The Royal Wolverhampton
NHS Trust

Summary Update Report on progress in addressing the Deloitte Governance Review Actions and NHS Trust License Self-Assessment
January 2018

Agenda Item No: 11.2

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	29 January 2018
Title:	Summary Update Report on progress in addressing the Deloitte Governance Review Actions and NHS Trust License Self-Assessment
Executive Summary:	The paper provides updates on: • The Deloitte Governance Review Action Plan. • The Trust License Self-assessment. They are being dealt with together as aspects of the self-assessment relate to areas of completion in the Action Plan. All the updates are since the last report to the Trust Board. In the Deloitte Action Plan, new updates are highlighted in yellow and the most recent updates in green. The areas highlighted in light Blue are currently under consideration having been clarified. In the License Self-assessment, new updates are highlighted in yellow. • Deloitte Action Plan - Overall all items are either complete, have a completion date or have a defined pathway to completion. • License Self-assessment – This will be updated for the next declaration point following the completion of the remaining items in the Action Plan. It is recommended that confirmation of completion and sign-off of the Deloitte Action Plan is delegated to the Trust Quality Governance Assurance Committee of the Board prior to the License Self-assessment Submission placed before the Board.
Action Requested:	**Receive and note** **Approve the recommended delegation**
For the attention of the Board	
Assure	• The agreed Action Plan from the Deloitte Governance Review is updated and scheduled for completion to support the update and next submission of the License Self-assessment.
Advise	• There are three remaining Actions where the final completion of the Action depends on a determination of approach by Directors.
Alert	• There are no items giving cause for concern and/or non-completion at this time.
Author + Contact Details:	Tel 01902 69 Email @nhs.net
Links to Trust Strategic Objectives	1. Create a culture of compassion, safety and quality 2. Proactively seek opportunities to develop our services 4. Attract, retain and develop our staff, and improve employee engagement 5. Maintain financial health – Appropriate investment to patient services 6. Be in the top 25% of all key performance indicators
Resource Implications:	See Specific Actions for any financial implications.

CQC Domains	**Well-led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.
Equality and Diversity Impact	None identified.
Risks: BAF/ TRR	BAF and Risk Register References are within the elements of the report.
Risk: Appetite	None identified at this time.
Public or Private:	Public
Other formal bodies involved:	QGAC
References	Revised NHSI/CQC Well-led Framework July 2017
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Report Details		
1	The Action Plan to address the recommendations in the Deloitte Review of Governance has been updated and all Actions are scheduled to be completed prior to the next submission of the License Self-assessment in 2018.	
2	The only areas still requiring determination by Directors relate to:	
R9.2	Business case/development pro-forma to include a section to capture views of stakeholders (where appropriate) and the extent of their involvement/impact	• CEO participation in National discussions re NHS Strategic direction. • Pro-forma to be revised to include section to explicitly capture views of stakeholders from April 2018.
R11.2	Refine the mechanism to assess compliance with policy as part of Accountability meetings	• Scoping exercise to be completed by the end of June 2017 to decide the feasibility and resource requirements of this initiative. • Options appraisal to be considered as per Action R11.3 below.
R11.3	Data Kite marking to be considered by the Trust	• Data Kite Mark criteria used by other NHS Trust's being reviewed. • Directors/Board decision regarding whether to use a Kite Mark methodology, better report existing challenge and confirm in existing systems in reports or to decline to use this approach in February 2018 and operating from April 2018.
3	There has been progress in all areas. All remaining actions to be completed have timescales for completion including those areas to be determined (see 2 above)	

Recommendation		Trust Board response
R1	The CEO should further reflect on his personal style and in particular the potential impact his strength of character and impulsive and honest style may have on internal and external stakeholders.	The Chief Executive, executive team and Board as a whole have spent time over the last couple of years exploring personal communication styles and how they impact on the functioning of the Board and support the Trust in delivering safe and effective services for patients. This work has supported different approaches to delivering the Trust strategy including how the Board explores and agrees on opportunities and approaches. The Chief Executive has reflected on his personal style, and as with all Board members participates in a broad approach for annual appraisal which includes 360 questionnaire. Both the CEO and chair have personal annual appraisal objectives, fully aligned with current NHSI strategy for Trusts, which are then circulated for review and consultation with NEDs before final implementation in a transparent way. The chair sustains a proactive schedule of periodic consultation meetings with key internal and external stakeholders to receive soundings and perceptions of the Trust, its strategy and key relationships, including the CEO.

