Board Assurance Framework (BAF) 2022-23

Meeting	Board of Directors		
Date	19/04/2023	**Agenda Item**	11
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

The purpose of this paper is to provide the Board of Directors with an update and assurance on the management of strategic risks through the Board Assurance Framework.

This update provides the position following the review of all strategic risks at the committees of the Board during March and April 2023 and provides a recommendation for approval by the Board in relation to one strategic risk.

The outcome of phase 2 of the Assurance Framework Review, completed by MIAA as part of the annual internal audit plan is also included for Board members information and assurance.

Executive Summary

The Board has in place a full Board Assurance Framework which reflects the priority areas of focus in each of the committees of the Board and is driving discussion and appropriate escalation to the Board of Directors.

Following the agreement of the initial strategic risks at the April 2022 Board of Directors meeting, the strategic risks were discussed by the committees of the board in order to agree any further changes. These changes reflected the emerging position with the establishment of the Integrated Care System in July 2022, and the current Trust position. These changes were presented at the June 2022 Board of Directors meeting and were agreed together with the format of the strategic risk structure template

During March and April 2023, the committees of the board have completed a further review of the strategic risks in order to provide a full update to the Board of Directors, included at **appendix 1**. This review also considered the position at M11 of the financial year with the committees reviewing progress to achieve target risk ratings.

The mitigation, gaps, outcomes and trajectories to mitigate risks have all been reviewed.

There were no recommendations for changes from the Quality & Safety Committee; all strategic risks were reviewed with some gaps noted as complete (highlighted in grey text).

The Finance & Performance Committee reviewed all strategic risks and agreed a recommendation to the Board that ID04 has achieved its target risk rating. This position was based on performance to achieve the financial plan set for 2022-23.

The People & Culture Committee scheduled for April 2023 was postponed with the agreement of the Chair and will meet on 10 May 2023 at which point all existing risks will be reviewed and any new or emerging risks considered.

Of the 9 strategic risks being actively tracked through the Board Assurance Framework none are scoring more than RR12, ID05 achieved its target risk rating in February 2023 and ID04 (*The financial settlement requires an unachievable efficiency target creating a risk to the financial sustainability of the organisation*) and is recommended to the Board of Directors as having achieved its target risk rating.

There are currently no high-level organisational risks which are being monitored via the committees of the board and which could impact on the rating of strategic risks.

A key component of the annual Internal Audit Plan is the Assurance Framework Review. This informs the annual Head of Internal Audit Opinion and supports the development of the Annual Governance Statement. In February 2023, the outcome of the Phase 1 review completed by MIAA was shared and the outcome of Phase 2 review has now been completed and confirms that;

- The organisation's AF is structured to meet the NHS requirements.
- The organisation considers risk appetite regularly and the risk appetite is used to inform the management of the AF.
- The AF is visibly used by the organisation. Quality & Alignment
- The AF clearly reflects the risks discussed by the Board

At the next informal board meeting in May 2023 the members of the Board will consider existing and emerging risks to determine the focus and priority strategic risk areas for 2023-24. This will be presented to the Board of Directors in June 2023.

Risks and opportunities:

The BAF records the principal risks that could impact on the Trust's ability in achieving its strategic objectives. Therefore, failure to correctly develop and maintain the BAF could lead to the Trust not being able to achieve its strategic objectives or its statutory obligations. There are opportunities through the effective development and use of the BAF, to enhance the delivery of the Trust's strategic objectives and effectively mitigate the impact of the principal risks contained within the BAF. .

Quality/inclusion considerations:

Quality & Equality Impact Assessment completed and attached No.

The quality impact assessments and equality impact assessments are undertaken through the work streams that underpin the BAF.

Financial/resource implications:

Any financial or resources implications are detailed in the BAF for each risk.

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.

People - Improve the wellbeing of our employees	Populations - Safe care and support every time	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? 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

To consider the mitigations, gaps, outcomes and actions already populated for each of the strategic risks
To approve the recommendation that ID05 has achieved its target risk rating.

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)

Submitted to	Date	Brief summary of outcome
Board of Directors	13/04/22	The Board of Directors received the update provided in relation to the strategic risks, noting the current risk rating, mitigations in place and identified gaps and approved the reduced risk rating for ID04 The Board of Directors received the BAF as the year-end position.

Informal Board	11/05/22	The members of the Board considered the strategic risks for 2022-23 reflecting on the risks tracked through the BAF in 2021-22 and the Trust's 5-year strategy.
Board of Directors	15/06/22	The members of the Board received and approve recommendations from the committees of the Board on the proposed strategic risks for tracking through the Board Assurance Framework during 2022-23; and approved the strategic risk structure template.
Board of Directors	17/08/22	The Board received an update following review of all strategic risks at the committees of the Board.
Board of Directors	17/10/22	- Approve the revised risk descriptions for ID01 and ID02 based on a recommendation from the Quality & Safety Committee - Note the position regarding ID03 - Approve the revised risk descriptions for ID05 and ID06 based on a recommendation from the Finance & Performance Committee - Approve the increase in risk rating for ID08 to RR12 (from RR8) - Approve the decrease in risk rating for ID09 to RR12 (from RR16) To be assured by the progress with the development of the strategic risk template for Board Assurance Framework through the sub-committees of the Board
Informal Board	02/11/22	The members of the Board completed a mid-year review of the strategic risks managed through the Board Assurance Framework. It was agreed to revisit the risk description and associated mitigations for ID03.
Board of Directors	14/12/22	The members of the Board approved the revised risk description for ID03 and noted all other updates provided for strategic risks.
Board of Directors	15/02/22	The members of the Board approved the recommendation that ID05 had achieved its target risk rating and noted that all other strategic risks continued to be reviewed by the

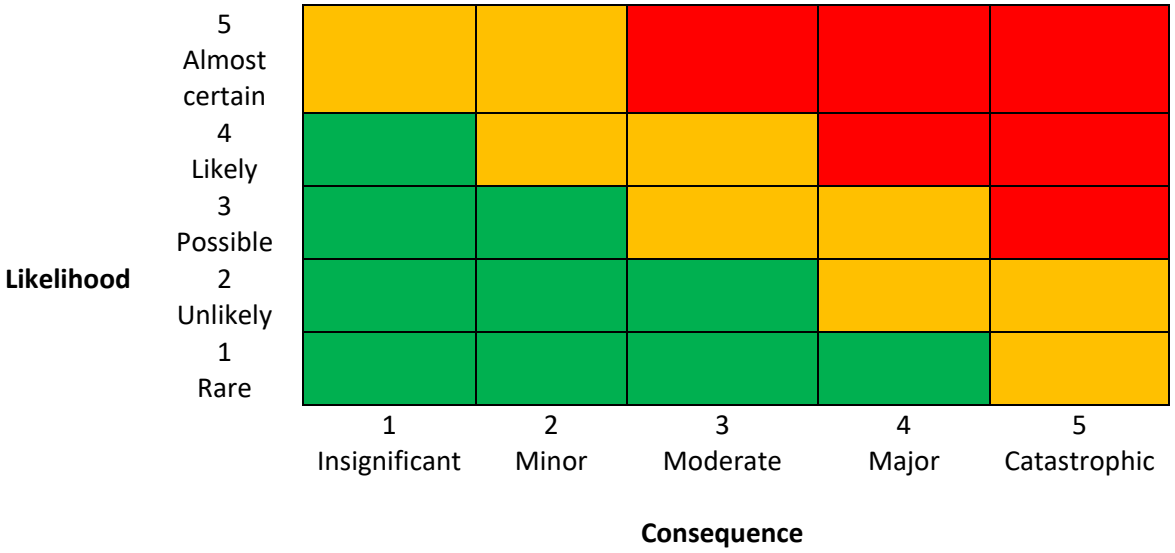
		relevant committees with updates provided on mitigations, gaps and actions. The Board of Directors also received the outcome of the Phase 1 Assurance Framework Review completed by MIAA to inform the Head of Internal Audit Opinion.

