University Hospitals Sussex
NHS Foundation Trust

Provider Licence – Self Certifications for 2021/22

Introduction

The Trust each year undertakes an assessment against each of the NHS Improvement Provider Licence requirements. These declarations are once approved placed on the Trust's website.

Certifications

There three declarations required.

Declaration 1 – this relates to NHS Provider Licence General Condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts). FTs that are providers of designated Commissioner Requested Services are required to make an extra declaration on their Continuity of Services condition 7 - Availability of Resources.

Declaration 2 - this relates to NHS Provider Licence General Condition FT4 – Corporate Governance

Declaration 3 - relating to the Training for Governors.

Declaration 1

General Condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

The Board is required to confirm it is compliant with the following certification or explain why it cannot certify itself as compliant.

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 requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

UHSussex does not have any conditions placed on its Licence and has not entered into any formal undertakings with NHS Improvement. The Trust was judged to be in segment 2 within the NHS system oversight framework where segments 3 & 4 indicate a significant risk or actual breech of the Licence.

The Trust has received a warning notice from the CQC following an inspection of Maternity services (across all sites) and Surgery at the Royal Sussex County Hospital site. Whilst the inspection was in respect of certain CQC domains one of the domains assessed was well led, this saw a significant reduction in the assigned ratings to requires improvement / inadequate.

The Trust has provided an improvement plan to the CQC with initial feedback being that the plan addresses all the requirements of the warning notice. The Trust has provided detailed assurance to the CQC by the 29 April 2022 and the services subject to the warning notice were reinspected in April 2022, with the outcome yet to be reported to the Trust.

Whilst actions are needed to deliver the identified improvements the Trust through its reporting to the established oversight committee and to its Quality Committee and Board has been provided assurance that the plan will be delivered.

Based on the above it is recommended that the Board can confirm its compliance.

Continuity of Service condition 7 – Availability of Resources

The Trust does not have any Commissioner Requested Services; *therefore, this declaration is not required.*

Declaration 2

Condition FT4 - Corporate Governance Statement

The Board is required to indicate it is compliant with the following statements or if not state why it is non-compliant.

1) **The Board is satisfied that the 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.**

The Trust has established its strategic intentions and has an established set of processes through its Board, Committees, Management and Divisional structures and processes where the monitoring of its strategic deployment takes place and is assured.

Each of the Board Committees have terms of reference agreed by the Board.. Each ToR includes details of their delegated responsibilities for scrutinising and assurance the Board on mandated governance reports and statements. As part of the development of these ToRs they were subject to both internal and external review as to their adequacy with the external review conducted by KPMG confirming their adequacy and effectiveness.

The Audit Committee membership is drawn from the respective Board Committee Chairs facilitating the ability to cross refer between committees matters where the

tracking of improvements in internal control have been identified by Internal Audit, External Audit, Counter Fraud or Management.

Within the development of the Trust's corporate operating model the lines of accountability were assigned to the respective Executive Directors and for each Committee there are assigned Executive Director committee leads.

As part of the merger the Trust's constitution was confirmed to be compliant with the NHS Act.

There are known areas where improvements are required, a number of these were flagged within the post transaction implementation plan, especially the integration of the Trust's quality governance arrangements. These improvements are tracked through the Trust's Merger and Acquisition oversight group.

The Trust's internal auditors have not identified any significant weaknesses within the Trust's internal financial control and the BAF risk 2.3 shows this risk at 12, with a likelihood of 3.

Based on the above it is recommended that the Board can confirm its compliance.

2) The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.

During the latest Covid 19 level 4 incident the Executive Team enhanced its reporting and information exchange with the NEDsso that there was a shared appreciation and understanding of the emerging risks and their planned mitigations.

Whilst the Board has overall responsibility for ensuring it complies with revised guidance from NHS Improvement the Trust takes an active role within the ICS both at an Executive Level but also through reporting to each Committee that allows it to horizon scan for likely changes.

Based on the above it is recommended that the Board can confirm its compliance.

3) The Board is satisfied that the Trust 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.

The Board has established a set of committees aligned to the Trust's strategic domains along with the mandated committees (Audit, Remuneration & Appointments and Charitable Funds). The planned review of their respective effectiveness is underway and will report to the Board and the Audit Committee.

There are clear lines of reporting for each Committee which include each Committee Chair providing a report to the Board after each of their respective meetings.

At the end of each Committee meeting there is a standing agenda item that allows for items to be cross referred to the most appropriate oversight committee enabling matters that cross committees to be more holistically considered.

