Agenda Item No:	F5

NHS
Mersey Care
NHS Foundation Trust

Report provided *(check necessary boxes)*:			
To Note:	☐	For Assurance:	☐
For Decision:	☒	For Consent:	☐

Paper No:	TB/17/18/102
Report to:	Board of Directors
Meeting Date:	24 May 2017

Foundation Trust Self-Certification Requirements

Accountable Director(s):	Andy Meadows, Trust Secretary
Report Author(s):	Sarah Jennings, Deputy Trust Secretary Dave Sproson, Senior Assistant Director of Finance

Alignment to the Trust's Strategic Objectives: *(listed by the 4 Strategic Aims)*								
	Our Services	☒	Save time and money	☒	Improve quality (STEEP)			
	Our People	☒	Great managers and teams	☒	A productive, skilled workforce	☒	Side by side with service users and carers	
	Our Resources	☒	Technology that helps us provide better care	☒	Buildings that work for us			
	Our Future	☒	Effective Partnerships	☒	Research and innovation	☒	Grow our services	

Purpose of Report:	• To seek the Board of Directors approval of the Provider License self-certifications (condition FT4 and G6/CoS7) required by NHS Improvement (NHSI).
Summary of Key Issues:	• The Trust has an NHS Provider Licence (No. 130163) New guidance was issued by NHSI on 21st April 2017that requires NHS Providers to self-certify only the following three Licence Conditions after the financial year-end: o The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution - Condition G6; o The provider has complied with required governance arrangements - Condition FT4; o If providing commissioner requested services (CRS), the provider has a reasonable expectation that required resources will be available to deliver the designated service - Condition CoS7. • The aim of self-certification is for providers to carry out assurance that they are in compliance with the conditions. • The Trust does not need to submit this to NHS Improvement but must ensure that the self-certifications are signed off by the Board of Director in line with the deadlines outlined in this report. NHS Improvement will undertake an annual audit on a small sample of Trusts from July 2017 to ensure compliance. If selected for an audit, Trusts will need to provide evidence that the self-certifications were signed off by the Board.
Recommendation:	The Board of Directors is asked to: 1) Consider and approve the proposed Condition FT4 and G6/ CoS7 self-certifications, taking note of the assurance provided in Appendices B & D; 2) Agree that the self-certification may be formally signed by the Chief Executive and Chairman.

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Next Steps: *(Subject to recommendation being accepted)*	None identified.

Previously Presented to:			
Committee Name	Date (Ref)	Title of Report	Outcome / Action

Do the action(s) outlined in this paper impact on any of the following issues?			
Area	**Yes**	**None**	**If 'Yes', outline the consequence(s)** ***(providing further detail in the report)***
Patient Safety	☐	☒	
Clinical Effectiveness	☐	☒	
Patient Experience	☐	☒	
Operational Performance	☐	☒	
CQC Compliance	☐	☒	
NHS Provider Licence Compliance	☒	☐	Failure to meet the range of conditions of the NHS Provider Licence for a licensed provider can lead to NHSI (Monitor) imposing compliance and restoration requirements or monetary penalties. Ultimately, it could lead to revocation of a provider's licence.
Legal / Requirements	☐	☒	
Resource Implications *(financial or staffing)*	☐	☒	

Equality and Human Rights Analysis	**Yes**	**No**	**N/A**
Do the issue(s) identified in this document affect one of the protected group(s) less or more favourably than any other?	☐	☒	☐
Are there any valid legal / regulatory reason(s) for discriminatory practice?	☐	☐	☒
If answered 'YES' to either question, please include a section in the report explaining why			

Does this paper provide assurance in respect of delivery of our Equality Delivery System goals and objectives *(if it does please click the appropriate ones below)*			
EDS 1.2 - Individual people's health needs are assessed and met in appropriate ways	☐	**EDS 1.4** – When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse	☐
EDS 2.2 – People are informed and supported to be as involved as they wish to be in decisions about their care	☐	**EDS 2.3** – People report positive experiences of the NHS	☐

Does this paper provide assurance in respect of a new / existing risk *(if appropriate)*							
Area	New	**Existing**	**N/A**	**If new or existing, please indicate where the risk is described**			
Type of Risk	☐	☐	☒	Board Assurance Framework	☐	Risk Register	☐
Risk Reference / Description: *(only include reference to the highest level framework / register)*							

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MERSEY CARE NHS FOUNDATION TRUST

Foundation Trust Self-Certification Requirements

PURPOSE

1. To seek the Board of Directors approval of the Provider License self-certifications (condition FT4 and G6/CoS7) required by NHS Improvement (NHSI).

