Board Assurance Framework (BAF) 2023-24

Meeting	Board of Directors		
Date	16/08/2023	**Agenda Item**	11
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

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 for 2023-24.

This update provides the position following the committees of the Board who have maintained oversight of relevant strategic risks during July and August 2023.

Executive Summary

The Board has in place a full Board Assurance Framework which is reviewed annually to reflect the strategic priorities of the Trust.

Each of the sub-committees of the Board maintain oversight of strategic risks relevant to the duties and responsibilities of the committee.

The current strategic risks and associated detail for 2023-24 are included in appendix 1 for Board approval.

There is one strategic risk scored at RR16 which relates to the Financial Plan 2023-24.

The Finance & Performance Committee reviewed this risk again at its meeting on 2 August 2023 and also noted a high-level organisational risk (ID2935 = RR16) escalated as per the Risk Policy which relates to emerging budget pressures and the Productivity & Efficiency programme impacting negatively on the delivery of the financial plan.

The committee therefore agreed that strategic risk ID04 - *The financial settlement for 2023/24, together with the Financial Plan negotiated with the C&M ICB, creates a challenging financial target which could result in a risk to the financial sustainability of the organisation* should remain scored at RR16. The committee will continue to keep this risk under review, alongside relevant organisational risks.

The Finance & Performance Committee also noted that following the revision in target risk ratings for ID05 and ID06, both with a cautious risk appetite, that the current risk rating for ID06 had consequently increased to RR12 recognising the gaps and outcomes to be achieved, against the identified trajectory. This was approved by the committee.

The strategic risk 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* continues to achieve the target risk rating, based on a risk appetite of 'open'. This position was reviewed again by the Finance & Performance Committee at its meeting on 2 August 2023 and it was agreed that it remained accurate with a continued focus as the value proposition and governance arrangements for the collaborative are finalised and agreed.

As reported in June 2023, the People & Culture Committee referred a discussion in relation to ID09 - *Safe Staffing levels are not maintained across the Trust impacting on the safe delivery of services, staff morale and regulatory compliance* to the Quality & Safety Committee meeting on 12 July 2023. The PCC asked QSC to consider ID09 in the context of the existing strategic risk ID01 - *Failure to deliver services safely and responsively to inclusively meet the needs of the population* and whether safe staffing should be tracked as part of this strategic risk.

It is therefore recommended to the Board of Directors that ID09 will be archived reflecting the governance processes established across the Trust to monitor and ensure Safe Staffing levels and these mitigations will be included in ID01 as core to ensuring the delivery of safe services.

Any organisational risks associated with staffing levels in services will continue to be managed via the organisational risk register with escalation as required through the governance structure as described in the Risk Policy. The robust governance arrangements in place will continue to be tested and tracked via the monitoring of ID01.

At the meeting of the People & Culture Committee on 9 August 2023, members noted the agreed position in relation to ID09 and agreed a recommendation to the Board of Directors that an emerging strategic risk related to the 'Growing our Future' ambition in the People Strategy be discussed at a forthcoming informal board session. This was considered in the context of the three strands of the People Strategy.

With the exception of ID04 as referenced above, all other risks are scored between RR8 and RR12.

The committees of the Board continue to receive a high-level organisational risk report and any impact on the strategic risks are highlighted in the BAF. There is one high-level organisational risk aligned to strategic risk ID04, as described above.

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 ID09 is archived, and safe staffing processes are incorporated as core mitigations to ID01.
To note that ID04 is scored as a high-level strategic risk at RR16 with on-going monitoring at the Finance & Performance Committee.
To approve the increase in current risk rating for ID06 following the amendment to the target risk rating.
To support the recommendation from the People & Culture Committee to consider an emerging strategic risk in relation to the 'Growing our Future' ambition of the People Strategy.

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	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.
Board of Directors	19/04/23	The Board of Directors received the year-end position in relation to all

