St George's Healthcare NHS
NHS Trust

Board Governance Statements for Self Certification

This document sets out compliance with the Monitor Board Statements as detailed in the document *Applying for NHS Foundation Trust Status: A Guide for Applicants (October 2013).* It has been annotated to provide a description of the assurances considered when completing the Trust's self-certification; it does not set out to provide a complete list of evidence. This statement is required to be submitted to Monitor following Trust Board approval in July 2014.

The assurances and statements of compliance are correct as at July 2014.

The Board is asked to consider the evidence presented for each statement, and confirm whether they agree with the proposed self-certification, or require any revisions to be made prior to approval and submission to Monitor.

Peter Jenkinson
Director of Corporate Affairs

24th July 2014

1	**The board is satisfied that plans in place are sufficient to ensure on-going compliance with the Care Quality Commission's registration requirements.**	**YES**
	Evidence: 1) The Trust is correctly registered with the Care Quality Commission at each of the locations from which it provides services. 2) A Compliance Framework is in place that ensures divisional-level self-assessment against the CQC Essential Standards of Quality and Safety, including overview by specific sub-committees of the Board, and action on any areas at risk of non-compliance. 3) Internal Audit (London Audit Consortium) completes annual reviews of the Trust's CQC compliance. On each occasion an overall finding of "reasonable assurance" has been presented to the Audit Committee. The overall reasonable assurance level was determined because there is a governance process in place that receives assurances on CQC outcomes at Divisional level and through the Trust's committee structure to the Trust Board, including mitigating action taken in respect of the Trust's Quality and Risk Profile. 4) **Positive Assurance:** The CQC has replaced its Quality Risk Profile with the Intelligent Monitoring Report. The first issue of this report was received in October 2013. This monitors a range of key indicators and places each NHS acute / specialist trust in a risk banding. St George's is placed in band 6, which is the lowest level of risk. As with the previous system of Quality Risk Profiles these reports will be reviewed regularly by the Compliance Unit and a formal report made to the Quality and Risk Committee on its status and any corrective action being taken. A summary report is made to the Trust Board through the Compliance and Risk report. The latest report, published in July 2014, shows no escalated risks for the Trust. 5) **Positive Assurance:** The CQC completed its Chief Inspector of Hospitals assessment in February 2014. The report was published in April 2014 and gave the Trust an overall rating of good, with critical care and maternity services rated as outstanding. 6) **Negative assurance:** The Trust is required to make improvements to two areas assessed by the CQC: availability of notes in out-patient clinics, and training and awareness of staff at QMH re. the Mental Capacity Act. The Trust has developed an action plan which was approved by the Trust Board in May and submitted to the CQC on 31st May. Progress against the plan is monitored by the Quality and Risk Committee, and the Clinical Quality Review Meeting (chaired by commissioners).	

2	**The board is satisfied that processes and procedures are in place to ensure all healthcare professionals providing care on behalf of the trust have met the relevant registration and revalidation requirements.**	**YES**
	Evidence: **Non-Medical Healthcare Professionals** 1) The Recruitment Department and Staff Bank undertake professional registration checks, or ensure that such checks have been undertaken by the supplying temporary staff agency, on all new starters joining the Trust, including temporary staff. This includes NMC, HPC, GDC, HCPC, GPHC. 2) A system is in place that informs the Trust when an employee's professional registration is due to expire. The HR department will then contact the relevant line managers to ensure that these employees are aware that they have to provide documentary evidence of their renewed registration prior to the expiry date or they will not be authorised to work. **Medical Registration** 1) Medical Staffing undertake GMC registration checks on all new doctors joining the Trust. All doctors that are subject to revalidation are required to provide their signed off revalidation plan. 2) A system is in place that informs the Trust should a doctor's GMC registration lapse or have sanctions against it. 3) A Trust policy and procedure is in place for Maintaining High Professional Standards. **Medical Revalidation** 1) An internal system of annual appraisal for doctors is in place. 2) The current appraisal rate (June 2014) is 84.85% of doctors with a recorded appraisal, against the required rate of 85%. This compares favourably with the average of 75.1% of consultants in the acute hospital setting having an appraisal as confirmed in the letter from Sir Bruce Keogh "organisational readiness self-assessment 2012-13 appraisal rates" (25th October 2013). The Trust put in place an action plan to improve the medical appraisal rate, which included the appointment of a Revalidation Support Officer (AFC Band 5) to enable further work to be carried out in this area. The Workforce Committee and Trust Board are regularly briefed on the actions being taken to improve performance, to ensure that the improvement in appraisal rate is sustained. This includes	

