Sheffield Children's NHS
NHS Foundation Trust

BOARD SELF CERTIFICATION 2018

Compliance with NHS provider licence conditions

NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence, have the required resources available if providing commissioner requested services, and have complied with governance requirements.

As part of the annual planning arrangements, NHS Improvement required the Trust to make a number of governance declarations which were certified at the Trust Board meeting on 23 May 2018.

NHS provider licence conditions

- The provider has taken all precautions necessary to comply with the licence, NHS Act and NHS Constitution (condition G6(3))
- The provider has complied with required governance standards and objectives (Condition FT4(8))
- If providing commissioner requested services (CRS), the provider has a reasonable expectation that the required resources will be available to deliver the designated service (Condition CoS7(3)).

The aim of the self-certification exercise is for providers to carry out assurance that they are compliant with these conditions. It is for providers to determine how they carry out this process. The process should ensure that the provider's Board understands clearly whether or not the provider can confirm compliance.

For 2018 the Board has followed the same self-certification process adopted in previous years and received at its meeting held on 23 May 2018 a discussion paper detailing suggested assurances to support the Board making required self-declarations.

Condition G6

Systems for compliance with licence conditions – in accordance with General condition 6 of the provider licence (G6).

The attached table in appendix I lists the evidence generated for discussion to support the Trust's self-declaration against this statement. This provided assurance to the Board on 23 May 2018 that the Trust meets the conditions of its Licence and identifies potential areas of risk. From the assurance provided, the Trust Board certified that:

"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."

Condition FT4(8)

Compliance with required governance standards and objectives

The Board has reviewed whether the Trust's governance systems meet the standards, requirements and objectives in the condition.

Provided in appendix II are details of the declarations, together with evidence of assurance against each declaration for consideration.

At its meeting on 23 May 2018, the Board agreed it could make positive self-declarations against all elements of its corporate governance statement, noting mitigations in place in respect of any identified risks.

Training of Governors – not a licence condition

S151(2) of the Health and Social Care Act (providers) must take steps to secure that the governors are equipped with the skills and knowledge they require…..

As has been the practice followed in previous years, the Lead Governor and the Governor Representative on the Risk and Audit Committee have been asked to endorse on behalf of the Council of Governors, the Trust's statement in relation to this declaration drafted in appendix II and have fully supported the Board making a positive declaration in this respect.

Condition CoS7

Commissioner requested services

Condition CoS7(3) of the NHS Provider Licence – The Trust has a reasonable expectation that required resources will be available to deliver the designated service in relation to commissioner requested services (CRS)

Appendix 1 - NHS provider licence conditions provided assurance to Trust Board on 23 May 2018 that the Trust complies with the continuity of services conditions in the NHS provider licence.

From the assurance provided, Trust Board certified that "***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***."

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Appendix I - Licence Condition Self-Assessment

Licence Condition	Compliance confirmed
Section 1 – General Conditions	
G1: Provision of information *'the Licensee shall furnish to Monitor such information and documents, and shall prepare or procure and furnish to Monitor such reports, as Monitor may require for any of the purposes set out in section 96(2) of the 2012 Act'*	The Trust complies with this condition as required. All information requested by NHSI is requested in a timely manner in the format requested.
G2: Publication of information '*The Licensee shall comply with any direction from Monitor for any of the purposes set out*	The Trust complies with this condition as required. The Trust publishes information as required in accordance with the FT NHS Code of Governance and the FT Annual Reporting Manual.
G3: Payment of fees to Monitor '*The Licensee shall pay fees to Monitor in each financial year of such amount as Monitor*	None required at present
G4: Fit and proper persons '*The Licensee shall ensure that no person who is an unfit person may become or continue as a Governor. The Licensee shall not appoint as a Director any person who is an unfit person'*	The Trust complies with this condition. All Board appointments are subject to checks / declarations. Board Directors and Council of Governor declarations complete annual declarations. Governors in May 2018 / Directors and NEDs through appraisal
G5: Monitor guidance '*the Licensee shall at all times have regard to guidance issued by Monitor'*	The Trust complies with this condition. NHSI guidance is reviewed in detail on publication by the relevant lead Director / Associate Director of Corporate Affairs and Trust lead assigned in accordance with the subject matter.
G6: Systems for compliance with licence conditions and related obligations *'Requires providers to take all reasonable precautions against the risk of failure to comply with the licence and other important requirements.'*	The Trust complies with this condition. Risk management system in place including BAF and Risk Register.

