

**Meeting of the**

**COG 20/2018**  
(Agenda item: 17)

**Oxford Health NHS Foundation Trust**

**Council of Governors**

**13th June 2018**

**Corporate Governance Self-Certification and other certifications**

**For: Approval**

**Executive Summary**

NHS Foundation Trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with NHS Act 2006; HSC Acts 2008, 2009 and 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements.

Providers need to self-certify the following after the financial year end:

NHS provider licence condition:

1. The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3)) 31st May 2018
2. The provider has complied with required governance arrangements (Condition FT4(8)) 30th June 2018
3. If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service (Condition CoS7(3)) 31st May 2018

The aim of self-certification is for the Trust to carry out assurance that we are in compliance with the conditions and it is up to providers how they carry out this process. Any process should ensure that the Board understands clearly whether or not the Trust can confirm compliance.

For 2018/19 NHSI are **not** requiring Trust’s to submit their declarations with a plan that from July 2018 spot audits will take place where selected FTs will be required to demonstrate that they have carried out the self-certification process (which can be demonstrated by signed templates or board minutes and papers etc).

**Recommendation**

The Council of governors is invited to support the declaration made by the Board at its May meeting (items 1. – 3. below) and to support the June declaration (item 4-5) proposed which will be discussed at the June Board meeting taking into account the views of CoG:

**May 2018 certification**

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**
3. Declaration 3a) That: 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.

**CONFIRMED**

Explanation: CRS are services which commissioners consider should be provided locally even if a provider is at risk of failing financially; the Required Resources to provide CRS include management, financial, personnel and other assets. Whilst the Trust is a going concern for FY19, there may be financial resourcing risks to delivery of CRS. As at 24 May 2018, none of the Trust's contracts with commissioners (in Oxfordshire, Buckinghamshire and for specialised services with NHS England) for FY19 had yet been signed. The Trust has evidenced activity increases and high levels of Trust efficiency but is now preparing for the possibility that it may need to review thresholds for access to services so that there is a realistic prospect of reducing activity levels to the capacity it is funded to provide, although this would have implications for the wider health and care system, as discussed at Board meetings in public 2018 to date.

**June 2018 certification**

1. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. **CONFIRMED**
2. The Licensee shall ……. within three months of the end of each financial year, approve:
   1. a corporate governance statement by and on behalf of its Board confirming compliance with Condition [FT4] as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks **CONFIRMED**
3. 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. **CONFIRMED**

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

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

**Background**

**Condition FT4 – for consideration at the June Board**

NHS foundation trusts must self-certify under Condition FT4(8). Providers should review whether their governance systems achieve the objectives set out in the licence condition.

There is no set approach to these standards and objectives but NHSI expect any compliant approach to involve effective board and committee structures, reporting lines and performance and risk management systems utilising best practice guidance referred to in:

a. well-led framework for governance reviews (updated September 2017)

b. the NHS foundation trust code of governance (July 2014)

c. Single Oversight Framework (November 2017).

* **Training of governors – for consideration at the June Board, with the support of the Governors**

Providers must review whether their governors have received enough training and guidance to carry out their roles. It is up to providers how they do this.

**Sign off**

The board must sign off its self-certification, taking into account the views of governors.

**Audits**

From July, NHS Improvement will contact a select number of NHS trusts and foundation trusts to ask for evidence that they have self-certified. This can be through providing relevant Board minutes and papers recording sign-off.

**Deadlines**

Boards must sign off on self-certification no later than:

a. G6/CoS7: 31 May 2018, and, b. FT4: 30 June 2018.

30 June 2018 Submission

* Corporate Governance Statement – confirming compliance with condition FT (4) of the provider licence;
* Certification for Academic Health Science Centres (AHSC) – as required by Appendix E of the Risk Assessment Framework (only required for Trusts that are part of a joint venture or AHSC), and
* Training of governors statement – as required by s151(5) of the 2012 Act. (relates to the requirement for Foundation Trusts to ensure that Governors are equipped with the skills and knowledge they require to undertake their role).

