

# Report to the Meeting of the

BOD 67/2019

(Agenda item: 18)

# Oxford Health NHS Foundation Trust

# Board of Directors

**24th May 2019**

**2019/20 Board Self-Certifications to NHS Improvement**

**For: Approval**

**Executive Summary**

The annual self-certification provides assurance that NHS providers are compliant with the conditions of their NHS provider licence. Compliance with the licence is routinely monitored through the Single Oversight Framework but, on an annual basis, the licence requires NHS providers to self-certify as to whether they have:

1. effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have regard to the NHS Constitution (condition G6);
2. complied with governance arrangements (condition FT4); and
3. for NHS foundation trusts only, the required resources available if providing commissioner requested services (CRS) (condition CoS7).

The Trust is required to self-certify the following after the year end:

|  |  |  |  |
| --- | --- | --- | --- |
| Condition G6(3) | The provider has taken all precautions to comply with the licence, NHS acts and NHS Constitution. | By 31 May |  |
| Condition G6(4) | Publication of condition G6(3) self-certification. | By 30 June |  |
| Condition FT4(8) | The provider has complied with required governance arrangements. | By 30 June |  |
| Condition CoS7(3) | The provider has a reasonable expectation that required resources will be available to deliver the designated services for the 12 months from the date of the statement. | By 31 May |  |

The aim of self-certification is for the Board to confirm assurance that the Trust complies with the conditions and it is at the discretion of each provider how they carry out this process. Any process however, should ensure that the Board understands clearly whether or not the Trust can confirm compliance.

For 2019/20 as for the previous 2 years now, NHSI are **not** requiring Trusts to submit their declarations. However, 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 through signed templates or board minutes and papers).

**Recommendation**

The Board of Directors is invited to approve the 31st May 19 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, 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. Regarding the declaration that the Trust has a reasonable expectation that required resources will be available to deliver the designated services for the 12 months from the date of the statement, Board is invited to pay particular attention to this aspect of the certification. It will need to determine if the supported declaration is 3a) or 3b). For the purposes of the recommendation in this report and by way of constructive stimulant for debate, the narrative of both 3a and 3b as presented at the May Board seminar is included in the body of the report to support Board in reaching agreement.

The 30th June declaration regarding Licence Condition ‘FT4 and governor training’ will be discussed and approved at the June meeting of the Board and the Council of Governors.

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**2019 Board Self-Certifications for NHS Improvement**

**Situation**

The [NHS provider licence](https://www.gov.uk/government/publications/the-nhs-provider-licence) is NHSI’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 amongst others, give NHSI the power to 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.

**Background**

This paper identifies the potential sources of assurance to support the Board make a statement of ‘confirmed’ or otherwise for **declarations 1 and 2**. This paper is submitted to the May Board of Directors meeting for this purpose.

**Declaration 3** is required at the end of June and will be reviewed in more detail during June Council of Governors’ 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.

**Declaration 1**

*Licence condition G6 is explained as follows:*

*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 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 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.*

***Proposed evidence to demonstrate compliance***

The Trust’s governance, performance, risk management and assurance architecture, 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 refreshed through reviews of Board Committee Terms of Reference.  The Board and relevant Committees regularly review the Trust’s performance (including, quality, safety, financial, and workforce matters) and assess risks. Where risks are identified, the Executive is tasked with implementing actions to mitigate the risk impact.  The Board has reviewed on at least a quarterly basis reports which provide assurances on: finance, quality/indicator performance, progress against the Trust’s annual plan, quality account, safety and experience. Additionally, the Board receives a regular update on the Board Assurance Framework re the movement and management of strategic risk and has a universal view of high level operational risk via the Trust Risk Register. Board sub committees, such as Well Led also oversee the effectiveness of and escalations from directorate risk registers to include a review of the revised clinical governance structures following the directorate restructure concluding in 2018.

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 activity.  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, and analysed by the Audit Committee 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’s meeting in April 2019. It has been reviewed by the External Auditor and is on the May Board agenda for final approval as part of the Annual Report, with 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 having considered the ‘new’ definitions of what ‘significant’ means in reaching that conclusion.

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 a range of matters to include 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 in its risk management review, to gain ongoing assurance of the effectiveness of the Trust’s risk and internal control processes with respect to the strategic risk environment.  The committee reviewed and approved the internal and external audit plans and oversees the outcomes, managements responses and follow up action.

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 committee meetings, to present updates on investigations, fraud prevention, and 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 and the internal auditors on the work they had undertaken in reviewing and auditing the control environment.

Furthermore, the work of the Quality Committee, Finance Committee, Charity Committee and Nominations, Remuneration and Terms of Service 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, safety, workforce and charitable objectives. A comprehensive assessment 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/review and formal adoption by the Board following approvals during the May Board meeting.

Finally, the process of self-assessment and external review with regard to the Trust’s Well Led governance review has informed the view of compliance and evidence thereof and in particular the external Well Led Review undertaken by PWC has highlighted a positive view of the Trust’s governance alongside some areas that could help strengthen which have across the year been monitored accordingly through to completion by the Quality sub Committee: Well Led through oversight of the development plan.

***Declaration 2***

*Licence condition CoS7 is explained as follows:*

1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.
2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.
3. The Licensee, not later than two months from the end of each Financial Year, shall submit to {the regulator} a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms:
4. *“After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.”*
5. *“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”.*
6. *“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”.*

**Evidence to demonstrate compliance**

The evidence presented for declaration 1 is directly relevant also to this licence condition. Additionally, the following is worthy of mention:

* Going concern statement – debated in detail at April and May audit committee’ meetings and supported by External Audit opinion
* Audit opinion – financial statements
* Budgeting process – demand and capacity review as part of activity and costing
* Monthly reporting to the Board (finance, performance, workforce, quality, safe staffing mix/levels and patient experience etc)
* Finance and Investment Committee scrutiny (EBITDA, liquidity, cash flow, use of resources, capital schemes, CIP schemes etc)
* NHSI segmentation and use of resources metrics
* STF funding and control total performance
* Developments in Service Line Reporting and performance dashboards

**Recommendation**

The Board of Directors is invited to consider and approve the declarations as follows:

* Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution. **CONFIRMED**
* The Board declares that the Licensee continues to meet the criteria for holding a licence. **CONFIRMED**
* Board is invited to pay particular attention to this aspect of the certification, in order to determine if the supported declaration is 3a) or 3b). To support deliberations, Board is reminded that the narrative of 3b was determined appropriate for 2018 due at the time to ongoing funding, activity and demand concerns. Board have been apprised of the longer-term expectation regarding recent contract negotiations that will deliver additional funding and agreement about cost and activity control. Workforce recruitment and retention of course remain challenging.
* The statements requiring Board’s decision for the purposes of the declaration are:
  + **3a**  *“After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.”*
  + **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*”.

Board will need to consider the financial resourcing risks to the delivery of CRS. As part of those considerations is the Trust’s current and anticipated contract position with commissioners (in Oxfordshire, Buckinghamshire and for specialised services with NHS England) for FY19. Board will need to reflect 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.