Commission (CQC) comprehensive inspection action plan in place and monitored quarterly Savile report reviewed for trends and learning points for the organisation and reported to board Morecombe Bay report reviewed for trends and learning points for the organisation and reported to board A Sign up to Safety action plan is in place. The trusts audit plan is developed to demonstrate full compliance with the Public Sector Internal Audit Standards (2013) and linked to the strategic objectives. Contractual quality indicators are reported on a monthly basis to CCG and quarterly to LA commissioners. Exceptions reported to board in IPRR Duty of Candour recorded on DATIX and validated by Governance and Patient Safety lead Reported by exception in quality report to QGC, in IPRR to board and to CCG		

Capability and Culture

No.	Question	Priority rating	Explanation of self-assessment rating	How is the board assured - evidence for assessment	What are the principal actions/areas for discussion with your independent review team
3.	Does the board have the skills and capability to lead the organisation?	**Green**	The board functions as a corporate decision making body considering the key strategic issues facing the trust. The trusts establishment order was revised and approved in July 2013 to reflect the current composition: • Non-Executive Chairman • 4 Non-Executive Directors • 4 Executive Directors The constitution is in place and complies with the NHS Act 2006 (as amended) A new CEO is in post with the skills and capability to lead transformation and integration. The board has addressed the lack the capacity to identify and pursue new business opportunities through restructure of the PMO and recruitment of a Director for Strategy and Business Development. The Director of Nursing and Director of Operations posts have been merged to ensure a focus on quality and delivery A new Director of Finance was appointed in January with experience of the FT process The trust is hosting a Director of	***Internal*** Integrated performance report reported to board (bi-monthly) Quality strategy approved at board (annual) Quality dashboard reviewed by board (bi-monthly) Quality report reported to QGC (monthly) Quality Assurance Report to QGC (quarterly) Risk Report presented to QGC (monthly) BAF presented to board (bi-monthly) Complaints report to QGC (quarterly) Annual reports Board approval of TOR for sub board committees (annual and as required) NHSI assurance statement reported to board (bi-monthly) Chief Executives report to board (bi-monthly) Workforce report to EWC (quarterly) ToR for ELT approved at board Workforce report to EWC (monthly) Learning and Development report to EWC (quarterly) Clinical Audit plan and annual report reported to QGC and Audit Committee (Annual) MIAA review of Quality Strategy and process	Action areas: • External review of Well Led self- assessment lead Trust board Secretary (dates set) • Review recommendations from the report into the Trust's approach to 'measuring and monitoring safety', aligned to the Charles Vincent framework and agree actions (December 2016) • Consider next steps in relation to the AQuA board observation and skills assessment work as part of the overall well-led framework and board review of performance • 'Leadership for All' to be incorporated in to overall review of board performance and effectiveness

			Integration post for the Healthy Wirral programme which ensures it is integral to all developments and a leader and key partner in Healthy Wirral A Board development programme is in place and reviewed quarterly Trust Chair attended the NHS Providers Well Led Framework board update day An annual review of TOR for board and committees is completed A revised board structure has been implemented to reflect the present and future focus for the board and revised board portfolios have been included in the IBP The Board composition and experience is balanced between those with knowledge of the organisation and new experience identified in the review of board composition and capability An Interim Director of Development is in post The NED portfolios bring a range of business, finance, third sector and governance experience The NED and Executive Directors are part of TDA clinical and professional networks and national and professional leadership forums. Examples include: • NHS Providers • TDA Clinical Networks • Regional Director of Nursing meetings An Associate Non- Executive	Council of Governors established Clinical forums established ***External*** External QGAF assessment: September 2012 October 2012 December 2012 July 2013 Monitor review of QGAF August 2014 Care Quality Commission (CQC) comprehensive inspection September 2014 rated as Good for Well Led Historic due diligence undertaken by independent accountants External review of the Trust's approach to 'measuring and monitoring safety', aligned to the Charles Vincent framework by AQuA Report from AQuA following board operational effectiveness and skills assessment work. Presentation at board development in October 2016 identified key areas of board cohesion and future opportunities for development as part of overall board effectiveness review.	

			Director has been recruited with a clinical background and experience in quality and governance A formal induction plan is in place for executive and non-executive roles A Training matrix for executive and non-executive roles is in place An Executive and Senior Leadership (ELT and SLT) team has been established Board visibility is a key priority to help board understand how the organisation is working: • Leadership Walk rounds • Patient Safety Visits • Patient shadowing • Annual plan presentations Senior Management job descriptions have been reviewed as part of divisional restructure and the following accountability highlighted:: • Leadership • Quality • Patient safety Appraisal for all staff are linked to: • Strategic objectives • Vision and values • Individual performance • Personal development and learning Annual appraisal of board members' performance is		

			completed by the CEO and Chair. The Terms of Reference and membership of board and Committees are reviewed annually. The board and committee structure is supported by the trusts governance structure which supports the work of the four sub committees of the board. Board skills and portfolios are reviewed regularly. The board utilises the Board Governance Assurance Framework (BGAF) to support its on-going assessment of: • Capacity • Capability • Governance structures • Assurance processes The trust regularly reviews its compliance with Monitors Quality Governance Assurance Framework (QGAF) and applies a risk based approach to evaluating the organisations rigour in relation to quality governance The trusts corporate governance manual is reviewed annually and includes: • Standing orders • Scheme of reservations and delegation • Standing financial instructions An annual review of board and committee performance undertaken.		

