NHS Provider Licence Self-Certification 2022-23

Meeting Title	Board of Directors		
Date	21/06/2024	**Agenda Item**	16
Lead Director	Alison Hughes, Director of Corporate Affairs		
Author(s)	Alison Hughes, Director of Corporate Affairs		

Action required (please select the appropriate box)

To Approve ☒	**To Discuss** ☐	**To Assure** ☐

Purpose

To provide evidence of compliance against the Provider Licence to support a decision by the Board of Directors.

Executive Summary

NHSE oversees an NHS Foundation Trust's compliance with its licence conditions.

NHS Providers are required to self-certify the following after the financial year-end.

Condition G6(3)	The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS constitution
Condition G6(4)	Publication of condition G6(3) self-certification.
Condition CoS7(3)	If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated services
Condition FT4(8)	The provider has complied with required governance arrangements (this includes the training of governors)

The process for 2023-24 does not require Trust's to return completed provider licence self-certifications. Instead, the process of audit allows NHSE to conduct a select number of audits.

There is no set process for assurance on how conditions are met, Boards need to understand the reported position and sign off on compliance.

Self-certification deadlines

1. ***Condition G6(3)*** - *Systems for compliance with licence* - self-certification must be published (on the Trust's website) by 30 June 2024 as per G6(4).
2. ***Condition FT4*** - *Corporate Governance Statement and Training of governors* - deadline for Board sign off 30 June 2024

Proposed position

3. The Director of Corporate Affairs has reviewed the statements and considered the evidence against each and is recommending that the Board of Directors self-certifies 'Confirmed' for all elements.

The evidence to support the proposed position is outlined in **appendix 1** for further Board discussion.

Strategic (Board Assurance Framework - BAF) and operational Risks and opportunities:

This is a requirement of the NHS FT Provider Licence.

Quality/inclusion considerations:

Quality & Equality Impact Assessment completed and attached No.

Not applicable. The evidence includes reference to QEIA processes to ensure quality of care.

Financial/resource implications:

None identified.

The Trust Vision - To be a population health focused organisation specialising in supporting people to live independent and healthy lives. The Trust Objectives are:

- Populations - We will support our populations to thrive by optimising wellbeing and independence
- People - We will support our people to create a place they are proud and excited to work
- Place - We will deliver sustainable health and care services within our communities enabling the creation of healthy places

Please select the top three Trust Strategic Objectives and underpinning goals that this report relates to, from the drop-down boxes below.

Place - Make most efficient use of resources to ensure value for money	Populations - Safe care and support every time	Place - Improve the health of our population and actively contribute to tackle health inequalities

The Trust Social Value Intentions

Does this report align with the Trust social value intentions? Not applicable

If Yes, please select all of the social value themes that apply:

Community engagement and support ☐

Purchasing and investing locally for social benefit ☐

Representative workforce and access to quality work ☐

Increasing wellbeing and health equity ☐

Reducing environmental impact ☐

Board of Directors is asked to consider the following action

Consider the responses and evidence aligned to each element of the provider licence conditions in **appendix 1**, which the Board is required to self-certify against, and confirm/approve the proposed response.

Note that the agreed return in relation to G6 will be published on the Trust's website no later than 30 June 2024.

Report history (Please include details of the last meeting that received this paper, including the title of the meeting, the date, and a summary of the outcome). This provides the audit trail through the governance structure.

Submitted to	Date	Brief summary of outcome
No previous reporting history - annual self-certification.		

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 2024)*

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 5 June 2024 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 August 2023, 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 - 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 - MIAA review of governance arrangements completed in 2023-24 providing ***Substantial Assurance***	No risks identified.