Strategic risk summary 2022-23

Risk Description	Committee oversight	Link to 5-year strategy	Initial risk rating (LxC)	Current risk rating (LxC)	Target risk rating (LxC)	Risk Appetite
ID01 - Failure to deliver services safely and responsively to inclusively meet the needs of the population	Quality & Safety Committee	Safe Care & Support every time	3 x 4 (12)	3 x 4 (12)	2 x 4 (8)	Averse
ID02 - Failure to deliver services inclusively with people and communities guiding care, supporting learning and influencing change	Quality & Safety Committee	Inequity of access and experience and outcomes for all groups in our community resulting in exacerbation of health inequalities	3 x 4 (12)	3 x 4 (12)	2 x 4 (8)	Averse
ID03 (NEW) The collaborative becomes a 'one size fits all' / Lead Provider collaborative and is not cognisant of the political climate, partner relationships and subtleties of working in Place for community services.	Finance & Performance Committee	Deliver sustainable health and care services	-	2 x 2 (4)	1 x 2 (2)	Open
ID04 - The financial settlement requires an unachievable efficiency target creating a risk to the financial sustainability of the organisation ***TARGET RISK RATING ACHIEVED***	Finance & Performance Committee	Make most efficient use of resources to ensure value for money	4 x 4 (16)	2 x 4 (8)	2 x 4 (8)	Averse
ID05 - Poor financial performance at Place creates a negative impact on the Trust and leads to increased monitoring and regulation ***TARGET RISK RATING ACHIEVED***	Finance & Performance Committee	Deliver sustainable health and care services	3 x 4 (12)	1 x 4 (4)	1 x 4 (4)	Averse
ID06 Trust operational and financial performance is poor and has an impact on Place	Finance & Performance Committee	Deliver sustainable health and care services	2 x 4 (8)	2 x 4 (8)	1 x 4 (4)	Averse

Risk Description	Committee oversight	Link to 5-year strategy	Initial risk rating (LxC)	Current risk rating (LxC)	Target risk rating (LxC)	Risk Appetite
performance and future monitoring and regulation						
ID07 - Our people do not feel looked after, their employee experience is poor, and their health and wellbeing is not prioritised	Education & Workforce Committee	Improve the wellbeing of our employees Better employee experience to attract and retain talent	3 x 4 (12)	3 x 4 (12)	1 x 4 (4)	Averse
ID08 - Our People Inclusion intentions are not delivered; people are not able to thrive as employees of our Trust and the workforce is not representative of our population	Education & Workforce Committee	Improve the wellbeing of our employees Better employee experience to attract and retain talent	3 x 4 (12)	3 x 4 (12)	1 x 4 (4)	Cautious
ID09 - Safe Staffing levels are not maintained across the Trust impacting on the safe delivery of services, staff morale and regulatory compliance	Education & Workforce Committee	Grow, develop and realise potential	3 x 4 (12)	3 x 4 (12)	2 x 4 (8)	Averse

Averse	Prepared to accept only the very lowest levels of risk
Cautious	Willing to accept some low risks
Moderate	Tending always towards exposure to only modest levels of risk
Open	Prepared to consider all delivery options even when there are elevated levels of associated risk
Adventurous	Eager to seek original/pioneering delivery options and accept associated substantial risk levels


5
Almost certain
4
Likely
3
Possible
2
Unlikely
1
Rare
Likelihood
1
Insignificant
2
Minor
3
Moderate
4
Major
5
Catastrophic
Consequence

Board Assurance Framework 2022-23

Strategic risks with oversight at Quality & Safety Committee

When considering the mitigations and structures in place for each strategic risk, the committee recognises the following standing mitigations which constitute the quality governance framework in place across the Trust.

Corporate Governance

- The Quality & Safety Committee meets on a bi-monthly schedule with an agreed annual workplan in place
- The committee has Terms of Reference in place, reviewed annually
- The Chief Nurse is the Executive Lead for the committee
- The Chief Nurse is also the Trust Lead for addressing health inequalities
- The Integrated Performance Board is the highest operational group in the Trust and maintains oversight and scrutiny of performance to provide assurance to the committee
- The committee completes a self-assessment against its work in respect of the agreed Terms of Reference
- In accordance with the Trust's Risk Policy, the committee receives a report on high-level organisational risks, and can access all operational risk status through the TIG on-line system, to monitor actions to mitigate risks and determine any impact on strategic risks being managed through the BAF
- The committee receives an update on trust-wide policies related to the duties of the committee (via SAFE) and on the implementation of recommendations from internal audit reviews (via TIG - Audit Tracker Tool)
- The Chair of the committee meets with the governor chair of the Governor Quality Forum to provide a briefing after each meeting of the committee

Quality Governance

- The quality governance structure in place provides clarity on the groups reporting to the committee
- The committee receives the Terms of Reference for the groups reporting to it
- The committee contributes to the development of the annual quality plan and priorities and receives bi-monthly assurance on implementation
- The committee receives the minutes from group meetings for noting
- The committee contributes to the development of, and maintains oversight on the implementation of the annual quality priorities
- The committee reviews and approves the Trust's annual quality report
- The committee ensures that processes are in place to systematically and effectively respond to reflective learning from incidents, complaints, patient/client feedback and learning from deaths
- Weekly Clinical Risk Management Group (CRMG) meetings in place to monitor incidents and learning
- Patient Safety Lead in post
- SAFE system in use trust-wide for self-assessments and audits (e.g., hand hygiene, medicines management, IG, team leader)
- New SAFE Operations Group (SOG) established to replace (SAFE and OOG) and reporting directly to the Integrated Performance Board
- Core Services Oversight Group (CSOG) established (to replace QSRDG) to ensure compliance with CQC standards across core services and beyond

- Regular formal and informal engagement with CQC in response to Level 4 incident to understand regulatory process activity
- Just and Learning culture supported by FTSU framework allowing staff to openly raise concerns
- FTSU Guardian appointed
- FTSU Executive Lead is a member of the committee
- FTSU NED Lead identified

Monitoring quality performance

- The committee receives a quality report from TIG providing a YTD summary of all quality performance metrics at each meeting
- The use of SPC charts has been built into the quality dashboard on TIG to allow committee to monitor data over time
- The members of the committee have access to the Trust Information Gateway, which covers Trust health and social care services, to monitor quality performance and to access the Audit Tracker Tool to monitor progress
- The committee contributes to, and receives the annual quality improvement audit programme and tracks implementation
- The committee receives updates live from the system on regulatory compliance including local audits and procedural documents
- Monitoring of new services in St Helens and Knowsley through existing governance arrangements – oversight of mobilisation plans
- Partnership working with Local Authorities and other stakeholder organisations – more information on groups to be named.

ID01 Failure to deliver services safely and responsively to inclusively meet the needs of the population	Quality & Safety Committee oversight

Link to 5-year strategy - Poor experience of care resulting in deterioration and poor health and care outcomes

Consequence;

- Poor experience of care resulting in deterioration and poor health and care outcomes
- Non-compliance with regulatory standards and conditions
- Widening of health inequalities

Current risk rating (LxC)	**Risk appetite**	**Target risk rating (LxC)**
3 x 4 (12)	**Averse**	2 x 4 (8)

Mitigations (i.e., processes in place, controls in place)	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs (i.e., proof points that the risk has been mitigated)**	**Trajectory to mitigate and achieve target risk rating**
Actions to ensure safe care and support every time to prevent variation of standards across localities and teams - Psychological safety of staff prioritised to enable delivery of the safest care and support - Clinical and professional supervision recorded on SAFE with improving position (~~74.5%~~ ~~82.1%~~ 79.5% vs 90% target) - Mandatory training compliance trust-wide achieved ~~92.1~~ ~~94~~ 94.5% target - Quality Strategy delivery plan monitored via Quality & Safety Committee - Safe Staffing project group established *(see link to risk ID09)* - Safe Staffing governance established for regular reporting to PCC and Board (see Board papers February 2023)	- ~~Role essential training compliance below 80% - **Service Directors (July 2022)** *(reference SAFE/OOG action log)*~~ - 84% compliance at M9 - Clinical and professional supervision compliance sustained 90% - **Team Leaders** - Deliver plan for roll out of Professional Nurse Advocate Programme across Nursing services **- Deputy Chief Nurse (see Quality Strategy delivery plan)** - Supervision Training Strategy - **Head of L&OD**	- CQC rating of Good or Outstanding - Mandatory training compliance maintained at 90% - **exceeded** - Role specific training compliance maintained at 80% - current compliance 81.2% (as of 03/11/22) - Successful implementation of PSIRF - Successful implementation of waiting list stratification tool	- CQC inspection - 2022/23 - System-wide harm prevention group to be established – **COMPLETE with Deputy Chief Nurse attendance** - Implementation of training strategy for the National Patient Safety Strategy - **May 2022 - ON-GOING** - Role essential training compliance to achieve target - currently 84% at M10 - Full delivery of the Quality Strategy delivery plan - **March 2023**

