Worksheet "FT4 declaration" | **Financial Year to which self-certification relates** | **2018/19** | Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee 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.	Confirmed	The Trust has remained in quality Special Measures throughout the year. The Trust has currently no conditions/warning notices in place. The Trust commissioned an independent external review of the Corporate Governance Board systems in October 2018 by Deloittes. An action plan has been put into place to address the recommendations identified in the review and monitored by a task and finish group consisting of non-executive and executive directors.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	NHSI guidance is reviewed by the Executive team and where appropriate brought to the attention of the Board. The Trust Management Executive also receives all guidance. A non-executive director has been identified to oversee and support governance development within the Trust.
3	The Board is satisfied that the Licensee has established and 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.	Confirmed	a&b. The Board Committees met regularly and report to each Board meeting. All terms of reference have been revised and approved by the Board during the year. The relevant risks within the Board Assurance Framework are reviewed by each Committee and changes approved by the Board. The Audit and Assurance Committee reviews the processes for the management of the BAF. The terms of reference for the Risk Management Group were revised during the year and meet monthly, chaired by the Chief Nurse. We commissioned a governance review from Deloitee to review Board and Board Committee governance arrangements and the Trust is currently acting upon the key findings and recommendations. c. Governance below the level of Committees was reviewed by the Interim Director of Governance in 2017/18 and is currently under review by the Trust NHS I Improvement Director in conjunction with our Chief Nurse and Company Secretary, overseen by an Associate NED. Once this review has been undertaken, an action plan will be developed to address any identified gaps.
4	The Board is satisfied that the Licensee has established and 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; (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.	Not confirmed	a&b. The Trust Management Executive (TME) (January 2019) meets monthly to oversee the operational business of the Trust. The Board Committees meet monthly (Finance and Performance, Quality Governance) and People and Culture meets bimonthly. The Board meets monthly (not August) and has a forward plan for business. At each meeting reports are given on quality, financial and workforce strategy and performance management. We remain in quality special measures and in enhanced oversight for finance. We are subject to monthly NHSI led quality system-wide oversight meetings and monthly NHSI led performance review meetings. We have a confirmed CQC inspection in quarter 1 of 2019/20. This will include an inspection of a number of core services, well led and use of resources. Action plans will be developed to address any 'must' and 'should do's' arising from this inspection. c. Whilst we are currently not compliant with all relevant standards, the Quality Governance Committee and Finance and Performance Committee and the TME meet monthly and receive detailed quality, performance and financial information including compliance with relevant standards. We have recently agreed the business objectives for 2019/20 and these have been reflected in the personal objectives of Executive Directors for which they will be held to account for delivering by the CEO and reported to the Remuneration Committee. The Trust holds monthly performance review meetings with all clinical divisions and corporate directorates in 2019/20. A non-executive director has been identified to support recovery of the urgent and elective performance. Launch of the Quality improvement Strategy – monitoring of must and should do's through the RAIT process. d. The Finance and Performance Committee meets monthly to receive assurance on financial performance and reports back to each Board meeting. The Trust Management Executive also meets monthly to review financial performance and monitor performance of the cost improvement programme. The revised control total was negotiated in-year (2018/19), in recognition of a deteriorating financial situation and was subsequently not achieved. The Trust remains subject to enhanced financial oversight. e. The Trust has achieved improvements in the accuracy, capture and flow of information. The staff have access real time information through locally developed systems (WREN and SQUID). The Trust is currently developing a Digital Strategy (to be approved by the Board in June 2019), to further strengthen data quality and information reporting and achieve the NHS long term plan ambition of paperless by 2024. A comprehensive action plan to facilitate implementation of the strategy will be developed and a Chief Digital Officer is currently being recruited to. The Quality Governance Committee uses performance data to inform its decision-making process. The Finance and Performance Committee scrutinise the performance dashboards and financial performance reports monthly. The People and Culture Committee has a bespoke dashboard which is reviewed at every meeting. f. The Board Assurance Framework (BAF) was reviewed during the year and is considered four times a year by the Board. We have recently reviewed the risk appetite for the organisation and this will be cascaded throughout the organisation during 2019/20. The relevant risks are considered by Board Committees at each meeting. The BAF is being revised in the first quarter, 2019/20 to be aligned to the Trust Strategy. g. Whilst we have a business case process in place, we are seeking to strengthen this in 2019/20 particularly in relation to the quality impact assessments. Annual business cycle under review to strengthen linked to service reviews. Clinical services strategy in development. h. The Trust was registered with the CQC during the year 2018/19.