Wirral Community Health and Care NHS Foundation Trust

FT4 Declaration - Corporate Governance Statement & Training of Governors *(by 30 June 2024)*			
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 2023-24 (to be approved by the Audit Committee on 24 June 2024) 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 compliance with key disclosures are included in the Annual Report.	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, and CQC through informal board sessions. The Board of Directors has considered the new Code of Governance published in April 2023.	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	**CONFIRMED** The Trust's governance arrangements were tested during 2023-24 through a MIAA Audit which provided ***Substantial Assurance***. The objective of the review was to review the design and operating effectiveness of the Oversight Groups including their reporting arrangements to the Integrated Performance Board.	No risks identified.

	those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	The CQC inspection report also noted *'significant improvements especially regarding governance and information management since our last inspection' (in 2018).* 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.	
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 2024-25 have been submitted (recognising the delayed release of planning guidance to the end of March 2024). The Trust was inspected by the CQC between July - September 2023. The comprehensive inspection included a well-led inspection and three core services inspections as follows: • Community Health Services for Adults • Community Health Inpatient Service • Community Health Sexual Health Services The final inspection report was published on 13 December 2023 with an overall Trust rating of Good. During the inspection outstanding practice was identified across all core services, with the following domains being formally assessed as outstanding: • Community Health Services for Adults - Outstanding in Caring	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.	• Community Health Sexual Health Services - Outstanding in Responsive • Community Health Sexual Health Services - Outstanding in Well-Led • Community Health Sexual Health Services - Outstanding Overall as a core service All areas inspected during 2023 achieved a minimum rating of good The Trust has a robust programme of clinical audit in place and during 2023-24, 58 local, service or national audits were completed, including 4 CQUINs. This position was reported to the Quality & Safety Committee in May 2024 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 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 2023-24 the Chair called extraordinary meetings related to the development and approval of the financial plan 2024-25, 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 2023-24 the BAF tracked 9 strategic risks. MIAA completed the annual Assurance Framework Review 2023-24 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 August 2023 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 2023-24 the need for robust systems and processes to support continuous programmes of risk management has remained essential, enabling	

		staff to integrate risk management into their activities and support informed decision-making through an understanding of risks, their likely impact and their mitigation. 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. In Q4 2023-24, 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.	
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;	**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 next meeting of the board. The TIG system, Datix and SAFE systems are	No risks identified.

	(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.	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 2023-24 with 125 Freedom To Speak Up champions across the Trust (an increase from 100 in 2022-23). During 2023/24 the Trust received 33,114 responses to the Friends and Family Test. Of those responses 92.3% of people rated their experience as either very good or good (an increase on the 2022-23 response rate of 27,266 over the year). 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 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 Trust delivered a highly successful Shadow Board Programme including	No risks identified.

		all Deputy Directors during 2022-23. The Board of Directors also engaged in a bespoke Board Development programme supported by the Northwest Leadership Academy.	
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. The Remuneration and Nomination subgroup conducted significant business during 2023-24 including the re-appointment of the Chair and one Non-Executive Director and the recruitment of a new Audit Chair. During 2023-24 the Board of Directors also supported the recruitment of an Associate Non-Executive Director in a developmental role; this was also a should do action from the Trust's CQC report published in December 2023.	

Green Plan 2022 – 2025 Update

Meeting Title	Board of Directors		
Date	19/06/2024	**Agenda Item**	17
Lead Director	Dave Miles, Interim Chief Finance Officer		
Author(s)	Dawn Williams Head of Capital Projects & Estates		

Action required (please select the appropriate box)

To Approve ☒	**To Discuss** ☐	**To Assure** ☐

Purpose

The purpose of this report is to seek approval from the Board of Directors on the organisational Green Plan in terms of targets met, progress and updates to the existing plan.

Executive Summary

The Trust has made some positive steps over the last 12 months in relation to the Green Plan and achieving the national targets, all of which are outlined within the report. However, progress will be limited until the Trust is able to recruit to the vacant Sustainability Manager post.

Strategic (Board Assurance Framework - BAF) and operational Risks and opportunities:

Lack of Sustainability resource - Risk ID 2951 Rating - 12

Quality/inclusion considerations:

Quality & Equality Impact Assessment completed and attached No.

N/A

Financial/resource implications:

The absence of the Sustainability post will mean a reliance on limited resources from other departments within the Trust together with some external resource, to progress some aspects of the plan.

The Trust Vision – To be a population health focused organisation specialising in supporting people to live independent and healthy lives. The Trust Objectives are:

- Populations – We will support our populations to thrive by optimising wellbeing and independence
- People – We will support our people to create a place they are proud and excited to work
- Place - We will deliver sustainable health and care services within our communities enabling the creation of healthy places

Please select the top three Trust Strategic Objectives and underpinning goals that this report relates to, from the drop-down boxes below.