Key Actions		Action Lead	Progress	Evidence	Timescale
R1.1	The Trust continues to deliver against its objectives, makes good progress in delivering its strategic intentions and is seen as a strong partner within the wider health and social care economy	Chairman, CEO	• Continual Professional Development of board members through appraisal and regular board development sessions and away days.	1. CEO Appraisal Documentation July 2017 2. Directors Appraisal Documentation (check dates?) 3. Non-executive Directors Appraisal Documentation (JV to confirm) 4. Rolling Board Development Programme	June 2018 Check dates JV to confirm Rolling
		CEO	• CEO leading part of Black Country STP	1. Pathology Business Case and Project. 2. Oncology patient service from Sandwell. 3. Walsall Stroke Service transfer. 4. Vertical Integrated General Practices. 5. Developing Black Country Accountable Care System.	
		Chairman	• Chairman attends Health & Well-being Committee with partner agencies.	1. Presentation with CCG regarding ACS Development. October 2017. 2. Chair and STP Accountable Officer attended. September 2017.	Completed Completed
		Chairman	• Chairman attends Overview & Scrutiny Committee with partner agencies.	1. Chair and deputy Director of Nursing presentation 6 months Update on Trust Quality Account. November 2017. 2. Chair and Medical Director presentation on Mortality Measures. January 2018. 3. Chair met with new Director for Public Health. October 2017. 4. Chair and DoPH 'State of the City's Health' to City Inclusion Board. January 2018.	Completed January 2018 Completed January 2018

(continued)

R1.2	Evaluation of Board effectiveness to be implemented in Q3 2017/18	Chairman, Company Secretary	• Revised NED Portfolio • Initial Evaluation Survey to commence in January 2018 using Well-led Framework	1. New NED responsibilities confirmed. August 2017. 2. New Workforce & Organisational Development committee established. October 2017. 3. Updated Board Development Programme. October 2017. 4. Review and revision of Trust Board Timings. November 2017. 5. Implementation of Boardpad Software. September 2017. 6. Revised Trust Board Reporting Template. January 2018.	Completed Completed Completed Completed Completed Completed

Recommendation		**Trust Board response**			
R2	The Trust should consider a more formal approach to the Medical Director's role in relation to the performance management of senior clinicians and ensure regular medical representation in performance review meetings and Board and Committee meetings.	The Medical Director meets regularly with the senior clinicians; the current arrangement is through short notice appointments which recognise their clinical commitments. These arrangements will move to a more formal planned schedule of meetings.			
Key Actions		**Action Lead**	**Progress**	**Evidence**	**Timescale**
R2.1	Schedule of 1:1meetings with DMDs	Medical Director	• Diarised.	1. Medical Directors Office confirms that 1:1 meetings have been arranged and are taking place with the Divisional Medical Directors.	Completed
R2.2	Diary attendance for MD at least 1 Divisional Accountability meeting per division per year	Medical Director	• DAA (now DPR) structure and approach reviewed and accepted then dates will be circulated for all ED diaries.	1. Medical Directors Office confirms that Dr Odum has attended the Divisional Accountability meetings this year.	Completed
R2.3	Minutes of sub committees/meetings evidence MD or deputy attendance	Medical Director	• Review of attendance from Diary and Minutes since Deputy in place from Sept 2017.	1. Medical Directors Office confirms that where Dr Odum has requested, his deputy has attended Committees in his absence.	Completed

Recommendation		**Trust Board response**			
R3	The Trust should consider the appointment of a Deputy Medical Director.	The Medical Director Intends to appoint 2 Deputy Medical Directors with corporate portfolios who will also support him in ensuring senior medical presence at all key meetings/committees.			
Key Actions		**Action Lead**	**Progress**	**Evidence**	**Timescale**
R3.1	2 Deputy Medical Directors with corporate portfolios are in post	MD or deputy attendance Medical Director	• Action revised to a single Deputy Medical Director (appointed Sept 2017) • Job description agreed and recruited to single Deputy Medical Director.	1. Deputy Medical Director in post.	Completed
R3.2	Minutes of sub committees/meetings evidence	MD or deputy attendance Medical Director	• Review of attendance from Diary and Minutes since Deputy in place from Sept 2017.	1. Medical Directors Office confirms that where Dr Odum has requested, his deputy has attended Committees in his absence.	Completed

