The Dudley Group
NHS Foundation Trust

E – Governance
Paper for Council of Governors - 5 June 2019

TITLE:	**NHS Provider Licence Self-Certification**		
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CLINICAL STRATEGIC AIMS		
Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.	*Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.*	*Provide specialist services to patients from the Black Country and further afield.*

ACTION REQUIRED OF BOARD			
Decision	**Approval**	**Discussion**	**Other (Assurance)**
		Y	

OVERALL ASSURANCE LEVEL			
Significant Assurance	**Acceptable Assurance**	**Partial Assurance**	**No Assurance**
☐	☐	☒	☐
High level of confidence in delivery of existing mechanisms / objectives	General confidence in delivery of existing mechanisms / objectives	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	No confidence in delivery

RECOMMENDATIONS FOR THE BOARD

The Trust operates under an NHS Provider Licence, and is required to self-certify on an annual basis whether or not they have complied in full with its condition of license G6, CoS7, FT4 and can confirm compliance on offering and undertaking training with Governors.

Recommendations:

(1) (a) **G6** - Systems for compliance with licence conditions and related obligations
Recommendation 1: The Trust was '**Not Confirmed'** compliant with Condition G6

Basis for recommendation:
Failure to meet all the conditions of its licence as demonstrated with the issuing of four section 31 breaches (*see appendix 5).*

(b) **CoS7** (FTs designated CRS only) – Availability of resources
Recommendation 2: The Trust was '**Confirmed'** compliant (*see appendix 6).*

Basis for recommendation
The Trust Board has approved the Trust's financial operational plans for the financial year

2019/20 that demonstrates that the Trust may require working capital to deliver sustainable services. A letter received from the Department of Health), indicates that if the Trust were to require working capital this would be made available to the Trust.

(2) **FT4** - governance compliance
Recommendation 3: The Trust was **'Not Confirmed'** compliant with condition FT4

Background
The Trust was compliant with all elements of FT4 conditions with the exception of section 5c and therefore cannot record compliance in full with the condition (*see appendix 7*).

Extract from NHSI FT4 (5c) - governance conditions:

5. The Licensee shall establish and effectively implement systems and/or processes:

(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

Basis for recommendation:
Breaches (4, s31s) of the licence, demonstrate a lack of effective governance.

(3) NHSI also requires the Trust to certify that during the financial year most recently ended the licensee has provided the necessary training to its Governors, as required in section 151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role (this must be certified by the Board, having regard to the views of the governors.

Recommendation 4: The Trust was **'Confirmed'** compliant with this condition

Basis for recommendation:

The results of the Council of Governors survey (April 2019):

- 94.7% of governors said they had received an effective induction on the role of the Council of Governors and its statutory powers
- 88.9% of governors reported that training was provided on an on-going and timely basis
- 89.5% said that briefings were provided in relation to key topics when required

Foundation Trust self-certification for Condition G6 must be published on Trust website on 31 May 2019 (this will be delayed by a week to allow for appropriate discussions to take place in various forums) and FT4 governance compliance by 30 June 2019.

CORPORATE OBJECTIVES:

SO1 Deliver a great patient experience

SO2 Safe and Caring services

SO3 Drive Service improvements, innovation and transformation

SO4 Be the place people choose to work

SO5 Make the best use of what we have

SO6 Deliver a viable future

SUMMARY OF KEY ISSUES:

The Trust failure to comply with its licence conditions due to its *s31s*, has resulted in the Trust having to record that it is 'not compliant' with its licence on the stated conditions below on its self-certification:

G6	Systems for compliance with licence conditions. DGFT – **'Not Confirmed'** (not compliant)
CoS7	Availability of resources DGFT – **'Confirmed'** (compliant)
FT4	Governance compliance DGFT – **'Not Confirmed'** (not compliant)
Statement required	Has the Trust provided the necessary training to its Governors DGFT – **'Confirmed'** (compliant)

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** covers many risks, nut key are those related to the Trust quality priorities, deteriorating patient and patient experience
	Risk Register: Y		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** links all domains
	NHSI	**Y**	**Details:** links to good governance
	Other	**N**	**Details:**

The Dudley Group
NHS Foundation Trust

Provider Licence Self-Certification Report

Content

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NHS Foundation Trust

Provider Licence Self-Certification Report

1 Background

On 1st April 2013, Monitor's healthcare licensing regime was implemented for all NHS Foundation Trusts (The Health and Social Care Act 2012). It replaced the Terms of Authorisation for Foundation Trusts and is the main tool NHS Improvement (NHSI - previously Monitor) uses for regulating providers of NHS services.

All NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence, and, have complied with governance requirements.

Providers should review whether their governance systems meet the standards and objectives in this licence condition. There is no set standard or model to follow; instead in determining whether the Trust is compliant, the Trust should assess effective board and committee structures, reporting lines and performance and risk management systems

NHSI guidance, most recently updated in March 2018, requires NHS Providers to self-certify the following three Licence Conditions after the financial year-end:

- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution - Condition G6;
- The provider has complied with required availability of resources arrangements - Condition CoS7;
- The provider has complied with required governance arrangements - Condition FT4;
- In addition, whilst not a condition of licence the Trust must, review and self-certify whether Governors have received enough training and guidance to carry out their roles.

2 What is required?

Overall the aim of self-certification is for providers to carry out the necessary due diligence to assure that they are in compliance with the conditions, and any internal process must ensure that the Board understand clearly whether the Trust is able to confirm compliance.

NHS Improvement has found the Trust to be in breach of specific licence conditions (G6 - during 2018/19 and the Trust has accepted this finding, the Board is unable to certify that it had effective governance arrangements as necessary in order to comply with the conditions of the licence in full during 2018/19).

3 Recommendations

G6	Systems for compliance with licence conditions. DGFT – **'Not Confirmed'** (not compliant)
CoS7	Availability of resources DGFT – **'Confirmed'** (compliant)
FT4	Governance compliance DGFT – **'Not Confirmed'** (not compliant)
Statement required	Has the Trust provided the necessary training to its Governors? DGFT – **'Confirmed'** (compliant)

Appendix 1

Condition G6 – Systems for compliance with licence conditions and related obligations

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:

(a) the Conditions of this Licence,

(b) any requirements imposed on it under the NHS Acts, and

(c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:

(a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and

(b) regular review of whether those processes and systems have been implemented and of their effectiveness.

3. Not later than two months from the end of each Financial Year, the Licensee shall prepare and submit to NHSI a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not 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 this Condition.

4. The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to NHSI in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it.

Appendix 2

Condition CoS7 – Availability of resources

1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.

2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.

3. The Licensee, not later than two months from the end of each Financial Year, shall submit to NHS Improvement a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms:

   (a) "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."

   (b) "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services".

   (c) "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate".

4. The Licensee shall submit to NHS Improvement with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.

5. The statement submitted to NHS Improvement in accordance with paragraph 4 shall be approved by a resolution of the board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.

6. The Licensee shall inform NHS Improvement immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have the reasonable expectation referred to in the most recent certificate given under paragraph 3.

7. The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.

8. In this Condition:

"distribution"	includes the payment of dividends or similar payments on share capital and the payment of interest or similar payments on public dividend capital and the repayment of capital;
"Financial Year"	means the period of twelve months over which the Licensee normally prepares its accounts;
"Required Resources"	means such: (a) management resources, (b) financial resources and financial facilities, (c) personnel, (d) physical and other assets including rights, licences and consents relating to their use, and (e) working capital as reasonably would be regarded as sufficient to enable the Licensee at all times to provide the Commissioner Requested Services.

Appendix 3

Condition FT4 – NHS foundation trust governance arrangements

1. This condition shall apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

2. The Licensee shall apply 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.

3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:

   (a) have regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time; and

   (b) comply with the following paragraphs of this Condition.

4. The Licensee shall establish and implement:

   (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.

5. The Licensee shall establish and effectively implement 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.

6. The systems and/or processes referred to in paragraph 5 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's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

8. The Licensee shall submit to NHS Improvement within three months of the end of each financial year:

(a) a corporate governance statement by and on behalf of its Board confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks; and

(b) if required in writing by NHS Improvement, a statement from its auditors either:

(i) confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its corporate governance statement applicable to the past financial year, or

(ii) setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year.

