Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting in Public

Subject:	NHSI – Self –certification declaration – General condition 6, FT4 and Continuity of Service Condition 7 of the NHS provider License	**Date:** 26th April 2018		
Prepared By:	Shirley A Higginbotham, Head of Corporate Affairs and Company Secretary			
Approved By:	Shirley A Higginbotham, Head of Corporate Affairs and Company Secretary			
Presented By:	Paul Robinson, Chief Finance Officer			
Purpose				
The Board are asked to: Consider and certify each Statement and if unable to do so, agree what supporting commentary Board wishes to submit		**Approval**	x	
		Assurance		
		Update		
		Consider		
Strategic Objectives				
To provide outstanding care to our patients	**To support each other to do a great job**	**To inspire excellence**	**To get the most from our resources**	**To play a leading role in transforming health and care services**
✓	✓	✓	✓	✓
Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**
		x		
Risks/Issues				
Financial	There are no risks or issues identified in this report			
Patient Impact				
Staff Impact				
Services				
Reputational				
Committees/groups where this item has been presented before				
The Executive Team meeting				

Executive Summary

NHS Foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence, have the required resources available if providing commissioner requested services and have complied with governance requirements.

Attached are draft templates, provided by NHSI which are to be completed and approved by board NHSI have changed the requirements from April 2017 and the Trust is no longer required to submit to NHSI, who will audit select providers from July 2017.

The Trust however must publish the G6 – Systems for compliance with license conditions, within one month of Board sign off.

The Trust must self-certify three declarations required by the NHS provider license

- Condition G6 (3) - Providers must certify that their Board has taken all precautions necessary to comply with the licence, NHS Act and NHS Constitution.
- Condition FT4 (8) - Providers must certify compliance with required governance standards and objectives.
- Condition CoS7 (3) - Providers providing CRS have to certify that they have a reasonable

expectation that required resources will be available to deliver the designated service.

Public - Board of Directors

NHSI – Self –certification declaration –
General condition 6, FT4 and Continuity of
Condition 7 of the NHS provider License **26th April 2018**

Author – Shirley A Higginbotham, Head of Corporate Affairs and Company Secretary

Introduction

NHS Foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence, have the required resources available if providing commissioner requested services and have complied with governance requirements.

Self-Certification

The Trust must self-certify three declarations required by the NHS provider license, Board members will need to reflect on their own sources of assurance, assess the adequacy and sufficiency of the evidence used to support each statement included in this report and determine the adequacy and appropriateness of assurances necessary to self-certify.

Condition G6 (3)

Providers must certify that their Board has taken all precautions necessary to comply with the licence, NHS Act and NHS Constitution.

The Trust must have processes and systems that:

- identify risks to compliance
- take reasonable mitigating actions to prevent those risks and a failure to comply from occurring.

The Trust must annually review whether these processes and systems are effective. During the year the Trust has significantly reduced its agency spend, and at the year end is under the ceiling set by NSHI, met its control total and improved recruitment.

The executive team recommend a self-certification of Confirmed

Condition FT4 (8) Providers must certify compliance with required governance standards and objectives.

The Trust should review whether the governance systems achieve the objectives set out in the licence condition. Proposed sources of evidence to substantiate each of the statements in the Board's declaration is included in an appendix to this paper

The executive team recommend a self-certification of Confirmed

Certification of training of governors

The Trust should review whether the governors receive enough training and guidance to carry out their roles. The Trust has an agreed governor development plan which is delivered by the Directors on various agreed subject areas during the year. A number of governors have also attended external Governor Development events and shared the learning from these with the wider Council of Governors

The executive team recommend a self-certification of Confirmed

Condition CoS7 (3) Providers providing CRS have to certify that they have a reasonable expectation that required resources will be available to deliver the designated service.

As a designated provider of Commissioner Requested Services (CRS) the Trust must self-certify under license condition CoS7 (3)

Commissioner requested services are services commissioners consider should continue to be provided locally even if providers is at risk of failing financially and which will be subject to regulation by NHS Improvement. Providers can be designated as providing CRS because:

- there is no alternative provider close enough
- removing the services would increase health inequalities
- removing the services would make other related services unviable

The Trust must select 'confirmed' for one of the three declarations about the resources required to provide designated services

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

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

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

Required resources include: management resources, financial resources and facilities, personnel, physical and other assets. Commissioner Requested Services include Accident and Emergency Services and Maternity Services. The Trust has a substantive leadership team, an agreed control total with NHS Improvement for 2017/18 and robust processes in place to ensure safe staffing across the organisation.

