This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

Oxford Health NHS Foundation Trust	*Insert name of organisation*

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template
1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration" Financial Year to which self-certification relates: 2020/21 — Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee 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 and 2019 'good' outcome, and 'good' overall 2019)	#REF!
2	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: DoCA/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. DoCA/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).	#REF!
3	The Board is satisfied that the Licensee 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. Mitigation: 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 ensures clarity of accountabilities and reporting and enhanced clinical governance structures have been implemented.	#REF!
4	The Board is satisfied that the Licensee 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 Board receives reporting on performance and operational matters at each meeting in public. 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 DoCA/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 and follow a business cycle. 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; and feedback of patient experience (received through a mixed medium of postal feedback and also real-time feedback / PALS /iWantGreatCare/staff and patient services).	#REF!
5	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 Licensee, 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 Licensee 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 Chief Nurse 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 DoCA/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 to satisfactory completion 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	#REF!
6	The Board is satisfied that there are systems to ensure that the Licensee 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 DoCA/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.	#REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature [signature] **Signature** [signature]

Name David Walker **Name** Dr Nick Broughton

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

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Please Respond

Worksheet "Training of governors"

Financial Year to which self-certification relates: **2019/20** Please Respond

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee 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	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	David Walker	**Name**	Dr Nick Broughton
Capacity	Trust Chair	**Capacity**	Chief Executive
Date	24 June 2020	**Date**	24 June 2020

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

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