G7: Registration with the Care Quality Commission	The Trust complies with this condition. The Trust is registered without conditions with the CQC. June 2016 CQC inspection – Good. Board monitored action plan in place during 2017/18. Action completed reported to Quality Committee May 2018 (action re elements of transition still outstanding)
G8: Patient eligibility and selection criteria *Requires licence holders to set transparent eligibility and selection criteria for patients and apply these in a transparent manner."*	The Trust complies with this condition. Trust access policy and statements re scope of service provision.
G9: Application of Section 5 (Continuity of Services)	The Trust complies with this condition and agrees its commissioner requested services on an annual basis. This is reviewed annually as part of the annual planning and contract negotiation process.

Section 2 – Pricing

P1: Recording of Information '*the Licensee shall obtain, record and maintain sufficient information about the costs which it expends in the course of providing services.*	The Trust complies with this condition and its implementation is in line with Trust current financial procedures. Reference costs presented to Board through Finance and Resources Committee (Feb 18)
P2: Provision of information *'the Licensee shall furnish to Monitor such information and documents, and shall prepare or procure and furnish to Monitor such reports, as Monitor may require for the purpose of performing its functions*	The Trust would comply with this condition as the requirement arose.
P3: Assurance report on submissions to Monitor *'If required in writing by Monitor the Licensee shall, as soon as reasonably practicable, obtain and submit to Monitor an assurance report in relation….to costing.*'	The Trust would comply with this condition as the requirement arose.
P4: Compliance engagement concerning local tariff modifications *'The licensee shall only provide health care services for the purpose of the NHS at prices which comply with, or are determined in accordance with, the national tariff published by Monitor'*	The Trust complies with this condition – national tariff or local tariff agreed with commissioners and reported appropriately

P5: Constructive engagement concerning local tariff modifications *'The Licensee shall engage constructively with Commissioners'*	The Trust complies with this condition – the Trust engages actively and constructively with its commissioners.

Section 3- Choice and Competition

C1: The right of patients to make choices *The licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by Commissioners, he or she is notified of that choice and told where information can be found.*	The Trust complies with this condition and had policies and procedures which are compliant with this condition.
C2: Competition oversight *'The licensee shall not enter into or maintain any agreement or other arrangement which has the object or which has (or would be likely to have) the effect of preventing, restricting or distorting competition in the provision of healthcare'*	No compliance issues identified

Section 4 – Integrated Care

IC1: Provision of integrated care *'The Licensee shall not do anything that reasonably would be regarded as against the interests of people who use healthcare services by being detrimental to enabling its provision of health care services for the purposes of the NHS to be integrated with the provision of such services'*	The Trust complies with this condition. This is part of the Trust's strategy and as such the Trust engages in significant partnership work. Details of which are reported in the Trust's annual report.

Section 5 – Continuity of Services

COS1: Continuing provision of Commissioner Requested Services ***'**The Licensee shall not cease to provide, or materially alter the specification or means of*	The Trust complies with this condition. See G9