- New operational structure reflected in governance arrangements to allow focus on locality-based incidents, risks and learning - TIG locality dashboards built and adopted through local SAFE and OPG meetings - Wide-ranging clinical audit programme in place leading to improvements in care and support - Policy review processes in place and bi-monthly reporting of SitRep to Quality & Safety Committee (all policies available on Staff Zone) - Timely identification and management of risk as described in Risk Policy (GP45) - Risk Report to every committee of the Board - Professional Nurse Advocate (PNA) programme commenced - Deputy Director of Adult Social Care leading implementation of Schwartz rounds - SOG highlight reports providing oversight - Monitoring of new services in St Helens and Knowsley through existing governance arrangements - Revised governance arrangements to strengthen oversight and reporting sub-IPB established - Safe Operations Group (SOG) established with revised Terms of Reference and membership - Implementation of PSIRF and recruitment of two Patient Safety Partners - Development of waiting list stratification tool aligned to CORE20PLUS 5	- Re-establish Schwartz Round steering group with supporting communications plan - **Deputy Director of Adult Social Care** - Mobilisation gap analysis to evaluate resources required for mobilisation - Availability of health inequalities data aligned to service provision and as part of personalised care assessment processes - **Head of Inclusion and Service Directors (September 2022) -** *see trajectory for improvement to address the gap but work on-going.* - Roll-out of waiting list stratification tool to services (phased approach) **- Deputy Chief Operating Officer - 2023-24**		- Embedding of health inequalities/AIS dashboard across all services - ~~**July 2022**~~ AIS template in SystmOne and dashboard developed and in use via SAFE Operations Group. Further embedding on-going. - Recruitment of Patient Safety Partner (as per national guidance) - **COMPLETE** - Supervision Training Strategy approved - ~~**July 2022**~~ **November 2022 -** (Extension for action approved by QSC) - Implementation of PSIRF - **April 2023** - Successful implementation of waiting list stratification tool - **2023-24**

Actions to ensure safe mobilisation of new services - Business decision making process aligned to strategic objectives - Establishment of mobilisation project at the commencement of new contracts - Mobilisation projects monitored at POG **Actions to ensure equitable outcomes across our population based on the Core20PLUS5 principles** - Health Inequalities & Inclusion Strategy developed and approved - Mechanism in place to ensure involvement of people always included within RCA's (agreed at CRMG) - Participation in C&M Prevention Pledge programme agreed with identified Executive lead - Chief Nurse - Inclusion dashboard developed - Partnership forum established - Bronze Status in the NHS Rainbow Pin Badge accreditation scheme - Bronze award in the Armed Forces Covenant Employer Recognition Scheme - EDS2 assessment criteria agreed and completed for 2022-23 - AIS template now available in S1 for all services. Performance against completion rates tracked via locality SAFE/OPG meetings. - Development of waiting list stratification tool aligned to CORE20PLUS 5		- Successful and safe mobilisation of new services - Availability and use of AIS data for all core services - Inclusion metrics - High % of patient feedback via FFT is maintained and feedback is representative of the community tested through equality data	

Actions to ensure safe demobilisation of services - Project Group established for the return of the Adult Social Care contract - Workstreams established e.g., HR, IMT, Communications, Service Delivery - Regular updates to staff - F2F and via newsletters/briefings with agreed communications approach with the LA - Executive Leadership through Chief Strategy Officer	• Approved project plan for the return of Adult Social Care contract to the Local Authority - **Chief Strategy Officer** • Effective service user engagement during ASC contract transfer - **Chief Executive/Director of Corporate Affairs**	- Smooth transfer of Adult Social Care contract to the Local Authority with good employee and service user experience	- Adult Social Care contract transfer - by 30 June 2023

<table>
<tr><td colspan="3">ID02 Failure to deliver services inclusively with people and communities guiding care, supporting learning and influencing change</td><td>Quality & Safety Committee oversight</td></tr>
<tr><td colspan="4">Link to 5-year strategy - Inequity of access and experience and outcomes for all groups in our community resulting in exacerbation of health inequalities</td></tr>
<tr><td colspan="4">Consequence;
• Inequity of access and experience and outcomes for all groups in our community
• Poor outcomes due to failure to listen to people accessing services
• Reputation impact leading to poor health and care outcomes</td></tr>
<tr><td>Current risk rating (LxC)</td><td colspan="2">Risk appetite</td><td>Target risk rating (LxC)</td></tr>
<tr><td>3 x 4 (12)</td><td colspan="2">Averse</td><td>2 x 4 (8)</td></tr>
<tr><td>Mitigations
(i.e., processes in place, controls in place)</td><td>Gaps
(Including an identified lead to address the gap and link to relevant action plan)</td><td>Outcomes/Outputs
(i.e., proof points that the risk has been mitigated)

NOTE: ensuring clear alignment of the outcome to the gap it addresses</td><td>Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td>Actions to ensure collaboration and co-design with community partners
- Quality Strategy ambition “People and communities guiding care”
- 6000 public members sharing their experience and inspiring improvement
- Level 1 Always Events accreditation focussing on what good looks like and replicating it every time
- Complaint’s process putting people at the heart of learning
- QIA and EIA SOP refreshed and approved
- Recruitment of Population Health Fellow role
- Quality Improvement sharing and celebration event planned for July 2022
Experience dashboard built on TIG</td><td>- ~~Review of health inequalities and inclusion training to support delivery of culturally sensitive care~~ - ~~Head of Inclusion~~ Complete
- ~~Agree workplan for Population Health Fellow including implementation of brief interventions~~ - ~~Head of Inclusion~~ Complete
- Poor compliance and completion of accessibility and inclusion template</td><td>- CQC rating of Good or Outstanding
- Measures of equity of access demonstrated through patient/service user data and experience
- Staff confident in delivering culturally sensitive care
- All reasonable adjustments are made to facilitate most effective care delivery</td><td>- CQC inspection - 2022/23
- 10% of eligible staff to be trained in inclusion and health inequalities curriculum by September 2022 - ON-GOING
- Recruit 10 Community Partners to support and influence change as part of our engagement/participation groups - September 2022
7 community partners recruited as of 03/11/22. Further recruitment continues.</td></tr>
</table>

Actions to address health inequalities by hearing from those with poorer health outcomes, learning and understanding the context of people's lives and what the barriers to better health might be - On-going work with system partners (system health inequalities group) to improve identification of minority and vulnerable groups within the population, ensuring that we reach into these communities and make it as easy as possible for people to access appropriate care when required **Actions to ensure that all voices, including under-represented groups can be heard and encouraged to influence change** - Active engagement through the Partnership Forum with multiple groups/agencies across Wirral (e.g., Wirral Change, Mencap, LGBT, veterans) supporting close links with our communities and positively influencing participation and involvement **Actions to ensure children and families living in poverty are engaged to improve outcomes and life chances** - Established service user groups including Involve, Your Voice and Inclusion Forum with a commitment to co-design - Participation in Local Safeguarding Children Partnerships across all Boroughs where 0-19/25 services are delivered - Good partnerships with other agencies	across all services - **Deputy COO/Service Directors** - improving position *(see ID01 - AIS template now available in S1 for all services and tracked through local governance)* - Lack of staff confidence in accessing and interpreting health inequalities data - **Head of Inclusion** - National workforce shortage for Health visitors (incentive scheme in place across Knowsley) and School nurses - C&M workforce strategy for Health Visitors and School nurses **Deputy COO/Service Director/Deputy Director of HR&OD**		- Model/framework to focus on the 20+5 model developed - **March 2023** - Improved completion of AIS template across all services (supporting waiting list management) - ~~**July 2022**~~ - **ON-GOING** - 4 Always Events coproduced alongside people with lived experience - **March 2023**

Board Assurance Framework 2022-23

Strategic risks with oversight at Finance & Performance Committee

When considering the mitigations and structures in place for each strategic risk, the committee recognises the following standing mitigations which constitute the quality governance framework in place across the Trust.

