

**BOD 71/2016**

(agenda item: 16)

# Report to the Meeting of the

# Oxford Health NHS Foundation Trust

# Board of Directors

**25th May 2016**

**FY17 Board Self-Certifications to NHS Improvement**

**For: Approval**

**Executive Summary**

Monitor requires each NHS Foundation Trust Board to make a series of declarations as part of its final operational plan for 2016/17 (submitted 18th April). The declarations should be aligned with the operational plan risks against healthcare targets and indicators.

NHS Foundation Trusts are required to consider six declarations to Monitor in the 2016/17 Annual Planning cycle. The templates for the declarations were included in the 10th May Board Seminar packs and for ease of reference can be viewed on the Monitor website here: [*https://www.gov.uk/nhs-foundation-trusts-planning-and-reporting-requirements*](https://www.gov.uk/nhs-foundation-trusts-planning-and-reporting-requirements)*.* The Seminar provided members with the opportunity to consider the supporting evidence in detail.

**Recommendation**

The Board of Directors is invited to approve the declaration as follows:

1. 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. **CONFIRMED**
2. The Board declares that the Licensee continues to meet the criteria for holding a licence. **CONFIRMED**

**Author and Title:** Kerry Rogers, Director of Corporate Affairs/Company Secretary

**Lead Executive Director:** Kerry Rogers, Director of Corporate Affairs/Company Secretary

**Background**

The [NHS provider licence](https://www.gov.uk/government/publications/the-nhs-provider-licence) is Monitor’s main tool for regulating providers of NHS services. The licence sets out conditions that healthcare providers must meet to help ensure that the health sector works for the benefit of patients. These conditions give Monitor the power to:

* set prices for NHS-funded care in partnership with NHS England
* enable integrated care
* safeguard patient choice and prevent anti-competitive behaviour that is against the interests of patients
* support commissioners to protect essential health services for patients if a provider gets into financial difficulties
* oversee the way NHS foundation trusts are governed

**Who needs a licence?**

As a provider of healthcare services for the purposes of the NHS, you need an NHS provider licence. This requirement came into effect from April 2014.

**Licensing criteria**

You need to meet Monitor’s two licensing criteria to be granted a licence:

1. you must be registered with the Care Quality Commission
2. your directors or governors must meet Monitor’s fit and proper test

You have to continue to meet these criteria to keep your licence.

**Self-certification**

Monitor requires each NHS Foundation Trust board to make a series of declarations as part of its final operational plan for 2016/17 (submitted 18th April). The declarations should be aligned with the operational plan risks against healthcare targets and indicators. NHS Foundation Trusts are required to make six declarations to Monitor in the 2016/17 Annual Planning cycle. The templates for the declarations were included in the 10th May Board Seminar packs and cover the certifications below:

|  |  |
| --- | --- |
| **Declaration** | **Submission date** |
| **1&2 -** General condition 6 - Systems for compliance with license conditions | 31st May |
| **3 -** Continuity of services condition 7 - Availability of Resources (included in APR 2016/17 Final Financial Template) | **Completed** 18th April |
| **4 -** Corporate Governance Statement (in accordance with the Risk Assessment Framework)  **5 -** Certification on AHSCs and governance (in accordance with Appendix E of the Risk Assessment Framework)  **6 -** Certification on training of Governors (in accordance with s151(5) of H&SCA) | 30th June |

This paper identifies the potential sources of assurance presented at the Seminar and subsequently considered by Board members to support the Board make a statement of ‘confirmed’ or otherwise for **declarations 1 and 2** (2016/17 Annual Planning Cycle). This paper is submitted to the May Board of Directors meeting for this purpose.

Declarations 4, 5 and 6 require evidence to be submitted to Monitor at the end of June and will be reviewed in more detail during both the June Seminar and Board of Directors’ meetings.

If the Board is unable to confirm any of the declarations, an alternate declaration is required that explains why the FT is unable to confirm, the actions it plans to take to address the situation, and any significant prospective risks and concerns it has regarding the delivery of high quality services and effective quality governance.

