NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board (public)
Tuesday 23 May at 9:30am
Small conference room, Learning and development centre,
Fieldhead, Wakefield, WF1 3SP

AGENDA

1. **Welcome, introduction and apologies** (verbal item)

2. **Declaration of interests** (verbal item)

3. **Trust Board self-certification – compliance with NHS provider licence conditions** (attached)

4. **Date of next meeting**

The next meeting of Trust Board will be held on Tuesday 27 June 2017 in Rooms 49/50, Folly Hall, Huddersfield.

With **all of us** in mind.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 23 May 2017
Agenda item 3

Title:	**Trust Board self-certification – compliance with NHS provider licence conditions**
Paper prepared by:	Director of Corporate Development
Purpose:	To provide assurance to Trust Board that it is able to make the required self-certifications that the Trust complies with the conditions of the NHS provider license.
Mission/values:	Good governance supports the Trust to deliver its mission and adhere to its values.
Any background papers/ previously considered by:	Trust Board received and approved the operational plan for 2017/18 on 20 December 2016. The Trust reviewed compliance with NHS Constitution on 20 December 2016. The attached documents were reviewed by the Executive Management Team on 11 May 2017.
Executive summary:	<u>Background</u> NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements. As part of the annual planning arrangements, NHS Improvement requires the Trust to make a number of governance declarations. Trust Board is required to make self-certifications in relation to: ➢ The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (as required by condition G6(3) of the NHS Provider Licence) (appendix 1 – NHS provider licence conditions); ➢ If providing commissioner requested services (CRS), the provider has a reasonable expectation that required resources will be available to deliver the designated service (as required by condition CoS7(3) of the NHS Provider Licence) (appendix 1 – NHS provider licence conditions). ➢ The provider has complied with required governance arrangements (as required by condition FT4(8) of the NHS Provider Licence) (appendix 2 – Corporate Governance Statement); and ➢ The training of Governors (as required by s151(5) of the Health and Social Care Act 2012) (see below). <u>Trust compliance with its Licence</u> The Licence is a requirement of the Health and Social Care Act 2012 and is the mechanism by which NHS Improvement/Monitor regulates providers of NHS services, both NHS and non-NHS. The provider licence is split into six sections, which apply to different types of providers. From 1 April 2013, all foundation trusts were automatically issued with a licence as the Health and

	Social Care Act 2012 specified that foundation trusts were to be treated as having met all the licence criteria. In the main, the licence requires the Trust to adhere to (and provide evidence that it has done so) certain conditions, which it does as part of its existing governance and reporting arrangements. The attached paper (appendix 1) provides assurance to Trust Board that the Trust meets the conditions of its Licence and identifies potential areas of risk. From the assurance provided, Trust Board is asked to certify that "***the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution***". <u>Providing commissioner requested services (CRS)</u> CRS designation is not simply a standard contract with a commissioner to provide services. CRS are services commissioners consider should continue to be provided locally even if a provider is at risk of failing financially and which will be subject to regulation by NHS Improvement. Providers can be designated as providing CRS because: ➢ there is no alternative provider close enough ➢ removing the services would increase health inequalities ➢ removing the services would make other related services unviable. The attached paper (appendix 1) sets out the way the Trust complies with the continuity of services conditions in the NHS provider licence. From the assurance provided, Trust Board is asked to certify that *"**the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking into account distributions which might reasonably be expected to be declared or paid for the period of 12 months**".* <u>Corporate Governance Statement</u> The attached paper (appendix 2) sets out the statements (numbered 1-6) Trust Board is required to make and the assurance to support self-certification against the statements. From the assurance provided, Trust Board is asked to certify that it is satisfied with the risks and mitigating actions against each area of the required six areas within the Trust's Corporate Governance Statement. <u>Training of Governors</u> Starting in 2013, the Trust has developed, through the Members' Council Co-ordination Group, a programme of training and development to ensure governors have the skills and experience required to fulfil their duties. The Trust supports the training and development of governors in a number of ways: ➢ Each governor has an induction meeting with the Chair and a review meeting to discuss individual performance and training and development needs.

