GOSH Foundation Trust Licence Self Certification 26 May 2020

Licence condition	Description	Confirmation: Confirmed or Not Confirmed	Assurance
G6 – Systems for compliance with licence conditions and related obligations (scope = past financial year 2019/20)	The Licensee shall take all reasonable precautions against the risk of failure to comply with the Conditions of this Licence, any requirements imposed on it under the NHS Acts, and the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS. The steps that the Licensee must take ….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. A statement shall be provided for Monitor to certify compliance with this condition no later than 2 months from the end of the financial year.	The Executive Team have considered the evidence cited and recommend 'Confirmed'. Response to be considered by the Board in light of assurance provided here and taking into account the views of the governors	The Trust has systems and processes to monitor risks of failure through lack of compliance or adverse variances in performance: There is clear accountability at Board level for safety and clinical quality objectives and structured reporting of performance against these objectives. (see Annual Governance Statement in annual report) The Trust's Assurance and Escalation framework sets out how the organisation identifies, monitors, escalates and manages concerns and risks in a timely fashion and at an appropriate level. This covers the following key areas: • Risk Management • Compliance • Performance • Information Governance • Safeguarding • Health and Safety <u>Risk Management</u> The Trust's risk management strategy, which sets out how risk is systematically managed, extends across the organisation from the front-line service through to the Board, to promote the reduction of clinical and non-clinical risks associated with healthcare and research, and to ensure the business continuity of the Trust. The strategy identifies the organisational risk management structure, the roles and responsibilities of committees and groups that have some responsibility for risk, and the duties and authority of key individuals and managers with regard to risk management activities. It describes the process to provide assurance for the Trust Board review

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			of the strategic organisational risks, and the local structures to manage risk in support of this policy. **Assurance**: The GOSH CQC report (2020) stated: *Staff at all levels were clear about their roles, areas of responsibility and accountability. This included delegation of responsibility to committees. The trust had an assurance and escalation framework with groups and committees providing the board with assurance or escalating concerns and/or risks relating to the quality of services, performance, targets, service delivery and achievement of strategic objectives.* *The GOSH Board Assurance Framework includes a strategic risk of failing to maintain compliance with the Trust Licence (BAF Risk 5). This is monitored by the Risk Assurance and Compliance Group and assurance sought of the robustness of the controls cited at the Audit Committee (see below).* On managing and learning from incidents, the CQC report stated: "*There was a clear system for categorising, reporting, investigating and learning from serious incidents, supported by the incident reporting and learning policy and duty of candour policy. Themes from serious incidents were used to inform targeted improvement work or organisational learning, for example the changes to handover and provision of revised duty of candour training*." The Board receives a regular, high level summary of significant quality related issues currently being managed by the executive team at GOSH. It includes summaries and learning from internal and external reviews of services as well as concerns identified through concerns raised by our staff and our patients and their families; and through the aggregation of data regarding quality performance. **Assurance**: The GOSH CQC report (2020) stated: *"The trust had systems and processes for identifying risks, planning to eliminate or reduce these, and coping with both the expected and unexpected. The risks recorded on the corporate risks*

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			register reflected those that leaders stated were the top risks and there was evidence that these were regularly reviewed." *"Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care."* The CQC stated (Surgery service): *Staff recognised and reported incidents and near misses.* Critical care service: *The last four governance committee minutes included discussions about complaints, incidents, key performance indicators (KPIs), training, risk register, learning, issues from other health and safety committees, and other clinical issues and audits. Actions to address concerns or outstanding issues were identified and monitored through the monthly critical care governance meetings. The meetings were minuted for dissemination to other staff who were not able to attend.* The Trust's Board Assurance Framework is used to provide the Board with assurance that there is a sound system of internal control in place to manage the key risks to the Trust of not achieving its strategic objectives. The BAF records the controls in place to manage the key risks, and highlights how the control is operating. The BAF includes cross-references to assurance obtained from internal and external audits, and self-assessments of compliance with other regulatory standards. It has been monitored by the Board assurance committees and updated throughout the year. In April 2020 the Board is reviewing an updated BAF which has been aligned with the refreshed 5 year Trust strategy. The Risk Assurance and Compliance Group monitors progress with the BAF. This includes a 'stress test' of BAF risks to check (using key performance indicators and external assurance information) whether the controls and assurances cited are working and appropriate.