provision of, any Commissioner Requested Service except where permitted to do so in the contract'	
COS2: Restriction on the disposal of assets **'***The Licensee shall establish, maintain and keep up to date, an asset register' to any proposal by the Licensee to dispose of, or relinquish control over, any relevant*	The Trust complies with this condition – asset register maintained and would comply with the terms of the condition regarding asset disposal as required.
COS3: Standards of corporate governance and financial management **'***The Licensee shall at all times adopt and apply systems and standards of corporate governance and of financial management which reasonably would be regarded as:* *(a) suitable for a provider of the Commissioner Requested Services provided by the licensee, and* *(b) providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern*	The Trust complies with this condition. Trust has well developed systems of corporate and financial governance as evidenced by risk ratings, annual governance statement, head of internal audit opinion, 2016 CQC inspection (well-led), internal and external audit reports, compliance with NHS FT Code of Governance, robust financial planning, monthly monitoring of financial and performance risks. The Board has undertaken a self-assessment against the Well Led Framework for Governance and Leadership reviews and this noted areas for development. Work is underway to identify priority areas and map against associated Executive workstreams.
COS4: Undertaking from the ultimate controller **'***The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee'*	Not applicable
COS5: Risk pool levy **'***The Licensee shall pay to Monitor any sums required to be paid in consequence of any requirement imposed on providers by way of any levy'*	The Trust would comply with this condition as the requirement arose.
COS6: Co-operation in the event of financial stress *information as Monitor may direct to Commissioners, allow such persons as Monitor may appoint to enter premises owned or controlled by the Licensee and co-operate with such persons as Monitor may appoint to assist in the management of the Licensee's affairs, business and property'*	The Trust would comply with this condition as the requirement arose.

COS7 Availability of resources **'***The Licensee shall at all times act in a manner calculated to secure that it has, or has access to the Required Resources'*	The Trust is compliant with this condition having made declaration upon submission of the Financial Plan / narrative. Also through monthly risk ratings submitted to NHSI. Approval of Trust as a going concern discussed and minuted at Risk and Audit Committee (and Board)

Section 6 – NHS Foundation Trust Conditions

FT1: Information to update the register of NHS foundation trusts '*The Licensee shall ensure that Monitor has available to it written and electronic copies of the following documents:* *(a) the current version of Licensee's constitution;* *(b) the Licensee's most recently published annual accounts and any report of the auditor on them, and* *(c) the Licensee's most recently published annual report'*	The Trust is compliant with this condition – all documents submitted and routinely updated for inclusion on NHSI website / changes reported to NHSI by Associate Director of Corporate Affairs as necessary.
FT2: Payment to Monitor in respect of registration and related costs *'the Licensee must pay to Monitor a fee in respect of Monitor's exercise of its functions'*	If NHSI required fees to be paid by the Trust, the Trust would comply with this condition.
FT3: Provision of information to advisory panel *'The Licensee shall comply with any request for information or advice made of it'*	The Trust would comply with this as required through the provision of any requested information.
FT4: NHS Foundation Trust governance arrangements *The Licensee shall have regard to such guidance on good corporate governance as may be issued by Monitor from time to time.* *The Licensee shall establish and implement:* *(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* *The Licensee shall establish and effectively implement systems and/or processes:*	The Trust complies with this condition and can demonstrate this through the annual governance statement. We will self-declare against the corporate governance statement in May 2018. There is a well-developed committee structure which is the subject of annual effectiveness review. The Trust Board has recently repeated self-assessment work against the Well Led Framework and any development areas relating to board and committee effectiveness will be integrated into planned focus on identified priorities.

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 for effective financial decision-making, management and control (including but continue as a going concern);* d) *to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;* e) *to identify and manage (including but not restricted to manage through forward plans)material risks to compliance with the Conditions of its Licence;* f) *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* g) *to ensure compliance with all applicable legal requirements* *The Licensee shall ensure the existence and effective operation of systems to ensure that 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.* *The Licensee shall submit to Monitor within three months of the end of each financial year a corporate governance statement*	

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Appendix II: Corporate Governance Statement 2017/18 – sources of assurance

Under NHS foundation trust condition 4 (the governance condition), boards of trusts are required to make a corporate governance statement outlining anticipated compliance (or otherwise) with the governance condition and risks to this.