The executive team recommend a self-certification of Confirmed for option a

Appendix: Proposed evidence for self-certification 2017/18

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.***

- Corporate Governance section of Annual Report outlining Code of Governance compliance
- Audit &Board approved Annual Governance Statement and Auditors' opinions
- Board Committee meeting focus – risk, control, performance and quality
- Revised BAF process implemented and sustained
- IG Toolkit self-certification and implementation work
- Conflicts of Interest policy - implemented and communicated across the Trust
- External Audit Opinion – annual report and quality accounts
- Head of Internal Audit Opinion and audit of quality indicators
- Internal Audit Plan – focus across the year approved
- Mandatory training compliance – monitored by Board
- Appraisal compliance monitored by Board
- Raising Concerns, - Whistleblowing policy revised, training for senior team delivered;
- Risk Management focus strategy approved by Board and implemented
- SFIs and SOs reviewed all governing document suite accords with Constitution & Act

2. ***The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time***
   As per 1. Above

3. ***The Board is satisfied that the Trust implements effective board and committee structures; clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees, and , clear reporting lines and accountabilities throughout the Trust***

- Board development programme being delivered,
- Board approved Committee Structure and ToRs / annual workplans/focus
- Escalations part of agendas, minutes from Committees circulated, and review aligning ToRs/workplans
  Single Oversight Framework Integrated Performance Reporting
- Staff communication / involvement evidence
- Board member appraisals & personal development plans
- Annual Governance Statement
- Audit Committee programme of work and IA approved workplan/focus
- IA reports on Governance matters (IG, Risk management, BAF, IA opinion, CQC compliance etc)
- Revised BAF process implemented and sustained

4. ***The Board is satisfied that the Trust effectively implements systems and/or processes to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively***

- External Audit Opinion – use of resources
- Head of Internal Audit Opinion
- Internal Audit annual plan – outcome of audits of transactional and financial controls
- Audit Committee annual work plan
- Single Oversight Framework Integrated Performance Report – tracking performance/success of remedial actions
- Monthly Finance Report; work of Finance Committee;
- Trust's going concern review
- BAF key risk monitoring, including committee focus, principal risks allocated to committees for scrutiny & monitoring
- Operational Plan and business planning process/scrutiny

- Divisional performance reports – Finance Committee work + performance of divisions
- Work progressing with regard to improvements in Service Line reporting and site profitability
- Budget setting process, improvements with more work taking place

5. The Board is satisfied that the Trust effectively implements systems and/or processes for timely and effective scrutiny and oversight by the Board of the Licencee's operations;

- Internal Audit workplan – focus approved annually – linked to BAF and organisational risks
- PLACE Audits – patient and governor involvement
- Governor involvement through observers on Board Committees, IAT visits etc
- Friends and Family, surveys, patient feedback loops
- CCG short notice/unannounced inspections; performance & quality meetings
- Communication Boards on wards
- BoD meeting minutes, evidencing debate & Decisions regarding declarations
- Operational Plan and business planning process/challenge
- Constitution
- BAF key issues, Exec leads and lead committees to provide scrutiny and monitoring
- Single Oversight Framework, Segment 3
- Mature relationships with Overview and Scrutiny and Healthwatch

6. The Board is satisfied that the Trust effectively implements systems and/or processes 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 healthcare professions;

- Quality Accounts – governor and Board engagement in priority setting
- Exception reports relating to Maintaining Professional Standards / referrals to professional bodies etc
- External assurance re Quality Account –CCG, Healthwatch , Overview and Scrutiny Committee commentary
- PLACE audits
- Audit Committee approval annual audit plan
- CQC inspections and reports
- Corporate risk register and mitigating action plans
- BAF key risks and implementation assurance process
- Quality reports, including Complaints, claims and incidents report
- Raising Concerns - Whistleblowing policy communicated across the Trust

7. The Board is satisfied that the Trust effectively implements systems and/or processes for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licence holder's ability to continue as a going concern)

- Finance Committee – assurance role
- Board finance reports / SoF Integrated Performance Report
- External Audit Opinion
- Head of Internal Audit Opinion
- NHSI Monthly Performance Review Meetings
- Achievement of Control Total
- Review of going concern assumption
- BAF key risks – scrutiny of financial risks at Finance Committee
- Operational Plan – assumption challenge and scenario sensitivity planning
- Internal Audit core Financial controls reviews
- Team focus on cost reduction e.g. agency staff master vendor

8. The Board is satisfied that the Trust effectively implements systems and/or processes to

obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making

- Quality and Finance reporting to Board, SoF Integrated Performance Report
- Operational Plan
- BoD annual cycle of business (workplan)
- Committee annual cycle of business and assurance focus/restructure
- External Audit opinion and Head of Internal Audit opinion
- Board development
- Quality account – EA opinion, stakeholder support
- Benchmarking work, Carter Model Hospital etc.

