Final post 22 June 2022 Board

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

Sheffield Health and Social Care NHS Foundation Trust

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 2021 a number of internal controls led to the Director of Nursing sharing serious concerns with the CQC regarding the quality of care at Firshill Rise Assessment and Treatment Service. This led to a number of actions to improve the service but following an unannounced visit by the CQC (although this was expected

	by the organisation), this resulted in the service being rated as inadequate and a condition and a requirement to stop new admissions until a number of conditions were met. A number of learning events were undertaken to understand the root causes of the findings of the report. One of the outcomes of these learning events was that the Trust made the decision to support the safe transfer of the service users in the unit with the support of system partners and then take the opportunity to redesign the model of care with an emphasis on a strengthened community offer. The unit remains closed while the system agrees a new model of care. 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 2021 a number of internal controls led to the Director of Nursing sharing serious concerns with the CQC regarding the quality of care at Firshill Rise Assessment and Treatment Service. This led to a number of actions to improve the service but following an unannounced visit by the CQC (although this was expected by the organisation), this resulted in the service being rated as inadequate and a condition and a requirement to stop new admissions until a number of conditions were met. A number of learning events were undertaken to understand the root causes of the findings of the report. One of the outcomes of these learning events was that the Trust made the decision to support the safe transfer of the service users in the unit with the support of system partners and then take the opportunity to redesign the model of care with an emphasis on a strengthened community offer. The unit remains closed while the system agrees a new model of care. 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**