Corporate Governance

- The Finance & Performance Committee meets on a bi-monthly schedule with an agreed annual workplan in place
- The committee has Terms of Reference in place, reviewed annually (last reviewed in October 2022)
- The committee completes a self-assessment against its work in respect of the agreed Terms of Reference (last completed in September/October 2022)
- The Chief Finance Officer is the Executive Lead for the committee
- The Integrated Performance Board is the highest operational group in the Trust and maintains oversight and scrutiny of performance to provide assurance to the committee
- The FROG reports to the IPB on all matters associated with financial and contractual performance and the SOG reports to the IPB on all matters associated with operational performance
- In accordance with the Trust's Risk Policy, the committee receives a report on high-level organisational risks, and can access all operational risk status through the TIG on-line system, to monitor actions to mitigate risks and determine any impact on strategic risks being managed through the BAF
- The committee receives an update on trust-wide policies related to the duties of the committee (via SAFE) and on the implementation of recommendations from internal audit reviews (via TIG - Audit Tracker Tool)

Financial and Operational Governance

- The governance structure in place provides clarity on the groups reporting to the committee
- The committee receives the Terms of Reference for the groups reporting to it
- The committee contributes to the development of the annual financial plan (including oversight of P&E and capital expenditure) and the Digital Strategy Delivery Plan and receives quarterly assurance on implementation
- The committee receives the minutes from group meetings for noting
- The committee reviews and approves the Trust's financial and operational plans prior to submission to the regulators

Monitoring performance

- The committee receives a finance report providing a summary of all financial performance metrics at each meeting (via TIG)
- The committee receives a report on progress to achieve Productivity & Efficiency targets across the Trust
- The committee receives an operational performance report providing a summary of all operational performance metrics (national, regional and local) at each meeting (via TIG)
- The members of the committee have access to the Trust Information Gateway to monitor performance

ID03 The collaborative becomes a 'one size fits all' / Lead Provider collaborative and is not cognisant of the political climate, partner relationships and subtleties of working in Place for community services.			Finance & Performance Committee oversight
Link to 5-year strategy - Deliver sustainable health and care services			
Consequence; • Non-compliance with Duty to Collaborate • Negative reputational impact across ICPs and in wider ICS			
Current risk rating (LxC)	**Risk appetite**		**Target risk rating (LxC)**
2x2 (4)	Open		1x2 (2)
Mitigations **(i.e. processes in place, controls in place)**	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs** **(i.e. proof points that the risk has been mitigated)** NOTE: ensuring clear alignment of the outcome to the gap it addresses	**Trajectory to mitigate and achieve target risk rating**
• The Trust is an active member of the collaborative and participant in discussions through the CEO and MD through the MHLDC management group • All decision making is based on consensus • The Good Governance Institute (GGI) has been commissioned to build the Strategic Outline Case (SOC) which will need to be agreed and signed off by ALL partners • New Managing Director is working to establish clear governance routes	• The SOC has not been developed or approved - **Chief Executive** • There isn't currently consensus across the collaborative for the position/direction of travel - **Chief Executive**	• The SOC is supported by ALL partners and agreed and approved by the ICB • A lead provider is agreed within the collaborative for MH and LD; community services stay in the collaborative space for the development and improvement of service delivery • The SOC is not agreed and / or accepted by the ICB	• The SOC will be developed and shared with partners and ICB - Q4 22/23

<table>
<tr><td colspan="3">ID04 The financial settlement requires an unachievable efficiency target creating a risk to the financial sustainability of the organisation</td><td>Finance & Performance Committee oversight</td></tr>
<tr><td colspan="4">Link to 5-year strategy - Make most efficient use of resources to ensure value for money</td></tr>
<tr><td colspan="4">Consequence;
• Financial sustainability impact
• Negative reputational impact</td></tr>
<tr><td>Current risk rating (LxC)</td><td>Risk appetite</td><td colspan="2">Target risk rating (LxC)</td></tr>
<tr><td>2x4 (8) ~~3x4 (12)~~</td><td>Averse</td><td colspan="2">2x4 (8)</td></tr>
<tr><td>Mitigations
(i.e. processes in place, controls in place)</td><td>Gaps
(Including an identified lead to address the gap and link to relevant action plan)</td><td>Outcomes/Outputs
(i.e. proof points that the risk has been mitigated)

NOTE: ensuring clear alignment of the outcome to the gap it addresses</td><td>Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td>• Financial plan 2022-23 reviewed and supported by Board of Directors with acknowledgement of best endeavours
• Robust CIP governance processes in place with oversight at Programme Oversight Group
• Capital expenditure plan reviewed monthly at Programme Oversight Group and reported by exception to monthly IPB
• Productivity & Efficiency programme status well monitored

<table><tr><td>M9</td><td>M11</td></tr><tr><td>Target: £4.1m</td><td>Target: £4.1m</td></tr><tr><td>£ and % projects approved against target: £3.49m (85%)</td><td>£ and % projects approved against target: £3.56m (87%)</td></tr></table></td><td>• Slippage on financial plan reported at M9 - Chief Finance Officer / ELT
• Productivity & Efficiency programme ideas / PIDs in development reduced since June 22 - Chief Strategy Officer</td><td>• Delivery of financial plan 2022-23
• Satisfactory delivery of Productivity & Efficiency programme target for 2022-23</td><td>• Financial plan delivered or mitigated position with ICS - March 2023 - ACHIEVED</td></tr>
</table>

£ and % delivered against plan: £2.74m (89%)	£ and % delivered against plan: £3.34 (88.7%) Approved schemes at 104.6% of planned savings at M11			
• Monthly monitoring of financial position at IPB and bi-monthly at FPC • Finance, Resources & Oversight Group (FROG) established to strengthen financial governance sub-IPB • Bi-weekly Capital group (with agreement to increase to weekly up to year-end) • Focused work at Senior Development Forum on areas of financial pressure followed up at ELT with action plans/impact on run rates to be monitored at FROG • Quarterly meetings of CFO with ICB CFO • Representation at C&M-led workshops – Place workshop in December 2022 with follow up in January 2023 – C&M CFO workshop in January 2023 • HFMA financial sustainability checklist completed and tested by MIAA with good assurance provided and reported to FPC (Jan 2023) • P&E risk (ID2778) reduced to ~~RR10~~ RR5 with likelihood of not achieving in full high (5) but consequence ~~minor (2)~~ insignificant (1) based on overall financial position				

• Non-delivery of financial plan 22/23 risk (ID2807) ~~rated at RR12~~ reduced to RR8. • Financial forecasting taking into account action plans and best/likely/worst case modelling			

ID05 Poor financial performance at Place creates a negative impact on the Trust and leads to increased monitoring and regulation	Finance & Performance Committee oversight

Link to 5-year strategy - Deliver sustainable health and care services

Consequence;

- Poor service user access, experience and outcomes
- Poor contract performance - financial implications (system)
- System regulatory action

Current risk rating (LxC)	**Risk appetite**	**Target risk rating (LxC)**
1x4 (4)	Averse	1x4 (4)

Mitigations **(i.e. processes in place, controls in place)**	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs** **(i.e. proof points that the risk has been mitigated)** NOTE: ensuring clear alignment of the outcome to the gap it addresses	**Trajectory to mitigate and achieve target risk rating**
• Place-based governance arrangements establishing following approval by CEOs • Target Operating Model approved • Place-based Partnership Board established • Wirral Place Director and CEOs meeting weekly • Strategic COOs meeting weekly • Wirral CFOs meetings regularly • ICB required Wirral Place, Finance & Resources Group established to be arranged - expected start date October 2022 • Wirral Provider Partnership MoU and ToRs developed - further review in January 2023 and presentation to PBPB in March 2023	- Arrangements for Wirral Provider Partnership to be agreed ~~*(including delegation of authority from Board of Directors - 2023/24)*~~ - **Chief Executive** - Place-based Partnership Board to establish and embed - **Chief Executive** - Wirral Provider Partnership to establish - **Chief Executive** ~~Place risk register to determine impact for Trust and mitigate system-wide risks - **Chief~~	• Delivery of financial plans • Improved performance at Place - measured by system-wide indicators • Patient satisfaction and feedback • Stakeholder satisfaction and feedback • Positive impact on health inequalities demonstrated	• Inaugural Place-Based Partnership Board - **September 2022** - **COMPLETE** • Establishment of Wirral Provider Partnership with oversight of provider performance - ~~**October 2022**~~ - inaugural meeting in December 2022 and subsequent meeting in January 2023.