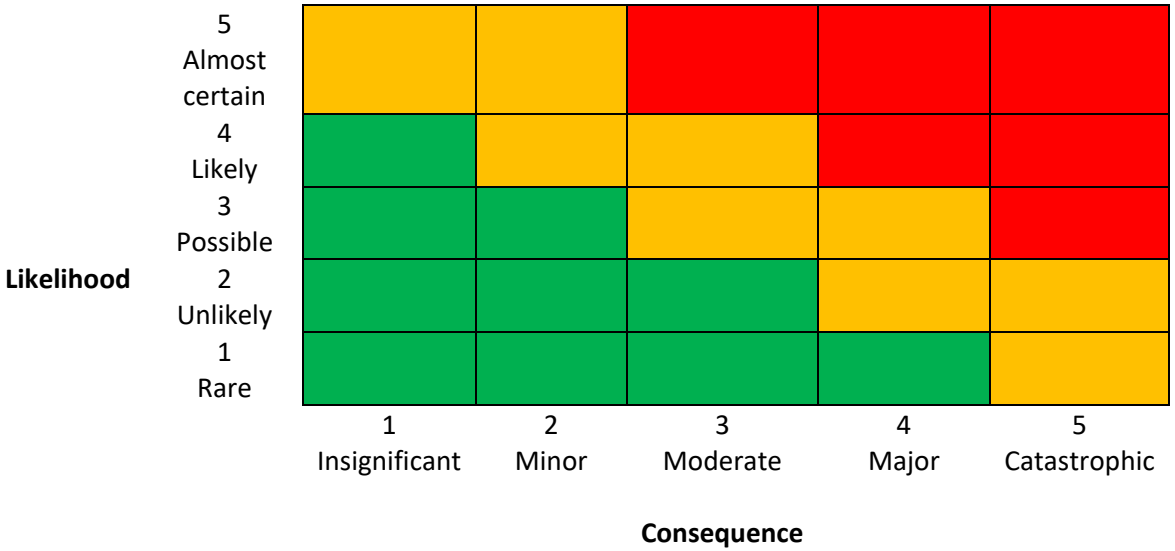
		strategic risks and considered the mitigations, gaps, outcomes and actions for each. The Board of Directors also approved a recommendation that ID05 had achieved its target risk rating.
Informal Board	17/05/23	The members of the board reviewed all proposed strategic risks for 2023-24 and revised risk appetite statements. These are presented to the Board for approval.
Board of Directors	21/06/23	The Board of Directors - reviewed the mitigations, gaps, outcomes and actions already populated for each of the strategic risks. - approved the proposed rewording of ID04 related to the financial plan 2023-24. - approved the recommendation that ID03 has achieved its target risk rating. - noted that the Quality & Safety Committee would review ID09 in the context of ID01.

Strategic risk summary 2023-24

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 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. ***TARGET RISK RATING ACHIEVED***	Finance & Performance Committee	Deliver sustainable health and care services	-	2 x 2 (4)	2 x 2 (4)	Open
ID04 - The financial settlement for 2023-24, together with the Financial Plan negotiated with the C&M ICB, creates a challenging financial target which could result in a risk to the financial sustainability of the organisation.	Finance & Performance Committee	Make most efficient use of resources to ensure value for money	4 x 4 (16)	4 x 4 (16)	2 x 4 (8)	Cautious
ID05 - Poor financial performance at Place creates a negative impact on the Trust and leads to increased monitoring and regulation	Finance & Performance Committee	Deliver sustainable health and care services	3 x 4 (12)	3 x 4 (12)	2 x 4 (8)	Cautious

Risk Description	Committee oversight	Link to 5-year strategy	Initial risk rating (LxC)	Current risk rating (LxC)	Target risk rating (LxC)	Risk Appetite
ID06 Trust operational and financial performance is poor and has an impact on Place performance and future monitoring and regulation	Finance & Performance Committee	Deliver sustainable health and care services	2 x 4 (8)	3 x 4 (12)	2 x 4 (8)	Cautious
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)	Moderate
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)	Moderate
~~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 2023-24

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 and two Patient Safety Partners recruited as per national guidance.
- PSIRF implementation is reported to the committee.
- SAFE system in use trust-wide for 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.
- Partnership working with Local Authorities and other stakeholder organisations via Place (e.g., Quality & Performance Group, Safeguarding Children Partnerships, Safeguarding Adults Partnership Board) and regional (e.g., C&M Chief Nurse Network, MHLDC Provider Collaborative) meetings

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 - Safe care and support every time			
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. - SAFE mechanism for recording supervision captures method of delivery to include peer, group and 1:1 delivery - 78% at M2 (vs 90% target) - Mandatory training compliance trust-wide achieved target (M2 = 93.4%) - Continued improvement on compliance with role essential training - 85.4% at M2. - Quality Strategy delivery plan monitored via Quality & Safety Committee ~~- Safe Staffing project group established.~~	~~- Role essential training compliance below 80% - Service Directors (July 2022) *(reference SAFE/OOG action log)*~~ - 84% compliance at M9 - Clinical, professional and safeguarding supervision compliance sustained at 90% - **Team Leaders** *(see quality goal 3 '90% of clinical staff receiving supervision')* - Baseline assessment to determine clear denominator and criteria for eligible staff for national patient safety curriculum - **Deputy Chief Nurse**	- CQC rating of Good or Outstanding - Mandatory training compliance maintained at 90% - **exceeded.** - Role essential training compliance maintained at 90% ~~- Implementation of PSIRF~~ ~~- Implementation of waiting list stratification tool~~ - Fully informed and engaged staff embedding the language and learning of PSIRF into clinical practice. - Shared understanding of Trust supervision standards and models of delivery by all clinical	- CQC inspection - 2023-24 ~~- System-wide harm prevention group to be established - **COMPLETE with Deputy Chief Nurse attendance.**~~ - 90% of eligible staff trained in national patient safety curriculum per annum - **31 March 2024** - Baseline assessment to determine clear denominator and criteria for eligible staff for national patient safety curriculum - **30 June 2023** - Tracking mechanism for national patient safety