			Identifying learning as a board is key part of meetings e.g. the business opportunity pipeline and successful and unsuccessful tenders and bids. A workforce strategy is in place which describes the organisations talent pipeline and approach to succession planning. A talent pipeline and succession plan has been established in the organisation. This is supported by the use of national leadership programmes A Core management skills programme is mandatory for all managers at band 4 – 7 internally A leadership framework has been developed incorporating talent management and succession planning. A leadership task and finish Group has been established 6 internal quality improvement workshops are offered to all staff: • Process mapping • Measurement • Patient engagement • PDSA • Thinking creatively • Lean thinking The trust is a Member organisation of AQuA (The Advancing Quality Alliance) and their expertise is used to support advancing quality courses e.g. End of life Care and to support board development e.g.		

			patient safety The trust has been successful in its application to host a national Graduate Management Trainee during 2015/16 in the post of Project Manager Children and Well Being Division NED leads have been identified for: • Committee chairs • Safeguarding • Equality and Diversity There is a plan in place for the election of the Council of Governors and external advice has been sought on the process including: • Consultation • Membership strategy • Election process Quality goals are based on national and local quality priorities e.g. safety thermometer is a national goal and Walk In Centre assessment times is a local priority following the CQC inspection report and the goals are approved by board Definitions for all quality goals and measures used in the quality dashboard and quality report are included with the papers. External benchmarking has been used for quality goals were possible - national safety thermometer - and action taken when concerns identified		

			Examples of challenge on clinical quality by the board include : • Insulin medication incidents • Pressure ulcers • Incident reporting • Safeguarding self-assessment A Clinical Effectiveness Strategy has been approved by the board A Clinical Effectiveness Group reports to QGC through QPER An Annual Clinical audit plan, which is agreed with QGC and approved by the Audit Committee Examples of external assurance/support on quality include: • TDA quality lead on pressure ulcer work in other areas • TDA IPC lead on reporting incidents • CCG, NHS England and TDA quality leads on the Never Event in 2014 NED leads for complaints and Freedom to Speak Up Guardian appointed AQuA board operational effectiveness and skills assessment work demonstrated good cohesion.		

No.	Question	Priority rating	Explanation of self-assessment rating	How is the board assured – evidence for assessment	What are the principal actions/areas for discussion with your independent review team
4.	Q4 Does the board shape an open, transparent and quality-focused culture?	**Green**	The quality strategy supports the delivery of high quality community services that meet people's needs. Quality is at the heart of the trusts vision to be the outstanding provider of high quality, integrated community care to the communities we serve. A Clinical Strategy has been developed and divisional plans on a page for 3 years Clinical Effectiveness strategy developed A Clinical Forum has been established and its function reviewed as part of the divisional restructure A Continuous Quality Improvement model has been developed as part of the quality strategy A Continuous Quality Improvement CQUIN in 2014/15 was agreed with the commissioners to embed the model in practice An Innovation Fund has been established ad funded by the board The revised ELT/SLT structure promotes devolved management to services Staff stories are used at Education and Workforce Committee to focus the	***Internal*** Plans on a Page presentation at FPC Ideas and Innovation paper for SLT (monthly) Leadership Walk around action plans reviewed at board (quarterly) Staff story paper reviewed at EWC (monthly) Complaints and Concerns report to board (bi-monthly) ELT focus for month presented to board in CEOs report (bi-monthly) Annual track record of being highest performing community trust for % of appraisals completed Annual quality assurance of appraisals completed Quality report at QGC (monthly) CQC action plans to QGC (quarterly) QGC minutes to board (bi-monthly) Chair of Staff Council sits on board (bi-monthly) Staff Council minutes reported to board (bi-monthly) Workforce report at EWC (monthly) Equality and Diversity strategy report to board (quarterly) Annual Equality and Diversity report Staff FFT reported to EWC (quarterly) Ideas and Innovation paper at ELT	**Action areas:** • Promote revised trust Raising Concerns Policy based on new national guidance lead Freedom to Speak Up Guardian team

			committee on staff Appraisal for all staff is linked to: • Strategic objectives • Vision and values • Individual performance • Personal development and learning Clinical staffs appraisal linked to 6 C's: • Caring • Companionate • Courage • Communication • Competence • Care Annual appraisal of board members' performance Is undertaken by CEO and Chair and links to the above including 6 Cs for clinical board members Duty of Candour briefings have been provided to the board and quality committee and are included in RCA reports Duty of Candour included in: • Essential Learning Being Open Policy updated to reflect the duty of candour. Being Open policy reflects: • NHS Constitution • Patient's First and Foremost, March 2013 • Francis 2 High Level Enquiry, 2013 • National Patient Safety	(monthly) MIAA internal audit of Raising Concerns process Clinical reference groups for all professional groups to provide professional leadership as part of the transformation agenda established Council of Governors established Revised trust Raising Concerns Policy based on new national guidance approved ***External*** External QGAF assessment: September 2012 October 2012 December 2012 July 2013 Monitor review of QGAF August 2014 Care Quality Commission (CQC) comprehensive inspection September 2014 rated as Good for Caring and commented the culture of the organisation was "*forward thinking culture of development and good leadership progression*". One of NHS Journals top 100 organisations to work for	

