Board of Directors Meeting Report

Subject: **Corporate Governance Statement – Self Certification**

Date: **26th June 2014**

Author: **KERRY ROGERS, DIRECTOR OF CORPORATE SERVICES/COMPANY SECRETARY**

Lead Director: **KERRY ROGERS**

EXECUTIVE SUMMARY

The Risk Assessment Framework (RAF) requires Foundation Trusts to submit both a 2-year Operational Plan and a 5-year Strategic Plan to Monitor, as part of the annual planning process. Monitor uses the information provided in these documents primarily to assess the risk that an NHS Foundation Trust may breach its licence in relation to finance and governance. Monitor will also assess the quality of the underlying planning processes.

Part of this annual planning process is the Board Statements, which for 2014/15 have been changed to reflect both Monitor's new licencing regime and the two-part planning submissions. The Statements require the Board's consideration and certification. The first part of the self-certification process was considered by Board at its May meeting when declarations were made regarding availability of resources and systems of compliance with the Trust's Licence.

In accordance with Monitor's Risk Assessment Framework, to comply with the governance conditions of their licence, NHS foundation trusts are required to provide a statement (**the corporate governance statement**) setting out:

- any risks to compliance with the governance condition; and
- actions taken or being taken to maintain future compliance.

The statement replaces the board statements that NHS foundation trusts were previously required to submit with their annual plans under the *Compliance Framework.* Where facts come to light that could call into question information in the corporate governance statement, or indicate that an NHS foundation trust may not have carried out planned actions, Monitor is likely to seek additional information from the NHS foundation trust to understand the underlying situation. Depending on the trust's response, Monitor may decide to investigate further to establish whether there is a material governance concern that merits further action. The Trust is expected to submit its declarations on 30 June 2014.

ACTIONS REQUIRED BY BOARD OF DIRECTORS

Members are invited to:

- Consider and certify each Statement and if unable to do so, agree what supporting commentary Board wishes to submit
- Approve (including any amendments agreed) the Corporate Governance Statement for submission to Monitor
- Consider how the work of the Committees might better support assurances concerning this annual declaration for the future and ensure the agendas and work of the committees are driven accordingly.

Relevant Strategic Objectives (please mark in bold)	
Achieve the best patient experience	**Achieve financial sustainability**
Improve patient safety and provide high quality care	Build successful relationships with external organisations and regulators
Attract, develop and motivate effective teams	
Links to the BAF and Corporate Risk Register	Board and its Committees are responsible for the systematic review of the trust's control environment to ensure delivery of objectives and standards of quality
Details of additional risks	n/a
Links to NHS Constitution	n/a
Financial Implications/Impact	n/a
Legal Implications/Impact	n/a
Partnership working & Public Engagement Implications/Impact	n/a
Committees/groups where this item has been presented before	n/a
QIA/EIA required?	n/a

1. Background

The Risk Assessment Framework (RAF) requires Foundation Trusts to submit both a 2-year Operational Plan and a 5-year Strategic Plan to Monitor, as part of the annual planning process. Monitor uses the information provided in these documents primarily to assess the risk that an NHS Foundation Trust may breach its licence in relation to finance and governance. Monitor will also assess the quality of the underlying planning processes.

Part of this annual planning process is the Board Statements, which for 2014/15 have been changed to reflect both Monitor's new licencing regime and the two-part planning submissions. The Statements require the Board's consideration and certification.

The Board Statements have now been replaced by a number of different statements and certifications relating to sections of the Risk Assessment Framework, provider licence and Health and Social Care Act 2012, and are contained in 2 submissions, as follows:

<u>31 May 2014 Submission</u> ***(which was considered at the May 14 Board meeting)***

- Availability of Resources Statement – as required by condition CoS 7 of the provider licence, and
- Certification regarding systems for compliance with the licence – as required by condition G6 of the provider licence.

<u>30 June 2014 Submission</u>

- Corporate Governance Statement – confirming compliance with condition FT (4) of the provider licence;
- Certification for Academic Health Science Centres (AHSC) – as required by Appendix E of the Risk Assessment Framework (only required for Trusts that are part of a joint venture or AHSC), and
- Training of governors statement – as required by s151(5) of the 2012 Act. *(relates to the requirement for Foundation Trusts to ensure that Governors are equipped with the skills and knowledge they require to undertake their role).*

The format for each of the above statements/certifications was recently issued by Monitor and the first series of statements were submitted for the Board's consideration and certification, prior to the 31 May 2014 submission deadline. The second submission is presented for consideration to the Board meeting on 25 June 2014.

