City Hospitals Sunderland
NHS Foundation Trust

ANNUAL SELF-CERTIFICATIONS STATEMENTS
PRESENTED TO BOARD OF DIRECTORS
APRIL 2018

Introduction

To comply with the governance conditions of their NHS Provider Licence, NHS Foundation Trusts are required to provide a number of statements including: the Availability of Resources Statement under Condition CoS7; Systems for compliance with Licence Conditions under General Condition 6; and a Corporate Governance Statement and training for Governors certification under Condition FT4.

Although there is no longer a requirement to return the completed Provider Licence Self-Certifications to NHS Improvement, NHSI will contact a select number of NHS Trusts and Foundation Trusts to ask for evidence that they have self-certified. This can either be through providing the completed templates if they have used them, or relevant board minutes and papers recording sign-off.

Condition G6 – Systems for Compliance for Licence Conditions

The Condition 6 statement regarding systems for compliance with the Licence (as outlined below) was submitted and approved at the April 2018 meeting of the Board of Directors.

"Following a review for the purpose of paragraph 2(b) of Licence Condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the Licence, any requirement imposed on it under the NHS Acts and have had regard to the NHS Constitution."

Condition CoS7 – Availability of resources

The Availability of Resources Statement as required by Condition CoS7 of the Licence (as outlined below) was submitted and approved at the April 2018 meeting of the Board of Directors.

"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."

Condition FT4 – NHS Foundation Trust governance arrangements

The Corporate Governance Statement regarding systems for compliance with NHS Foundation Trust governance arrangements are set out in Appendix 1.

Certification on Training for Governors (not a Licence Condition)

The certification on training for Governors, although not a Licence condition, is outlined below:

“The Board is satisfied that during the financial year most recently ended, the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role”.

Recommendation

The Board is asked to:

- Confirm that the Trust continues to meet the criteria for holding a Licence to ensure compliance with Condition G6 of the Provider Licence;
- Confirm that the Board has a reasonable expectation the Trust will have the required resources available to it for the coming year in line with Condition CoS7 of the Provider Licence;
- Approve the corporate governance statement and confirm that the Board has sufficient arrangements in place for compliance with NHS Foundation Trust governance arrangements; and
- Confirm that sufficient arrangements have been in place to ensure Governors are equipped with the skills and knowledge to undertake their role.

CAROL HARRIES
Director of Corporate Affairs & Legal/Trust Secretary

Worksheet "FT4 declaration"

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1	Corporate Governance Statement	Response	Risks and Mitigating actions
	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	The Trust's compliance with all principles, systems and standards for a supplier of health care services is reviewed in detail through the Clinical Governance Steering Group and Corporate Governance Steering Group. Highlight reports with any outstanding risks are escalated to the Governance Committee which then reports to the Board of Directors. The Governance Committee also oversees the work of the Clinical Governance Steering Group and the Corporate Governance Steering Group to provide assurance on risks and the quality of services delivered to our patients. The Board is satisfied with the systems and processes in place to monitor and improve the quality of healthcare provided to patients. The Board intended to undertake a joint external well led review, however, following the CQC review at STFT and the impending CHS CQC review a decision was made to defer this until after the outcomes of the CQC reviews. The Trust's overall vision, strategy and philosophy are based on the quality and safety of its service. The strategic business planning process provides a framework for delivering against national, local and internal quality and performance key quality objectives. Overall performance is aligned and tracked against these Trust-wide priorities for quality improvement. This ensures that quality underpins any major service change. The quality priorities reflect local as well as national priorities and discussions with stakeholders continue to shape these. There are clear lines of responsibility in relation to the quality targets within our Performance Report presented to the Board. The Clinical Governance Steering Group, on behalf of the Board, reviews progress against clinical quality benchmarks and outstanding risks are escalated to the Governance Committee and to the Board of Directors. The Foundation Trust routinely analyses organisational performance on key quality indicators, benchmarked against national comparisons, leading to the identification of any priorities for quality improvement. The Clinical Governance Steering Group monitors, reviews and oversees the implementation of clinical developments such as NICE guidance, NICE quality standards, national guidance and guidance from Royal Colleges. The Trust also carries out a regular review of Trust policies and procedures. In addition the Annual Report and Accounts for 2016/17 including the Quality Accounts were reviewed by the Audit Committee as a sub-committee of the Board. The Audit Committee signed off the