• Wirral Provider Partnership, once operational, accountable to the Place-based Partnership Board • Financial plan 2022-23 reviewed and supported by Board of Directors with acknowledgement of best endeavours • Robust P&E governance processes in place with oversight at Programme Oversight Group and monthly IPB • Service contracts in place, approved and with strengthened scrutiny and governance arrangements • HFMA financial sustainability checklist completed and tested by MIAA with good assurance provided • **As at the end of 2022, there is no formal monitoring of Wirral Place combined Financial Performance**	~~**Executive/Deputy Chief Executive**~~ *Residual gaps to be addressed through 2023-24 strategic risk as not currently established at Place or ICS* - *Delegation of authority to WPP from ICS and respective Boards of Directors* - *Place risk register to determine impact for Trust and mitigate system-wide risks* - *WPP oversight of provider performance*		

ID06 Trust operational and financial performance is poor and has an impact on Place performance and future monitoring and regulation	Finance & Performance Committee oversight

Link to 5-year strategy - Deliver sustainable health and care services

Consequence;

- Poor service user access, experience and outcomes
- Poor contract performance - financial implications (Trust)
- Negative reputational impact

Current risk rating (LxC)	**Risk appetite**	**Target risk rating (LxC)**
2x4 (8)	Averse	1x4 (4)

Mitigations **(i.e. processes in place, controls in place)**	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs** **(i.e. proof points that the risk has been mitigated)** NOTE: ensuring clear alignment of the outcome to the gap it addresses	**Trajectory to mitigate and achieve target risk rating**
• Performance and governance framework in place to monitor performance across the Trust • Monthly Integrated Performance Board established and embedding • TIG dashboards allowing tracking of performance • KPI performance monitored and reported monthly - actions plan in place for red KPIs • Waiting list management process in place (also aligned to health inequalities) • Service Directors in post and Organisational Design based on localities in place • Organisational risks tracked through the governance structure • Strategic COOs meeting weekly	• Evidence and assurance on performance according to population need and demographics - **Chief Operating Officer, Chief Nurse and EDI Lead** • Safe Staffing systems and processes embedded to ensure optimum workforce levels to deliver operationally - **Director of HR&OD (via Safe Staffing Group)** • Waiting list data and trajectories to be built into TIG - **Chief Operating Officer**	• Improved position on red KPIs • (c10%) Reduction in agency usage across the Trust • Sustained strong patient satisfaction and feedback (average 92% recommending Trust services) - see mitigations • Stakeholder satisfaction and feedback through Place Based Partnership Board • Positive impact on health inequalities demonstrated through service provision (waiting list data and patient experience) • Smooth return of Adult Social Care contract to the Local Authority	• Reduction in number of red KPIs - **October 2022 - ONGOING** • Segmentation of waiting lists according to Health Inequalities data - CORE20plus5 model - **March 2023** • Staff survey results - **March 2023** • Adult Social Care contract transfer - **Q1, 23/24**

• Trust position clear in Place governance - *see ID03 and ID05* • Wirral CFOs meetings regularly • Wirral Provider Partnership MoU and ToRs developed - further review in January 2023 and presentation to PBPB in March 2023 • Wirral Provider Partnership accountable to the Place-based Partnership Board • Service contracts in place, approved and with strengthened scrutiny and governance arrangements • Finance, Resources & Oversight Group established to strengthen financial governance sub-IPB • Waiting list oversight workshops established through Deputy COO leadership • Winter plan in place across providers (and presented to Board in December 2023) • Good service user feedback (at M7 2nd highest Trust in C&M for volume with 94% recommending the Trust; at M9 volume = 1,895 with 90.4% recommending; at M11 volume = 1,295 responses with 92.2% recommending) • Waiting list data built into TIG dashboard • HFMA financial sustainability checklist completed and tested by MIAA with good assurance provided • Project Group established jointly with the Local Authority for the return of the Adult Social Care contract	• Redesign of Operational Performance dashboard in TIG to include SPC charts and trajectories for improved performance, as required - **Chief Operating Officer** • Reduction in agency usage across core services - **HRD** • Approved project plan for the return of Adult Social Care contract to the Local Authority - **Chief Strategy Officer** • Effective stakeholder engagement (Wirral, C&M and Northwest) during ASC contract transfer - **Chief Executive/Director of Corporate Affairs**		

• All waiting lists to be within 52 weeks (with one exception - paediatric SLT - associated risks being managed on risk register, ID2834 (4x3), ID2865 (4x3), ID2830 (4x3))			

Board Assurance Framework 2022-23

Strategic risks with oversight at People & Culture Committee

When considering the mitigations and structures in place for each strategic risk, the committee recognises the following standing mitigations which constitute the quality governance framework in place across the Trust.

Corporate Governance

- The People & Culture Committee meets on a bi-monthly schedule with an agreed annual workplan in place
- The committee has Terms of Reference in place, reviewed annually (last reviewed in October 2022)
- The committee completes a self-assessment against its work in respect of the agreed Terms of Reference (last completed in September/October 2022)
- The Director of HR & Organisational Development is the Executive Lead for the committee
- The Integrated Performance Board is the highest operational group in the Trust and maintains oversight and scrutiny of performance to provide assurance to the committee
- The PCOG (People & Culture Oversight Group) reports to the IPB on all matters associated with people and workforce performance; the FROG reports to the IPB on all matters associated with operational performance
- In accordance with the Trust's Risk Policy, the committee receives a report on high-level organisational risks, and can access all operational risk status through the Datix on-line system, to monitor actions to mitigate risks and determine any impact on strategic risks being managed through the BAF
- The committee receives an update on trust-wide policies related to the duties of the committee (via SAFE) and on the implementation of recommendations from internal audit reviews (via TIG - Audit Tracker Tool)
- The Chair of the committee is the NED health and wellbeing lead for the Trust

Workforce Governance

- The governance structure in place provides clarity on the groups reporting to the committee
- The committee contributes to the development of the annual People Strategy Delivery Plan and priorities and receives bi-monthly assurance on implementation
- The committee receives the Terms of Reference for the groups reporting to it
- The committee receives the minutes from group meetings for noting
- The committee contributes to the development of, and maintains oversight on the implementation of the annual people/workforce priorities
- The committee reviews and approves the EDS2 (workforce domains), WRES and WDES annual reports and associated action plans
- The committee ensures that processes are in place to systematically and effectively respond to reflective learning from staffing incidents and employee relations cases
- The committee receives and approves the Trust's workforce plan
- FTSU Guardian appointed and FTSU Executive Lead is a member of the committee

Monitoring workforce performance

- The committee receives a workforce report providing a summary of all workforce performance metrics (YTD) at each meeting
- The members of the committee have access to the Trust Information Gateway, to monitor workforce performance

- The committee receives updates live from the system on regulatory compliance including local audits and procedural documents
- Monitoring of new services in St Helens and Knowsley through existing governance arrangements – oversight of mobilisation plans

ID07 Our people do not feel looked after, their employee experience is poor, and their health and wellbeing is not prioritised (NOTE: risk will be reviewed again at the rescheduled PCC meeting on 10 May 2023)	Education & Workforce Committee oversight

Link to 5-year strategy - Improve the wellbeing of our employees
Better employee experience to attract and retain talent

Consequence;