~~- Safe Staffing reporting to PCC and QSC agreed (see cycle of business and ToRs)~~ ~~- Safe Staffing governance established for regular reporting to PCC, QSC and Board (see Board papers February 2023)~~ *(Mitigations transferred from previous ID09)* - Safe Staffing on CICC - safe staffing model supports professional judgement by maximising use of available staffing resource, implementing a holistic multidisciplinary team model including the use of therapies staff. - Establishment of Safe Staffing Project Group - Safe Staffing Project tracked through PMO with PID approved at POG. - Enhanced reporting through the governance agreed via PCC and QSC - Metrics and measures developed to monitor, analyse and review and report against e-rostering system use and performance *(MiAA recommendation completed)* - Reporting timetable developed to ensure regular, timely updating to PCOG and SOG including any trends or areas for improvement *(MiAA recommendation completed)* - Trust engaged in national pilot of Community Nursing Safer Staffing Tool	- Robust tracking mechanism for national patient safety curriculum to be developed with monitoring via SAFE/OPG and SOG - **Deputy Chief Nurse** - Relaunch of supervision policy - **Deputy Chief Nurse** ~~- Deliver plan for roll out of Professional Nurse Advocate Programme across Nursing services - **Deputy Chief Nurse** ***(tracked through PCOG)***~~ - Supervision Training Strategy - **Head of L&OD** - Re-establish Schwartz Round steering group with supporting communications plan - **Deputy Director of Adult Social Care** - complete. - Mobilisation gap analysis to evaluate resources required for mobilisation - complete. - 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 to improve AIS compliance (raised at IPB in April 2023).*	staff evidenced via clinical supervision audit. - Staff will be committed to providing and receiving high quality supervision. - Staff will report increased skill, knowledge and confidence in quality improvement methodology. - Fully informed and engaged staff embedding the language and learning of PSIRF into clinical practice.	curriculum compliance - **30 June 2023** - 40% of eligible staff trained in QI curriculum - **31 March 2024** *(10% of eligible staff will staff will be trained by end of Q2 with a further 5% each during Q's 3 and 4)* ~~- Implementation of training strategy for the National Patient Safety Strategy PSIRF - May 2022 - ON-GOING~~ - 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 and highlighted to IPB in April 2023 to support improved compliance. ~~- Recruitment of Patient Safety Partner (as per national guidance) - **COMPLETE**~~ ~~- Supervision Training Strategy approved - **July 2022 November 2022 -** (Extension for action approved by QSC)~~ - Relaunch of supervision policy - **Deputy Chief Nurse -** 30 September 2023

(CNSST) - the **first cohort of community trusts** to collect safe staffing data - 170 Community Nursing staff within the community nursing day teams trained in data collection on the tool - 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 in place - 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.	- Roll-out of waiting list stratification tool to services (phased approach) **- Deputy Chief Operating Officer -** in use in MSK - Access the Safer Nursing Care Tool to validate workforce establishment setting - **Deputy Chief Nurse**		- 90% of clinical staff receiving supervision - 31 March 2024 - Implementation of PSIRF - **April 2023** - Successful implementation of waiting list stratification tool - **2023-24** - 6-monthly staffing audit using SNCT - Q1 2023-24 - Initial findings from CNSST data collection (to PCC) - October 2023

- Implementation of PSIRF and recruitment of two Patient Safety Partners. - PSIRF stakeholder group established. - Robust gantt chart aligned to the national PSIRF implementation timeframes, reporting to POG monthly by exception. - Development of waiting list stratification tool aligned to CORE20PLUS5 (in pilot phase) - Quality Account 2022-23 developed with key achievements and progress to deliver quality goals highlighted. - 20% baseline of staff trained in Quality Improvement curriculum. **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.		~~- Successful and safe mobilisation of new services - **complete 22-23**.~~ - 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	

