Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Confidential Trust Board Meeting: Monday 10 July 2023

CoG2024.17

Title:	**Provider Licence Self-Certification**

Status:	**For Discussion**
History:	Annual Self-Certification (TBC2023.41 for 2022/23 year)

Board Lead:	**Chief Assurance Officer**
Author:	**Joan Adegoke, Corporate Governance Officer**
Confidential:	**Yes**
Key Purpose:	**Assurance**

1. Background

1.1. NHS Improvement requires NHS Foundation Trusts to self-certify the following declarations annually:

- Condition G6(3) – the Trust has complied with the conditions of the NHS provider licence, NHS Acts and NHS Constitution. This declaration must also be published;
- Condition CoS7(3) – the Trust has the required resources available to provide services if providing commissioner requested services. For OUH this represents all services that were provided at initial licencing. NHS foundation trusts designated as providing CRS must self-certify under Condition CoS7(3);
- Condition FT4(8) – the Trust governance systems achieve the objectives set out in the licence condition;
- Training of governors – governors have received sufficient training and guidance to carry out their roles.

1.2. The aim of the self-certification is for Trust Boards to assess whether they comply with these conditions. There is no process prescribed by NHS Improvement but templates have been provided for Boards to use. As a Foundation Trust, the views of the Council of Governors should be sought.

1.3. This paper outlines the ways in which the Trust's governance framework, its committee structure, regular cycle of business and external review, including by independent external auditors, regulatory bodies, and the activities of the Council of Governors contributes to robust governance and compliance with the terms of the provider licence.

2. Sources of Evidence

2.1. Corporate Governance is the combination of leadership, systems of internal control, risk management, and assurance that together enable the Trust Board to direct and control the Trust safely, sustainably, and in accordance with legislative and regulatory requirements. Assurance is derived from the evidence provided to the Board by the management of the Trust, the auditors, external review bodies, and independent stakeholders.

Governance Framework

2.2. There are four key documents: the Trust Constitution (revised July 2021), the Standing Financial Instructions (revised November 2023), Board

Reservation and Delegation of Powers (revised November 2023) and Limits of Delegation Policy (revised November 2023) revised against the new Code of Governance. Between them, they provide the governance framework with its supporting protocols (election rules, standing orders) and set out what responsibilities the Board has delegated and what responsibilities it has chosen to retain.

2.3. The principles of the NHS Constitution are reflected in the Trust's own Constitution and in its values as a provider. As part of the revision process, the Trust Constitution was assessed for, and confirmed to meet, legal and regulatory compliance. The Code

2.4. The Standing Orders for the Trust Board and Council of Governors support the operation of the Trust within its governing documents. If the Standing Orders are suspended, this must be recorded in the minutes and no formal business may be transacted. In the case of the Trust Board, the Audit Committee must review every decision to suspend the Standing Orders. For both the Council of Governors and Trust Board, instances of non-compliance with the Standing Orders are required to be reported and reviewed at the next formal meeting.

2.5. During 2023/24 a detailed review was also undertaken of the Trust's compliance with the provisions of the Code of Governance for NHS Provider Trusts. This was reported to the Integrated Assurance Committee and provided assurance that the Trust's compliance with the main provisions of the Code and FT ARM was being reviewed as part of the preparation of the Annual Report and that the "comply or explain" provisions and information provisions in the Code had been met.

Committee Structure

2.6. The committees of the Board (Audit Committee, Integrated Assurance Committee, Investment Committee and Remuneration and Appointments Committee) have been constituted to provide scrutiny and assurance in key areas:

- Audit Committee: assure the Trust Board on the Trust's system of internal control through independent and objective review of financial and Corporate Governance, and risk management arrangements, including compliance with the law, guidance, and regulations governing the NHS.
- Integrated Assurance Committee: provide a structured forum for receiving, scrutinising and triangulating the main sources of evidence across the Trust to enable the Board to assess its level of confidence in the assurances provided regarding organisational performance, in the quality, effectiveness and safety of services across the organisation,

and the appropriate identification, assessment and management of risks.

- Investment Committee: advising the Trust Board in relation to investments.
- Remuneration and Appointments Committee: one of its responsibilities is to ensure that succession planning and skills assessments are undertaken as necessary in relation to staff covered by its Terms of Reference (Chief Executive Officer, Chief Officers, Divisional Directors, and all other VSMs who are not covered by Agenda for Change or Medical and Dental Terms and Conditions).