	escalation of details of those doctors requiring appraisal to the Divisional Chairs. The Trust Board has also agreed a process defining non-engagement in revalidation, which identifies a process for dealing with doctors who are not complying with the appraisal/revalidation policy and allows for appropriate disciplinary action/notification to the GMC that a doctor is not engaged, and therefore to begin the process for removal of the licence to practice. 3) National revalidation system became live in December 2012**.** Since April 2013 the Trust has revalidated 166 doctors and deferred 33 (for various reasons, maternity leave, career break, etc). A revalidation team led by the Medical Director is managing this process. 4) The Trust's Organisational Readiness Statement of Assessment (ORSA) produced by the Department of Health was rated Green in May 2013. This tests the Trust's preparation for the revalidation process and evaluates the progress made since revalidation was introduced. The Trust is in the process of submitting the Annual Organisational Audit (August 2014), the document which ascertains an organisation's assurance of revalidation on an ongoing basis, including a statement of compliance which requires Board sign-off. The Trust is confident that the rating will continue to be green based on appraisal figures for the Trust and processes in place.	
3	**Issues and concerns raised by external audit and external assessment groups (including reports for the NHS Litigation Authority assessments have been addressed and resolved. Where any issues or concerns are outstanding, the board is confident that there are appropriate action plans in place to address the issues in a timely manner.**	**YES**
	Evidence: 1) The Trust has an established Assurance Map, a schedule of all external visits / inspections which is updated on a regular basis, and all actions arising from external inspections/visits are monitored by the commensurate Trust committee with oversight and scrutiny by the Trust's Quality and Risk Committee. A summary report is provided to the Trust Board. The Assurance Map ensures corporate oversight of all actions arising from statutory and mandatory accreditations/inspections including NHSLA and CQC, as well as assurance that the Trust is appropriately prepared for forthcoming inspections/visits. 2) All audit recommendations, both internal and external, are presented to the Audit Committee and are then entered into an audit tracker. Progress against these recommendations is then monitored by the Corporate Office, with a report on progress being presented to each Audit Committee meeting. The Audit Committee scrutinises the executive response to audit recommendations and the chair of the committee presents a report to the Board after each meeting, reporting any concerns raised by auditors and a judgement on the efficacy of the executive response.	

4	**All recommendations to the Board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned.**	**YES**
	Evidence: 1) All Audit Committee actions are entered onto a tracker that is managed by the Corporate Office. The status of every action on the tracker is reviewed and updated at each meeting. 2) The chair of the audit committee presents a report to the Board following each meeting, including any recommendations. Actions agreed by the Board will be entered into the Board matters arising tracker and progress monitored at the Board meetings.	

5	**The necessary planning, performance management and risk management processes are in place to deliver the integrated business plan, including but not restricted to:** **a) obtaining and disseminating accurate, comprehensive, timely and up-to-date information for board and committee decision-making;** **b) the timely and effective scrutiny and oversight by the board of the trust's operations;** **c) effective financial decision-making, management and control; and** **d) taking appropriate account of quality of care considerations.**	**YES**
	Evidence: **Planning** 1) The Trust has a robust annual business planning cycle, including development of annual corporate objectives and divisional-level business plans. The Board approves the Trust's annual business plan and budget, and reviews progress against the annual objectives on a quarterly basis. 2) The board has scheduled strategy development sessions which have included the review of the Trust strategy and the key supporting strategies. 3) Key stakeholders have been engaged in the development of the integrated business plan through the FT stakeholder steering group. 4) The Trust has a robust system of corporate governance, including Board sub-committees, which provides assurance to the Board on the delivery of the Trust strategy and objectives. The effectiveness of these committees is reviewed on an annual basis. The Trust has also reviewed the effectiveness of its divisional governance model, with actions being taken to strengthen where necessary.	

Performance Management

1) A Performance Management Framework is in place that mirrors Monitor's Risk Assessment Framework. This sets out a standardised corporate framework with clear devolution of responsibilities to the clinical and corporate divisions. A mechanism for escalation and action on poor performance is included.

2) Annual business planning is in place supported by activity planning at specialty level leading to an overall Trust capacity plan. Winter capacity plans are also developed.

Risk Management

1) An analysis of the CQC's Intelligent Monitoring Report has been received by the Trust's Quality and Risk Committee and Trust Board on a regular basis. This includes an explanation of action being taken in areas of concern.

2) The Quality and Risk Committee receives a Risk and Compliance Report every two months, which includes a review of the Board Assurance Framework. This is then received by the Trust Board.

