EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS MEETING - 27 JUNE 2014**
SUBJECT:	**CORPORATE GOVERNANCE STATEMENT: MONITOR DECLARATION**
REPORT FROM:	**TRUST SECRETARY**
PURPOSE:	**Decision**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

The purpose of the Corporate Governance Statement (Previously known as the Board Statement of Self-certification) is a requirement of NHS foundation trust licence condition 4 (NHS Foundation Trust Governance Arrangements). NHS foundation trusts must submit a Corporate Governance Statement within three months of the end of each financial year. The governance condition requires boards to confirm:

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

Where the corporate governance statement indicates risks to compliance with the governance condition, Monitor will consider whether any actions or other assurance is required at the time of the statement or whether it is more appropriate to maintain a watching brief.

Additionally there are two other declarations in relation to the effect on the Trust if they are in, or considering entering into a major joint venture with an Academic Health Science Centre (AHSC); and that the Trust has met its obligations in relation to training as set out in the Health and Social Care Act s.151(5)

SUMMARY:

Corporate Governance Statement

Appendix D of Monitor's Risk Assessment Framework provides the text of the statements the Board is required to make as part of its Annual Plan submission. These have been extracted into the attached table. The statements are concerned with clinical quality, finance, governance and Board capability.

The Statement has been produced by the relevant Executive Directors and has been reviewed by the Executive Team at Corporate Performance Management Team meetings and by the IAGC on 20 May 2014 and 12 June 2014. At the IACG meeting it was agreed that the evidence was sufficient to allow the Board to sign the declaration.

The Corporate Governance Statement is attached for reference and Board is asked to note that the statement is not submitted to Monitor; Appendix 2 is the Monitor Declaration which is submitted to Monitor and made available to the public.

The risk relating to the CQC visit was discussed at the IAGC meeting and recommended that it would be prudent to note it but not for it to impact on the response (Q1c).

Other Certifications

The Trust is not in a major joint venture / partnership with an AHSC nor does it intend on entering into one and so the Trust can answer "confirmed".

In terms of governor training the evidence for compliance with s.151(5) HSCA is as follows:

- All governors follow a prescribed and comprehensive induction programme;
- Each Council of Governors meeting has a Part 2 which always includes an element of learning about specific parts of the Trusts business; and
- Two governors have the opportunity to attend the Foundation Trust Governor's Association training when advertised and those that attend feedback to the whole Council to disseminate the leaning.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:
A number of statements reflect progress and achievement against strategic objectives.

FINANCIAL IMPLICATIONS:
No financial resource implications but provides evidence around the governance for financial reporting and financial governance.

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:
The Corporate Governance Statement reflects compliance with licence the Trust's arrangements - licence condition 4 (NHS Foundation Trust Governance Arrangements).

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES
None

BOARD ACTION REQUIRED:

In relation to the Corporate Governance Statement and on recommendation of the Integrated Audit and Governance Committee

(a) The Board is asked is asked to review the evidence (Appendix 1) and determine whether the Trust should declare compliance ('yes' or 'no') against each individual statement for 2014/15 (Appendix 2). On the basis of the IAGC's discussion in May and June 2014 the risks discussed and mitigated have been included.

In relation to the other certifications:

(a) The Board is asked to review the evidence asset out above in relation to joint ventures with AHSC's and governor training and determine whether the Trust should declare compliance ('yes' or 'no') against each individual statement for 2014/15 (Appendix 2).

CONSEQUENCES OF NOT TAKING ACTION:
Failure of the Trust to take the necessary consideration when completing the corporate governance process may lead to regulatory action.