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			Assurance: The GOSH CQC report recommended (must do): "*Ensure the board assurance framework reflects all known medicine risks, including the storing, administration and destroying of medicines in line with legislation and the trust medicines management policies."* This recommendation has been acted upon and the relevant BAF updated to reflect the different stages of managing medicines safely. <u>Compliance</u> The foundation trust is fully compliant with the registration requirements of the Care Quality Commission. The Trust has identified an executive director and a manager who are respectively accountable and responsible for ensuring compliance with the CQC registration standards. It is the responsibility of these staff to collate evidence of compliance with the standards. The evidence is reviewed periodically by compliance staff. In December 2019, the CQC conducted a scheduled unannounced inspection of three services (critical care, surgery and CAMHS) and an announced inspection against the well-led criteria. The report was published in January 2020. The Trust retained a rating of 'Good' overall. The CQC issued 2 enforcement notices: • Regulation 12: Safe Care and Treatment: This recommendation relates to the robustness of access control measures in PICU medication room; the safe storage of IV fluids in theatres, interventional radiology and on one of the surgical wards; the process for denaturing controlled drugs on wards; and the temperature monitoring arrangements for medication rooms. **Assurance**: Work has been conducted to review and secure storage of IV fluids across theatres and radiology and update access control in PICU. Progress with denaturing of controlled drugs and temperature monitoring arrangements are underway. • Regulation 17: Good Governance: This recommendation relates to the articulation of the breadth of the medicines risk on the board assurance framework; and the need to ensure that the EPR system fully meets the needs of the staff in the CAMHS service to deliver safe care.

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			Assurance: Medicines risk: The medicines BAF has been updated and is subject to regular review by the Risk Assurance and Compliance Group. **Assurance**: EPR and CAMHS service: Following the inspection in October 2019, work began immediately between the EPR and CAMHS team to identify and address problems. This included instigating a formal Speciality Level Optimisation process. There is an associated action log which tracks progress, and all actions which had been classified as high risk were completed in March 2020. In total the hospital was advised of 4 'Must Do' actions which were required to bring services in line with legal requirements. The Trust was also been advised of 18 'Should Do' actions (10 Trust wide, 2 Critical Care, 3 Surgery and 3 Mental Health) which were required to comply with minor breaches that did not justify regulatory action and to prevent the service from failing to comply with legal requirements in future, or to improve services. **Assurance**: The Trust ran a programme of work to ensure CQC readiness and to maintain compliance for the Trust with a view to ensuring that compliance and governance are interlinked with quality, safety and experience and embedded in day to day working within the Trust. A CQC action plan has been developed to address all actions. An executive led committee, Always Improving, has been established and meets monthly to review progress against this action plan, whilst supporting the ongoing work with the Trust's CQC compliance. This committee reports into the Risk, Assurance and Compliance meeting with regular reports to Board and the Council of Governors. The Trust will continue to conduct mock inspection framework (CQC Quality Rounds) in clinical directorates and review potential areas/sources of learning for example reviews of themes from other CQC reports and evaluation of CQC Insight reports. The Quality, Safety and Experience Assurance Committee receives updates on CQC compliance and all other compliance areas on a regular basis. A database supports monitoring of ongoing inspections, audits and self -assessments.

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			<u>Information Governance</u> The Information Governance Steering Group monitors information governance risks and compliance with GDPR. The Trust has been compiling its submission for the Data Security and Protection Toolkit (DSPT). This annual submission demonstrates GOSH's position against the legal requirements providing assurance that we are practicing good data security and our personal information is handled correctly. While GOSH is already compliant with the majority of mandatory requirements, some areas of improvement have been identified for which action plans have been produced. These include fully implementing the compliance with the national data opt-out and training levels for staff. This year there have been three serious information governance incidents (classified at a reportable level using the Incident Reporting Tool within the DSPT) involving sensitive information. Details are as follows: • Over 60 cases were identified of staff having sent emails containing patient data non-securely to personal emails. • Monitoring information of 10 new members of staff was erroneously sent to their new managers. • A letter containing sensitive safeguarding information was sent to an incorrect address local to a patient. Each of these cases have been reported to the Information Commissioner's Office (ICO) and NHS England as Serious Reportable Incidents with an internal root cause analysis completed and shared. The learning from these has been implemented back into Trust practice to ensure similar incidents do not occur. The ICO considered the information provided via reporting and investigating and in each case decided that no further action was necessary given the Trust's response and approach.