3) A Quality Report is presented to each Trust Board meeting. This is structured to include reports on Patient Safety, Experience and Outcome. This includes an analysis of complaints.

4) A Quality Governance Framework Reassessment was completed by Deloitte in April 2013, with an associated action plan. The Trust undertook a repeat self-assessment against Monitor's Quality Governance Framework which informed the Board Quality Memorandum, presented to the May 2014 Trust Board meeting for review and approval.

5) The Trust Board is notified of all serious incidents on a weekly basis.

6) All actions from serious incidents and complaints are followed up by the divisions and an action plan audit is presented to the Patient Safety Committee for serious incidents and the Patient Experience Committee for complaints, which reports on the completion of actions. Each division reports on serious incidents to the Patient Safety Committee and complaints to the Patient Experience Committee. This reporting includes lessons learned and recommendations.

7) A selection of serious incidents (SI) is reported to the Trust Board through the Quality and Risk Committee. These incidents will have already undergone an SI investigation and are presented in synopsis form with the identified actions.

8) Lessons learnt from Quality and Patient Safety reports are discussed at the Divisional Governance Boards and the

	Patient Safety Committee. In addition, the Head of Patient Safety carries out thematic reviews on a six monthly basis; lessons learnt are shared both at future training but also at all divisional governance meetings. 9) Some investigations are used to create a "patient story" in video form. These videos are made available on the Trust intranet for all staff to view. This creates a powerful representation of the experience of the patient in incidents and complaints. These are included in the Quality Reports presented to the Trust Board. 10) A monthly Clinical Quality Review meeting is held with commissioners.	

6	**An Annual Governance Statement is in place, and the Trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).**	**YES**
	Evidence: 1) An Annual Governance Statement is produced by the Corporate Office and in accordance with all available guidance. 2) The statement includes a description of the Trust's risk management and assurance frameworks. 3) It is reviewed by our External Auditors and presented to the Audit Committee as part of the Trust's annual accounts before receiving sign-off by the Trust Board. The 2013-14 Annual Governance Statement was approved by the Board in June 2014.	

7	**The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in appendix A of Monitor's Risk Assessment Framework; and all known targets going forwards.**	**Risk**
	Evidence: 1) As in 5 above the Trust has a Performance Management Framework in place, by which means the executive team holds the divisions to account for delivery against annual objectives and performance targets. 2) The output of the quarterly performance reviews with divisions is reported to the Finance and Performance (F&P) Committee, and issues of non-compliance with performance targets escalated appropriately. 3) The F&P Committee reviews performance (financial, quality and operational), on a monthly basis and then reports to each Trust Board meeting. The Trust performance report, along with a finance report, workforce report, quality	

	report and risk report, is presented at each Trust Board meeting. 4) Key performance indicators include: **MRSA:** There have been two MRSA blood stream infections year to date. The MRSA target is not part of the Monitor Risk Assessment Framework in 2014-15, however the Trust is being monitored against this by the NTDA. **C-Difficile:** There were 3 C-diff cases in May, against a trajectory of 5. The Trust has a target of no more than 40 C-diff incidents in 2014-15 **Cancer**: The 62 day target was met in April with performance at 85.3%. All other cancer targets were compliant. **A&E:** Quarter 1 performance 2014/15 was 94.85%. Current year to date performance stands at 95.1% Performance for Q3 of 2013-14 was 94.1%, and for Q4 93.6%. The Trust has therefore failed to deliver the 95% performance standard for three quarters in a row, which is an indicator of negative assurance for Monitor. **RTT:** The Trust was compliant at over the 90% standard for both admitted and non-admitted pathways in May. The Trust is on YTD trajectory for all other compliance framework requirements, and has a Governance Risk Rating of amber-green at Month 2.	

8	**The Trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance (IG) Toolkit.**	**YES**
	Evidence: 1) The Trust submits: self-assessed scores against the DoH IG toolkit on an annual basis, two sets of benchmarking scores during the financial year, and a final submission in March of each year. 2) The scores are evidenced by current practice and existing procedures. 3) In 2013-14 the Trust submitted returns for each of the 45 requirements set out in the IG Toolkit at Level 2 or above i.e. Level 3, achieving a 79% score and an overall "satisfactory" grade. 4) The IG Toolkit submission is internally audited on an annual basis by the Trust's internal auditors. The 2013-2014 submission received a "reasonable assurance" overall assessment.	