- Low staff morale - increase in sickness absence levels and reduced staff engagement
- Poor staff survey results
- Poor staff retention
- Reputation impact leading to poor health and care outcomes
- Increase in staff turnover and recruitment challenges

Current risk rating (LxC)	**Risk appetite**	**Target risk rating (LxC)**
3 x 4 (12)	Averse	1 x 4 (4)

Mitigations **(i.e., processes in place, controls in place)**	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs** **(i.e., proof points that the risk has been mitigated)** NOTE: ensuring clear alignment of the outcome to the gap it addresses	**Trajectory to mitigate and achieve target risk rating**
• People Strategy published with clear alignment to the NHS People Promise and ambition 1 'Looking after our people' • Wellbeing Champions in services across the Trust • Quarterly pulse survey embedded across the Trust (11% completion rate for Q2 - 52.2% of respondents 'feeling calm', 39.2% of respondents 'feeling anxious') • Q2 pulse survey results saw an improvement in scores for feeling proactively supported in health and	• ~~Pulse survey completion rates - **Deputy Director of HR and L&OD**~~ • Pulse survey engagement score tracking through Trust governance - **Deputy Director of HR and L&OD** • Effective exit processes to ensure learning and improve retention - **Deputy Director of HR and L&OD**	• Improved levels of staff engagement and satisfaction in national and local surveys - *see mitigations for on-going tracking* • Improvement in quarterly pulse survey engagement score • Reduction in staff turnover rates (M9 = 14.7% M7 = 15% M5 = 14.5%) • Reduction in staff sickness rates (M9 = 7.9% M7 = 6.3% M5 = 6.9% Year on year comparison M9 2021/22 = 8.62%)	• Team WCHC values embedded and visible - **March 2023** • Health and wellbeing is personalised for all staff - **March 2023** • Embedding of e-roster - **March 2023** (supported by MiAA audit review Q4, 2022-23) • Outcome of insight work following pilot of agile working principles - ~~**October 2022-January 2023**~~ **- Q4, 2022/23**

wellbeing and feeling supported as a team - higher than NHS overall • Q2 engagement score = 6.47% – Motivation = 6.41 – Involvement = 6.47 – Advocacy = 6.54 • Staff survey team intentions at local level • Team WCHC staff recognition scheme & Staff Awards successfully delivered • Health and wellbeing conversation training for managers (87 staff received training in 2022) • Wellbeing (including financial wellbeing) information on Staff Zone for all staff • Wagestream available for all staff • NEW Vivup staff benefits platform launched • FFT results providing high satisfaction levels from service users (>90%) • Leadership Qualities Framework in place and supporting development of leadership skills • System Leadership Training for senior leaders • Staff Council • Agile working principles developed with JUSS and Staff Council for pilot (Q2) • Managers briefings in place and issued to support with the dissemination of key messages • Annual appraisals with focus on health and wellbeing	• Greener grass conversations when staff are considering leaving - **Deputy Director of HR and L&OD** • ~~Review of people governance structure to reflect tracking of metrics - **interim Director of HR & L&OD**~~ • Trust-wide retention plan - **interim Director of HR & L&OD** • Impact of industrial action - **Interim Director of HR&OD** • Behavioural standards framework linked to values and LQF - **Head of L&OD** • Wellbeing conversations training with managers to achieve target of 100 - **Head of HR** • Approved project plan for the return of Adult Social Care contract to the Local Authority - **Chief Strategy Officer** • Supporting internal communications plan to support staff during transfer - **Director of Corporate Affairs**	• Health and wellbeing conversation training is delivered to all managers • Reduction in staffing related risks on Datix (M9 = 27 active staffing risks on Datix of which 1 high-level, 12 medium and 14 low; M7 = 26 staffing risks on Datix of which 0 high-level, 24 medium and 2 low level) • Team WCHC values are visible in all people practices (recruitment, appraisal, supervision) and at all levels • Wellbeing conversations achieved according to target in People Strategy Delivery Plan (n=100) • Leadership Quality Framework embedded across the Trust • Launch behavioural standards framework • Smooth transfer of Adult Social Care contract to the Local Authority with good employee experience	• Increase in % of responses to quarterly pulse survey - **October 2022** (Q2 achieved 11% against an NHSE benchmark of 10%) • Improved engagement score *(involved, advocacy, motivated)* in quarterly pulse survey • Annual Staff Survey results - **March 2023** • Amendments to LQF - **January 2023** • Behavioural statements framework **- to PCC in April 2023** • Adult Social Care contract transfer - **Q1, 2023/24**

• Freedom To Speak Up Guardian connecting across the Trust • Revised People Governance arrangements established to support tracking and monitoring of metrics - People and Culture Oversight Group • Recruitment deep dive completed and presented to IPB (October 2022) and PCC (December 2022) providing greater awareness of initiatives and understanding of available data • Recruitment task and finish group established • Pulse survey Q4 closing on 31 January 2023 with early indication of high(er) uptake • Minimal impact from industrial action due to pre-planning • Industrial action engagement well managed and positive in tone. Close engagement with staff both in the planning and on the days of action; clear communication and supportive action to staff in derogated services and on the picket line • Wellbeing conversations training for managers - more targeted approach to areas with high sickness due to stress, anxiety and depression • Project Group and HR workstream established for the return of the Adult Social Care contract			

ID08 Our People Inclusion intentions are not delivered; people are not able to thrive as employees of our Trust and the workforce is not representative of our population (NOTE: risk will be reviewed again at the rescheduled PCC meeting on 10 May 2023)	Education & Workforce Committee oversight
Link to 5-year strategy - Improve the wellbeing of our employees Better employee experience to attract and retain talent	
Consequence; • Poor outcomes for the people working in the Trust • Reduced staff engagement • Failure to meet the requirements of the Equality Act 2010 • Increase in staff turnover and recruitment challenges	

Current risk rating (LxC)	**Risk appetite**	**Target risk rating (LxC)**
3 x 4 (12)	**Cautious**	1 x 4 (4)

Mitigations **(i.e., processes in place, controls in place)**	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs** **(i.e., proof points that the risk has been mitigated)** NOTE: ensuring clear alignment of the outcome to the gap it addresses	**Trajectory to mitigate and achieve target risk rating**
• Inclusion and Health Inequalities Strategy published with a commitment to empowering and upskilling our people • People Strategy published with clear alignment to the NHS People Promise and ambition 1 'Looking after our people' • Staff network groups established for BAME, LGBTQ, (Dis)Ability and Carers • Staff Council • Leadership Qualities Framework in place and supporting development of leadership skills	• WDES and WRES actions to improve the experience of disabled staff and BAME workforce have not achieved the intended outcome - **Deputy HRD/Head of HR/Head of Inclusion** • Trust to raise awareness of reasonable adjustments, sharing lived experiences, increasing declaration rates and membership of the	• Improved staff experience for disabled staff (WDES) • Improved levels of staff engagement in national and local surveys • Reduction in staff turnover rates • Improvement in quarterly pulse survey engagement score (by equality groups) • Increased numbers of people joining the organisation from currently underrepresented groups	• Deliver cultural awareness training - **March 2023** • Further develop staff networks - **March 2023** • Deliver all actions from the WDES action plan - **June 2023** • Deliver all actions from the WRES action plan - **July 2023** • Increased diversity at senior roles in the trust and at Trust Board - **2023/24**

