Sheffield Teaching Hospitals
NHS Foundation Trust

Executive Summary

Report to the Board of Directors

Held on 25 May 2021

Subject	Self-certification against the conditions of the Provider Licence 2020-21
Supporting TEG Member	Sandi Carman, Assistant Chief Executive
Author	Judith Green, Corporate Governance Manager
Status	Approval

PURPOSE OF THE REPORT

The report provides assurance of compliance with the conditions of the NHS Provider Licence in accordance with the NHS Improvement self-certification guidance.

KEY POINTS

NHS Foundation Trusts are required to self-certify whether or not they have complied with the conditions of the NHS Provider Licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements.

Trusts need to self-certify the following after the financial year end:

Provider licence condition reference	Provider licence condition	Deadline for Board sign off
Condition G6 (3)	The provider has taken all precautions necessary to comply with the licence, NHS acts and NHS Constitution	31 May 2021
Condition FT 4 (8)	The provider has complied with required governance arrangements	30 June 2021
Condition CoS 7 (3)	If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated services	31 May 2021

Providers must also review whether their Governors have received enough training and guidance to carry out their roles and should confirm / not confirm as appropriate.

The purpose of the self-certification is for providers to carry out assurance that they are in compliance with the conditions. There is no set process for assurance on how to do this.

The draft self-certification for 2020/21 draws on the content of a number of documents which are being completed in readiness for the submission to the Audit Committee on 24 May 2021. Drafting work is at a stage to allow conclusions to be drawn from these documents, with final confirmation to be provided in the Board of Directors' meeting.

In consultation with the Membership Manager the Lead Governor is reviewing the section relating to Governor training and guidance, to confirm the certification.

The draft self-certification for the Trust for 2020/2021 is attached to this paper (Appendix A and Appendix),

IMPLICATIONS

AIM OF THE STHFT CORPORATE STRATEGY		TICK AS APPROPRIATE
1	Deliver the Best Clinical Outcomes	✓
2	Provide Patient Centred Services	✓
3	Employ Caring and Cared for Staff	✓
4	Spend Public Money Wisely	✓
5	Deliver Excellent Research, Education & Innovation	✓

RECOMMENDATIONS

The Board of Directors is asked to:

- **REVIEW** and **APPROVE** the content of the draft self-certification (attached at Appendix A and Appendix B); and
- **NOTE** that the final approved version of the self-certification must be published within a month following the Board of Directors sign-off.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
TEG	12 May 2021	Y
Audit Committee	24 May 2021	Tbc on 25 May
Board of Directors	25 May 2021	

APPENDIX A

Sheffield Teaching Hospitals
NHS Foundation Trust

Self-certification against Provider Licence Conditions 2020-21 - DRAFT

Condition G6(3): Systems for compliance with licence conditions and related obligations

Details of Condition	1. The Licensee shall take all reasonable precautions against the risk of failure to comply with: a) the Conditions of this Licence, b) any requirements imposed on it under the NHS Acts, and c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS. 2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include: a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and b) regular review of whether those processes and systems have been implemented and of their effectiveness. Not later than two months from the end of each Financial Year, the Licensee shall prepare and submit to Monitor a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition.
This means	This means a provider is required to have in place effective systems and processes to ensure compliance, identify risks to compliance and take reasonable mitigating actions to prevent those risks and a failure to comply from occurring.
Assurance	• Robust governance infrastructure and arrangements • Board and Board Committee Structure • Trust Executive Group (TEG), Management Board Briefing / Clinical Management Board • Trust's Framework for Risk Management including Safety and Risk Committee
Evidence	• Annual Reports and Accounts 2020/21 including Annual Governance Statement and Accountability Section setting out governance arrangements • Integrated Risk and Assurance Report (IRAR) and Risk Register • Head of Internal Audit Opinion Statement 2020/21 – significant assurance tbc
Self-certification	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts, and have had regard to the NHS Constitution. **CONFIRMED**

Note: tbc indicates where external assurance will be confirmed by receipt / approval of other papers being presented to the Audit Committee on 24 May 2021

APPENDIX A

Condition FT4(8): NHS foundation trust governance arrangements

Details of Condition

1. 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.

CONFIRMED

2. Without prejudice to the generality of paragraph 1 and to the generality of General Condition 5, the Licensee shall:

(a) have regard to such guidance on good corporate governance as may be issued by Monitor from time to time; and
(b) comply with the following paragraphs of this Condition.

CONFIRMED

3. 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.

CONFIRMED

4. 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 CQC, the NHS Commissioning Board and statutory regulators of health care professions*;
(d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
(e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
(f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
(g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
(h) to ensure compliance with all applicable legal requirements.