BACKGROUND

2. The Provider License is the main tool through which providers are regulated and sets out a number of obligations.

3. The Trust has an NHS Provider Licence (No. 130163). New guidance was issued by NHSI on 21st April 2017 that requires NHS Providers to self-certify only the following three Licence Conditions after the financial year-end:

   a) The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution [Condition G6] – submission deadline 30 June 2017;

   b) The provider has complied with required governance arrangements [Condition FT4] – submission deadline 31 May 2017;

   c) If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service [Condition CoS7] – submission deadline 31 May 2017;

4. The aim of self-certification is for providers to carry out assurance that they are in compliance with the conditions.

5. The Trust does not need to submit this to NHS Improvement but must ensure that the self-certifications are signed off by the Board of Director in line with the deadlines outlined in this report. NHS Improvement will undertake an annual audit on a small sample of Trusts from July 2017 to ensure compliance. If selected for an audit, Trusts will need to provide evidence that the self-certifications were signed off by the Board of Directors.

SELF CERTIFICATIONS

Condition FT4

6. NHS Foundation Trusts must self-certify under condition FT4 (8) and review whether their governance systems achieve the objectives set out in the licence condition. Details of Condition FT4 are outlined in **Appendix A**.

7. In **Appendix B** are the assurances received by the Board of Directors which enable a declaration of compliance with each statement to be made. In the event that a FT is unable to fully self-certify, it must provide commentary explaining the reasons for the

absence of a full self-certification and the action it proposed to take to address the issues.

8. FTs are also required to confirm (or otherwise) the following declaration:

   "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 section 151 (5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role."

9. Based on the evidence set out in Appendix B, it is recommended to the Board of Directors that the Condition FT4 self-certification is formally signed-off as **Confirmed**.

Condition G6 / CoS7

10. Conditions G6(2) and CoS7 require NHS Foundation Trusts to have systems for compliance with license conditions and related obligations. Details of Conditions G6 and CoS7 are outlined in **Appendix C**. Only NHS Foundation Trusts designated as providing commissioner requested services (CRS) must self certify under Condition CoS7.

11. For information, the Trust provides the following NHS England commissioner requested services:

    a) High Secure (England and Wales)
    b) Medium Secure
    c) Low Secure
    d) Step Down
    e) Maplewood II non recurrent funding (repayment over 3 yrs)
    f) Forensic Support Service
    g) Advocacy Services

12. In **Appendix D** are the assurances received by the Board of Directors which enable a declaration of compliance with each statement to be made. Based on the evidence set out in **Appendix D**, it is recommended to the Board of Directors that the Condition G6 and CoS7 self-certifications are formally signed-off as **Confirmed**.

CONSEQUENCES OF NOT TAKING ACTION

13. Failure to meet the range of conditions of the NHS Provider Licence for a licensed provider can lead to NHSI (Monitor) imposing compliance and restoration requirements or monetary penalties. Ultimately, it could lead to revocation of a provider's licence.

RECOMMENDATION

14. The Board of Directors is asked to:

    a) Consider and approve the proposed Condition FT4 and G6 self-certifications, taking note of the assurance provided;

b) Agree that the self-certifications may be formally signed by the Chief Executive and Chairman.

ANDY MEADOWS

TRUST SECRETARY

May 2017

Appendix A

Provider License - Condition FT4

Condition FT4 – NHS foundation trust governance arrangements

1. This condition shall apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

2. 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.

3. Without prejudice to the generality of paragraph 2 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.

4. 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.

5. 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;

(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.

6. 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.

7. 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.

8. 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; and

(b) if required in writing by Monitor, a statement from its auditors either:

(i) confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its corporate governance statement applicable to the past financial year, or

(ii) setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year.

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Appendix B

Condition FT4 Self-Certification – Evidence of Compliance

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.