The details of each of the declarations and the suggested evidence used to enable Board to determine its final certification are outlined below.

|  |  |
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| **General condition 6 - Systems for compliance with license conditions** | |
| 1. 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. | *The board is required to respond "Confirmed" or "Not confirmed" to these statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.* |
| 1. The board declares that the Licensee continues to meet the criteria for holding a licence. |

**Declaration 1**

*Licence condition G6 is explained as follows (also included in Appendix 1):*

*[1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:*

*(a) the Conditions of this Licence,*

*(b) any requirements imposed on it under the NHS Acts, and*

*(c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.]*

*2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:*

*(a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and*

*(b) regular review of whether those processes and systems have been implemented and of their effectiveness.*

*The Licensee is required to prepare and submit to Monitor a certificate to the effect that, following a review for the purposes of paragraph 2b above,* ***the Directors of the Licensee are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the Condition****.*

*The Licensee is* ***also required to publish each certificate submitted for the purpose of this Condition*** *within one month of its submission to Monitor in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it.*

***Evidence to demonstrate compliance***

The Trust’s governance, performance, risk management and assurance systems and processes are designed to ensure that the Trust meets its obligations and achieves its objectives as required by regulation, statute and central mandate and are clearly set out in governance documents and in the Integrated Governance Framework approved and implemented from May 2015.  The Board and relevant Committees regularly review the Trust’s performance (including, quality, financial, and contractual matters) and assess risks. Where risks are identified, the Executive is tasked with implementing actions to mitigate the risk impact.  The Board and Executive review on a quarterly basis reports which enable it to make quarterly submissions and declarations to Monitor; these reports cover finance, performance, progress against the Trust’s annual plan, quality, safety and experience. Additionally, the Board receives a regular update on the Board Assurance Framework and on the movement and management of strategic risk.

Key aspects of the governance, performance, risk management and assurance systems and processes are reviewed by the Audit Committee and Board, throughout the year and as part of the year-end reporting stage.  In particular, the Internal Audit annual report (which sets out a summary of the audits undertaken through the year) and the Head of Internal Audit Opinion provide evidence of the review of controls and systems throughout the year.

In addition, the Annual Governance Statement, signed by the Chief Executive, also provides evidence of the systematic review of the risk and control environment across the year, and in its draft form, was reviewed and commented upon by the Audit Committee in April 2016, the final draft receiving approval for recommendation to the Board at the May Audit Committee meeting. No significant control weaknesses indicative of systemic problems have been identified during the year.

Audit committee provides an independent and objective review of the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the Trust and plays a pivotal role in supporting the Board.

As is acknowledged in the Trust’s Annual Governance Statement, in discharging its delegated responsibilities the Audit Committee has reviewed the following non-exhaustive range of matters.  A detailed review of the Annual Governance Statement within the context of the wider Annual Report alongside robust scrutiny of the Annual Accounts and Financial statements.  It has considered the effectiveness of the Board Assurance Framework to include consideration of the internal auditors’ positive report on the same, to gain ongoing assurance of the effectiveness of the Trust’s risk and internal control processes.  The committee reviewed and approved the internal and external audit plans and undertook a robust assessment of the scope, cost, independence and impartiality safeguards with regard to the commissioning in-year of non-audit work to be undertaken by the external auditors in connection with the Trust’s cost improvement plans. This included specific consideration of all potential threats to auditor independence identified in Accounting Principles Board(APB) Ethical Standard 5 (revised), the review of which was reported to the Council of Governors.

There has been a regular review of internal audit progress reports including performance indicators and consideration of the effectiveness of internal audit to ensure a systematic review of the systems of internal control to include finance, clinical governance and clinical audit, risk management and quality assurance.  Additionally there has been a regular review of single action tender waivers and losses and special payments.  The committee approves and monitors the workplan of the counter fraud service. The counter fraud service attended the majority of meetings, to present updates on investigations, fraud prevention, deterrent and awareness-raising activities.

In assessing the quality of the Trust’s control environment, the committee received reports during the year from the external auditors Deloitte LLP, and the internal auditors TIAA on the work they had undertaken in reviewing and auditing the control environment.

The Audit Committee also considers the key risks identified by the external auditor and used its resources and the internal audit programme to provide assurance around the following key areas; recognition of NHS revenue, partnership arrangements, capital expenditure and financial sustainability. During the year, in addition to the coverage already detailed, the Committee has examined the following key risks in detail:

Procurement

The Committee has maintained oversight over the sustained improvement in payroll accuracy and has reviewed the arrangements for contracting in Information Management and Technology areas.

Clinical audit

The Committee has continued to monitor the revised governance arrangements for clinical audit and to follow up internal audit recommendations on end of life care.

