

Annual Self-Certifications



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Corporate Governance Statement

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

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.

Confirmed

Risks and mitigating actions

The Board has reviewed the Code of Governance published by Monitor in 2014 and confirms compliance with all requirements, except for the requirement for all Non-executive Directors to be independent. The spouse of one of the Trust's Non-executive Directors was employed in a strategic role (a Clinical Director) during the year, (this arrangement was changed in March 2014). The Chairman is also in his final year of office having served 8 years as a Non-executive Director and Chairman.

The Board continues to keep the Corporate Governance arrangements under review as part of its approach to good governance. During the year internal audit identified some areas of development for the risk management processes employed in the Trust. The Risk Management Department have secured the support of an external advisor who will provide some additional training and support to the planned improvements that are being put in place to ensure the organisation has fully integrated risk management arrangements in place during 2014/15. This work is being overseen by the Corporate Risk Committee.

The Board of Directors has confirmed that it complies with the elements of Monitor's Quality Governance Framework. Assurance and compliance are monitored via the Quality and Safety Committee, a subcommittee of the Board of Directors and the Board will review a revised action plan to ensure the Trust continues to comply with the framework.

An Annual Plan is produced each year which underpins the strategic plan that covers 5 years. The Board has reviewed both the Annual Plan and the Strategic Plan. The development of these Plans has involved consultation with the Governors and the key stakeholders of the Trust.

The Board has in place a number of Board Committees that support the Board in the discharge of its duties. These are Quality and Safety, Finance and Performance, Corporate Risk, Audit, Workforce Strategy and Remuneration.

The Board reviews performance monthly through the Performance Report, Patient Quality and Safety Report, Chief Nurse Report and Medical Director Report, Finance Director Report and Chief Executive Report. In preparation for the monthly Board meeting, the Quality and Safety Committee and Finance and Performance Committee meet and discuss the performance in detail. The results of these meetings are included in the Board meeting and so provide current assurance. Quarterly, the Board reviews the draft statements submission to Monitor and confirms that the information included is consistent with the information received by the Board during the quarter.

The Patient Safety and Quality Report provide detailed information about patient safety issues such as mortality, harm events, infection control issues, drugs administration and patient safety walk rounds. It provides information on clinical effectiveness and patient experience. The Medical Director Report supports this information and provides more detail around key topics such as SHMI, PROMS and the Patient Safety Strategy.

The Trust produces an annual quality report. It identifies the priorities for patient safety, clinical effectiveness and patient experience for the coming year. These are aligned to the CQUIN targets and the Patient Safety Strategy.

All members of the Board of Directors have received an appraisal in the last 12 months; the executive directors are appraised by the Chief Executive, and the Chief Executive is appraised by Chairman. The non-executive directors are appraised annually by the Governors, through the leadership of the Chairman. The Chairman is also appraised annually; this appraisal is jointly-led by the Senior Independent Director and the Lead Governor

The Board has developed and articulated a clear vision for the organisation which is supported by the strategies that have been formulated by the Trust.

The Trust has in place a fully developed clinical audit programme which is led by the Medical Director. The programme includes national audits and confidential enquires, along with local clinical audits designed to improve the quality of healthcare provided.

The Trust implements a programme of patient safety walk rounds that involve all Board members. The output from these walk rounds is reviewed and actioned by the executive directors and reviewed by the Quality and Safety Committee and reported monthly to the Board.

The Trust has in place a Nursing & Midwifery Strategy and a new Patient Safety Strategy. These strategies underpin the approach the Trust adopts to quality and safety.

The Board receives a quarterly update from the Director of Infection Prevention and Control on the performance of infection control and the actions being undertaken to improve performance. This quarterly report is underpinned by the monthly update the Board receives as part of the monthly performance reporting presented by the Medical Director.

The Board agenda is designed so the Board considers patient safety and quality issues first and all other items are related back to patient safety and quality.

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

Confirmed

Risks and mitigating actions

The Board has put in place a system where all guidance on good corporate governance is reviewed and any areas of non-compliance are reported to the board on a 'comply or explain' basis.

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.**

Confirmed

Risks and mitigating actions

The Board has recently reviewed the committee arrangements and has created a new Board Committee to address the management of key risks and the assurances identified by the executive directors as part of the assurance framework. The Board keeps the governance structure under review during the year to ensure it remains fit for purpose.

The accountability arrangements in place at Board and Committee level are clearly understood and acted upon. The Chairs of the Committees report regularly to the Board of Directors on the progress of the work in the Committee. The key committees associated to performance in the Trust (Quality and Safety and Finance and Performance) report monthly to the Board and provide assurance around the previous month's reports.

As part of a governance review the Trust has reviewed the accountability arrangements across the organisation and is undertaking a further piece of work to strengthen the understanding that staff have around their reporting lines and accountability arrangements across the Trust.

