MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce & OD – Margot Johnson
Paper prepared by:	Director of Corporate Services / Trust Secretary – Alwyn Hughes
Date of paper:	May 2018
Subject:	2018-19 NHSI FT Self-Certification Requirements
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Resolution • Approval ✓
Consideration of Risk against Key Priorities	Failure to meet the range of conditions of the NHS Provider Licence for a licensed provider can lead to NHSI (Monitor) imposing compliance and restoration requirements or monetary penalties. Ultimately, it could lead to revocation of a provider's licence. The greatest damage is most likely to be to reputation, and the impact that has on patient choice and stakeholders' confidence in MFT as a provider of NHS services.
Recommendations	The Board of Directors is asked to approve NHSI (Monitor) FT Self-Certifications for Condition G6 & CoS7 and note progress with Self-Certificate FT4
Contact	Name: Alwyn Hughes (Director of Corporate Services / Trust Secretary) Tel: 0161 276 6262

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

1. Background

On 1st April 2013, Monitor's healthcare licensing regime was implemented for all NHS Foundation Trusts (The Health and Social Care Act 2012). It replaced the Terms of Authorisation for Foundation Trusts and is the main tool NHSI (Monitor) uses for regulating providers of NHS services.

All 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.

The Manchester University NHS Foundation Trust has an NHS Provider Licence (**No. 130164**) and in the past, the previous Legacy FTs (UHSM & CMFT) were required to submit six self-certifications, on an annual basis, to meet NHSI's (Monitor) Provider License conditions for NHS services, along with a declaration of risks against healthcare targets and indicators. However, this year (2018/19), similar to last year, the guidance issued by NHSI on March 2018 requires NHS Providers to self-certify only the following three Licence Conditions after the financial year-end:

- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution - **Condition G6**

- The provider has complied with required governance arrangements - **Condition FT4**

- If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service - **Condition CoS7**

2. NHSI Foundation Trusts Self-Certification

2.1 Self-Certification - Condition G6

Not later than two months from the end of the Financial Year (by 31st May 2018), the MFT Board of Directors ('the Licensee') is required to self-certificate to the effect that it "Confirms" or "Does not confirm" that it had well established and effective processes and systems to identify risks and guard against their occurrence in 2017/18, and, that these are still in place and their implementation and effectiveness is regularly reviewed going forward.

Recommendation: Based on the evidence highlighted in Appendix A, it is recommended to the Board that the 'Condition G6' Self-Certification is formally signed-off as **"Confirmed".**

2.2 Self-Certification - Condition FT4

The Board of Directors is required to self-certificate "Confirmed" or "Not confirmed" (by 30th June 2018) to a number of governance-related statements (see Appendix B for summary of statement requirements) and set-out any risks and mitigating actions planned for each one within the NHSI self-declaration template. The Board has already received an electronic copy of the *draft* summary set of evidence to support this 'Condition FT4' Self-Certification with the aim of identifying any risks with compliance and any action taken, or, being taken to maintain future compliance.

Recommendation: The Board is recommended to review and comment (via the Board Secretary) on the draft governance statements during May and early June 2018.

Recommendation: The Board is recommended to delegate authority for 'sign-off' of the Self-Certification for 'Condition FT4' to the Group Chairman & Group Chief Executive in order to meet the self-certification deadline of 30th June 2018; which is prior to the next Board of Directors meeting on 9th July 2018.

2.3 Self-Certification - Condition CoS7

Not later than two months from the end of the Financial Year (by 31st May 2018), the MFT Board of Directors ('the Licensee') is required to self-certificate to the effect that it "Confirms" one of the following three declarations about the resources required to provide 'Commissioner Requested Services' (CRS):

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 (Appendix C)**, 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 Appendix C) **which may cast 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.

(Footnote: Providers do not need to state the other two are not confirmed)

Recommendation: Based on the statement of main factors taken into account in Appendix C, it is recommended to the Board that **Declaration B** within the Condition CoS7 Self-Certification is formally signed-off as **"Confirmed".**

N.B. All MFT Self-Certifications will be made public on the Trust's website within one month of the highlighted self-certification deadlines.