Appendix 4

Statement of Compliance / Non Compliance G6, CoS7, FT4 & Training Governors

1 Condition G6 – Systems for compliance with licence conditions and related obligations

Not confirmed (non-compliance)

- *Non-compliance as evidenced by the issuing of four s31s during 2018/19.*

2 Condition CoS7 – Availability of resources

Confirmed (compliant)

- *Trust's financial operational plans for 2019/20, demonstrates that the Trust may require working capital to deliver sustainable services.*
- *Extract from Dept of Health letter - indicates working capital would be made available if the Trust were to require it.*

3 Condition FT4 - Governance compliance

Not confirmed (non-compliance)

- *Breaches (four, s31s) of the licence demonstrate a failure of the governance arrangements in particular but not limited to a failure by the Licensee to ensure appropriate systems and standards of governance, adequate oversight by the Board and establishment.*

4 Statement on training governors

Confirmed (compliant)

- *The Trust has surveyed the views of Governors (April 2019) on whether Governors have received effective training and guidance to carry out their roles. The view of governors was 89%, in the affirmative.*

Condition G6 – Systems for compliance with licence conditions and related Obligations – Evidence on elements of compliance

Lead Exec	Compliant	Comment	Evidence (supporting information)
Overall: **Not Compliant** with Condition G6 – Systems for compliance with licence conditions			
Part 1			
COO	**N**	The DGFT was registered with CQC throughout the financial year. DGFT are currently registered with four conditions. The Executive Lead for the CQC is the Chief operating Officer. Breaches (s31s) of the licence demonstrate a failure of effective governance arrangements.	Non-Compliant ED: Action being taken in the following areas: 1 – Triage Activity 2– Triage Audit 3 – Sepsis 4 – ED staffing 5 – e-Observations 6 – Safeguarding 7 – Specialist Clinical Expertise
DoG	Y	**Comments:** (A) Controls relating to this are described in the whole of this appendix (B) The Trust is registered with the CQC and the HTA as per the NHS Acts. (C) The Board is not aware of any other significant requirements under the NHS Acts.	**Evidence - to support elements of compliance in comments section:**
		The NHS constitution establishes the principles and values of the NHS in England. The constitution can be broken down into 6 key areas, 4 of which apply to requirements for the organisation: guiding principles, NHS values, rights of patients & public and rights for staff. The Trust's two year strategy echoes the **guiding principles** in the NHS constitution including putting the patient at the heart of everything the organisation does, working across organisational boundaries and aspiring to achieve the highest standards of excellence & professionalism. The strategy also provides a set of **values** that are consistent with those in the NHS constitution including promoting respect & dignity, commitment to quality of care and being compassionate. The measurement of the outcomes of these indicators is through consideration of a suite of reports received by the Board and its Committees and at an Executive level by reports to the weekly Executive meeting.	• Two year forward strategy and strategy refresh • Integrated Performance Report • Quality Account • Dudley Improvement Plan • Clinical Quality, Safety and Patient Experience papers • Finance & Performance Committee meeting papers • Use of Resources • Quality & Patient Safety report • Executive complaints reports • National Staff Survey results

Lead Exec	Compliant	Comment	Evidence (supporting information)
		The Trust has also established a number of arrangements to monitor quality governance and improvements in quality. These include the use of performance dashboards, a clinical audit programme, the review and monitoring of Nursing Care Indicators and the robust monitoring against local and national targets for quality measures including healthcare associated infections (HCAI), pressure ulcers and falls, all of these linking to the Trust's own Quality Priorities. The Trust has further developed its integrated performance report during 2018/19 which sees a consistent base set of data being used to report to each of the Committees of the Board - Finance and Performance and Clinical Quality, Safety and Patient Experience as well as operationally to the divisions and the executive. Complementing this reporting has been the enhancement of the quality dashboards for each ward providing visual feedback on quality metric delivery for staff and patients. Nursing Care Indicator audits, along with the undertaking of Matrons' observation audits, measure the quality of care given to patients and the monthly audits of key nursing interventions and associated documentation, are published, monitored and reported to the Board of Directors by the chief nurse. This is supported by the implementation of real-time surveys, capturing the views of patients and using these to make improvements. The Trust continues to monitor the hospital standardised mortality ratio (HSMR) to ensure it is consistent with national levels. In terms of compliance with the constitutional requirements relating to the **rights of the public and patients**, compliance is demonstrated through performance against the range of nationally commissioned targets set out in the Quality Account & Annual Report. The specifics relating to confidentiality & consent are monitored respectively by the Caldicott and information Governance Group (the DPO, SIRO, CIO and Caldicott Guardian. In terms of complaints and redress, the Trust has made improvements to its processes for complaints handling during the year and	• Quality Account 2018/19 • Annual Report 2018/19 • Data security toolkit toolkit submission • Minutes of Clinical Quality, Safety and Patient Experience • Annual complaints reports to Clinical Quality, Safety and Patient Experience Committee • Duty of Candour updates to Clinical Quality, Safety and Patient Experience Committee • CQC report and CQC action plan • Screenshot of joint formulary • NICE guidance internal audit and action plan • Performance against access targets included in the Integrated and Performance report