	➢ The Trust offers 1:1 support and 'buddying' as part of the induction programme for Governors. ➢ Attendance at national GovernWell training modules is also encouraged and the Trust facilitates attendance. ➢ There is an annual session to evaluate the contribution and work of the Members' Council, facilitated by an external facilitator and includes a self-assessment by governors, both individually and collectively, of their contribution and effectiveness. New members also participate in the annual evaluation of Members' Council activity, which enables them to learn from the experience of others. ➢ Most formal Members' Council meetings include a discussion item, which allows governors, with the support of Trust Board, to look at a particular area of Trust services or activity in more detail. Examples include child and adolescent mental health services (CAMHS), the Trust's strategic approach and sustainability, and transformation of Trust services. In 2014, the Members' Council signed up to the principle that there should be a level of minimum commitment and contribution from Governors at two levels: *Required* ➢ Attendance at a minimum of three out of four formal Members' Council meetings. ➢ Attendance at the annual evaluation session. ➢ 1:1 introductory meeting with the Chair. ➢ Annual review meeting with the Chair. ➢ Attendance at the annual members' meeting. *Desirable* ➢ Attendance at the Foundation Trust Network's GovernWell modules. ➢ Attendance at Trust Board meetings. ➢ Attendance at training and development sessions organised by the Trust. ➢ Membership of formal groups (currently Members' Council Co-ordination Group, Quality Group and Nominations Committee). From the assurance provided, Trust Board is asked to certify this it "***is satisfied that, during the financial year most recently ended, the Trust has provided necessary training to its governors, as required by S151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role***."
Recommendation:	**Trust Board is asked to NOTE the outcome of the self-assessments against the Trust's compliance with the terms of its Licence and with Monitor's Code of Governance and CONFIRM that it is able to make the required self-certifications in relation to:** ➢ **compliance with the conditions of its Licence;** ➢ **the Corporate Governance Statement; and** ➢ **the training for Governors.**
Private session:	Not applicable.

Trust Board 23 May 2017
NHS provider licence

This paper is intended to provide assurance that the Trust complies with the terms of its Licence and sets out a broad outline of the licence conditions and any issues for Trust Board to note.

The provider licence is split into six sections, which apply to different types of providers.

1. General conditions (G) – general requirements applying to all licensed providers.
2. Obligations about pricing (F) – obliges providers to record pricing information, check data for accuracy and, where required, charge commissioners in line with tariff. Applies to all licensed providers who provide services covered by national tariff.
3. Obligations around choice and competition (C) – obliges providers to help patients make the right choice of provider, where appropriate, and prohibits anti-competitive behaviour where against patients' interests. This applies to all licensed providers.
4. Obligations to enable integrated care (IC) – enables the provision of integrated services and applies to all licensed providers.
5. Conditions to support continuity of service (CoS) – allows NHS Improvement/Monitor to assess whether there is a risk to services and to set out how services will be protected if a provider gets into financial difficulty. Applies to providers of commissioner requested services (CRS) only.
6. Governance licence conditions for Foundation Trusts (FT) – provides obligations for Foundation Trusts around appropriate standards of governance. Applies to Foundation Trusts only.

Condition	Provision	Comments
General licence conditions (G)		
1. Provision of information	Obligation to provide NHS Improvement/Monitor with any information it requires for its licensing functions.	The Trust is currently obliged to provide NHS Improvement/Monitor with any information it requires and, within reasonable parameters, to publish any information NHS Improvement/Monitor requires it to. We have systems in place to identify and respond to routine and ad-hoc requests. Formal articulation of this Condition, therefore, does not present any issues for the Trust although the Conditions are so broad the obligation could become overly burdensome.
2. Publication of information	Obligation to publish such information as NHS Improvement/Monitor may require.	
3. Payment of fees to NHS Improvement/Monitor	Gives NHS Improvement/Monitor the ability to charge fees and for licence holders to pay them.	There are currently no plans to charge a fee to Licence holders. Trust Board should note that there is, currently, no provision in the budget for

With all of us in mind.

Condition	Provision	Comments
		additional fees and this would, therefore, become a cost pressure.
4. Fit and proper persons	Prevents licences from allowing unfit persons to become or continue as governors or directors.	The Care Quality Commission (CQC) published the fit and proper person requirements to take effect from 1 October 2014. The Trust has included the requirement for members of Trust Board to make an annual declaration against the requirements on an annual basis and has robust arrangements in place for new appointments to the Board (whether non-executive or executive).
5. NHS Improvement/Monitor guidance	Requires licensees to have regard to NHS Improvement/Monitor guidance.	The Trust responds to guidance issued by NHS Improvement/Monitor. Submissions and information provided to NHS Improvement/Monitor are approved through relevant and appropriate authorisation processes.
6. Systems for compliance with licence conditions and related obligations	Requires providers to take reasonable precautions against risk of failure to comply with the licence.	The Trust has systems and processes in place to ensure it complies with its Licence and this is co-ordinated by the Director of Corporate Development.
7. Registration with the Care Quality Commission (CQC)	Requires providers to be registered with the CQC and to notify NHS Improvement/Monitor if their registration is cancelled.	The Trust is registered with the Care Quality Commission (CQC).
8. Patient eligibility and selection criteria	Requires licence holders to set transparent eligibility and selection criteria for patients and apply these in a transparent manner.	The Trusts website sets out the service directories for each BDU and the relevant access criteria for the services.
9. Application of section 5 (which relates to continuity of services)	Sets out the conditions under which a service will be designated as a CRS	Covers all services which the licensee has contracted with a Commissioner to provide as a Commission Requested Service (CRS)." See CoS1.
Pricing conditions (P)		
1. Recording of information	Obligation of licensees to record information, particularly about costs.	The Trust responds to guidance and requests from NHS Improvement/Monitor. Information provided is approved through the relevant and appropriate authorisation processes.
2. Provision of information	Obligation to submit the above to NHS Improvement/Monitor.	
3. Assurance report on submissions to NHS Improvement/Monitor	Obliges licensees to submit an assurance report confirming that the information provided is accurate.	

