

 **Report to the Meeting of the**

**Oxford Health NHS Foundation Trust**

**Board of Directors**

**BOD 51/2022**
(Agenda item: 15)

**20 July 2022**

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

**For: Approval**

**Executive Summary**

The Board discussed this report previously at its meeting on 25 May 2022. It was not agreed whether declarations 3(a) or 3(b) (referred to in more detail below) could yet be made in relation to whether 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, or declarations 1 or 2 in relation to licence conditions. The Chair of the Audit Committee highlighted uncertainty in relation to risks which may emerge from Clinical Audit, in the absence of Clinical Audit annual reporting. The Clinical Audit team have since presented their Clinical Audit annual report to the Audit Committee on 15 June 2022 and to the Quality Committee on 14 July 2022.

The Board is invited to consider whether it can now satisfy itself through its work and that of its committees that it can be reasonably assured of its compliant status and be in a position to approve the declarations proposed, in support of the publication of the Corporate Governance Statement.

**Background**

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 are normally required 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)) – 31 May;
2. the provider has complied with required governance arrangements (Condition FT4(8)) – 30 June; and
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)) – 31 May.

The Board would normally expect to receive a report on its self-certifications around the time of approval of the Annual Report & Accounts which also report annually on compliance with the licence. The self-certifications on compliance with the licence and reasonable expectation that required resources will be available should be made by 31 May (whilst the self-certification on governance arrangements can be by 30 June), although under current reporting requirements the Annual Report & Accounts are to be submitted to NHS England/Improvement during June and the Board therefore received the final versions of the Annual Report & Accounts on 15 June 2022. Earlier versions of the Annual Report & Accounts were reviewed by the Audit Committee during April and May 2022, and the final version was reviewed by the Audit Committee earlier in the day on 15 June 2022.

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.

NHS England/Improvement no longer require trusts to submit declarations but selected trusts may 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 Board is invited to satisfy itself through its work and that of its committees that it can be reasonably assured of its compliant status and be in a position to approve the declarations proposed, in support of the publication of the Corporate Governance Statement. Members are asked to:

* consider and certify each Statement, including the risks associated with each, or if unable to certify then agree what supporting commentary should be submitted; and
* approve the final Corporate Governance Statement.

The declaration no. 6 below, regarding governor training, was presented to the 15 June 2022 meeting of the Council of Governors and there approved.

**For certification:**

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, the Board is invited to pay particular attention to this aspect of the certification. It will need to determine if the supported declaration is **3(a) or 3(b)**. The narrative of both 3(a) and 3(b) (and also the option of 3(c)) is included in the body of the report (**see pages 8-9 below**) to support the Board in reaching agreement.  **TO BE AGREED**
4. 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**
5. 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**
6. 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**

**Authors and Titles:** Hannah Smith, Assistant Trust Secretary, and

 Kerry Rogers, Director of Corporate Affairs/Company Secretary

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

1. *A risk assessment has been undertaken around the legal issues that this report presents and there are no issues that need to be referred to the Trust Solicitors*
2. ***Strategic Objectives*** *– this report relates to or provides assurance and evidence against the following Strategic Objective(s) of the Trust:*

*1) Quality - Deliver the best possible care and health outcomes*

*3) Sustainability – Make best use of our resources and protect the environment*

**Background**The Board Statements include a number of different self-declarations and certifications relating to sections of the Single Oversight Framework, provider licence and Health and Social Care Act 2012.

**Declarations 1 & 2 - Licence condition G6:**

*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 policy, in governance documents and in the Integrated Governance Framework refreshed primarily 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 across the year on: finance, quality/indicator performance, progress against the Trust’s plans, 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 committees and sub committees also oversee the effectiveness of and escalations from directorate risk registers. Themes from Patient Safety Incident Investigations and such as claims and inquest outcomes are key sources of intelligence in terms of the effectiveness of risk and safety management and are triangulated through the weekly review meeting and quality and risk team.

Key aspects of the governance, performance, risk management and assurance systems and processes are reviewed by the Board and its Committees. The Audit Committee receives independent reports concerning the Trust’s control environment throughout the year and as part of 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 key aspects of risk management, controls and systems throughout the year.  The Audit Committee reviewed drafts of the Head of Internal Audit Opinion at its meetings on 18 May 2022 and 15 June 2022.