Ref	Declaration to be made *(actual wording of the declaration to be made by the Board to Monitor)*	Board confirmation of compliance for 2017/18	Evidence for self certification *(This information has been provided specifically for the Board to review whether it has sufficient assurance to confirm compliance with the required declarations)*	Risks and mitigating actions *(to be completed even where the Board is able to respond 'Confirmed')*
Corporate Governance Statement				
1.	**The Board is satisfied that Sheffield Children's NHS Foundation Trust 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 provides assurance on the strength of Internal Control regarding risk management process, review and effectiveness; • Quality Governance review undertaken in 2015/16 and implementation of new quality governance arrangements embedded with ongoing incremental development; • Head of Internal Audit Opinion for 2017/18, presented to Board in May 2018 (draft already reviewed by Risk and Audit Ctte in March 2018 – no material issues raised); • Internal audit plan agreed and overseen by Risk & Audit Committee; • Follow up reviews to check compliance with internal audit recommendations – focus given by Risk and Audit Ctte during 2017/18 drive completion rate; • ISA 260 / Annual Governance Report for 2017/18 from KPMG to be presented to Board May 2018; • Trust Board Committee Structure and annual review of terms of reference. Annual Committee Effectiveness review programme; • Board self-assessment against Well Led Framework (Spring 2018) Priority areas aligned to Exec-led workstreams. • Financial Plan 2018/19 approved by Board; • Segmentation under Single Oversight Framework – segment 2 as at May 2018) • Feedback from Quarterly Review meetings with NHSI; • Strategy refresh; • Quarterly progress reports against Corporate Objectives; • Monthly finance reports to the Board; • Monthly performance reports to the Board; • Programme of regular Board quality reports and monitoring information in respect of patient safety, workforce issues and patient experience including incidents, complaints and infection control; • Board Assurance Framework and Risk & Audit Committee review of key strategic risks; • Development of Risk Appetite Statement; • Risk management strategy; • June 2016 CQC Inspection Visit Report and completion of action plan with exception of transition element; • IG Toolkit compliance (March 2018);	None identified

			• Workforce Information Report reviewed by the Board quarterly and monthly snapshot presented to Finance & Resources Committee; • Back to the floor programme in place; • Governor elections held in accordance with model election rules; • Revision and implementation of revised guidance around Register of Interests / Gifts and Hospitality; and • Fit and Proper Persons Checks. • Committees in Common governance arrangements given full Board review and scrutiny.	
2.	**The Board has regard to such good guidance on corporate governance as may be issued by NHS Improvement from time to time.**	**CONFIRMED**	In addition to having in place arrangements set out in (1) above, the all guidance issued by NHSI is reviewed by the appropriate members of the executive team / associate director of corporate affairs and implemented as appropriate / relevant. The risk and audit committee receives a standing technical update from its External Auditor (KPMG) identifying action requires / items for information. Compliance against the NHS FT Code of Governance is reviewed by the risk and audit twice a year. Declarations made within Annual Report	None identified
3.	**The Board is satisfied that the Trust implements:** **(a) Effective board and committee structures;**	**CONFIRMED**	Trust Board Committee and Reporting Structure including: ○ Risk and Audit Committee (statutory) ○ Board Nominations & Remuneration Committee (Execs) (statutory) ○ Finance & Resources Committee ○ Quality Committee ○ Hospital Development Project Board ○ Committee in Common (Working Together) ○ Also Council of Governors Recruitment & Remuneration Committee (NEDs) • Annual review of terms of reference (work in progress May 2018) with relevant changes made to ensure they are fit for purpose; • Formalised reporting to Board by Committee Chairs • Annual effectiveness review (in progress May 2018) • Cross Board Committee NED membership and reporting lines; • Embedding of recommendations from Internal Audit advisory report on Committee reporting lines (2017); • Annual cycle of business for Trust Board and all Board Committees agreed; and • In line with reporting lines between Committees, the Risk and Audit Committee reviews terms of reference of aligned Board Committees, ie the Finance and Resources Committee and the Quality Committee.	None identified