2.7. The Trust's executive decision-making committee, the Trust Management Executive (TME), is tasked with the operational delivery of the Board's approved strategic direction and objectives. TME's specialist sub-committees support review and scrutiny to inform TME decision-making and oversight. The cycle of business of the Board, its committees, and TME provides evidence and assurance that the conditions of the provider licence are appropriately reviewed and monitored.

Cycle of Business

2.8. Reporting presented to the Board, or to its committees, most relevant to the provider licence is set out in the table below.

Regular Report	**Committee**	**Frequency (minimum)**
Board Assurance Framework and Corporate Risk Register	IAC	CRR to each meeting and BAF available in the reading room for each meeting
	Audit	every meeting (excluding the meeting to discuss the Annual Report and Accounts)
	Board in Public	every 4 months
Integrated Performance Report (indicators directly relevant to conditions of provider licence)	IAC	every meeting
	Board in Public	every meeting
Divisional Reviews	IAC	4x per year
Committee Reports (TME, IAC, Audit)	Board in Public	report provided to the Board following each Committee meeting, including an Annual Report which includes an effectiveness review
Committee Reports (Investment)	Board in Private	report provided to the Board following each Committee meeting, including an Annual Report which includes an effectiveness review
Register of Interests, Gifts, and Sponsorship	Audit and Board in Public	annually

Regular Report	Committee	Frequency (minimum)
Annual Governance Statement	Audit	annually
	Board in Private	annually
Staff Survey	Board in Private	annually
Going Concern Analysis	Audit	annually
Annual Plan (including finance, people, activity)	Board in Private	annually
Fit and Proper Persons Assurance	Board in Public	annually
Capital Prioritisation	Board in Private	annually

2.9. Two crucial reports for the Board are the Integrated Performance Report (IPR) and the Board Assurance Framework and Corporate Risk Register (BAF/CRR) to review the risk appetite. The IPR is considered by either the Board or Integrated Assurance Committee at each meeting; the BAF/CRR is considered by the Board three times each year and at most meetings of the Audit Committee. The CRR is considered at every meeting of the Integrated Assurance Committee with the BAF available for reference in the reading room.

2.10. The IPR consolidates data from across the Trust against a range of indicators to provide a snapshot of performance. The BAF identifies existing risks in relation to patient care, quality, IT, operational and financial performance, staff recruitment and retention, and other areas. The controls and level of assurance for each are mapped and a risk score assigned. Gaps in control or assurance are identified, along with mitigating actions. The CRR tracks progress toward the target level risk score in line with the Board-approved Risk Appetite Statement.

2.11. From these two reports, the Board is presented, on a monthly basis, with data and assurance directly relevant to the requirements of the self-certification of the provider licence.

2.12. Committees report regularly to the Board and provide an annual assessment of their effectiveness, which includes proposals for changes to Terms of Reference. In this way, the Trust's governance is kept "live" and responsive to changes in the environment, for example the anticipated changes as a result of the Integrated Care System.

2.13. As part of the approval of the Annual Report and Accounts, the Audit Committee and the Board review the Trust's compliance with the NHS Code of Governance. A separate Annual Governance Statement is included which details the Trust's risk and control framework, the work of

Board committees, Board membership, processes to enable the discharge of statutory functions and legislative requirements, workforce safeguards, compliance with CQC, efficient use of resources and a general review of effectiveness.

2.14. The TME cycle of business demonstrates executive oversight and review to support the Board in key areas related to the provider licence: compliance with the health care standards, effective financial decision-making, risks to licence conditions, business planning, compliance with legal requirements, and sufficient appropriately-qualified staff.

External Review

2.15. The Trust Board can be confident that relevant assurance is also received from external sources, including regulatory bodies. In instances where full assurance is not obtained, action plans are developed and monitored by relevant committees in the governance structure.

2.16. Internal Audit undertakes a rolling programme of work to review internal processes. The programme is agreed by the Audit Committee and each cycle includes a review of governance – corporate, divisional, or both. The most recent Internal Audit report in relation to Corporate Governance (2023/24) gave an advisory statement and recommendations for improvement which are currently being implemented.

2.17. In 2023/24, the Committee reviewed the results of two unrated advisory reports on the Corporate Governance Framework and HFMA guidance on financial sustainability. In 2023/24, audits of Corporate Risk Register and the Board Assurance Framework were carried out to support the Board's assessment of its governance.

