Wirral Community Health and Care NHS Foundation Trust

Appendix 1 - Provider licence self-certification

G6 (3) - *Systems for compliance with licence (to be published by 30 June 2023)*

The board are required to response 'Confirmed' or 'Not confirmed' to the following statement. Explanatory information should be provided where required.

	Statement	**Response *(& supporting information/evidence for board assurance)***	**Risks/Mitigations**
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** At the meeting of the Audit Committee on 27 April 2023 the Trust's internal auditors Mersey Internal Audit Agency (MIAA) presented their Head of Internal Audit Opinion providing overall **Substantial Assurance** confirming that *"there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently"*. This is a key piece of evidence to support compliance with this condition of the provider licence. Further evidence to support this condition include; - the Trust's Risk Policy (GP45), and an internal audit reivew of Risk Management as part of the internal audit plan 2022-23 which provided HIGH assurance with no recommendations. - the Board Assurance Framework supported by the Annual Assurance Framework Opinion from MIAA - the Quality & Patient Experience Report received by the Quality & Safety Committee - the annual Quality Account - the Integrated Performance Board as a central forum for the effective operation of Trust's governance framework including monitoring the delivery of performance across the Trust - the establishment of oversight groups supporting and directly accounting to the IPB	No risks identified.

FT4 Declaration - Corporate Governance Statement & Training of Governors *(by 30 June 2023)*

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.			
	Statement	**Response *(& supporting information/evidence for board assurance)***	**Risks/Mitigations**
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** The Annual Governance Statement 2022-23 (to be approved by the Audit Committee on 27 June 2022) 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. There is an internal audit programme in place, under the direction of the Audit Committee to ensure systems and processes are appropriately tested. The external auditors deliver a robust annual audit plan reporting to the Audit Committee. The new Code of Governance issued in April 2023 has been reviewed by the Trust and is informing the process for NED re-appointments.	No risks identified
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	**CONFIRMED** The Board retains oversight of new guidance issued by regulatory bodies including NHSE/I, CQC and ADASS through informal board sessions. In April 2023, the new Code of Governance was released and is supporting the process for the re-appointment of the Chair and Non-Executive Director.	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	**CONFIRMED** In April 2021 the Trust returned to extant governance arrangements, re-established with improvements to reflect learning from the emergency position during the COVID-19 pandemic. Consequently, the Integrated Performance Board (IPB) was established in September 2021. The IPB is central to the effective operation of the Trust's governance framework to	No risks identified.

	(c) Clear reporting lines and accountabilities throughout its organisation.	- monitor the delivery of performance across the Trust - ensure the appropriate flow of information and assurance from services to the Board (via the sub-committees) - provide oversight and correlation of key themes and risks across multiple domains and, - be responsive to service delivery needs as a modern community health and care organisation. During 2022-23 members of the IPB, led by the Executive Leadership Team and supported by the Board of Directors, assessed the purpose, objectives and operating framework of the IPB based on. - individual and collective reflections - learning from the well-led developmental review - an analysis of information and assurance being received and reported to committees of the Board. This resulted in a further enhancement to the governance structure with the establishment of oversight groups supporting and directly accounting to the IPB. - The previously established SAFE Assurance Group transitioned to the Safe Operations Group (SOG) - The previously established Programme Management Group transitioned to the Programme Oversight Group (POG) - New groups were established as follows. - Finance and Resources Oversight Group - People and Culture Oversight Group - Research, Innovation and Digital Oversight Group All of these groups have a direct reporting line to the Integrated Performance Board. Each group is Chaired by a Deputy Director and meets on a monthly basis to review performance across key metrics at locality level, including corporate	

		services, and an aggregated trust-wide as well as risk. These enhanced arrangements were supported by the Board of Directors in October 2022 and were operational throughout the rest of 2022-23 demonstrating a strengthening of reporting to the IPB. The new arrangements have also been observed by Non-Executive Directors to provide assurance on the flow of information from oversight groups, to IPB to committees of the Board. All Terms of Reference of Board and committee meetings are reviewed on annual basis and each committee of the Board completes an annual self-assessment of effectiveness. The reporting line from committees to the Board is clear and all committee Chairs provide a briefing on the work of the committee at every meeting of the Board.	
4	The Board is satisfied that the Licensee 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	**CONFIRMED** In accordance with national guidance, operational plans for 2022-23 were submitted. A robust programme of clinical audit remained in place and during 2022-23, 64 local, service or national audits (including CQUIN) were completed. The key quality outcomes from the audits will be reported in the Annual Quality Account. The Standing Orders for the Practice and Procedure of the Board of Directors (Para 3.1) provide for the Chairman to call a meeting of the Board at any time. The Trust's risk management processes were tested during 2022-23 with an internal audit review providing HIGH assurance with no recommendations. The development of a monthly health risk score assessing the management of risks against five key criteria, has provided further assurance on the effectiveness of the risk management framework. The five criteria are;	No risks identified.