Response: ***CONFIRMED***

In confirming this statement, the Board of Directors has considered the following:

- The trust's Annual Governance Statement 2016/17 presented to the Board for approval in May 2017, which outlines the main arrangements in place to ensure the trust applies the principles, systems and standards of good corporate governance expected of it as a provider of health and social care services. The Governance Statement defines the trust's
    - Scope of responsibility
    - Governance Framework
    - Arrangements for assessing the Board's effectiveness
    - Quality governance arrangements
    - Regulatory Requirements
    - Risk and control framework,
    - The effectiveness of risk management and internal control
- Since April 2015 the trust's governance arrangements were subject to a series of external reviews, the findings of which were utilised to inform a number of the changes to the trust's governance framework. Such reviews included:
    - a Well-led Governance Framework review undertaken by the NHS Trust Development Authority
    - a Quality Governance and Risk review which the trust commissioned from the Good Governance Institute;
    - two independent reviews of Board skills undertaken by External Auditors;
    - the Chief Inspector of Hospitals Inspection of the Mersey Care in June 2015 and subsequently, in March 2017;
    - assessment of the trust's application for Foundation Trust status by regulators.
    - Robust and comprehensive due diligence undertaken in 2016 and 2017 in respect of the acquisition of Calderstones Partnership NHS Foundation Trust and South Sefton Community Services transactions.
- The Board of Directors has a dynamic Board development programme in place that ensures the performance of the Board is reviewed appropriately, seeking the views of internal and external stakeholders as part of the process.

Risks & Mitigations

- **Risk:** systems and processes become dated or not fit for purpose as a result of significant change and or transformation.

Mitigation: Corporate Governance Systems will require on-going testing via management the Board Committee structure. Systems and controls assurances are obtained via the Audit Committee and a Well-Led Governance review will be undertaken internally on an annual basis and externally assessed every three years as required by NHS Improvement. The Corporate Governance Framework will continue to be regular reviewed and updated to ensure it remain fit for purpose including the Constitution.

- **Risk:** The Council of Governors may not have the skills and experience to undertake its role.
- **Mitigation:** Following FT authorisation on 1 May 2016, the trust established its Council of Governors which held its inaugural meeting on 6 May 2016. A comprehensive induction and visit programme has been delivered to the Council of Governors over the previous year and work is on-going to develop a full Governor Development Programme to reflect internal and external training in addition to options participation and training in Quality Review Visits. The Board of Directors has clear accountability arrangements in place with its Council of Governors and will continue to invest in this relationship ensuring the Governors are well placed to discharge their responsibilities of ensuring local accountability.

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

Response: ***CONFIRMED***

In confirming this statement, the Board of Directors has considered the following:

- The trust has arrangements in place to ensure all guidance issued by Monitor (NHS Improvement) is received and issued to all members of the Board of Director via the regular *NEDBrief*. These are also brought to the attention of the Audit Committee via External Auditors and are responded to through a regular update report to this Committee.
- Guidance issued by regulators is issued to the Board of Directors through the Chief Executive's Report at every Board of Directors meeting.
- Following the completion of any external or internal review, it is confirmed if any actions are required by the Trust to ensure the Ttrust continues to apply best practice / regulatory requirements. Progress against the required actions is monitored by the Board of Directors or relevant Board Committee (i.e. the Well-Led, GGI and CQC Action Plan)

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The Board is satisfied that the Licensee has established and implements:

a) Effective board and committee structures;
b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
c) Clear reporting lines and accountabilities throughout its organisation.

Response: ***CONFIRMED***

In confirming this statement, the Board of Directors has considered the following:

- The Board has a well established committee structure that provides for effective review, scrutiny and decision making on the priority areas of the Board's business, namely quality of care, financial performance, operational delivery, strategy and governance. This structure is regularly reviewed to ensure it remains appropriate.
- All Board Committees are supported by terms of reference which are regularly reviewed and reviewed on an annual basis as a minimum. These terms of references are reflected in the Scheme of Reservation and Delegation of Powers.
- The Board reviews the performance of its Committees on an annual basis to ensure that they are discharging their duties as defined by their terms of reference, and to ensure they continue to remain focussed on the needs of the trust going forward. The Board Committee Annual Reports are presented to the Audit Committee each year and subsequently, to the Board of Directors.
- Since April 2015 the trust's governance arrangements were subject to a series of external reviews, the findings of which were utilised to inform a number of the changes to the trust's governance structure. Such reviews included:
    - a Well-led Governance Framework review undertaken by the NHS Trust Development Authority
    - a Quality Governance and Risk review which the trust commissioned from the Good Governance Institute;
    - two independent reviews of Board skills undertaken by External Auditors;
    - the Chief Inspector of Hospitals Inspection of the Mersey Care in June 2015 and subsequently, in March 2017;
    - assessment of the trust's application for Foundation Trust status by regulators.
    - Robust and comprehensive due diligence undertaken in 2016 and 2017 in respect of the acquisition of Calderstones Partnership NHS Foundation Trust and South Sefton Community Services transactions.
- There is an established reporting programme in place that ensures the Board Committees report to the Board, and that the Board Committees are provided with the necessary range of information and reporting to enable them to discharge their responsibilities. The Chair of each Board Committee provides its minutes and a chairs report to each public meeting of the Board of Directors meeting to advise the Board of the Committee's activity and to escalate any issues, concerns or risks as appropriate.

- The Board has an annual Internal Audit Programme in place, under the direction of its Audit Committee to ensure appropriate prioritisation.
- There is a clear accountability structure in place throughout the trust. This defines the responsibilities of the Executive Team and the operational structures under their control. In line with good practice, executive portfolios are reviewed as necessary to ensure adequate capacity, most recently in 2016.
- The accountability arrangements are clearly set out in the Annual Governance Statement 2016/17 approved by the Board of Directors in May 2017.

Risks & Mitigations

- **Risk:** Board and committee structures become unfit for purpose due to environmental or system change including new business.
- **Mitigation:** The Trust will continue to test its governance structures via the Well-Led Governance review to be undertaken internally on an annual basis and assessed externally every three years. The Board Committee's will continue to be subject to annual reviews of effectiveness and annual terms of reference reviews.

The Board is satisfied that the Licensee has established and effectively implements systems and/or processes (A-G below):

Response: ***CONFIRMED***

In confirming this statement, the Board of Directors has considered the following:

(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;

- The Board's infrastructure, namely the committees of the Board of Directors together with various operational groups, ensures that the Board of Directors is assured that the organisation, decisions and business of the trust is monitored effectively.
- This is undertaken through agreed annual cycles of business (approved by the Committees and reported to the Board) to that ensure the Board of Directors, Council of Governors and Committees are able to review and consider key areas including quality of care, workforce performance, financial performance, operational performance and risks to the Trusts quality, resources, reputation and regulatory requirements.
- The Board has established processes in place to review Cost Improvement Programmes that ensure proposed changes are appraised in respect of benefits and impact alongside the formal processes of Quality Impact Assessments.
- The Performance, Investment and Finance Committee considers, in detail, the trust's financial performance at each meeting to ensure achievement of statutory financial duties.

(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;

- An annual cycle of business ensures that the Board receives regular performance updates in respect of quality and safety, workforce, financial, external performance. This provides an overview of the trust's operations and ensures the appropriate escalation and monitoring of on-going areas of concern.
- Relevant Board Committees scrutinise throughout the year, key areas of performance including quality and finance. The Committees review such matters at each meeting and subsequently provide assurance to the Board of Directors at each meeting.
- Following a review of working capital and financial reporting procedures in early 2016, the trust has further enhanced its financial reporting to provide further detail to the Performance, Investment and Finance Committee.

(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;

- See above (b)
- In addition to the above systems and processes the Board has reviewed and approved a revised Quality Framework that has further strengthened the existing quality surveillance systems across the trust for monitoring standards of care.
- An approved Quality Improvement and Clinical Audit Programme is in place, implementation of which is overseen by the Quality Assurance committee to ensure a culture of continuous improvement.
- The Quality Assurance Committee reviews, in detail, the quality of care through a performance dashboard and a report which enables the triangulation of intelligence including (but not limited to) quality surveillance, quality visits, incidents, complaints and safer staffing.
- The Trust has developed a Quality Account for 2016/17 that highlighted the quality improvements made across the Trust during this period and the priorities for quality improvement in 2017/18. These priorities align to the trust's Strategy and include:
  - No Force First implementation
  - Striving for zero suicide
  - Improvement in physical health pathways
  - A just and learning culture

(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 has clear *Standing Financial Instructions (SFIs)* and a *Scheme of Reservation and Delegation of Powers (SoRD)* in place that determines the agreed framework for financial decision making, management and control.
- There is an established and appropriate governance structure in place to ensure the SFI's and the SoRD are complied with and decision making and control relating to financial matters is effective through oversight of the Performance, Investment and Finance Committee and also by the Audit Committee.