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

- (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;**
- (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;**
- (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;**
- (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);**
- (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;**
- (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;**
- (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.

Confirmed

Risks and mitigating actions

The Board is satisfied that the Trust has effectively implemented systems and processes that ensure compliance with the Licensee's duty to operate efficiently, economically and effectively. As part of the year-end process, the Trust undergoes an independent audit which includes a review of the use of resources. The external auditors gave an unqualified opinion of the use of resources in the Trust. The Trust's Audit Committee reviews the systems and processes (including clinical audit) that are in place, which includes those parts of the Licensee duty and reports regularly to the Board of Directors on the findings and assurances the committee has received. The Trust has in place a robust internal audit service provided by an independent organisation and an agreed work programme of audits that are undertaken during the year. These audits are reported directly to the Audit Committee.

The Board has received information on the requirements of the licence and during the year has reviewed the quarterly compliance of the Trust with the expected targets and trajectories.

The Board maintains awareness of the regulatory, legal and standard requirements that are placed on Trusts and raises them at the Board as they become known and as they come into effect. The most recent example of this is the recent requirement around staffing establishment in ward areas.

The Board has received assurance from the External Auditors on the effectiveness of the systems and processes in place around effective financial decision making, management and control. This has formed part of the year end assurances received by the Board. This is also underpinned by the Internal Audit programme of audits undertaken during the year. Reports are submitted for review to the Audit Committee. The Audit Committee raises any concerns with the Board of Directors. The Trust also underwent a review by Monitor on the Cost Improvement Programme. That report was positive in most regards about the systems and processes in place in the organisation around the management of cost improvements and provided recommendations, which have been accepted, to further strengthen the programme.

The Board has a robust work programme which ensures that information required at the Board is received in a timely manner. The Committees supporting the Board meet on a regular basis and have a detailed forward work programme which is fed from the Board and other more operational groups and which feeds information forward to the Board. Between meetings there is ongoing debate between the Chairman, Chief Executive, other Directors, Non-executive Directors and Foundation Trust Secretary to ensure any adjustments to programmes or agendas are addressed. The Trust has in place an action plan following each meeting which is implemented within the agreed timelines.

The Board receives monthly information on the performance of the Trust and reviews any potential breach of the terms of the licence. The most recent example of this was at quarter 3 when the Trust reviewed the number of patients that were waiting more than 18 weeks for treatment. A thorough analysis identified the historic and operational reasons for a growth in the number of patients waiting in excess of 18 weeks and discussed a plan

to ensure these patients' treatment were expedited with both Monitor and Commissioners. The plan, including a "planned failure" of the target, was subsequently agreed and delivered.

As part of the management of the operational performance of the Trust there is a weekly meeting that includes: the Chief Executive, Chief Operating officer, Director of Finance and Director of Systems and Network and the Director of Operations where there are detailed discussions about the current operational performance and any concerns or issues that might require action and forward planning. At the end of each week the Directorate Managers and the Deputy Director of Performance and the Director of Operations meet to review and escalate any performance issues that maybe coming apparent.

The Trust keeps the annual plan under review during the year. The Chief Executive provides a six month summary of performance against the annual plan in his Board report. During 2013/14 the Trust also underwent a review of the quality aspects of the annual plan through the second stage review process. The report identified that the Board was well informed and had an appropriate support system in place to review quality and safety issues. The Trust involves the governors in the development of the annual plan and strategic plan that is currently being developed. The intention is to hold a Board to Board meeting in July with the Governors and to reflect on the next five year strategy of the Trust.

5 The Board is satisfied that 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 Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and**
- (f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.**

Confirmed

Risks and mitigating actions

The Board considers the capabilities of the Board members during the year and at the beginning of 2013/14 increased the executive membership by adding a Director who specialised in organisational and corporate development. The Board recognised during the continuing integration of Scarborough and formulation of a larger Trust the additional

significance of organisational development in the effective functioning of the Trust. The Board has a Medical Director (who is the DIPC and Caldicott Guardian) and Chief Nurse as part of the executive management of the Board. The Board also includes attendance by the Director of Nursing and a further director has a background in midwifery. The Board reviews the capabilities of the Board members individually as part of the annual appraisal process, including discussion of succession planning

The Board makes collective decisions and takes into account the quality aspects of any decision made. During discussions in the Board meeting, the Chairman actively seeks the views of the Medical Director, Chief Nurse and Director of Nursing in terms of the implications on the quality of care of a decision. The Quality and Safety Committee also provides an additional opportunity for the Board to receive assurance on the impact on quality as the Committee reports to the Board on a monthly basis. The Quality and Safety Committee reviews papers in advance of the Board and provides the Board with the assurance it needs around the accurate and comprehensive nature of the papers.

Each Board meeting receives a patient experience item as the first item on the agenda. This sets the context of the Board meeting and helps to ensure that the rest of the meeting is linked to quality and safety of services and patients. The Board has, through the Quality and Safety Committee, reviewed the Quality Governance Framework and will undertake a further review later in the year.