Recommendation		Trust Board response			
R4	The Board should reflect on the respective roles of EDs and NEDs and consider whether the current balance between support and challenge is optimal.	The Chair and Chief Executive intend to visit 2-3 Trusts who are deemed to have achieved the optimal level of challenge and support to understand how this looks and operates in practice. The learning will be incorporated within the current Board Development programme. Progress in this area will be reflected in the Trust's Annual Governance Statement and Annual Report			
Key Actions		**Action Lead**	**Progress**	**Evidence**	**Timescale**
R4.1	Facilitated Board Development session to explore "next level" questioning/challenge to ensure it is relevant and adds value to debate and decision making	Chairman	• Board Development Session Sept 16 (facilitated workshop) and Board Development Session March 17.	1. BDS and TB Away-days continued – Sept 16, March 17, Sept 17 externally facilitated. 2. Output of BDS and AD with Strategic Development Director fed into revised Trust Strategy. November 2017.	March 2018
R4.2	External consultant to undertake a Board observation in April 2017 to determine progress in this area	Chairman	• External Consultant to be sought and engaged by Chairman to commence external review. Early 2018.		February 2018
R4.3	Review operation of Board in light of revised Well-Led Framework (July 2017)	Chairman, Company Secretary	• Board Members engaging with development programme 'from Requires Improvement to Good' NHSI/CQC. • Review of WLF underway. February 2018. • See R1 Review of Board Effectiveness – Survey of Views against Well-led Framework.	1. Board Members engaging with development programme 'from Requires Improvement to Good' NHSI/CQC. December 2017, February 2018.	February 2018

Recommendation			Trust Board response		
R5	The Chair and NHSI should consider the need to appoint two new NEDs over the next 6-9 months to help bring a refreshed perspective to the Board. The skill set of new appointees should reflect the challenges the Trust faces over the next few years, particularly skills in partnership working as it moves towards the ACO.		The Chairman has formulated a proposal for discussion with NHSI for the recruitment of new non executives which is aligned to the Trust's evolving plan to operate within the ACO model. It is anticipated that advertisements will be placed mid-December. Progress in this area will be reflected in the Trust's Annual Governance Statement and Annual Report		
Key Actions		**Action Lead**	**Progress**	**Evidence**	**Timescale**
R5.1	Recruitment process completed as close to end of January 2017 as possible	Chairman	• New NED Recruited commenced 1/8/17, induction completed. • New Associate NED Recruited re-commenced 1/9/17, induction to be completed by March 2018. • Both the above are from Clinical/Public Health and Clinical/Commissioning backgrounds.	1. Completed Induction package JS. October 2017.	Completed
R5.2	Induction of new appointees during February/ March	Chairman	• NED interview 16th June 2017	1. See above.	Completed
R5.3	Commencing review of future NED requirements and skill profile	Chairman	• NED Re-appointments on 2 year basis to follow for future flexibility.	1. Re-appointment of NED (3 in 2017) (1 in 2018) on 2 year basis and 1 for 12 months.	Completed

Recommendation		Trust Board response		
R6	The Board should consider further mechanisms for enhancing Non-Executive visibility over activities at the divisional and directorate level, for example activities such as greater divisional representation at Board level or buddying arrangements with divisions or directorates.	The Board intends to spend time at its next development session reviewing options for how the non-executive directors can best spend their time to ensure they have a raised profile across the organisation whilst maintaining the very positive contribution to sub committees and key groups as well as their commitment to Trust Board matters. Proposed changes and ongoing monitoring will be reported to the Board at regular intervals to coincide with staff survey results and action plans. Progress in this area will be reflected in the Trust's Annual Governance Statement, Annual Report and Quality Account		
Key Actions	**Action Lead**	**Progress**	**Evidence**	**Timescale**
R6.1 NED attendance at sub committees revised to release NED time	Chairman	• NED's all aligned to specific Committee's and identified lead responsibilities. • 3rd Rotating NED role being explored – to be evaluated for greater visibility, continuity, triangulation and succession planning.	1. Committee ToR and Minutes. 2. New Workforce Committee. October 2017. 3. New rotation at QGAC. November 2017.	Completed Completed Completed
R6.2 "Back to the floor" programme for NEDs and Executives in the form of "leadership Walkabouts'	Chairman	• Programme in place for Leadership Walkabouts. • Programme of Lay Chair of Interviews by NED's.	1. Deputy CEO Office Copy of Programme plus documentation provided to QSAG. 2. Programme of Lay Chair of Interviews by NED's held by Company Secretary.	Completed Completed
R6.3 Drop in programme similar to ED monthly sessions now replaced by 'Meet the Executive' Drop-in Sessions	Executive Directors	• Previous action now replaced by 'Meet the Executive' rolling programme of monthly drop-in sessions in place. • Programme managed by Director of Workforce Office.	1. Copy of rolling programme. 2. Respective Executive Directors diaries. 3. Issues raised requiring further action raised either at Directors Meeting or directly with responsible Director/Manager.	Completed
R6.4 Communication to promote the role of the NED with a "focus on" individual NEDs and their role via the staff bulletin and intranet	Chairman	• Trust Magazine publication scheduled to include NED information and visibility on a regular basis.	1. Trust Magazine will feature 'NED of the Quarter' from April 2018.	April 2018
R6.5 Review questions within the Chat back survey to test effectiveness of revised arrangements	Director of Workforce	• Not currently reviewed in 2017 Chat back questions – to consider in next round of question review	1. Workforce Committee established to progress both Chat-back and use of data/information from it. October 2017. 2. Changed system being scoped for use from April 2018.	Completed April 2018