**Self-certification process**

The Board declarations are made through the Corporate Governance Statements. The Board is supported in the Self-Certification and Declaration process by the work of the Board and its prospective focus going forwards; Board seminar sessions, reporting mechanisms, and Board committee work alongside independent views and inspections of patients, regulators, consultants and professional bodies. Proposed sources of evidence to substantiate the statements in the Board’s declaration were included in the self-assessment process regarding the Trust’s Well Led Governance Review, and were robustly debated by Board members at that time thereby supporting the final composition of the declaration for approval at June Board.

Board members will in June need to reflect on their own sources of assurance, assess the adequacy and sufficiency of the evidence used to support each corporate governance statement and determine the adequacy and appropriateness of assurances necessary to self-certify. Governors are invited to support the proposals herein.

In the event that a Foundation Trust is unable to fully self-certify, it must provide commentary explaining the reasons for the absence of a full self-certification and the action it proposes to take to address the issues.

The table included in the following pages details the exact wording of the Corporate Governance Statement as obligated by NHSI along with the proposed declarations that will be discussed at the Board meeting in June.

The Council of Governors is invited to:

* to support the declaration made by the Board at its May meeting and to support the June declaration and corporate governance statement below which will be discussed at the June Board meeting:

**CORPORATE GOVERNANCE STATEMENT**

**30th June Board Certification – to take into account the views of the Governors at their June meeting**

|  |  |  |
| --- | --- | --- |
| **Corporate Governance Statement** | **Response** | **Risks and mitigating actions** |
| 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. | **Confirmed** | Risk: governance framework and supporting structures not fit for purpose. Mitigation: Governance framework approved by Board to take account of CQC focus on 5 domains; Trust’s internal audit function which reports to the Audit Committee reviews and makes recommendations on the effectiveness of internal controls. Audit Committee and Board annual review of compliance with Code of Governance (best practice in corporate governance) as part of Annual Report. Robust scrutiny annually of the Annual Governance Statement as part of the Annual Report (Audit Committee, External Auditors and Board); Trust’s Well Led Governance Review 2017: PWC and action plan. (CQC Well Led review 2018 outcome awaited) |
| 1. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time | **Confirmed** | Risk: Information not presented to Board to enable it to consider issued guidance in a timely manner. Mitigation: Company Secretary 'horizon scans' and prepares monthly legal/statutory/regulatory update to Board on such guidance both in and out of session to include updates on ‘Trust position’ against requirements. Company Secretary on NHSI circulation list so receives early notification of NHSI guidance/consultations/bulletins on governance, the same applying to membership of NHS Providers and other legal/regulatory networks. Board assesses compliance with Code of Governance as part of processes for Annual Report. Board/Board Committee Reports (eg Self-certifications) routinely clarify regulatory and legal obligations. |
| 1. 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. | **Confirmed** | Risk: governance framework and supporting structures not fit for purpose. Annual Report approved by Board focusses on the depth and breadth of committee workplans providing opportunity for Board to scrutinise the work, and assess the effectiveness of the Committees and the overall structure and responsibilities of committees. Trust’s internal audit function which reports to the Audit Committee reviews and makes recommendations on the effectiveness of internal controls. Information above in 1. re governance framework applies. Approved Terms of Reference extant for all Board Committees outlining responsibilities; Scheme of Delegation and Reservation of Powers to Board. Detail of AGS, audited by the External Auditor includes the work of the committees and minutes of Board committees circulated to all members of the Board alongside escalation reports from Committee chairs following each meeting.  The imminent directorate reorganisation implementation will be monitored to ensure clarity of accountabilities and reporting on conclusion of the restructure. |
| 1. 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. | **Confirmed** | Risk: Failure to put effective governance (both corporate and clinical) arrangements in place may lead to: poor oversight at Board level of risks and challenges; strategic objectives not being established or structures not in place to achieve those objectives; or appropriate structures and processes not in place to maintain the Trust's reputation and accountability to its stakeholders. Mitigations. The governance framework includes both a Finance & Investment Committee and an Audit Committee which have roles in ensuring the Trust operates efficiently, economically and effectively and have roles in reviewing the Trust’s financial decision-making, management and control; and going concern status. The Trust has a Chief Operating Officer who regularly reports to board on operational matters. In addition, the Trust’s internal audit function which reports to the Audit Committee reviews and makes recommendations on the Trust’s clinical and corporate governance regimes and information management systems. The External Auditor’s Opinion comes out of work by the auditor to assess efficiency and value for money through effective use of resources. The Board monitors NHSI’s use of resources rating. The Company Secretary’s office maintains work plans for Board, Council and committees which set out when reports / information are required allowing Executive Directors to plan accordingly. The Board Assurance Framework sets out all material risks to the Trust achieving its strategic objectives which inherently includes compliance with licence conditions; the BAF is reviewed by Board and its Committees. Committees review areas of key risk such as mental health act compliance with legal update reports going to Board and Charity Committee. The Trust has retained legal solicitors and relevant Trust departments have responsibility for managing legal risks. The board set out in its 18/19 Forward/operational plan submission its concerns about parity of MH funding and investment. We continue to evidence activity increases and our high levels of efficiency, whilst preparing for the possibility that we may need to review thresholds for access to services so that we have a realistic prospect of reducing activity levels to the capacity we are funded to provide. Clearly that is undesirable, and would have implications for the wider health and care system, but options will be developed to prepare for those circumstances.  