Condition	Provision	Comments
4. Compliance with the national tariff	Obliges licensees to charge for NHS health care services in line with national tariff.	All contracts are agreed annually and are in line with the national tariff. The Trust continues to work with its commissioners on the requirement to develop a local tariff within the terms of national guidance.
5. Constructive engagement concerning local tariff modifications	Requires licence holders to engage constructively with commissioner and to reach agreement locally before applying to NHS Improvement/Monitor for a modification.	See P4.
Choice and competition (C)		
1. Patient choice	Protects patients' rights to choose between providers by obliging providers to make information available and act in a fair way where patients have a choice of provider.	The Trust has in place a service directory setting out the services available. Commissioners monitor the Trust's compliance with the legal right of choice as part of contract monitoring in line with NHS Standard Contract requirements.
2. Competition oversight	Prevents providers from entering into or maintaining agreements that have the effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users.	Trust Board has reviewed its position and considers that it has no arrangements that could be perceived as having the effect of preventing, restricting or distorting competition in the provision of health services. The Trust is aware of the requirements of competition in the health sector and would seek legal and/or specialist advice should Trust Board decide to consider any structural changes, such mergers or joint ventures.
Integrated care condition (IC)		
1. Provision of integrated care	Requires Licensee to act in the interests of people who use healthcare services by facilitating the development and maintenance of integrated services.	The Trust actively works with its partners, through formal and informal mechanisms to foster and enable integrated care and is involved in several pilots aimed at developing new ways of working and new models of delivery. A number of services provided are done so through partnership working with other local stakeholders.
Continuity of service (CoS)		
1. Continuing provision of commissioner requested services (CRS)	Prevents licensees from ceasing to provide CRS or from changing the way in which they provide CRS without the agreement of relevant	As part of contract negotiations, the Trust has agreed CRS with commissioners, with the exception of Barnsley, that all mental health

Condition	Provision	Comments
	commissioners.	services will be considered as CRS. Barnsley Clinical Commissioning Group has reviewed the guidance and has determined that services provided under their contract will not be designated as Essential or CRS.
2. Restriction on the disposal of assets	Licensees must keep an up-to-date register of relevant assets used in commissioner requested services (CRS) and to seek NHS Improvement/Monitor's consent before disposing of these assets IF NHS Improvement/Monitor has concerns about the licensee continuing as a going concern.	As the majority of services the Trust provides are classed as CRS, all assets associated with these services are classed as restricted and these can be identified by the Trust. Any changes to estate and the asset base are discussed with commissioners in relation to the provision of services. The Trust has an asset register in place. The Trust is only required to seek NHS Improvement/Monitor's consent for disposal of assets if NHS Improvement/Monitor was concerned about its ability to continue as a going concern.
3. NHS Improvement/Monitor risk rating (standards of corporate governance and financial management)	Licensees are required to adopt and apply systems and standards of corporate governance and management, which would be seen as appropriate for a provider of NHS services and enable the Trust to continue as a going concern.	The Trust has robust and comprehensive corporate and financial governance arrangements in place with significant assurance received from an internal audit in 2016/17.
4. Undertaking from the ultimate controller	Requires licensees to put a legally enforceable agreement in place to stop the ultimate controller from taking action that would cause the licensee to breach its licensing conditions.	Does not apply to the Trust.
5. Risk pool levy	Obliges licensees to contribute to the funding of the 'risk pool' (insurance mechanism to pay for vital services if a provider fails).	Further guidance on this is awaited from NHS Improvement/Monitor. It could have the potential to bring significant further financial burden on providers.
6. Co-operation in the event of financial stress	Applies when a licensee fails a test of sound finances and obliges the licensee to co-operate with NHS Improvement/Monitor.	The Trust is aware it would need to co-operate with NHS Improvement/Monitor in such circumstances.
7. Availability of resources	Requires licenses to act in a way that secures resources to operate commissioner requested services (CRS).	The Trust has sound and robust processes and systems in place to ensure it has the resources necessary to deliver its services.