Recommendation			Trust Board response		
R7	The Trust and NHSI should consider a succession plan to manage the transition in Chairmanship over the medium term.		The Trust will work with NHSI as required on the succession plan.		
Key Actions		**Action Lead**	**Progress**	**Evidence**	**Timescale**
R7.1	NHSI to advise	CEO, Chairman	• Extend Chair's tenure.	1. Chairman post extended for 2 years to March 2019.	Completed
R7.2	Succession planning for Chair to be included in Trust Succession Planning and organisational development in local Health Community	CEO, Chairman, Director of Workforce	• Planned to commence early 2018 leaning from work undertaken on succession planning of Directors.	1. Succession plan in place for Executive Directors January 2018. 2. Updates on Directors Succession Plan to Remuneration Committee scheduled 6 monthly by CEO from July 2018.	Completed

Recommendation		Trust Board response			
R8	The Trust should ensure that there are more clearly defined succession plans in place to manage the transition in key ED posts over the medium to long term.	As described in the report the executive team have spent time individually and as a group reviewing success plans. Recognising the national position regarding recruitment to a number of these roles the executive team are ensuring that there are plans in place to cover short to medium term requirements. The recruitment of substantive appointments in the majority of roles is untested and as such the executive team and Board will take steps to ensure the Trust is well placed to secure high calibre leaders when posts are advertised			
Key Actions		**Action Lead**	**Progress**	**Evidence**	**Timescale**
R8.1	Regularly refreshed plan for short to medium term requirements – skills/gap analysis to be undertaken in the next 3 months	Director of Workforce	• Initial Succession Planning analysis completed. • Refresh and further reporting cycle in place.	1. Succession plan in place for Executive Directors January 2018. 2. Updates on Directors Succession Plan to Remuneration Committee scheduled 6 monthly by CEO from July 2018.	Completed Completed
R8.2	Profiles developed for each role to determine the qualities required and support early identification of potential candidates	Director of Workforce	• Initial Succession Planning analysis completed. • Refresh and further reporting cycle in place.	1. Succession plan in place for Executive Directors January 2018. 2. Updates on Directors Succession Plan to Remuneration Committee scheduled 6 monthly by CEO from July 2018.	Completed Completed
R8.3	High quality recruitment material developed to attract the best people	Director of Workforce	• Changes to Recruitment process in place by April 2018. • Revision of Recruitment Materials to follow revised process from April 2018.	1. Plan in place to centralise Recruitment process and control from April 2018. 2. Plan in place to revise Recruitment Materials from April 2018.	April 2018 April 2018

Recommendation		Trust Board response			
R9	The Board should reflect on the Trust's approach to partnership working in situations where developments are not necessarily fully aligned with the Trust agenda.	The Board recognises the importance of strong, effective and mutually beneficial partnership working. Key examples are the approach the Trust took during the transfer of services from Mid Staffordshire Foundation Trust, short term transfer of services from neighbouring acute providers and the progress for Vertical Integration with GP practices in Wolverhampton. With all new partnerships the Board takes a considered view of the implications on other relationships and contractual arrangements in determining its level of engagement and continues to review this as the partnership evolves. Areas of relevance will be reflected in the Trust's Annual Report			
Key Actions		**Action Lead**	**Progress**	**Evidence**	**Timescale**
R9.1	Board stakeholder map refreshed to support easy identification of those impacted by proposed changes/developments	Director of Strategic Planning and Performance	• Executive participation on STP. • Stakeholder views part of Strategic review. • Stakeholder consultation part of contract and tendering process.	1. Stakeholder mapping and consideration included in Board Strategic Review workshop. 2. Plans shared with Healthwatch, Voluntary Sector, Health & Well-being Board, overview & Scrutiny Committee, CCG review. 3. Series of Stakeholder engagement events to review Trust Strategic Objectives.	Completed Completed Completed
R9.2	Business case/development pro-forma to include a section to capture views of stakeholders (where appropriate) and the extent of their involvement/impact	Director of Strategic Planning and Performance	• CEO participation in National discussions re NHS Strategic direction. • Pro-forma to be revised to include section to explicitly capture views of stakeholders from April 2018.		April 2018
R9.3	Board minutes reflect discussions about impact on stakeholders of developments	Director of Strategic Planning and Performance	• Executive leadership re ACO/ ACS development with Wolverhampton CCG and wider partners.	1. Board & Trust Management Committee Minutes reflect range of stakeholder views re Pathology, Walsall Stroke Services, Ambulatory and Frailty, Cancer Care transfer et al.	Completed
R9.4	Internal communications to ensure staff have easy access to updates on the Trust performance and progress with plans and test effectiveness through Chat back survey	Director of Workforce	• New Communications Team recruited and in role from November 2017. • Continuation of National Staff Survey for all staff responses. • Development of replacement for Chat-back underway.	1. Communications Team recruited and in role from November 2017. 2. National staff Survey response rates monitored and promoted – over 40% in 2017. 3. Replacement approach to Chat-back underway.	Completed Completed June 2018