• WRES and EDS completion with oversight at PCC (recent moderation/assessment of Cardiology and Bladder & Bowel services rated as 'achieving' in relation to EDS) • Gender pay gap report to PCC • Wellbeing Champions in services across the Trust • Inclusion Champions in services across the Trust • WDES reporting increase in number of staff reporting they are disabled • WDES reporting increase in the likelihood of being appointed as a disabled member of staff • A more representative board in comparison to the rest of the workforce • Implementation of the reverse mentoring scheme with BAME staff • WRES reporting an increase in the percentage of the workforce from a BAME background • Recruitment deep dive completed and presented to IPB (October 2022) and PCC (December 2022) providing greater awareness of initiatives and understanding of available data • Recruitment task and finish group established • NHS Rainbow Pin Badge scheme - achieved bronze status - January 2023	(Dis)Ability network - **Head of HR/Head of Inclusion** • Reverse mentoring scheme to be set up with directors and disabled staff - **Head of HR/ Head of Inclusion** • Race Disparity Ratio data pending from NHS England - **Head of HR** • Involvement in widening participation initiatives and share lived experiences to encourage BAME applicants to the Trust - **Head of HR/ Head of Inclusion** • Increased diversity at senior roles in the trust and at Trust Board - **Director of HR & OD**	including those from Core20Plus5 communities • Development of multiple career pathways • Training is delivered to senior leaders and line managers in culture, equality, inclusion, fairness and justice • Targets are set and monitored to ensure workforce is more representative of the local community at all levels • Further develop staff networks as active partners in decision making processes • Improved and sustained levels of staff satisfaction and feedback	• Annual Staff Survey results - **March 2023**

ID09 Safe Staffing levels are not maintained across the Trust impacting on the safe delivery of services, staff morale and regulatory compliance (NOTE: risk will be reviewed again at the rescheduled PCC meeting on 10 May 2023)	Education & Workforce Committee oversight
Link to 5-year strategy - Grow, develop and realise potential	
Consequence; • Inability to attract and recruit appropriately skilled staff • Poor staff retention • Low staff morale • Reputation impact leading to poor health and care outcomes	

Current risk rating (LxC)	**Risk appetite**	**Target risk rating (LxC)**
3 x 4 (12) *(decreased likelihood from 4 to 3)*	**Averse**	2 x 4 (8)

Mitigations **(i.e. processes in place, controls in place)**	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs** **(i.e. proof points that the risk has been mitigated)** NOTE: ensuring clear alignment of the outcome to the gap it addresses	**Trajectory to mitigate and achieve target risk rating**
• Establishment of Safe Staffing Project Group • Safe Staffing Project tracked through PMO with PID approved at POG • Core Services Oversight Group established to support regulatory compliance across core services • SAFE/OOG and PCOG have oversight of key safe staffing metrics • Mandatory training compliance high and stable - 95.1% at M9, 94.4% at M7 • Safe Staffing on CICC - safe staffing model supports professional judgement by	• Full roll-out of E-roster including SafeCare facility - **Deputy Director of HR & L&OD** • Role essential training compliance - **Service Directors & Quality Leads** - M9 = 84%, M7 = 81.2% • Sustained reporting of supervision levels - **Service Directors & Quality Leads** M9 = 77.8% clinical and professional, 65.9% ASC, 70.5% management	• Full roll-out of E-roster across the Trust M7 = 85% roll-out where technically possible including newly TUPE in services). • Improved and sustained role essential training and clinical/professional supervision levels - improving position to be monitored via SOG and IPB for a sustained position over 5-6 months (by March 2023) • Reduction in staffing incidents and risks (M9 = 62 staffing incidents on Datix; 39 = no harm and 23 = low	• Future presentation of safe staffing data from automated system - Q4 2022-23 - IN PROGRESS (Committee - December 2022; Board - February 2023) • E-rostering utilisation is optimised to support safe care delivery - **March 2023** (supported by outcome of MiAA review Q4, 2022/23) • SNCT training delivered - Q4 2022-23

maximising use of available staffing resource, implementing a holistic multidisciplinary team model including the use of therapies staff	supervision (M7 = 84.3% clinical and professional supervision, 76.4% ASC supervision, 73% management supervision) • Trust-wide retention plan - **interim Director of HR & L&OD** • Triangulation of safe staffing data with quality and safety metrics - **Deputy HRD and Deputy Chief Nurse** • Access the Safer Nursing Care Tool to validate workforce establishment setting - **Deputy Chief Nurse**	harm) M7 = 26 staffing risks on Datix of which 0 high-level, 24 medium and 2 low level) (M7 = 38 staffing incidents (increased from 22 in M6) • Staff satisfaction and feedback	• 6-monthly staffing audit using SNCT - Q1 2023-24 • Mitigation of risk ID2784 (RR12 L3 x C4) - Lack of availability of Safe Staffing Dashboard to provide best management of staffing resource and high-quality assurance to Board of Directors - expected date of completion on Datix 31.12.22 • ID2784 (RR12 L3 x C4) revised risk description 'Inability to effectively demonstrate Safe Staffing compliance' - expected date of completion 31.3.23 • Development of a WCHC widening participation offer to create new talent pipelines into the organisation

To: Alison Hughes – Director of Corporate Affairs
Mark Greatrex – Chief Finance Officer
Karen Lees – Head of Corporate Governance

From: Ann Ellis – Senior Audit Manager

Date: 13/03/23

Re: 2022/23 Assurance Framework Review – Phase 2

1 Introduction and Background

An efficient and effective Assurance Framework (AF) is a fundamental component of good governance, providing a tool for the Board to identify and ensure that there is sufficient, continuous and reliable assurance, organisational stewardship and the management of the major risks to organisational success.

The principles of assurance frameworks have been in place for a number of years, and there has been a continued focus on ensuring the embeddedness of these processes and the extent they are used by the Board.

Whilst traditionally the AF focused on risks, controls and assurances within the organisation, we are starting to see a wider focus across organisation boundaries and an increase in external risks to reflect the environment within which organisations are operating.

This AF review is a key piece of evidence to support your annual governance statement (AGS), and the Board's conclusions on the effectiveness of their internal control systems.

2 Objectives & Scope

The overall objective was to assess the approach to which the organisation has maintained and uses the AF to support the overall assessment of governance, risk management and internal control.

The review was conducted in two stages:

Phase 1 consisted of a survey of Board members and other relevant personnel, to collate views on the utilisation and effectiveness of the AF within the organisation. Examples of areas covered by the survey included:

- Alignment of the organisation's strategic objectives and key risks
- Utilisation and consideration of risk appetite
- Board engagement with and scrutiny of the AF
- System related risks

Phase 2 consisted of an assessment of the following sub objectives (utilising findings from Phase 1 where appropriate):

- The structure of the AF meets the NHS requirements
- The organisation considers risk appetite and risk appetite is used to inform the management of the AF
- There has been Board engagement in the review and use of the AF throughout the financial year; and
- The quality of the content of the AF demonstrates clear connectivity with the Board agenda and external environment.

Limitation to Scope: The review focused on the elements described above and therefore did not include review/ confirmation of the controls or actual assurances received.

3 Objectives & Assurance Statement

Opinion

Structure	**The organisation's AF is structured to meet the NHS requirements.**
Risk Appetite	**The organisation considers risk appetite regularly and the risk appetite is used to inform the management of the AF.**
Engagement	**The AF is visibly used by the organisation.**
Quality & Alignment	**The AF clearly reflects the risks discussed by the Board.**

4 Detailed Assessment

4.1 Structure

Desktop review of the Assurance Framework (Date on AF provided: December 2022)

Requirement	Conclusion	Wider Commentary
4.1.1 The structure of the AF meets the NHS requirements in respect of defining objectives, risks, controls, assurances and gaps.	The structure of the AF does meet the NHS requirements.	• The organisation's AF includes scoring for current and target risk ratings. These are included on both the summary AF and the detailed AFs (one section for each committee e.g. Finance & Performance Committee). Although, it was identified that the
4.1.2 The objectives within the AF align with those in the strategic plan.	The objectives within the AF do align with those in the strategic plan.	

4.1.3 The AF includes risk scoring, i.e. initial, current and target risk scores.	The organisation's AF does include reference to the movement of risks / risk profile.	December 2022 AF did not include initial risk scoring, it was noted that this has since been added as a column on the summary AF. • The organisation's AF does provide updates of progress against actions. **However, our review of the AF identified that some actions had been recorded as "ongoing" when the initial deadline had passed.** • Audit review confirmed that each gap had been allocated a responsible lead to address the gap and that action plans were in place to mitigate these. **However, the Trust should consider allocating a responsible lead for each action rather than for each gap.** • **The organisation's AF does not use dashboards / graphs to provide visual overviews although this is not a mandatory requirement.**
4.1.4 The format of the AF provides an action plan to address the gaps.	The AF includes actions to address gaps under the "trajectory to mitigate and achieve target risk rating" heading of the AF.	