The Trust was part of a second stage review of the annual plan during September, specifically related to quality. The report demonstrated that the Board had appropriate and robust systems in place to review quality on a monthly basis.

The Trust engages the Governors and users in the quality of services. The Trust has an active patient experience department where patients and carers are actively encouraged to be part of the development of services.

Members of the Board have a weekly meeting, specifically involving the Chief Executive, Chief Nurse and Director of Nursing where the complaints received by the organisation during the previous week are reviewed and an understanding of the scale and trend of the complaints is appreciated at a senior level. On a selective basis, the Chief Executive requests directors to personally supervise particularly sensitive or important complaints. There are number of reports that the Board of Directors receive on a monthly and quarterly basis which outlines the views and involvement of patients and the public in the work of the Trust.

The Trust also has a Patient Experience Steering Group which includes Healthwatch as part of its membership. This meeting collates information about patient experience and interprets it into future actions and ideas for strategy development.

The Medical Director and Chief Nurse meet weekly with the patient safety and risk and legal teams to review all infection control, mortality and serious incidents and other matters pertaining to patient safety and a summary of this meeting is presented weekly at the meeting of Executive Directors to ensure timely reporting and where required, immediate action.

Where there are issues or concerns raised by staff or patients there are a number of routes that can be used to ensure the Board is made aware of the issue when

appropriate. The Directors, including the Non-executive Directors, undertake Patient Safety Walkrounds on a regular basis and speak to staff during those walkrounds. The walkrounds are also undertaken at night.

Staff are also encouraged to raise concerns with their immediate managers or with a Director. The Chief Executive encourages staff to write to him directly on any matter they wish to raise with him and he has a policy that he will aim to respond to any enquiry within 24 hours.

The Medical Director, Chief Nurse and Director of Nursing raise quality issues at the Board monthly as part of their regular reporting. Recently the Finance and Performance Committee raised a quality issue with the Board around the potential effect there might be on a vacancy being held over in a directorate as part of a delivery savings programme. The issue was investigated by the finance team and it was proven that the process used to hold over a vacancy was tested to ensure it did not affect the quality of the service being provided.

6 The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.

Confirmed

Risks and mitigating actions

The Trust has recently undertaken a nursing staff establishment audit and increased the number of nurses in the organisation. The Workforce Strategy Committee, a committee of the Board reviews the detail in advance of the Board and provides support to the Board on the future development of staffing in the organisation.

The Board reviews its membership regularly and specifically on each occasion that there is a vacancy in the Board.

Certification on AHSC's and Governance

For NHS foundation trusts:

- that are part of a major Joint Venture or Academic Health Science Centre (AHSC); or
- whose Boards are considering entering into either a major Joint Venture or an AHSC.

The Board is satisfied it has or continues to:

- ensure that the partnership will not inhibit the trust from remaining at all times compliant with the conditions of its licence;
- have appropriate governance structures in place to maintain the decision making autonomy of the trust;
- conduct an appropriate level of due diligence relating to the partners when required;
- consider implications of the partnership on the trust's financial risk rating having taken full account of any contingent liabilities arising and reasonable downside sensitivities;
- consider implications of the partnership on the trust's governance processes;
- conduct appropriate inquiry about the nature of services provided by the partnership, especially clinical, research and education services, and consider reputational risk;
- comply with any consultation requirements;
- have in place the organisational and management capacity to deliver the benefits of the partnership;
- involve senior clinicians at appropriate levels in the decision-making process and receive assurance from them that there are no material concerns in relation to the partnership, including consideration of any re-configuration of clinical, research or education services;
- address any relevant legal and regulatory issues (including any relevant to staff, intellectual property and compliance of the partners with their own regulatory and legal framework);
- ensure appropriate commercial risks are reviewed;
- maintain the register of interests and no residual material conflicts identified; and
- engage the governors of the trust in the development of plans and give them an opportunity to express a view on these plans.

Confirmed

Training of Governors

The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in 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.

Confirmed

The Board are unable make one of more of the confirmations on the preceding page and accordingly declare:

The Trust is a signatory to the original partnership submission to establish the AHSN Yorkshire and the Humber. The Trust has in place full governance processes relating to any research activity and successfully satisfied the requirements of a MHRA inspection last year. The York Teaching Hospital NHS Foundation Trust operates a Research and Development Committee with strong lay membership, a steering group for the Clinical Research Facility and has Board representation via the Director of Corporate Development. We subscribe to Medipex® and utilise their services regarding protection of intellectual property issues arising through practice. We can confirm that activity is reported through the sub-committees of the Board.

Signed on behalf of the Board of Directors, and having regard to the views of the governors.



Alan Rose
Chairman
26 June 2014



Patrick Crowley
Chief Executive
26 June 2014