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			The Trust's internal auditors conducted an audit of compliance with elements for GDPR and provided a rating of 'partial assurance with improvements required'. Whilst the report found that *"Effective governance structures have been established to oversee the delivery of the Trust's information governance and data privacy requirements", the Trust's information asset register did not document all requirements and additional physical controls for limiting access to the Trust IT systems were recommended.* The CQC also stated that the Trust should *"Improve the accuracy of the trust's information asset register".* An action plan is in place – the port control programme has been rolled out and the information asset register is in the process of being completed across the Trust. *The CQC report stated: "The board were sighted on information governance issues including some issues with data quality which could impact on its ability to accurately report performance internal and externally. While data quality was improving, and action was taken when specific data issues were identified, more work was required to ensure accurate data was available to inform discussions and provide assurance."* In the CQC evidence base document: *"Information breaches were taken seriously, and action taken to mitigate the risks associated with the breach and reduce the risk of re-occurrence. It was recorded on the BAF that personal and sensitive data was not always effectively collected, stored, shared or made accessible in line with statutory and regulatory requirements. There had been several breaches of regulatory requirements in the last 12 months which could be attributed to staff not following trust policies or human error. All these breaches had been investigated and none to date had been 'upheld' by the ICO. To facilitate learning the trust had held a learning event which considered internal breaches. To widen this learning the trust was collating learning from external breaches and issues which would be shared with staff."* <u>Infection Control</u> The Infection Prevention and Control Committee (IPCC) meets monthly and reports to Patient Safety and Outcome Committee. A continuous advice service is provided by IPC Team /

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			Consultant Microbiologists. The Director of Infection Prevention and Control meets bi-weekly with the Chief Nurse. *The CQC reported that "Some services did not always control infection risk well. Staff used equipment and control measures inconsistently, they did not always use hand sanitisers when entering or leaving the wards, or when moving between patient bays". In other services, the CQC stated (surgery): "controlled infection risk well. Staff used equipment and control measures to protect patients, their families and themselves from infection. They kept equipment and the premises visibly clean".* An action plan is in place to respond to these matters and ensure a consistent approach to infection control across the Trust. <u>Health and Safety</u> The Trust is committed to effectively minimising risks, controlling hazards and preventing harm to all. This is done through a proactive programme of risk assessment and audit. There are clear processes for incident reporting and we encourage a culture in which staff report incidents. The Trust's governance structure ensures statutory compliance is undertaken within legislative requirements. Assurance via the Health and Safety Committee has been provided on a range of subjects such as violence against staff, sharps compliance, Control of Substances Hazardous to Health and fire safety. The Trust's internal auditors conducted an audit into estates health and safety and provided a rating of 'partial assurance with improvements required'. The audit recommended improvements to planning of quarterly visual inspections and annual inspections of ventilation equipment and monitoring of findings/ actions to close gaps; development of an action plan to respond to the self-assessment against estates health and safety requirements; and, development and management of derogations for the Trust's sites where ventilation is not fully compliant with recommended practice, such as Health Technical Memoranda. A plan is in place to implement the necessary actions. <u>Safeguarding</u>

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			The Strategic Safeguarding Committee, chaired by the Chief Nurse, oversees all safeguarding matters across the Trust and reports into the Patient Safety and Outcomes Committee (PSOC). The CQC stated (CAMHS): *"Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it. The provider had a named nurse and doctor for child safeguarding and the unit had a safeguarding lead."* In the CQC evidence base document*: "We saw safeguarding information displayed in waiting areas, offering advice and guidance to staff and patients on how to recognise and report abuse. Staff knew how to access safeguarding policies and procedures on the trust intranet. The trust had recently updated its safe and respectful behaviour policy, which provided the steps for staff to follow when faced with an aggressive parent. The update to the policy protected staff as they could now escalate the incident quickly, using a warning card system."* *"Staff used an electronic flagging system, held on the patient's electronic record, to identify children at risk or on a child protection plan. Staff could also see if a safeguarding referral had been made. A safeguarding referral is a request made to the local authority or police to intervene, support or protect a child or vulnerable adult from abuse. From June 2018 to May 2019, there were 107 child safeguarding referrals made by staff within surgery."* The CQC report cited a number of areas that the Trust should focus on following the inspection and a plan is in place to act upon these matters, monitored at the Always Improving Group: *Raise staff awareness of the safe and respectful behaviour policy and improve access to conflict resolution training.* A survey has been conducted with staff and feedback used to raise awareness of the policy. <u>Performance monitoring</u> Directorate performance reviews take place on a monthly basis, attended by directorate management and Trust executives. These reviews are designed to facilitate a triangulated and