4.2. Risk Appetite

Requirement	Conclusion	Wider Commentary

4.2.1 The organisation has a high-level risk appetite statement in place	The organisations risk appetite was not clearly defined and communicated.	• Whilst it is acknowledged that a risk appetite has been presented alongside each risk within the BAF, **no overall defined risk appetite statement was in place which had been approved by the Board.**
		• We were informed that the risk appetite for each risk had been discussed and agreed at Informal Board in April 2022. We confirmed from a review of sub-committee minutes that the risk appetite had also been discussed in the following meetings:
		  ◦ Finance and Performance Committee – August 2022;
		  ◦ Education and Workforce Committee – August 2022; and,
		  ◦ Quality and Safety Committee – July 2022.
		• The risk appetite had been reviewed for system risks that are the same or similar to partnering

4.2.2 The organisations risk appetite is reviewed and updated at least annually	Sub-committee minutes demonstrate review of the risk appetite. The risk appetite had been updated and re-agreed within the period under review.	
4.2.3 The organisation has defined its risks appetite for each strategic objective and this is clearly linked to individual risks.	The AF risks are clearly linked to a strategic objective. The risk appetite is detailed for each risk.	
4.2.4 Risk responses within the AF are reflective of the corresponding risk appetite for the relevant strategic objective.	Risk responses are reflective of the corresponding risk appetite.	

		Trusts/organisations in the context of the shared objectives. • Risk responses are reflective of the corresponding risk appetite. No risk has a target risk rating of more than 8, and 7 of the 9 risks have a risk appetite of "averse". For the remaining two risks, the Trust is willing to accept more risk, however believe that they can achieve a target risk rating of 4.

4.3. Engagement

Review of Board minutes for April 2022 to February 2023 (Dates on meetings when the AF was presented: April, June, October and December 2022 and February 2023)

Requirement	Conclusion	Wider Commentary
4.3.1 The AF is regularly presented to the Board.	The AF was regularly presented to the Board.	The AF was presented to the Board in the following months: • April 2022; • June 2022; • October 2022; • December 2022; and,
4.3.2 The minutes of the Board clearly demonstrate discussion, review and update of the AF.	Board minutes clearly demonstrate discussion and update of the AF.	
4.3.3 Where the AF is regularly presented to the relevant committees of Board.	The AF was regularly presented to committees/subcommittees.	

4.3.4 The minutes of Board Body Committees clearly demonstrate consideration of the AF and associated risks.	Committee minutes received by the Board demonstrate the use of AF by the Committees/Sub Committees.	• February 2023 (as per the meeting papers) Examples of Board discussion of the AF include: • June 2022 – Following presentation of the 2021-22 year-end position in April 2022, members of the Board had considered existing and new themes for the BAF to be tracked during 2022-23 • October 2022 – The consideration and approval of changes in risk descriptions for AF risk reference ID01, ID02, ID05 and ID06, and changes in risk rating for AF risk reference ID08 and ID09. • December 2022 – The consideration and approval of revision to risk scoring for AF risk reference ID03. The AF was presented to Committees/Sub-committees in the following months: • Quality and Safety Committee – May 2022, July 2022, September 2022, November 2022 and January 2023. • Finance and Performance Committee – April 2022, June 2022, August 2022,

		October 2022, November 2022 and February 2023. • People and Culture Committee (formerly named Education and Workforce Committee) – April 2022, June 2022, August 2022, October 2022, December 2022 and February 2023. Examples of committee / sub-committee consideration of the AF include: <u>Quality and Safety Committee:</u> • May 2022 – A member suggested a new theme associated with hearing the voice of patients and communities to be aligned to ID02 and a consideration of a new risk around connectivity to primary care. • September 2022 – Committee members considered the detail of two risks and segmented the mitigations to align with the Quality Strategy and the Health Inequalities & Inclusion Strategy. <u>Finance and Performance Committee:</u> • April 2022 – Discussed changes to the risk rating of AF risk reference ID05. Evidence of challenge by members, noting difficulty in defining the

		consequences of having a deficit and the impact on services and quality. Discussed the ongoing negotiations and mitigations in place, and the update required to reflect the new financial year. • August 2022 – 3 strategic risks were discussed in detail, with consideration being given to both current and target scoring and the mitigations required e.g. introduction of the Finance Oversight Group. • October 2022 – the committee agreed the temporary suspension of the risk relating to lead providers (ID03) until further guidance was received. In addition, there was a proposed revision to AF risk reference ID05 (financial performance) with a detailed discussion around funding streams and accountability. <u>People and Culture Committee:</u> • June 2022 – Recommended updating the wording for AF risk reference ID10 to be more focused and explicit on Safe Staffing. • October 2022 – Discussions on whether previous committee

		discussions on retention and turnover rates had any impact on AF risk reference ID07, no change to the scoring was subsequently agreed.

4.4. Quality and Alignment

Review against Board minutes and Benchmarking (Dates of last three Board meetings: October 2022, December 2022 and February 2023).

Requirement	Conclusion	Wider Commentary
4.4.1 The risks within the AF are visible on the Board agenda.	The risks within the AF were visible on the Board agenda.	The AF includes a wide range of risks reflective of the NHS and external environment for example: • ID01 – Failure to delivery services safely and responsibly to inclusively meet the needs of the population; • ID05 – Poor financial performance at Place creates a negative impact on the Trust and leads to increased monitoring and regulation; and, • ID08 – Our People inclusion intentions are not delivered; people are not able to thrive as employees of our Trust and
4.4.2 The risks identified within the Board minutes are reflected in the AF.	Risks identified by the Board were reflected in the AF.	
4.4.3 Board assurances are clearly identified within the AF.	Assurances were clearly identified.	
4.4.4 Controls are clearly defined within the AF.	Controls were clearly defined.	
4.4.5 Gaps are clearly identified within the AF and actions detailed.	Gaps were clearly identified and mitigating actions were in place	

		the workforce is not representative of our population. System risks have been clearly articulated and consider Trust and system wide position (set out in controls, gaps in controls and assurances). There was evidence of the Board connecting risks in papers and discussions to the AF, examples include: • In June 2022, as part of the Workforce Dashboard, it was reported that there has been an increase in staff turnover and sickness absence which links to AF risk reference ID09; and • In August 2022, as part of the Finance Dashboard, pressures on the budget were considered resulting in a change of scoring to risks on the risk register relating to AF risk reference ID05. The assurances detailed within the AF were clear in terms of scope, frequency and reporting routes to the Board.

4.5. Action Plan:

No	Requirement	Recommendation	Management Response / Responsibility for Action / Date
1.	Structure	The way that the AF is structured, the gaps within the AF are worded as "actions" which have a responsible lead to ensure completion of the action. As the identified gaps and corresponding actions are not recorded separately (in the gaps and "trajectory to mitigate and achieve risk rating" columns of the AF), the Trust should ensure the following: • A responsible officer is allocated for each gap/action; • Full description of the action required to address the identified gap is recorded; and, • Implementation due date/deadline is allocated for each gap/action. Where actions are due for review, an update should be provided with	Management Response: This will be addressed in the revisions to the AF for 2023-24 using the structure in place but ensuring clarity on the lead and timeframe for each gap/action to be addressed. Responsible Officer: Director of Corporate Affairs Implementation Date: June 2023

		a new deadline agreed, "ongoing" should not be accepted as a deadline date.	
2.	Structure	The Trust should consider the use of dashboards / graphs within the AF to provide visuals, e.g. heat maps to illustrate areas of high risk or radar graph showing differences between current and target risk scores. This is not a mandatory requirement.	Management Response: This will be explored for the AF in 2023-24 but as it is not a mandatory requirement any graphs or visuals will be introduced when relevant and appropriate. Responsible Officer: Director of Corporate Affairs Implementation Date: July 2023
3.	Risk Appetite	The Trust should ensure there is an overall risk appetite statement in place and that this is subject to an annual review.	Management Response: This will be discussed as part of an informal board session during Q1 2022-23. Responsible Officer: Director of Corporate Affairs (to facilitate with all members of the board) Implementation Date: May 2023