9	**The board has in place a register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans to ensure any Board vacancies are filled.**	**YES**
	Evidence: 1) The Trust has a complete register of interests which is reviewed annually by the Board. The annual review was undertaken by the Trust Board in its meeting in May 2014. 2) There are no executive or non-executive director vacancies.	

10	**The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.**	**YES**
	Evidence: 1) Job descriptions for executive directors are approved by the Nominations and Remuneration Committee. These include the required person specification and qualifications against which the recruitment process is based. 2) All Board members have an annual appraisal to review performance and identify any development needs. A summary of executive director appraisals is presented to the Nominations and Remuneration Committee. 3) For the recruitment of non-executive directors the Board determines the specific skills and qualifications needed. 4) The Board has completed a skills audit, which has been used to determine any gaps in experience and skills as a Board, and to inform succession planning for Board appointments. Following this skills audit all Board members have completed a coaching session with Deloitte as part of the Board development programme. 5) The Board also has a Board development programme in place, with the purpose of developing an effective unitary Board and to ensure all Board members have sufficient knowledge of core areas.	

11	**The selection process and training programmes in place ensure that non-executive directors have appropriate experience and skills.**	**YES**
	Evidence: 1) The selection of non-executive directors is overseen by the NTDA who approve any appointments. The selection process is informed by the Trusts identification of the skills and experience needed to ensure a balanced and effective Board. This succession planning is informed by a range of factors including the Board skills audit. 2) Upon appointment, each non-executive director follows a standard induction which will help identify any training required in the short-term. On an on-going basis, non-executive directors are encouraged to attend conferences or additional training to help them develop their knowledge and skills.	

12	**The management team has the capability and experience necessary to deliver the integrated business plan**	**YES**
	Evidence: 1) An organisational management structure is in place that provides robust management of each Clinical Division through the Divisional Chair, Divisional Director of Operations and Divisional Director of Nursing and Governance, in order to deliver the annual operating plan and Trust strategy. The Divisional Chairs report directly to the Chief Executive. 2) Each executive director assesses the capacity and capability within their directorates to deliver the annual and strategic objectives as part of their annual appraisal with the chief executive. They appraise their senior management team and identify any capacity or capability issues that require addressing to ensure delivery. 3) The Trust has implemented the Leadership Framework, which identifies the competencies and skills expected of different levels of staff in the organisation. This framework, when used in conjunction with appraisal, identifies any gaps in capability and experience that need to be addressed, which are then picked up with individuals as part of their annual appraisal and personal development plan.	

13	**The management structure in place is adequate to deliver the integrated business plan, including but not restricted to:** **a) Effective board and committee structures** **b) Clear responsibilities for the board, for committees to the board and for staff reporting to the board and those committees** **c) Clear reporting lines and accountabilities throughout its organisation**	**YES**
	Evidence: 1) The Trust has a robust corporate governance structure in place, including a clear Board and sub-committee structure and divisional governance structure. Each committee has clear terms of reference which are reviewed on an annual basis, and the effectiveness of each Board sub-committee is evaluated on an annual basis through self-assessment. Each committee reports to the Board after each meeting. 2) Responsibilities of the Board and its sub-committees are outlined in the Trust's scheme of delegation and responsibilities of individual members of those committees are made clear where appropriate in the committee's terms of reference. 3) Clear lines of accountability are established throughout the organisation and are published via organisational charts in the Trust's governance manual. 4) A Divisional governance review has been undertaken to provide assurance re. the effectiveness of the governance model and management structures at divisional/ directorate level, including roles and responsibilities and lines of accountability. Delivery of the action plan for this is overseen through the Executive Management Team meeting.	

14	**The Board has considered all likely future risks to compliance with the NHS Provider Licence and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach of conditions occurring and the plans for mitigation of these risks to ensure continued compliance.**	**YES**
	Evidence: 1) The Trust is required to complete a monthly self-certification of compliance with selected Monitor licence requirements to the NTDA as part of the Accountability Framework oversight arrangements. The self-certifications are as follows: a) General conditions: self-certification is required for 3 of the conditions (G4, 7 and 8) b) Pricing: self-certification is required for all 5 of the conditions c) Choice and Competition: self-certification is required for both the 2 conditions d) Integrated Care: self-certification is required for the only condition e) Continuity of Services: self-certification is required for 4 of the 7 conditions 2) The Trust is in full compliance against the above licence requirements, as evidenced by the monthly oversight submission to the NTDA. Any risks to compliance with these standards would be presented to the Board via the Risk and Compliance report. The Trust Board is required to self-certify against all Monitor Provider Licence conditions. The licence conditions which are not part of the monthly return to the NTDA are summarised below, with the assurance/evidence to support compliance: **General Conditions:** <u>G1: Provision of information</u> *This condition requires an obligation for all licensees to provide Monitor with any information we require for our licensing functions* **Assurance/Evidence:** The Trust has not yet been required to provide information in relation to the Monitor licence function, but would be in a position to do so if requested. <u>G2: Publication of information</u> *This condition requires licensees to publish such information as Monitor may require* **Assurance/Evidence:** As above. <u>G3: Payment of fees to Monitor</u> *The Act gives Monitor the ability to charge fees and under this condition oblige licence holders to pay fees to Monitor if requested* **Assurance/Evidence:** The Trust would comply with any reasonable requests for payment of fees.	