Populations - People and communities guiding care	People - Improve the wellbeing of our employees	Place - Make most efficient use of resources to ensure value for money

The Trust Social Value Intentions

Does this report align with the Trust social value intentions? Yes.

If Yes, please select all of the social value themes that apply:

Community engagement and support ☒

Purchasing and investing locally for social benefit ☐

Representative workforce and access to quality work ☐

Increasing wellbeing and health equity ☐

Reducing environmental impact ☒

Board of Directors is asked to consider the following action

To approve the updates on the organisational Green Plan.

Report history (Please include details of the last meeting that received this paper, including the title of the meeting, the date, and a summary of the outcome). This provides the audit trail through the governance structure.

Submitted to	Date	Brief summary of outcome
Finance & Performance Committee	4 October 2023	Update provided for assurance
Finance & Performance Committee	3 April 2024	Update provided for assurance

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NHS
Wirral Community Health and Care
NHS Foundation Trust

Green Plan 2022-2025 Update

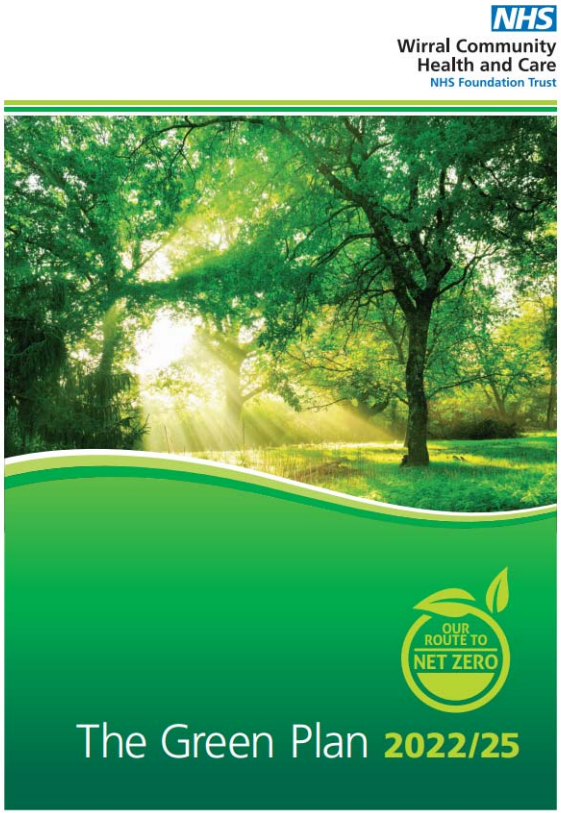
24th May 2024

Name: Dawn Williams, Head of Capital Projects & Estates

Background

What is the Green Plan

- Outline how the Wirral Community Health and Care NHS Foundation Trust will meet the NHS National Net Zero Targets:
  - Net Zero in direct operations by 2040
  - Net Zero Plus by 2045
  - 80% carbon reduction goal by 2032
- This is the first iteration of the plan which is to be updated by 2025. The plan sets out the first steps for achieving Net Zero, through 3 core objectives to incorporating both national commitments and local carbon reduction targets.



National Targets

The NHS Standard Contract

- Every Trust to ensure a Board member is responsible for their net zero targets and their Green Plan.
- Every trust to procure 100% renewable electricity from April 2021.

NHS Operational Contracting and Planning Guidance

- Where outpatient attendances are clinically necessary, at least 25% of outpatient activity should be delivered remotely, resulting in direct and tangible carbon reductions.

Delivering a Net Zero NHS

- Ensure that, for new purchases and lease arrangements, systems and trusts solely purchase and lease cars that are ultra-low emissions vehicles (ULEVs) or zero emissions vehicles (ZEVs).
- Develop a green travel plan to support active travel and public transport use for staff, patients and visitors.

Green Plan Objectives

1. Maintain and improve processes for the effective management of the Trust's environmental impacts, while increasing engagement with employees.