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			risk-focused discussion across a number of key domains: Caring, Safe, Responsive, Well-Led (people, management and culture), Effective, Finance, Productivity. The information presented at the performance reviews include an integrated dashboard which provides a one page summary of key metrics across the domains, allowing rapid identification of linked risks and issues. An integrated performance report is then scrutinised at each Trust Board meeting. This provides a summary of the key issues in each domain and actions planned to resolve, as well as an integrated dashboard – this provides trust level data using the same format as the directorate integrated dashboard reviewed in the monthly performance reviews. **Assurance**: The internal auditors conducted an audit into the Trust's directorate governance framework and provided an assurance rating of 'Significant assurance with minor improvement potential' (October 2019). **Assurance**: The CQC report stated: *"There were clear reporting lines from ward to board and from board to wards, to manage performance and identify, potential issues or failure to meet local and national standards. These were informed by the integrated quality and performance report which included both safety and financial information and discussed at the monthly directorate performance review meetings, attended by the directorate management team and representatives from the trust executives".* However, the CQC stated that the Trust should: "*Improve the oversight of delivery of services by the pharmacy department, including identifying and reporting key performance indicators via the directorate performance process to the board*." A number of actions have been delivered in response to improve reporting through to the Trust Board. <u>Escalation</u> The Trust has systems and processes in place to support staff and patients in escalating concerns in provision of care or management of systems. These include the complaints process, PALS, Freedom to Speak Up Guardian, Guardian of Safe Working, Raising Concerns Policy, Counterfraud service etc. The Trust is one of the first UK hospitals to partner with the Cognitive Institute in

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			their Safety and Reliability Improvement Programme. Signing up to this partnership recognises our commitment to achieving zero preventable harm and delivering the best possible outcomes through providing the safest, most effective and efficient care. Safety Champions from across the hospital have been appointed. **Assurance**: CQC stated (2020): "*Staff at all levels were clear about their roles, areas of responsibility and accountability. This included delegation of responsibility to committees. The trust had an assurance and escalation framework with groups and committees providing the board with assurance or escalating concerns and/or risks relating to the quality of services, performance, targets, service delivery and achievement of strategic objectives.*" *Managers at all levels in the trust had the skills, knowledge and experience to run a service providing high-quality sustainable care. Leadership had been strengthened since the last inspection with several changes of both executives and non-executives. The executives were described as an inclusive, dynamic team who were open and transparent.* *Leaders were knowledgeable about the challenges to quality and sustainability the trust faced including those arising from the current NHS financing model for specialised services; and its dependence on continuing to be able to attract international private patients. Leaders were proactive in addressing these through a range of initiatives including exploring alternative international markets and research activity.* *The trust had a vision and strategy that was currently being refreshed in consultation with staff, children, families and stakeholders. Staff understood the trust's vision, values and strategy and were supportive of these. Several strategies to support the trust strategy were either in place or currently being developed. These aligned and supported the trust's vision.* *The hospital had a culture in which staff could speak openly about safety concerns allowing these to be effectively managed and safe high-quality care delivered. Leaders at all levels across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.*