2. Introduction:

Monitor uses a set of national measures to assess the quality of governance at NHS foundation trusts. Monitor uses performance against these indicators as a component of the service performance score used to calculate governance risk ratings.

In accordance with Monitor's Risk Assessment Framework, to comply with the governance conditions of their licence, NHS foundation trusts are required to provide a statement (the corporate governance statement) setting out:

- any risks to compliance with the governance condition; and
- actions taken or being taken to maintain future compliance.

The statement replaces the board statements that NHS foundation trusts were previously required to submit with their annual plans under the *Compliance Framework.* Where facts come to light that could call into question information in the corporate governance statement, or indicate that an NHS foundation trust may not have carried out planned actions, Monitor is likely to seek additional information from the NHS foundation trust to understand the underlying situation. Depending on the trust's response, Monitor may decide to investigate further to establish whether there is a material governance concern that merits further action. The Trust is expected to submit its declarations on 30 June 2014.

3. Self certification process

The Board declarations are made through the Corporate Governance Statements which are provided in the Risk Assessment Framework. The Board is supported in the Self-Certification and Declaration process by the work of the Board and its prospective focus going forwards; confirm and challenge sessions, reporting mechanisms, and Board committee work alongside independent views and inspections of patients, regulators, consultants and professional bodies. Proposed sources of evidence to substantiate each of the statements in the Board's declaration is included in an appendix to this paper.

Board members will need to reflect on their own sources of assurance, assess the adequacy and sufficiency of the evidence used to support each corporate governance statement included in this report and determine the adequacy and appropriateness of assurances necessary to self-certify.

In the event that a Foundation Trust is unable to fully self-certify, it must provide commentary explaining the reasons for the absence of a full self-certification and the action it proposed to take to address the issues.

4. Recommendations

Members are invited to:

- Consider and certify each Statement and if unable to do so, agree what supporting commentary Board wishes to submit
- Approve (including any amendments agreed) the Corporate Governance Statement for submission to Monitor
- Consider how the work of the Committees might better support assurances concerning this annual declaration for the future and ensure the agendas and work of the committees are driven accordingly.

Appendix: Proposed evidence for self certification 2014/15

1. ***The Board is satisfied that the trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.***

- Constitution review
- Corporate Governance section of Annual Report outlining Code of Governance compliance
- Audit &Board approved Annual Governance Statement and Auditors' opinions
- Corporate Governance Review and revised governance structures (Dec13 BoD report)
- Board Committee meeting focus – risk, control, performance and quality
- BAF key issues and review of BAF process (May14 Audit Committee)
- PMO – tracking of action implementation – CQC, Keogh, PWC&KPMG reviews
- Introduction of Board Assurance Statement twice per annum to support AGS (Mar14)
- IG Toolkit self-certification and implementation work
- NHSLA Level 2 achievement – Maternity
- Approved Quality Strategy and workforce/OD strategy
- QGF process, assessment and PWC External Assurance
- Response to Francis; Keogh; Berwick and CQC – positive December 13 follow ups
- Revised Standards of Business Conduct approved at Audit (to incl Bribery Act)
- External Audit Opinion – annual report and quality accounts
- Director of Internal Audit Opinion and audit of quality indicators
- Board walk rounds, IAT visits, NED confirm and challenge introduced
- Internal Audit Plan – focus across the year approved
- CQC Intelligent Monitoring Reports
- Mandatory training compliance – monitored by Board
- Appraisal compliance monitored by Board
- Whistleblowing policy revised, training for senior team delivered; annual report to Board
- Clinical Audit plan being reviewed to align with priorities – further work to embed process and understand how audit has supported improvement in outcomes of care
- Risk Management focus, training roll out and draft strategy under consultation
- Director of Corporate Services commenced review of: External visits/inspection policy and process and Trust policy framework – to report in Q2
- Code of Conduct revision – Governors. Review of Directors' code of conduct and Declarations of Interest guidance. SFIs and SOs under review so all governing suite accords with Constitution & Act

2. ***The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time***

   As per 1. Above

3. ***The Board is satisfied that the Trust implements effective board and committee structures; clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees, and , clear reporting lines and accountabilities throughout the Trust***

