

## TRUST BOARD in Public

### Self-certification with regard to the Provider Licence and Review of Compliance with the Code of Governance for NHS Providers

29<sup>th</sup> May 2024

#### 1.0 INTRODUCTION

NHS Foundation Trusts are required to self-certify annually whether or not they have complied with the conditions of the NHS provider licence. In addition, NHS England (NHSE) requires the Trust to make a number of governance declarations which are certified by the Board of Directors.

NHS England (NHSE) replaced the *NHS Foundation Trust Code of Governance* on 1<sup>st</sup> April 2023 with the *Code of Governance for NHS Provider Trusts*.

The declarations required in relate to the following conditions of the licence are:

1. Condition GS6(3): Providers must certify that their Board has taken all precautions necessary to comply with the licence, NHS Act and NHS Constitution by 31<sup>st</sup> May each year and publish this by 30 June each year.
2. Condition FT4(8): Providers must certify compliance with required governance standards and objectives by 30<sup>th</sup> June each year.
3. Section 151(5) of the Health and Social Care Act 2012 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 by 30<sup>th</sup> June each year
4. Conditions to support continuity of service (CoS7): Allows NHSE to assess whether there is a risk to services and to set out how services will be protected if a provider gets into financial difficulty by 31<sup>st</sup> May each year.

As reported to the Audit Committee and Board of Directors in 2023, the Guidance on Good Governance and Collaboration was enacted by NHSE in October 2022. Therefore the Trust is also required to review its compliance in relation to this guidance for 2023-24.

The key characteristics and illustrative minimum behaviours and KLOEs have been added to the template the Trust has in place for seeking compliance with the Provider Licence (under condition FT4).

The Executive Lead is identified as the Chief Executive Officer, supported by his Executive Directors and the Associate Director of Quality and Corporate Affairs (*company secretary*).

This paper provides a summary of the Provider Licence, the contextual information and sources of assurance.

These documents are presented as follows:

- HDFT self-assessment of compliance with the Provider Licence Conditions (including the information required with regard to Good Governance and Collaboration) (Section 2 of this report and Appendix 1)
  - Statements required to be confirmed by the Board and published by the Trust (Appendix 2)
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The Board will be required to provide a specific declaration with regard to Condition FT4(8) of the provider licence in the form of the annual report. To support the self-certification against Condition FT4(8), the Board of Directors will be required to certify that they are satisfied with the risks and mitigating actions against each area listed.

The Annual Report will be presented to the Executive Management Team for sign-off prior to final submission to the Board for approval on the 26<sup>th</sup> June 2024.

## 2.0 SELF-CERTIFICATION

### **Condition GS6(3) Providers must certify that their Board has taken all precautions necessary to comply with the licence, NHS Act and NHS Constitution**

From the assurance provided the Trust Board of Directors is required to certify that it “is satisfied that, during the financial year most recently ended, it has taken all precautions necessary to comply with the licence, NHS Act and NHS Constitution.”

It is recommended as outlined in Appendix 1 that this is certified as **Confirmed**

### **Conditions to support continuity of service (CoS7)**

“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.” NB This declaration depends on the outcome of the financial planning process, therefore further information will be added in relation to the relevant factors once that process is complete.

It is recommended as outlined in Appendix 1 that this is certified as **Confirmed**

### **Section 151(5) of the Health and Social Care Act 2012 Training of Governors**

From the assurance provided the Trust Board is required to certify that it “is satisfied that, during the financial year most recently ended, the Trust has provided necessary training to its governors, as required by 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 as outlined in Appendix 1 that this is certified as **Confirmed**

### **Condition FT4(8): Providers must certify compliance with required governance standards and objectives by 30<sup>th</sup> June each year.**

Is subject to the above, and will be review as part of the Annual Report and Accounts discussed at Trust Board in June 2024.

## 3.0 RECOMMENDATIONS

The Trust Board is recommended to:

- Confirm approval of the self-certification as outline in Section 2 of this report and in Appendix 1

**Jonathan Coulter**  
Chief Executive  
May 2024

**Kate Southgate**  
Associate Director of Quality & Corporate Affairs

**Condition GS6(3) Providers must certify that their Board has taken all precautions necessary to comply with the licence, NHS Act and NHS Constitution**

The Trust is required to respond ‘Confirmed’ or ‘Not confirmed’ to the following statement. Explanatory information should be provided where required.

	<b>Statement</b>	<b>Response (and supporting information/ assurance)</b>	<b>Risks and Mitigations</b>
	<p>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</p>	<p><b>Confirmed</b> Audit Committee received the draft annual in late April 2024.</p> <p>The Trust’s Internal Audit progress report highlighted that they believe that the Head of Internal Audit Opinion would confirm that “there is a good system of internal control designed to meet the organisation’s objectives, and that controls are generally being applied consistently”.</p> <p>The Head of Internal Assurance Report is planned to be presented to the Audit Committee. This is a key piece of evidence to support compliance against this condition of the provider licence. Further evidence to support this condition includes the Board Workshops and Board meeting discussions on the Annual Plan 2023-24. This includes all known risks to compliance, risk reports presented to each Audit Committee and Board meetings, the development of the Board Assurance Framework supported by the Annual Assurance Framework Opinion from Internal Audit, Resource Committee reports, Quality Committee reports, the Integrated Board Reporting arrangements, the quality governance review and the development of the Corporate Governance Framework.</p> <p>The Trust’s information processes provide the opportunity to review performance data across multiple domains, to improve the availability and accuracy of data and the flow of information and assurance through the governance structure.</p>	<p>No risks identified</p>

**Conditions to support continuity of service (CoS7)**

The Trust is required to respond 'Confirmed' or 'Not confirmed' to the following statement. Explanatory information should be provided where required.

	<b>Statement</b>	<b>Response (and supporting information/ assurance)</b>	<b>Risks and Mitigations</b>
	This condition requires licensees to act in a way that secures access to the resources needed to operate Commissioner Requested Services.	<p><b>Confirmed</b></p> <p>The Trust complies with this condition and has agreements and contracts in place with Commissioners to continue to provide services.</p> <p>Full details are contained in the Annual Report</p>	No risks identified

**Section 151(5) of the Health and Social Care Act 2012 Training of Governors**

The Trust is required to respond 'Confirmed' or 'Not confirmed' to the following statement. Explanatory information should be provided where required.

	<b>Statement</b>	<b>Response (and supporting information/ assurance)</b>	<b>Risks and Mitigations</b>
	<p>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.</p>	<p><b>Confirmed</b>            During the year a wide range of activities have taken place to ensure that Governors have required training. This has included:</p> <ul style="list-style-type: none"> <li>• Training, learning and development opportunities are available to Governors throughout the year and a comprehensive Governor induction programme is in place for new Governors.</li> <li>• All Governors have access to the external courses programme delivered by Governwell (the National Training Programme for Governors) which is routinely publicised amongst Governors</li> <li>• Communications from a range of sources, including the Kings Fund, NHS Providers, NHS England, CQC, WYAAT, ICB and the local Healthwatch are shared with Governors as appropriate to inform and support the development of their knowledge base with regard to the national and local health economy.</li> <li>• 4 x a year Public and Private Council of Governor meetings</li> <li>• 6 weekly informal governor sessions where the Chair, Chief Executives and rotating executive directors meet with governors to brief them on key areas of business as well as respond to a wide range of questions</li> <li>• Bespoke training sessions which have included: back to basis training, code of conduct training, specific topics such as digital strategy and PSIRF</li> <li>• 2 x governors observe each sub-committee of the Board</li> <li>• Weekly governor briefing via email</li> </ul>	<p>No risk identified</p>

**Condition FT4(8): Providers must certify compliance with required governance standards and objectives**

The Trust is required to respond 'Confirmed' or 'Not confirmed' to the following statements, setting out any risks and mitigating actions planned for each one.

	<b>Statement</b>	<b>Response (and supporting information/ assurance)</b>	<b>Risks and Mitigations</b>
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.	<p><b>Confirmed</b></p> <p>The Annual Governance Statement (AGS) outlines the main arrangements in place to ensure the Trust applies the principles, systems and standards of good corporate governance expected of it as a provider of health and social care services. This was reviewed in draft at the Audit Committee in May 2024.</p> <p>There is an internal audit programme including clinical audits in place, under the direction of the Audit Committee to ensure systems and processes are appropriately tested.</p> <p>The external auditors will deliver a robust annual audit plan reporting directly to the Audit Committee.</p>	No risks identified
2.	The Board has regard to such guidance on good corporate governance as may be issued by NHS E from time to time.	<p><b>Confirmed</b></p> <p>Declaration of compliance included in Annual Report;</p> <p>NHSI segmentation as per its Single Oversight Framework;</p> <p>Well Led assessment by the CQC last rated as "Good".</p>	No risks identified
3.	The Board is satisfied that the Licensee 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	<p><b>Confirmed</b></p> <p>The Board Committee structures reporting to the Board are defined and supported through a review of Committee Terms of Reference and reporting arrangements. The Board has formally delegated specific responsibilities to the Committees listed below, summary Chair's reports and formal minutes are provided to the Board following each of their meetings.</p>	No risks identified

	<p>(c) Clear reporting lines and accountabilities throughout its organisation.</p>	<ul style="list-style-type: none"> <li>• Quality Committee</li> <li>• Resource Committee</li> <li>• Remuneration Committee</li> <li>• Audit Committee</li> <li>• People and Culture Committee</li> <li>• Innovation Committee</li> </ul> <p>The Trust's governance structure ensures the appropriate flow and review of information at service level and up through the Directorates to Senior Management Team (SMT) and SMT supporting groups, providing assurance to the Board and its Committees. The quality/clinical governance structure has been reviewed and revised, with Quality Governance Management Group playing a key role in this.</p> <p>The monthly SMT meeting provides scrutiny and monitoring of operational performance, which supports the working of the Board's Committees.</p> <p>An internal audit review of governance through the working of the Board Assurance Framework was carried out during 2023-24, the report of which is expected in May 2024 to the Audit Committee noting Significant Assurance.</p>	
	<p>The Board is satisfied that the Licensee effectively implements systems and/or processes:</p> <p>(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;</p> <p>(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;</p>	<p><b>Confirmed</b></p> <p>The Board's infrastructure includes Board scrutiny/assurance Committees and various operational groups, to ensure that the Board of Directors can be assured that the organisation's decisions and business are monitored effectively and efficiently.</p> <p>There are clear escalation routes up to the Board of Directors (as described above).</p> <p>b) SMT and supporting groups scrutinise key areas of performance including quality, workforce, finance, operational and contractual. The Committees review performance and risk by exception (and in accordance with ToR) at each meeting and subsequently provide</p>	<p>No risks identified</p>

	<p>(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;</p> <p>(d) For effective financial decision-making, management and control <i>(including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern)</i>;</p> <p>(e) To obtain and disseminate accurate, comprehensive, timely and up to</p>	<p>assurance to the Board of Directors through the Chair's reports highlighting any key recommendations or key risks identified.</p> <p>c) The Quality Committee reviews the patient experience and quality report, with quality performance data available and the Trust's compliance with CQC fundamental standards using an on-line tool to support service self-assessments against the CQC domains.</p> <p>An approved Quality Improvement and Audit Programme is in place, overseen by the Audit Committee.</p> <p>The Trust will also produce a Quality Account in accordance with regulatory requirements.</p> <p>d) The Trust reviewed its Standing Financial Instructions (SFIs) in 2019/20 to reflect current procurement practices and to respond to COVID; this determines the agreed framework for financial decision making, management and control. Following consideration by the Audit Committee and Board these temporary changes were made permanent in 2020/21. The SFIs are due for full review in 2024-25</p> <p>Systems of internal control are in place and are subject to regular audit on an annual basis through the Trust's internal audit programme and by external auditors.</p> <p>The Resource Committee and Audit Committee are the principal Committees that maintain oversight on this area. It is determined that there are robust systems and processes in place to monitor and oversee all CIP schemes.</p> <p>The Trust has a good track record of effective financial management and of achieving its statutory financial duties and this is of particular note during the COVID pandemic period.</p> <p>e) The Board and Committee meeting dates are scheduled to allow the most up-to-date information to be provided to meetings for scrutiny and assurance.</p>	
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	<p>date information for Board and Committee decision-making;</p> <p>(f) To identify and manage (<i>including but not restricted to manage through forward plans</i>) material risks to compliance with the Conditions of its Licence;</p> <p>(g) To generate and monitor NHS Improvement delivery of business plans (<i>including any changes to such plans</i>) and to receive internal and where appropriate external assurance on such plans and their delivery; and</p> <p>(h) To ensure compliance with all applicable legal requirements.</p>	<p>The Standing Orders for the Practice and Procedure of the Board of Directors enable the Chair to call a meeting of the Board at any time.</p> <p>The review of the quality governance framework as well as the introduction of the Corporate Framework is evidence of continued review and refresh required to ensure the information provided to the Board is timely and up to date.</p> <p>f) The Trust has an approved Risk Policy in place, the Board Assurance Framework (BAF) and Corporate Risk Register provide the framework through which risks are considered, reviewed and managed.</p> <p>The Board receives a summary of the Corporate Risk Register.</p> <p>The Board Assurance Framework forms the basis of the structure to Trust Board in Public and each section is reviewed at each Sub-Committee of the Board. The Audit Committee retains overall review of the process for the development of the BAF. The BAF is in the process of being revised for 2024-25 to align to the HDFT Impact Programme.</p> <p>g) The Trust has an Annual Planning process that ensures future business plans are developed and supported by appropriate engagement across the organisation. The Annual Plan is discussed in detail at the Resource Committee and by the Board before this is approved.</p> <p>h) The governance, risk and control processes in place ensures that any risks to legal requirements are considered to ensure the Trust remains compliant.</p>	
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<p>5.</p>	<p>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:</p> <p>(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;</p> <p>(b) That the Board's planning and decision making processes take timely and appropriate account of quality of care considerations;</p> <p>(c) There is collection of accurate, comprehensive, timely and up to date information on quality of care;</p> <p>(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;</p> <p>(e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other</p>	<p><b>Confirmed</b></p> <p>a) There are appraisal processes in place to support Board members individually and collectively. The outcome of appraisals are reported to the Remuneration Nomination and Conduct Committee for Non-executive Directors, including the Chair and to the Remuneration Committee for the Executive Directors including the Chief Executive.</p> <p>b) There are QIA and EIA processes in place to support decision making processes for any service development or changes and any impact on the quality of care is carefully considered.</p> <p>c) The Quality Committee supports the monitoring of information on the quality of care; the monthly SMT receive a quality performance report from the Executive Director of Nursing, Midwifery and AHPs and the Executive Medical Director and the Quality Committee consider a detailed patient experience and quality report. Review and refresh of the quality/clinical governance in 2020/21 aims to further strengthen this area.</p> <p>The Quality Committee Chair reports any key decisions, risks and escalations to the Board.</p> <p>d) As above - the Board receives a report from the Quality Committee Chair and receives approved minutes of the Committee at the Board meeting held in private. The Board also receives the Quality Account.</p> <p>e) The Board, both Executive and Non-executive Directors play an active part in the organisation and the visibility of this was highlighted in the NHS Staff Survey. This has been further enhanced in year with</p>	<p>No risks identified</p>
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	<p>relevant stakeholders and takes into account, as appropriate, views and information from these sources; and</p> <p>(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.</p>	<p>a programme of “Meet the Executives” and “Walk-arounds” being development.</p> <p>Freedom to Speak Up arrangements were strengthened with the support of associate FTSUGs and champions, the “At Our Best” programme to support the cultural agenda, the health and well-being offer was particular strengthened, which was all overseen by People and Culture Committee.</p> <p>One of the Non-executive Directors (NED) is nominated as a NED lead to support ‘Freedom to Speak Up’ for the Trust and the Executive Director of Nursing, Midwifery and AHPs support the assurance arrangements in place to provide advice and support to the Board as necessary.</p> <p>The members of the Board, meet with the Council of Governors formally 4 times a year with 6 weekly informal meetings being held. Ad hoc activities are also programmed in through out the year.</p> <p>f) There is clear accountability for quality of care through the governance structures in place across the Trust, which reported to the Executive Director of Nursing, Midwifery and AHPs and the Executive Medical Director supported by the Associate Director of Quality and Corporate Affairs.</p>	
6.	<p>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.</p>	<p><b>Confirmed</b></p> <p>All members of the Board, Clinical Directors, relevant Deputy Directors and those that carrying out a role to provide advice to the Board comply with the requirements of the Fit and Proper Persons Regulation. All members of the Board and senior decision makers are required to comply with the declaration of interests including loyalty interest policy, which was refreshed and processes and systems strengthened during the year.</p>	No risks identified

		<p>The annual appraisal process supports effective succession planning through talent conversations and a number of senior managers are engaged in national programmes to support their development to Director level, as appropriate.</p> <p>The Board of Directors during the year had considered its development needs discussing through its Board Workshops. External facilitation was engaged to support the Board development agenda throughout the year.</p>	
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## **Appendix 2 – Statements Required to be Confirmed by Board by May and June 2024**

### **1. Statements required to be confirmed by Board by 31 May 2024**

#### **G6 Declaration**

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.

#### **CoS7 Declarations**

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.

### **2. Statements required to be confirmed by Board by 30 June 2024**

#### **FT4 Declaration**

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

### **3. Certification on Training of Governors in accordance with s151(5) of the Health and Social Care Act 2012**

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.

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