Under the NHS provider licence, NHS foundation trusts are required to complete self-certification submissions on an annual basis. The annual self-certification provides assurance that NHS providers are compliant with the conditions of their NHS provider licence. Compliance with the licence is routinely monitored through the Single Oversight Framework but, on an annual basis, the licence requires NHS providers to self-certify as to whether they have:

a) effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have regard to the NHS Constitution (condition G6);
b) complied with governance arrangements (condition FT4); and
c) for NHS foundation trusts only, the required resources available if providing commissioner requested services (CRS) (condition CoS7).

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| Condition G6(3) | The provider has taken all precautions to comply with the licence, NHS acts and NHS Constitution. |
| Condition G6(4) | Publication of condition G6(3) self-certification. |
| Condition FT4(8) | The provider has complied with required governance arrangements. |
| Condition CoS7(3) | The provider has a reasonable expectation that required resources will be available to deliver the designated services for the 12 months from the date of the statement. This only applies to foundation trusts that are providers of CRS. |

The Board of Directors reviewed and considered the Self-Certification process and approved the statements outlined in the report below.

**Introduction**

As part of the annual planning process, YDH is required to complete self-certifications to NHS Improvement as set out below:

- Systems for compliance with licence conditions - in accordance with general condition 6 of the NHS provider licence;
- FT4 declaration, Corporate Governance Statement;
- Certification on training of governors – in accordance with s151(5) of the Health and Social Care Act; and
- Availability of resources and accompanying statement - in accordance the continuity of service condition 7 of the NHS provider licence.

However, in light of the current COVID-19 pandemic, NHS England/Improvement does not intend to undertake any audits of compliance against the self-certification requirements of the provider licence or to use our enforcement powers in the event of a breach in this financial year, where resource has been prioritised to address Covid19.

## Self-Certification

## General condition 6 - Systems for compliance with licence conditions

Condition G6(2) requires NHS providers to have processes and systems that:

a) identify risks to compliance with the licence, NHS acts and the NHS Constitution
b) guard against those risks occurring.
c) Providers must complete a self-certification after reviewing whether their processes and systems were implemented in the previous financial year and were effective (condition G6(3)).

The Yeovil District Hospital Board of Directors **confirmed** the following statement:

*"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."*

Basis for confirming statement:
The Trust has processes and systems in place to identify risks to compliance, which are outlined in the wording of the Annual Report. This report is audited by the Trust's external auditors. These systems and processes have been strengthened over the last 12 to 18 months following the comprehensive review of the Risk Register and Board Assurance Framework to improve the monitoring processes. In addition, the Trust has the newly implemented Ulysses Risk Management Module (prior to this implementation, the Trust had an internally developed system), which provides robust methods for the monitoring and recording of actions against risks identified and how these risks are to be mitigated to safeguard against these occurring. With regard to the requirement to have consideration of the NHS Constitution, YDH's version is based upon the Model NHS Constitution.

The Trust was inspected by the Care Quality Commission and NHS England and Improvement in 2019 where a rating of Good was received for clinical Services. A rating of Inadequate was received for Use of Resources. A dedicated action plan, following the subsequent Financial Governance Review, was implemented and the Trust has subsequently achieved its financial Control Total for 2019/20.

The Trust undertakes continued review processes of systems in place within the Trust, through both internal reviews, audits completed by the Internal Audit function and through external reviews completed by relevant parties, such as the CQC and NHS Improvement.

BDO, as the Trust Internal Auditors, completed an audit on the Risk Management Processes in place within YDH where Substantial assurance was provided for Design and Moderate assurance was provided for Operational Effectiveness. The report also outlined a several areas of good practice.

## FT4 declaration, Corporate Governance Statement

Condition FT4 is about systems and processes for good governance. NHS providers must make a corporate governance statement under condition FT4(8) as to current and future compliance with condition FT4. Before making the statement, providers should review whether their governance systems and processes enable them to achieve compliance with condition FT4.