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			Leaders did not tolerate behaviour that was not in line with the trust's values, regardless of seniority. In some directorates staff continued to report issues with bullying and harassment, low morale and lack of staff engagement. Several initiatives had been implemented to address these including a 'stand up for our values', program to tackle those behaviours that were not in line with the trust's values and promoting the Dignity at work policy. At the time of our inspection the impact of these initiatives had not yet been measured but will be measured through the next NHS staff survey and staff engagement. "*Children, young people and their families were aware of how to raise a complaint. Complaints and concerns were taken seriously and responded to in a timely manner. Improvements were made to the quality of care as a result of complaints and concerns being raised*." The CQC report cited a number of areas that the Trust should focus on following the inspection and a plan is in place to act upon these matters, monitored at the Always Improving Group: • *Continue to promote the role of the Freedom to Speak Up Guardian (FTSUG), taking proactive action to identify and address themes from staff contacts with the FTSUG.* Work is underway but delayed due to Covid-19 planning. • *Raise staff awareness of the role of the accredited safety champions.* Work is underway and due for delivery in June 2020. • *Take action to improve the number of incidents closed within the trust's 45 working day target.* Some actions have been delivered and some remain underway and delayed due to Covid-19 planning. The internal auditors conducted an Incident Reporting audit looking at the processes in place for the recording and management of operational risks. The report allocated a rating of 'Partial assurance with improvement required'. The audit report identified a large number of open incident reports, exceeding the Trust 45 day target. Recommendations were made related to the management of incident reporting and a plan is in place to implement the necessary actions.

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			In 2019, the NAO public sector award for excellence in public sector reporting was won by Great Ormond Street Hospital. The award recognises good corporate reporting that builds trust and transparency. The Trust assesses compliance with the FT licence annually.
CoS7 – Availability of resources (scope = next financial year 2020/21)	The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources. 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. The Licensee, not later than two months from the end of each Financial Year, shall submit to Monitor 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:	The Executive Team have considered the evidence cited and recommend "Confirmed" for (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	The Trust sets its budget on an annual basis and actively manages and monitors its financial position and resource levels on a regular basis throughout the year through routine performance reporting to the Board and its Committees. The Executive Team actively monitors the finance position at every meeting to ensure that the mitigations in place are effective and appropriate. As the national NHS operational planning process has been suspended for 2020/21 the Trust has still approved a budget for the year based on the planning process prior to COVID19. To date, it has received confirmation from DHSC that all expenditure would be funded until at least the end July 2020 after which time the system is expected to return to a block contracting system. Discussions remain ongoing with NHSE/I about how any loss of commercial income will be rectified after exiting from the COVID19 crisis recognising there will be a lead time to build the business back up. No material agreements which might create a material risk have been entered into. The Trust Audit Committee and Board will review for approval the 2019/20 annual report and accounts (26 May 2020), on a going concern basis, confirming that the Directors have a reasonable expectation that the organisation has the required resources available for the next 12 month licence (a). The Trust is implementing a robust savings plan for 2020/21. The Trust is holding discussions with other NHS trusts on managing implications of tariff changes.

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	(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." OR (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".	months referred to in this certificate." Response to be considered by the board in light of assurance provided here and taking into account the views of the governors	Assurance: Both External and Internal Audit services provide assurance that reporting is accurate and there is no material mis-statement. The CQC stated: "The trust had developed a long-term financial model that was subject to regular in-depth scrutiny by the board through its finance and investment committee. The trust had concluded that, under current NHS financial assumptions, it was likely to face significant financial challenge over the next two years." …The Trust should: "Take action to develop and assure itself about financial sustainability going forward .". "Leaders were knowledgeable about the challenges to quality and sustainability the trust faced including those arising from the current NHS financing model for specialised services; and its dependence on continuing to be able to attract international private patients. Leaders were proactive in addressing these through a range of initiatives including exploring alternative international markets and research activity." The internal auditors conducted an audit into the Better Value programme and provided an assurance rating of 'Significant assurance with minor improvement potential' (October 2019). The internal auditors conducted an audit into the Trust's financial controls and provided an assurance rating of 'Significant assurance with minor improvement potential' (October 2019).