			Agency (NPSA), Patient Safety Alert: Being open • (2009). • Being Open Safer Practice Notice (2005). The first action is about reviewing and strengthening local policies to ensure they are aligned with the Being open framework and embedded within risk management and clinical governance processes. • NPSA, Being open: Communicating patient safety incidents with patients, their families and carers (2009). • NPSA, *Seven Steps to Patient Safety* (2004) • National Health Service Litigation Authority (NHSLA), Apologies and • Explanations. Letter to chief executives and finance directors (2009). • General Medical Council (GMC), *Good Medical Practice* (2001). • Nursing Medical Council (NMC), The Code: Standards of conduct, performance and ethics for nurses and midwives (2015) • Department of Health, *Listening, Responding, Improving - A guide to better customer care* (2009) Equality and Diversity Strategy developed and an action plan in place NED lead for equality and diversity NED SID in place		

			On-boarding introduced for all staff with 100% uptake Evidence of staff not being permitted to start work until on-boarding completed Vision and values used as part of recruitment with values based questions Vision and values included in job descriptions Vision, values and underpinning behaviours shared at induction and underpin annual appraisals Trust values: • provide compassionate care, with empathy, kindness, respect and dignity • act with honesty and integrity • communicate openly with patients and colleagues • act with courage when things are not right • build effective partnerships Evidence of behaviours contrary to the trust's vision and values managed using HR policies and procedures and challenged by board. GP induction led by clinicians in OOHs Staff survey action plans owned by local teams Learning not Blaming focus at board RCA training procured for key staff in organisation		

			Board to Board meetings held with CCG Board to Board meetings held with WUTH Regular contract monitoring meetings with evidence of performance improvement held – CCG KPIs The trust has an excellent track record of achieving the annual CQUIN schemes. The 2015/16 schemes are a combination of national and local measures and include: • Dementia and Delirium • Urgent Care • Integrated Therapy pathway • Single Point of Access Senior staff in attendance at commissions quality and patient safety review meetings on specific issues e.g. pressure ulcers External support and networks used by the trust include : • Community trust benchmarking network • NHS England regional quality forum membership • NTDA clinical networks A peer review relationship is being developed with Bridgewater Community FT and three other community organisations (Solent, Lincolnshire and Hertfordshire) with a view to seeing how we can		

			all share information to help each other benchmark Direct observation of quality by board includes : • Leadership Walkarounds • Patient shadowing Examples of where these have inflicted improved to patient care include podiatry at Clatter bridge Evidence of staff engagement with board includes: • Leadership focus groups • Staff Council • Joint Union Staff Side • Annual planning briefings (750 staff) Managing attendance incremental improvement goal of 4% set Managing attendance supported by wellbeing and resilience support and board focus on returning staff to the work place Resilience and well- being part of key managers appraisal process The revised managing Attendance policy has a clear focus on staff welding including: • Employee Assist programme • In house fast track physiotherapy • In house wellbeing initiatives • Service action plans Examples of improvement based on this approach include:		

			• Reduction in the number of staff falls • Introducing moving and handling champions Quarterly staff FFT survey completed A How well are we doing visual developed for use at Directors briefing Divisional governance structures focused on feedback on: • Managing absence • KPIs • Budget • CIP • Ideas and innovation Annual staff awards including for long service (annual) developed with Staff Council and includes a patient choice award Ideas and innovation section on Staff Zone developed and staff encouraged to sue CIP presentations have been delivered at team meetings to increase understanding and engagement following annual plan briefings Revised Raising Concerns policy/pathway approved at EWC based on Freedom to Speak up guidance Learning in the organisation is shared through: • patient safety bulletin • staff bulletin		

			• medicines management bulletin • workshops • briefings • Directors briefing Feedback from patients actively used by board to promote improvement, leading to challenge of poor performance or identifying areas of patient safety concerns and action taken		

Process and structures

No.	Question	Priority rating	Explanation of self-assessment rating	How is the board assured – evidence for assessment	What are the principal actions/areas for discussion with your independent review team
5.	Does the board support continuous learning and development across the organisation?	**Green**	As a Community Trust It is of paramount importance that our strategy for managing our workforce is aligned to our vision, values and strategic objectives. Trusts vision is: To be the outstanding provider of high quality, integrated care to the communities we serve The quality strategy is based on a continuous quality improved model and the annual clinical audit programme also contains 12 continuous improvement programmes across the organisation. This is supported by internal quality improvement workshops offered to staff: • Measurement • Patient engagement • PDSA • Thinking creatively The quality strategy has a clear underpinning communications plan supported by a quality goal on a page leaflet for all staff. Draft quality goals developed with QGC and wide spread consultation: • Staff Council • Joint Union Staff Side • ELT/SLT • Healthwatch	**Internal** QGC minutes (monthly) Quality strategy approved at board (annual) Quality dashboard reviewed by board (bi-monthly) Quality report reported to QGC (monthly) Quality Assurance Report to QGC (quarterly) Annual reports: Quality Account Patient Safety Patient Experience Clinical Effectiveness Medicines Optimisation strategy BMEG minutes (monthly) FPC minutes (monthly) CIP paper to board (quarterly) Divisional Governance Group minutes reported to QPER (monthly) Innovation report QGC (August 2015) IPRR to board (bi-monthly) Organisational Capacity Assessment Tool reported to board Transformation projects reported to FPC (monthly) Workforce Transformation projects reported to EWC (quarterly) Patient safety dashboard extended to 0 -19	**Action areas:** • Develop CIP QI dashboard and report to QGC monthly – lead Head of BI (May 2016) • Review CIP QIA process to involve clinicians to a greater extent and to implement milestone QIAs for high risk projects lead Director of Nursing and Performance and Medical Director (July 2016)