APPENDIX 1: CORPORATE GOVERNANCE STATEMENT 2014/15

	MONITOR STATEMENT	SUPPORTING EVIDENCE	CONFIRMED YES/NO+ TEXT
1	The Board is satisfied that East Kent Hospitals University NHS Foundation 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.	*a) compliance with the Licensee's duty to operate efficiently, economically and effectively;* Internal Audit regularly conducts Value for Money (VFM) exercises effectively testing the impact of investment through Service developments (approved Business Cases) which are reported back to the Strategic Investment Group (SIG). A Benefits Realisation Group (a sub-group of the SIG) also meets monthly to discuss smaller scale investments discussing the successes and pitfalls of implementation and identifying lessons learnt for future proposals. Cost Improvement Schemes (CIP) are drafted, quality assured, signed off by Clinical service leads, implemented and subsequently tested through a monthly CIP Delivery Review at the Finance & Investment committee. The Trust follows a robust Procurement process ensuring value for money is sourced through Whole-Life-Costing comparisons and use of relevant commercial framework agreements. *b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations;* The Board has an annual plan of its business which includes a number of standing items that include a detailed review of the metrics and financial statements that make up the Trusts Governance and Financial Ratings. A governance structure supports the Board and ensures reporting lines allow for timely flow of relevant information in relation to the Trust's operations. The Board and its	CONFIRMED (c)The Trust has participated in the new Care Quality Commission's inspection regime during March 2014. The results of this inspection are awaited; however, the Trust is fully compliant against the 16 standards of quality and safety relevant to the organisation.

		Committees undertake an annual review of their effectiveness against the terms of reference, which are also reviewed annually, and where appropriate actions are agreed to improve the Board / Committee effectiveness. The Constitution, Standing Orders and Standing Financial Instructions (which include the terms of reference of the committees) provide an effective system of control. In addition an escalation framework is in place to ensure that any operational performance not in line with expected resulted is escalated within the governance structure. In addition to the mandated committees the Trust has a Finance and Investment Committee and a NED Governance Committee that specifically looks at a number quality performance indicators that have been identified internally as a risk. *c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the SoS, the CQC, the NHS Commissioning Board and statutory regulators of health care professions;* The Trust reviews compliance against health care standards through a number of corporate committees including the Risk Management and Governance Group (RMGG), the Clinical Management Board (CMB) and the Integrated Audit and Governance Committee (IAGC). Responsibilities for clinical standards which relate to Laboratory Medicine, including MHRA compliance for blood products, fall under the auspices of the Clinical Support Services Division for monitoring and reporting regulatory compliance. Similarly, endoscopy accreditation under the Joint Advisory Group (JAG) falls under the responsibility to the Urgent Care and Long-Term Conditions Division. There is a clear governance process for reporting into the	

		corporate quality meetings, as well as those at the relevant divisional level. The results of any external visit to the Trust or a peer review are reported to RMGG and the IAGC six-monthly, where any outstanding actions are monitored against the target date for completion. *d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and / or processes to ensure the Licensee's ability to continue as a going concern);* All Trust investment proposals are approved through a Business Case approval structure involving several Groups and escalation is dependent on the materiality or nature of the proposal. A Board approved Benefits Scoring Model is used to both prioritise competing proposals and assess the impact of options in terms of quality, financial and strategic impact. Cash flow projections against plan are presented to the Finance & Investment Committee on a quarterly basis for review, comment and action if required. Internal Audits have been undertaken in the past two years assessing the processes in place for both investment decisions (capital) and reviewing the processes in Financial Services. External Audit also review the annual accounts. *e) The Trust has a governance structure in place through which it obtains and disseminates accurate, comprehensive, timely and up to date information for Board and Committee decision-making;* Within the Information team there is a strict governance process around how data is collected and recorded. Alongside the Informatics team,	

		there is a Clinical Information Systems which controls all software containing patient data, importantly this team sets all standards for data dictionaries and recording conventions so that there is consistency through all reporting. In addition, there is a concept of a watermark ie that all data leaving the Trust has to be approved by the Head of Information. This creates assurance around external reporting. Each month, the Corporate Performance and Management Team and Financial Investment Committee receive data packs which then go forward to the Board of Directors'. The corporate team then appraise each of the division's performance in a monthly Executive Performance Review there is a signed off Operational Framework which covers the workings of this and the penalties and rewards. In addition, weekly and daily reports are provided on A&E performance, activity versus plan and measures of patient safety. *f) to identify and manage material risks to compliance with the Conditions of its Licence*; The Trust has a comprehensive Risk Management Strategy, which sets out the overall vision and intention for the management of risk across the organisation. The strategy details the responsibility of the Board of Directors for the effective control of integrated governance corporately. Delegated authority is given by the Board of Directors to the IAGC for monitoring and receiving assurance on the effective management of risk. The existing Risk Management Strategy was reviewed by the RMGG and IAGC and approved by the Trust Board in November 2013. The key elements of the strategy continue to include the purpose of risk management, the authority of managers regarding the management of risk, the process of risk	