Within the development of the Trust's corporate operating model the lines of accountability were assigned to the respective Executive Directors noting that for each Committee there are assigned Executive Director committee leads.

Based on the above it is recommended that the Board can confirm its compliance.

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;
(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;
(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;
(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
(h) To ensure compliance with all applicable legal requirements.

Through reports to the Board directly and through its Committee structure assurance has been provided on the Trust's efficient and economic operation, the lead committees with oversight are the Sustainability and People Committees.

Whilst there have been numerous changes to the NHSEI financial frameworks the Trust will achieve its financial plan and break even (subject to audit) and it will deliver a substantial proportion of its the efficiency programme.

The Systems and Partnerships Committee has a lead role for the oversight of operational performance and whilst the Trust recognises the significant risks within this area, the Board is sighted on the respective operational performance plans.

The Quality Committee is the lead Committee for providing assurance to the Board on the Trust's compliance with health care standards. Noting that for a number of areas, such as maternity and the CQC improvement plan these are also reported in detail to the Board.

The Board receives and reviews the BAF at each of its scheduled meetings, this review is supported by the prior consideration of the BAF segments within each responsible Committee. There has been a gap in the reporting of supporting corporate risks to the respective Committees.

The Board meets following Committee meetings allowing the Board to receive timely assurance to complement the Executive reporting against the Trust's strategy deployment within their Integrated Performance Report.

The Board's cycle of business ensures that it receives all mandated reports allowing it to meet its obligations in respect of its required declarations. The Committee workplans link to these requirements allowing the Board to receive greater depth of commentary at its meetings.

Based on the above it is recommended that the Board can confirm its compliance.

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 Trust, 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 Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

The Board Remuneration and Appointments Committee has received regular updates on the Executive, Corporate Director and Clinical Operating Model structures including the rationale for any changes. All changes have been endorsed by the Committee.

In respect of the Non Executives the Council of Governors Appointment and Remuneration Committee received information on the NED skills and were actively involved in the development of the person specification and their subsequent recruitment.

In respect of the quality of care then there are clear executive and committee accountabilities for their oversight.

The Board both directly and through its Committee structures ensures that a focus is maintained on the delivery of safe services. Reporting of the delivery against the Trust's stated quality priorities is provided through the Trust SDR processes and Integrated Performance Report.

Whilst the Trust has a number of CQC improvement actions their delivery is tracked by the Quality Committee.

Based on the above it is recommended that the Board can confirm its compliance.

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.

The Trust has an established process that ensures that all Board Members are "fit and proper" persons. This process has been applied to Board appointments made in the year. An annual review of all Board Members' continuation as fit and proper persons will be reported to the Audit Committee at the end of the year. The Board and its Committees through the receipt of Workforce reports have oversight of the actions being taken to mitigate the workforce risks in relation to recruitment and retention complemented and the Board's review of workforce BAF risks.

There is scheduled reporting to the Board on the Trust's compliance with the nursing safer staffing levels and the revalidation of its nursing and medical workforce.

All transformation schemes are subject to a detailed quality impact assessment and this rigor includes those schemes which include any workforce reduction and through this process the Board is assured that the Trust retains an appropriately qualified workforce to deliver its services.

The Board Remuneration and Appointments Committee has received regular updates on the Executive, Corporate Director and Clinical Operating Model structures including the rationale for any changes. All changes have been endorsed by the Committee.

The Trust has reviewed and relaunched its Patient First director development programme.

Based on the above it is recommended that the Board can confirm its compliance.

Declaration 3

Training of Governors

The Board is required to indicate it is compliant with the following statement or if not state why it is non-compliant.

The Board is satisfied that during the financial year most recently ended the Trust 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.

As part the merger planning work was undertaken with the support of the Governors to assess the Governor Training Programme. The revised programme and enhanced Governor Induction Handbook have been used to support all new governors elected during 2021/22.

The Governor training programme is supplemented by information workshops / briefings where information on Trust and NHS developments are discussed. Also, at the Council of Governors meetings, a presentation is made by a Non-Executive Director on their role and work of their Committee thus allowing Governors knowledge over the governance of the Trust to be enhanced.

The Chair and Chief Executive regularly meet with the Governors and no issues over their training have been raised during this year.

Based on the above it is recommended that the Board can confirm its compliance.

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions G6 and CoS7

University Hospitals Sussex NHS Foundation Trust *Insert name of organisation*

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates | **2021/2022** | Please complete the explanatory information in cell E36

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

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.		Please Respond

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.		Please Respond

OR

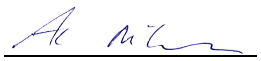
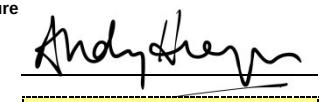
3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

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 does not have amy continuty of services conditions within its licence.