CONFIRMED

** refer to appendix B*

Note: tbc indicates where external assurance will be confirmed by receipt / approval of other papers being presented to the Audit Committee on 24 May 2021

APPENDIX A

	5. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure: (a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) the collection of accurate, comprehensive, timely and up to date information on quality of care; (d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate. **CONFIRMED** 6. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation* who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence. 5 **CONFIRMED** ** refer to appendix B* 7. The Licensee shall submit to Monitor within three months of the end of each financial year: (a) a corporate governance statement by and on behalf of its Board confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks. **CONFIRMED**
This means	This means that Providers should review whether their governance systems meet the standards and objectives in the condition. There is not a standard / set model but any compliant approach would involve effective Board and Committee structures, reporting lines, and performance and risk management systems.
Assurance	• Robust governance infrastructure and arrangements • Board and Board Committee Structure • Board Governance Business Continuity Arrangements during Covid-19 • Trust Executive Group, Management Board Briefing / Clinical Management Board • Risk Reporting, Escalation and Assurance arrangements • Business Planning Processes • Robust Performance Management Framework

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APPENDIX A

Evidence	• Incident Management processes and procedures including Command and Control arrangements established in response to the Covid-19 pandemic • Patient Experience Committee • Raising concerns process • Duty of Candour process • Appraisal process for Board of Director members • Standards for Business Conduct arrangements overseen by Audit Committee • CQC inspection process and outcomes • Annual Board Statements • Annual Reports and Accounts 2020-21 including Annual Governance Statement and Accountability Section • Head of Internal Audit Opinion Statement 2020/21 – significant assurance (tbc) • 2020/21 External Auditors' ISA 260 issues a tbc opinion on the financial statement • Value for Money conclusion (tbc) • Trust Constitution including Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation • Terms of Reference for Board committees and Annual Reports • Effectiveness Survey for the Board of Directors (Nov 2020) • Management Arrangements • Healthcare Governance Arrangements and Framework for Delivery • Framework for Risk Management • Integrated Performance Report • Quality and Safety Integrated Performance Report • Integrated Risk and Assurance Report / Risk Register • Fit and Proper Persons requirement processes 2020-21 • Declarations of Interest Register (Declare) and May 2021 compliance data • Appraisal process for Executive Directors and Non-Executive Directors • Freedom to Speak Up reporting to Board • Safer Nursing Care Tool and Care Hours Per Patient Day • Data Security and Performance Toolkit submission 2021 • Robust Responsible Officer arrangements for Medical Staff • Mandatory and Statutory training compliance reporting to Board • Local, regional and national training and development opportunities via NHS Providers

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APPENDIX A

Risks and Mitigation Actions	• Governor Forums and Governor Briefings • Command and Control Arrangements • Board Governance Business Continuity Plans The Board's Integrated Risk and Assurance Report (IRAR) articulate the Trust's Principal risks. Risks that align to self-certification statements made above can be confirmed in the attached appendix (Appendix B)

Condition CoS7(3): Availability of Resources

Details of Condition	1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources. 2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee. 3. The Licensee, not later than two months from the end of each Financial Year, shall submit to NHS Improvement a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms: (a) "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate." (b) "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services". (c) "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate".

APPENDIX A

This means	This means that providers designated as providing Commissioner Requested Services will have the required resources to continue to provide those services for example management, financial, facilities and resources. Commissioner Requested Services are services that: • Services that should continue to be provided locally even if a provider is at risk of failing financially • There is no alternative provider close enough • Removing them would increase health inequalities • Removing them would make other related services unviable
Assurance	• Board of Directors • Audit, Finance and Performance and Human Resources and Organisational Development Committees • Trust Executive Group
Evidence	• Going Concern assessment process • External Audit Opinion • Trust patient services contract(s) • Financial Reports and updates, including Annual Accounts and supporting narrative • Financial Plan 2021/22 • Capital Programme 2021/22
Self-certification	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. **CONFIRMED**

Note: tbc indicates where external assurance will be confirmed by receipt / approval of other papers being presented to the Audit Committee on 24 May 2021

APPENDIX A

Governor Training (not a licence condition)

Details of Condition	S151 (2) of the Health and Social Care Act:[Providers] must take steps to secure that the governors are equipped with the skills and knowledge they require ….
This means	This means that providers must review whether their governors have received enough training and guidance to carry out their roles. It is up to providers how they do this.
Assurance	• A programme of governor training and support is available and accessed by governors
Evidence	• Governors induction following election • Bespoke training sessions delivered by NHS Providers as part of the GovernWell programme (not during Covid-19 pandemic) • Governors attendance at various NHS Providers GovernWell events (not during Covid-19 pandemic) • Full time Membership Manager to provide support and guidance to Governors • Regular programme of Governor / Board engagement opportunities • Regular Chair and Chief Executive Briefings during Covid-19 pandemic to provide information and guidance to Governors and support their engagement with Trust • Involvement in Directorate and Corporate work programmes/schemes
Self-certification	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role. **CONFIRMED**

