The Royal Orthopaedic Hospital NHS Foundation Trust

NHS IMPROVEMENT ANNUAL STATEMENTS & SELF-CERTIFICATION – EVIDENCE FOR STATEMENT OF COMPLIANCE

DECLARATION	SUB REQUIREMENT	RATIONALE AND CORE EVIDENCE	LEAD
CORPORATE GOVERNANCE STATEMENT			
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.	None	• **Annual Governance Statement which outlines the key controls in place to ensure that the Trust's governance arrangements are sound and effective.** • **Annual Report contents in 'Accountability Report' summarising how the Trust complies with the Code of Governance.** • **Progress reports on delivery of actions raised in response to the Good Governance Institute review.** • **Quarterly judgements under the Single Oversight Framework by NHS Improvement.** NHS Improvement Corporate Governance ratings for 2015/16: Q1= Green (Risk Assessment Framework); Q2 = Segment 2; Q3 = Segment 2; Q4 = TBC. • **Head of Internal Audit Opinion 2015/16** which concludes that 'the organisation has an adequate and effective framework for risk management, governance & internal control. However, our work has identified further enhancements to the framework of risk management, governance & internal control to ensure it remains adequate and effective'. • Further progress during the year with strengthening the Board Assurance Framework and risk management systems & processes. **Minutes from Audit Committee and Quality & Safety Committee confirming the improvements made.** • **Audit Committee annual report**	ADG&CS

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The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time		• **Trust Board paper outlining changes from the Risk Assessment Framework to the Single Oversight Framework in October 2016.** • **CEO reports to Board highlighting new guidance issued.** • There has been new guidance issued by NHS Improvement around Non Executive appraisal which the Trust is required to satisfy **– e-mails between Associate Director of Governance/Company Secretary and NHS Improvement** • **New national guidance issued on annual self-certification and declarations of interest** • Routine bulletins from NHS Improvement are received and reviewed by the Executive Team – **bulletins**	ADG&CS
The Board is satisfied that the Trust implements:	(a) Effective board and committee structures;	• The Committee structure has been reviewed and refined during the year, with the creation of a Major Projects & OD Committee for oversight of staff engagement, leadership and development, together with governance oversight of the major initiatives being undertaken by the Trust. **Paper proposing the establishment of a Major Projects & OD Committee considered at the January 2017 Board meeting.** • The **terms of reference for the Committees** have been reviewed and amended during the year • All Committees report back at each Board meeting on key highlights and matters needing to be escalated via an **assurance report**. • **Annual Governance Statement** 2016/17 outlines the Board & Committee structure. • The Board and Committees have **annual workplans**.	ADG&CS

DECLARATION	SUB REQUIREMENT	RATIONALE AND CORE EVIDENCE	LEAD
		• Notwithstanding the evidence above, in a draft letter from NHS Improvement in connection with concerns over the Trust's management of its 18 weeks RTT list, it was suggested that licence condition FT4 (4) which refers to the establishment and implementation of effective board and committee structures and clear reporting lines may have been breached. On this basis, ahead of a formal letter being received, it is felt prudent to declare non-compliance with this element of the corporate governance statement.	
	(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees;	• The Trust has a **Scheme of Delegation** in place which sets out the matters reserved to the Board. • The **terms of reference for the Committees** have been reviewed and amended during the year and the Major Projects & OD Committee was established during 2016/17. **Paper proposing the establishment of a Major Projects & OD Committee considered at the January 2017 Board meeting.** • **Organisational charts** have been presented to the Quality & Safety Committee during the year setting out the Groups & Committees that sit within the clinical governance environment. • The **Quality & Safety Committee workplan** includes reports from the clinical governance committees that present by rotation. • The Trust Management Committee (TMC) was disestablished during the year, with the Executive Team weekly meeting now being the main advisory group to the Chief Executive. **Agendas of Executive Team business meetings**	ADG&CS