- Systems of internal control are in place and are subject to regular audit on an annual basis through the trust's internal audit programme and by external auditors
- The trust's forward planning arrangements ensure appropriate review of the trust's ability to continue as a going concern and this is formally reviewed by the Performance, Investment and Finance Committee and the Board of Directors annually.
- Systems and processes are in place to scrutinise all CIP plans for both financial and quality impact prior to implementation and to monitor both delivery and in-year changes through the Performance Investment and Finance Committee.
- The trust was subject to an in-depth review of working capital and financial reporting procedures in 2015 and 2016 by Ernst and Young and has implemented all of the associated recommendation to further strengthen its financial management, control and reporting.
- The trust has a history of effective financial management and of achieving all statutory financial duties including, most recently for the year ended 31 March 2017.

(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;

- See above (b).
- The trust has well established annual cycles of business in place for the Board of Directors and its committees.
- Audits undertaken through the year on a range of matters relating to the trust's business and operations have not identified undue concerns regarding the timeliness and accuracy of information used to report to the Board in respect of decision making.
- In 2015, the trust introduced a data quality kite mark to assess the quality of data reported to the Board through a series of indicators (this process has also been subject to review by internal audit).
- The Board and committee meeting dates are schedule to allow the most up-to-date information to be provided to meetings. Where necessary, meeting dates are revised to ensure contemporaneous data is available.

(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;

- The Board Assurance Framework and Risk Register provide the framework through which risks are considered, reviewed and managed. These are managed through the committee structure and Risk Management Group and are reported formally, via the appropriate Board committee, to the Board of Directors.
- Regulatory risks are reflected in the trust's Risk Register and Board Assurance Framework are monitored by the Executive Committee and reported to the Board of Directors.

- The trust's risk management arrangements and Board Assurance Framework are subject to an internal audit on an annual basis. The most recent audit of the Board Assurance Framework undertaken in 2017 provided *significant* assurance.
- In 2016, the trust's risk management arrangements were subject to review through a review of quality governance and risk by the Good Governance Institute and the arrangements further strengthened as a result.
- A Board approved Risk Management Strategy, which includes a risk appetite statement, is in place and is reviewed annually.
- The Board undertaken regular development/ training in respect of risk management, most recently in April 2017.

(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;

- The trust has an annual planning process that ensures future business plans are identified at the early stages and are supported by appropriate engagement and approvals to proceed.
- The direction of the trust is outlined in the trust's Strategy and Annual Operating Plan, supported by division level business plans. This annual process includes wide engagement with the Board (through development session), committees, Council of Governors, wider membership and service users and carers.
- Progress against the Strategy is reviewed during the year through the Performance, Investment and Finance Committee and is monitored through the monthly Care at a Glance report (which is also reported to the Board of Directors).
- For individual plans the trust has a well-established business case process in place that ensure appropriate a clear rational is provided and relevant project milestones.

(h) To ensure compliance with all applicable legal requirements.

- The above governance, risk and control processes ensure that the trust remains compliant with all the legal requirements pertaining to it and its business.
- The trust seeks legal advise where appropriate.

Risk & Mitigations

- **Risk:** Systems and processes are disrupted due to change including new business
- **Mitigation:** Any new business including acquisitions and mergers are overseen by a committee. A new Director of Integration was appointed in July 2016. Formal programme management methodology is utilised for any mergers and acquisitions to ensure impact of this on the trust's license is foreseen and mitigated.

- **Risk:** The trust fails to deliver its operational plan and/ or transformational programmes.