Condition	Provision	Comments
Foundation Trust conditions (FT)		
1. Information to update the register of NHS foundation trusts	Obliges foundation trusts to provide information to NHS Improvement/Monitor.	See G1. The Trust is currently obliged to provide NHS Improvement/Monitor with any information it requires, including information to update its entry on the register of NHS foundation trusts.
2. Payment to NHS Improvement/Monitor in respect of registration and related costs	The Trust would be required to pay any fees set by NHS Improvement/Monitor.	NHS Improvement/Monitor has undertaken not to levy any registration fees on foundation trusts without further consultation.
3. Provision of information to advisory panel	NHS Improvement/Monitor has established an independent advisory panel to consider questions brought by governors. Foundation trusts are obliged to provide information requested by the panel.	The independent advisory panel was established in April 2013 and the Trust provided a briefing on the Panel for the Members' Council. The Trust's governors understand the role and remit of the Panel and the seriousness of any reference to it, representing a breakdown of the existing communication channels between the Trust Board and the Members' Council.
4. NHS Foundation Trust governance arrangements	Gives NHS Improvement/Monitor continued oversight of the governance of foundation trusts.	The Trust has sound corporate governance processes in place and reviews of these arrangements are a core part of the internal audit annual work programme. This was also evidenced in the outcome of the well-led review of the Trust's governance arrangements.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 23 May 2017
Corporate Governance Statement 2016/17

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.

The Trust continues to implement, develop and improve its arrangements to ensure it meets the principles and standards of good corporate governance and to ensure it has the systems and processes in place to meet these as well as its statutory, legal and regulatory duties and requirements. As part of this continuous improvement process, Trust Board undertook a well-led governance review during May, June and July 2015. The outcome of this review was reported to Trust Board in July 2015.

In summary, following a robust and thorough review and scrutiny of the Trust's governance arrangements, which included interviews and focus groups with Trust Board, key stakeholders, the Members' Council and staff, the review concluded that there were no 'material governance concerns'. Out of the ten areas assessed, two areas were rated as green (in relation to Board engagement with patients, staff, governors and other stakeholders, and the Board having the skills and capability to lead the organisation) and eight as amber/green. In terms of the outcome, this reflected the developmental approach taken by Trust Board and the report very much reflected Trust Board's own assessment of the Trust's arrangements. The report identified a series of areas for development around clear articulation of our strategic priorities and strengthening how these are communicated, clear monitoring and reporting against these, further development of the Board assurance framework, monitoring and assurance of the Trust's transformation programme, and strengthening and enhancing staff engagement. A final report on the completion of the action plan was received by Trust Board in September 2016. Internal audit undertook a review of implementation which received **significant assurance**.

Risks
The Trust does not apply or applies inconsistently good corporate governance. Mitigated by robust scrutiny through the Trust's governance and assurance processes.

The Trust was also subject to an inspection by the Care Quality Commission (CQC) in March 2016 and re-inspection in January 2017. The Trust was rated "Good" overall with some areas that require improvement. The Trust was rated as 'good' for the well led domain.

Risk
The outcome of the inspection required some areas that require improvement. Mitigated by an action plan to address areas for improvement.

There are a number of areas to provide assurance that the Trust applies the principles, systems and standards of good corporate governance.

- The Trust's Constitution underpins its governance arrangements and the Trust operates within its Constitution at all times. Where necessary, the Trust

With all of us in mind.

seeks external advice on any changes, and ensures amendments are approved in line with the process set out in the Constitution.

- The Trust complies with all relevant rights and pledges set out in the NHS Constitution with the exception of the pledge "The NHS commits to make the transition as smooth as possible where you are referred between services, and to include you in the relevant discussions". The Trust endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care; however, there are occasions where the nature of an individual's illness makes this inappropriate. The annual self-assessment was presented to Trust Board in December 2016.
- The Trust undertakes an annual assessment of compliance against NHS Improvement/Monitor's Code of Governance which is reported to Trust Board.
- The Trust has a register of interests in place for both Trust Board and the Members' Council, which is reviewed annually and both Directors and Governors are proactively asked to update their declarations. Directors and Governors are expected to declare any additions or changes to their declarations. The Chair of the Trust reviews the declarations and considers whether there are any conflicts of interest presenting a risk to the Trust. Non-Executive Directors also make a declaration of independence on an annual basis. All Non-Executive Directors have made a positive declaration. From April 2015, members of Trust Board have also been asked to make a declaration that they meet the fit and proper person requirement introduced in response to a recommendation made in the Francis Report. All members of Trust Board have made such a declaration and the Trust undertakes appropriate enquiries to ensure that newly appointed Directors meet the requirements as well as seeking an individual declaration. All members of Trust Board and the Executive Management Team have disclosure and barring checks in place.
- All elections made to the Members' Council are held in accordance with the election rules in the Trust's Constitution. Elections are overseen by an external organisation (currently Electoral Reform Services) to ensure independence and transparency, and to ensure the Trust meets its statutory duties.
- The Trust was awarded a Licence on 1 April 2013. The Trust ensures it meets the conditions of its Licence through a process of self-assessment. There are no major issues or risks identified in relation to the Trust's continued compliance with its Licence.