11. The Board is satisfied that the Trust effectively implements systems and/or processes to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with Conditions of its Licence;

- BAF focus on key strategic risks, reported to Audit and Assurance Committee
- IA opinion, Risk Management audit
- Corporate risk register & mitigating action plans
- Review of compliance with provider licence conditions
- Operational Plan and business planning process (Governor involvement in forward plan)
- Better Together – engagement, support, programme board, assumption challenge
- Committee meeting workplans and ToR – accountabilities for risk and BAF process
- Risk management strategy implemented, effective risk management training roll out,
- Monitoring of complaints, survey results, incidents, claims – work progressing to allow reporting mechanisms to provide greater opportunities to triangulate intelligence
-

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

- Partnership work, meeting membership – regarding Alliance, NUH and strategic alignment
- Operationall Plan – involvement
- Head of Internal Audit Opinion
- Single Oversight Framework Integrated Performance Report
- External audit opinion
- BAF principal risks
- Single Oversight Framework Segmentation

13. The Board is satisfied that the Trust effectively implements systems and/or processes to ensure Compliance with all applicable legal requirements.

- Mandatory training approved programme, implementation and monitoring
- Annual reports-Health and Safety; Fire Safety; Safeguarding; Infection Control
- KPIs/Board metrics
- Internal Audit workplan focus, Counter Fraud deterrent activity and reporting
- Standards of Business Conduct; Register of Interests; Sponsorship & Hospitality register
- Staff & Patient Surveys
- Head of Internal Audit opinion
- Local Security management activity
- BAF key issues reports from Audit Committee
- Trust policies on professional registration Recruitment and Selection and booking of consultants
- Board approved medical staff appraisal policy

- Revalidation reports
- Counter fraud review on pre-employment checks and prevention/detection work
- Fit and proper person test for Board members implemented
- Review of SIs, RCAs, link to learning, adherence, improvement

14. ***The Board is satisfied: that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided***

- Outcome of appraisals
- Nomination and Remuneration Committees approved ToR
- Details of training undertaken by NEDs and EDs
- Board Development Programme
- Conflicts of interest Register
- Code of Conduct for Board and Governors
- Pre-employment checks; contractual conditions regarding other employment
- Constitution - Board composition and work of Remuneration Committee

15. ***The Board is satisfied: that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations***

- Quality Accounts – priority development process and monitoring
- Patient Story and follow up to every Board meeting
- External assurance (re Quality Account)
- Operational Plan
- Head of Internal Audit Opinion
- Quality impact assessments

16. ***The Board is satisfied: the collection of accurate, comprehensive, timely and up to date information on quality of care, and;***
17. ***The Board is satisfied: that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care***

- External assurance (re Quality Account)
- Operational Plan
- Head of Internal Audit Opinion
- Single Oversight Framework Integrated Performance Report
- IG toolkit compliance reporting
- NHSI Monthly Performance Review meetings
- CQUIN performance reports
- CCG performance meetings
- CCG exec to exec meetings
- Committee meeting minutes focusing on quality improvement
- Complaints, claims and incidents report
- SUI reporting to Board each month and through committees, robust RCA process with further work commencing to improve learning loop and dissemination of learning

18. ***The Board is satisfied: 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***

- Operational Plan – bottom up – divisions, Service lines
- Alliance; quality and performance meetings with CCG, media relations, workstreams
- Friends & family test
- Patient Survey

- Staff Survey
- COG Forum – independent, influencing agenda CoG and committees
- Governor feedback – PLACE audits
- Lead governor observer at Quality Committee, governor member of Outpatient working group
- Team Brief; iCARE, e-communications

19. The Board is satisfied: that there is clear accountability for quality of care 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.

- Nurse staffing reporting to Board
- Board approved Committee ToRs – clear responsibilities
- Head of Internal Audit opinion
- Patient surveys
- Staff surveys
- Serious Incident process implemented
- Single Oversight Framework Integrated Performance Report
- SUI reporting to Quality Committee
- Risk registers are supported and fed by quality issues captured in Divisional registers overseen by established Risk Committee
-

20. The Board of the Trust effectively implements systems to ensure that it 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 the NHS provider licence.

- Pre-employment checks
- Self Declarations – Fit and Proper Person Requirement
- Outcome of appraisals
- Minutes of Nom and Rem committee meetings
- Board approval of composition; Constitution review
- Outcomes from appraisals and revalidation
- Appraisal / feedback process
- HR policies and procedures
- Workforce Plan
- Medical revalidation and appraisal process
- Nurse staffing review, monitoring of nursing numbers
- Understanding of incidents reported concerning staffing numbers