		management, assurance, training and monitoring. The strategy also describes the responsibilities of all staff including risk assessment and risk reporting, as well as communicating the Board of Director's attitude to risk, which is essential if decision-making is to be successful. Through the strategy this is made clear and is consistent with the strategic objectives for the Trust. Risk appetite is a series of boundaries, which are authorised by the Board and by delegated authority, which guide all staff on the limits of risk they can take. In line with British Standard BS31100, the Trust is committed to not taking risks that affect the quality of care and the experience of every person accessing our services. To ensure that the FT is better able to manage risks which may impact on public stakeholders and is providing an effective service, there is comprehensive communication and engagement, at a service and organisational level, with patients, members of the public, governors and voluntary and community organisations. *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;* The Trust Annual Plan is developed involving all key stakeholders following the principles of its' licence and subsequent guidance issued by external regulators. The Plan is approved at Board level following detailed review by the Finance & Investment committee, Council of Governors and the Corporate Performance Management teams. Through its Performance Management Framework, the Trust monitors performance against plan every month through:	

		Executive Performance Reviews (Division specific); Corporate Performance Management Team; Finance & Investment committee (thorough review of the Trust Corporate Performance Report and Balanced Scorecard). *h) to ensure compliance with all applicable legal requirements.* The Trust holds a list of legal requirements that includes Health & Safety, Financial, Patient Safety, and Information Governance which is reviewed annually and signed off by the Executive Director responsible. This provides assurance that the Trust complies will all applicable legislation and regulation.	
2	The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time	The Trust Secretariat reviews Monitor guidance to ensure the Board is fully aware and up to date with what is required. In particular the Trust undertakes a review of compliance with Monitor's Code of Governance on an annual basis with the output forming part of the Annual Report.	CONFIRMED
3	The Board is satisfied that East Kent Hospitals University NHS Foundation implements: (a) effective board and committee structures; (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.	All Board Committee's Terms of Reference are reviewed on an annual basis to ensure that there are clear lines of reporting and clear responsibilities. The agenda planning in undertaken by the central Secretariat team in conjunction with the various chairs. In addition the Secretariat Team attends all Board and committee meetings and provides a singular link that ensures flow through the governance structure. Board and Executive Committees review their effectiveness on an annual basis. This takes the form of a survey with questions relating to the terms of reference of the individual committee and whether the member believes that the committee has discharged its duty. These surveys are reviewed by the Chair of the committee and the lead	CONFIRMED

		executive director who develop a draft action plan to be discussed by the full committee. The Committee structure is mapped out to provide a clear picture of information flows from ward to board. The terms of reference clearly show the reporting lines between committees and minutes and annual reports are received by the committee that the sub-committee reports to.	
4	The Board is satisfied: (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 and appropriate account of quality of care considerations;	The Trust has a robust appraisal system for both non-executive and executive directors. The appraisal process for non-executive directors is led by the Chairman with the Council of Governors and for the Chairman the process is led by the Senior Independent Director. The Chief Executive appraises the executive directors and discusses the outputs at the Remuneration Committee. The two Nomination Committee's review the skill mix every time an appointment is required but will do so in any case on an annual basis. The Chief Nurse and Director of Quality and Operations submits a monthly report on Clinical Quality and Patient Safety to the Board of Directors. This report aligns with the three-year Quality Strategy and the Strategic and Annual Objectives; quality of care is embedded across all areas and reviewed at each planning stage. All business case submissions to the SIG formally take account of any possible impact on the quality of care provided. Business cases are also risk assessed for their impact on quality. Similarly, CIPs are assessed in order to provide the necessary assurance regarding any possible adverse impact on the quality of care provided.	CONFIRMED