Risk
The Trust does not comply with the requirements of its Licence. Mitigated by ongoing review of Trust compliance and reporting to Trust Board as part of the NHS Improvement/Monitor requirements.

The following also provide assurance to Trust Board that the Trust has good corporate governance arrangements in place.

- The Head of Internal Audit Opinion for 2016/17 provides **significant assurance** with minor improvement opportunities on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.
- As Accounting Officer, the Chief Executive prepares an Annual Governance Statement. This document describes the risk and assurance processes for the Trust and meets the requirements set out in NHS Improvement's Foundation Trust Annual Reporting Manual. The Statement for 2016/17 was assessed as fit for purpose and meeting guidance as part of the audit of the Trust's annual report and accounts.
- The Trust's assurance framework and risk register have been assessed as appropriate as part of an internal audit of the Trust's risk management processes which received **significant assurance**.

Risk
The Trust does not continue to have good corporate governance arrangements in place. Mitigated by close scrutiny of NHS Improvement performance targets by the Executive Management Team quarterly reporting to Trust Board as part of the NHS Improvement reporting process.

2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time-to-time.

DRAFT

The Accounting Officer and Company Secretary ensure that Trust Board is made aware of guidance on good corporate governance from NHS Improvement, an assessment of the Trust's immediate position is undertaken and any action or development required to ensure compliance is initiated.

Risk
Trust does not have regard to guidance. Mitigated by the Company Secretary having oversight of the systems and processes in place to ensure guidance is identified, captured, assessed and implemented.

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.**

Trust Board is clear that its role is to set the strategic direction and associated priorities for the organisation, ensure effective governance for all services and provide a focal point for public accountability. The general duty of Trust Board, and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for members of the Trust as a whole and the public. Trust Board is clear of its accountability and responsibility.

Trust Board and Committee structures in place are effective and meet the requirements of the Trust's Constitution. Committees are supported by terms of reference and annual work plans and have clear reporting mechanisms to Trust Board. The Trust has four risk-based Committees:

- Audit Committee;
- Clinical Governance and Clinical Safety Committee;
- Mental Health Act Committee;
- Remuneration and Terms of Service Committee.

Committees are chaired by a Non-Executive Director and, with the exception of the Audit Committee, have Non-Executive and Executive Director membership. The Audit Committee membership comprises exclusively of Non-Executive Directors. Agendas, which are risk-based, are compiled and agreed by the Chair of the Committee in conjunction with the Lead Director. Each Committee has an annual work programme, which is incorporated into agendas as appropriate. Lead Directors are responsible for ensuring, with the Director of Corporate Development in her role as Company Secretary, that papers are commissioned to meet the requirements of the Committee, to provide assurance that risk is mitigated within the Trust and to provide assurance that the Trust is working to deliver and continuously improve the services it provides whilst achieving value for money and best use of resources.

The membership of Committees is reviewed regularly by the Chair of the Trust in terms of Non-Executive Directors. The Committee structure is reviewed for appropriateness from time-to-time by the Chair.

Each Committee is required to prepare an annual report, which is presented to the Audit Committee. This provides assurance to Trust Board that each Committee is meeting its terms of reference and is seeking assurance on areas of risk in line with its terms of reference.

The Executive Management Team's (EMT) role is to ensure that resources are deployed to support the delivery of the Trust's plan, to ensure that the Chief

DRAFT

Executive can discharge his accountability to best effect through effective delegation and prioritisation of work, to support each other to find appropriate linkages and synergies, to ensure performance is scrutinised and challenged, both Trust-wide and by BDU, and to ensure the work of the EMT is aligned with that of Trust Board.

Trust Board is supported by an involved and proactive Members' Council, which forms a key part of the Trust's governance arrangements. The Members' Council is clear that its role is to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors and to represent the interests of the members of the Trust as a whole and the interests of the public. The Members' Council continues to develop its skills and experience in its ability to challenge and hold Directors to account for the Trust's performance.