Recommendation		Trust Board response
R10	The Board should consider the various observations made throughout section B.1 in relation to potential refinements to the operation of committees.	The Board will review the structure of reports and the presentation at sub committees and at the Board and make refinements to ensure there is a more streamlined approach with the most effective levels of debate and assurance. Where relevant the changes will be included for review in the internal audit plan for future years. Actions taken will be reported to the Board via the monthly subcommittee reports and minutes and will be formally noted in the joint meeting between the Audit Committee and Quality Governance Assurance Committee with relevant references being made in the Annual Governance Statement, Annual Report and Quality Account. In addition amendments to the Integrated Quality Performance Report will be detailed in the report to the Board outlining changes to reporting for the year 2017/18

Key Actions		Action Lead	Progress	Evidence	Timescale
R10.1	Mapping exercise to show flow of reports through sub committees to the Board	Company Secretary, Board Committee Chairs	• Review TB reporting schedule underway. • Review reporting content to TB underway. • Appointment made to Company Secretary role.	1. Revised Cycles of Business for Trust Board and Trust Management Committee from January 2018. 2. Appointment made to Company Secretary role January 2018.	Completed
R10.2	Reporting process to committees and exception report to the Board refined to remove duplication of debate	Company Secretary, Board Committee Chairs	• Review TB reporting schedule underway. • Review reporting content to TB underway. • Appointment made to Company Secretary role.	1. Revised Trust Board Reporting Summary Template and Trust Management Committee Reporting Summary Template from January 2018. 2. Mapping of information flows underway for completion by February 2018.	Completed February 2018
R10.3	Report structure/content refined to support robust exception reporting	Company Secretary, Board Committee Chairs	• Review TB reporting schedule underway. • Review reporting content to TB underway. • Appointment made to Company Secretary role.	1. Revised Cycles of Business for Trust Board and Trust Management Committee from January 2018. 2. Revised Trust Board Reporting Summary Template and Trust Management Committee Reporting Summary Template from January 2018. 3. Mapping of information flows underway for completion by February 2018.	Completed Completed February 2018
R10.4	Review options to refine contents of key reports for implementation from April 2017 and reported to the Board in its public meeting	Company Secretary, Board Committee Chairs	• Review TB reporting schedule underway. • Review reporting content to TB underway. • Appointment made to Company Secretary role.	1. See above	See above
R10.5	Roll out quality markers such as data kite marking to provide greater assurance on the robustness and validity of individual indicators to support more focussed debate in meetings.	Company Secretary, Board Committee Chairs	• Proposed initial approach to Kitemarking to be considered at February 2018 Board Development Session	1. See Sandwell note from JV.	February 2018
R10.6	Each sub Board Committee will review its effectiveness for contributions, presentation and decision making.	Company Secretary, Board Committee Chairs	• Review against Committee ToR, Deloitte Report Recommendations and Well-Led framework to be undertaken in March 2018.	1. Review against Committee ToR, Deloitte Report Recommendations and Well-Led framework to be undertaken in March 2018.	March 2018