APPENDIX A

Self-Certification Condition G6 – MFT Supporting Evidence of Compliance
• The Board and supporting Committees (Audit Committee, Quality & Performance Scrutiny Committee, Human Resources Scrutiny Committee, Finance Scrutiny Committee and the Trust Risk Management Committee) receive regular reports and supporting data analysis covering patient safety, clinical quality, patient experience, workforce, performance and finance. Examples include: Board Assurance Reports; Internal Audit Reports; External Audit Reports; Clinical Audit Reports; Patient Surveys; Staff Surveys; CQC Inspection Reports; Board Assurance Framework (BAF); Royal College Accreditation; H&S Executive Inspection Reports; Internal Quality Review Reports (and FU); Senior Leaderships Walk-rounds; Ward / Department Accreditation; Clinical Pathology Accreditation; E&D Reports; General Medical Council Reports and CCG Walk Round Reports. • A programme of Board Seminars provide an opportunity for 'deep dives' into specific topics/themes and these are identified through the governance structure, the BAF, the risk register and the Accountability Oversight Framework (AOF). • The Group Risk Management Committee (GRMC) is informed by the Governance structure as a whole and ensures that high level risks are overseen by the Board of Directors. The Committee is Chaired by the CEO, attended by the Group Executive Director Team, Hospital/MCS CEO's and open to all Non-Executive Directors. The Committee reviews the management of risk as detailed below: - New risks at level ≥15 – single report detailing management and oversight arrangements - Group wide risks - Risks escalated for review/support by Hospitals/MCS where further mitigation is outside of the control of the Hospital/MCS (for example a national tariff issue) - Level ≥15 risks in Hospital/MCS with an AOF score of 6 - The GRMC may also identify risks that require more detailed scrutiny arising from the Group Board Assurance Report, Group Board Assurance Framework, regulatory issues, national reports, patient/service user feedback and public interest issues The risk registers from the legacy organisations have been reviewed and brought together. • The Trust's Single Operating Model is underpinned by the AOF which contributes to the overarching Board Governance Framework enabling the Group Board of Directors to fulfil its obligations and effectively run the organisation. The AOF is one of the key enabling processes to support the delivery of the MFT vision, strategic objectives, and operational plan, and incorporates the key elements below: - Fosters a culture of devolved decision making and accountability. - Sets out how the Group Board of Directors and Hospitals/MCS/LCO will interact. - The framework supports the principle of earned autonomy in high performing Hospitals/MCS/LCO and the support provided to challenged sites. - An annual performance agreement process will formally capture the contribution of each Hospital/MCS to Group corporate objectives and targets for the year. - The framework operates a process of performance review, led by the Group Executive Team, which assesses the performance and risk of each Hospital/ MCS in delivering its plans and objectives and meeting agreed KPIs. - Enables the corporate functions to identify potential support needs, by theme, as they emerge, allowing tailored support packages to the specific needs of each Hospital/ MCS, and drawing on expertise from across the corporate functions.

APPENDIX A (continued)