- Chief Nurse = Prevention Pledge Executive Lead - Inclusion dashboard developed. - Partnership forum established. - Bronze Status in the NHS Rainbow Pin Badge accreditation scheme - Silver award in the Armed Forces Covenant Employer Recognition Scheme - Veteran Aware accreditation achieved for the Trust. - EDS2 assessment criteria agreed and completed for 2022-23 - AIS template available in S1 for all services. Performance against completion rates tracked via locality SAFE/OPG meetings with increased oversight at IPB. - Development of waiting list stratification tool aligned to CORE20PLUS5 (in pilot phase) - FFT 22/23 reported 27,876 responses with 93% rating their experience as *Very Good* or *Good* (a significant increase in response rate of over 9,000 from 21/22) **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	~~- 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 - **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 - **COMPLETE**

ID02 Failure to deliver services inclusively with people and communities guiding care, supporting learning and influencing change			Quality & Safety Committee oversight
Link to 5-year strategy - Safe care and support every time			
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			
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)** NOTE: ensuring clear alignment of the outcome to the gap it addresses	**Trajectory to mitigate and achieve target risk rating**
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 events in July 2022 and March 2023 - Experience dashboard built on TIG	- ~~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	- 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. - 35% *(Amendment to 20% requested of QSC)* of eligible staff trained in Tier 2 Oliver McGowan mandatory training.	- CQC inspection - 2022/23 - 10% of eligible staff to be trained in inclusion and health inequalities curriculum by **September 2022 - ON-GOING** - Recruit ~~10~~ 8 Community Partners - **31 March 2024** - ~~Model/framework to focus on the 20+5 model developed - **March 2023**~~ - Improved completion of AIS template across all services (supporting waiting list management) - *see ID01 work*

- Partner Safety Partners recruited. **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. - Veteran Aware accreditation (Bronze and Silver) achieved for the Trust. - EDS 2022-23 published on public website. **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.	across all services - **Deputy COO/Service Directors** - *see ID01 work on-going to improve AIS compliance (raised at IPB in April 2023).* - 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 - **campaign has increased establishment but remains an on-going national challenge.** - C&M workforce strategy for Health Visitors and School nurses **Deputy COO/Service Director/Deputy Director of HR&OD**	- 4 care pathways across the trust that will be co-developed with patients. - 40% of eligible staff will have received Training in Quality improvement curriculum. - Staff will report increased skill, knowledge and confidence in quality improvement methodology.	*on-going to improve AIS compliance* - ~~4 Always Events coproduced alongside people with lived experience - **March 2023** (1 completed, 2 on-going and a further event planned)~~ - 4 care pathways across the trust that will be co-developed with patients - **30 September 2023** - 40% of eligible staff trained in QI curriculum - **31 March 2024** *(10% of eligible staff will staff will be trained by end of Q2 with a further 5% each during Q3 & 4)*

- Participation in Local Safeguarding Children Partnerships across all Boroughs where 0-19/25 services are delivered. - Good partnerships with other agencies			

Board Assurance Framework 2023-24

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 financial and performance 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; review in progress August 2023)
- The committee completes a self-assessment against its work in respect of the agreed Terms of Reference (last completed in September/October 2022; scheduled for August 2023)
- 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 Finance & Resources Oversight Group (FROG) reports to the IPB on all matters associated with financial and contractual performance and the Safe Operations Group (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 the status of trust-wide policies (related to the duties of the committee) at every meeting
- The committee receives an update on the implementation of recommendations from internal audit reviews (via TIG - Audit Tracker Tool) at every meeting
- The committee receives assurance reports in respect of the Data Security & Protection Toolkit submission
- The committee receives an IG /SIRO Annual Report

Financial and Operational Governance

- The governance structure in place provides clarity on the groups reporting to the committee
- The committee reviews and approves the Trust's financial and operational plans prior to submission to the Board of Directors and relevant regulators
- 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 Terms of Reference for the groups reporting to it and decision and action logs from each meeting for noting

Monitoring performance

- The committee receives a finance report providing a summary of YTD 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 a YTD 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		2x2 (4) **ACHIEVED (reported to Board in June 2023)**
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 continues to be 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 Strategic Outline Case (SOC) has been developed, agreed and signed off by ALL partners • New Managing Director is working to establish clear governance routes • Value Proposition (VP) supported to travel to respective statutory bodies for support and approval (September 2023)	• ~~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 - on-going 2023-24 • VP to be considered by all statutory bodies for support and approval - September 2023

ID04 The financial settlement for 2023-24, together with the Financial Plan negotiated with the C&M ICB, creates a challenging financial target which could result in a risk to the financial sustainability of the organisation. ***Organisational risk ID2935 = 4 x 4 = RR16***	Finance & Performance Committee oversight
Link to 5-year strategy - Make most efficient use of resources to ensure value for money	
Consequence; • Financial sustainability impact • Negative reputational impact	

