NHS Improvement self-certification 2017/18

1 Introduction

As an authorised Foundation Trust the Board needs to be confident that robust arrangements are in place to ensure:

1) Compliance with the NHS Improvement Licence; and

2) Compliance with the requirements of NHS Improvement's *Single Oversight Framework*.

2 2017/18 Certifications

As part of the Annual Planning process for 2017/18 the Trust is required to submit the following certifications to NHS Improvement by 30 June:

- Corporate Governance Statement;
- Joint Ventures and Academic Health Science Centre; and
- Training of Governors.

Certifications against the 'Licence General Condition 6 (systems for compliance with Licence conditions)' were approved by the Board in May.

3 30 June certifications

3.1 Corporate Governance Statement

The Trust is required to certify against six statements. Appendix 1 provides these statements and the risk and mitigation actions against each of these.

3.2 Joint Ventures and Academic Health Science Centre

This certification is not applicable to the Trust.

3.3 Training of Governors

The Board must certify that during the year it has provided the necessary training to its Governors as required by s151(5) of the Health and Social Care Act.

Regular dialogue is maintained with Governors on the types of briefing and information sessions required. In 2016/17 this has included sessions on the staff survey results, Business planning, Sustainability and Transformation Plans, and Quality Account.

In November 2016 the Trust organised an in-depth induction day covering information on Foundation Trust governance arrangements and its core business.

4 Recommendation

The Board is recommended to approve the proposed self-certifications

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Appendix I - Corporate Governance Statement:

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Statement	Risks and mitigating actions
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.	**Risk: Failure to adhere to accepted standards of corporate governance and/or best practice.** **Mitigating actions:** Compliance with NHS Foundation Trust Code of Governance: Compliance against all aspects presented to Audit Committee in May 2017. The Trust's Standing Orders require that a register of director's governors' interest is in place and kept up to date. There are no material conflicts of interest in the Board. All governors elections and by elections held in accordance with model election rules.
2. The Board has regard to such guidance on good corporate governance as may be issued by NHSI from time to time.	**Risk**: **Non-compliance with NHS Foundation Trust Code of Governance and other governance guidance issued by the regulator.** **Mitigating actions:** Compliance with NHS Improvement's (NHSI) Single Oversight Framework A briefing on the proposed Single Oversight Framework was provided to Board in July 2016. Subsequently, a paper went to Board in September 2016 providing a short update on the changes following consultation, detailing any resultant impact on ASPH. The paper summarised the approach NHSI will take in overseeing providers using a Single Oversight Framework (SOF) for both NHS trusts and foundation trusts and shaping the support they provide.
3. The Board is satisfied that the Trust implements: (a) Effective board and committee structures;	**Risk: Ineffective Board and Committee structures in place which are not reviewed and updated. Unclear reporting lines.** **Mitigating actions:**

(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	The Trust has seven Board committees (Audit, Finance, Quality & Performance (QPC), Nominations, Remuneration, Charitable Funds and Workforce and Organisational Development). All are chaired by a Non-Executive Director (NED) with more than one NED in attendance. The Trust Executive Committee is not a formal sub-committee of the Board but its membership contains the Executive Directors, Divisional Directors, Associate Directors, Divisional Chief Nurses, and the Chief of Patient Safety, and is chaired by the Chief Executive. Terms of Reference are in place for all Board and other committees and groups within the Trust which are reviewed on an annual basis. The Scheme of Delegation, Standing Financial Instructions is due for review in October 2017 and the Standing Orders were reviewed and approved in March 2017. Approved Committee minutes are presented to the Board. Annual Governance Statement in place which identifies areas of potential risk and mitigating actions.
4. The Board is satisfied that the Trust effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (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; (d) For effective financial decision-making, management and control (including but not restricted to	**Risk: Lack of systems to assess compliance with Licensing requirements.** **Mitigating actions:** Monthly Finance Management Committee review of Trust financial performance and position. May 2017 certification against Licence condition 6 (General Conditions) approved by Board. Quality and Risk Management Strategy developed in 2012. Reviewed annually. Datix risk management system in place. Board Assurance Framework and Trust Risk Register reviewed quarterly by QPC and Board. The Trust Risk Register is also reviewed monthly at the Trust Executive Committee. Targeted internal audit reviews overseen by the Audit Committee. The trust was inspected in February 2017 and retains its good rating. The trust has no conditions from the CQC upon its registration. The Trust has a process for the completion of in-year and annual returns to NHS Improvement.

appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) 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; and (h) To ensure compliance with all applicable legal requirements.	Data is compiled from source records and validated where applicable by specialists from Finance and Information, Business Development, and Corporate Quality. Regular assessment against the CQC framework is via the Regulations Gap Analysis and the Domains in Clinical Practice Audit. The External Agencies report to QPC summarises key external assessments and the action plan status. An independent review of governance arrangements undertaken in late 2016 against NHSI's Well-Led Governance Framework reported the following key findings: • Quality-focused organisation under the leadership of a competent, cohesive and visible Board consisting of a stable Executive Director team and a relatively new but impactful Non-Executive Director team; • An active commitment to seek patient and staff feedback to improve services, including investment in iWantGreatCare, which will provide patient feedback directly to individual staff and provide qualitative and quantitative data to demonstrate improvements; and • A clear and widely known approach to quality improvement that encourages staff to be innovative and empowered to make changes. This is a strong endorsement however there were some key recommendations and we have implemented a trust wide action plan to address the areas for improvement. Contracts for services agreed with both NHS England and clinical commissioning groups. Quarterly report to Board on progress against Strategic Objectives. Counter Fraud specialist appointed - report to the Audit Committee.
5. The Board is satisfied that the systems and/or processes referred to in paragraph 4 should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely	**Risk: Lack of capability to provide effective organisational leadership on the quality of care provided.** **Mitigating actions:** The Trust has a Medical Director (MD) and Chief Nurse (CN) on the Board. Both are appropriately professionally qualified and accountable to their professional body. Chief of Patient Safety appointed in 2013/14 who attends Board quarterly to present the Trust Risk Register. The NEDs individually bring extensive experience and expertise from many different areas of private

and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) 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; and (f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	and public sector activity. Collectively, the NED component of the Board is suitably qualified to discharge its functions. The Balanced Scorecard, Performance and Quality Report provide timely and up to date information on relevant metrics and indicators of good quality of care. The Board are actively engaged in the quality of care provided. The Quality & Performance Committee (QPC) is chaired by a NED with attendance from three other NEDs. Membership of the Committee includes the Chief Executive, Medical Director, Chief Nurse, Directors of Operations and Director of Workforce Transformation alongside the Chief of Patient Safety, Associate Director of Quality and Assistant Director of Regulation and Improvement. The Quality Governance Committee, Risk Scrutiny Committee and Patient Experience Monitoring Group report into QPC. Consideration of the board committee structure including the need for more focus on patient experience is currently being undertaken in response to the Well Led Review recommendations. The Governors Patient Experience Group is attended by the Chief of Patient Safety, Associate Director of Quality and Head of Patient Experience and Involvement. Executive walkabouts undertaken.
6. The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Risk: Appointment of inexperienced board directors and senior staff and insufficient staff to comply with conditions of licence.** **Mitigating actions:** The Medical Director, Chief Nurse and Director of Finance and Information are all appropriately professionally qualified and accountable to their professional body. The interview panels for Executive and Non-Executive Director appointments include external assessors. All appointments are subject to the necessary checks of qualification, professional registration (where applicable), references and induction arrangements. Collective & individual skill-sets reviewed as part of board development.

	Appraisals including Personal Development Plans (PDPs) for Executive Directors are carried out by the Chief Executive, and in the case of the Chief Executive, by the Chairman and are reviewed by the Remuneration Committee. The appraisals of Non-Executive Directors are conducted by the Chairman, and in the case of the Chairman, by the Senior Independent Director, and endorsed by the Governors Remuneration and Appraisal Committee and reported to the Council of Governors. NEDs have been appointed by the Council of Governors – recommended by the Governors' Nominations and Appointments Committee which is Chaired by the Chairman of the Trust. Prior to appointments/re-appointments the Committee will have reviewed the skills mix of the Board to ensure there is an appropriate mix. All Non-Executive Directors are recruited in accordance with the Non-Executive Director Recruitment and Selection Policy. Board training and development provided by way of regular 'masterclass' sessions. NEDs attend relevant external courses and networking sessions. Nursing levels on wards reported to Board in accordance with 'safer staffing' requirements.