Approved at Board of Directors meeting held 11 May 2023
Approved at Council of Governors meeting held 22 June 2023

NHS Provider Licence Self-Certification
Report to Audit Committee 22nd May 2023

1 EXECUTIVE SUMMARY

1.1 The Board is required to make a number of declarations at the year-end for the period 2022/2023. In respect of its annual plan the self-certification set out below is required.

1.2 The Declarations are required by NHSE but do not need to be submitted unless specifically requested by them. However, the declarations in respect of conditions 6 and 7 must be signed off by the chair and chief executive 31st May and the declaration in respect of FT 4 must be published by 30th June.

1.3 The declarations are informed by the Annual Governance Statement, the Annual Accounts, and the Internal Audit opinion.

1.4 The options available are "confirmed" or "not confirmed". If the declaration is not confirmed the Trust are invited to provide summary explanatory information.

2 BACKGROUND INFORMATION

2.1 *Declaration 1&2:*

General Condition 6 (G6) - Systems for compliance with license conditions (FTs and NHS trusts)
The Board is required to confirm it is compliant with the following certification or explain why it can't certify itself as compliant.

Following a review for the purpose of paragraph 2(b) of license condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the license, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

It is recommended that a **"confirmed"** declaration is made.

Continuity of service condition 7 – Availability of Resources
The Board is required to make one of the following three declarations[1]

3a. After making enquiries the Directors of the Licensee have reasonable expectations 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 enquires the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources[2] *available to it after taking account in particular (but without limitation) and 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*

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.

[1] The period of 12 months, is the 12 months from the date of the certificate
[2] Required Resources include: management resources, financial resources and facilities, personnel, physical and relevant asset guidance.

It is recommended that **'confirmed'** declaration is made against 3a. In making this declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Trust's financial operational plans, Cost Improvement Programme and working capital requirements are under continual review to ensure resources are effectively applied.

The withdrawal of central resources to deal with ongoing COVID-19 and the drive to restore and recovery activity to pre-covid levels has imposed pressures on the Trusts revenue resources throughout the financial year 2022/23. Looking forward the Trust will have a continued requirement to invest resources to meet the targeted initiatives to address the high number of patients on the waiting lists for both the Trust and the wider System.

The shift towards System working is evolving with increased emphasis on financial parity and risk share amongst providers. Based on the Trust's understanding of resource allocation for 2023/24 it will be extremely challenging to deliver a break even position for the Trust.

2.2 *Declaration 2:*

Condition FT4 - Corporate Governance Statement
The Board is required to indicate it is compliant with the following statements, or if not, state why it is non- compliant. In addition, the Board is invited to identify any risks and mitigating actions in relation to each of the statements.

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.

It is recommended that a **"confirmed"** declaration is made as the Board is assured from the work of the Audit Committee, its Internal and External Auditors and their opinions received during the year. The Trust has no significant control issues, this is reflected in the Trust's Annual Governance Statement.

2) The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.

It is recommended that a **"confirmed"** declaration is made as The Trust Secretary works closely with the Board, Audit Committee and Executives on matters of NHSE guidance and any impact / improvements to be made within Trust systems as a result.

3) The Board is satisfied that the Trust 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.

It is recommended that a **"confirmed"** declaration is made.

The Board has an established sub-committee system with clear responsibilities as described in the Scheme of Delegation. The work plans of each committee are reviewed during the year as part of a comprehensive Committee Effectiveness Review. The findings from the Review are used to inform on development and improvements as required. The exception reporting introduced for each Committee up to the Board continues to work effectively.

Risks/Mitigations: The Board acknowledged the need to review the "Ward to Board" reporting arrangements and commissioned an external Well-Led developmental review that concluded during quarter 4 of the preceding year. Findings of the review have been prioritised and an action plan developed and delivered to reflect the recommendations as set out in the feedback report. The Board had received regular updates to maintain oversight of the plan.

4) The Board is satisfied that the Trust 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.

It is recommended that a **"confirmed"** declaration is made.

The Board has both directly and through its Committee structure been assured that the Trust's designed systems of internal control have been operating effectively and as intended over the year as a going concern. Where issues have arisen during the year, for example in respect of operational or financial performance, timely actions have been implemented to improve these areas.

Assurance is routinely and regularly obtained as to the quality of the data supporting the Trust's performance reporting and decisions being taken and improvements have been introduced through the adoption of Statistical Process Control (SPC) reporting. IPR structure kept under review.

Updates on progress to delivery of the Trust's Strategic plan 2021 - 2024 is provided to the Board of Directors on a quarterly basis. The Board Assurance Framework (BAF) provides a structure and process that has been comprehensively refreshed and relaunched to focus on the key risks that might compromise the achievement of the Trust's strategic goals. Each BAF risk clearly sets out the inherent risk score, residual risk score and the target risk score. Key controls, the gaps in those key controls and the mitigating actions for those gaps are clearly articulated in each BAF risk. Each committee of Board receives their individual BAF risks scheduled throughout the year tabled by the Executive lead for that risk. The Board of Directors receive a one page summary of the BAF at its public meetings.

In the current year, the Trust has not received any regulatory notices.

The Trust adopts a robust approach to developing its Annual Plan. Key risks and associated assurance have been reported to the Audit Committee and Board during the year and the process has been subject to Internal Audit review which concluded positively over the Trust corporate risk and assurance processes.

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 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.

It is recommended that a **"confirmed"** declaration is made as there is clear leadership and accountability for the delivery of high quality and safe services within the Trust. The Board both directly, and through its Committee structures, ensures that a focus is maintained on the delivery of quality services. The Trust's Quality Priorities are set in consultation with the Council of Governors and other stakeholders with regular reporting of the delivery against these priorities provided to the Board and the Council of Governors and our Commissioners. The patient experience strategy was refreshed during the year and relaunched with an emphasis on acting on the patient voice. There are clear initiatives designed to engage to hear the staff voice and pursue the inclusivity agenda.

6) 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.

It is recommended that a **"confirmed"** declaration is made.

The Trust has undertaken performance reviews and 360 degree appraisals with all directors.

The Trust has developed a series of internal and externally facilitated board development activities over the year with a focus of key areas to support cohesive working in relation to the Trust Board and the wider integrated healthcare system. The Trust has an established process that ensures that all Board Members are "fit and proper" persons. The Board through its Workforce and Staff Engagement Committee has been assured over the actions being taken to mitigate the workforce risks captured on the Board Assurance framework in relation to mandatory training, recruitment and retention. Regular reporting is provided to the Board on the Trust's compliance with the nursing safer staffing levels and the revalidation of its nursing and medical workforce.

2.3 Declaration 3: Training of Governors

The Board is required to indicate it is compliant with the following statement or if not state why it is non-compliant.

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.

It is recommended that a **"confirmed"** declaration is made.

The governor training programme is constructed on a modular basis with the modules structured to support newly appointed and elected governors. These modules were run for the newly elected governors from the elections in quarters one and four as refresher for those returned for a further term of office and new governors who took up office in June and December 2022. One to one support is in place for all new governors and buddying is encouraged for those more experienced governors to support newly appointed governors. Annual training on fire safety and Infection Control is offered across the year allowing governors to attend at least one of these sessions. The Council of Governors Experience and Engagement Committee monitors the take up of induction and "mandatory" training, along with overseeing the content of the training programme utilising feedback from those attending the individual modules. All governors are offered an opportunity to access a national programme of training facilitated by NHS Providers.

A series of engagement events supplement the training and enable Governors to attend strategy workshops with the Board, coupled with presentations from elements of the Trust on their services. Whilst members of the Council regularly participate in review and inspection activities including PLACE and Quality & Safety Review audits, owing to COVID-19 this had been paused on occasion and has resumed once operational capacity allowed. Governors are also invited to attend Trust Board and its committees and receive regular update briefings hosted by the chair and fellow NEDs. The Trusts Council of Governors are supported to engage with governors across the wider system and periodically share joint training and development sessions.

The Trust is working with the Council of Governors to refresh its engagement plan for 2022- 2025 with the governors 'out there' initiative at its core supporting governors out and about in their respective constituencies. This is monitored by the Experience and Engagement Committee.

3 RISKS AND MITIGATIONS

3.1 These are contained in the body of the report

4. RECOMMENDATIONS

- ✓ That the Council receive the document for endorsement at the June 2022 meeting of the Council of Governors.

Helen Board
Board Secretary
May 2023