- Board development programme initiated (strategy, data/intelligence master-class; time out)
- Governance Review and implementation of recommendations – clear focus assurance vs delivery
- Board approved Committee Structure and ToRs / annual workplans/focus
- Annual Business cycle approved Dec13 – allocation of accountabilities across committee structure
- Escalations part of agendas, minutes from Committees circulated, and review aligning ToRs/workplans
- Quality for All – development, launch and implementation – Board reports re progress
- Integrated Performance Reporting – TMB focus on monitoring performance; escalations
- Accountability Matrix (Newark specific matrix in development)
- Staff communication / involvement evidence
- Board member appraisals & personal development plans

- Board member training records
- Annual Governance Statement
- Changes in structure / governance processes / quarterly self-certifications/NED confirm&challenge
- Audit Committee programme of work and IA approved workplan/focus
- IA reports on Governance matters (IG, Risk management, BAF, IA opinion, CQC compliance etc)
- BAF key issues and review of BAF process (approved May14 Audit Committee)
- Constitution Review – and supporting suite of governing documents finalised Q2 14/15
- Divisional structures implemented – devolution. Further work to commence to understand the Effectiveness of divisional governance structures (Div Board, Service Line performance meetings And supporting clinical governance structures)

4. The Board is satisfied that the Trust effectively implements systems and/or processes to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively

- External Audit Opinion – use of resources
- Director of Internal Audit Opinion
- Internal Audit annual plan – outcome of audits of transactional and financial controls
- KPMG financial governance review and implementation of recommendations
- Board walk rounds
- Audit Committee annual work plan
- Clinical Audit plan – including role of Audit and Quality committees defined in ToR
- Integrated Performance Report – tracking performance/success of remedial actions
- Monthly Finance Report; work of Finance Committee;
- Trust's going concern review
- CQC Intelligent Monitoring Report
- PMO independence
- Approval of Transformation Strategy - IIP
- Quarterly compliance reports to Monitor and robust self declaration process
- BAF key risk monitoring, including committee focus (roll out of new process imminent)
- Annual Plan and business planning process/scrutiny
- Divisional performance reports – Finance Committee work + performance of divisions
- Work progressing with regard to improvements in Service Line reporting and site profitability
- Budget setting process
- Divisional Performance meetings, Service Line meetings – work progressing with regard to Performance Management Framework – alignment of PM meetings with TMB, escalation process etc

5. The Board is satisfied that the Trust effectively implements systems and/or processes for timely and effective scrutiny and oversight by the Board of the Licencee's operations;

- Internal Audit workplan – focus approved annually
- Commissioning of consultants to review Trust operations (EY, KPMG, PWC)
- PLACE Audits – patient and governor involvement
- Governor involvement through PE Committee, IAT visits etc
- Friends and Family, surveys, patient feedback loops
- Clinical Audit plan
- NED led confirm and challenge
- CCG short notice/unannounced inspections; performance & quality meetings
- Board dashboard / IPR / developments in ward dashboards
- Communication Boards on wards – link to performance improvement
- IAT programme, Outcome Guardian work, restructure of Complaints and GSU teams
- CQC Intelligent Monitoring Tool
- BoD meeting minutes
- Annual Plan and business planning process/challenge
- Constitution

- BAF key issues
- Monitor risk ratings
- Compliance with the provider license to be reviewed following quality summit (Discretionary Reqmts and enforcement Undertakings
- Need to mature relationships with Overview and Scrutiny and Healthwatch

6. ***The Board is satisfied that the Trust effectively implements systems and/or processes to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of healthcare professions;***

- Board approved Quality Strategy
- Quality Accounts – governor and Board engagement in priority setting
- CQC Reports to Board, supported by IAT visits, confirm & Challenge, Outcome guardian work
- Ongoing assessment against Monitor's Quality Governance Framework
- Exception reports relating to Maintaining Professional Standards / referrals to professional bodies etc
- Quarterly Monitor submission supported by reports concerning Learning Disability compliance, Medical Revalidation etc; May14 Revalidation report to support August Statement of Compliance
- External assurance re Quality Account – KPMG limited opinion, CCG, Healthwatch commentary
- PLACE audits
- Audit Committee approval of IA focus and annual audit plan
- CQC Intelligent Monitoring Tool
- CQC unannounced inspection – informal feedback and Dec13 visit (plus Keogh team)
- Corporate risk register and mitigating action plans
- BAF key risks and approval of new assurance process
- CQC Registration Certificates; focus on action plans re Discretionary Requirements/Enforcements
- Quality reports, including Complaints, claims and incidents report
- Response to Francis/Keogh/Berwick/Hard Truths
- GMC junior doctor feedback – LETB survey
- Whistleblowing policy review and roll out
- Work progressing to ensuring close alignment of clinical audit plan with Trust priorities
- Clinical audit plan – alignment with priorities, testing of compliance (egWHO checklist)