	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 NHS Improvement 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.	- Has the risk been recently reviewed? - Is the expected date of completion still in date? - Is there evidence of recent progress and assurance notes to show actions taken and steps towards mitigation - Is there an action plan with forward dates of actions yet to be completed - Has the action plan had recent oversight at a Divisional level meeting During 2022-23 the average monthly risk health score for all organisational risks recorded on Datix, assessed as above, was 100%. The Trust has a Board Assurance Framework (BAF) in place which the Board of Directors receives at every meeting; the BAF records the principal risks that could impact on the Trust achieving its strategic objectives and provides a framework for reporting key information to the Board of Directors. The BAF is recognised as a key tool to drive the board agenda by ensuring the Board focuses attention on those areas which present the most challenge to the organisation's success. During 2022-23 the BAF tracked 9 strategic risks. Each risk was rated according to the risk matrix with the risk rating being the product of a score of 1-5 for 'likelihood' of the risk occurring and a score of 1-5 on the 'consequence/impact' of occurrence. The monitoring and management of the risks was considered in relation to the agreed risk appetite with current and target risk ratings agreed based on existing controls and assurances and identified mitigating actions. The mitigating actions were intrinsic in the reset and recovery plans for the Trust. Of the 9 principal risks (at year-end) seven were categorised as risk averse; these related to safe delivery of services, ensuring equity of access, financial sustainability, staff wellbeing and workforce levels. Two risks in-year achieved the agreed target risk ratings due to the mitigations in place and the ability to	

		close identified gaps. The structure of the Board Assurance Framework (BAF) was outcome focused providing clarity on the actions to be taken and the outcomes to be achieved to mitigate the risks. In December 2022 and March 2023, Mersey Internal Audit Agency (MiAA) completed the annual Assurance Framework Review in two phases. This provided a range of assurances and noted the development of the BAF recognising that ***"it was structured according to the NHS requirements"***, ***"it was clearly visible and used by the organisation"*** and it was noted that ***"the BAF clearly reflected the risks discussed by the Board"*** and risks were reviewed and changed in year to reflect the position and support the effective management of risks. The audit identified some areas where further development would strengthen the BAF, and the recommendations and the actions planned by the Trust to address these were agreed at the Board of Directors meeting in April 2023 with first actions completed in May 2023 at an informal board session where risk appetite statements were reviewed. The Trust Information Gateway (TIG) provides real-time access to data providing groups, committees and the Board the opportunity to receive timely accurate data for scrutiny and on-going monitoring and for the basis of decision-making.	
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;	**CONFIRMED** a) There are effective appraisal processes in place to support the Board members individually and collectively. All of this is described in the Annual Report. The members of the Board include an Executive Medical Director and Chief Nurse and the Chair of the Quality & Safety Committee who has significant national and international experience and expertise in public health and population health. b) There are robust 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.	No risks identified.

	(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.	c) The quality governance framework is robust. The SAFE Operations Group (referenced above as part of enhanced governance arrangements) has supported the monitoring of information on quality of care and the Quality & Safety Committee has received a detailed quality report outlining key risks, incidents and assurances on safety. The committee chair reports any key decisions and recommendations to the next meeting of the board. The TIG system, Datix and SAFE systems are embedded in the quality governance framework to ensure timely and up to date information on quality and safety. The weekly CRMG meeting also monitors quality of care through incident reviews. d) As above - the board receives a report from the QSC. The board also receives the Quality Account annually. e) Members of the board are engaged in quality initiatives and the board has remained informed on the delivery of high-quality care. The members of the board have remained engaged with the Council of Governors and the Trust's Your Voice group to take account of views from outside the organisation. The opportunity for staff to raise concerns through Freedom To Speak Up (FTSU) processes also remained throughout 2022-23 with over 100 Freedom To Speak Up champions across the Trust. The national FFT during 2022-23 resulted in almost 28,000 responses with 93% of those recommending the Trust as a place to receive care. At every meeting of the Board, a Journey of Care (patient / service user) story and a Staff Story is shared. f) There is clear accountability for quality of care through the Chief Nurse and Medical Director.	
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	**CONFIRMED** All members of the Board comply with the requirements of the Fit and Proper Persons Regulation and all members of the board and senior decision makers complete annual declaration of interests.	No risks identified.

	and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	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. The Trust has secured a Shadow Board Programme which will include all Deputy Directors during 2022-23.	
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** The Council of Governors meets formally on a quarterly basis with a further development days 3-4 times per year. The governor development days provide an opportunity for shared learning and updates, most recently this has included on the Trust's forward plan and NHS reforms. The Lead Governor has attended system wide learning events hosted by MIAA. In November/December 2022 a series of governor elections were held, and an induction day held in early 2023 to provide an overview on the role of the FT governor, their statutory responsibilities and governance within the Trust. The governor Quality Forum was temporarily suspended but at the meeting in January 2023 it was agreed to re-establish it. The Remuneration and Nomination subgroup conducted significant business during 2022-23 including concluding the appointment of a new Non-Executive Director/ Audit Chair and starting the process to re-appoint the Chair and one Non-Executive Director in 2023-24, in accordance with the new FT Code of Governance.	

NHS
Wirral Community
Health and Care
NHS Foundation Trust