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 meetings in April and May 2022 and reviewed again on 15 June 2022 as well as being subject to audit by the External Auditor. No significant control weaknesses indicative of systemic problems have been identified during the year having considered the published definition of what ‘significant’ means in reaching that conclusion.

The Audit Committee provides an independent and objective review of the establishment and maintenance of an effective system of governance, risk management and internal control across the Trust over a rolling period and plays a pivotal role in supporting the Board in understanding the effectiveness of key controls.

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 mechanisms 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, management’s responses and follow up actions.

There has been a regular review of internal audit progress reports including performance indicators and informal consideration of the effectiveness of internal audit to ensure a systematic review of the systems of internal control to include finance, clinical governance, 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 anti-crime (counter fraud) service. The anti-crime (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. The committee has also reviewed a Clinical Audit annual report at its meeting on 15 June 2022.

Furthermore, the work of the Quality Committee, Finance & Investment Committee, People, Leadership & Culture Committee, Mental Health Act 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 in June 2022.

Historically, the Board has considered it reasonable as part of the 3-5 year Well Led Governance Review process of self-assessment and external review to rely on the Trust’s Well Led governance review back in 2017 which has thereafter continued to inform the view of compliance and evidence thereof given the external Well Led Review undertaken by PWC highlighted a positive view of the Trust’s governance alongside some areas that could help strengthen it. Board Development activity in 2021-22 has continued to build upon that work and in particular the positive developments in the Integrated Performance Report which was a key area for development in the last external review. Furthermore, the Board conducted a self assessment in early 2022 across the CQC Well Led key lines of enquiry and against a ‘True for Us’ assessment of high profile governance failings across the NHS. Work is also underway to commission an external, quality governance focused Well Led Review during 2022. This will be an externally run development review of leadership and quality governance arrangements in accordance with best practice contained within NHS England/Improvement’s Well Led Framework and in compliance with the Code of Governance.

**Declaration 3 - Licence condition CoS7:**

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”.*

**The 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, the Board is reminded that the narrative of 3b has been determined appropriate each year since 2018 due to ongoing funding, activity and demand concerns. Workforce recruitment and retention also remain challenging.

The Board will need to consider the financial resourcing risks to the delivery of Commissioner Requested Services. 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 FY23. Our expectation with regard to the ongoing commissioning of services is that the block payment arrangements currently in place will continue to the end of the financial year. Board is aware of the challenges concerning the removal of COVID-19 funding arrangements and the ambiguities of new commissioning and funding allocation arrangements through the BOB Integrated Care System. The Board will need to reflect upon anything impeding the Board’s ability to conclude its ‘reasonable expectation’.

The Trust has over the past few years evidenced activity increases and high levels of efficiency. The MH contract for Oxfordshire was successfully renegotiated to increase the funding for the services provided which contributed to decreases in funding gaps for mental health provision and Board is apprised of the allocations with regard to the Mental Health Investment Standard. There is also of course the impact of COVID-19 on the Trust, its existing service users and patients, the system and on society and also the strong expectation consequentially that this will have significantly increased the levels of demand for our services alongside exacerbated workforce shortages.

Commissioner affordability with regard to the mental health investment standard in meeting the required mental health investment, including the additional growth in patient demand and acuity across the system, will mean that the receipt and effective application of the additional funding is essential.

It is anticipated that there will be considerable need for psychological and mental health support and a recognition of increasing demand post COVID-19. It seems increasingly likely that demand on the NHS will be spread over a much longer period of time than initially expected. But this will still require staff to work at a very high levels of intensity and pressure. The Trust has began a number of initiatives aimed at supporting staff and their wellbeing.

The Trust is lead provider for three provider collaboratives: adult forensic mental health; CAMHS Tier 4 inpatient; and adult eating disorders. These provider collaboratives add a new dimension to risk as the total funding for the services comes to the Trust which is responsible for managing the other providers and passing the funding on as appropriate. If costs exceed income, the risk is shared amongst the partners. However, as lead provider we have established the appropriate controls to manage this. This has been approved at the Board and at the Finance and Investment Committee.