7. ***The Board is satisfied that the Trust effectively implements systems and/or processes for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licence holder's ability to continue as a going concern)***

- KMPG External assurance re Financial Governance (Discretionary requirements)
- EY review - PFI
- Finance Committee – assurance role, new ToR
- Board finance reports / IPR
- External Audit Opinion
- Director of Internal Audit Opinion
- Monitor monthly and quarterly submission
- Annual accounts – on plan performance
- CIP performance and PMO control/independence
- Review of going concern assumption
- BAF key risks – scrutiny of financial risks at Finance Committee
- Annual Plan – assumption challenge and scenario sensitivity planning
- Internal Audit core Financial controls reviews

8. ***The Board is satisfied that the Trust effectively implements systems and/or processes to obtain and disseminate accurate, comprehensive, timely and up to date information for***

Board and Committee decision-making

- Quality and Finance reporting to Board, TMB and Divisions
- Divisional senior managers attend TMB; Strategic planning sessions
- Monthly and quarterly Quality Report
- Annual Plan
- BoD annual cycle of business (workplan)
- Committee annual cycle of business and 'new' assurance focus/restructure
- External Audit opinion and Director of Internal Audit opinion
- Board development masterclass – data quality
- Quality account – EA opinion, stakeholder support
- Data quality committee reinstated
- IA focus to include data quality, Newcastle buddying to improve data quality, validation processes within performance data collection processes
- Business analyst appointments and intended roll out
- TMB initiated Performance Management Framework and formal escalation protocols
- Communication Strategy – approval (with further work) May14 BoD
- Planned improvements regarding engagement strategy re cost control
- IPR – and service line and divisional reporting – improvements in progress
- Progressing stakeholder engagement mapping, relationship management, clinical summits etc
- Benchmarking work commenced, but require broader roll out

11. The Board is satisfied that the Trust effectively implements systems and/or processes to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with Conditions of its Licence;

- BAF focus on key strategic risks, approval of new BAF reporting process
- IA opinion, Risk Management audit
- Corporate risk register & mitigating action plans
- Review of compliance with provider licence conditions regarding October declaration against Discretionary Requirements
- Annual Plan and business planning process (Governor involvement in forward plan)
- Board and senior manager self assessment of strategic planning process using Monitor's self-assessment tool
- Better Together – engagement, support, programme board, assumption challenge
- IPR – exception/variance focus and escalations
- CQC Intelligent Monitoring Tool
- Committee meeting workplans and ToR – accountabilities for risk
    - Finance Committee BAF risk focus
- Monitor quarterly self-certifications – and supporting narrative in reporting to Board
- Risk management strategy in consultation, effective first phase training roll out, GSU restructure
- Monitoring of complaints, survey results, incidents, claims – work progressing to allow reporting mechanisms to provide greater opportunities to triangulate intelligence
- Approved SI policy and process following review

12. The Board is satisfied that the Trust effectively implements systems and/or processes to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery

- Partnership work, meeting membership – regarding Better+Together and strategic alignment
- Board strategy time out
- Annual Plan – involvement
- Appointment of Strategic Finance Advisor
- Strategic Time out with senior team May – quarterly roll out

- Director of Internal Audit Opinion
- IPR
- CQC Intelligent Monitoring Tool
- External audit opinion
- BAF key issues
- Monitor's evaluation of Annual Plan submission
- Monitor risk rating
- Business Plan Process
- Self Assessment of strategic planning process using Monitor tool

13. The Board is satisfied that the Trust effectively implements systems and/or processes to ensure compliance with all applicable legal requirements.

- Constitution review and corresponding suite of governing documents
- Mandatory training approved programme, implementation and monitoring
- Annual reports-Health and Safety; Fire Safety; Safeguarding; Infection Control
- KPIs/Board metrics
- Internal Audit workplan focus, Counter Fraud deterrent activity and reporting
- Standards of Business Conduct; Register of Interests; Sponsorship & Hospitality register
- External Reviews – CPA, JAG, CQC, KPMG/EY/PWC
- Staff & Patient Surveys
- Director of Internal Audit opinion
- CQC Intelligent Monitoring Tool
- Local Security management activity
- BAF key issues reports from Audit Committee
- Trust policies on professional registration Recruitment and Selection and booking of consultants
- Board approved medical staff appraisal policy
- Revalidation reports
- Director of Internal Audit opinion
- Level of overtime payments & agency expenditure monitored
- Infection prevention annual report
- Counter fraud review on pre-employment checks
- Review of SIs, RCAs, link to learning, adherence, improvement