This self-certification is signed by Annette Laban, Chair of Sheffield Teaching Hospitals NHS Foundation Trust on behalf of the Board of Directors

Signed	
Dated	**25 May 2021**

Note: tbc indicates where external assurance will be confirmed by receipt / approval of other papers being presented to the Audit Committee on 24 May 2021

APPENDIX B

Self-certification against Provider Licence Condition FT4(8) 2020-21	
Self-Certification Statement	Risk and Mitigating Actions
4. 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;	*Operational pressures and risks to the provision of quality of care* In each successive wave of the Covid-19 pandemic the Trust has identified and managed a number of potential risks associated with the ability to maintain high quality clinical outcomes during periods of challenging operational pressures. Establishment of a full Major Incident Command and Control Structure provided a robust and transparent method of mitigating, preparing and responding to the demands of the pandemic. These arrangements would be redeployed in the event of a further wave of the pandemic.
	Disparity between capacity and demand impacts waiting times and patient experience There are risks associated with increased demand and the need to recover waiting list backlog while managing planned care alongside fluctuating Covid-19 demand. This is likely to result in disparity between capacity and demand, impacting on waiting times and patient experience and leading to underperformance against national quality and performance standards. A Restoration, Recovery and Reset programme overseen at Executive level will embrace new ways of working and manage these changes through well embedded governance and leadership arrangements and effective partnership working.
	Failure to sustain financial stability due to an inability to predict future income Our external strategic landscape continues to be driven by government policy, focused on managing systems rather than organisations, recognising the need to integrate services. This is driving uncertainty around future funding models and a change to future commissioning arrangements, including allocation of resources at an ICS level. The inability to predict future income and the impact of this on Trust's business planning and resource allocation processes will require the need to effectively mitigate associated risks threatening the financial stability of the Trust. We will need to continue to keep abreast of developments relating to funding arrangements, maintain active engagement in regional system work and mitigate any risks emerging from revised arrangements.
	Inability to appropriately identify and utilise capital monies in future years A further future strategic financial risk relates to changes in the allocation of capital funding to a system-wide Operational Capital Envelope and a failure to secure sufficient capital funding to fund necessary investment. Again, there will be a need to continue to closely monitor developments in capital allocations to ensure the Trust is best placed to identify future capital monies and progress plans.

APPENDIX B

4. The Licensee shall establish and effectively implement systems and/or processes: (c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the CQC, the NHS Commissioning Board and statutory regulators of health care professions;	*Risk of ineffective healthcare governance arrangements* The Trust's overall CQC rating is good across all areas apart from 'Responsive' for which it is rated Outstanding. However, the following issues have recently been identified by the CQC. In March 2021 the Trust received a letter from the CQC requesting information regarding mental health governance processes, triggered by a specific Serious Incident. The Trust responded to the request to provide additional assurance and an action plan. The CQC has confirmed that it was satisfied that this response provided sufficient assurance pertaining to the risks identified and that immediate enforcement action was not required. However, the Trust was required to take action and provide further assurance with regard to training, risk assessments and the environment. The Trust is required to update the CQC on a regular basis on delivery of the agreed action plan. Following an unannounced inspection by the CQC of the maternity service in March 2021 the Trust was informed that due to initial findings on some processes and systems the CQC were imposing temporary conditions on our licence and required an action plan to be submitted by 12 April 2021. Immediate actions have been taken by Maternity Services to address and, where possible immediately rectify, as many of the issues as possible and to develop plans for the remainder to be addressed as a priority. The Trust submitted an action plan to the CQC on 9 April 2021. Monitoring of which will be undertaken through a Maternity Oversight Committee reporting into the Trust Executive Group and providing assurance to the Board through the Healthcare Governance Committee.
6. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence. 5	*Staffing / skill mix not adequate to provide high quality services* At the height of successive waves of the pandemic not having appropriately skilled or trained staff was identified as a risk in preventing the Trust from implementing an effective Covid-19 escalation plan due to national shortages across key areas of the workforce being compounded with Covid-19 related absences. Key to mitigating this risk was a central workforce support team that was established to respond to workforce capacity requests from across the Trust. A key function of this team, which would be redeployed in any future wave of the pandemic, was the central co-ordination of the deployment of medical, clinical and non-clinical staff.