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	OR (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".		
FT4- NHS foundation trust governance arrangements (scope = next financial year 2020/21) **PLEASE NOTE – all four parts need to be confirmed for an overall 'confirmation'**	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.	The Executive Team have considered the evidence cited and recommend "Confirmed". Response to be considered by the Board in light of assurance provided here and taking into account the views of the governors	The Trust has a range of governance and assurance structures and systems in place including a Trust wide strategy, scheme of delegation, risk management framework, accountability framework, compliance framework, escalation framework, policy framework and assurance framework and a financial management framework (see controls and assurances above). Directors and governors are asked to sign a code of conduct (both documents were refreshed in 2018) and declare any interest for publication on a Register of Interests. **Assurance**: A new Declarations of Interest and Gifts and Hospitality Policy has been launched, updated in line with NHS England's policy and identifying key decision makers. The Trust has also implemented a new electronic declaration portal for staff to update declarations immediately and to ensure timely reporting publicly. The Trust's Local Counter Fraud Service is in the process of collating evidence toward the Trust's NHS Counter Fraud Authority Self-Review Tool and informed the Trust Audit Committee in April 2020 that they are proposing an overall green (compliant) return. Directors complete a self-assessment for the Fit and Proper Person Test (and are reviewed against the criteria annually) and are required to declare any interests annually. Governors sign an eligibility form which includes reference to the Fit and Proper Person's Process.

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Assurance: The CQC stated: “The trust had a process and a recently updated and approved fit and proper persons (FPP) policy to assess that staff with director level responsibilities, including the NEDs, were compliant with FPP in accordance with Regulation 5 of the Health and Social Care Act (2014). Overall responsibility for FPP was held by the chairperson, who delegated this responsibility to the company secretary.

FPP checks were completed on appointment and annual reviews were the responsibility of a member of the human resources team, supported by the company secretary. We saw evidence that checks were carried out and that an electronic spreadsheet of compliance was maintained. This spreadsheet was a live document and used as a tool to identify any checks i.e. Disclosure and Barring Service (DBS) checks which were due for renewal. The trust also required all directors, NEDs, budget holders and councillors to complete an electronic annual conflict of interest and hospitality declaration. This approach facilitated on-going compliance with Regulation 5 of the Health and Social Care Act (2014).”

A self-assessment is prepared annually against the Monitor code of Governance and will be reported to the Board in May 2020. The Trust Board considers that from 1 April 2019 to 31 March 2020 it was compliant with the provisions of The NHS foundation trust Code of Governance and proposes to explain its compliance (on a comply or explain basis) for the following criteria in the annual report :

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<tr><td>B.1.2</td><td>The Board is normally comprised of a Chair, Deputy Chair, Senior Independent Director (SID), three additional independent Non-Executive Directors, and six Executive Directors. One of the Non-Executive Directors is appointed by University College London. Professor Rosalind Smyth (UCL appointment) stepped down from the Board on 31 December 2019. From 1 January 2020 until 30 April 2020, the Board comprised a chair and five non-–executive directors.</td></tr>
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			Further information about corporate governance systems and standards at GOSH is detailed below.
	The Licensee shall: (a) have regard to such guidance on good corporate governance as may be issued by Monitor from time to time; (b) comply with the following paragraphs of this Condition.	The Executive Team have considered the evidence cited and recommend 'Confirmed'. Response to be considered by the Board in light of assurance provided here and taking into account the views of the governors	The Trust has regard to guidance on good corporate governance as issued by NHS Improvement.
	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.	The Executive Team have considered the evidence cited and recommend 'Confirmed'. Response to be considered by the Board in light of assurance provided here and taking	The Board has a formal schedule of matters reserved for its decision, and delegates certain matters to committees. The Board has a work programme, which includes all matters the Board is required to consider by statutory, regulatory and other forms of guidance. It also has a range of strategic and operational performance information, which enables it to scrutinise the effectiveness of the Trust's operations, and deliver focused strategic leadership through its decisions and actions. The Board maintains its commitment that discussion of patient safety will always be high on its agenda. There are three Board assurance committees - the Audit Committee, the Quality, Safety and Experience Assurance Committee and the People and Education Assurance Committee. These