Current risk rating (LxC)	**Risk appetite**	**Target risk rating (LxC)**
4x4 (16)	Cautious	2x4 (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**
• CFO engagement in forthnightly ICB discussion on financial pressures across C&M • Medium-term financial plan developed with the ICB • System expenditure control arrangements in place • External audit of financial year 2022-23 providing unqualified opinion and VFM assessment concluded • Financial plan 2023-24 reviewed and approved by Board of Directors	• P&E gap and slippage on delivery at M3 - **Chief Strategy Officer and IPB** • Achievement of financial plan reported at M3 (£129k surplus) - **Chief Finance Officer and IPB** • Productivity & Efficiency programme ideas / PIDs in development - **Chief Strategy Officer**	• Delivery of financial plan 2023-24 • Delivery of Productivity & Efficiency programme target for 2023-24 • Compliance with all necessary and relevant system expenditure controls • Mitigated position in relation to ID2935 and reduction in risk rating.	• P&E target of £5.3m delivered - March 2024 • Financial plan delivered or mitigated position with ICB - March 2024

- Financial pressures for 2023-24 reviewed and reduced, funded or mitigated
- Monthly monitoring of financial position (including P&E) at FROG and IPB and bi-monthly at FPC
- Structured process in place via the PMO for developing, approving and tracking schemes to meet the P&E target
- Monthly oversight via FROG, POG, IPB and FPC
- Weekly P&E tracking meetings

P&E target	**£ and % projects approved against target**	**£ and % delivered against plan**
5.3m	£1.142 m (22%) Additional transformation schemes approved to a notional value of £550k	£127k (29% of M1 plan)
	£2.59m (49%) Additional transformation schemes approved to a notional value of £462.5k (9%).	£531k (40% of M3 plan)

- Capital expenditure plan reviewed monthly at Programme Oversight Group and reported by exception to monthly IPB

• HFMA financial sustainability checklist completed and tested by MIAA with good assurance provided and reported to FPC (Jan 2023) • New organisational risks raised for 2023-24 related to achieving P&E target and delivery of the financial plan • Leadership Forum held on 13 & 14 July with line managers - raised awareness of financial plan challenges and c.500 ideas generated related to productivity and/or efficiency (currently being reviewed by PMO and Finance)			

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 - Make most efficient use of resources to ensure value for money			
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)**	
3x4 (12)	Cautious	2x4 (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**
• Place-based governance arrangements establishing following approval by CEOs including Finance, Investment and Resources Group (FIRG) • FIRG collectively reviewing P&E and financial position across all providers • System workshops to evaluate all system investments and ROIs • System workshops reviewing medium-term financial recovery plans • Pooled fund budget arrangements and governance in place • BCF risk share arrangements agreed • Place-based Partnership Board established with renewed governance approach	- Delegation of authority to Place from ICB - **Chief Executive & Chief Finance Officer** *(update provided at ICB Finance Committee in May 2023 but no confirmation of timeframes)* - Place risk register to determine impact for Trust and mitigate system-wide risks - **Chief Finance Officer & Director of Corporate Affairs** (anticipated October 2023) - Place accountability and performance framework to be implemented (from ICB) - **Chief Executive** (via CEOs forum)	• Delivery of financial plans • ~~Improved~~ Established Place financial governance via the Finance, Investment & Resources Group (providing assurance and the opportunity to triangulate at Place Based Partnership Board) • Improved performance at Place - measured by system-wide indicators / accountability and performance framework • Patient satisfaction and feedback • Stakeholder satisfaction and feedback • Staff satisfaction and feedback (i.e., staff reporting ability to collaborate,	• Quarterly review of financial performance at Place to confirm trajectory - July, October, January, April • Place accountability and performance framework to be implemented (from ICB) - Q3, 2023-24 • Delivery of financial plan or mitigated position agreed with ICB - March 2024

• Monthly Place Director and CEOs forum embedded in Place governance • Wirral CFOs meetings regularly • CFO and CEO engagement in ICB discussion on financial pressures across C&M • Financial plan 2023-24 reviewed and approved by Board of Directors • Place Review Meetings established with ICB • System expenditure control arrangements in place		influence and work effectively with partners) • No negative changes to System Oversight Framework (SOF) ratings at Place • No increased monitoring or enhanced financial regime for the Trust • Mitigated position agreed with ICB	

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 - Make most efficient use of resources to ensure value for money