The Yeovil District Hospital Board of Directors **confirmed** the following statement:

*"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.*

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

*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.*

*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.*

*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.*

*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.*

Basis for confirming statement:
The statement provided above is standard wording provided by NHS Improvement; our basis for confirming this statement is outlined in the wording of the Annual Report. The Trust has structured governance arrangements in place with clear lines of reporting from "ward to Board" across operational, quality, safety, patient experience and finance, through assurance committees, to the Board.

The Trust is subject to the recommendations of the NHS Foundation Trust Code of Governance (which is modelled on best practice UK governance principles) and the Well-Led framework, which encourages Boards to conduct formal evaluations of its performance and that of its committees and directors.

During 2019/20, BDO as the Trust's internal auditors completed a review of the organisation's Effectiveness of Governance. This review highlighted several areas of good practice, including the Trust having a clearly documented Governance Framework in place, which outlines the responsibilities of the key Board Assurance Committees, as well as the sub-groups and committees that feed into them.

The review did identify potential opportunities for the membership of committees to be reviewed and reduced to improve their effectiveness. A small number of findings were identified, including some lack of attendance across all levels of committees, particularly the wording groups feeding into the Board Assurance Committees. In addition, there were a number of groups where a directors and their deputy were both required to attend. The Trust is in the process of undertaking a full review of the attendance of the groups/meeting in line with the results of the audit. This includes consideration of whether the groups/meetings are still required or whether the schedule for these meetings could be revised. A programme of work has also commenced to ensure that all terms of reference are all reviewed within a set period. The Board Assurance Committee's terms of reference are to be reviewed by the Board of Directors on 3 June 2020.

Previously, the Company Secretary, the clinical governance team and members of the executive team reviewed and revised the Board governance structure. This review included a revised schedule for the Board of Directors that now rotates between strategically and operationally focussed meetings, providing a suitable framework for the review and consideration of strategic developments, both within the hospital, the Somerset STP and the wider healthcare system.

## Continuity of services condition 7 - Availability of Resources (FTs designated Commissioner Requested Services (CRS) only)

CRS are services commissioners consider should continue to be provided locally even if the provider is at risk of failing financially and, as such, are subject to closer regulation by NHS Improvement. Providers can be designated as providing CRS because:

- there is no alternative provider close enough
- removing the services would increase health inequalities
- removing the services would make other related services unviable.

The CoS7 declaration requires the Trust to confirm one of three statements about the availability of resources required to provide commissioner designated services.

The Yeovil District Hospital Board of Directors confirmed the following statement:

*"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."*

The following statement of main factors have been taken into account in making the above declaration:
*"The Licensee has received revenue and capital loans from the Department of Health (DoH) in 2015/16, 2016/17, 2017/18, 2018/19 and 2019/20 (in 2019/20 this was a short term requirement due to the timing of non-recurrent central funding). Loans have since been converted to Public Dividend Capital and it has been confirmed that future support requirements will also be met through Public Dividend Capital.*

*In light of the COVID-19 situation, the Operational Planning process for 2020/21 was suspended although the Licensee has reasonable expectations that Yeovil District Hospital will receive the required resources for the provision of Commissioner Requested Services through national arrangements which have superseded this process. However, in the event that funding is not forthcoming, the Licensee would reasonably expect that it would be replaced with Public Dividend Capital in order to allow the Licensee to meet its liabilities as they fall due."*

## Certification on training of governors – in accordance with s151(5) of the Health and Social Care Act.

NHS foundations trusts must review whether their governors have received enough training and guidance to carry out their roles.

The Yeovil District Hospital Board of Directors **confirmed** the following statement:

*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.*

Basis for confirming statement:
All governors attend mandatory induction to the Trust, which provides training across a range of topics, including Safeguarding, Information Governance etc. In addition, the Council of Governors receive annual reminders, key updates and an overview of their responsibilities from KPMG. This session took place on 5 September 2019 and a further session will take place later this year following the Governor Election process.

Furthermore, the Trust provides ad hoc training where requested; one example is Managing Conflicts, which also took place in September 2019. Governors also have the opportunity to attend both regional and national Governor events, such as the NHS Providers Governor Focus Conference. Training may also be provided at these events.