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		into account the views of the governors	committees assess the assurance available to the Board in relation to risk management, review the Trust's non-clinical and clinical and quality risk management processes and review the structures and processes in place to deliver the Trust's vision for a supported and innovative workforce, an excellent learning environment and a culture that aligns with the Trust's strategy and always values. All three committees raise issues that require the attention of the Board at every Board meeting. In addition to the three assurance committees, the Finance and Investment Committee considers financial performance, productivity and use of resources. The chairs of these committees report to the Board following every committee meeting. Each committee is charged with reviewing its effectiveness annually. The Trust has terms of reference and work plans in place for the Board, Council and assurance committees. The Board committees conduct annual effectiveness reviews (surveys) on the delivery of their terms of reference and running of the committees. Findings are reviewed and where appropriate, changes to the terms of reference and workplans of the committees are made. The assurance committees receive minutes from other assurance committees to prevent matters falling between them. Summaries of assurance committee meetings are reported at the Board and the Council. At the Council, the chairs of the assurance committees present the summary reports and are held directly to account by the governors at the Council meeting. Governors are also invited to attend assurance committees and Board meetings throughout the year. The Trust's Assurance and Escalation Framework presents a single, comprehensive picture of the governance and assurance structures and systems through which the Trust Board and other stakeholders receive assurance. The Trust routinely reviews and reports this assurance through the following key governance processes and frameworks including: • Performance Management: The Trust has a range of frameworks and policies in place that outline how the Trust's performance objectives and standards will be met, reviewed and managed.

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			• The Trust's Risk Management Strategy (see above) sets out how the organisation identifies, monitors, escalates and manages risks in a timely fashion and at an appropriate level. • The Trust has in place a comprehensive and integrated Compliance Framework that seeks to ensure on-going compliance with statutory and regulatory requirements through integrated, rigorous and proactive structures, policies and practices. It ensures appropriate controls are in place to maintain compliance with statutory and regulatory requirements and that external guidance and alerts are considered in a fulsome and responsive way. • Policy Framework: This provides for clear and accessible policies, procedures and guidelines which support staff in undertaking their duties in a safe and effective way that takes account of all relevant legislation, regulation and guidance. The Trust's policy framework is administered by the Policy Approval Group (PAG) and reported through to the Risk Assurance and Compliance Group. • Committee structure: The Trust's committee structure, developed from the Trust Board down, is currently under review to ensure each committee or group has a clear purpose, scope and authority. Some committees have statutory functions, others have authority to make decisions and direct actions, and others provide advice, support and oversee specific functions. The review is being conducted via the Risk Assurance and Compliance Group. • The Risk Assurance and Compliance Group monitors progress with the strategic risks on the Board Assurance Framework (see above). There are eight directorates, each with a Chief of Service, Deputy Chief of Service, Head of Nursing and General Manager. The Senior Leadership Team meets weekly (around 100 senior managers from across the clinical and corporate areas of the Trust). An Operations Board made up of senior operational managers from across the Trust meets fortnightly. The purpose of the Operational Board is to bring together clinical and corporate senior leadership members to ensure the robust, effective and efficient operational management of the Trust.

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			The Trust's risk management strategy sets out how risk is systematically managed. This extends across the organisation, from the front-line service through to the Board, to promote the reduction of clinical and non-clinical risks associated with healthcare and research, and to ensure the business continuity of the Trust. **Assurance**: The CQC reported stated: "*Staff at all levels were clear about their roles, areas of responsibility and accountability. This included delegation of responsibility to committees. The trust had an assurance and escalation framework with groups and committees providing the board with assurance or escalating concerns and/or risks relating to the quality of services, performance, targets, service delivery and achievement of strategic objectives*." The CQC evidence base document stated: "*The trust board had the appropriate range of skills, knowledge and experience to perform its role. Executives and non-executive directors (NEDs) had a mix of skills and attributes which were complimentary to each other and their backgrounds ensured there was cover across clinical and operational activity."* *"All those we spoke with said leadership had been strengthened since the last inspection and that the CEO was very visible and open. Some staff reported that the CEO had visited their departments and explored how staff were feeling. This made them feel he was genuinely interested in the work they were doing and their wellbeing. The executives were described as an inclusive, dynamic team who were open and transparent.* *We observed that the board worked effectively together. At the board meeting we attended, all board members were prepared for the meeting, constructively challenged each other. Those NEDs not present had sent in comments on papers which were shared at the meeting by the chair. Board members were knowledgeable not only about their own portfolios but also about those of other board members, this provided support if the portfolio lead was not available."* The internal auditors conducted an audit into the Trust's directorate governance framework and provided an assurance rating of 'Significant assurance with minor improvement potential' (October 2019).