	(c) Clear reporting lines and accountabilities throughout its organisation.	• The structure of the Executive team and the portfolios of the Executive Directors have been reviewed during the year. The remit of the Director of Nursing & Clinical Governance (now the Director of Patient Services) has been refocussed to provide additional accountability for operational matters. The remit of the Director of Strategy & Transformation (now Director of Strategy & Delivery) was revised to include Workforce, OD, Estates and Facilities. The responsibility for performance was made more explicit within the role of the Director of Finance (now Director of Finance & Performance) **Job descriptions for Executive Directors. Report to the Remuneration Committee in December 2016.** • An Associate Director of Governance & Company Secretary holds responsibility for risk management and policy governance as well as more traditional elements of support to the Board & Chairman. **Job description for Associate Director of Governance & Company Secretary.** • A revised divisional structure has been implemented during the year to create clearer accountability and greater capacity within the operational areas. **Papers and presentations outlining the divisional structure as part of Team Brief** • **Job descriptions and divisional management structures may be used to evidence compliance with this requirement.** • Notwithstanding the evidence above, in a draft letter from NHS Improvement in connection with concerns over the Trust's management of its 18 weeks RTT list, it was suggested that licence condition FT4 (4) which refers to the establishment and implementation of effective board and committee structures and clear reporting lines may have been breached. On this basis, ahead of a formal letter being received, it is felt prudent to declare non-compliance with this element of the corporate governance statement.	CEO

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;	• **Internal and External Audit opinions considered by Audit Committee** • **Going Concern statement in Annual Report and paper to Audit Committee on Going Concern.** • **Finance & Performance Committee meeting papers demonstrating the detail considered to assess efficiency and effectiveness.** • **Financial recovery plan actions and assurance monitoring**	DOF
	(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;	• **Board cycle of business** and the **workplans of the Board Committees** ensure that there is comprehensive oversight of key matters. This has been further strengthened during 2016/17 by the additional of a Major projects & OD Committee. **Paper proposing the establishment of a Major projects & OD Committee considered at the January 2017 Board meeting.**	Ch/ ADG&CS

	(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;	• **CQC:** Assurance is obtained routinely on compliance with CQC registration requirements through Directors and Senior Managers of the Trust having specific responsibilities in respect of CQC standards and more generally in maintaining internal control systems to support those standards. After the CQC inspection in June 2014, the Trust produced a CQC **action plan** which includes strengthened internal controls, systems and responsibilities for quality which continued to be delivered through 2016/17. Likewise, an action plan was developed following the inspection in July 2015 (and subsequent publication in December 2015) which has sought to address any shortfalls identified by the CQC. At the request of the CQC, the Trust also hosted an inspection by the Royal College of Paediatrics and Child Health (RCPCH) in summer 2016, which identified a set of improvements needed. A task and finish group was set up to develop and monitor the delivery of an action plan to address these shortcomings. This action plan is also reviewed by the Trust board in private at each formal meeting. • **NHS Commissioning Board**: The Trust works in partnership with the Clinical Commissioning Groups and NHS England. Quality Standards are devolved through the Standard Contracts and are agreed at the commencement of each financial year. The Trust evidenced adherence to the quality contract requirements through submission of evidence and are held to account through the monthly contract meetings. Non adherence to agreed standards will lead to increased scrutiny/re-medial action plans and breach of contract notices/fines if non adherence to the contracts continues. Assurance of contractual compliance with Quality Standards is measured and gained through the **Patient Safety & Quality Report** scrutinised at Quality & Safety Committee and a **specific monthly report on performance against contract quality requirements considered quarterly by the Quality & safety Committee**. • **Board and Statutory Regulators of health care professionals**: All registered NHS professionals are bound to their code of conduct and the rules and requirements of their registration therein. Failure to comply with their expected professional standards would lead to disciplinary action via the Trust's disciplinary policy and in some cases removal from their professional register.	DPS

		Assurance is obtained routinely on compliance with professional member registration requirements through Directors and Senior Managers of the Trust having specific responsibilities in respect to members of staff working within their specific areas and more generally in maintaining internal control systems such as annual PDR, and re-validation processes. **Appraisal and revalidation reports.** • Notwithstanding the evidence above, in a draft letter from NHS Improvement in connection with concerns over the Trust's management of its 18 weeks RTT list, it was suggested that licence condition FT4 (5 (a, b, e & f)) which refers to the establishment and implementation of effective board and committee structures and clear reporting lines may have been breached. On this basis, ahead of a formal letter being received, it is felt prudent to declare non-compliance with this element of the corporate governance statement.	
	(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);	• The Trust Board approves the **annual budget and operational plan.** • Budget meetings are held with Divisions and Corporate areas. **Diary invites of these meetings may be used to evidence this.** • Financial performance is discussed and challenged at every Board meeting and in detail by the Finance & Performance Committee. **Minutes of Board & Finance & Performance Committee.** • Performance meetings held between Executive and Divisions ensure appropriate challenge and control; these meetings are held monthly with Divisions 1 and 2 and quarterly with Divisions 3 and 4. **Agendas and minutes for these meetings may be used to evidence this.** • The Audit Committee considers Going Concern status and recommends statements for the annual report and accounts. **Going Concern paper to Audit Committee.** • The Trust has **Standing Financial Instructions** in place.	DOF