5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) 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 Licensee, 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 Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Not confirmed	a. The Quality Governance Committee (QGC) oversees all aspects of quality within the trust. This meets monthly and escalates via a written report to each Board meeting. The Chief Nurse and Chief Medical Officer are the executive directors accountable for quality within the organisation and both posts were filled substantively throughout the year. A non-executive director has been identified to provide leadership with respect to learning from deaths. He is also the Chair of the Quality Governance Committee. b. The Board has an annual plan of business which incorporates regular updates on quality and performance and the statutory annual reports are presented to the Board (e.g. safeguarding, quality account, annual report, local security management service). We have suitable standing financial instructions (including scheme of delegation) and standing orders which govern decision making of the Board. Quality Impact Assessments are undertaken for all changes in services and are signed off by the Chief Nurse and Chief Medical Officer and are reported to the TME and a six monthly assurance report is provided to QGC. Any QIAs not signed off are escalated immediately to the QGC and then to Trust board. c. The majority of information is collected electronically within the Trust with only small number of data collection remaining paper based. We have built real time information systems for staff to utilise in their day to day activities (WREN and SQUID) to support operational and performance management. The Digital Strategy (due for Board approval in June 2019) will seek to further improve data quality and strengthen information reporting and achieve the NHS long term plan ambition of paperless by 2024. A comprehensive action plan to facilitate implementation of the strategy will be developed and a Chief Digital Officer is currently being recruited to. Monthly performance review meetings with divisions. d. QGC considers quality performance data at each of its meetings. This is then reported to the Board via the written report from QGC and the integrated performance report. The Board considers the integrated performance report at each meeting. The implementation of the Digital Strategy will further improve all aspects of quality information presented to the board. e. The Board receives a patient story or equivalent at each Board meeting and receives updates via the QGC report on the Quality Improvement Strategy and associated plans (including the Patient, Carer and Community Plan) which were approved at its March 2018 meeting and are currently being refreshed. Patient representatives attend the QGC meeting and participate in ward visits. HealthWatch also attends QGC. A Youth Forum is currently being set up. We regularly attend the Health Overview and Scrutiny Committee. The Quality Oversight Group is attended by the HealthWatch and Clinical Governance Group. f. The Chief Nurse is the executive director responsible for quality and is very visible and accessible to staff members. This was recently endorsed by an external report undertaken as part of the preparations for the Well Led inspection. Through the performance review meetings the divisions are held to account for the quality of care within the Trust. Each division reports monthly to the Clinical Governance Group which in turn provides a report to the Trust Management Executive and for assurance, to the Quality Governance Committee which reports to the Board at every meeting.
6	The Board is satisfied that there are systems to ensure that the Licensee 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.	Not confirmed	The Board had one vacancy (Chief Finance Officer) as at 31 March 2019 which was filled with an interim position. The substantive post is currently being recruited to. All Board members have undertaken the Fit and Proper Person Test. We are reliant on bank and agency staff to maintain safe staffing levels and whilst we are able to recruit to permanent positions, we need to improve the retention of staff. We have recently implemented a suite of HR modules which will improve the management of our rotas and annual leave. We continue to work with Health Education England in respect of doctors in training and the development of our strategy will improve recruitment to consultant posts. We are also exploring the appointment of clinical fellowships. These initiatives are being overseen by the People and Culture Committee through the monitoring of the People and Culture Strategy.

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature  **gnature** 

Name Sir David Nicholson **Name** Matthew Hopkins

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Please Respond