2. Reduce direct emissions resulting from the Trust's own operations.

3. Work with suppliers, employees and service users to reduce greenhouse gas emissions throughout, and beyond, the Trust's direct value chain.

Progress Against Targets

Objective 1: Maintain and improve processes for the effective management of the Trust's environmental impacts, while increasing engagement with employees.	Progress
National Target. Every Trust to ensure a Board member is responsible for their net zero targets and their Green Plan.	Complete. CFO is nominated Trust lead.
1a. Set up a "Sustainability Champions" working group to influence environmental decisions made within the Trust, with representation from all relevant departments.	Complete. Set up Green Plan Group with input from various departments and currently meeting on a quarterly basis.
1b. Highlight sustainability learning opportunities throughout the workforce.	Looking to include sustainability matters as part of induction process and highlight available carbon literacy training.
1c. Maintain EMS ISO 14001 accreditation.	Audit successfully passed in November 2023. Next audit due in November 2024.

Progress Against Targets

Objective 2: Reduce direct emissions resulting from the Trust's own operations.	Progress
National Target. Every trust to procure 100% renewable electricity from April 2021.	Complete. On renewable electricity contract as of April 2023.
National Target. Where outpatient (day patient) attendances are clinically necessary, at least 25% of outpatient activity should be delivered remotely, resulting in direct and tangible carbon reductions.	In development as part of Green Plan Group agenda. Will require input from clinical and business intelligence. No progress in this area due to limited resource and limited attendance at Green Group.
2a. Continue to meet the Trust's long-standing target to reduce the greenhouse gas emissions associated with energy use in estates by 2.5% on the previous year.	Greenhouse gas emissions increased by 15% in 2022/23 due to higher gas consumption as more staff return to the workplace following COVID.
2b. Procure only ultra-low or zero emissions when purchasing or leasing new vehicles.	Unable to achieve this action. Additional cost could not be met following application for additional funding through the budget setting process.
2c. Promote digital technology as a low carbon alternative to face-to-face meetings.	Working towards online meetings being considered preferable as default. Have reduced meeting room space at St Catherine's.

Progress Against Targets

Objective 3: Work with suppliers, employees and service users to reduce greenhouse gas emissions throughout, and beyond, the Trust's direct value chain	Progress
National Target. Develop a green travel plan to support active travel and public transport use for staff, patients and visitors.	Action required. Pending appointment of dedicated sustainability resource.
3a. Maintain and improve procurement policy and decisions to better integrate environmental concerns.	Success in particular policy areas such as 'Tiger Bags'. Looking to integrate sustainability into policy template going forward.
3b. Raise awareness of low carbon travel opportunities including the availability of tax exemptions and government grants among staff, as part of a wider green travel plan to support active travel and public transport use for staff, patients and visitors.	Action required. Linked into green travel plan action (reliant on dedicated sustainability resource).
3c. Increase electric vehicle charging infrastructure at Trust sites.	Completed at St Catherine's and VCHC. Current resource appears appropriate for demand but under regular review as number of EV users increases.

Successes

Key successes of Green Plan 2023/24

- Entered into renewable energy electricity contact
- Re-accreditation to ISO 14001 during November 2023 audit
- Electric vehicle charging infrastructure at SCHC & VCHC

Key Deliverables for 2024/25

- Recruit dedicated sustainability resource to drive forward actions from 2022/25 Green Plan and start to update plan for the next 3 years challenging due to resource requirements
- Complete Green Travel Plan challenging due to resource requirements
- Explore potential benefits of applying for Public Sector Decarbonisation Scheme funding (Phase 4) challenging due to resource requirements. Will need to access other departments within the Trust to support
- Take back control of utilities management at VCHC Accounts have been transferred to WCHC
- Reduce greenhouse gas emissions across the Trust in line with target challenging due to resource requirements

Risks and Mitigations

- **Resource -** There is no dedicated, in house, sustainability resource.
- **Mitigation –** Have sought additional external sustainability resource but this is not sufficient or readily available. Support from neighbouring Trusts has also been sought with discussions underway.
- **Funding –** There is a limited access to funding and will be competing against other Trusts and ICBs.
- **Mitigation –** Preparing bids in advance of the Public Sector Decarbonisation Scheme (Phase 4). This will be reduced without a dedicated resource in place to oversee this..
- **Engagement –** There have been successes in increasing engagement beyond estates, further input from clinical, infection control and business intelligence will be needed.
- **Mitigation –** Re-engage with Green Group members. This is difficult with no responsible person to lead on this.