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)**
3x4 (12)	Cautious	2x4 (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**
• Performance and governance framework in place to monitor performance across the Trust • Monthly Integrated Performance Board established • TIG dashboards allowing tracking of performance • KPI performance monitored and reported monthly - actions plan in place for red KPIs • Waiting list management process developed (also aligned to health inequalities) and reported monthly to IPB • Organisational risks tracked through the governance structure • Strategic COOs meeting weekly	• ~~CICC contract extension confirmation - **Chief Finance Officer & Chief Operating Officer**~~ • Successful expansion of Home First service according to agreed system plan - **Chief Operating Officer** • Waiting lists performance to be within 52 weeks - **Chief Operating Officer** • Evidence and assurance on performance according to population need and demographics - **Chief**	• Improved position on red KPIs • Reduction in agency usage across the Trust • Sustained strong patient satisfaction and feedback (average 92% recommending Trust services) • 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~~ • Good CQC inspection outcome	• Reduction in number of red KPIs • Full roll-out of waiting list stratification tool to all services - **March 2024** • Delivery of financial plan or mitigated position agreed with ICB - **March 2024** • Staff survey results - **March 2024** • ~~Adult Social Care contract transfer - **Q1, 23/24**~~

• Trust position clear in Place governance - *see ID03 and ID05* • Wirral CFOs meetings regularly • Service contracts in place, approved and with strengthened scrutiny and governance arrangements • Finance, Resources & Oversight Group established and meeting monthly to provide assurance to IPB • Sustained monthly performance with FFT feedback • 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 • COO is SRO for Home First across the system • Sustained strong performance (monitored via IPB and FPC) for Community Integrated Response Team services and CICC (i.e., positive system impact) • Downward trajectory in turnover rates, vacancy rates, temporary staffing levels and sickness absence rates across the Trust (i.e., resilience in workforce) • Waiting list stratification tool pilot in services (MSK and podiatry) demonstrating positive impact	**Operating Officer, Chief Nurse and EDI Lead** • ~~Effective stakeholder engagement (Wirral, C&M and Northwest) during ASC contract transfer - **Chief Executive/Director of Corporate Affairs**~~		

• KPI review exercise in progress with commissioners and agreement to refine by Q3, 2023-24 • TIG waiting list dashboard with targets visible with RAG status against performance compared to previous quarter (methodology reported to IPB) • TIG functionality allowing drill down for full caseload and new patient waiting list (SLT)			

Board Assurance Framework 2023-24

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; review in progress August 2023)
- The committee completes a self-assessment against its work in respect of the agreed Terms of Reference (last completed in September/October 2022; scheduled for August 2023)
- The Chief People 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 PCOG (People & Culture Oversight Group) reports to the IPB on all matters associated with people and workforce 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 the status trust-wide policies (related to the duties of the committee) at every meeting.
- The committee receives an update on the implementation of recommendations from internal audit reviews (via TIG - Audit Tracker Tool) at every meeting.
- 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 and decision and action logs from each meeting for noting.
- The committee reviews and approves the EDS (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.
- The 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

ID07 Our people do not feel looked after, their employee experience is poor, and their health and wellbeing is not prioritised	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)	**Moderate**	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' • People Strategy Delivery Plan 2023-24 developed and progress reviewed bi-monthly by committee • Wellbeing Champions in services across the Trust • Enhanced monitoring and reporting on progress against Trust and locality level staff survey action plans (via PCOG) • Quarterly tracking of wellbeing actions from staff survey in PCOG	• ~~Pulse survey completion rates - Deputy Director of HR and L&OD~~ • Trust-wide staff engagement plan to respond to national NHS staff survey 2022 results *(stabilised position but little improvement with low ranking in recommending the Trust as a place to work and staff morale)* - **Chief People Officer** - plan approved and	• Staff engagement score in the National Staff Survey (NSS) $\geq$ 7.2 • NSS uptake $\geq$ 50% • Q23c in NSS *"I would recommend my organisation as a place to work"* $\geq$ 63.9% • Q24a in NSS *"I often think about leaving the organisation"* (lower % is better) $\leq$ 28.0% • Improve staff retention $\leq$12% over 12 months.	• ~~Team WCHC values embedded and visible - **March 2023**~~ • Embedding of e-roster - **August 2023** as per MiAA recommendation - **complete.** • Outcome of insight work following pilot of agile working principles - **- Q2, 2023-24** • Amendments to LQF - LQF under review and proposed amendments to PCOG - ~~**March 2023**~~ October 2023 (as amended in delivery plan)