		• Governors are required to approve 'significant transactions' • The Trust uses the services of a Counter Fraud specialist to monitor and investigate any potential fraudulent practice and report back to the Audit Committee. **Updates to Audit Committee.**	
	(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;	• The Board makes every effort to ensure that reports to both the Board and its Committees contain relevant timely and accurate information. • The Board met formally on a monthly basis during the year, with board workshops & development sessions being additional to this. **Board minutes and workshop papers** • The sequencing of Board Committees has been altered such that they meet prior to the Trust Board and can provide appropriate upwards assurance on matters of detail considered. **Meeting schedule. Assurance reports.** • **Workplans for the Board & its Board Committees** ensure that there is a forward view of matters needing to be considered several months ahead. • Notwithstanding the evidence above, in a draft letter from NHS Improvement in connection with concerns over the Trust's management of its 18 weeks RTT list, it was suggested that licence condition FT4 (5 (a, b, e & f)) which refers to the establishment and implementation of effective board and committee structures and clear reporting lines may have been breached. On this basis, ahead of a formal letter being received, it is felt prudent to declare non-compliance with this element of the corporate governance statement.	Ch
	(f) To identify and manage (including but not restricted to manage through forward plans)	• **Declaration submitted by 31 May 2017, confirming how the Trust operates to meet the conditions of its licence.** • Material risks are considered through the **Board Assurance Framework** which has been refreshed during the year.	Ch/ ADG&CS

	material risks to compliance with the Conditions of its Licence;	• The risk registers previously considered separately by the Quality & Safety Committee and Trust Management Committee have been merged to provide an overarching view of all risks rated red and amber, the most serious of which are included on the Board Assurance Framework. **Corporate Risk Register.** • Notwithstanding the evidence above, in a draft letter from NHS Improvement in connection with concerns over the Trust's management of its 18 weeks RTT list, it was suggested that licence condition FT4 (5 (a, b, e & f)) which refers to the establishment and implementation of effective board and committee structures and clear reporting lines may have been breached. On this basis, ahead of a formal letter being received, it is felt prudent to declare non-compliance with this element of the corporate governance statement.	
	(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	• Trust Board approves the **annual budget and operational plan**. • Performance discussed and challenged at every Board meeting and in detail by the Finance & Performance Committee. **Minutes from Board and Finance & Performance Committee.** • Quarterly performance meetings are held between Executive and Divisions to ensure appropriate challenge and control; these meetings were held monthly between Director of Finance, Director of Operations and Divisional representatives for the second half of 2016/17. **Agendas for these meetings may be used to evidence this.** • Internal Audit review key areas of interest and report findings to Audit Committee. **Internal Audit plan. Internal Audit progress reports.** • Delivery of audit recommendations is monitored at Audit Committee via **recommendation tracking reports.** There have been concerns raised during the year about the robustness of closing these recommendations, with a date of September 2017 being set for the trackers to be fully updated.	ALL

	(h) To ensure compliance with all applicable legal requirements. "	• The Trust uses the services of an established law firm to provide legal advice on request. • The **Trust's constitution** has been revised within the last three years and sets out the framework in which the Trust is to operate. • The Board is not aware of any other material issues that would place it in contravention of any legal requirements. During the year work was undertaken informed by the CQC review to strengthen the systems and processes for complying with Regulation 20 of the Health & Social Care Act: Duty of Candour. The Trust Executive has maintained a close focus on the process for handling incidents reaching the Duty of Candour threshold and there is confidence now that the improvements are delivering sustained compliance. **Duty of Candour reports.**	ALL
"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;	• The Board keeps the balance of its skills and competencies under review to ensure completeness and appropriateness for the requirements of the Trust. Within the year, the Trust has been joined by two new Non-Executive Directors, with particular skill sets in partnership working/commercial acumen and a Non-Executive who is currently a practicing clinician at University Hospital Birmingham. **Board member profiles in annual report.** • During the year and in response to a request from our regulators, the Trust reduced its management overhead, resulting in a streamlined Operations structure and smaller Executive team. **Board structure in annual report. Paper to Remuneration Committee in December 2016.** • The Board's composition includes a Medical Director who is a practicing clinician, a registered nurse and two Non Executives with a clinical background. **Board structure in annual report.**	Ch