The Trust works within a framework that devolves responsibility and accountability throughout the organisation through robust service delivery arrangements. There are clear structures with clear responsibility and accountability below Director level. Within BDUs, deputy directors provide operational leadership and management allowing BDU Directors to focus on building and managing strategic and partner relationships and to lead the transformation agenda. BDUs are supported by arrangements at service line level where a clinical lead, general manager and practice governance coach work together and carry responsibility at ward, unit and department level to ensure excellence in service delivery and quality and to enact the service change required to achieve transformation.

BDUs are supported by the Quality Academy, which provides co-ordinated support services linked to the accountabilities of executive directors. There are six domains comprising financial management, information and performance management, people management, estates management, compliance, governance and public involvement and engagement, and service improvement and development. A review of Director portfolios is being undertaken, led by the Chief Executive.

Risk
The Trust does not have effective structures at Trust Board level. Mitigated by annual committee review process, independent review by internal audit of effectiveness, clear view of roles and responsibilities, and clear approach to leadership and management throughout the Trust.

4. The Board is satisfied that the Trust effectively implements systems and/or processes:

- **a) to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively;**
- **b) for timely and effective scrutiny and oversight by the Board of the Licence holder's operations;**
- **c) to ensure compliance with healthcare standards binding on the Licence holder, including, but not restricted to, standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of healthcare professions;**
- **d) for effective financial decision-making, management and control (including, but not restricted to, appropriate systems and /or processes to ensure the Licence holder's ability to continue as a going concern);**
- **e) to obtain and disseminate accurate, comprehensive, timely and up-to-date information for Trust 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.**

As part of its annual audit, the Trust's external auditor, Deloitte, was satisfied that the Trust has made proper arrangements for securing economy, efficiency

DRAFT

and effectiveness in its use of resources in 2016/17. There were no issues identified to report in the audit opinion.

Risk
The Trust does not have the systems and processes to ensure compliance with its Licence. Mitigated by performance reporting arrangements to Trust Board, including exception reports on areas of risk or concern, quarterly exception reports, robust committee arrangements in place providing assurance that the systems and processes in place are effective.

The Trust's internal audit plan is risk-based to enable the Trust to identify areas where improvement is sought and to learn from best practice. The Audit Committee approved the internal audit plan for 2016/17. The plan included core reviews to inform the Head of Internal Audit Opinion relating to core financial controls, corporate governance arrangements, which will focus on Care Quality Commission inspection and well-led review follow up, payroll, risk management and board assurance framework, and information governance toolkit. This was supported by a number of cyclical and risk reviews covering serious incidents, trio effectiveness and benefits realisation, clinical record keeping/data quality, delivering service change, workforce strategy, and support services value for money focussing on IT services. Internal audit also undertook follow up reviews of limited assurance audits in 2015/16, including patients' property, job planning and medicines management.

The Trust continues to develop and implement service line reporting, which is monitored and scrutinised by the Audit Committee on behalf of Trust Board. Further work will be undertaken in the coming year to use the information to benchmark internally and learn from best practice.

Trust Board receives an integrated performance report (IPR) on a monthly basis. This enables Trust Board to satisfy itself that the Trust is meeting its financial and quality performance targets. Other reports to Trust Board and its Committees provide 'soft' information that the Trust is fulfilling its purpose in an effective and efficient manner.

The Trust was (and continues to be) registered with the Care Quality Commission (CQC) with no conditions. The Trust has a robust process in place to ensure that it meets the requirements of its registration. The Trust was subject to an inspection by the CQC in March 2016 and re-inspected in January 2017. Action plans were developed in response to recommendations included in the inspection reports. For 2016/17, the Trust's programme of visits to services focused on areas 'requiring improvement' in the reports. Mental Health Act visits occur regularly and, following each visit, an action plan is submitted to the CQC to address any issues raised. The action plans and progress against these are monitored and scrutinised by the Mental Health Act and Clinical Governance and Clinical Safety Committees. Local actions have also been implemented in relation to any identified concerns arising from the Trust's own unannounced visit programme.

Based on evidence provided by finance and performance reports and the Trust's operational plan for 2017/18, supported by Audit opinion, the Trust will remain a going concern at all times. As part of its accounts audit for 2016/17, the Trust's external auditor was able to agree with management's view that the Trust could account on a going concern basis. The coming year presents a challenge to the Trust in meeting its operational and financial plans. Trust Board will review the Trust's position at its meeting in July 2017 in terms of the first three months of 'trading' and the outcome of the CQC inspection

Risk
The Trust is unable to meet the requirements of its operational and financial plans for 2017/18. Mitigated by a review at month 3 (reporting to Trust Board in July 2017) to ensure its plans provide sufficient investment in services and to consider the planned end-of-year outturn position.

