Compassion Open Trust

Wirral Community Health and Care NHS Foundation Trust

Board Assurance Framework (BAF) 2023-24 - year-end position

Meeting	Board of Directors		
Date	17/04/2024	**Agenda Item**	12
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 March and April 2024 and presents the year-end position for each strategic risk.

This paper also provides the final report and opinion following completion of the MIAA Assurance Framework Review.

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 strategic risks and associated detail for 2023-24 are included in appendix 1 for Board approval. Each of the committees have reviewed the position of each relevant strategic risk during March and April to provide a year-end position to the Board of Directors.

Year-end position 2023-24

There remains 1 high-level strategic risk (ID04) reported in the BAF. This risk relates to the financial settlement for 2023-24 and the financial sustainability of the Trust.

All other strategic risks recorded on the BAF are scored between RR8 and RR12.

Three risks achieved their target risk rating during 2023-24 - ID03, ID05 and ID06.

Following review by the People & Culture Committee on 10 April 2024, the risk rating associated with ID07 has reduced from RR12 (3 x 4) to RR8 (2 x 4). This reflects the 'moderate' risk appetite and recognises the action taken to address the gaps and the progress reported to the committee to achieve mitigations, predominantly through the findings of the national NHS staff survey.

A number of strategic risks have been identified to be carried forward to 2024-25. At the meeting of the Finance & Performance Committee on 3 April 2024 it was agreed that the strategic risk associated with the financial plan 2024-25 and Place impact on both financial and operational performance would be discussed further at the informal board on15 May 2024 and following final submission of the finance plan for 2024-25.

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 are no high-level organisational risks to report.

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. The review was completed by MIAA in February 2024 providing the following opinion;

- 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

Wirral Place Delivery Assurance Framework

The Wirral Place Based Partnership Board manages key system strategic risks through the Place Delivery Assurance Framework. The PDAF has been developed and was initially reviewed at the PBPB in December 2023 with a three-monthly review schedule thereafter. The PDAF identifies key strategic risks across 7 areas and those of relevance have been highlighted to the committees of the Board for further context and tracking during 2024-25 against identified Trust strategic risks.

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 review the mitigations, gaps, outcomes and actions already populated for each of the strategic risks and to approve the position reported for the year-end 2023-24 for each of the strategic risks.

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	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.

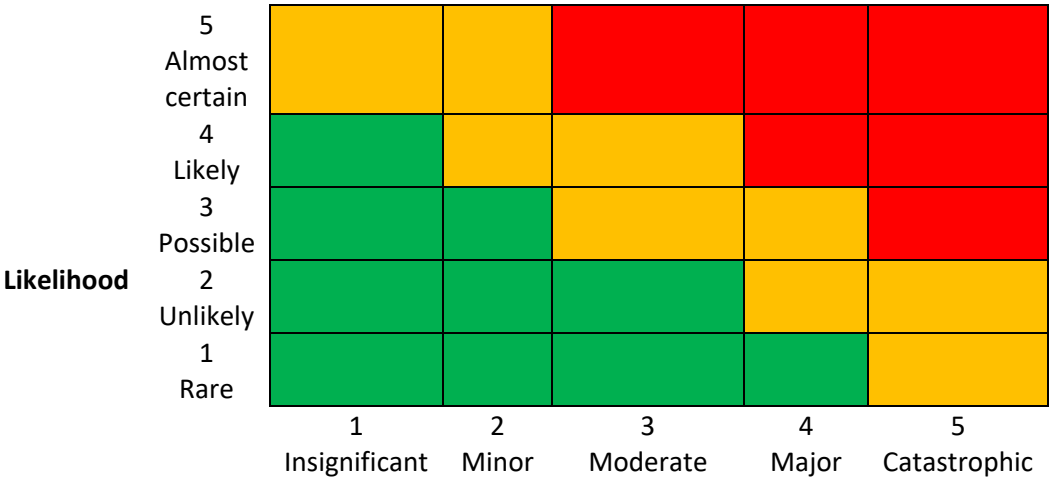
Informal Board	17/05/23	The members of the board reviewed all proposed strategic risks for 2023-24 and revised risk appetite statements. These are presented to the Board for approval.
Board of Directors	21/06/23	The Board of Directors - reviewed the mitigations, gaps, outcomes and actions already populated 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.
Board of Directors	16/08/23	The Board of Directors - considered the mitigations, gaps, outcomes and actions already populated for each of the strategic risks. - approved the recommendation that ID09 is archived, and safe staffing processes are incorporated as core mitigations to ID01. - noted ID04 as a high-level strategic risk at RR16 with on-going monitoring at the Finance & Performance Committee. - approved the increase in current risk rating for ID06 following the amendment to the target risk rating.
Board of Directors	17/10/23	The Board of Directors reviewed the mitigations, gaps, outcomes and actions for each of the strategic risks and noted ID04 as a high-level strategic risk at RR16 with on-going monitoring at the Finance & Performance Committee. The Board of Directors also supported a recommendation from the People & Culture Committee to consider a strategic risk in relation to retaining talent and growth of the workforce.