		• Notwithstanding the evidence above, in a draft letter from NHS Improvement in connection with concerns over the Trust's management of its 18 weeks RTT list, it was suggested that licence condition FT4 (6 (a, c, d, e & f)) which refers to the establishment and implementation of effective board and committee structures and clear reporting lines may have been breached. On this basis, ahead of a formal letter being received, it is felt prudent to declare non-compliance with this element of the corporate governance statement.	
	(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;	• Every full length public Board includes a Patient Story. **Minutes and agendas of Board meetings.** • The Quality & Safety Committee provides a written update on its work at each Board meeting. **Assurance reports from Quality & Safety Committee.** • Progress with the delivery of the **CQC action plan** is considered by the Board and the Quality & Safety Committee. • CIP schemes are quality impact assessed, although it has been identified that further work is required to strengthen this process during the coming year. **CIP scheme schedule.** • The **Quality Account** includes a set of quality priorities, delivery of which will be monitored by the Quality & Safety Committee on a quarterly basis. • Notwithstanding the evidence above, in a draft letter from NHS Improvement in connection with concerns over the Trust's management of its 18 weeks RTT list, it was suggested that licence condition FT4 (6 (a, c, d, e & f)) which refers to the establishment and implementation of effective board and committee structures and clear reporting lines may have been breached. On this basis, ahead of a formal letter being received, it is felt prudent to declare non-compliance with this element of the corporate governance statement.	DPS

	(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;	• The Quality & Safety Committee receives a monthly **Patient Safety & Quality report**, the highlights of which are reported up to the Board as part of the assurance report from the Committee. • Detailed reports into specific quality indicators are considered by the Quality & Safety Committee. **WHO compliance, VTE reports, mortality reports**. • The Board considers a monthly **Finance & Performance Overview**, which includes a set of metrics including key national priority indicators and regulatory requirements. • Notwithstanding the evidence above, in a draft letter from NHS Improvement in connection with concerns over the Trust's management of its 18 weeks RTT list, it was suggested that licence condition FT4 (6 (a, c, d, e & f)) which refers to the establishment and implementation of effective board and committee structures and clear reporting lines may have been breached. On this basis, ahead of a formal letter being received, it is felt prudent to declare non-compliance with this element of the corporate governance statement.	DPS
	(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;	• The Quality & Safety Committee receives a monthly **Patient Safety & Quality report,** the highlights of which are reported up to the Board as part of the assurance report from the Committee. • Detailed reports into specific quality indicators are considered by the Quality & Safety Committee. **WHO compliance, VTE reports, mortality reports**. • A formal quality assurance walkabout schedule has been introduced during year which involves a number of staff from across a range of disciplines and areas. The outputs of these are considered by the Quality & Safety Committee. **Paper to the Quality & Safety Committee on quality assurance walkabouts**	DPS

		• Notwithstanding the evidence above, in a draft letter from NHS Improvement in connection with concerns over the Trust's management of its 18 weeks RTT list, it was suggested that licence condition FT4 (6 (a, c, d, e & f)) which refers to the establishment and implementation of effective board and committee structures and clear reporting lines may have been breached. On this basis, ahead of a formal letter being received, it is felt prudent to declare non-compliance with this element of the corporate governance statement	
	(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	• Data is reported through into the **Patient Safety & Quality Report** which includes PALS contacts, friends and family test results, compliments and complaints. • Patient stories are shared at the Board. **Minutes from Board meetings**. • The **Quality Account** is issued to external stakeholders for comment, including Healthwatch • Governors and patient representatives are included on the Patient & Carers Council. **Minutes of Patient & Carers' Council.** • A **schedule of walkabouts** is in place, overseen by the Deputy Director of Nursing & Clinical Governance, which involves patient representatives and Non-Executive Directors • A governor attends meetings of the Quality & Safety Committee as an observer **Minutes of Quality & Safety Committee** • Notwithstanding the evidence above, in a draft letter from NHS Improvement in connection with concerns over the Trust's management of its 18 weeks RTT list, it was suggested that licence condition FT4 (6 (a, c, d, e & f)) which refers to the establishment and implementation of effective board and committee structures and clear reporting lines may have been breached. On this basis, ahead of a formal letter being received, it is felt prudent to declare non-compliance with this element of the corporate governance statement.	DPS