	G5: Monitor Guidance *This requires licensees to have regard to any guidance that Monitor issues.* **Assurance/Evidence:** The Trust takes account of changes to Monitor guidance, e.g. the Board performance report has been revised to take account of the change from the Compliance Framework to the Risk Assessment Framework G6: Systems for compliance with licence conditions and related obligations *This requires providers to take all reasonable precautions against the risk of failure to comply with the licence and other important requirements* **Assurance/Evidence;** Board assurance framework; risk and compliance report to Trust Board G9: Application of Section 5 (Continuity of Services) *This sets out the conditions under which a service will be designated as a Commissioner Requested Service, and all these conditions apply to the licence holder (see below).* **Continuity of Services Conditions:** CoS1: Continuing Provision of Commissioner Requested Services (CRS) *This prevents licensees from ceasing to provide CRS, or from changing the way they provide CRS, without the agreement of commissioners* **Assurance/Evidence:** The Trust has not made any changes to the way it provides CRS without agreement from the commissioners CoS 2: Restriction on Disposal of Assets *This ensures that licensees keep an up-to-date register of relevant assets used in the provision of CRS. It also requires licensees to obtain Monitor's consent before disposing of these assets where Monitor is concerned about the ability of the licensee to carry on as a going concern.* **Assurance/Evidence:** The Trust maintains an asset register; a letter of assurance re. relevant assets was submitted to the NTDA as part of the FT preparation process in December 2013. CoS 3: Monitor Risk Rating *This requires licensees to have due regard to adequate standards of corporate governance and financial management* **Assurance/Evidence:** Monthly Integrated Delivery Meetings with the NTDA re. performance; monthly reports to Trust Board/ FPI Committee CoS 4: Undertaking from the Ultimate Controller *This requires the licensee to put in place a legally enforceable agreement with their "ultimate controller" to stop ultimate controllers from taking any action that would cause licensees to breach the licence conditions.*	

	Assurance/Evidence: This licence condition protects against the risk that outside influences (mainly parent companies that are not licensed by Monitor) take action that prevents licensees from complying with the licence conditions. This is therefore not an issue for the Trust. CoS 5: Risk Pool Levy *This obliges licensees to contribute, if required, towards the funding of the "risk pool" (an insurance mechanism to pay for vital services if a provider fails).* **Assurance/Evidence:** This will not come into effect before April 2015 and Monitor will undertake a separate consultation of how this will work. CoS 6: Cooperation in the Event of Financial Distress *This applies when a licensee fails a test of sound finances, and obliges the licensee to cooperate with Monitor in these circumstances* **Assurance/Evidence:** The Trust has a 5 year LTFM in which it remains financially viable CoS 7: Availability of Resources *This requires licensees to act in a way that secures access to the resources needed to operate CRS* **Assurance/Evidence:** Licensees will be required to provide Monitor with a certificate, signed by their Board, on an annual basis, which confirms their position in relation to having the required resources to keep their CRS There are in addition four licence conditions which apply specifically to Foundation Trusts. It is not anticipated that there will be an issue in the Trust complying with these at the point of FT authorisation: • FT 1: Information to update the register of NHS FTs – Trusts must provide required documentation to Monitor • FT 2: Payment to Monitor in respect of registration and related costs – this would be in the instance that Monitor moves to funding collecting fees • FT 3 Provision of information to advisory panel – the Act gives Monitor the ability to establish an advisory panel that will consider questions brought by governors. Monitor has stated that they will establish a panel. This condition requires FTs to provide the information requested by an advisory panel. • FT 4: FT Governance Arrangements – enables Monitor to continue oversight of FTs	

Signed for and on behalf of the Board:

Title: **Christopher Smallwood, Chairman**

Date:
Trust: St. George's Healthcare NHS Trust