Finally, the new Health and Care Act 2022 establishes Integrated Care Systems (**ICSs**) on a statutory footing from 01 July 2022 when Integrated Care Boards (**ICBs**) will replace Clinical Commissioning Groups as the NHS funding channel and strategic commissioning body. This will sit alongside the creation of Integrated Care Partnerships, and the increased partnership arrangements between the NHS and Local Authority social care provision. When making decisions, the Trust and the ICSs it works with will need to have regard to the ‘triple aim’ of better health for everyone, better care for all and efficient use of NHS resources, as well as the effect in relation to health inequalities.

**Review of Economy,**

**Evidence to demonstrate compliance**

The evidence presented for declarations 1 and 2 is also directly relevant to this licence condition. Additionally, the following evidence is worthy of mention:

* Going concern statement – discussed at the April Audit Committee meeting and reviewed again at the June Audit Committee meeting alongside the External Audit opinion
* The Trust’s Internal Audit Plan, which was agreed by the Audit Committee, sets out the full range of audits across the Trust, to include reviews around: data quality/waiting lists in the context of demand and capacity; Provider Collaborative governance; Procurement; and projects and programme assurance
* Audit opinion – financial statements
* Budgeting process – demand and capacity review as part of activity and costing
* Regular reporting to the Board (finance, performance, workforce, quality 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
* Developments in Integrated Performance Reporting;Service Line Reporting and performance dashboards
	+ Financial and non-financial performance is reported through a framework which generates ‘dashboard’ presentation and analysis at Board, at Executive and at divisional/directorate levels.
	+ To support ongoing attainment of value for money, service line analysis and reporting will continue to provide a more granular understanding of the areas through which we can drive even greater efficiencies.

**Declarations 4 & 5 - Condition FT4:**

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) / NHS System Oversight Framework 2021/22.

**Declaration 6 - Training of 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**

Usually boards should sign off on the self-certification for required governance arrangements no later than the end of June for FT4, 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**

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 and workshop 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 including those as were identified in the self-assessment process regarding the Well Led Governance Framework recently discussed along with the Trust-wide CQC Key Lines of Enquiry assessment early in 2022 at a Board workshop. The Board’s and the Executive’s externally facilitated development activity is pertinent in the context of ‘well led’ along with progress in delivering against the journey to outstanding as part of the Trust-wide self assessment improvement activities.

Board members are 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.

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, so in such circumstances, the Board will need to reach a consensus view.

The table included in the following pages details the exact wording of the Corporate Governance Statement as obligated by NHSE/I along with the proposed declarations.

The Board is invited to:

* consider and certify each Statement, including the risks associated with each, or if unable to certify then agree what supporting commentary should be submitted; and
* approve the final Corporate Governance Statement for publication.

**CORPORATE GOVERNANCE STATEMENT**

**May/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 committee framework approved by Board which also in particular through sub committees takes account of CQC focus on fundamental standards of care; Trust’s internal audit function which reports to the Audit Committee reviews and makes recommendations on the effectiveness of internal controls across a risk based rolling programme to cover the control environment. 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 Board’s own self assessment and true for us review early 2022 and work regarding ‘journey to outstanding’. (CQC Well Led review 2018 and 2019 ‘good’ outcome, and ‘good’ overall 2019). Board Development activity 2021 and 2022 to improve its own effectiveness. |
| 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: 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). Chief Medical Officer is lead executive of the MHA and Law Committee and keeps the Board appraised of matters concerning MHA, DoLS and MCA. Policy and Standard Operating Procedure frameworks safeguard compliance with existing statute and regulation and incident and complaint investigations triangulate trends and themes which might identify non compliance with policy and mandatory frameworks. |
| 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 across a rolling programme of audit plans to cover . 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. As a minimum NED Chairs and Lead Executives agree the agendas and focus of each Board Committee meeting. New Monthly Executive Committee with cross directorate membership, OMT, WRM and Directorate governance meetings with escalation routes. |
| 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 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. Regular monitoring of financial performance and prospective views of performance against plan; The DoCA/Company Secretary’s office maintains work plans for Board, Council and committees which set out when reports / information are required allowing an effective business cycle to be followed. 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. Risk: Failure to (i) meet quality standards for clinical care; (ii) continuously improve care quality and safety; and/or (iii) engage patients and carers in that care, could result in patient harm, impaired outcomes, and poor experience. Some of the mitigating actions include:- 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. The Board composition of NEDs and EDs has been strengthened over the last 2 years. The Chief Nurse has lead responsibility for quality and reports to Board on these matters supported by the Chief Medical Officer. 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: Failure to protect the information we hold as a result of ineffective information governance and/or cyber security could lead to: personal data and information being processed unlawfully (with resultant legal or regulatory fines or sanctions), cyber-attacks which could compromise the Trust’s infrastructure and ability to deliver services and patient care; data loss or theft affecting patients, staff or finances; reputational damage 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. Specific reports on Cyber Security overseen along with Board training activity on same. 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. Data Quality Strategy progressed through the Board and the CoG strategy session and to be approved by Board (circa July 2021). DPO and Deputy DPO lead on the DP Impact Assessment process aligned to business/process change along with the QIA for service change led by the CN and CMO. 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 and leading to the introduction of the Integrated Performance Framework.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 also reviewed by the People Leadership and Culture Committee. Strong reporting culture promoted across the organisation. The clinical audit function is a key component of the wider clinical governance framework with healthcare professionals expected to participate in clinical audit work and clinical audit is embedded in medial revalidations with nurses also expected to use audit. As a minimum, the Trust takes part in mandatory national clinical audits which seek to improve patient care and outcomes by looking at current practice against best practice and delivering improvements where necessary. The aim is to improve healthcare where it is most helpful and will improve outcomes for patients.  |
| 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 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. Robust apprenticeship and cadet schemes, and progressive nursing practitioner (ANPs) programmes and international recruitment drives. Improving Quality and Reducing Agency focus has been prioritised. |