	(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and	**CONFIRMED**	• All board Committees, Trust Executive Group and those standing reporting committees / groups have terms of reference in place; • Responsibilities are in line with Trust Standing Orders, Standing Financial Instructions and Scheme of Delegation reviewed and presented to Risk and Audit Committee in April 2015; • Risk management strategy and policy outlines flow of information through organisation regarding risk and the management of corporate and local risk and how these are escalated and deescalated; • Risk management strategy updated May 2016 to reflect revised quality governance arrangements; • Internal Audit advisory report on Committee reporting lines; and • Review of Trust Executive Group terms of reference to reposition within the assurance and escalation framework and define reporting lines between other groups / forums.	
	(c) Clear reporting lines and accountabilities throughout its organisation.	**CONFIRMED**	• Terms of reference for committees include purpose, membership, duties and reporting arrangements; • Board Committees Chairs all present minutes to Trust Board / from 2018 formalised reporting to Board by Committee Chairs • PDRs (Board and all staff) provide opportunity to agree annual objectives and expected behaviours in line with delivery of Corporate Objectives and Trust Values; • Annual Governance Statement confirmed by Risk and Audit Committee as being consistent with Committee's view on the Trust's system of internal control; • Development of quality metrics / ward to board reporting being embedded • Development of Escalation framework / Integrated Performance Reporting SOP • Revision of governance arrangement for Recovery and Transformation Programme	

4.	**The Board is satisfied that the Trust effectively implements systems and/or processes:** **(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;**	**CONFIRMED**	• As part of its review and approval of the Financial Plan for the forthcoming period the Board has reviewed in detail key areas of potential risk in respect of performance that may impact on compliance with its licence. These relate to the Trust's duties with regard to quality of services and financial performance; • Areas of potential risk have been reported to the Board through the above processes and are documented in the Financial Plan narrative and Board Assurance Framework; • The Board's Finance and Resources Committee and Quality Committee provide on-going review, scrutiny and monitoring of required development actions throughout the year – ensuring that the Board has appropriate mechanisms to respond should any concerns develop in year; • Annual internal audit cycle confirmed by annual accounts audit opinion (HOIA) and ISA 260 report to Risk and Audit Committee from KPMG; • Risk & Audit Committee annual work plan including focus on key BAF risks; • Review of governance arrangements for the recovery and transformation programme; • Annual Planning arrangements; and • Development of Escalation framework / Integrated Performance Reporting SOP.	**Delivery of Efficiency Programme identified as a risk.** **Mitigations include: Implementation of revised governance structure in relation to efficiency delivery.**
	(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;	**CONFIRMED**	The Board has access on an on-going basis to inform its assessment of the risks to compliance with its licence: • Monthly performance data is reported to the Board and reviewed in respect of targets and standards under the compliance framework. In addition, the Board receives a programme of regular quality reports and monitoring information in respect of workforce information, patient safety, patient experience including incidents, complaints and infection control. From May 2018 this will form an Integrated Performance Report. • Monthly Board finance reports track the overall financial position / performance against efficiency savings and key financial risks; and • Board consideration of financial risk ratings.	
	(c) To ensure compliance with health care standards binding on the Licensee	**CONFIRMED**	• Quality priorities agreed by the Board within annual Quality report; • Quality Dashboard received by Board monthly (from May 2018 to be incorporated within Integrated Performance Report);	**Managing and responding efficiently to increased demand / reduced funding identified as a risk.**

	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;		• Verbal update against CQC Action Plan reported monthly to Quality Committee / written report quarterly to Quality Committee . • CQUIN reporting to Quality Committee • Quarterly reports to Quality Committee (integrated governance report); • Quality & risk profile tracked by Risk Management department to identify any increase in risk of non-compliance and more recently the new risk banding profile; • Risk Management Strategy (risk registers / BAF); • Incident Reporting; • Information Governance Toolkit submitted annually; • CQC Inspection visit (June 2016); • Cleanliness audits / PLACE inspections / Clinical Audit & Effectiveness programme / Infection Control Standards / Complaints monitoring; • CCG contract review meetings; and • Routine finance, performance and quality reports to the Board and Board Committees.	**Mitigations include: new hospital wing, partnership working with local GP commissioners and the local authority; Working Together Programme, STP / ICS and ACP.**
	(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);	**CONFIRMED**	• SFIs, Standing Orders and scheme of delegation reviewed annually by Risk & Audit Committee (high level benchmarking by internal audit for gaps / levels – May 2015); • Going concern paper presented to 21 May 2018 Risk and Audit Committee & Trust Board annually confirming Directors agreement to ongoing financial viability; • Monthly Board finance reports presented to Finance & Resources Committee and Trust Board, including progress on delivery of efficiency savings programme; • Internal audit reports on financial systems and controls; • Standard financial reporting to Risk & Audit Committee; • Escalation framework approved by Finance & Resources Committee (March 2018); • External audit report (ISA 260) on the 2017/18 annual accounts and annual report ; and • Approval of financial plan submission to NHSI.	
	(e) To obtain and disseminate	**CONFIRMED**	• Annual cycle of business for Trust Board and Board Committees ensures appropriate scheduling of	