Summary

- The lack of a dedicated resource in this area has meant the Trust has not been unable to progress in many of the areas outlined in this report over the last year.

- Efforts continue with the limited resources available and the Trust has achieved re-accreditation to ISO 14001, entered a renewable energy contract and installed additional charging points at St Caths and VCHC.

- The Inteb resource originally being utilised has sought employment elsewhere. Inteb unable to recruit to the vacancy to support WCHC as no long term assurance can be given.

- Discussions are underway with neighbouring Trust to identify any collaboration opportunities. A dedicated resource is in place, although initial feedback is that there is no spare capacity to utilise across both Trusts. Confirmation has been sought.

Remuneration & Terms of Service Committee Revised Terms of Reference

Meeting Title	Board of Directors		
Date	19/06/2024	**Agenda Item**	18
Lead Director	Alison Hughes, Director of Corporate Affairs		
Author(s)	Karen Lees, Head of Corporate Governance		

Action required (please select the appropriate box)

To Approve ☒	**To Discuss** ☐	**To Assure** ☐

Purpose

All committee Terms of Reference (ToR) are reviewed annually, and further updates are made during the year when required.

The annual review of the Remuneration and Terms of Service Committee ToR has been completed, and the ToR updated to reflect the role of the committee in relation to the other committees, in particular the People & Culture Committee (PCC).

The Board of Directors are asked to be approve the revised ToR.

Executive Summary

In order for Wirral Community Health & Care NHS Foundation Trust to fully discharge its responsibilities, a committee structure has been established to ensure effective control and governance arrangements are in place and that the Board of Directors receives good quality, timely information through a robust committee structure and reporting schedule.

The board and committee structure form a key part of the governance framework.

The annual review of the Remuneration & Terms of Service Committee Terms of Reference (ToR) was completed in December 2023. The slightly revised ToR were presented and supported at the Committee meeting on 13 December 2023, and then presented to the Board of Directors in February 2024.

The Board of Directors asked for a further review of the ToR to include the quoracy. This review was completed, and the updated ToR were agreed by the Remuneration & Terms of Service Committee in March 2024.
In the updated ToR the governance of the committee had been further enhanced to include the reporting of the committee decisions to the private board of directors, together with a reduction

in the number of members required for quoracy, and the attendance of the Chief Executive for decisions relating to staff on Very Senior Manager pay. Several activities have been removed from the ToR e.g., policy approval as this is undertaken by the PCC.

The updated ToR were received by the Board of Directors at the private meeting in April 2024, and these ToR were approved to be presented to this public meeting of the Board of Directors for approval.

The changes to the Committee Terms of Reference are in red font for ease of review

Strategic (Board Assurance Framework - BAF) and operational Risks and opportunities:

In order to discharge the duties of the board and committees effectively and provide strong leadership in all matters associated with workforce, culture and inclusion, Terms of Reference are a key governance tool; a lack of current Terms of Reference does not support a well-led organisation

Quality/inclusion considerations:

Quality & Equality Impact Assessment completed and attached No.

Not applicable for Terms of Reference, however all ToRs have been assessed for AIS.

Financial/resource implications:

None identified

The Trust Vision – To be a population health focused organisation specialising in supporting people to live independent and healthy lives. The Trust Objectives are:

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Please select the top three Trust Strategic Objectives and underpinning goals that this report relates to, from the drop-down boxes below.

Populations - Safe care and support every time	People - Improve the wellbeing of our employees	Place - Make most efficient use of resources to ensure value for money

The Trust Social Value Intentions

Does this report align with the Trust social value intentions? Yes.

If Yes, please select all of the social value themes that apply:

Community engagement and support ☒

Purchasing and investing locally for social benefit ☒

Representative workforce and access to quality work ☒

Increasing wellbeing and health equity ☒

Reducing environmental impact ☒

Board of Directors is asked to consider the following action

The Board of Directors are asked to be assured by the review of the terms of reference, and approve the revised version.