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	Alan McCarthy	**Name**	Andy Heeps
Capacity	Trust Chair	**Capacity**	Chief Executive
Date	05 May 2022	**Date**	05 May 2022

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

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

University Hospitals Sussex NHS Foundation Trust

Insert name of organisation

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

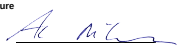
Worksheet "FT4 declaration" | **Financial Year to which self-certification relates** | **2021/2022** | Please Respond

Corporate Governance Statement (FTs and NHS trusts)

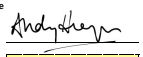
The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Board is assured over its systems of corporate governnce from the work of the Audit Committee, its Internal and External Auditors and their opinions received during the year. The Board's view as to its governance processes is also reflected within the Trust's Annual Governance Statement.	#REF!
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 Chief Financial Officer and Trust Board Secretary has made the Board, Audit Committee and Executives aware of monitor guidance and any impact / improvements to be made within Trust systems as a result. Also during the period where the Trust is delivering the Covid-19 challenges then the established Gold structure ensures the Executives and NEDs are updated on any governance guidance changes. The Trust through its processes ensured that apprpirate focus was maintained by the Board and Committees during the year.	#REF!
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	These processes were referred to and their effectiveness was considered by the Accounting Officer when drafting the Trust's Annual Governance Statement with this description then considered by the Audit Committee as it endorsed the AGS for submission to the Auditors. Respective Committee reporting to the Board is operating effectively as evidenced by the regular reports to the Board from each Committee Chair.	#REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	The Board both directly and through its Committee structure has been assured that the Trust's designed systems of internal control have been operating effectively and as intended over the year. Where issues have arisen during the year, for example in respect of operational performance, timely actions have been implement to improve these areas. The Trust will achieve its financial plan and break even (subject to audit) and it will deliver a substantial proportion of its the efficiency programme. The Audit Committee has recommended based on the information it has received that the Trust can prepare its financial statements on a going concern basis. Assurance is obtained as to the quality of the data supporting the Trust's performance reporting through the annual internal audit work programm and management reviews. The Board has received regular assurance over the delivery of the Trust's control total and efficiency plan. Key risks and associated assurance have been reported to the Board during the year through receipt and review of the Trust's Board Assurance Framework.	#REF!
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	There is clear leadership and accountability for the delivery of high quality and safe services within the Trust. This is detailed with the Trust's Annual Report and the statements contained therein. The Board both directly and through its Committee structures ensures that a focus is maintained on the delivery of quality services. The Trust's quality priorities continue to be set having regard to feedback from our patients, carers , the Governors and other stakeholders with regular reporting of the delivery against these priorities provided to the Board and the Council of Governors and to our Commissioners. The effectiveness of these processes was again considered by the Accounting Officer in drafting the Annual Governance Statement which in turn was subject to consideration by the Audit Committee prior to its submission to the Auditors and inclusion within the Annual Report.	#REF!
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 established a process that ensures that all Board Members are "fit and proper" persons. This process has been applied to Board appointments made in the year. An annual review of all Board Members continuation as fit and proper persons has been undertaken and reported to the Audit Committee at the end of the year. The Board and its Committees through its receipt of Workforce reports has been assured over the actions being taken to manage the workforce risks in relation to recruitment and retention complimented and the Board's review of people BAF risks. Regular reporting is also provided to the Board on the Trust's compliance with the nursing safer staffing levels and the revalidation of its nursing and medical workforce. All transformation schemes are subject to a detailed quality impact assessment and this rigor includes those schemes which include any workforce reduction and through this process the Board is assured that the Trust retains an appropriately qualified workforce to deliver its services. The Trust has a number of established Executive and Senior Management development programmes and these activities are designed to support and strengthen the personnel on the Board, those reporting to the Board and those within the rest of the Trust.	#REF!

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 Alan McCarthy

Signature 

Name Andy Heeps

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Please Respond

Worksheet "Training of governors" | **Financial Year to which self-certification relates** | **2021/2022** | Please Respond

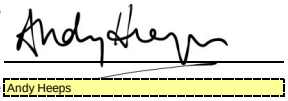
Certification on training of governors (FTs only)

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

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	OK

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	Alan McCarthy	**Name**	Andy Heeps
Capacity	Trust Chair	**Capacity**	Chief Executive
Date	05 May 2022	**Date**	05 May 2022

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

A