i.e., Q9d - *'My immediate manager takes a positive interest in my health and wellbeing'.* Q11a - *'My organisation takes positive action on health and wellbeing'.* • Improved monitoring of national quarterly pulse survey (NQPS)) via TIG • Team WCHC staff recognition scheme & Staff Awards successfully delivered • Wellbeing conversation training for managers (100+ staff received training to date) and uptake monitored at PCOG • Wellbeing (including financial wellbeing) information on Staff Zone for all staff • Wagestream available for all staff • 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 *(LQF under review to identify any gaps in current behavioural statements)* • System Leadership Training for senior leaders • Staff Council • Agile working principles developed with JUSS and Staff Council • Managers briefings in place and issued to support with the dissemination of key messages (to be enhanced through staff engagement plan)	shared with committee in August 2023 • ~~Pulse survey engagement score tracking through Trust governance - Deputy Director of HR and L&OD~~ (via TIG dashboard) • Implement Recruitment and Retention Action Plan (inc. improved leaver data, improved exit processes) - **Deputy Director of HR and L&OD** • ~~Effective exit processes to ensure learning and improve retention - **Deputy Director of HR and L&OD** - on-going via R&R group & PCOG~~ • ~~Greener grass conversations when staff are considering leaving - **Deputy Director of HR and L&OD** - on-going via R&R group~~ • ~~Review of people governance structure to reflect tracking of metrics – **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**	• We work flexibly NHS People Promise score in NSS = 6.7 • Positive position from appraisal audit to verify quality and staff experience. • Positive FFT results at 'very good' or 'good' ≥92.2% • 'Morale' theme score in NSS ≥6.1. • 'Inclusion' sub-score of 'We are compassionate and inclusive' NHS People Promise score in NSS ≥7.3. • 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 including refreshed Leadership Forum. • Launch of behavioural standards framework. • Smooth transfer of Adult Social Care contract to the Local Authority with good employee experience	• Behavioural standards framework launched - ~~**July 2023**~~ October 2023 (as amended in delivery plan) • Adult Social Care contract transfer - **Q1, 2023/24 (30 June 2023) - complete.** • Comprehensive review of senior management leadership development (to date) - **June 2023** - commenced with Leadership Forum • Review and refresh of Leadership Forum - **August 2023** - **complete.** • Appraisal audit to verify quality and staff experience - **December 2023** • Staff engagement score in the National Staff Survey (NSS) ≥ 7.2 – **March 2024** (quarterly monitoring via NQPS) • NSS uptake ≥ 50% - **March 2024** (quarterly monitoring via NQPS) • Q23c in NSS *"I would recommend my organisation as a place to work"* ≥ 63.9% - **March 2024** (quarterly monitoring via NQPS) • Q24a in NSS "I often think about leaving the organisation" (lower % is better) ≤ 28.0% - **March 2024** (quarterly monitoring via NQPS) • Improve staff retention ≤12% over 12 months by **March 2024**

• Annual appraisals with focus on health and wellbeing and inclusion of career conversation in 2023 • Training packages in place via ESR to support managers to undertake more effective appraisals. • Freedom To Speak Up Guardian connecting across the Trust. • Organisational-wide recruitment and retention (R&R) group reporting to PCOG • R&R group developed Exit Plan to ensure coherent approach. • ~~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~~ • ~~Project Group and HR workstream established for the return of the Adult Social Care contract.~~ • Reduction in vacancy rate in June 2023 to 3.3% (= 58 vacant posts) *(3.9% in May, 3.6% in April 2023)* • Refresh and relaunch of MDT preceptorship programme. • Shadow board programme secured for Deputies *(starting September/October 2023)*	• Review of LQF to identify any gaps in current behavioural statements and develop support materials - **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** - on-going to end of June 2023~~ • Comprehensive review of senior management leadership development (to date) - **Head of L&OD** • ~~Review and refresh of Leadership Forum - **Head of L&OD**~~		• We work flexibly NHS People Promise score in NSS = 6.7 - **March 2024** • 'Morale' theme score in NSS ≥6.1 - **March 2024** • 'Inclusion' sub-score of 'We are compassionate and inclusive' NHS People Promise score in NSS ≥7.3 - **March 2024**.

• Leadership Forum for Band 7 managers and below held in July 2023 with good feedback and plan for twice yearly engagement. • People Pulse Survey (July 2023) included local questions on the intention to leave (aligning to question 24 in the staff survey) - *response rate 22% (410 staff)* - results to PCC in October 2023.			