Report history (Please include details of the last meeting that received this paper, including the title of the meeting, the date, and a summary of the outcome). This provides the audit trail through the governance structure.

Submitted to	Date	Brief summary of outcome
Annually to the Remuneration & Terms of Service Committee for review and approval	13/12/2023	The Committee reviewed its ToR and approved onward presentation to the Board of Directors.
Public Board of Directors	21/02/2024	The Board of Directors asked for a further review of the ToR
Remuneration & Terms of Service Committee for review and approval	20/03/2024	The Committee reviewed its ToR and approved onward presentation to the Board of Directors.
Private Board of Directors	17/04/2024	The ToR were approved for presentation at the next public Board of Directors meeting

Terms of Reference Remuneration & Terms of Service Committee

What is the aim of RemCom?

To set appropriate remuneration and terms of service for the Chief Executive and other Executive Members including all aspects of salary, provision for other benefits and arrangements for contractual terms. The remuneration committee has delegated responsibility from the Board of Directors.

What is the purpose of the RemCom?

- The Committee is authorised by the Board to act within its terms of reference to;
- Determine and agree with the Board the framework and overarching policy statements for the remuneration, and termination/redundancy payments of the Chief Executive and individuals on the Very Senior Manager (VSM) pay scale, whilst ensuring they are in accordance with national guidance
- In accordance with all relevant laws, ensure that the Chief Executive, all individuals remunerated on the ~~Very Senior Manager (~~VSM~~)~~ pay scale ~~and other very senior managers on local pay~~ are fairly rewarded for their individual contribution to the organisation, having proper regard for the organisation's circumstances and performance and any national arrangements where appropriate, including the VSM Pay Framework
- ~~Within the terms of the agreed policy, determine the total individual remuneration packages of the Chief Executive and Executive Directors paid on the VSM Pay Framework including, where appropriate, bonuses and incentive payments; to have regard as required to any national policy on VSM pay~~
- ~~Determine the policy for and scope of termination/redundancy payments whilst ensuring they are in accordance with national guidelines~~
- Determine any major changes in remuneration structures within the Trust
- ~~Determine and agree with the Board the policy statements on Trust specific terms and conditions of service~~
- ~~Determine the expenses policy for the Trust~~
- ~~Determine the relocation policy for the Trust~~
- Consult with regulators as required , and obtain outside legal or other independent professional advice if considered necessary

What is the operating framework for the committee?

Membership

Chair - Chair of the Trust (Prof. Michael Brown)
Executive Lead – Chief People Officer

5 x Non-Executive Directors (including the Chair of the committee)

In attendance;
Chief Executive ~~(as required)~~ for decisions relating to staff on Very Senior Manager (VSM) pay

The Executive Lead will declare any necessary conflicts of interest and support any mitigating actions as required.
No committee attendee shall participate in any discussion or decision on their own remuneration
Other senior employees may be invited to attend according to specific agenda items.

Any disputes will be escalated to the Board of Directors; all votes will be taken at Board level.

Quoracy

- ~~5~~ 3x Non-Executive Directors

In the absence of the Chair another NED member will be nominated to take the chair.

Governance

- Reporting of decisions to the private Board of Directors
- Following each meeting, a decision and action log detailing discussions will be circulated to members for approval

Standing agenda

- Declarations of interest
- Approval of decision and action log from previous meeting
- Any appropriate or new risks to be added to the risk register

In performing its duties, the Committee will have due regard to the Trust's commitment to equality, diversity and human rights as well as compliance with the Equalities Act 2010 and other legislation requirements.

Frequency

At least annually or as required and supported by the Chair

Members and attendees shall abide by the following etiquette;

- **Presence** - colleagues are required to attend and contribute
- **Prepared** - colleagues must have read the papers and materials
- **Punctual** - attend in good time for the meeting to begin; and
- **Participate** - colleagues are required to engage in the discussion or debate and be prepared to challenge and be challenged, accepting differing perspectives and observing the Trust values of **Trust, Open and Compassion**

Reviewed: March 2024

Compassion | Open | Trust