Recommendation		Trust Board response
R11	The Board should consider the various observations made throughout section B.3 in relation to potential refinements to risk management tools.	The Trust's approach to risk management has evolved significantly over the last couple of years and has been subject to review through the internal audit programme as well as through external processes such as CQC inspections. As part of the ongoing review of risk management the Board will ensure that the processes outlined in its Risk Management Strategy are complied with at all levels across the Trust and will continue the work already underway (and referenced in the report) to embed accountability at a divisional and directorate level. Actions taken will be reported to the Board via the monthly subcommittee reports and minutes and will be formally noted in the joint meeting between the Audit Committee and Quality Governance Assurance Committee with relevant references being made in the Annual Governance Statement, Annual Report and Quality Account **Observations in section B.3** ~ We recommend the introduction of a kite-marking tool, in order to clearly identify the level of assurance that can be placed on particular figures. ~ Trust to consider the impact of the current portfolio of integrated governance in light of its growing scope and size. ~ Strengthen accountability and ownership from Divisions and Directorates to ensure that application in practice is aligned with the strategic theory. ~ Board meeting observations highlighted various risk based discussions although the distinction between the BAF and the Risk Register was not always clear.

Key Actions		Action Lead	Progress	Evidence	Timescale
R11.1	Work to give divisions/directorates accountability for risk management is completed	All Executive Directors	• Divisional Performance Reviews (DPR) meetings established. • Finance Confirm and Challenge Meetings established and include Risks identified on the Risk Register.	1. Divisional Performance Reviews (DPR) meetings dates in diary 2. Finance Confirm and Challenge meetings in place and minutes provided as information at Trust Management Committee. 3. QGAC challenge and confirm regarding updates and progress against Risk register entries.	Completed Completed Completed
R11.2	Refine the mechanism to assess compliance with policy as part of Accountability meetings	All Executive Directors	• Scoping exercise to be completed by the end of June 2017 to decide the feasibility and resource requirements of this initiative. • Options appraisal to be considered as per Action R11.3 below.	1. Divisional Performance Reviews in progress and programmed quarterly 2017/2018 based on Divisional Objectives/KPI's aligned to Trust Objectives and Trust Quality Priorities 2017/2018, Divisional Priorities and Key Risks with dashboard overview of Performance – Finance, Performance, Human Resources and Quality.	Completed
R11.3	Data Kite marking to be considered by the Trust	All Executive Directors	• Data Kite Mark criteria used by other NHS Trust's being reviewed. • Directors/Board decision regarding whether to use a Kite Mark methodology, better report existing challenge and confirm in existing systems in reports or to decline to use this approach.	1. Report on Data Kite Marking by Simon Evans with recommendation to Directors Meeting. 2. Assurances already in place to be considered: Internal Audit programme, Audits of Quality Account, Trust Accounts, F&P/QGAC Challenge and confirm on data & information, existing internal checking and challenge, Director sign-off of Reports and papers.	Completed Decision to be made by Directors February 2018
R11.4	Review of the current Portfolio for Integrated Governance in the context of Vertical Integration.	All Executive Directors	• DPR reviewed and restructured and timetabled.	1. Division 3 DPR's timetabled from April 2018. 2. Divisional Performance Reviews (DPR) meetings dates in diary 3. Finance Confirm and Challenge meetings in place and minutes provided as information at Trust Management Committee.	April 2018 Completed Completed

R11.5	Links between the BAF and TRR to be considered on review of the BAF format.	All Executive Directors	• BAF format amended – to be agreed through QGAC and Audit committee – May 2017. • Board Development Session on BAF, TRR and Risk Flow to be considered for 2018 programme.	1. Initial BAF format amended and agreed by QGAC and Audit committee – May 2017. 2. Review of proposed BDS as part of review of this Action Plan January 2018.	Completed January 2018

Recommendation			**Trust Board response**		
R12	The Board should consider the appropriateness of the current number of divisions as the Trust is currently an outlier relative to similar organisations.		The current divisional structure evolved over a number of years with a decision to move from a larger number of divisions to 2 to support synergy of cross specialty working. As the Trust determines its plans to move to an ACO model the executive team will review the structure required to support effective and safe service delivery.		
Key Actions		**Action Lead**	**Progress**	**Evidence**	**Timescale**
R12.1	Any revisions to the structure will be reported through the Board as part of progress reports on delivering the next phase of VI and the move to an ACO model	Executive Directors	• Being reviewed currently in the context of Vertical Integration	1. Proposed Division 3 agreed by Trust Board, operational from May 2018 Reporting.	May 2018

