Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

TRUST BOARD
25th June 2015

TITLE	**Monitor self-certification 2015/16**
EXECUTIVE SUMMARY	As part of the Annual Plan Review process 2015/16 the Board are required to submit two self-certification documents to Monitor. This paper details the second of these certifications which is due by 30th June.
BOARD ASSURANCE (RISK)/ IMPLICATIONS	Submission of the Annual Plan and associated certifications is a fundamental principle of the Trust's Licence. The Board needs to be confident that the certifications are accurate and underpinned by robust evidence.
LINK TO STRATEGIC OBJECTIVE/BAF	Links to all Strategic Objectives.
STAKEHOLDER/ PATIENT IMPACT AND VIEWS	Not relevant
EQUALITY AND DIVERSITY ISSUES	None known
LEGAL ISSUES	The Health and Social Care Act 2012 requires the Trust to submit its Annual Plan to the regulator.
The Board is asked to:	Discuss and agree the certifications.
Submitted by:	George Roe, Head of Corporate Affairs
Date:	18th June 2015
Decision:	For Approval

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

Monitor self-certification 2015/16

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 Monitor Licence; and

2) Compliance with the requirements of Monitor's *Risk* Assessment *Framework*.

2 2015/16 Certifications

As part of the Annual Planning process for 2015/16 the Trust are required to submit the following certifications to Monitor by 30th 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)' and 'Continuity of Services Condition 7 – Availability of Resources' were approved by the Board in May and submitted to Monitor.

3 30th 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 2014/15 this has included sessions on the staff survey results, Information Technology in the Trust, Business planning, Outpatients and progress with merging with the Royal Surrey County Hospital (RSCH).

In April 2014 the Trust participated in a joint training event, facilitated by the FTN, with Governors from four other FTs.

In November 2014 the Trust arranged a training event facilitated by DAC Beachcroft and Ernst & Young to discuss the role of the Governor with particular focus on the proposed merger with RSCH.

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 Monitor's Code of Governance for Foundation Trusts: Compliance against all aspects presented to Audit Committee in May 2015. 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 Monitor from time to time.	**Risk**: **Non-compliance with Monitor's Code of Governance for Foundation Trusts and other governance guidance issued by the regulator.** **Mitigating actions:** Compliance with Monitor's Code of Governance for Foundation Trusts: Compliance against all aspects presented to Audit Committee in May 2015. Risk Assessment Framework (RAF) briefing provided to Board in 2013 when new RAF was introduced. Minimal changes to the Framework since this time.
3. The Board is satisfied that the Trust 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.	**Risk: Ineffective Board and Committee structures in place which are not reviewed and updated. Unclear reporting lines.** **Mitigating actions:** The Trust has eight Board committees (Audit, Finance, Integrated Assurance and Governance (IGAC), Nominations, Remuneration, Strategy, 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 memberships contains the Executive Directors, Divisional Directors and Associate Directors and the Chief of Patient Safety. This is chaired by the Chief Executive.

	Terms of Reference 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 and Standing Orders are reviewed on an annual basis (last approved by Board in May 2014 and to be presented for approval at June 2015 meeting). 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 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;	**Risk: Lack of systems to assess compliance with Licensing requirements.** **Mitigating actions:** Monthly Finance Committee review of Trust financial performance and position. Finance Committee reviews Monitor declarations against Licence condition 7 (Continuity of Service). May 2015 certification against Licence condition 6 (General Conditions) and 7 (Continuity of Service) 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 IGAC and Board. Targeted internal audit reviews overseen by the Audit Committee. CQC Compliance in Practice. CQC planned inspection in December 2014 led to a 'Good' rating for the Trust. Inpatient surveys reviewed and acted upon. 2014 survey did not demonstrate significant concerns. Compliance with NHSLA and CNST risk management standards. 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 (previously Gateway Assure, now TIAA) who report to the Audit Committee. Fraud training provided to the Board in May 2014.

(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.	
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 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.	**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 public sector activity. Collectively, the NED component of the Board is suitably qualified to discharge its functions. The Balanced Scorecard, Performance and Quality Report provides 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 IGAC is chaired by a NED with attendance from two other NEDs. Membership of the Committee includes all the Executive Directors alongside the Chief of Patient Safety and Associate Director of Quality. The Quality Governance Committee, Risk Scrutiny Committee and Patient Experience Monitoring Group reports into IGAC. A NED regularly attends the Trust Patient Panel. The Governors Patient Experience Group is attended by the Chief of Patient Safety, Associate Director of Quality and Head of Patient Experience and Involvement. Board and 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 all 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 monthly 'masterclass' sessions. NEDs attend relevant external courses and networking sessions. Nursing levels on wards reported to Board in accordance with 'safer staffing' requirements.