- **Mitigation:** To further strengthen its monitoring of strategy and transformational change, delivery of transformational programmes is now led centrally and overseen by the Executive Director of Operations. Progress against transformational programmes is monitored at every meeting of the Performance, Investment and Finance Committee. Progress against the Trust's Operational Plan is monitored through the Care at a Glance Report scrutinised by the Executive Committee, Performance, Investment and Finance Committee and the Board of Directors.

The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure a-f below:

Response: ***CONFIRMED***

In confirming this statement, the Board has considered the following:

(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;

- The Board's dynamic development programme ensures that the Board is engaged with the quality agendas of the trust, and that the Board is equipped with the necessary knowledge and skills to provide clear and effective leadership focussed on delivering quality care. Most recently, the Board held a development session regarding Care Quality Commission compliance, culture and safeguarding in February 2017.
- There are effective appraisal processes in place to support the Board members individually and collectively. The Board reviews its performance periodically, including reviews of Board skills in 2015 and 2016, and uses the learning and feedback from this to inform its future development agenda.
- The Board is engaged with key development and leadership programmes that focus on quality and quality improvement across the trust. Examples of this are the Strategic Development Forum, Leadership Development Forum, Quality Improvement Group and the Council of Governors.
- The review of Executive portfolios in June 2016 has ensured improved arrangements are in place to provide effective leadership in respect of service quality. There is a clear focus on Quality, Quality Improvement and Care Standards within the Executive Team. Revised portfolios also take into account the acquisition of the Calderstones and the appointment of two additional officers to the Board of Directors (i.e., the Executive Director of Operations as a voting officer of the Board and the Director of Integration as a non-voting officer of the Board).

(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;

- The trust's plans including business cases are subject to appropriate Quality Impact Assessment (QIA) processes.
- In addition, Board and Committee annual cycles are kept under review to ensure adequate time for consideration of quality and financial impact prior to decision making.
- Financial plans, including the annual Cost Improvement Plans, are subject to quality impact assessment led by the Medical Director and Executive Director of Nursing.

(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;

- The trust operates a weekly quality surveillance process involving weekly meetings at a divisional level (informed by service teams and wards as well as other information sources) which then report into the weekly corporate Stand-up surveillance meeting involving members of the senior management team. This allows for consideration, escalation and resolution of quality issues on a timely basis.
- The trust has a range of service level forums in place to support service user engagement about the experiences of different services. These forums are used to support on-going dialogue about services to inform and shape improvements, and to gather feedback about potential and proposed changes.
- A Service User and Carer Assembly and Standing Committee is in place which provides one method through which concerns and compliments regarding quality of care can be raised and addressed.
- The Board receives the outcomes of, and participates in, visits to clinical services to gain first-hand knowledge and rich intelligence on the quality of services.
- The trust participates in the National Annual Patient Survey, the outcomes of which are developed into recommendations for implementation and overseen by the Quality Assurance Committee.
- Service users and carers actively support and work with the trust to obtain service user views, inspect services and provide feedback as appropriate.
- The trust engages with its staff to explore potential changes within services, to seek their views and opinions about service experiences and options for change. This is through the Your Voice Your Change programme, Leadership Forums and Divisional Road shows.
- There are a range of formal processes in place to provide engagement between the trust and its key commissioners on matters relating to quality of care.

(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;

- The trust has planned and established annual cycle of business in place for the Board of Directors and its committees.
- The trust operates a weekly quality surveillance process involving weekly meetings at a divisional level (informed by service teams and wards as well as other information sources) which then report into the weekly corporate Stand-up

surveillance meeting involving members of the senior management team. This allows for consideration, escalation and resolution of quality issues on a timely basis.

- Audits undertaken through the year on a range of matters relating to the trust's business and operations have not identified undue concerns regarding the timeliness and accuracy of information used to report to the Board in respect of decision making.
- In 2015, the trust introduced a data quality kite mark to assess the quality of data reported to the Board through a series of indicators.
- The Board and committee meeting dates are scheduled to allow the most up-to-date information to be provided to meetings.
- A service users or carer provides a summary of their experience (both positive and negative) at the commencement of every public Board meeting.
- The Board receives the outcomes of, and participates in, visits to clinical services to gain first-hand knowledge and rich intelligence on the quality of services.