	(c) the collection of accurate, comprehensive, timely and up to date information on quality of care;	Within the Information team there is a clear assurance process making sure that data is recorded and signed off and is auditable. In the collection of all key statutory and internal metrics all reasons for any validation are recorded in trust core systems such as the patient administration system so that review can be undertaken at any time. All trust data is available in as near real-time as possible so that validation and operational decisions can be made more quickly.	
	(d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;	There is a clear patient safety governance structure corporately and in each of the divisions. A Patient Safety Board takes place each month and the Chief Nurse and Director of Quality and Operations takes a Clinical Quality and Patient Safety report to the board each month. In the divisions there is a corresponding structure led by the Divisional Heads of Nursing.	
	(e) that East Kent Hospitals University NHS Foundation NHS 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	There is a Public Patient Engagement Strategy that sets out the way the Trust engages and listens to its users. This is led by the Head of Equality and Engagement. The Trust has a strategy described in its values that welcomes feedback from patients, staff and other relevant stakeholders. These comprise a policy that describes how a person may make a formal complaint or raise a concern or give a compliment. All concerns and complaints are fully investigated and responded to with action plans in place and learning shared via the Risk Management and	

		Governance Group and also at Divisional level via their Governance processes. The Trust also welcomes feedback via NHS Choices, Patients Opinion, Inpatient real-time Meridian surveys and the Friends and Family Test. This feedback is also reviewed and acted upon. There is also in place a Patient and Staff Experience Committee which sets its annual workplan and is chaired by a Governor. Staff are encouraged to feedback to the Board of Directors via the 'Meet the Director' sessions, 'Walk the Floor' sessions, attend the Board of Directors meeting where the agenda sets a different topic for discussion and listening every month. The We Care Programme, a cultural change piece, is being rolled out and invites the views of staff and patients through its events. The inpatient and staff surveys are also a valuable means of engaging. The Trust also invites staff to comment via its Twitter site, Yammer site and blog.	
	(f) that there is clear accountability for quality of care throughout East Kent Hospitals University NHS Foundation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	The Board of Directors approved the three-year Quality Strategy in May 2012; this strategy articulates the accountability for quality across all levels of the organisation. Executive responsibility for quality rests with the Chief Nurse and Director of Quality and Operations. There is a quarterly report on progress against the annual quality goals and an annual report to the Board of Directors. The divisions are responsible for the delivery of their quality and patient safety plans; progress is monitored via the Patient Safety Board (PSB) and by RMGG. There is also a six-monthly presentation to the joint IAGC/FIC meeting where progress against plan is assessed and any gaps identified for further action. Any risk to the provision of quality and safety is escalated using the process within the Risk Management Strategy,	

		which is via the Trust's governance committee structure. There is flexibility to escalate a significant quality issue directly to the Executive team. This ensures that a timely response to a significant emergent quality risk of managed in a timely way.	
5	The Board of East Kent Hospitals University NHS Foundation effectively implements systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licence holder's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.	<u>Nominations and Remuneration Committee of the Council of Governors</u> Nominations and Remuneration Committee of the Council of Governors review the size, structure and composition of Non-Executive Directors and Chair. The Terms of Reference have been amended to formalise the new requirement for the Nominations Committee to evaluate, at least annually, the balance of skills, knowledge and experience of the Non-Executive Directors. <u>Nominations Committee of the Board of Directors</u> A Nominations Committee of the Board of Directors is in place. The Terms of Reference have been amended to reflect the new requirement for the Nominations Committee to evaluate, at least annually, the balance of skills, knowledge and experience on the Board of Directors. Additionally the Board and its Committees, as well as the Executive Committees, review performance information including Complaints, Incidents and Claims to determine whether resources are insufficient to provide sufficient duty of care. Consideration of appropriate workforce metrics also provides assurance.	CONFIRMED