General Condition 6 – Systems for compliance with licence conditions and related obligations – Sign off Due 31st May 17	Lead/s to respond	Trust position statement	Risks and gaps	Evidence/ Comment
Condition G6 – **1.** The Licensee shall take all reasonable precautions against the risk of failure to comply with: **(a)** the Conditions of this Licence,	a, b, c) CEO/ Finance Director/ Board Secretary	Each subcommittee monitors compliance against contractual requirements and provides assurance to the Board with identification of risk and mitigation.		• BAF • Trust Risk Register
(b) any requirements imposed on it under the NHS Acts, and	a, b, c) CEO/ Finance Director/ Board Secretary	The Trust has had no conditions imposed upon it preventing it from discharging its statutory responsibilities.		• BAF • Trust Risk Register
(c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.	a, b, c) CEO/ Finance Director/ Board Secretary	The NHS Constitution is considered against each report/paper presented the Board and its sub committees.		• Trust Board Papers • Trust Board Committee Papers
2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include: **(a)** the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and	a, b) Finance Director	The Trust Board approved a financial plan at its March Board meeting agreeing to the NHS Improvement control total of £11.6m surplus for 2017/18. Financial risks to the plan have been identified along with mitigation plans and these have been highlighted in the Trust's Board Assurance Framework and risk register. The Trust's Finance and Performance Committee will monitor the key risks to the financial plan ensuring all appropriate action is taken to deliver the 17/18 financial position.	The BAF contains 3 financially related risk (SR 8,9,10) which are monitored and managed though the F&P Committee and reported to Trust Board.	• BAF/TRR • Minutes of F&P • Escalation reports to Board monthly
(a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and	a) Chief Nurse, Head of Governance and Legal	The Trust has a well-established framework for governance to inform the Trust Board of operational and strategic risks as well as to provide assurance on business performance and compliance. The framework sets in place a high level committee and management structure, below the Trust Board, for the delivery of assured governance. Trust Board Committees are constituted to ensure the delegated operation of effective risk management systems, processes and outcomes. These committees inform and assure the Trust Board through the functioning and reporting of sub-groups and specialist working groups defined in their terms of reference.	Completion of recommendations from Deloitte Governance Review.	• Risk Management Assurance Strategy • RM Assurance Strategy Trust Audit 2016.

(b) regular review of whether those processes and systems have been implemented and of their effectiveness.	a, b) Finance Director	An Internal Audit report on Divisional Governance concluded that the governance arrangements from Directorate to Trust Board level have been well designed and, from the evidence gathered, are working in an effective manner and assurances are received throughout the whole structure. During 2016-2017 the Trust also underwent an independent review of governance by Deloitte. As part of the review the Trust Board and its Committees were observed, and Directors and senior staff were interviewed. The report was largely positive, but identified recommendations for improvement that have now been included in an action plan, this is currently being implemented.	Completion of recommendations from Deloitte Governance Review.	• Internal Audit Reports on Governance, BAF etc. • Completion of internal audit recommendations Report to Board June 2017 on progress against Deloitte Governance review actions.
3. Not later than two months from the end of each Financial Year, the Licensee shall prepare and submit to Monitor a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition.	Board Secretary, CEO, Finance Director	A report was presented to the Trust Board in May 2017 demonstrating how the Trust has taken all precautions necessary to comply with the license, NHS Acts and NHS Constitution along with required governance arrangements. A full compliance document followed in June 2017. The Trust Board is satisfied it can declare full compliance.	An update on the interim License position will be presented to the Board in January 2018.	• Agenda for Board meeting for approval.
4. The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to Monitor in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it.	Board Secretary, Communications manager	The Trust completed the first self-certification sign off. Self-certification template was published on RWT internet site 30 June 2017 post Board approval and can be found here: http://www.royalwolverhampton.nhs.uk/about-us/declarations/nhs-improvement-self-certification/		

Condition FT4 – NHS foundation trust governance arrangements – Sign off due 30th June 17	Lead/s to respond	Trust position statement	Risks and gaps	Evidence/ Comment
Condition FT4 - **1.** This condition shall apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.	Board Secretary	The Trust Board received assurance at the June 2017 Trust Board meeting that it complies with the governance arrangements. This was published on the Trust webpage and can be found here: http://www.royalwolverhampton.nhs.uk/about-us/declarations/nhs-improvement-self-certification/		
2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Chief Nurse, Board Secretary	Corporate governance elements have previously been shared between the Governance and Legal Service department and the Trust Secretary with some areas supplied by the CFO. Following restructure and development of a Head of Corporate Affairs role (now Company Secretary) the corporate governance arrangements will be the responsibility of this new post holder and advised through the Board via the Deputy CEO.	The Company Secretary role is being appointed to in January 2018 – see also Completion of recommendations from Deloitte Governance Review.	• Conflict of Interest Policy • SFI • Standards of Conduct in a Public Body
3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall: **(a)** have regard to such guidance on good corporate governance as may be issued by Monitor from time to time; and	Chief Nurse, Board Secretary	As section 2 above.	As Section 2 above plus; Recently published guidance from NHSI on Developmental Reviews of leadership and governance (June 2017) not yet formally considered. *This is not deemed a significant risk*	• Structured review against the Well Led Framework to be undertaken commencing January 2018
(b) comply with the following paragraphs of this Condition.	Chief Nurse, Board Secretary			
4. The Licensee shall establish and implement: **(a)** effective board and committee structures;	Board Secretary	Following an external governance review in 2013 (PWC) a review of the Board structures and reporting lines was undertaken and the Board committee structure developed. This was also reviewed in the latest Deloitte review. Terms of reference for all committees reviewed annually to ensure alignment with Strategic objectives and relevant responsibilities.	Completion of recommendations from Deloitte Governance Review.	• Terms of Reference • Subcommittee reports to Board
(b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees;	b) Chief Nurse, Head of Governance and Legal Services	The Risk Management Assurance Strategy describes the Committee structure and risk management reporting arrangements.		• Terms of Reference • Subcommittee reports to Board

