Avon and Wiltshire Mental Health Partnership NHS Trust

Trust Board meeting	Date:	27 September 2017

Agenda item	Title	Executive Director lead and presenter	Report author
BD/17/146	**Provider Licence - Self certification Q2 2017/18**	**Interim Company Secretary**	**Interim Company Secretary**

This report is for:	
Decision	x
Discussion	
To Note	

History

Discussed at Executive Team on 20 June 2017, Trust Board 28 June 2017 and Audit & Risk 1 September 2017.

A self-certification declaration against condition G6 was agreed by the Trust Board for 2016/2017 which is published on the Trust website.

The following impacts have been identified and assessed within this report	
Equality	
Quality	x
Privacy	

Executive summary of key issues

All NHS trusts are now required to self-certify against a provider licence in 2017/18.

The Trust is required to make a quarterly declaration regarding corporate governance - Condition FT4 (8). The proposed declarations are included in Appendix 1. In all instances the Executive Team are proposing to reply confirmed, with the exception on FT 4 'the Board is satisfied that the Licensee has established and effectively implements systems and/or processes'.

The Audit & Risk Committee discussed the declaration on 1 September 2017, considering the CQC visit, the Financial Improvement Plan and partial budget approval for 2017/18 and agreed that they were content with the recommendation from the Executive Team.

The Board is asked to approve the self-certification against the provider license.

This report addresses these strategic priorities:	
We will support our service users and carers: We will engage our staff: We will be sustainable:	

1 Purpose

1.1 Purpose

1.1.1 To provide evidence of compliance against the Provider Licence to support a self-certification decision by the Board.

2 Background

2.1 Background

2.1 This is the first year NHS trusts must self-certify against a provider licence. Although NHS trusts are exempt from needing the provider licence, directions from the Secretary of State require NHS Improvement (NHSI) to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate.

2.2. The Single Oversight Framework (SOF) bases its oversight on the NHS provider licence. NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions (including Condition G6 and Condition FT4) and must self-certify under these licence provisions.

2.3. NHS trusts are required to self-certify that they can meet the obligations set out in 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 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that they have complied with governance requirements. The self-certification requirement set out in CoS7 (3) does not apply to NHS trusts.

3 Self-Certification Requirements

3.1 Self-Certification requirements

3.1. Providers need to self-certify the following after the financial year-end:

NHS provider licence condition

- The provider has complied with required governance arrangements (Condition FT4(8))

3.2. It is up to providers how they undertake the self-certification. Appendix 1 includes a summary of the evidence for compliance, for discussion.

3.3. Trusts are required to state either “confirmed” or “not confirmed” against each element of the licence condition, and if the Trust chooses “not-confirmed” it must provide an explanation why.

3.4. Boards must sign off on self-certification no later than:

• FT4: 30 September 2017. It is anticipated that this will be a quarterly return.

3.5. The outcome of the assessment must be reported to NHS Improvement via Board minutes. NHS Improvement have confirmed that the Trust will not be required to submit the declaration via the portal.

4 Proposed Outcome

4.1

4.1. The evidence to support the response is outlined in Appendix 1.

4.2. For FT4, the Board is required to consider any risks and mitigating actions for each element of the provider licence condition. These are described in Appendix 1. There is one element of FT4 where is currently showing a 'not confirmed' declaration for Board discussion, this is the same declaration made in Q1, and supported by the audit & Risk Committee.

5 Recommendation.

The Board is asked to discuss and approve the Self Certification as attached in Appendix 1

	FT4 – Corporate Governance Statement	Response	Evidence	Risks	Mitigating actions
1.	The Board is satisfied that the Licensee 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.	Confirmed	Annual Governance Statement Well-led Framework self-assessment currently being undertaken. Head of Internal Audit Opinion – identified weaknesses in governance and risk management in 2016/17 but noted progress towards the end of the year. Board Assurance Framework Board effectiveness evaluation	The recent governance review means there is a risk that good governance is not fully embedded in all areas of the Trust. Capacity with the Trust to deliver the transformation agenda within the required timeframes.	The Trust utilises its management and committee structures to ensure that good governance is applied. The risks processes have been reviewed and are being strengthened. Additional support provided by SSG with the development of the FIP.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.	Confirmed	As above plus: Work with NHSI during oversight meetings. Financial Improvement Programme.	Guidance is not identified or implemented in a timely manner.	The Trust ensures that regular communications from NHSI, CQC and other key bodies are reviewed and acted upon. Internal and external audit consider application of good governance during their audit programmes. NHSI Oversight meetings.
3.	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.	Confirmed	Committee annual effectiveness reviews Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions - reviewed annually Committee Terms of Reference have been reviewed. Revised operational and clinical governance structures.	The scope of the Quality and Standards Committee is very widespread. The capacity of the Committees to provide effective oversight of the transformation agenda. Embedding the agreed changes to the risk management processes.	A well led framework review is being undertaken. Agreed Undertakings with NHSI and regular oversight meetings. Targeted internal audits reports. Frequent Committee meetings.

4.	The Board is satisfied that the Licensee has established and effectively implements 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.	Not Confirmed	Head of Internal Audit Opinion Financial Improvement Programme and CIP programme Budget setting Financial reporting Benchmarking against peers Revised Integrated Performance Report Committee Deep Dives Quality & Standards Committee oversight of quality and CQC regulatory compliance External Audit of the Trust Annual Accounts Risk Management Strategy Risk Register - Operational risks and corporate risks Board Assurance Framework - Strategic Risks Business Plan and annual objectives	The Trust's internal control systems are not sufficiently robust to ensure compliance. Unidentified CIPs. Capacity to deliver transformation.	The systems and processes are regularly tested through the internal and external audit programmes as well as through deep dive reviews by the Assurance Committees. Financial Improvement plan Development of the Project Management Office. SSG support
5.	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) That there is sufficient capability at Board level to	Confirmed	Board Development Programme Non-Executive Director and Executive Challenge of proposals	The Trust's internal control systems are not sufficiently robust to ensure compliance Focus of effort on FIP to the	The systems and processes are regularly tested through the internal and external audit programmes as well as through deep dive reviews by the Assurance Committees.

	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 including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		Integrated Performance Report Active engagement with local Health Scrutiny, Health & Wellbeing Boards and Healthwatch Patient Experience programme of activities 15 step walkabouts Patient stories Quality Account	detriment of quality of care. CQC rating Risk to the quality of care due to the aging estate	Quality impact assessments undertaken on CIP schemes. CQC programme Capital work plan Estates and Facilities Programme
6	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.	Confirmed	Board Skills and Knowledge Review which led to the appointment of a Director of HR and Strategy Operations Directorate Review Corporate Affairs Directorate Review Fit and Proper person checks.	There is a risk of unforeseen changes at Board level which may impact on the requirements. Inability to recruit and retain staff	Succession planning Listening into Action Recruitment strategy Roster process and design programme Action plan to reduce turnover