	accurate, comprehensive, timely and up to date information for Board and Committee decision-making;		reports.	
	(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;	**CONFIRMED**	• Trust risk register and Board Assurance Framework reports key compliance risks for finance and performance; • Risks and mitigations identified in Financial Plan narrative / Annual Report; • Head of internal audit opinion; • Statutory annual audit; • Annual Governance Statement • Assessment work as part of Board self-declaration against Board statements – incorporated within annual cycle of business; and • Monthly Board reports cover performance against key performance indicators.	
	(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	**CONFIRMED**	• Robust annual planning cycle / process to develop business plans with stakeholder involvement; • Strategic Aims and Corporate Objectives approved by Trust Board; • NHSI feedback considered by Board; • A quarterly Board report on progress with key elements of the organisation's strategy and corporate objectives; • Hospital Development Project Board – NED membership and formal reporting line into Finance & Resources Committee and Trust Board • Process agreed for post implementation reviews – need to embed	

	(h) To ensure compliance with all applicable legal requirements.	**CONFIRMED**	• Governance arrangements (constitution, standing orders); • Annual cycle of Board business • Monthly reporting to NHSI; • Risk & Audit Committee • Board Assurance Framework; • Risk Management Policy and Strategy • Quarterly Human Resources and Workforce reports to the Board; • Monthly Chairman's report to the Board; • Monthly Chief Executive's report to the Board highlights key issues; • NHS FT Code of Governance compliance reviews by Risk and Audit; • Updates from the FT Secretary as relevant; • Internal Audit reports provide assurance that systems and processes are in place relevant to specific areas audited. Where limited assurance has been provided this is closely monitored and action plans reviewed for progress	
5.	**The Board is satisfied that the systems and/or processes referred to in paragraph (section) 5 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;**	**CONFIRMED**	• Board composition - membership of the board of directors is considered balanced, complete and appropriate. • During the year there has been the opportunity to assess the composition of the board while considering the process to appoint to an executive director vacancy (medical director) and NED vacancy. The Board is satisfied that its current membership allows it to function effectively. • Register of Interests; • PDRs; • Fit & Proper Persons declarations; • SID in place	

	(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;	**CONFIRMED**	• Approved Quality Priorities set out within annual Quality Report; • External Assurance on the Quality Report; • Board routinely receives reports on quality, providing details of incidents, complaints, patient feedback and other indicators of quality and it is expected that any adverse impact arising from new initiatives would be reported on via this route; • Board planner incorporates a cycle of updates on quality indicators to ensure that on a monthly basis there is focus on quality metrics; • Patient Stories to Board; • Divisional Deep dives at Quality Committee • Back to the Floor Programme; and • Process for quality impact assessing being embedded.	
	(c) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;	**CONFIRMED**	• The Trust operates a range of evaluation, measurement and reporting systems in order to ensure that a wide range of essential quality data is regularly and routinely analysed and challenged; • Internal Auditor reports on quality of data; • Quality accounts (external assurance on); and • There is an appropriate level of high-level reporting to the Board in this area with risk, clinical effectiveness and patient experience reports being presented to the Board on a regular and timely basis.	
	(d) The collection of accurate, comprehensive, timely and up to date information on quality of care;	**CONFIRMED**	• Self-Assessment against Well-led Framework confirms Board is assured re data timeliness and quality • Committee Effectiveness reviews • External audit of quality report	
	(e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant	**CONFIRMED**	• 'Back to the floor' programme gives members of the Board (NEDs and Exec Directors) the opportunity to regularly visit both clinical and non-clinical areas to look at how care and quality initiatives are being delivered and to gain a better understanding from front-line staff of issues related to quality; • Governors provide feedback on quality of services through involvement in PLACE assessments, and Cleanliness Audits at Council Meetings; • NEDs are fully engaged with the Trust's quality agenda via their Chairmanship of subcommittees.	

