The Royal Wolverhampton
NHS Trust

NHSI Self Certification
25 June 2018

Agenda Item No: 11.2

Safe & Effective | Kind & Caring | Exceeding Expectation

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	25 June 2018
Title:	NHSI Self Certification
Executive Summary:	This paper outlines the required process of self-certification for NHS Trusts for their license to operate.
Action Requested:	For the Board to review the updated evidence for self-assessment and to **Approve** the self-assessment declaration.
For the attention of the Board	This section requires a brief, focussed summary of the points of fact for the Board plus any/all of the following:
Assure	• The self-assessment update indicates that the Trust continues to meet the declaration requirements.
Advise	• There remain areas of planned work for future delivery.
Alert	• No areas of immediate high risk have been identified.
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Links to Trust Strategic Objectives	1. Create a culture of compassion, safety and quality 2. Proactively seek opportunities to develop our services 3. To have an effective and well integrated local health and care system that operates efficiently 4. Attract, retain and develop our staff, and improve employee engagement 5. Maintain financial health – Appropriate investment to patient services 6. Be in the top 25% of all key performance indicators
Resource Implications:	None
CQC Domains	**Safe:** patients, staff and the public are protected from abuse and avoidable harm. **Effective:** care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence. **Caring:** staff involve and treat everyone with compassion, kindness, dignity and respect. **Responsive:** services are organised so that they meet people's needs. **Well-led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.
Equality and Diversity Impact	No implications identified.
Risks: BAF/ TRR	No new or changed risks identified.
Public or Private:	Public
Other formal bodies involved:	None
References	NHS Provider License February 2013 Single Oversight Framework September 2016
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Report Details	
1	**Introduction** Prior to the merger of Monitor and TDA each Foundation Trust was required to self-certify against their license terms. From 2017 NHSI now require all NHS Trusts to make a declaration following the instruction from the Secretary of State for Health. This Declaration is based on an update of the declaration review made in June 2017. The two conditions against which Trusts are required to comply are: Condition 1 – G6 (3) The Board takes precautions necessary to comply with the license, NHS Act and NHS Constitution. The Trust Board has previously approved the declaration against Conditions G6 for 2018. **Condition 2 – FT4 (8)** Providers must certify compliance with governance standards and objectives. This is the second condition where the declaration has to be agreed and made by the Trust before the end of June 2018.
2	**Requirements** Trusts are required to make two submissions for their Trust Board's approval: 1. By the 31st May 2018 each Trust is required gain Board approval for self-certification against G6 (3). This was done in May 2018. 2. By 30th June 2018 a further declaration for FT4 (8) is required to be approved by the Board. Both declarations must be published on the Trust's webpage by 30th June 2018. There is no requirement for any return to NHSI nor to provide any information with the submission however random audits will be undertaken by NHSI from July 2017 for Trusts to demonstrate their evidence of compliance. Further evidence will be added to the document as it is established. The NHSI guidance was circulated to Board members for reference in May 2017.
3	**Summary** The Board is asked to consider the attached declarations against each condition and obligation and approve for the Trust to declare compliance with our license conditions.

NHS Provider License Conditions – Compliance Statement 2018/19

Condition FT4 – NHS foundation trust governance arrangements – Sign off due 25 June 2018	**Lead/s to respond**	**Trust position statement**	**Risks and gaps**	**Evidence/ Comment**
Condition FT4 - 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.	CFO/Deputy CEO, Company Secretary	The Trust Board received assurance at the April and May 2018 Trust Board meeting that it complies with the governance arrangements. This will be published on the Trust webpage.		
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.	CFO/Deputy CEO, Company Secretary	Corporate governance elements have now been combined as responsibilities of the CFO/Deputy CEO and Company Secretary. This has reduced any risk from the previously fragmented position. The CFO/Deputy CEO holds the Director responsibility supported by the Company Secretary. The principles, systems and practice are contained in the Standing Orders and Standing Financial Instructions for the organisation.		
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 NHSI from time to time; and	CFO/Deputy CEO, Company Secretary	As section 2, plus: The Trust Board has now commenced a Self-assessment and development process regarding leadership and governance under the CQC Well-led Key Lines of Enquiry (KLOE). Although not previously deemed a significant risk, the matter is being addressed.		• Structured review against the Well Led framework in process
(b) comply with the following paragraphs of this Condition.	CFO/Deputy CEO, Company Secretary	As section 2, plus:		