**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 but recognising that the second pandemic year mandated prioritisation of the response to the pandemic:

* Governor Induction programme – for all new governors in June 2021 (no election in the previous year) and starting again in May-June 2022;
* Peer Review programme (last trained in pre pandemic period) to provide opportunities to participate in site and ward peer review programme. This is being reintroduced post pandemic with ongoing relaxation in IPC measures and governors are scheduled to receive Quality Improvement peer reviewer training in 2022;
* PLACE audit programme (last trained in pre pandemic period) to provide opportunity to participate in annual audit subject to that training. This will be reintroduced post pandemic and any relaxation in IPC measures;
* 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:
* Governor Strategy and Development Sessions in February and July 2021, February 2022 and planned for July 2022;
* Open presentations at meetings
* Governor attendance at Board of Directors and Board Committee meetings and feedback to CoG
* Governor involvement in patient experience feedback tools (I want great care) and other working and sub group participation (Oxevision, carers groups, mortality group, exceptional people awards etc)
* CoG sub-groups which during the pandemic were replaced with an Integrated Sub-Group Meeting with direct support and expertise provided by the Executive Directors and NEDs along with the introduction of governor attendance at Board Committee meetings as observers.
* Market/benchmark information presented to Nominations and Remuneration Committee members – expertise and full support provided by Director of Corporate Affairs/ Company Secretary and Chief People Officer;
* New Governors have the opportunity to access peer support from an experienced Trust Governor ‘buddy’;
* Lead and Deputy Lead Governor have previously participated in the Board site visit programme (rolled out to the full CoG from Apr19) which will be reinstated post pandemic and relaxation of IPC measures;
* Director of Corporate Affairs’ and team support to Governors and to Governor Forum, and communications such as Governor update email and Governor extranet with access to the CEO webinars;
* Direct access to senior leaders to address assurance concerns;

COVID-19 has challenged the delivery of some training activities, for example site visits and face to face training, since March 2020. The Trust has however facilitated virtual meetings/digital options. Governor sub-group meetings have also recommenced in 2022, focused around Safety & Clinical Effectiveness, Patient & Carer Experience and Staff Experience.

 ***Certification for Academic Health Science Centres (AHSC)***

Formerly, this certification was required under Appendix G of Monitor’s Risk Assessment Framework (only required for trusts that were part of a joint venture or AHSC). The Risk Assessment Framework was replaced during 2016 by NHSI’s Single Oversight Framework and now the System Oversight Framework and self-certification on AHSCs and governance is no longer required.

To remind the Board of those past requirements, and so Board continues to give due consideration to its AHSC (now Oxfordshire Academic Health Partnership) and governance, the historical requirements are contained in the list below:

* 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; a
* engage the governors of the Trust in the development of plans and give them an opportunity to express a view on these plans.