Lead Exec	Compliant	Comment	Evidence (supporting information)
		acknowledge complaints within 3 working days of receipt. The right to drugs and treatments can be demonstrated by the Joint Formulary available on the internet and by the work undertaken during the year to address a shortcoming in the handling of new NICE guidance issued. Regarding the **rights of staff**, the Trust has policies and procedures in place to support staff and ensure that their needs are met appropriately. The Trust has a Workforce Strategy which identifies the Trust's workforce priorities over the next 5 years with alignment directly with the Trust Strategy 2019-2021 (Care Better Every Day) as well as consideration of the NHS 10 year plan. The Strategy supports our staff to achieve the 6 strategic objectives within our Trust Strategy underpinned by our values of Care, Respect and Responsibility. The Workforce Strategy provides four strategic workforce priorities that are underpinned by Strategic aims as well as initiatives to support these aims and measures of success. The strategic workforce aims are: Diversity & Inclusion; Improvement and Learning Culture; Staff Well-Being; and Workforce Capacity. The aims to support each of the strategic priority areas will be overseen by the Workforce and Staff Engagement Group that reports to the Finance and Performance Committee of the Board to provide assurance that priorities are being met. The Trust has a raising concerns speak up safety (whistleblowing) policy in place The Trust has in place a Freedom to Speak Up Guardian who reports to the Chief Nurse. The Trust Board is supported by the Finance & Performance Committee underpinned by the work of the Workforce and Staff Engagement Woking Group. The Finance Committee seeks assurance on the Trust's adherence to staff-related policies, workforce matters and organisational development.	• Workforce policies, including Freedom to Speak Up • Establishment of the Equality & Diversity network • Schwartz Round information • EDS2 assessment to Trust Board and Staff Experience & OD Committee • WRES assessment to Staff Experience & OD Committee • Freedom to Speak Up presentation to Trust Board • Freedom to Speak Up Guardian role description • Staff Experience & OD Committee terms of reference • National staff survey results

Lead Exec	Compliant	Comment	Evidence (supporting information)
Part 2			
DoG	Y	**Comments:** The Director of Governance / Trust Board Secretary has Board level responsibility for the oversight of the Trust's risk management policies and processes. Board Committees have oversight and assurance reporting of BAF and Corporate Risks assigned to them. Bard Committees meet monthly; each Committee is in place to challenge the levels of assurance throughout the organisation and to ensure the effective management and mitigation of risks. Additionally, each division of the Trust, through their divisional governance framework, reports to the Clinical Quality, Safety and Patient Experience Committee on operational risks. The Trust has a comprehensive induction and training programme, supplemented by e-learning training packages and additional learning opportunities for staff. Collectively, these cover a wide range of governance and risk management topics for both clinical and non-clinical staff in all disciplines and at all levels in the organisation. The Head of Internal Audit Opinion for 2018/19 confirms that the Trust has adequate internal control mechanisms, however there is further work to do.	**Evidence - to support elements of compliance in comments section:** • Annual Governance Statement • Board Assurance Framework • Corporate Risk Register • Risk Management Strategy • HOIA 2018/19

Appendix 6

Condition CoS7 – Availability of resources

Evidence on elements of compliance

Lead Exec	Compliant	Comment	Evidence (supporting information)
Overall: Compliant with Condition CoS7 – Availability of resources			
DoF	Y	**Comments:** After making enquiries the Directors of Finance of the Trust has a reasonable expectation, subject to what is explained below, that the Trust will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factor which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services. The Trust Board has approved the Trust's financial operational plans for 2019/20 that demonstrates that the Trust may require working capital to deliver sustainable services	**Evidence - to support elements of compliance in comments section:** Financial operational plans, CiP programme (2019/20) and working capital considered by the Finance & Performance Committee in March and April, 2019. *Extract from Dept of Health letter 21 May 2019:* 'In advance of wider reforms, the Department recently agreed extensions to loans due during the 2018-19 financial year to November 2019. The Department will continue to take refinancing decisions on loans due in the coming year. Such options, as well as the ongoing availability of interim support, are available to ensure that NHS providers remain operationally viable'.