Healthcare contracting and partnership governance arrangements.

In view of the increasing role of partnership working in our health system the Committee has reviewed the assurance and governance arrangements for these new models of delivery.

In addition, the adequacy of systems of internal control were reviewed through the internal audit work plan and presented within internal audit reports, which included the following non exhaustive list:

* + Asset Disposal
  + Financial management
  + Medical Devices
  + E-Rostering
  + IG Toolkit and information/data quality governance
  + CIP
  + Estates maintenance and procurement
  + Risk Management
  + Quality Governance
  + Patient Experience/Complaints

Furthermore, the work of the Quality Committee, Finance Committee, Charity Committee and Remuneration Committee have all contributed to a more granular understanding and attainment of reasonable assurance of the effectiveness of controls in the management of risks to the achievement of financial, quality, workforce and charitable objectives. Details of the specific focus of each of the Board committees is included in detail within the Annual Governance Statement, Remuneration Report and Corporate Governance sections of the Annual Report, all subject to audit and formal adoption by the Board following approvals in May.

**Declaration 2**

*The two criteria that the provider must meet in order to be granted a license are as follows:*

*a) The provider must be registered with the Care Quality Commission; and*

*b) The provider’s directors or governors must meet our fit and proper test.*

***The fit and proper test***

*To be licensed, your directors and governors (or people performing equivalent functions) must be ‘fit and proper’. This is in line with the statutory fitness requirements set out for directors and governors of NHS foundation trusts, and certain requirements on directors of companies.*

*For example, directors and governors must not:*

* *be an undischarged bankrupt*
* *have undischarged arrangements with creditors*
* *be subject to a moratorium period under a debt relief order*
* *have received a prison sentence of 3 months or longer during the previous 5 years*
* *be subject to a disqualification order or undertaking*

***The Board is required to declare that it continues to meet the criteria for holding a licence.***

**Evidence to demonstrate compliance**

a) OHFT is a registered provider with the CQC. The Trust was registered by the CQC on 14 March 2010. Ros Alstead, Director of Nursing and Clinical Governance is the nominated individual responsible for our registration.

Reasonable assurance has been obtained in respect of compliance with CQC registration requirements through regular review by the Executive team and the Quality Committee of a self-assessment against the CQC registration requirements. Where gaps were identified action plans were implemented to ensure the CQC outcomes were able to be met; also a combination of internal peer reviews across the Trust against the CQC framework with the results assessed by the Executive team, and assurance reports to Quality Sub-committees assessing CQC compliance contributed to the assurances Board received with regard to it continuing to meet its registration requirements. In 2015/16 assurance was provided on the outcomes of analysis of the data gathered for internal reviews, the results of internal reviews and other intelligence by service line which was integrated into Directorate quarterly quality reports. These were assessed by Directorate Performance Meetings with the Executive team and via the Quality sub-committees.

Further assurance with regard to the quality of care provided, and clarity with respect to the focus for improvement was received when at the end of September 2015 the CQC undertook an inspection of our services. The CQC rated Oxford Health NHS Foundation Trust ‘good’ in three out of five quality measurements – *caring*, *responsive* and *well-led* and ‘requiring improvement’ in the remaining two, *effective* and *safe*. This gives Oxford Health an overall rating of ‘requires improvement’ based on weighted scoring across all services inspected. No enforcement notices were issued and the majority (11 out of 15) of the Trust’s services were rated ‘good’ (10) or ‘outstanding’ (1). Luther Street evidence of improvement was reviewed in April, with the CQC confirming a revised rating for the service from ‘good’ to ‘outstanding’ in it draft report issued in May.

The Trust is fully compliant with the registration requirements of the Care Quality Commission and following its September inspection remains registered without conditions.

b) The Trust constitution, standing orders, code of conduct and election rules all require directors and governors to make certain declarations upon appointment and throughout the year. These declarations cover elements of the fit and proper person test including:

An individual (governor or director) must not:

* be an undischarged bankrupt;
* have undischarged arrangements with creditors;
* be subject to a moratorium period under a debt relief order;
* have received a prison sentence of three months or longer during the previous five years; or
* be subject to a disqualification order or undertaking.

New regulations setting out fundamental standards of care came into force for all care providers on 1 April 2015. However, the fit and proper person requirement for directors came into force for ‘NHS bodies’ on 27 November 2014.