Licence condition	Description	Confirmation: Confirmed or Not Confirmed	Assurance
			See assurances cited on risk management above.
	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;	The Executive Team have considered the evidence cited and recommend 'Confirmed'. Response to be considered by the Board in light of assurance provided here and taking into account the views of the governors	The Board has agreed standing orders and standing financial instructions, which provide the framework for ensuring appropriate authorisation of expenditure commitments in the Trust. The Board's processes for managing its resources include approval of annual budgets for both revenue and capital, reviewing financial performance against these budgets, and assessing the results of the Trust's cost improvement programme on a monthly basis. In addition, the Trust has a prescribed process for the development of business cases for both capital and revenue expenditure and, where significant, these are reviewed by the Trust Board. Each specialty and clinical directorate has an internal monitoring structure so teams regularly review their progress and identify areas where improvements may be required. Each directorate's performance is considered at monthly performance review meetings (see above). The Finance and Investment committee reviews the operational, productivity and financial performance and use of resources both at Trust and divisional level. The Board has a work programme (aligned with the Well Led Assessment Key Lines of Enquiry), which includes all matters the Board is required to consider by statutory, regulatory and other forms of guidance. It also has a range of strategic and operational performance information, which enables it to scrutinise the effectiveness of the Trust's operations, and deliver focused strategic leadership through its decisions and actions. The Board maintains its commitment that discussion of patient safety will always be high on its agenda. A Board development programme is under review. The Board assurance committees scrutinise the strategic risks facing the trust on a rotational basis every year, with committee members reviewing the effectiveness of controls and seeking assurances that any gaps in controls will be closed in a timely manner.

Licence condition	Description	Confirmation: Confirmed or Not Confirmed	Assurance
			Key performance indicators are presented on a monthly basis to the Trust Board. The report, which has recently been refreshed and integrates quality and performance data includes progress against external targets, internal safety measures, operational efficiency/process measures, well-led and other clinical quality measures such as complaints, incidents and reports from specific quality functions within the Trust such as the Patient Advice and Liaison Service (PALS). It also includes the external indicators assessed and reported monthly by the CQC. The report is aligned to the CQC key lines of enquiry: Safe, Effective, Caring, Responsive and Well Led. It asks the question: are our patients receiving high quality care? In December 2019, the Trust was inspected by the CQC and achieved an overall rating of GOOD for its clinical services and GOOD for the assessment of Well Led. An action plan was developed and rolled out across the Trust (see above for monitoring framework). **Assurance**: See statements from the CQC above on senior management, performance management and internal audit reports.

s.151(5) of the Health and Social Care Act (not a licence condition) **(scope = past financial year 2019/20)**	NHS Improvement require the Board to state whether it is satisfied that during the financial year most recently ended the Trust has provided the necessary training to Governors, to ensure that they are equipped with the skills and knowledge they need to undertake their role.	The Executive Team have considered the evidence cited and recommend 'Confirmed'. Response to be considered by the board in light of assurance provided here and taking into account the views of the governors	**Governor Induction and training and development:** During 2019/20, governors received mandatory Trust training and were provided with access to the Trust's internal on line training portal (GOLD) to update their training during their tenure. This is actively monitored by the Deputy Company Secretary and governors reminded and supported to complete the training during the year. Prior to each Council of Governors' meeting, the Chair meets with all governors in a private session. This gives the Governors an opportunity to discuss any issues directly with the Chair and to gather information about the Trust and its activities and processes. The Trust has established a buddying programme between Non-Executive Directors (NEDs) and governors. The buddying programme provides governors with direct contact with a NED to support their role and share information on matters of interest or concern. The programme has been evaluated and revised during the year. Governor Development sessions have been developed in partnership with Governors to provide them with the skills and knowledge needed to deliver their key duties over their tenure. Several Governors attended external training and events throughout the year and provided reports back to the Trust. These included: • Governor Focus conference, to help Governors explore how they can be best equipped to support their Trusts in delivering quality healthcare. • GOVSEC's Government IT Security Conference, which explored how public sector organisations and professionals could make sense of securing their IT functions in a rapidly changing environment. • GovernWell: Member and public engagement, which aimed to help Governors explore what 'Representation' meant. Governors have access to an online library of resources. This provides governors with 24/7 access to key documents and information.

			Governors receive a monthly newsletter from the Corporate Affairs team containing key dates, developments and training and development opportunities.