	(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	• As described within the **Annual Governance Statement**; • The Board receives assurance on the Quality of Care through the oversight of the Quality & Safety Committee which is chaired by a NED with a clinical background and attended by the Executive Director of Patient Services, the Medical Director and the Chief Executive. **Terms of Reference for Quality & Safety Committee.** • The Trust has in place a Clinical Quality Committee, chaired by the Deputy Director of Nursing & Clinical Governance which is attended by a range of clinical and non-clinical senior staff from across the Trust. **Agendas and terms of reference for Clinical Quality Committee.** • The Quality & Safety Committee in turn receives more detailed reports from subgroups covering particular aspects of quality, for example drugs and therapeutics and safeguarding. This supports the process of escalation of risk related to quality throughout the Trust. **Quality & Safety Committee workplan.** • Some Board members carry out walkabouts in which they gain first-hand experience regarding the quality of care and the views of patients and staff and others. • The CEO holds regular briefings with Heads of Department & other senior managers for dissemination to teams. **Team Brief.** • The development of the Knowledge Hub has gathered together a number of clinically focused processes, including Outcomes, Effectiveness and Audit. **Material launching the Knowledge Hub and update to the Quality & Safety Committee on the development of the Knowledge Hub (April 2017).**	DPS

		• Notwithstanding the evidence above, in a draft letter from NHS Improvement in connection with concerns over the Trust's management of its 18 weeks RTT list, it was suggested that licence condition FT4 (6 (a, c, d, e & f)) which refers to the establishment and implementation of effective board and committee structures and clear reporting lines may have been breached. On this basis, ahead of a formal letter being received, it is felt prudent to declare non-compliance with this element of the corporate governance statement	
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.		• The Board keeps the balance of its skills and competencies under review to ensure completeness and appropriateness for the requirements of the Trust. • Both the Board and the Council of Governors considered that there was a need to strengthen clinical governance among the non-executive directors. There have been two changes at Non-Executive Director level this year, with two NEDs completing their term of office. Both of those have been replaced with suitably qualified appointments and Governor approval. In addition there has been a reconfiguration of the Executive director's portfolios, with an overall reduction in the Director team. The Director of Operations left the organisation in July 2016 and the Director of Workforce and OD in March 2017. The new structure has been approved by the Board, restructuring director portfolios to have 4.4 WTE Executives (reduction of 2 WTE) consisting of the Chief Executive, Executive Medical Director, Executive Director of Finance and Performance, Executive Director of Patient Services (incorporating Operations, Nursing and Governance) and Executive Director of Strategy and Delivery (incorporating Strategy, Estates, catering and Facilities, Knowledge Hub: Research, Training, medical and non-medical education, Workforce and Organisational Development). **Board structure in annual report.** • As per the **declaration to NHS Improvement concerning availability of resources (Continuity of Services Condition 7)**, there remain some risks in relation to sufficient medical and theatre workforce, but these are not believed to be sufficiently serious to impact upon NHS Improvement's licence requirements as arrangements are in place to ensure sufficient safe staffing. Additionally, some staffing considerations for Paediatric care in HDU are being worked through at present, in line with the recommendations from the CQC raised as part of its last visit.	DSD

GOVERNOR TRAINING			
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.		New governors receive induction during which any specific training issues are identified and addressed. Bespoke training is provided in-house each year for all Governors on topics identified by them; the sessions held during the year have included NHS Finances and the CQC regulatory framework. Further work is planned during 2017/18 to strengthen the partnerships with governors of other peer organisations. **Minutes from Council of Governors meetings. Training material on CQC regulatory framework and NHS finances.**	ADG&CS

KEY:

Abbreviation	Job Title
CEO	Chief Executive Officer
DOF	Director of Finance & Performance
DPS	Director of Patient Services
DSD	Director of Strategy & Delivery
ADG&CS	Associate Director of Governance and Company Secretary
Emboldened text indicates evidence available to confirm compliance	