There is a risk that a failure to meet quality standards for clinical care will result in poorer outcomes for patients and poorer patient safety and experience. Some of the mitigating actions are as follows:  - models of care for every service with clear standards of care and standard operating procedures (SOPs); - clinical and managerial leaders focusing on achieving standards; - day-to-day operational management structures, effective team working and evidence of training for team-based approaches; - optimal staffing levels closely monitored and reported; - processes to pick up exceptions/variations and for staff to raise concerns e.g. through the Whistleblowing policy and Speak up Guardian; - improvement initiatives including productive wards, safer care programme, patient experience feedback, patient advice and liaison service feedback; - feedback of patient experience (received through a mixed medium of postal feedback and also real-time feedback / PALS /iWantGreatCare) |
| 1. 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. | **Confirmed** | Risk: Board does not have sustained capability or expertise to lead the quality of care delivery in current climate. Mitigation: Chief Executive accountable for the Executive Director composition and performance, and reports to Board, through Remuneration Committee on same. Completed well-led review and increased capacity on Board (non-voting) and executive management team. The Director of Nursing and Clinical Standards has lead responsibility for quality and reports to Board on these matters supported by the Medical Director. The Chairman regularly reviews the whole Board composition to ensure the skill mix and experience is appropriate and balanced through the work of the Governor and NED Nominations and Remuneration Committees whose succession planning responsibilities are clearly outlined in ToR operationally led by the Company Secretary.  See above re risk and mitigation regarding governance frameworks. Risk: The failure to ensure timely, accurate and reliable data on quality is available may lead to lack of oversight of areas of poor care, failure to prioritise remedial actions appropriately and compromised decision-making. Mitigation: Dedicated departments, reporting to Executive Directors that have responsibility for information management. The Trust’s internal audit function which reports to the Audit Committee reviews and makes recommendations on the management of information. The Board receive regular reports on quality performance and the Board scrutinises the reliability of data through this. Work is progressing to enhance the quality of data: - development of internal data warehouse; quality account priority to develop quality dashboard and standard operating procedures for data to assure data quality and reliability; benchmarking of data and performance against other trusts improving; triangulation of data to assess validity and accuracy. The implementation of Carenotes/EHR includes activity to improve and safeguard the quality and accessibility of data. Progress with Performance framework and SLR monitored through Well-Led action plan via Quality sub-committee:Well Led.  Risk: Failure to ensure patients and carers are involved in managing and leading on their own care could lead to compromising patient outcomes and not delivering sustainable health care. Failure to work collaboratively and effectively with external partners may compromise service delivery and stakeholder engagement. Mitigating actions are as follows: clear procedures for involving patients and carers in care planning supported by regular audits and monitoring; development of shared outcome measures with patients and carers; partnership and joint working with other providers (including section 75 agreements); the Multi-Agency Safeguarding Hub (MASH) in Oxfordshire to bring together Health, Social Services, the Police, Education and Youth Offending services in an integrated multi-agency team to share information appropriately and securely on children or young people in order to take timely and appropriate action to safeguard them from harm; new service models including integration with social care for Older People's physical health services; establishment of local/divisional patient groups; accessible complaints service, PALS surgeries and collecting and sharing results of patient experience surveys. New Patient Involvement and Engagement Strategy.  Risk that there is not an agreed and clear system for escalating and resolving quality issues. The mitigation is that the Trust has processes to identify, report and investigate incidents and complaints, and the Quality Committee receives assurance reports on such. The Audit Committee received holistically review of the effectiveness of processes for raising concerns, to include Whistleblowing policies and the work of the Speak Up Guardian. Strong reporting culture promoted across the organisation. |
| 1. 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** | Risk: Trust does not have systems and processes to ensure Directors, managers, clinicians and staff are sufficient in number and qualifications. See previous section. The mitigation is that the Chairman regularly reviews the whole Board composition to ensure the skill mix and experience is appropriate and balanced with the Governors supporting determination of the NED composition and skills and the CEO accountable for the executive and conducting regular performance reviews. The Trust HR department manages the workforce strategy and reports to Board on workforce matters, including staff numbers, training and development, and appraisals. Workforce plans set establishments which are monitored for variation and appropriate actions taken to rectify any concerns. Nurse Staffing Report sent monthly to Board. Vacancies and sickness closely monitored, and use of locums and agency workers overseen and where possible use mitigated. Medical revalidation process and reporting, and significant progress with implementation of Nursing revalidation |