			documents including the Annual Governance Statement, taking account of internal and external audit review.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Trust annually assesses its compliance with NHSI's Code of Governance and this is detailed within the Annual Report. Any additional guidance issued by NHS Improvement, NHS Providers and other regulatory bodies are considered through the appropriate governance groups and when it is released.
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	The Trust has a clearly defined structure, which covers all committees reporting to the Board and there is board representation (executive and non-executive) on all committees. The Board and committees have terms of reference which define clear reporting lines and accountabilities. The structure of the committees and terms of reference are reviewed and a formal review has been undertaken following the establishment of the Alliance and the single Executive Management Team whereby there is alignment or Board sub committees and terms of reference. This review has resulted in a number of joint committees for CHSFT and STFT.
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	Confirmed	The Trust uses a number of systems and processes such as service line reporting, performance management, lean practices/continuous improvement combined with internal audit and assurance process to ensure they operate on an economic efficient and effective basis. The Trust uses a monthly 'Quality, Risk and Assurance Report' and a 'Performance Report' that enables the board to have oversight of the operations and to ensure compliance with the appropriate health care standards. These reports are refreshed monthly to provide timely information to aid the trust's decision-making process. The performance report is RAG rated and therefore enables the Board to manage any risks and manage delivery of business plans etc. Planning/performance management – The annual business review process is delivered through our OGSM process and monitored by the Finance and Performance Committee and Executive Committee. All strategic planning frameworks have been signed off by the board. Performance against all key targets is presented monthly and reviewed by the aforementioned sub-committees. Risk Management processes – The Trust Board reviews the Trust Assurance Framework formally to gain assurance that top risks for the Trust are being managed to the lowest level. The Trusts top corporate risks are also reviewed by the Board and each of the relevant sub committees during the year. Audit Committee recommendation – Audit Committee review all recommendations during the course of the financial year. An escalation process is in place should there be any concern around the implementation of any actions as recommended by Internal or External Audit. At the end of the financial year, the Audit Committee reviews the Annual Governance Statement and takes account of the views of internal and external auditors relating to the Trust's compliance with appropriate national standards.

	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.		
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 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.	Confirmed	The Trust has a robust process in place to ensure all Executive and Non Executive Directors are able to discharge their functions effectively. The trust also has a robust process in place for performance, objective setting and personal development plans to ensure individuals are equipped to carry out their role and function within the organisation. The Non Executive Directors provide appropriate oversight on executive performance to ensure plans are delivered. In addition, the Board reviewed its structure which resulted in the implementation of the single Executive Management Team during 2016/17 to ensure the Board has sufficient capacity and capability to provide effective leadership on the quality of care provided. The Board of Directors and the Executive Committee review the Quality, Risk and Assurance report, the Service Report and Corporate Performance Dashboards monthly. The Quality, Risk and Assurance report provides assurance on external sources such as the nationally reported mortality and outcome data, the internal mortality review panel, information from our quality provider (Methods Analytics), the results of national audits and external inspections, and national survey programmes. The Governance Committee therefore provides assurance upon the adequacy and effectiveness of risk management and integrated governance within the organisation. The Trust's Board takes part in ward visits, surveys and activities with other stakeholder groups such as CCGs, Council of Governors and patient groups to take due account of the views of its staff and patients in terms of improving the quality of care. The Trust has clear responsibilities and accountability which is defined for staff as well as established escalation routes and processes through the Trust's standing committee structure. The Trust also has a Freedom to Speak Up Guardian and has trained Freedom to Speak Up ambassadors which include members of the Council of Governors.

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	The Trust has a robust process in place for performance, objective setting and personal development plans to ensure individuals are equipped to carry out their role and function within the organisation. The Non Executive Directors provide appropriate oversight on executive performance to ensure plans are delivered. Non Executive membership of the Board is monitored by the Council of Governors and its Nominations Committee - details of which are included in the Trust's Annual Report.

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature 

Name John Anderson, Chairman

Signature 

Name Julia Pattison, Director of Finance

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.

Worksheet "Training of governors"

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

2 Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name		**Name**	
Capacity	Chairman	**Capacity**	
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

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Worksheet "G6 & CoS7"

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS prov licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1	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.	Confirmed

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed

OR

3b	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 (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	

OR

3c 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.

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

The Trust Board has not accepted its control total for 2018/19 but has put in place a draw down facility to enable it to deliver continuity of services.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	John Anderson	**Name**	Julia Pattison
Capacity	Chairman	**Capacity**	Director of Finance
Date	19 April 2018	**Date**	19 April 2018

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

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