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 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)	**Moderate**		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. • 97.3% compliance with mandatory EDI learning (as at 2 August 2023) • 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, Ability and Carers. New Menopause Network.	• Achievement of WDES and WRES actions to improve the experience of disabled staff and BAME workforce - **Deputy HRD/Head of HR/Head of Inclusion** • Raise awareness of reasonable adjustments, sharing lived experiences, increasing declaration rates and membership of the Ability network - **Head of HR/Head of Inclusion**	• Staff engagement score in the National Staff Survey (NSS) $\geq$ 7.2 • NSS uptake $\geq$ 50% • Q23c in NSS *"I would recommend my organisation as a place to work"* $\geq$ 63.9% • Q24a in NSS *"I often think about leaving the organisation"* (lower % is better) $\leq$ 28.0% • Improve staff retention $\leq$12%	• Cultural awareness training for staff and managers - ~~**March 2023**~~ - ~~**June 2023**~~ **October 2023** (as amended in delivery plan) • Deliver all actions from the WDES action plan - ~~**June 2023**~~ **June 2024** *of the 5 actions, 3 were completed, 1 reframed and 1 carried forward to 2023-24 action plan. • Deliver all actions from the WRES action plan - ~~**July 2023**~~ **June 2024**

• Executive sponsorship of all staff networks refreshed and agreed. • Staff Council • Leadership Qualities Framework in place and supporting development of leadership skills *(LQF under review to identify any gaps in current behavioural statements)* • 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 (June 2023) • 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 • WRES reporting an increase in the percentage of the workforce from a BAME background. WRES action plan rated a '3' (best score) by the national team. Representatives of BAME staff network supporting the development of more inclusive recruitment practices. • Organisational-wide recruitment and retention (R&R) group reporting to PCOG	• Allyship support between directors and disabled staff - **Head of HR/ Head of Inclusion** • ~~Race Disparity Ratio data pending from NHS England - **Head of HR** - received and areas for improvement to be incorporated into the WRES action plan for 2023-24~~. • 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 - **Chief People Officer** • Implement Recruitment and Retention Action Plan (inc. improved leaver data, improved exit processes) - **Deputy Director of HR and L&OD** • Further develop staff networks as active partners in decision making processes - **Head of HR** • Targeted recruitment for entry level roles/ career pathways, in areas of high deprivation	• 'Compassionate culture' sub-score of 'We are compassionate and inclusive' from NHS People Promise in NSS $\geq$7.2. • 'We are safe and healthy' from NHS People Promise in NSS $\geq$6.3. • 'Morale' theme score in NSS $\geq$6.1. • 'Inclusion' sub-score of 'We are compassionate and inclusive' NHS People Promise score in NSS $\geq$7.3. • Improved staff experience for disabled staff (WDES) • Increased numbers of people joining the organisation from currently underrepresented groups including those from Core20Plus5 communities • Development of multiple career pathways • Launch of cultural awareness training for managers and staff • Targets are set and monitored to ensure workforce is more representative of the local community at all levels	*action plan for 2022-23 notes completed actions with some carried forward to 2023-24 • Increased diversity at senior roles in the trust - **September 2023** • Development of pre-employment programmes - **September 2023** • Implement the WCHC approach to Widening Participation - **December 2023** • Staff engagement score in the National Staff Survey (NSS) $\geq$ 7.2 – **March 2024** (quarterly monitoring via NQPS) • NSS uptake $\geq$ 50% - **March 2024** (quarterly monitoring via NQPS) • Q23c in NSS *"I would recommend my organisation as a place to work"* $\geq$ 63.9% - **March 2024** (quarterly monitoring via NQPS) • Q24a in NSS "I often think about leaving the organisation" (lower % is better) $\leq$ 28.0% - **March 2024** (quarterly monitoring via NQPS) • Improve staff retention $\leq$12% over 12 months by **March 2024** • 'Compassionate culture' sub-score of 'We are compassionate and inclusive' from NHS People Promise in NSS $\geq$7.2 - **March 2024**

• R&R group developed Exit Plan to ensure coherent approach • NHS Rainbow Pin Badge scheme - achieved bronze status - January 2023 *(aiming for Silver 2023-24)* • Armed Forces Covenant community inclusion initiatives - covenant signed, silver DERS achieved and VCHA accreditation achieved • E-Learning sourced to support Armed Forces Community inclusion • Recruitment and Retention Policy includes positive action in respect of increasing diversity at senior roles (8a and above). • WRES data 2022-23 – BAME staff in the Trust increased from 3.6% to 4.1%	according to CORE20Plus5 - **Head of L&OD** • Development of pre-employment programmes as part of Trust Widening Participation approach - **Head of L&OD** • Implement the WCHC approach to Widening Participation *(incorporating Work Experience, pre-employment programmes and an engagement programme with schools and FE providers)* - **Head of L&OD**		• 'We are safe and healthy' from NHS People Promise in NSS ≥6.3 - **March 2024** • 'Morale' theme score in NSS ≥6.1 - **March 2024** • 'Inclusion' sub-score of 'We are compassionate and inclusive' NHS People Promise score in NSS ≥7.3 - **March 2024.**