Condition FT4 - governance compliance

Lead Exec	Compliant	Comment	Evidence (supporting information)
Overall: Not Compliant with Condition FT4 - governance compliance			
DoG	N	The DGFT was registered with CQC throughout the financial year. DGFT are currently registered with four conditions. The Executive Lead for the CQC is the Chief operating Officer. Breaches (s31s) of the licence demonstrate a failure of the governance arrangements in particular but not limited to a failure by the Licensee to ensure appropriate systems and standards of governance, adequate oversight by the Board and establishment.	**Non-Compliant ED (S31s):** Weekly reporting - 'ED' covering: • Report 1 – Triage Activity • Report 2– Triage Audit • Report 3 – Sepsis • Report 4 – ED staffing • Report 5 – e-Observations • Report 6 – Safeguarding • Report 7 – Specialist Clinical Expertise
DoG	Y	**Comments:** **The Trust was compliant with all elements of FT4 conditions with the exception of section 5c and therefore cannot record compliance in full with the condition.** The Board is assured from the work of the Audit Committee, its Internal and External Auditors and their opinions received during the year. The Trust has also been rated as "good" by the CQC within the domain of well led This is reflected in the Trust's Annual Governance Statement. 2) The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time. 3) The Board is satisfied that the Trust implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation. 4)The Board is satisfied that these processes were referred to and their effectiveness was considered by the	**Evidence (to support statement in comment section:** • The Board of Directors has a Strategic Framework for Risk Management which is reviewed and updated bi annually • The Trust's Internal Auditors conducted a review of the Trust's risk management processes, and has provided assurance that there were no significant control issues • The Board of Directors receives quarterly reports on the Trust's new top risks • The Board Assurance Framework (BAF) is in place as the framework for identification and management of strategic risks, and will be reviewed regularly by Executive Directors and the Board's assurance committees • 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. This statement includes a description of the Trust's risk management and assurance frameworks. It is reviewed by the Trust's external auditors and presented to the Board's Audit Committee as part of the Trust annual accounts before receiving sign off by the Board of Directors • Annual Head of Internal Audit Opinion does not identify any significant control gaps • The Board of Directors has established Assurance Committees each chaired by a Non-executive Director together with other Non-executive Director members that

Lead Exec	Compliant	Comment	Evidence (supporting information)
		Accountable Officer when drafting the Trust's Annual Governance Statement with this description then considered by the Audit Committee as it endorsed the AGS for submission to the Auditors. Respective Committee reporting to the Board is operating effectively as evidenced by the regular reports to the Board from each Committee Chair. 5)The Board is satisfied that the Trust effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (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. The Board is satisfied directly and through its Committee structure has been assured that the Trust's designed systems of internal control have been operating effectively and as intended over the year. Where issues have arisen	ensure that there is effective monitoring and assurance arrangements in place to support the system of internal control • Audit Committee provides assurance to the Board of Directors about the soundness of the overall systems of governance and internal control. It reviews risk management Systems and Processes, Financial Risk Management and seeks assurance on the overall management of strategic risk on the Board Assurance Framework • The Head of Internal Audit opinion stated that "The organisation has an adequate and effective framework for risk management, governance and internal control" and identified "further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective".

Lead Exec	Compliant	Comment	Evidence (supporting information)
		during the year, for example in respect of operational performance, timely actions have been implement to improve these areas. Assurance is routinely and regularly obtained as to the quality of the data supporting the Trust's performance reporting and decisions being taken. The Board has approved the Trust's longer term strategy and annual plan. Key risks and associated assurance has been reported to the Audit Committee and Board during the year and the process has been subject to Internal Audit review which concluded positively over the Trust corporate risk and assurance processes.	

KEY	Lead
COO	Chief Operating Officer
DoF	Director of Finance
DoG	Director of Governance