			• Members Quality Strategy and goals approved by board There is a clear action plan each quality goal. Examples of use of best practice from other industries/countries: • Through AQuA membership and patient safety training for board – Virginia Mason and safety huddles used as basis for patient safety briefing at clinical handover in community nursing • Use of SPC charts in quality report from Quality Improvement Advisors course with IHI Boston • Use of SBAR reviews for incidents from USA Navy • Use of Human Factors training in Essential Learning from aircraft industry Benchmarking data from national safety thermometer used Monthly quality report uses SPC charts and data over time to improve performance Clear definitions of measures provided Quarterly Quality Strategy Assurance Report contains community nursing patients safety dashboard bringing together key quality metrics that highlight those teams performing well and those who require support Examples of how board/QGC have used quality data to improve	services Effectiveness of performance management framework reviewed Transformation materials for staff developed Transforming Care Together Workforce Report introduced at EWC Nurse Revalidation successfully implemented Talent management introduced in appraisals **External** External QGAF assessment: September 2012 October 2012 December 2012 July 2013 Monitor review of QGAF August 2014 Care Quality Commission (CQC) comprehensive inspection September 2014 rated as Good for Safe and Effective CQC report states "*The trust promoted learning throughout the organisation. It placed high importance on staff continual development*" and "*The trust placed great importance on innovation*".	

			performance: • Insulin medication incidents • Incident reporting • Pressure ulcers The Quality Strategy outlines the following 4 main priorities: • Putting people at the heart of quality • Advancing quality • Measuring quality • Balancing cost and quality Three main supporting strategies underpin implementation of the quality strategy; Patient Safety, Patient Engagement and Clinical Effectiveness. In addition, our Medicines Optimisation strategy provides a further tier of governance to ensure that patients are kept safe under our care. The Quarterly Quality Strategy Assurance Report measures the success of this strategy and provides an analysis of triangulated data forming intelligence that highlights areas of potential concern and provides assurance that systems are in place to mitigate any potential risk. The Quarterly Quality Strategy Assurance Report highlights the key kerning from any failures in the quality of our services which is shared with staff in the Patient Safety Learning bulletin. Deputy Director of Nursing and Deputy Director of Performance both invited to QGC to discuss quality performance		

			Division Mangers invited to QGC to discuss quality performance when specific quality issues occur. Examples of board involvement in quality: Safeguarding – Director of Nursing and Performance and Non-Executive Lead are part of the Safeguarding Strategic Group Patient Experience – Non Executive chair of the Patient Engagement Group Complaints – NED dip sampling of complaints process and response and challenge on response times Pressure ulcers – NED championing of pressure mapping Also see NED and Executive director portfolios The corporate methodology for driving improvement in the organisation is based on Prince2 project management methodology led by the Project Management Office. There is a clear policy for driving improvements linked to the CIP which has been shared with all staff. CIP policy approved at FPC This is supported by a robust governance structure through the BMEG up to FPC. BMEG has held two recent benchmarking groups with clinical		

			and corporate staff. There is an ideas and innovations section on staff zone and process for all ideas being reviewed and responses provided by ELT. Key staff are trained in Prince2 methodology and internal workshops are provided on: • Process mapping • Lean thinking Transformation Model developed Transformation project launched Use of 90 day improvement cycles introduced Project ton a page reporting introduced Transformation board introduced Divisional governance groups are used to review operations performance against targets. These report through QPER to the QGC. Deputy Director of Performance invited to FPC to discuss performance. Division Mangers invited to FPC to discuss performance when specific quality issues occur. A performance management framework is in draft which describes this performance management process for all staff. Frontline staff have opportunities to identify and report areas for improvement including :		

			• Team meetings • Directors briefing • Leadership Walkarounds • Ideas and innovations page on Staff Zone • Annual plan briefings There is an organisational development process which links to the annual planning cycle. A review of organisational capacity is undertaken annually. Divisional Performance management framework and policy approved New style IPRR introduced		

6.	Are there clear roles and accountabilities in relation to board governance (including quality governance)?	**Green**	The trust board recognises that quality is an integral part of its business strategy and for the Trust to be most effective quality must become the driving force of the organisation's culture. The Trust Board is committed to on-going Board development to ensure it has the necessary leadership, skills and knowledge to ensure the delivery of the Quality Agenda. The Trust has revised the committee structure to ensure a clear Quality Governance Framework and reporting through to the Board to ensure the delivery of the strategy and the provision of assurance and escalation of risk. The 'duty of quality' is held by the organisation through the Board of Directors. The Board is responsible for the development of strategy and for ensuring risks to quality are mitigated and quality improvement is promoted and all required standards are achieved It is responsible for promoting an open culture which promotes learning and is supported by 'Being Open' policy. A revised board structure and portfolios is included in the in IBP Board composition and	***Internal*** Chief Executive Report on board capacity and capability (bi-monthly) Board report on ToR (annual) Review of Committee effectiveness (annual) Board paper on Fit and Proper Person Chairs briefing at board (bi-monthly) Revised cover sheets approved at board Approval of quality strategy by board (annual) Approval of supporting strategies by board (as required) Approval of supporting policies by Committees (as required) Quality Strategy and Quality goals approved at board (Annual) Quality Dashboard to board (bi-monthly) Quality report to QGC (monthly) Quality Strategy assurance report to QGC (quarterly) MIAA internal audit of sub contracts gives limited assurance – action plan to August QGC ***External*** External QGAF assessment: September 2012 October 2012 December 2012	**Action areas:** • Deliver a business planning session for each division to cascade vision and strategy for quality, performance, finance and human resources, including escalation, role in patient safety and raising concerns Senior Leadership team (30 September 2016) • MIAA audit to test effectiveness of leadership cascade (September 2016)

