

**Meeting of the**

**COG 16/2019**  
(Agenda item: 14)

**Oxford Health NHS Foundation Trust**

**Council of Governors**

**12th June 2019**

**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 2019
2. The provider has complied with required governance arrangements (Condition FT4(8)) 30th June 2019
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 2019

The aim of self-certification is for the Trust to carry out assurance that it is 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.

NHSI no longer require Trusts to submit declaration but 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 next Board meeting taking into account the views of CoG:

**May 2019 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. **CONFIRMED**
   * Declaration **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 which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services*”.

*(Note: 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/workforce and other assets.)*

Board considered the financial resourcing risks to the delivery of CRS amongst the other areas relevant to this certification aspect. As part of those considerations was the Trust’s current and anticipated contract position with commissioners (in Oxfordshire, Buckinghamshire and for specialised services with NHS England) for FY19. Board reflected upon anything impeding the Board’s ability to conclude its ‘reasonable expectation’ given the necessary clarity needed with regard to the planned closure of funding gaps over a period of time greater than 19/20. The Trust has evidenced activity increases and delivers high levels of efficiency but is negotiating and 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. It is recognised this would also have implications for the wider health and care system, all of which recently discussed in public Board meetings, but equally, the recognition and support of commissioner to resolve this was accepted. The Board did consider the point regarding workforce was the area this year of most uncertainty, and although with respect to finance, the position is improved from last year, we are yet to resolve our longer-term perspective of funding risk.  From a cash point of view, it was considered the Trust would continue to deliver services 12 months from now, but concerning workforce, Board felt this would continue to be a challenge despite the positive actions including such as nursing associates which are now starting to come good, but it was acknowledged would not solve all problems quickly enough as the temporary closure of City indicated.

**June 2019 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 also 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 November 2018);

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

c. Single Oversight Framework (March 2019).

* **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.

**Deadlines**

Boards must sign off on self-certification no later than for FT4: 30 June 2019 with declarations in relation to:

* Corporate Governance Statement – confirming compliance with condition FT (4) of the provider licence; 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**

The Board declarations are made through a published Corporate Governance Statement.

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 remain relevant as were identified 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 in June.

Board members will be invited 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 (and reviewed in depth at Board’s May seminar).

The Council of Governors is invited to:

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

**CORPORATE GOVERNANCE STATEMENT**

**30th June Board Certification – taking into account the views of the Governors**

|  |  |  |
| --- | --- | --- |
| **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 adversely affecting good corporate governance and decision making. 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 and External Audit’s review of auditable sections and opinion. 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 ongoing oversight of delivery of action plan. (CQC Well Led review 2018 ‘good’ outcome) |
| 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: Board members unaware of guidance in a timely manner affecting compliant status. 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 when appropriate clarify regulatory and legal obligations (eg NRATS committee reporting cover sheets). |
| 1. The Board is satisfied that the Trust 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** | Risk: governance framework and supporting structures not fit for purpose adversely affecting good corporate governance and accountability constructs. Annual Report and committee annual reports, approved by Board focus across the depth and breadth of committee workplans and CQC fundamental standards/core domains 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 also applies. Approved Terms of Reference extant for all Board Committees outlining responsibilities; Scheme of Delegation and Reservation of Powers to Board in place (relevant but due for review). 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 escalations from Committee chairs following each meeting. Directorate reorganisation implementation was monitored to ensure clarity of accountabilities and reporting on conclusion of the restructure and enhanced clinical governance structures have been implemented. May19 Board Seminar commenced a review of the Integrated Governance Framework in parallel with a review of the future governance needs of the Board. |
| 1. The Board is satisfied that the Trust 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** | 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. Monitoring of financial performance and prospective views led to a recovery plan and reforecast which was delivered in 18/19; 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 and 19/20 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. Options are being developed to prepare for those circumstances.  Risk: 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 to include 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/staff and patient services) |
| 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. Following 17/18 well-led review -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. Robust processes and defined panel compositions for recruitment of NEDs and EDs.  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. Developing Data Quality Strategy focus supported at Quality SCWL. 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 SCWL.  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. Refresh of Patient Involvement and Engagement Strategy and consultation (for approval May19)  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 reviews the effectiveness of processes for raising concerns, including Whistleblowing policies and the work of the Freedom to 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 qualified affecting quality and decision making. See previous section. The mitigation is: 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 Company Secretary leads on annual Fit and Proper Person Test for the members of the Board. The Trust’s HR department manages the workforce strategy and reports to Board on workforce matters, including staff numbers, with L&D reporting on strategies for training and development, and appraisals and the work to improve achievement against targets. Workforce plans set establishments which are monitored for variation and appropriate actions taken to rectify any concerns. Inpatient Safer Staffing (Nursing) Report sent monthly to Board. Vacancies and sickness closely monitored and use of locums and agency workers overseen and where possible use mitigated (including HCA agency reduction strategy). 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 the statement.

**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.*  **CONFIRMED**

Evidenced by the following non-exhaustive reflection on activity:

* Governor development programme to include Governor:NED reflection and development session March 2019;
* Governor Induction programme – for all new governors;
* 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;
* Access to and attendance at, NHS Provider Govern Well and other Governor events/training and Govern Well training session in Thame (by NHSP);
* 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 meetings
  + Governor attendance at Board of Directors meeting and feedback to CoG
* Successful process for appointment of new chairman and new NED and Trust officer support to the governor led process;
* CoG sub-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/benchmark information presented 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 have participated in the Board site visit programme (rolled out to the full CoG from Apr19);
* Director of Corporate Affairs’ support to Governors and to Governor Forum;
* Fortnightly Governor update;
* Direct access to senior leaders to address assurance concerns;
* Fortnightly governor update emailed to all governors.