Public Board meeting

SUMMARY	Meeting Date:	22 June 2022
	Agenda Item:	3

Report Title:	**Compliance against Provider Licence Conditions**	
Author(s):	Deborah Lawrenson, Director of Corporate Governance	
Accountable Director:	Deborah Lawrenson, Director of Corporate Governance	
Other meetings this paper has been presented to or previously agreed at:	**Committee/Tier 2 Group/Tier 3 Group**	Audit and Risk Committee
	Date:	14 June 2022
Key points/ recommendations from those meetings	The Audit and Risk Committee have approved the compliance statement and commend it for final endorsement at the Board	

Summary of key points in report

Foundation Trusts are required to make an annual declaration in relation to compliance with Provider Licence conditions G6(3), FT4 and CoS7. In 2020/21 the Trust declared non-compliance against licence conditions G6(3) and FT4 and compliance with CoS7.

The attached assessment recommends a declaration of compliance against each of the above licence conditions for 2021/22

The document has been updated since received at the May Board meeting and was received, discussed and approved at the Audit and Risk Committee on 14 June 2022.

The updated document will be received for final approval at the Public Board in June 2022.

Recommendation for the Board/Committee to consider:

Consider for Action		Approval	X	Assurance		Information	

The Board is asked to review the final Compliance with Provider Licence Conditions statement, post receipt at Audit and Risk Committee, confirm compliance against all conditions has been satisfied and endorse the statement for publication.

Please identify which strategic priorities will be impacted by this report:				
Covid-19 Recovering Effectively	*Yes*	*x*	*No*	
CQC Getting Back to Good	*Yes*	*x*	*No*	
Transformation – Changing things that will make a difference	*Yes*	*x*	*No*	
Partnerships – working together to have a bigger impact	*Yes*	*x*	*No*	

Is this report relevant to compliance with any key standards ?	State specific standard				
Care Quality Commission Fundamental Standards	*Yes*		*No*		
Data Security and Protection Toolkit	*Yes*		*No*		
Any other specific standard?					Foundation Trust Provider Licence, Annual Governance Statement, NHS Foundation Trust Code of Governance

Have these areas been considered ? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Service User and Carer Safety and Experience	*Yes*		*No*		
Financial (revenue &capital)	*Yes*		*No*		
Organisational Development /Workforce	*Yes*		*No*		
Equality, Diversity & Inclusion	*Yes*		*No*		
Legal	*Yes*		*No*		

Compliance against Provider Licence Conditions 201/22

Section 1: Analysis and supporting detail

Summary

1.1 Foundation Trusts are required to make an annual declaration in relation to compliance with Provider Licence conditions G6(3), FT4 and CoS7.

1.2 G6(3) related to systems for compliance with licence conditions and related obligations. FT4 is in relation to Foundation Trust governance arrangements. CoS7 is related to the availability of resources to undertake required business.

1.3 Last year it was agreed that SHSC was not in a position to declare compliance against conditions G6(3) or FT4. This was as a direct result of the CQC inspection which had highlighted issues which were likely to amount to breaches of those conditions. Compliance was declared in respect of condition CoS7.

1.4 As outlined on the attached appendix SHSC has been re-rated by the CQC as 'requires improvement', the Section 29a Notice has been closed, and the Trust was been formally notified of its transition from System Operating Framework (SOF) category 4 to Category 3 before the end of 2021/22.

1.5 It is therefore proposed that SHSC can declare compliance against each of the licence conditions.

Next Steps

1.3 Following consideration by, and approval of the Board the declarations will be published in accordance with the mandated reporting arrangements.

Appendix 1

Sheffield Health and Social Care NHS Foundation Trust Self-certification against Provider Licence Conditions 2021-22

Details of Condition	**General condition G6(3) – 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 the generality of paragraph 1, the steps 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 the financial year, the Licensee shall prepare a certificate to the effect that, following a review of 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	• Governance infrastructure and arrangements • Board and Committees (Audit & Risk, Finance & Performance, Quality Assurance, People, Remuneration, and Mental Health Legislation) • Data & Information Governance committee

	• Trust's Risk Management Strategy and risk management processes • Incident management processes and procedures • Speaking Up processes • Service User Engagement Group • Wide ranging opportunities to learn from good practice through reporting, groups, forums, visits, events and feedback • Service User Safety Group • Clinical Effectiveness Group • Transformational Operational Group • Policy Governance Group The Trust regularly reviews these processes and systems and their effectiveness. This has included a range of internal audit reports and management reviews of systems and processes.
Evidence	Annual report and Accounts Annual Governance Statement Head of Internal Audit Opinion Corporate Risk Register Board Assurance Framework Governance and Risk Management Internal Audit Report
Assessment	The organisation has continued to make significant improvements during 2021/22 to address issues highlighted by the CQC inspection undertaken in early 2020. In May 2021 the CQC carried out follow up inspections for the areas previously rated as inadequate - mental health wards for older people, crisis and health-based places of safety and moved these to 'requires improvement'. The Well Led element was also re-visited at this time and moved from 'inadequate' to 'requires improvement'. The acute wards and psychiatric intensive care unit were inspected but remained rated as 'inadequate' as further improvement was required. Following re-inspection in December 2021 they were re-rated as 'requires improvement'. In August 2021 the CQC re-rated the Trust overall from 'inadequate' to 'requires improvement' In February 2022 the CQC confirmed the Trust had made significant improvements in the areas highlighted in the previous Section 29A enforcement notice and this enforcement notice was closed.

	In March 2022 NHS England and NHS Improvement formally notified the Trust of its transition from system Operating Framework (SOF) Category 4 (formerly 'Special Measures) to Category 3. This was in recognition of the progress made against Quality and the further work around sustained delivery of improvements.
Self-certification	**Compliance status: Confirmed**

Details of Condition	**FT4: NHS Foundation Trust Conditions governance arrangements** 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 in the NHS. 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 NHS Improvement from time to time; and (b) comply with the following paragraphs of this Condition. 3. The Licensee shall establish and implement: (a) effective board and committee structures; (b) clear responsibilities for its Board, its 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. 4. The Licensee shall establish and effectively implement systems and/or processes: (a) to ensure compliance with the Licensees' 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 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 change 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. 5. The systems and/or processes referred to above include, but are not restricted to, systems and/or processes that ensure: (a) sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) 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) the Board receives and takes into account accurate, comprehensive, timely and up-to-date information on quality of care; (e) that the Licensee including the 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) there is a 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. 6. The Licensee shall ensure the existence and effective operation of systems to ensure 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. 7. The Licensee shall publish within three months of the end of the 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.
This means	This means Providers should review whether their governance systems meet the standards and objectives in this 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	Governance infrastructure and arrangements Board and Committees Business planning processes Business Planning Group Incident management processes and procedures Appraisal process for Board Members and Executive Directors CQC inspection process and outcomes Review meetings with CQC Review meetings with NHS Improvement Trust's Risk Management Strategy and risk management processes Service User Safety Group Policy Governance Group
Evidence	Annual Board Statements Annual Operational Plan Annual Report and Accounts Annual Governance Statement Annual Quality Report Head of Internal Audit Opinion Trust Constitution and Standing Orders Standing Financial Instructions and Scheme of Delegation Terms of Reference for Board Committees 'Back to Good' Board Management arrangements Performance report Performance framework and performance management reviews Board Assurance Framework 'Alert, Assure, Advise' reports from Committee Chairs to Board Allocate Health Roster and Safe Care Fit and Proper Persons Requirement processes Stable executive leadership team and operational leadership arrangements with the right skills and expertise Robust Board development plan alongside executive, non-executive, and staff leadership programmes Appraisal process for Board Members and Executive Directors Robust responsible officer arrangements for medical staff

	Governor induction Governor training and development opportunities via NHS Providers Governor informal meetings
Assessment	The organisation has continued to make significant improvements during 2021/22 to address issues highlighted by the CQC inspection undertaken in early 2020. In May 2021 the CQC carried out follow up inspections for the areas previously rated as inadequate - mental health wards for older people, crisis and health-based places of safety and moved these to 'requires improvement'. The Well Led element was also re-visited at this time and moved from 'inadequate' to 'requires improvement'. The acute wards and psychiatric intensive care unit were inspected but remained rated as 'inadequate' as further improvement was required. Following re-inspection in December 2021 they were re-rated as 'requires improvement'. In August 2021 the CQC re-rated the Trust overall from 'inadequate' to 'requires improvement' In February 2022 the CQC confirmed the Trust had made significant improvements in the areas highlighted in the previous Section 29A enforcement notice and this enforcement notice was closed. In March 2022 NHS England and NHS Improvement formally notified the Trust of its transition from system Operating Framework (SOF) Category 4 (formerly 'Special Measures) to Category 3. This was in recognition of the progress made against Quality and the further work around sustained delivery of improvements.
Self-certification	**Compliance status: Confirmed**

Details of Condition	**CoS7: Availability of Resources** 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 publish a certificate as to the availability of the requires 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 of 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 case 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."
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: • 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 could make other related services unviable.

Assurance	Board of Directors and Committees
Evidence	Going concerns assessment process External audit opinion Trust patient services contracts Financial reports and updates, including annual accounts and supporting narrative Financial plan
Assessment	The organisation has continued to make significant improvements during 2021/22 to address issues highlighted by the CQC inspection undertaken in early 2020 and moved to an overall CQC rating of 'requires improvement' during the year and from SOF 4 to SOF3. The areas giving rise to the CQC report in 2020, or to issues raised and addressed in 2021, did not impact upon compliance with this condition. In addition, during 2021/22, SHSC has been sufficiently resourced to undertake the significant changes detailed while also coping with the enormity of the impact of the Covid-19 pandemic.
Self-certification	**Compliance status: Confirmed**