DRAFT

The Trust has policies and procedures in place to ensure it complies with legislation both as an employer and as a provider of NHS services.

5. The Board is satisfied that:

a) there is sufficient capability at Trust Board level to provide effective organisational leadership on the quality of care provided;
b) Trust 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) Trust Board receives and takes into account accurate, comprehensive, timely and up-to-date information on quality of care;
e) the Trust, including Trust 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) 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 Trust Board where appropriate.

The Trust continues to regularly reviews processes against governance best practice, including:

- policies developed, reviewed and in place;
- governance systems;
- the assurance framework and risk register presented to Trust Board quarterly;
- audits undertaken both internally and externally;
- the programme of unannounced visits; and
- reports submitted to Trust Board and its Committees, as well as the Members' Council.

The Trust's Quality Report for 2016/17 provides a summary of the Trust's quality achievements and challenges, demonstrating how it meets its statutory and regulatory requirements as well as how it meets the expectations of its service users, carers, stakeholders, its members and the public. The Report was externally audited. This provided the required limited assurance opinion on the content and consistency of the report, that the content was in line with the Annual Reporting Manual (2016/17) issued by NHS Improvement and consistent with documents reviewed. In terms of the performance indicator testing of two mandatory indicators (access to crisis resolution home-based treatment and delayed transfers of care), a small number of minor errors or points for improvement were identified; however, the impact was not considered to be significant. For DToC, which was tested in previous years, which represents an improvement in performance. The review of the local indicator (care plans) has resulted in a number of recommendations, which will be taken forward by management.

The process introduced by the Director of Nursing and Quality to assess risk to and impact on quality and safety of the cost improvement and efficiency savings proposed by BDUs was again applied in 2016/17. The Quality Impact Assessment, led by the Director of Nursing and Quality and undertaken in conjunction with clinical and general management within BDUs, provides assurance throughout the process to the Executive Management Team (EMT) and, through regular reports, to the Clinical Governance and Clinical Safety Committee and Trust Board that cost improvements do not have an adverse effect on Trust services. In 2017/18, assessment of the impact of substitutions or mitigating action are included in the process as well as cost pressures.

The Trust's approach to quality improvement is clear that quality is the responsibility of all staff from 'ward to board'. Reporting processes and mechanisms through Trust Board, its Committees, EMT and through to BDUs and their governance processes reflects this approach. Accountability for quality is also clear through the leadership and management arrangements within the Trust. BDUs continue to enable better and more rapid decision-making, as close as

DRAFT

possible to the point of care delivery, which, in turn, enables more effective clinical engagement and leadership in service development and delivery as well as providing service users with greater access to decision-making.

The Trust's approach to clinical quality improvement is supported by the Quality Academy approach, which is based on continuous service improvement, working in innovative ways to meet local priorities, to ensure compliance with national standards and external regulation, adoption of lean systems thinking, and making the most of shared learning opportunities across the healthcare system, using quality to deliver best value. The Trust's strategic priorities and combined support service offer aligns clinical services and support functions to deliver the best care possible to those who use Trust services. The approach also links to the national Quality, Innovation, Productivity and Prevention (QIPP) agenda.

Trust Board receives regular reports, directly and through the Clinical Governance and Clinical Safety Committee, on all aspects of clinical quality and safety including management of incidents and complaints, equality and diversity, service user experience, control of infection and research and development. The Clinical Governance and Clinical Safety Committee provides assurance to Trust Board that issues and risks identified in a number of portfolio areas, such as managing aggression and violence, safeguarding adults and children, infection prevention and control, and information governance, are being addressed. where the Clinical Governance and Clinical Safety Committee identifies an area of concern which has been raised at a particular time, we scrutinise that on behalf of the board by receiving regular reports for a period.

Performance reports to Trust Board provide assurance against a range of Key Performance Indicators relating to service quality and, where reports indicate underperformance, action plans are provided to and monitored by Trust Board.

The Trust has a range of arrangements in place for monitoring service user experience as an indicator of service quality. This includes surveys, consultations and engagement events. The Trust's approach to insight and service user experience is set out in its Communication, Engagement and Involvement Strategy. Regular meetings are also held in community and ward settings to receive service user and carer feedback. The Trust continues to look for innovative ways to capture service user and carer feedback at the point of contact.