**Other certifications**

The Board is only required to confirm or otherwise, providing explanations and mitigations only when unable to confirm a particular statement. It is acknowledged in terms of the design of clinical and corporate governance structures that nothing significant has changed since the Board’s ‘confirmed’ statement in FY17. The proposed statement for each is **CONFIRMED.**

1. **Certification on AHSCs and governance:**

**The Board is satisfied it has or continues to:**

* ensure that the partnership will not inhibit the trust from remaining at all times compliant with the conditions of its licence;
* have appropriate governance structures in place to maintain the decision making autonomy of the trust;
* conduct an appropriate level of due diligence relating to the partners when required
* consider implications of the partnership on the trust’s financial risk rating having taken full account of any contingent liabilities arising and reasonable downside sensitivities;
* consider implications of the partnership on the trust’s governance processes;
* conduct appropriate inquiry about the nature of services provided by the partnership, especially clinical, research and education services, and consider reputational risk;
* comply with any consultation requirements;
* have in place the organisational and management capacity to deliver the benefits of the partnership;
* involve senior clinicians at appropriate levels in the decision-making process and receive assurance from them that there are no material concerns in relation to the partnership, including consideration of any re-configuration of clinical, research or education services;
* address any relevant legal and regulatory issues (including any relevant to staff, intellectual property and compliance of the partners with their own regulatory and legal framework);
* ensure appropriate commercial risks are reviewed;
* maintain the register of interests and no residual material conflicts identified; and
* engage the governors of the trust in the development of plans and give them an opportunity to express a view on these plans.

1. **Training of Governors**

**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.**

Evidenced by:

* Governor development programme since 2017
* Governor Induction programme – for all new governors
* Access to and attendance at, NHS Provider Govern Well and other Governor events/training
* Enhanced knowledge and understanding of possible opportunities and strategies to support the organisation’s health and potential risks and challenges to the achievement of the organisation’s plans
  + Governors workshop focussed on review of forward plans
  + Open presentations at GC meeting
  + Governor attendance at Board of Directors and feedback to CoG
* Successful process for appointment of External Auditors (Governors supported by Audit Committee)
* CoG Groups, with direct support and expertise provided by the Executive Directors /NEDs and the senior management team
* Governor Handbook roll out and approved Engagement policy
* Market information presented on annual basis to Nominations and Remuneration Committee members – expertise and full support provided by Director of Corporate Affairs/ Company Secretary and Director of HR
* New Governors have the opportunity to access peer support from an experienced Trust Governor ‘buddy’.
* Lead and Deputy Lead Governor invited members of Board site visit programme
* Peer Review Training and opportunities to participate in site and ward peer review programme
* PLACE audit training and opportunity to participate in annual audit subject to that training
* Trust officer support to Governor Forum
* Fortnightly Governor update