(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

- Public Board of Directors meetings commence with a service user or carer story, the speakers of which are recommended by the Standing Committee of the Service User and Care Assembly.
- The trust has a range of service level forums in place to support service user engagement about the experiences of different services. These forums are used to support on-going dialogue about services to inform and shape improvements, and to gather feedback about potential and proposed changes.
- A Service User and Carer Assembly and Standing Committee in place which provides a structure through which concerns and compliments regarding quality of care can be raised and addressed.
- The Board receives the outcomes of, and participates in, visits to clinical services to gain first-hand knowledge and rich intelligence on the quality of services.
- Service users and carers actively support and work with the Trust to obtain service user views, inspect services and provide feedback as appropriate.
- The trust engages with its staff to explore potential changes within services, to seek their views and opinions about service experiences and options for change. This is through the Your Voice Your Change programme, Leadership Forums and Divisional Road shows.
- There are a range of formal processes in place to provide engagement between the trust and its key Commissioners on matters relating to quality of care.

(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

- The trust has a well established and clear accountability structure in place for quality of care, and an established performance monitoring and reporting programme in place.
- Systems for raising concerns are embedded across the organisation including *Tell Joe* and the *Raising Concerns at Work* policy, which includes the whistleblowing process and the recently appointed *Freedom to Speak Up Guardian*.
- An effective quality surveillance process is in place where concerns regarding quality are both escalated to and identified. The areas under surveillance are escalated to the Board through the regular quality report and are subject to Quality Review Visits.

Risks & Mitigations

- **Risk:** Gaps in knowledge arising as a result of change e.g. new business, environmental change and Board member turnover.
- **Mitigation:** The Board Development Plan will continue to be refined and updated to account for any gaps in knowledge or skills. Board skills reviews were undertaken in 2015 and 2016 and succession plans are in place. Arrangements and associated timescales are already in place to ensure forthcoming Board members vacancies are appointed to in advance to allow sufficient handover. This is most recently evidenced in the appointment of a new Non Executive Director prior to the stepping down of an existing NED.

- **Risk:** Lack of standardisation of good clinical governance practice across all clinical divisions.
- **Mitigation**: The trust has already reviewed its quality governance arrangements to ensure standardisation and the Board have approved a series of changes to these arrangements, subject to the acquisition of Calderstones Partnership NHS Foundation Trust, to ensure these are standardised across the enlarged organisation. The quality governance arrangements were included in the CQC inspection undertaken in June 2015 in which a rating of 'good' was awarded. A further inspection was undertaken in March 2017 and the outcomes are awaited.

The Board is satisfied that there are systems to ensure that the Licensee 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.

Response: ***CONFIRMED***

In confirming this statement, the Board of Directors has considered the following:

- The Board of Directors is well established and was subject to Board skills reviews in 2015 and 2016 to determine any gaps. The recruitment of additional Non-Executive Directors was led by the outcomes of these reviews.
- The necessary skills are maintained by the Board of Directors through its robust and dynamic Board Development Plan which is regularly reviewed and updated to take account of changing needs.

- Succession planning arrangements are in place and were considered by the Board in January 2017 in respect of expected turn-over with the Board membership. The Board of Directors has an effective and broad skill set available to it through its membership to ensure compliance with the conditions of its licence.
- The divisional structures within the trust provide for strong clinical and managerial leadership and supports the Executive Team in ensuring service delivery.
- Resources are in place to support the Board and front line services through:
    - Strong clinical leadership – through a range of Associate Medical Director positions, led by the Medical Director, leading on operational delivery, quality and strategy in addition to an Executive Director of Nursing and executive nursing team.
    - The composition of the Board of Directors was strengthened in July 2016 through the appointed of two additional officers, an Executive Director of Operations (a voting officer) and a Director of Integration (a non voting officer)
    - Corporate capacity to support the delivery of current and future plans has been reviewed through changes to executive portfolios in June 2016.
- A Board approved Workforce Plan is in place to ensure the right skill mix of teams to support the on-going transformation change.

Risks & Mitigations

- **Risk:** The Board of Directors does not have people with the appropriate skills and experience
- **Mitigations:** Externally led Board Skills Reviews were undertaken in 2015 and 2016 so as to inform the future recruitment requirements in respect of Non Executive Directors. Succession plans are in place and have been considered by the Board in January 2017 and being further strengthened. Executive portfolios were reviewed and updated in June 2016 to ensure appropriate use of skills and experience.