The Trust is compliant with the Health Act 2006: Code of Practice for the Prevention and Control of Healthcare Associated Infection (Hygiene Code). The Trust has an Infection Control Strategy in place and the infection control annual plan and annual report are considered by the Clinical Governance and Clinical Safety Committee on behalf of Trust Board. Trust Board monitors infection control through the monthly performance reports and the quarterly compliance report. Hygiene and quality of environment are maintained through cleaning schedules and through service level agreements and regular visits to clinical areas by the Director of Nursing and Quality, include checks for cleanliness.

The Trust publishes information in relation to the Friends and Family test for service users and staff.

The Trust actively engages with its service users, their carers, staff and stakeholders on the quality of its services through the development of its Quality Accounts and in the development of its services.

The Trust has a whistleblowing policy in place, which sets out clearly staff responsibility to raise concerns and how they can do this. The policy is clear on the escalation process and who concerns should be reported to. The policy is supported by information on the Trust's intranet and in associated documentation, such as the fraud and bribery act policy, safeguarding policies, and serious incident reporting and management policy. Arrangements are scrutinised by the Audit Committee. The Trust has also appointed its staff Governors on the Members' Council as a network of Freedom to Speak Up guardians (FTSU

DRAFT

guardians) rather than one individual due of the diverse nature of services and large geographical spread of the Trust, the FTSU guardians provide staff with another way to raise concerns at work. Trust Board has also identified the Deputy Chair as the Senior Independent Director.

Risk
The Trust does not have the capacity and capability at Trust Board level. Mitigated by quality performance reporting to Trust Board, annual quality report, customer services processes and ongoing engagement with stakeholders, service users/carers and staff, clear process in place for whistleblowing and raising concerns, and processes in place for recruitment and selection of Trust Board members.

6. Trust Board effectively implements systems to ensure that it has in place personnel on Trust Board, reporting to Trust Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of the Trust's NHS provider licence.

Trust Board is satisfied that all Directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability.

The Chair and Non-Executive Directors have a broad base of skills and experience, including financial, commercial, marketing, legal, community engagement, and health and social care. It is the role of the Nominations Committee to assess the mix of skills and experience across Trust Board when appointing Non-Executive Directors to the Board and to ensure a balance is maintained with skills complementing those of Executive Directors. To inform this process and to ensure Trust Board retains a balance of skills and experience to operate effectively as a unitary board, a review of Trust Board skills and experience will be undertaken as part of the Trust Board development plan.

All new Non-Executive Directors have a detailed induction programme tailored to individual requirements and Board responsibilities. The Chair is subject to an annual assessment of performance by the Members' Council, led by the Senior Independent Director, and involving Non-Executive Directors, Executive Directors and Governors. Trust Board undertakes ongoing Board development, using external expertise where required.

The Chief Executive is subject to formal review by the Chair. Executive Directors are subject to annual appraisals by the Chief Executive, and Non-Executive Directors are subject to annual appraisal by the Chair, both of which inform individual development plans for all Board members. The outcome of the Non-Executive Director appraisals is reported to the Members' Council.

Continuous professional development of clinical staff, including medical staff, supports the delivery of high quality clinical services. The Trust has policies, processes and procedures in place to ensure all medical practitioners providing care on behalf of the Trust have met the relevant registration and re-validation requirements. This process of assessing the organisation's readiness for medical and nursing re-validation has been scrutinised both by Trust Board and by the Clinical Governance and Clinical Safety Committee.

Trust Board satisfies itself that the management team has the necessary skills and competencies to deliver the Trust's strategic objectives. Where gaps are perceived, the Chief Executive will seek to address Trust Board concerns, supported by the Remuneration and Terms of Service Committee.

All appointments to senior management positions are subject to rigorous and transparent recruitment processes. Senior managers have objectives linked to the delivery of the strategic objectives and operational plan. The Chair and Chief Executive continue to review the capacity of senior managers within the

DRAFT

Trust to ensure there is the required and necessary balance to deliver and maintain high quality and safe services during a time of unprecedented transformational change within the organisation. Professional and clinical leadership is devolved into the organisation under the leadership of the Director of Nursing, Clinical Governance and Safety, and the Medical Director.

The Trust also has a programme in place for all managers within the Trust at Bands 7 and above, Middleground, which aligns effort and resources to shared organisational goals, ensures all effort and initiatives link together to create added value, ensures behaviours and actions are aligned to the organisational vision, values and goals, and ensures behaviours help produce performance, assurance and improvement at individual, team and organisational level. The Talent Pool is now well-established to identify, nurture and develop talent within the organisation.

Risk
The Trust does not have suitably qualified individuals at all levels of the organisation. Mitigated by recruitment and selection processes for Trust Board, Director-level appointments and staff at all levels.

*Areas in red will be confirmed at the Audit Committee meeting on 25 May 2017 as part of the approval of the Annual report and accounts 2016/17.

DRAFT