			experience reviewed to ensure balance between those with knowledge of the organisation and new experience identified in review of board composition and capability Standing Financial Instructions in place Fit and Proper Persons declarations completed for all board members Chairs briefing with key items discussed and recommendations from Committees to board to ensure information flow is timely. Board agenda structure: • Statutory business • Quality/Governance • Strategy/Planning • Business/performance • Corporate Governance Recent review of board paper cover sheets to highlight risk and link with BAF Regular review of attendance at both board and committees Terms of Reference and membership of board and committees reviewed annually Roles and Accountability clear in all strategies and supporting policies. Annual governed audit of delegated processes and decision making approved at audit committee.	July 2013 Monitor review of QGAF August 2014 Care Quality Commission (CQC) comprehensive inspection September 2014 rated as Good Trust 25 in Learning from Mistakes League NTDA/Monitor) AQUA review of board operational effectiveness and skills audit	

			The Governance audit programme has been developed utilising similar methodology to the Clinical audit programme. The programme includes the following policy areas: • Health, Safety and Security • Medicines Management • Safeguarding • Emergency Planning Resilience and Response • Information Governance • Risk Management • Complaints and Claims • Incident Reporting The results of audits are reported by exception to the representative Group e.g. Health, Safety and Wellbeing Group, Quality Patient Experience and Risk. Accountability explicit in key job descriptions e.g. Director of Nursing and Performance Medical Director Deputy Director of Nursing Deputy Director of Performance Divisional Managers Key Non Executive appointments for quality related issues: Equality and Diversity Safeguarding Actions logged at each group, committee and board meeting. Sub committees of the board focus on: Quality and Governance		

			Finance and Performance Education and Workforce The governance structure of the organisation describes the underpinning groups which support this. Evidence of recent challenge to agenda structure by NED in relation to Quarterly Quality Assurance Report and for this to be further up agenda and given more time for discussion. Partnership boards in place to manage sub contracts: • Sexual Health Wirral • Dental Services • 0 – 19 Key Non Executive appointments for quality related issues of Complaints and Freedom to Speak Up Guardian internal audit of sub contracts completed and action plan agreed with QGC Sub-contract performance reported by expectation to FPC and to board in IPRR		

7.	Are there clearly defined, well-understood processes for escalating and resolving issues and managing performance?	**Green**	The IBP contains the agreed performance management system and measures in relation to: • Quality • Finance • Clinical operations • HR • Strategy The Trust has in place systems and processes for monitoring performance and for escalating concerns and risk. These currently include the following and provide a clear assurance and escalation framework for the Trust within its new directorate structure. Trust wide: • The risk register • Integrated Performance Report. • Board and its committees • Board Assurance Framework and Escalation process • Board Governance Assurance Framework • Quality Governance Assurance Framework • Monitoring of the delivery of strategic objectives • Assignment of monitoring functions to a committee	***Internal*** IPR report to board on key measures (bi-monthly) Annual review of board ToR Board approval of TOR for sub board committees (annual and as required) Committee approval of TOR for sub-committee groups (annual and as required) Quality report to QGC (monthly) Risk report to QGC (monthly) Workforce report to EWC (monthly) Finance report to FPC (monthly) Review of Committee effectiveness (annual) Approval of quality strategy by board (annual) Approval of supporting strategies by board (as required) Approval of supporting policies by Committees (as required) Divisional restructure paper reviewed at FPC (monthly) MIAA annual plan approved at Audit Committee MIAA reports which do not give assurance are presented to the relevant committee with an action plan e.g. MIAA audit of Raising Concerns process Monitor Risk Assessment Framework which includes performance against finance, quality governance and access and outcome measures self-certification	**Action areas:** • Communication plan to support the introduction of the revised Raising Concerns policy lead Deputy Director of Nursing (September 2016) • Develop lessons learnt system for performance issues - lead Deputy Director of Performance (September 2016)

			Services / Directorates: • Performance review The Quality and Risk strategies contain the detailed escalation processes Draft Performance Management Framework in development Committee and sub groups are in –place to ensure appropriate reporting lines to manage overall performance against targets in a transparent and timely fashion for all key performance targets including: • Quality • Finance • Clinical operations • HR • Strategy Lessons learnt process in place for clinical and quality measures which are under performing. Monthly departmental finance statement are produced and there is a web based interactive statement which allows budget holders to drill down into the detail. Finance and performance dashboards are produced for each division and FPC receives a monthly report with a summary dashboard going to board each month. Finance and performance reports are reviewed at divisional	green Raising concerns policy reviewed and now based on national guidance ***External*** External QGAF assessment: September 2012 October 2012 December 2012 July 2013 Monitor review of QGAF August 2014 Care Quality Commission (CQC) comprehensive inspection September “014 rated as Good TDA Accountability Framework – green rating for 18 or 21 TDA Accountability Framework indicators (sickens absence amber, Never Event red, staff survey results red)	

			and service level with plans documented at monthly meetings and issues escalated to the BMEG and FPC. Lessons from performance measures are documented and shared across the organisation. Examples shared include: • Pressure ulcers • CIP 2015/16 gap • Managing absence Examples of rapid improvement at scale include: • Decrease in appointment times in physiotherapy • Improvement n KPIs in continence following process mapping Quality, risk, workforce and financial escalation process in place. Quality risks are drawn together in the monthly quality report . Risks is detailed in the monthly risk report to the QGC Workforce risks are identified in the monthly workforce report Finance risks are identified in the Finance report A revised Raising Concerns policy has been approved at EWC based on the Freedom to Speak Out guidance Raising concerns including in on boarding and local induction Key external reports are reported to board and any learning for the		

			organisation highlighted and adopted. E.g. Savile, Berwick, Rose report, Morecambe Bay, Carter review Significant issues are brought to the boards attention outside of board meetings using a filch confidential email system e.g. Never Event Julys 2015 The Trust is signed up to the Speak Out Safely Campaign and this has been promoted to staff Freedom to Speak Up report reviewed for key trends and learning Feedback loop introduced on Datix Lessons learnt bulletin introduced TOR for board. Board committees and sub- committee groups describe the escalation process. Processes for escalating and resolving issues and managing performance are tested using the MIAA internal audit annual planning process e.g. • Quality strategy review • Risk review • Raising Concerns review Examples of action plans in place to address performance issues: • KPI performance improvement • Pressure ulcer incidence • Incident reporting		

			improvement plan • Benchmarking action plans Each quality goal has an action plan to support implementation The quality Strategy implementation is supported with a communication plan. There is an annual clinical audit plan approved by Audit Committee. The annual clinical audit cycle is described within the clinical audit policy and includes a reedit process based on a RAG rating to ensure performance improvement e.g. SLT audit MIAA annual plan discussed at ELT and linked to areas of risk e.g. CQC action plan and sub contract monitoring, IG previously limited assurance so reaudited Freedom to Speak Up Guardian appointed		

8.	Does the board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?	**Green**	The trust board recognises that engagement with patients, staff, members and key stakeholders is essential for providing high quality healthcare and achieving our strategic objectives. The draft annual Quality Strategy and quality goals and consultation process includes: • Clinical Forum • Staff Council • Joint Union Staff Side • HealthWatch • Members • CCG Director of Nursing and Patient Safety A board engagement calendar is provided for staff on staff zone Leadership walk arounds provide an opportunity for the board to engage with staff and patients A Quarterly quality forum is provided for members to engage them in developing the quality strategy of the organisation. A Quarterly quality forum is provided for Health watch to engage them in developing the quality strategy of the organisation The trust has a Communications and marketing strategy which is monitored by the board There has been a year on year increase in patient feedback with	***Internal*** Update on Communications and marketing strategy reported to board (quarterly) Patient Experience Group reporting through QPER to QGC (quarterly) Service development paper for board (bi-monthly) Quality Strategy and Quality goals approved at board (Annual) Quality Strategy communication plan Quality Dashboard to board (bi-monthly) Quality report to QGC (monthly) Quality Strategy assurance report to QGC (quarterly) Complaints, Concerns and Compliments report to board (bi-monthly) Staff FFT report to EWC (quarterly) Staff survey report to EWC (annual) Leadership walkaround feedback reported to board (quarterly) Council of Governors established NHS National Staff Survey Action Plan 2016 developed Staff Health and Wellbeing Plan reviewed ***External*** External QGAF assessment: September 2012	**Key actions:** • Embed patient engagement in the organisation and in the transformation programme lead Deputy Director of Nursing (March 2017) • Develop staff governors – lead Trust board Secretary (on-going)

			an overall patient FFT score of 95% for 2014/15 Feedback from patients is sought through: • Patient FFT • Feedback cards • Email, phone, letter and kiosks • Patient groups in services • Patient shadowing • Patient stories • Leadership walkarounds • Complaints, concerns and compliments process Norfolk Community Healthcare Trust has a similar E and D profile to Wirral, the trust serves a population of 882,000 people, in and around Norfolk. The trust provides very similar services to us with the exception of unplanned care services**.** The trust was rated as Good by CQC in Dec 2014. Both organisations have very comparable patient FFT results The quality dashboard is used to summarise previous months feedback for the board This is then analysed in more depth at the QGC in the Quality Report The QGC review trends and lessons learnt in relation to feedback in the Quality Strategy assurance report quarterly	October 2012 December 2012 July 2013 Monitor review of QGAF August 2014 Care Quality Commission (CQC) comprehensive inspection September 2014 rated as Good Benchmarking in national staff survey reports Staff survey reported to commissioners Commissioners Quality and Safety forum Regional NHs England Quality and Safety Forum	

			Examples of improvement resulting from patient feedback includes: Following feedback the Speech and language services has devised and trialled two different patient feedback forms; the first for children under the age of 10 years and the second for young people and adults. At a patient shadowing event a patient described that the trusts appointment letters were in different styles and formats across different services making them more difficult to follow as they were too complex and didn't contain the day of the week. The trust developed a simple standard letter template and gained patient feedback from patients and services Over the past year the Health Visiting Service have used questionnaires and feedback forms to inform a planned redesign of the "Parents to Be" sessions. The CQC action plan included ways in which patient experience could be improved and this has been implemented. A group of trust members and trust staff have been recruited to form a patient engagement group. A welcome and introduction session has commenced, meeting dates for the coming year have been set. The group aims to provide support and consultation for services undergoing redesign		

			and also participate in projects which aim to improve the patient experience. Summary complaints, concerns and compliments are reviewed monthly at board. This includes lessons learnt and actions taken. None execs dip sample complaints quarterly and review complaint letters and responses. The patient FFT results are reviewed monthly at the QGC and action taken to improve when required e.g. ADHC and WIC feedback Patient experience feedback from external organisations has been used to improve services e.g. CQC comprehensive inspection report and WIC waiting room environments The board uses a variety of methods to capture staff feedback: • Quarterly staff FFT • Annual national staff survey • Focus groups – CQC inspection, leadership model • Annual plan briefings (750 staff) • Leadership walkarounds • Staff Council - provides a monthly temperature check form staff across the organisation • Joint Union Staff Side • Staff stories at EWC		

			• Directors Briefing Examples of improvement from staff feedback include: • We have developed a CIP presentation for team meetings, and the CIP section on staff zone is being updated • managers have been asked to ensure feedback on service budgets is a standing time at team meetings • all service specifications are being put on staff zone • all key performance indicators (KPIs) have been shared with heads of service for team meetings and are also on staff zone • we are promoting more widely the ideas and innovations pages on staff zone Serious Incidents (Sis) are reported monthly to the board in the quality dashboard and the details are reviewed in month at the QGC in the quality report. Examples of improvement following SI investigation include: • pressure ulcer champions introduced • child safety Facebook page A paper has been provided for the QGC on the new NHS England Serious Incident and Never Event Frameworks. AQuA has been asked to support		

			a board development session on SI reporting and Never Events Monthly contract monitoring meetings focus on: • quality • performance • finance • workforce The trust presents any learning from SIs to the commissioners at the Quality and Safety forum The trust is represented at the Regional NHs England Quality and Safety Forum Engagement with commissioners and GP colleagues is maintained through regular meetings including: • contract monitoring meetings • practice managers' meetings • monthly E bulletin for GPs • personal engagement meetings • Board to board meetings • the AGM		

Measurement

No.	Question	Priority rating	Explanation of self-assessment rating	How is the board assured – evidence for assessment	What are the principal actions/areas for discussion with your independent review team
9.	Is appropriate information on organisational and operational performance being analysed and challenged?	**Green**	Good Business Intelligence ensures the trust can achieve its strategic objectives. The integrated performance report is based on the strategic objectives and is used to bring together reporting in relation to: • quality • finance • performance • workforce The Quality dashboard provides a monthly summary of progress against the Quality goals Key national and local quality metrics are included in the dashboard e.g. National – safety thermometer Local – triage times in WICs following CQC inspection The monthly quality report then looks in depth at quality performance monthly The monthly finance report then looks in depth at finance performance monthly The monthly divisional performance report then looks in depth at performance monthly The monthly workforce report then looks in depth at workforce	***Internal*** Quality dashboard reviewed by Board (bi-monthly) Quality report based on quality goals scrutinised at QGC (monthly) Quality Strategy assurance report to QGC (quarterly) Community Nursing Patient Safety dashboard report to QGC (quarterly) Risk Management Report to QGC (monthly) Fundamental Standards Report (CQC) report to QGC (quarterly) Board Assurance Framework report presented to each committee and board (monthly) CQC comprehensive action plan presented to QGC (quarterly) Claims report presented to QGC (as new claims received or claims settled/closed) Workforce Report presented to EWC (monthly) Finance report presented to FPC (monthly) Oversight & Escalation (TDA & Monitor) presented to FPC (monthly) Minutes of sub committees presented to relevant committee of board (Monthly) Annual reports presented to board or relevant committee of board	**Action areas:** • Develop an Learning and Improvement Strategy lead Deputy Directors of Nursing/Performance/HR (March 2017) • Board development work on QI infrastructure (December 2016)

			performance monthly Benchmarking is used where available e.g. managing absence and the national safety thermometer The Quality Strategy assurance report reviews quarterly trends and key learning for quality A patient safety dashboard has been developed for community nursing The workforce assurance report reviews quarterly trends and key learning for workforce A Community Nursing Patient Safety dashboard has been developed containing key advanced warning indicators for patient safety A Risk Management Report has been developed A Fundamental Standards Report (CQC) report has been developed based on the new CQC standards The Board Assurance Framework report on assurance against principle risks The CQC comprehensive action plan is reviewed and reported on quarterly New and closed claims reports are submitted to the QGC along with learning from the claims Reports are RAG rated and where possible supported by historical performance e.g. • Quality report SPC charts	Patient safety dashboard developed for relevant clinical services ***External*** External QGAF assessment: September 2012 October 2012 December 2012 July 2013 Monitor review of QGAF August 2014 Care Quality Commission (CQC) comprehensive inspection September 2014 rated as Good Safety thermometer Commissioners Quality and Safety forum Regional NHs England Quality and Safety Forum Local Intelligence Network for controlled drugs Regional resilience and major incident planning groups Director of Public Health and Infection Prevention and Control annual report Commissioners Quality and Safety forum Regional NHs England Quality and Safety Forum	

