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 2025)*			
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 30 April 2025 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) updated in February 2025, and a core control review of Risk Management as part of the internal audit plan 2023-24. - 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 and the Annual Report (including the NHS oversight framework compliance) - 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 role of the oversight groups supporting and directly accounting to the IPB - the AGS highlights matters identified by the Trust through existing systems of internal control and Trust governance	No risks identified.

		- the Trust is currently in segment 2 which reflects flexible support as required - the development of a Partnership Agreement with Wirral University Teaching Hospital NHS FT to support joint functions as per amendments to the NHS Act 2022	

FT4 Declaration - Corporate Governance Statement & Training of Governors *(by 30 June 2025)*			
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 2024-25 (to be approved by the Board of Directors on 18 June 2025) 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 AGS highlights matters identified by the Trust through existing systems of internal control and Trust governance. At the end of 2024-25, two executive posts were held by interims, the Interim Executive Medical Director and Interim Chief Operating Officer. In year, there has also been an Interim Chief Executive (June - November 2024) and Interim Chief Finance Officer (June - November 2024 and February - March 2025).	No risks identified
2	The Board has regard to such guidance on	**CONFIRMED**	No risks identified.

	good corporate governance as may be issued by NHS Improvement from time to time	The Board retains oversight of new guidance issued by regulatory bodies including NHSE/I, and CQC as appropriate.	
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 (c) Clear reporting lines and accountabilities throughout its organisation.	**CONFIRMED** The governance arrangements established in recent years are well embedded and subject to regular testing to ensure they remain fit for purpose, efficient and safeguard high standards of care whilst supporting delivery of the Trust's duties. 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.	No risks identified.
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	**CONFIRMED** In accordance with national guidance, financial, workforce and operational plans for 2025-26 were submitted with full Board oversight. This also included the submission of Board Assurance Statements. The Trust maintains regular engagement with the CQC following inspection in 2023. The Trust has a robust programme of clinical audit in place and during 2024-25, 59 local, service or national audits were completed. This position will be reported to the Quality & Safety Committee in May 2025 and the key quality outcomes from the audits are reported in the annual Quality Account. All progress against clinical and professional audits is tracked on the Trust's SAFE system ensuring there is visibility and an active repository of evidence accessible to all staff. Health and care audits are a way to support services and identify what's going well, to celebrate best practice and highlight	No risks identified.

	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 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.	opportunities for improvements. Clinical and professional audit is embedded into the Trust's governance structure to ensure that results are shared. 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. During 2024-25 the Chair called extraordinary meetings related to the development and approval of the financial plan 2025-26, reflecting requirements from the ICB and system coordination of the overall C&M plan. Under the System Oversight Framework, NHS England segments providers based on the level of support required across five key themes of quality of care, finance and use of resources, operational performance, strategic change and leadership, and improvement capability. The Trust is currently in segment 2 which reflects flexible support as required. The Trust has established systems and processes, as set out in a revised Procurement Policy to ensure compliance with the new Provider Selection Regime from 1 January 2024. The Trust has a Board Assurance Framework (BAF) in place which the Board of Directors receives at every meeting; the BAF records the strategic risks that could impact on the Trust achieving its strategic objectives. 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 2024-25, 8 strategic risks were tracked through the BAF. MIAA completed the annual Assurance Framework Review 2024-25 providing 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 Trust's Risk Policy sets out the responsibility and role of the Board of Directors, the Chief Executive and Executive Directors in relation to risk management with overall responsibility for the management of risk lying with the Chief Executive, as Accountable Officer. The policy, updated in February 2025 and approved by the Audit Committee, provides a systematic approach to the identification, management and escalation of risks within the Trust. The policy ensures clear alignment to the Trust's governance arrangements at a local and trust-wide level recognising the flow and escalation of risk appropriately and the mechanisms in place to ensure robust risk management and monitoring. During 2024-25, the Trust has continued to operate within a clear risk management framework ensuring the quick identification, reporting, monitoring and escalation of risks throughout the organisation.	
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	**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. c) The quality governance framework is robust. The SAFE Operations Group (SOG) 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	No risks identified.

	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.	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 bi-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 2024-25 with 135 Freedom To Speak Up champions across the Trust. There were 50 FTSU concerns reported during 2024-25. During 2024-25 the Trust also received 33,145 responses to the Friends and Family Test. Of those responses 93% of people rated their experience as either very good or good. At every meeting of the Board, a Journey of Care (patient / service user) 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 and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**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. 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 Board of Directors engaged in a bespoke Board Development	No risks identified.

		programme supported by the Northwest Leadership Academy in 2024-25. A Joint Chair, Joint CEO and Joint Chief People Officer (with WUTH) were appointed in 2024-25, in response to a recommendation from an ICB commissioned review of the Wirral system. At the end of 2024-25, two executive posts were held by interims, the Interim Executive Medical Director and Interim Chief Operating Officer. In year, there has also been an Interim Chief Executive (June - November 2024) and Interim Chief Finance Officer (June - November 2024 and February - March 2025).	
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. The governor Quality Forum was re-established with revised Terms of Reference agreed and approved by the full Council of Governors. During 2024-25 the Council of Governors made important appointments as follows; - The first Associate Non-Executive Director - A new Audit Chair - A new Joint Chair with Wirral University Teaching Hospital NHS Foundation Trust and - Reappointed an existing NED for a third term	

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