Guidance was published at the end of November 2014 and details were presented to the Board of Directors in February 2015 where a FPPT paper was approved by the Board and a FPPT policy/procedure using the standards outlined in the guidance was subsequently approved in June 2015 together with an assurance framework (see appendix 1).

This regulation does apply to directors – by which, CQC mean executive and non-executive, permanent, interim and associate positions, irrespective of their voting rights. The guidance is also explicit that this regulation **will not apply to the board of governors of a foundation trust**. However, the Code of Governance requires the Trust to comply or explain any deviation from the requirement that *Directors on the board of directors and governors on the council should meet the “fit and proper” persons test described in the provider licence.*

The provider has to ensure that it complies with the regulations by not having an unfit director in place. Ultimately, it is for providers to determine which individuals fall within the scope of the regulation, and for CQC to take a view on whether this has been done effectively. According to the HR Department, the executive directors and non-executive directors all have contractual terms in accordance with the guidance and have each had up to date checks in line with FPPT and fitness to practice including DBS (Disclosure and Barring Service) checks for the year under review. The FPPT checks have been extended to all directors in the Trust and declarations and DBS checks have already been completed. Recruitment processes have been amended and any new appointments at board/director level must pass the FPPT tests.

NEDs, Directors and deputies are required to complete an annual declaration each year as part of their normal appraisal process.  In addition insolvency and the disqualified directors register is to be checked annually.  In terms of DBS checks, individuals were asked to sign up to the DBS update service which they should renew on an annual basis.  If everyone has not signed up to this service it is not clear from the policy how this will be covered, and so the Director of Corporate Services has raised this with the HR Department to ensure it is structured into process.

The Council of Governors and the Chair also have responsibility to ensure that these checks are carried out. Set out below is an extract from the FPPT policy which identifies the processes to be followed and the policy Assurance Framework is included in Appendix 1:

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| The fitness of directors is regularly reviewed by the provider to ensure that they remain fit for the role they are in; the provider should determine how often fitness must be reviewed based on the assessed risk to business delivery and/or the service users posed by the individual and/or role. | Post-holders undertake annual declarations of fitness to continue in post.  Checks of insolvency and bankruptcy register and register of disqualified directors to be undertaken each year as part of the appraisal process | Annual declaration  Non-Executive Director appraisal process  Executive Director appraisal process |

**Recommendation**

The Board of Directors is invited to approve the declaration as follows:

1. 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. **CONFIRMED**

2. The Board declares that the Licensee continues to meet the criteria for holding a licence. **CONFIRMED**

*Appendix 1*

**Assurance Framework**

**Complying with the regulations – Extract from OHFT FPPT Policy**

Recruitment stage

|  |  |  |
| --- | --- | --- |
| **Standard** | **Assurance** | **Evidence** |
| Providers should make every effort to ensure that all available information is sought to confirm that the individual is of good character. | Qualification and professional registration check  Verification of identity checks  Verification of eligibility to work  References that cover a 5 year period, minimum of 2 and 1 must be from their current/most recent employer  Appropriate DBS check  Occupational Health clearance  Search of insolvency and bankruptcy register  Search of disqualified directors register | Copy of qualifications/professional registration check held on file  Completed recruitment checklist (including recent photograph)  Copy of document held on file  References held on file to include evidence of conduct and verification at to reason why employment ended.  Confirmation of DBS check/certificate number held on file and ESR record  Clearance letter from Occupational Health held on file  Result of search held on file  Result of search held on file |
| Where a provider deems the individual suitable despite not meeting the characteristics outlined in the regulations, the reasons should be recorded and information about the decision should be made available to those that need to be aware. | Report and debate at the Council of Governors Nomination & Remuneration Committee  Report and recommendation at the Board of Directors Remuneration Committee  Decisions and reasons recorded in minutes  External advice sought as necessary | Ensure that copies of the report, recommendations, decisions and minutes are held on central record for FOIA purposes. |
| Where specific qualifications are deemed by the provider as necessary for a role, the provider must make this clear and should only employ those individuals that meet the required specification, including any requirements to be registered with a professional regulator. | Requirements included within the person specification  Checked as part of the pre-employment check process | Person specification  Recruitment and Selection procedure |
| The provider should have appropriate processes for assessing and checking that the individual holds the required qualifications and has the competence, skills and experience required, (which may include appropriate communication and leaderships skills and a caring and compassionate nature), to undertake the role; these should be followed in all cases and relevant records kept. | Employment checks include a candidate’s qualifications and employment references.  The recruitment process also includes qualitative assessment and values-based questions. | Recruitment and Selection procedure – copies of documentation to be kept on file.  Values-based recruitment procedure |
| The provider may consider that an individual can be appointed to a role based on their qualifications, skills and experience with the expectation that they will develop specific competence to undertake the role within a specified timeframe. | Any such decision would be discussed by the council of governors and would be included in minutes. Actions would be subject to follow-up as part of ongoing review and appraisal. | Non-Executive Director appraisal framework  Non-Executive Director competence framework  Executive Director appraisals |
| When appointing relevant individuals the provider has processes for considering a person’s physical and mental health in line with the requirements of the role. | All post-holders are subject to clearance by occupational health as part of the pre-employment process. | Occupational health clearance |
| Wherever possible, reasonable adjustments are made in order that an individual can carry out the role. | Trust’s Disabled Workers policy. | Recruitment and Selection procedure  Access to Work procedure  Disabled Workers policy |
| The provider has processes in place to assure itself that the individual has not been at any time responsible for, privy to, contributed to, or facilitated, any serious misconduct or mismanagement in the carrying on of a regulated activity; this includes investigating any allegation of such potential behaviour. Where the individual is professionally qualified, it may include fitness to practise proceedings and professional disciplinary cases.  *(“Responsible for, contributed to or facilitated” means that there is evidence that a person has intentionally or through neglect behaved in a manner which would be considered to be or would have led to serious misconduct or mismanagement.*  *“Privy to” means that there is evidence that a person was aware of serious misconduct or mismanagement but did not take the appropriate action to ensure it was addressed.*  *“Serious misconduct or mismanagement” means behaviour that would constitute a breach of any legislation/enactment CQC deems relevant to meeting these regulations or their component parts.”)* | Incorporated into the recruitment and selection procedure | Senior appointment self-declaration  Senior appointment reference request form  Disqualified Directors Register check |
| Only individuals who will be acting in a role that falls within the definition of a “regulated activity” as defined by the Safeguarding Vulnerable Groups Act 2006 will be eligible for a check by the Disclosure and Barring Service (DBS).  *(CQC recognises that it may not always be possible for providers to access a DBS check as an individual may not be eligible.)* | DBS checks are undertaken only for those posts which fall within the definition of a “regulated activity” or which are otherwise eligible for such a check to be undertaken. | DBS Code of Practice  DBS enhanced checks for eligible post holders  DBS basic check for all post not eligible for enhanced checks |
| As part of the recruitment/appointment process, providers should establish whether the individual is on a relevant barring list. | Eligibility for DBS checks will be assessed for each vacancy arising. | DBS Code of Practice |
| The fitness of directors is regularly reviewed by the provider to ensure that they remain fit for the role they are in; the provider should determine how often fitness must be reviewed based on the assessed risk to business delivery and/or the service users posed by the individual and/or role. | Post-holders undertake annual declarations of fitness to continue in post.  Checks of insolvency and bankruptcy register and register of disqualified directors to be undertaken each year as part of the appraisal process | Annual declaration  Non-Executive Director appraisal process  Executive Director appraisal process |
| The provider has arrangements in place to respond to concerns about a person’s fitness after they are appointed to a role, identified by itself or others, and these are adhered to. | The disciplinary policy provides these arrangements, and revised contracts (for EDs and director-equivalents) and agreements (for NEDs) incorporate maintenance of fitness as a contractual requirement. | Disciplinary policies  Capability policy  Executive Director contracts of employment  NED agreements |
| The provider investigates, in a timely manner, any concerns about a person’s fitness or ability to carry out their duties, and where concerns are substantiated, proportionate, timely action is taken; the provider must demonstrate due diligence in all actions. | This will be undertaken if concerns are identified and revised contracts provide for termination if individuals fail to meet necessary standards. | Revised employment contracts for Executive Directors and Non-Executive Directors |
| Where a person’s fitness to carry out their role is being investigated, appropriate interim measures may be required to minimise any risk to service users. | To be reviewed when concerns are identified. | Disciplinary policy  Capability policy |
| The provider informs others as appropriate about concerns/findings relating to a person’s fitness; for example, professional regulators, CQC and other relevant bodies, and supports any related enquiries/investigations carried out by others. | This would be completed if any concerns were identified. | Referrals made to other external agencies. |