2.18. External Audit provides assurance on the Trust's financial position. This includes an assessment of value for money, risk identification and management, and the Trust's plans for managing its resources to ensure it continues to deliver services. The Audit Committee receives a report from the external auditors at each meeting.

2.19. Members of the external audit team, internal audit team, and counter fraud service meet privately with the Audit Committee without Executive Directors present as part of each meeting of the Audit Committee.

2.20. The Trust is under no Enforcement Undertakings.

2.21. The Trust is subject to regular inspections, the results of which are reported to the Board, along with any required action plans. In 2023/24, Horton Midwifery Led Unit (MLU) inspection was reported to the Board.

Council of Governors

2.22. The Council of Governors has a duty to hold Non-Executive Directors (NEDs) individually and collectively to account for the performance of the Trust Board, including in those areas relevant to the provider licence, and represents the interests of the Trust's membership and local population.

2.23. Members of the Council of Governors interact with NEDs through the Patient Experience, Membership and Quality Committee and Performance, Workforce and Finance Committee, as well as by observing the public meetings of the Trust Board. The views of the Council of Governors are sought in areas relevant to the terms of the provider licence; for example, the Annual Plan, Quality Priorities and Quality Account.

2.24. The Governors' Remuneration, Nominations and Appointments Committee (RNAC) monitors the skills balance for NEDs and considers NED succession planning.

2.25. The Lead Governor provides a contact point between NHSE/I should there be concerns regarding the Trust's leadership, non-compliance with the Trust's Constitution, or risk of a significant breach of the provider licence.

2.26. At OUH, the Lead Governor role has been expanded to include regular agenda-setting meetings with the Chair, Vice-Chair and Head of Corporate Governance.

2.27. The Council of Governors plays an important role in enforcing the training requirements for new and existing Governors, providing input and insight into the Trust's Annual Plan and scrutiny of the Annual Report and Accounts, including the Annual Governance Statement.

2.28. The Trust's Constitution requires that all Governors, in order to remain members of the Council of Governors, attend the induction training available (NHS Providers GovernWell: Core Skills as well as a local induction) and complete any other reasonable training requirements. Member of RNAC undertook bespoke recruitment training. Evidence of attendance is retained, and non-compliance escalated to a full meeting of the Council of Governors.

2.29. Through its oversight of NED contributions to the Trust Board, its monitoring of NED terms of office and skills balance and Governor training completion, and by providing its views, the Council of Governors provide additional assurance that the Trust is compliant with the terms of the provider licence.

3. Recommendations

3.1. The Council of Governors is asked to:

- Note and discuss the Self-Certification templates in Appendix 1 in advance of consideration by the Board for approval.

Appendix 1

Worksheet "G6 & CoS7" Financial Year to which self-certification relates: 2023/24

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

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	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

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		

OR

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 (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	Confirmed	OK

OR

3c	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.		

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

At its meeting in public on 10 July 2024, the Board reviewed the evidence of assurance available to it in relation to Conditions G6 and CoS7 and the risk management structures in place and deteremined it was sufficient. The Board therefore confirmed compliance with the provisions of Conditions G6 and CoS7.

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 Professor Sir Jonathan Montgomery	**Name** Professor Meghana Pandit
Capacity Chair	**Capacity** Chief Executive
Date	**Date**

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

Appendix 1

Worksheet "FT4 declaration" **Financial Year to which self-certification relates** 2023/24

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	At its meeting in public on 10 July 2024, the Board reviewed the evidence of assurance available to it in relation to Condition FT4(8) and determined it was sufficient. The Board therefore confirmed compliance with the provisions of Condition FT4(8).
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	[including where the Board is able to respond 'Confirmed']
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	[including where the Board is able to respond 'Confirmed']
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	[including where the Board is able to respond 'Confirmed']
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	[including where the Board is able to respond 'Confirmed']
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	[including where the Board is able to respond 'Confirmed']

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 Professor Sir Jonathan Montgomery **Name** Professor Meghana Pandit

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

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Appendix 1

Worksheet "Training of governors" **Financial Year to which self-certification relates** 2023/24

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	Professor Sir Jonathan Montgomery	**Name**	Professor Meghana Pandit
Capacity	Chair	**Capacity**	Chief Executive
Date		**Date**	

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

A: