**NHS Provider Licence Self-Certification**

**Executive Summary**

**Condition FT4**

1. NHS Foundation Trusts must self-certify under condition FT4 (8) and review whether their governance systems achieve the objectives set out in the licence condition. Details of Condition FT4 are outlined in Appendix 1. This is also known as the Corporate Governance Statement.
2. Appendix 2 contains the evidence received by the Board of Directors which enables a declaration of compliance with each statement to be made. In the event that an NHS 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.
3. Based on the evidence set out in Appendix B, it is recommended that the Condition FT4 self-certification is formally signed-off as Confirmed.

**Condition G6 / CoS7**

1. Conditions G6 and CoS7 require NHS Foundation Trusts to have systems for compliance with licence conditions and related obligations. Details of Conditions G6 and CoS7 are outlined in Appendices 3 and 4.
2. Only NHS Foundation Trusts designated as providing commissioner requested services (CRS) must self-certify under Condition CoS7.
3. For information, the Trust provides the following NHS England commissioner requested services:
* Central Nervous System Tumours
* Spinal Surgery
* Neurosciences
* Neurosurgery
* Specialised Pain
* Specialist Rehabilitation for Complex needs
* Stereotactic Radiosurgery
* Thrombectomy
1. Appendix 4 outline the assurances received by the Board of Directors which enable a declaration of compliance with each statement to be made. Based on the evidence set out in Appendix 4, it is recommended that the Condition G6 and CoS7 self-certifications are formally signed-off as Confirmed.
2. NHS Foundation Trusts are also required to confirm (or otherwise) the following declaration:

***“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 section 151 (5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.”***

1. Although training of Governors is not a licence condition, the Board should be satisfied that during the financial year the Licensee has provided the necessary training to its Governors as set out in the HSCA 2012 to ensure they are equipped with the skills and knowledge they need to undertake their role. Appendix 5 sets out the training delivered in 2022/23.

**Background and Analysis**

1. The Trust currently holds an NHS Provider Licence - No. 130132
2. Upon establishment NHS Foundation Trusts are issued with an NHS Provider Licence and on an annual basis are required to self-certify whether or not they have:
3. Complied with the conditions of the NHS Provider Licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution),
4. The required resources available if providing commissioner requested services (CRS), and
5. Complied with governance requirements.
6. Failure to meet the range of conditions of the NHS Provider Licence for a licenced provider can lead to NHS Improvement imposing compliance and restoration requirements or monetary penalties. NHS Improvement now incorporates Monitor which is the regulatory body for Foundation Trusts referred to throughout the licence.
7. The Trust is no longer required to submit this certification (as set out in point 8 Appendix 1 and Appendix 3 point 3) but must publish this statement of compliance on its website and regulators may undertake random audits of compliance.

**New Provider Licence**

1. In April 2023 the Trust received a new version of its Provider Licence from NHS England following a consultation and review of the standard conditions which was reported to Audit Committee and Board during 2022/23. The changes to the licence reflect the new statutory picture and associated legal and policy requirements, including in relation to system working, the triple aim and climate change. It also introduces a number of technical changes, aimed at reducing burden and bringing the licence up to date.
2. As part of reducing the burden the annual self-certification publication process reported to Audit and Board alongside the annual report each year will not be required for the new licence and this will be last such report received and published.

**Conclusion**

1. The Trust continues to meet the conditions of its Provider Licence and has in place good systems of corporate governance.

**Recommendation**

* + - To approve the self-certification statements

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**Date: June 2023**

Appendix 1 – Compliance with Condition FT4

Appendix 2 – Compliance with Condition FT4(8)

Appendix 3 – Compliance with Condition G6

Appendix 4 – Compliance with Condition CG6 and CoS7

Appendix 5 – Governor Training

**Appendix 1**

**Condition FT4**

**NHS Foundation Trust Governance Arrangements**

1. This condition shall apply if the Licensee is an NHS Foundation Trust, without prejudice to the generality of the other conditions in this Licence.
2. 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.

3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:

1. Have regard to such guidance on good corporate governance as may be issued by Monitor from time to time; and
2. Comply with the following paragraphs of this Condition.
3. The Licensee shall establish and implement:
4. Effective board and committee structures,
5. Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees, and
6. Clear reporting lines and accountabilities throughout its organisation.

5. The Licensee shall establish and effectively implement systems and/or processes to ensure compliance with the Licensee’s duty to operate efficiently, economically and effectively:

1. For timely and effective scrutiny and oversight by the Board of the Licensee’s operations.
2. 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.
3. 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).
4. To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and committee decision-making.
5. To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence.
6. 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.
7. To ensure compliance with all applicable legal requirements.
8. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:
9. That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided,
10. That the Board’s planning and decision-making processes take timely and appropriate account of quality of care considerations,
11. The collection of accurate, comprehensive, timely and up to date information on quality of care,
12. That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care,
13. 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
14. That there is clear accountability for quality of care throughout the Licensee’s organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee’s organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

8. The Licensee shall submit to Monitor within three months of the end of each financial year:

1. A corporate governance statement by and on behalf of its Board confirming compliance with this Condition 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; and
2. If required in writing by Monitor, a statement from its auditors either:
	* 1. Confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its corporate governance statement applicable to the past financial year, or
		2. setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year.

**Appendix 2**

 **Evidence of Compliance with Condition FT4(8)**

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| **Condition FT 4(8)** |
| **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.** |
| In confirming the above statement the Board has considered: 1. The Trust’s Annual Governance Statement 2022/23 was presented to the Board for approval on 18 June 2023 as part of the Annual Report & Accounts 2022/23. This 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.
2. The Governance Statement defines the Trust’s:
	* Scope of responsibility
	* Governance Framework
	* Quality governance arrangements
	* Regulatory Requirements
	* Risk and control framework,
	* The effectiveness of risk management and internal control
3. The Board of Directors has approved a robust corporate governance framework including Standing Financial Instructions, Scheme of Reservation and Delegation, Standards of Business Conduct and the Constitution. These are reviewed on a regular basis to ensure they are fit for purpose and reflect changes in national guidance. In 2022/23 the Board of Directors reviewed the revised delegated financial limits set under emergency powers arrangements to ensure timeliness of decision-making in the context of the Covid-19 pandemic situation and agreed that these could be stepped down.
4. Over the last three years, the Trust’s governance arrangements have been subject to a series of reviews, the findings of which were utilised to inform changes to committee terms of reference and membership. Such reviews included:
	* A Care Quality Commission inspection in 2019 which resulted in an overall rating of ‘Outstanding’ including a rating of ‘Good’ for Well-Led.
	* Annual reviews of Committee Effectiveness for all Committees that report into Board in 2022/23.
	* An external Well Led Assessment against the NHS England Well Led Framework in 2023
	* Board Effectiveness self-assessment in April 2022 and 2023.
	* Council of Governors Effectiveness self-assessment in April 2022 and 2023.
	* Annual Internal Audit review of the Trust’s assurance framework.
5. The Board of Directors has a dynamic Board development programme in place that ensures the performance of the Board is reviewed appropriately. Once a year this session includes senior managers from across the Trust.
6. The Trust has arrangements in place to ensure that guidance issued by NHS England is received and issued to all members of the Board of Directors via the Chair and Chief Executive’s reports to Board, key compliance reports and regular Non-Executive Director briefings. These items are also brought to the attention of the Audit Committee via External Auditors and are responded to through a regular update report to Audit Committee. In 2022/23 changes to the Code of Governance, Provider Licence and consultation on the associated enforcement regime were discussed at Board.
7. Following the completion of any external or internal review, it is confirmed if any actions are required by the Trust to ensure that best practice and/or regulatory requirements are met. The Trust’s External Visits Policy outlines how such action plans are monitored and the relevant committees with responsibilities for this. A summary report of external reviews is presented to the Audit Committee. This process was reviewed in 2022/23 to ensure that it remains fit for purpose.
8. The Board has a well-established committee structure that provides for effective review, scrutiny and decision making on the priority areas of the Board’s business, namely quality of care, financial performance, operational delivery, strategy and governance. This structure is regularly reviewed to ensure it remains appropriate.
9. All Board committees are supported by terms of reference which are reviewed on an annual basis as a minimum. These terms of references reflect the delegation of powers in the Scheme of Reservation and Delegation.
10. The Board reviews the performance of its committees on a regular basis to ensure that they are discharging their duties as defined by their terms of reference, and to ensure they continue to remain focused on the needs of the Trust going forward. In 2022/23 a standardised process for reviewing the effectiveness of those groups reporting into Committees was also introduced.
11. There is an established reporting programme in place that ensures the Board committees report to the Board, and that the Board committees are provided with the necessary range of information and reporting to enable them to discharge their responsibilities. The Chair of each Board committee presents a Chair’s Report to each public meeting of the Board of Directors to advise the Board of the committee’s activity and to escalate any issues, concerns or risks as appropriate.
12. The Board has an annual Internal Audit Programme in place, under the direction of its Audit Committee to ensure its key control systems are prioritised and tested.
13. There is a clear accountability structure in place throughout the Trust. This defines the responsibilities of the Executive Team through the Scheme of Reservation and Delegation and the operational structures under their control. In line with good practice, executive portfolios are reviewed as necessary to ensure adequate capacity.
14. The accountability arrangements are clearly set out in the Annual Governance Statement 2022/23 submitted to the Board of Directors in June 2023 for approval.
15. The Board’s infrastructure, namely the committees of the Board of Directors together with various operational groups, ensures that the Board of Directors is assured that the organisation, decisions and business of the Trust is monitored effectively.
16. This is undertaken through agreed annual cycles of business (approved by the committees) to ensure the Board of Directors, Council of Governors and committees are able to review and consider key areas including quality of care, workforce performance, financial performance, operational performance, digital transformation and risks to the Trust’s quality, resources, reputation and regulatory requirements.
17. The Board has established processes in place to review Quality Improvement Programmes (QIPs) that ensure proposed changes are appraised in respect of benefits and impact alongside the formal processes of Quality Impact Assessments. These are reported through to the appropriate Board Committee as well as the Hospital Management Group.
18. The Business Performance Committee considers, in detail, the Trust’s financial performance at each meeting to ensure achievement of statutory financial duties.
19. The Board receives regular performance reports in respect of quality and safety, workforce, financial and external performance through the Integrated Performance Report (IPR). This provides an overview of the Trust’s operations and ensures the appropriate escalation and monitoring of ongoing areas of concern.
20. The Quality Committee reviews, in detail, the quality of care through a performance dashboard and a governance report which enables the triangulation of intelligence including (but not limited to), quality visits, incidents, complaints and safer staffing.
21. A Clinical Audit Programme is developed on an annual basis, implementation of which is overseen by the Quality Committee to ensure a culture of clinical excellence. This is supported by a Service Transformation Programme which focuses on service and quality improvements. The Audit Committee also receive an annual report and plan to ensure that the process of Clinical Audit is working appropriately.
22. In addition to the above systems and processes, the Board has reviewed and approved, with input from Governors its Quality Priorities that outline the areas of focus for improving and monitoring the existing quality surveillance systems across the Trust for monitoring standards of care. Progress against this is reported to the Trust Board and externally through the Quality Account.
23. The trust has clear Standing Financial Instructions (SFIs) and a Scheme of Reservation and Delegation of Powers (SoRD) in place that determines the agreed framework for financial decision making, management and control.
24. There is an established and appropriate governance structure in place to ensure the SFIs and the SoRD are complied with and decision making and control relating to financial matters is effective via oversight by the Business Performance Committee and also by the Audit Committee.
25. Systems and processes are in place to scrutinise all QIP plans for both financial and quality impact prior to implementation and to monitor both delivery and in-year changes through the Business Performance Committee.
26. The Trust has a history of effective financial management and of achieving all statutory financial duties.
27. The Board and committee meeting dates are scheduled to allow the most up-to date information to be provided to meetings. Where necessary, meeting dates are revised to ensure contemporaneous data is available.
28. The Trust has an annual planning process that ensures future business plans are identified at the early stages and are supported by appropriate engagement and approvals to proceed.
29. The direction of the Trust is outlined in the Trust’s Strategy 2022-2025 which sets out the Trust’s strategic ambitions. This is underpinned by seven enabling strategies: Quality, Financial and Commercial Development, People, Digital, Estates, Facilities & Sustainability, Communications and Marketing and Charity.
30. Progress against the Annual Operating Plan is reviewed during the year through the Business Performance Committee and is monitored through the monthly Integrated Performance Report which is also reported to the Board of Directors
31. For individual plans the Trust has a well-established business case process in place to ensure an appropriate and clear rationale is provided, risks are understood, and timelines are clear. This includes review at Hospital Management Group which is a forum with executive directors and senior managers to ensure that the Trust-wide implications of any business case are understood and considered.
32. The Board has a Risk Management Framework Strategy in place, which includes a risk appetite statement which was reviewed in 2023.
33. The Board Assurance Framework and Risk Register provide the framework through which risks are considered, reviewed and managed. The risks are managed through the committee structure and divisional risk and governance groups and changes are reported formally, via the appropriate Board Committee Chair’s Report, the Executive Team and through the Board Assurance Framework to the Board of Directors. This includes risks to the delivery of constitutional standards and statutory duties.
34. All risks rated 12 and above are regularly scrutinised by the Executive Team and by the Quality, the Business Performance Committee and the Research, Innovation & Medical Education (RIME) Committees.
35. The Trust’s Board Assurance Framework is subject to an internal audit review on an annual basis. The most recent audit of Board Assurance Framework undertaken in January 2023 concluded that the Board Assurance Framework is structured to meet NHS requirements, is aligned with the Trust’s strategic plan, is visibly used by the organisation, and has actions in place to address any gaps identified.
36. The recruitment process for Board members ensures that members have the appropriate skills and knowledge to fulfil their duties and that all members satisfy the requirements of the Fit and Proper Persons Test
37. The Board’s development programme ensures that the Board is equipped with the necessary knowledge and skills, to provide clear and effective leadership focussed on delivering quality care. Executive portfolios are kept under review to ensure there is sufficient capacity to deliver the strategy.
38. There are effective appraisal processes in place to support the Board members individually and collectively and the recruitment processes for new Board members is informed by a review of the Board’s skills and knowledge.
39. The Board is engaged with the quality agenda and receives regular patient stories at meetings of the Board to ensure that it remains focused on the quality of patient care. The Executive Team conduct walkabouts to chat to staff, patients and families and determine if any issues are present. Non-Executive Director and Governor walkabouts were reinstated in 2022/23 following the easing of restrictions in place for the Covid-19 pandemic. Feedback from these are reported to the Quality Committee so that the Board members can triangulate data that is collected from various sources. This enables further discussion, questioning and support where required.
40. The Trust has a Freedom to Speak Up Policy in place to support staff in raising concerns. Staff are aware of the policy and have direct access to the Freedom to Speak Up Guardian and a number of champions in different teams and wards. The Guardian reports to Trust Board regularly and any themes of concerns are monitored. The Board has nominated a Non-Executive Director to be a Freedom to Speak Up champion. The Freedom to Speak Up Guardian can also meet with the Senior Independent Director at any time to ensure that any matters that may relate to the Chair or Chief Executive can be addressed if required.
41. The above governance, risk and control processes ensure that the Trust remains compliant with all the legal requirements pertaining to it and its business.
42. The Trust seeks legal advice where appropriate.
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| **Risk and Mitigations** **Risk:** Systems and processes become dated or not fit for purpose as a result of environmental or system change including new business.**Mitigation:**Corporate Governance Systems require ongoing testing via the Board Committee structure and in addition, systems and controls assurances are obtained via the Audit Committee. **Appendix 3**  |

**Condition G6**

**Systems for Compliance with Licence Conditions and Related Obligations**

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:

1. The Conditions of this Licence,
2. Any requirements imposed on it under the NHS Acts, and
3. 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:

1. The establishment and implementation of processes and systems to identify risks and guard against their occurrence, and
2. Regular review of whether those processes and systems have been implemented and of their effectiveness.

3. Not later than two months from the end of each financial year, the Licensee shall prepare and submit to Monitor a certificate to the effect that, following a review for the purpose of paragraph 2(b) 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 this Condition.

4. The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to Monitor 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.

**Appendix 4**

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| **Condition CG6** **Evidence of Compliance**  |
| **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.**  |
| * + - 1. In confirming this statement, the Board of Directors has considered the following:
* There is a Board approved Risk Management Framework in place which clearly outlines the Trust’s approach to identifying, managing and escalating risk which would include those risks to compliance with the Provider Licence.
* The Quality Committee, Business Performance Committee and Research, Innovation & Medical Education (RIME) Committee monitor risks across the organisation and make recommendations to the Board of Directors as appropriate.
* The Board Assurance Framework is reported to, and considered by the Board of Directors on a quarterly basis and is scrutinised by the relevant committees and the Executive Team on a quarterly basis.
* During the financial year 2022/23 no potential risks of compliance have been identified with regard the Provider Licence.
* There were no additional requirements imposed under the NHS Acts during 2022/23.
* The Trust continues to have regard to the provisions contained within the NHS Constitution through the formulation and adoption of trust policies and procedures.
* The Trust’s governance structure reflects the needs of the NHS constitution and the rights of patients, service users and staff.
* Through its business planning process, the Board continues to take into account the conditions of the Provider Licence in the delivery of health care services.
* The Board has considered the 2022/23 Annual Report and Accounts.
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| **Condition G6 CoS7****Evidence of Compliance** |
| **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.** |
| * + - 1. In confirming this statement, the Board of Directors has considered the following:
* The long and medium term financial position.
* The year to date and the annual financial position as detailed in the monthly financial section of the Integrated Performance Report presented to the Board of Directors and Business Performance Committee.
* The 2022/23 annual accounts that were prepared on a going concern basis subject to confirmation once approved at the end of June 2023.
* All key statutory financial targets were achieved for the year ended 31 March 2023 and the Trust delivered the control total agreed with the Cheshire & Merseyside Integrated Care System.
* NHS England have stated that the government issued a mandate to NHS England for the continued provision of services in 2023/24 and allocations have been set for 2023/24.

**Appendix 5** |
| **Governor Training** |
| **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.** |
| * + - 1. In confirming this statement, the Board of Directors can be assured that:
* Upon appointment, Governors have been provided with a Governor Induction Pack containing relevant policies, procedures, guidance, and information relevant to their role. A Governor Handbook is refreshed annually, to further support their information needs.
* An externally facilitated induction session was provided to new Governors outlining the role of an NHS Foundation Trust, the role of the Board of Directors and how to develop skills in holding to account, questioning and challenging and increasing public engagement. Existing Governors were invited to attend to refresh their skills.
* Governors were offered bespoke financial reporting training in 2022 to support them with interpretation of key financial information.
* Governors are given a tour of the ward areas when they are elected / appointed and are invited to participate in PLACE review visits and walkabouts with Non-Executive Directors.
* Governors were encouraged to attend training opportunities that were held locally with Liverpool partners and national offers from NHS Providers.
* The format of Council of Governors meetings allows for Governors to raise questions and identify any additional items that they may wish to receive on future agendas.
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