(c) clear reporting lines and accountabilities throughout its organisation.	c) Director of Strategic planning and Performance, Deputy Director of Strategic Planning and Performance	The Trust Board has strengthened its arrangements for reporting and accountability across the organisation and introduced a new Divisional Performance Review Process. This uses current data and a balanced scorecard approach to enable clear visibility of performance across a range of themes from operational performance through to the strategic objectives.	Completion of recommendations from Deloitte Governance Review.	• Terms of Reference • Subcommittee reports to Board • Evidence in G6(2)
5. The Licensee shall establish and effectively implement systems and/or processes: **(a)** to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;	a) Director of Finance, Chief Operating Officer	The following Board Committees oversee the key areas of performance: F&P – Financial performance including CIP, Operational performance, related risks WODC - Workforce indicators, staff health & well-being, related risks QGAC – Quality and Safety, BAF/TRR overview Audit – BAF/TRR detail/audit/assurance, effectiveness of systems FRB – Efficiency overview/delivery of CIP TMC – CEO senior management meeting		• Minutes and Board reports • IQPR • Escalation reports from Board committees
(b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations;	b) Board Secretary	The Trust Board receives a comprehensive suite of information in a timely fashion that enables it to oversee and scrutinise operations. Assurance reports are received from all sub committees alongside a monthly Quality, Finance and Performance report. The Trust Board and Board Committee moved on to using the Boardpad product to access Board and Board Committee papers.	Evaluation of Boardpad to commence as part of Self-assessment against Well-led Framework January 2018.	• Minutes and Board reports • Escalation reports from Board committees

(c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;	c) Chief Nurse, Head of Governance and Legal Services	The Trust has developed a framework (self-assessment against core services and QRV's) for assessing on-going compliance with CQC Fundamental standards of care (and 5 key questions of Safe, Caring, Effective, Responsive and Well Led). The assessment of compliance uses a combination of quality performance indicators, clinical audits and observational ward and department visits to measure on-going compliance with care standards. The Trust uses the CQC rating characteristics to make judgements about compliance with the fundamental standards of care and judgments are cross checked and challenged at Divisional Management Performance / Quality meetings and by Executives at QSAG and QGAC. This approach allows for information to be triangulated between performance results and observation of care standards and allows for assurance to be reported from ward to Board. All Hospital in-patient and service areas are part of the QRV rolling programme.	Self-assessments are subject to challenge and confirm when presented at Quality Standards Action Group (QSAG) where self-assessment is compared with other key data and information – Incidents, complaints, risks, never events, workforce satisfaction, turnover.	• FSC and Core Service self-assessments and reports minutes were reviewed. • Internal Audit report in relation to self-assessment against Fundamental Standards. • IA Action Plan in place re FS. • QSAG Challenge and Confirm of QRV Self-assessments.
(c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;	c) Director of Strategic planning and Performance, Deputy Director of Strategic Planning and Performance	The Trust uses the NHS Standard contract for all material contracts with commissioners and has developed contracts with NHS Wales to ensure a consistent approach to contracting. Where possible all sub contracts and provider to provider agreements now utilise the non-mandatory NHS Standard Sub-Contract template. All contracts are subject to internal and external audit where required and actions all completed. We work collaboratively with other contract parties to ensure that we are compliant with contract conditions. The requirements placed upon providers to meet the NHS Operating Framework are all detailed within the standard contract.	Non-compliance of other contract parties. This is an accepted risk as reported by the Director of Strategic performance & Development.	• Contract documentation. • Audit logs for contract tracking. • Minutes of contract meetings (internal and external). • SQPR and Information submissions.