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.

Response: ***CONFIRMED***

In confirming this statement, the Board of Directors can be assured that:

- All Governors have been provided with a Governor Handbook and Information pack containing relevant policies, procedures, guidance and information relevant to their role.
- An externally facilitated induction session was provided to Governors outlining the role of a Foundation Trust, the role of the Board of Directors and the role of the Council of Governors in fulfilling its statutory duties.
- A comprehensive induction programme was development and implemented for Governors which included sessions on:
    - Striving for perfect care;
    - Quality of services;

    - Supporting processes;
    - Divisional arrangements
- Governors were invited on visits to a range of services including Clock View, Scott Clinic, Ashworth Hospital, Mossley Hill Hospital, Norris Green, Hesketh Centre and the Whalley site.
- Governors have been invited to participate in our Quality Review Visits and appropriate training has been provided on the visit process.
- The format of Council of Governors meetings allow for information sharing and development at each meeting.

Risks and Mitigations

- **Risk:** The Council of Governors may not have the skills and experience to undertake its role.
- **Mitigation:** Following FT authorisation on 1 May 2016, the trust established its Council of Governors which held its inaugural meeting on 6 May 2016. A comprehensive induction and visit programme has been delivered to the Council of Governors over the previous year and work is on-going to develop a full Governor Development Programme to reflect internal and external training in addition to options participation and training in Quality Review Visits. The Board of Directors has clear accountability arrangements in place with its Council of Governors and will continue to invest in this relationship ensuring the Governors are well placed to discharge their responsibilities of ensuring local accountability.

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Appendix C

Provider License - Condition G6

Condition G6 – Systems for compliance with licence conditions and related obligations

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.

3. 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.

4. The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to Monitor in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it.

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Appendix D

Condition G6 / CoS7 Self-Certifications – Evidence of Compliance

Condition G6

Following a review for the purpose of paragraph 2(b) of licence condition G6, The Directors of the Licensee are satisfied 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.

Response: ***CONFIRMED***

In confirming this statement, the Board of Directors has considered the following:

- There is a Board approved Risk Management Strategy in place which clearly outlines the Trust's approach to identifying, managing and escalating risk which would include those risks to compliance with the Provider License.
- The Executive Committee, Quality Assurance Committee and Performance, Investment and Finance Committee monitor their relevant risks across the organisation and make recommendations to the Board of Directors as appropriate
- The Board Assurance Framework is reported to, and considered by the Board of Directors at every meeting.
- During the financial year 2016/17 no potential risks of compliance have been identified with regard the Provider License.
- There were no additional requirements imposed under the NHS Acts during 2013/14.
- The Trust continues to have regard to the provisions contained within the NHS Constitution through the formulation and adoption of trust policies and procedures. The Trust's governance structure reflects the needs of the NHS constitution and the rights of patients, service users and staff.
- The Board continues to take into account the conditions of the provider licence in delivery of health care services.

Condition CoS7

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.

Response: ***CONFIRMED***

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

- The long and medium term financial position as detailed in the Trust Financial Framework considered and approved by the Board of Directors in November 2016.

- The year to date and the annual financial position as detailed in the following reports presented to the Board of Directors and relevant Board Committee's:
    - Budget Book
    - Monthly Financial Performance Reports
    - Monthly Care at a Glance Report
- The 16/17 annual accounts were prepared on a going concern basis
- Income and expenditure budgets have been set on robust and agreed principles and divisions should be able to provide high quality healthcare within the resources available, provided the cost improvement plans are achieved.
- The Performance, Investment and Finance Committee approved a financial strategy 2018/19-2020/21 in April 2017 which outlined the Trusts intention to continue to plan to deliver against key national control targets and delivery savings of £11m from non-clinical areas.
- The trust achieved a surplus of £5.2M in 2016/17. As a consequence, Sustainability Transformation Funding (STF) funding of £1.7M was awarded. This had the effect of increasing the surplus to a control total of £6.9M at the year end.
- The Board approved Financial Plan for 17/18 set out the surplus of £4m to be delivered and a control total of £5.2m.

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