	stakeholders and takes into account as appropriate views and information from these sources; and		• Patient Experience Strategy developed / Care Experience Board established • The Board actively engages with its key stakeholders on quality through: - commissioners - commissioner representative attends the Quality committee / agreeing of CQUINS which are monitored through, and discussed at, regular contract meetings / partner governor represents Sheffield CCG - analysis of staff survey results and patient survey results (including Friends and Family test) / Open Forum) - Governor involvement in strategy refresh - Parent Register / Establishment of our Youth Forum - Patient Stories presented to Trust Board meetings - Healthwatch / local health overview and scrutiny committee.	
	(f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	**CONFIRMED**	• Revised arrangements for quality governance put in place to develop a clear organisation structure that cascades responsibility for delivering quality performance. • Divisional performance management arrangements ensure that quality indicators are monitored at divisional level. Divisional Performance Reviews monitor at divisional level quality measures alongside financial and performance measures. These measures will also be cascaded and monitored at clinical team level (eg Ward); • Risks to quality identified through routine monitoring of key performance indicators. Where necessary quality risks would be escalated to the Risk Management Department and managed through the Risk Register as necessary; • New Escalation Framework approved by Finance & Resources Committee March 2018 • Quality Committee Terms of Reference; • Review of Trust Executive Group terms of reference to reposition within the assurance and escalation framework and define reporting lines between other groups / forums; • Executive Directors job descriptions; • Trust Values; and • Inpatient Quality dashboards presented to Board;	

6.	**The Board is satisfied that there are systems to ensure that the Trust 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**	• Appraisals for CE & Execs undertaken and overview reported verbally into the Board Nominations and Remuneration Committee; • Board Nominations Committee reviewed Board balance at outset of any recruitment; • Board contains appropriately qualified FD, MD, DoN; • Successful delivery of Trust plan – Segmentation under Single Oversight Framework '2' / 2017/18 Control total met; • The Board receives a quarterly workforce information dashboard containing details on staffing levels, vacancy rates, turnover, sickness absence, employee relations, statutory and mandatory training compliance, appraisals completed, agency and bank expenditure. The dashboards highlight areas of concern enabling the development or remedial action plans; • Board focus on recruitment key performance indicators and Trust-wide roll out of new recruitment process; • Nursing staffing review undertaken annually. • Successful implementation of E-roster being rolled out across Trust • A monthly update on nursing establishments has been presented to Board and the public from June 2014; • Nurse recruitment has proved challenging due to shortages of available RN (Child) applicants; and • Revalidation process for doctors has been implemented, assurance re progress in executing duties provided to Board	**<u>Supply and availability of suitably qualified clinical staff identified as a risk.</u>** **Mitigations include: regular nursing recruitment drives; six-monthly nurse staffing establishment review; working with Health Education England / Training of Advanced Nurse Practitioners / roll out of implementation of Calderdale Framework / action plan re Health Visitor recruitment agreed with NHS England / working with Sheffield Hallam University on future nurse requirements (looking to incorporate this into STP planning as new models required for delivery of care across the STP will require some adjustments to be made to the nursing workforce)** **Development of Trust Workforce Strategy**

Other Declarations		
6.	**Training of Governors** **The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to Governors, as required within s151(5) of the Health and Social Care Act, to ensure that they are equipped with the skills and knowledge they need to undertake their role.**	**CONFIRMED** On the election of each new cohort of Governors the Trust commissions NHS Providers to provide their Governwell induction programme. This forms part of the formal induction training for new governors and also provides refresher training for Governors during their current term of office. All current Governors have been offered the opportunity to attend this training and take up has been very good. Working with the Council, and based on opportunities for Governor feedback / discussion, the Chair and Lead Governor identify the skills and training needs of Governors and ensure that the annual work plan of the Council of Governors supports this