			• Divisional performance KPI s • Finance performance • Managing absence data Reports are humanised where possible e.g. level of harm in safety thermometer related to number of patients harmed The information reviewed is the most recent available e.g. quality dashboard is performance from the previous month reported within days of the reporting period closing On demand data is available. The trust uses the following live systems: • Prodecapo • Datix The trust reports on the 2015/16 Accountability Framework. The Oversight model within the accountability framework is summarised by an overarching Escalation Rating on a scale of 1 to 5, where the higher the score the better. Wirral Community NHS Trust's overall score is currently 5, reflecting the Trust's progress towards formal assessment by Monitor following a "Good" rating by the CQC. The Escalation Rating is the culmination of two other elements, a Quality Rating, and a Finance RAG rating. The Finance RAG rating is essentially based on the Monitor financial assessment metrics and		

			covered within the Committee's Finance Report. The Quality Rating is reported in the Overview and Escalation paper to the FPC. The TDA also consider Sustainability. The TDA's view on Sustainability is influenced by an organisation's 5 year plans on suitable organisational form and triangulated with the assistance of NHS England against the views of commissioners. Much of the access and outcomes metrics in the escalation framework do not apply to the trust but in those areas of service performance where it relevant e.g. WIC A&E performance the trust performance is good and we score of less than 4. Divisional governance groups underpin the governance structure and report into the QPER group Triangulation takes place between what is rep[orated and softer intelligence from patient and staff feedback and direct observation The following groups provide assurance at sub- committee level: • Quality, Patient Experience and Risk • Information Governance • Safeguarding Strategic Group • Infection Prevention and		

			Control Group • Mortality Review Group • Resilience Group • Learning and Development Group • Right Staffing Steering Group Annual reports summarise activity in the previous year and key learning: • Risk • Clinical Audit • Clinical Effectiveness • Patient Safety • Quality Account • Medicines Optimisation • Controlled Drugs • Learning and Development • Patient Experience • Safeguarding • Infection Prevention and control • Caldicott • Siro Information sharing agreements are in place to support the sharing of data to support patient safety e.g. with commissioner sin relation to patient safety concerns in nursing homes, with WUTH for risk sharing		

10.	Is the board assured of the robustness of information?	**Green**	All reports, KPIs and analysis are subject to rigorous data quality checks in addition to extensive data completeness and quality checks on data extracts flowing into the trust's data warehouse. All quality goals and KPIs, have targets and trend information (from at least the prior year as well as the year to date where possible), forecast information and source data. The Trust has instigated a "Data Quality Improvement Group" which meet on a monthly basis to review Data Completeness and Quality as well as the publication of statutory items such as Information Standard Notices (ISNs). The minutes from the group are submitted to the Trust's Finance & Performance Committee for assurance. The Trust's main focus for data quality and improvement is SystmOne which currently covers the majority of the Trust's community services and is being expanded to ultimately be the single PAS system across the organisation. As part of the role out and use of this system staff receive documented training material. SystmOne is fully CIDS (Community Information Dataset) compliant with all salient information mapped to national	***Internal*** Data Quality Group ToR approved at FPC Data Quality Group minutes reported at FPC (monthly) Activity report and analysis presented to FPC (monthly) Quality Strategy and Quality goals approved at board (Annual) Quality Dashboard to board (bi-monthly) Quality report to QGC (monthly) Quality Strategy assurance report to QGC (quarterly) MIAA audit on data quality Clinical audit plan report presented to QGC (annual) Clinical audit report presented to QGC and Audit Committee (annual) Clinical Effectiveness Strategy monitored in Quality Assurance paper at QGC (quarterly) Quality dashboard presented to board (bi-monthly) Quality report presented to QGC (monthly) Quality Strategy assurance report to QGC (quarterly) ***External*** External QGAF assessment: September 2012 October 2012	**Action areas:** • Developing a Data Quality Policy – Head of BI (September 2016)

			CIDS codes. Whilst not yet a national mandated return, the Trust has been submitting a monthly CIDS dataset to Commissioners for over 2 years. The Information Team perform a number of data cleansing routines on data extracted from SystmOne on a weekly basis as part of the weekly load of our Data Warehouse. Information is then presented in a number of reports, available electronically on the Trust's intranet for clinical areas to access and perform the final stages of data validation. For example checking suspected patient waiting time breaches. The Trust generates a significant number of KPIs each month for Commissioners and for internal performance management via Finance and Performance Committee. Management of adverse performance against KPIs is undertaken through the Trust's performance management software supported by the information team The information team managers are made aware of adverse performance, either through direct contact or automated emails. The team ensures responsible managers detail their plans to improve performance on the proDacapo software solution and that this information is available for review at all levels	December 2012 July 2013 Monitor review of QGAF August 2014 Care Quality Commission (CQC) comprehensive inspection September 2014 rated as Good	

			of the organisation These KPIs are subject to review via Internal Audit for Board Assurance. MIAA has also recently reviewed activity recording within District Nursing on SystmOne. Data completeness is assessed on a regular basis and divisional managers and service managers are immediately made aware of where activity information is missing and the financial consequences of continued under-recording. Quality data assurance is included in the quality strategy, report and Quality Strategy assurance report Clear and measurable definitions are provided in the quality strategy, report and Quality Strategy assurance report The trust has a Clinical Audit Policy approved by the QGC An annual clinical audit plan is produced by services following the guidance in the policy including national and local audit priorities and risks. The audit plan is agreed at the QGC and approved at the Audit Committee. The annual clinical audit cycle includes action to be taken to resolve audit concerns and an escalation process. There is evidence of audit being used to improve performance e.g. ensuring compliance with		

			National Patient Safety Agency guidance for dysphagia screening for adults with a learning disability. A clinical effectiveness flyer which highlights areas for improvement is shared with staff following audits. An annual clinical audit report is produced for both the QGC and Audit Committee There is a Clinical Effectiveness Strategy in place Divisional Performance Framework and Policy approved IMT strategy approved IMT work plan approved		