14. The Board is satisfied: that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided

- Self Declarations - Monitor
- Outcome of appraisals
- Nomination and Remuneration Committees approved ToR
- Details of training undertaken by NEDs and EDs
- Induction programme
- Rem committee appraisal when staff leave
- Board skills audit and a succession plan
- Register of interests and standards of business conduct
- Pre-employment checks; contractual conditions regarding other employment
- Constitution - Board composition and work of Remuneration Committee
- QGF process and on-going assessment
- Additional external support for financial planning and cost control

15. The Board is satisfied: that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations

- Approved Quality Strategy

- Quality Accounts – priority development process and monitoring
- Quality for All development, engagement, roll out, implementation monitoring
- Patient Story and follow up to every Board meeting
- QGF – process and on-going assessment
- Board line of sight – walk rounds, IAT, confirm & challenge, Chair/CEO HCA experience
- Confirm and challenge focussing specifically on complaints process – complaints trends and themes to Board
- External assurance (re Quality Account)
- CQC Intelligent Monitoring Tool
- CQC Compliance assessment – IAT, Quality report
- Annual Plan
- Director of Internal Audit Opinion
- Quality impact assessments
- Monthly and Quarterly Quality reports – complaints/surveys themes and trends
- Board dashboard – further work progressing regarding triangulation of eg claims/complaints/incidents
- Clinical Audit plan improvements – time required to understand progress and link to improvements in outcomes of care

16. ***The Board is satisfied: the collection of accurate, comprehensive, timely and up to date information on quality of care, and;***
17. ***The Board is satisfied: that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care***

- External assurance (re Quality Account)
- CQC Intelligent Monitoring Tool
- Annual Plan
- Director of Internal Audit Opinion
- IPR
- IG toolkit compliance reporting
- Clinical audit plan improvements in process
- CQUIN performance reports
- Committee meeting minutes focusing on quality improvement
- Complaints, claims and incidents report
- SUI reporting to Board each month and through committees, robust RCA process with further work commencing to improve learning loop and dissemination of learning
- Board monthly quality dashboard
- Survey outcomes to Board with remedial actions
- Data quality focus increasing – DQ Group, validation, internal audit focus, business analysts, coding, Buddying arrangements etc

18. ***The Board is satisfied: that the Trust including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources***

- Annual Plan – bottom up – divisions, governors, CCG, Council
- Quality for All – engagement, involvement, roll out
- Better Together; quality and performance meetings with CCG, media relations, workstreams
- Friends & family test
- Patient Survey
- Staff Survey
- CQC Intelligent Monitoring Tool
- Board walk rounds, IAT
- COG Forum – independent, influencing agenda CoG and committees
- Governor feedback – PLACE audits, IAT visits etc

- Complaints team reorganisation and improvements in processes and reporting
- Stakeholder mapping – will need to develop stakeholder/marketing strategy; clinical (+GP) summits etc
- Team Brief; iCARE, e-communications – need to progress comms and engagement strategy implementation

19. The Board is satisfied: that there is clear accountability for quality of care the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

- Quality Strategy driving analysis of Trust's performance on key quality metrics
- Direct link to quality improvement through quality accounts and quality strategy
- Nurse staffing reporting mechanisms to Board (Berwick)
- Board walk rounds
- Board approved Committee ToRs – clear responsibilities
- Director of Internal Audit opinion
- Patient surveys
- Staff surveys
- Incidents, complaints and claims report
- Approved Serious Incident process and reporting (May14)
- IPR
- SUI reporting to Board
- Executive job descriptions
- CQC standards reporting – Outcome Guardian work/focus
- Ward dashboards
- Service improvement focus, approved Transformation Strategy
- Risk registers are supported and fed by quality issues captured in Divisional registers – more work to gain confidence of effectiveness of this at service line down to ward level
- TMB escalation protocols re off plan performance/quality
- Service line performance meetings – quality and finance focus – need to progress performance management framework

20. The Board of the Trust effectively implements systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of the NHS provider licence.

- Pre-employment checks
- Self Declarations
- Outcome of appraisals
- Minutes of Nom and Rem committee meetings
- Board approval of composition; Constitution review
- Outcomes from appraisals and revalidation
- Appraisal / feedback process
- HR policies and procedures
- Medical revalidation and appraisal process
- Keogh nurse staffing review, monitoring of nursing numbers
- Understanding of incidents reported concerning staffing numbers