4. The Licensee shall establish and implement: (a) effective board and committee structures;	CFO/Deputy CEO, Company Secretary	a) Following an external governance review in 2013 (PWC) a review of the Board structures and reporting lines was undertaken and the sub Board committee structure developed. This was also reviewed in the latest Deloitte review (December 2016). Terms of reference for all committees reviewed annually to ensure alignment with Strategic objectives and relevant responsibilities.		• Terms of Reference reviewed April 2018 • Sub-committee reports to Board • Strategic objectives reviewed late 2017 • New QGAC Structure in place • WODC established late 2017
(b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and	b) Chief Nurse, Head of Governance	b) The Risk Management Assurance Strategy describes the Committee structure and risk management reporting arrangements.		• Evidence in G6(2) • Risk Strategy for approval at TMC June 2018
(c) clear reporting lines and accountabilities throughout its organisation.	c) Director of Strategic planning and Performance, Deputy Director of Strategic Planning and Performance	c) The Trust Board has strengthened its arrangements for reporting and accountability across the organisation and introduced a new Divisional Performance Review Process. This uses current data and a balanced scorecard approach to enable clear visibility of performance across a range of themes from operational performance through to the strategic objectives. The new Division 3 commenced operation from April 2018 and reporting from May 2018.		• Evidence in G6(2)
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;	a)Director of Finance, Chief Operating Officer	a)The following sub Board committees oversee the key areas of performance: F&P – Financial performance including CIP, Operational performance, BAF related risks QGAC – Quality and Safety, BAF/TRR Audit – BAF/TRR, Effectiveness of systems, Audit programmes FRB – Efficiency overview/delivery of CIP TMC – CEO senior management meeting WODC – New Board Committee with a focus on Workforce and Organisational Development requirements.		• Minutes and Board reports
(b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations;	b)Company Secretary	b) The Trust Board receives a comprehensive suite of information in a timely fashion that enables it to oversee and scrutinise operations. Assurance reports are received from all sub committees alongside a monthly Quality, Finance and Performance report.		• Boardpad product used for the Trust Board from October 2017. • Plans to extend this use to all Trust Board Committees from Sept 2018 • Enables remote/mobile access to papers • Boardpad records

(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;	c) Chief Nurse, Head of Governance	c) The Trust has developed a framework (self-assessment against core services and QRV's) for assessing on-going compliance with CQC Fundamental standards of care (and 5 key questions of Safe, Caring, Effective, Responsive and Well Led). The assessment of compliance uses a combination of quality performance indicators, clinical audits and observational ward and department visits to measure on-going compliance with care standards. The Trust uses the CQC rating characteristics to make judgements about compliance with the fundamental standards of care and judgments are cross checked and challenged at Divisional Management Performance / Quality meetings and by Executives at CoG and QGAC. This approach allows for information to be triangulated between performance results and observation of care standards and allows for assurance to be reported from ward to Board.	Not all areas have received a QRV, a programme of visits runs throughout the year. Self-assessment is relied upon against the Fundamental Standards of Care and Core service assessments.	• IQPR • Escalation reports from sub committees • FSC and Core Service self-assessments and reports minutes were reviewed. • A process of self-assessment signoff is in place by either Divisional Management or Specialist leads.
	c) Director of Strategic planning and Performance, Deputy Director of Strategic Planning and Performance	c) The Trust uses the NHS Standard contract for all material contracts with commissioners and has developed contracts with NHS Wales to ensure a consistent approach to contracting. Where possible all sub contracts and provider to provider agreements now utilise the non-mandatory NHS Standard Sub-Contract template. All contracts are subject to internal and external audit where required and actions all completed. We work collaboratively with other contract parties to ensure that we are compliant with contract conditions. The requirements placed upon providers to meet the NHS Operating Framework are all detailed within the standard contract. Contracts have recently been reviewed to establish contractor GDPR status (May 2018).	Non-compliance of other contract parties.	• Contract documentation. • Audit logs for contract tracking. • Minutes of contract meetings (internal and external). • SQPR and Information submissions