Self-Certification Condition G6 – MFT Supporting Evidence of Compliance
• The Trust AOF process incorporates 6 domains: safety, experience, operational excellence, finance, Leadership and OD, Strategy. The process provides a holistic and transparent process for the monitoring of Hospital/MCS performance, all domains are equally weighted with the exception of safety which is the override for monthly Hospital/MCS AOF scores • To support the AOF, monthly cycle a performance dashboard for each Hospital/MCS has been developed which captures in one place the overarching Hospital/MCS AOF score, individual domain scores and performance against the KPIs which form each domain. The process incorporates 6 domains: safety, experience, operational excellence, finance, Leadership and OD, Strategy. All domains are equally weighted with the exception of safety which is the override for monthly Hospital/MCS AOF scores. • The Trust has an agreed document Responding to Recommendations and, Requirements of External Agency Visits, Inspections and Accreditation Policy. The policy sets out the processes to ensure that all recommendations made by external agency visits, inspections and accreditations are implemented within a specific time scale, that they are monitored following their implementation, and that there is a formal reporting and review process and that the Group Board of Directors are assured of the outcome. • The Trust has an established Quality Review process in place since 2013/14 in response to the recommendations set out by the Francis, Keogh and Berwick reports earlier the same year (2013). Internal reviews are informed by extensive data packs which pull together key indicators reflecting the quality of care across each Hospital/MCS. • The Trust has a well-established Improving Quality Programme (IQP) and Accreditation process in place which examines performance across four domains; culture of continuous improvement, environment of care, communication about and with patients and nursing processes: including medication management and the meals service. Findings are mapped against agreed criteria for each standard and clinical areas are scored as white, bronze, silver, gold or diamond. The Board of Directors receive regular reports on accreditation outcomes. • The Trust has in place a staffing escalation process to ensure the appropriate deployment of nursing and midwifery staff to support the needs of patient groups. An electronic e-rostering system is used to ensure that the planning and management of nursing and midwifery staffing across the Trust is effective and safe. • Governors hold Group Non-Executive Directors (individually and collectively) to account for the performance of our Board of Directors by ensuring that they act so that MFT does not breach the terms of authorisation. Governors receive details of meetings, agendas and approved minutes of each Board of Directors' Meeting. A private session between the MFT Governors and the full Board of Directors is held immediately following each bi-monthly Public Meeting of the Board of Directors (bi-monthly). The aim of this regular session is to enable Governors to discuss with the full Board issues raised during the Public Meeting and/or any other issue(s) which may require further feedback, clarification, consideration and dialogue. In early 2018, regular Governor/NED Networking Sessions have been introduced on the same day as the Council of Governors meetings. Also, monthly Chairman Surgeries are held with Governors (with NEDs in attendance). Governors monitor the performance of MFT via the main Council of Governors meetings, quarterly Performance Review Meetings to ensure high standards are maintained along with three (x3) Governor Groups which are due to commence in Q1 (2018/19) focused on Patient Experience, Staff Experience, and, Membership & Engagement.

APPENDIX B

Self-Certification Condition FT4 - Corporate Governance Statement Requirements

1. The Board is satisfied that Manchester University 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.

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

3. The Board is satisfied that Manchester University NHS Foundation 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.

4. The Board is satisfied that Manchester University NHS Foundation Trust effectively implements systems and/or processes:
a) to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively;
b) for timely and effective scrutiny and oversight by the Board of the Licence holder's operations;
c) to ensure compliance with health care standards binding on the Licence holder 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 Licence holder'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.

5. The Board is satisfied that the systems and/or processes referred to in paragraph 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;
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 Manchester University NHS Foundation 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 Manchester University NHS Foundation Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to Board where appropriate.

6. The Board of Manchester University NHS Foundation Trust is satisfied that there are systems to ensure that it 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 this Licence.

Training of Governors

The Board is satisfied that during the financial year most recently ended, the Trust has provided, and continues to develop the necessary training to its new Governors (since the formation of the new MFT Council of Governors on 6th December 2017), 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.

APPENDIX C

Self-Certification Condition CoS7 - Commissioner Requested Services (CRS) Requirements

CRS Definition: *Services that will be subject to regulation by NHSI (Monitor) in the course of a licensee's operations; and, Location Specific Services, which is a subset of CRS that, in the event of a provider failure, must be identified and kept in operation at that specific locality*.

- The current designation of MFT services as CRS is a 'default' position (i.e. automatic full designation, across all services), as Commissioners have deferred a full and recurrent review of MFT services to make a proper and considered CRS designation.

- In effect, the current CRS designation is inherited from the position in April 2013, when CRS principles were first established. At that point in time, the FT licence saw all NHS-funded services "grandfathered" into CRS status (pending service-line review) until 31st March 2016.

- In March 2016, the Manchester CCGs decided to extend that position through until at least October 2017, and again in October 2017 Manchester CCG wrote formally to extend this through to March 2019 in light of the MFT merger and establishment of the LCO model. Given this it would not be meaningful for MFT in isolation to undertake self-certification work across all services

- The current CRS position therefore remains an interim one, and it is the CCG's intention to work with the CCG as part of the Manchester Health and Care Commissioning (MHCC) partnership to identify a revised list of CRS designated services. In the meantime, the CCG's view is that the current default designation provides stability and protection for services even though Commissioners remain able to re-procure or transfer services as has been the case over the period since April 2013 (e.g. outpatient Dermatology by CCGs, ACHD by NHS England).

- Given this position, MFT is unable to fully self-certify, across all services provided, that Option **A** or Option **C** are definitive.