Board of Directors	13/12/23	The Board of Directors approved the recommendations in the report and was assured of the oversight and management of strategic risks in the BAF through the sub-committees of the Board. In particular, the Board noted ID04 remained the highest scoring strategic risk.
Board of Directors	21/02/24	The Board of Directors reviewed the mitigations, gaps, outcomes and actions already populated for each of the strategic risks. The Board of Directors noted the detail provided in relation to the new risk ID10 and approved a revised risk description for 2024-25 for ID04.

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. **RISK TO BE ARCHIVED AT YEAR-END** *(new risk description for 2024-25 in development and to be agreed at informal board in May 2024)*	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
TARGET RISK RATING ACHIEVED						
ID06 Trust operational and financial performance is poor and has an impact on Place performance and future monitoring and regulation. ***TARGET RISK RATING ACHIEVED***	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. ***RISK TO BE CARRIED FORWARD FOR 2024-25.***	People & Culture Committee	Improve the wellbeing of our employees Better employee experience to attract and retain talent	3 x 4 (12)	~~3 x 4 (12)~~ 2 x 4 (8)	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. ***RISK TO BE CARRIED FORWARD FOR 2024-25.***	People & Culture 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.~~ ***RISK ARCHIVED AND INCORPORATED INTO ID01***.	~~Education & Workforce Committee~~	~~Grow, develop and realise potential~~	~~3 x 4 (12)~~	~~3 x 4 (12)~~	~~2 x 4 (8)~~	~~Averse~~
ID10 - We are not able to attract, grow and develop our talent sufficiently to ensure the right numbers of engaged, motivated and skilled staff to meet activity and operational demand levels. ***RISK TO BE CARRIED FORWARD FOR 2024-25.***	People & Culture Committee	Grow, develop and realise employee potential Better employee experience to attract and retain talent	2 x 4 (8)	2 x 4 (8)	1 x 4 (4)	Open



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

Board Assurance Framework 2023-24 year-end position

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 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 and on the implementation of recommendations from internal audit reviews
- 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.
- Governance arrangements established for the mobilisation of the Lancashire Healthy Child Programme with Executive SRO and supporting project structure.

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 (also including the Freedom To Speak Up steering group with effect from September 2023).
- 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 (also including the Freedom To Speak Up steering group with effect from September 2023).
- 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)
- SAFE Operations Group (SOG) reporting directly to the Integrated Performance Board
- Regular formal and informal engagement with CQC

- CQC inspection completed July – August 2023 and report published (December 2023).
- 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 and attends committee.
- FTSU Steering Group reporting to the committee.

System Governance

- Wirral Place Quality Performance Group established with CNO as member

Monitoring quality performance

- The committee receives a quality report from TIG providing a YTD summary (via SPC charts) of all quality performance metrics at each meeting.
- The members of the committee have access to the Trust Information Gateway 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

RISK TO BE CARRIED FORWARD FOR 2024-25. **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. ~~- CQC inspection completed - draft report pending~~ - CQC rating (published 13 December 2023) - GOOD with outstanding areas - Sexual Health Service rated Outstanding by CQC - Community Services for Adults rated Outstanding for Caring - Psychological safety of staff prioritised to enable delivery of the safest care and support. - SAFE mechanism for recording clinical and professional supervision captures method	~~- Role essential training compliance below 80% - Service Directors (July 2022) *(reference SAFE/OOG action log)*~~ - 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 report - **October 2023** - **COMPLETE (see mitigations)** - 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** *(on track)* - Baseline assessment to determine clear denominator and criteria for eligible staff for national patient safety

of delivery to include peer, group and 1:1 delivery - ~~85.5% at M3 92.2% at M6, 92.7% at M8,~~ 85.5% at M10 (vs 90% target) - Mandatory training compliance trust-wide achieved target - ~~M3 = 94.5% 95.2% at M6~~, ~~95.1% at M8,~~ 95.1% at M10 (vs 90% target) - Continued improvement on compliance with role essential training - ~~91.6% at M7, 92.2% at M8,~~ 92.8% at M10 (vs 90% target) - Quality Strategy delivery plan monitored via Quality & Safety Committee - 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 (Q2 Safe Staffing data reported to PCC in December 2023; nothing further reported in Quality Report (M8) - 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	~~- 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*	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 - **COMPLETE** *(see Quality Strategy delivery plan)* - Tracking mechanism for national patient safety curriculum compliance – **COMPLETE** *(see Quality Strategy delivery plan)* - 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 - on track)* - Embedding of health inequalities/AIS dashboard across all services - **July 2023** - Recruitment of Patient Safety Partner (as per national guidance) - **COMPLETE** - Supervision Training Strategy approved - **November 2023 -** (Extension for action approved by QSC) - Relaunch of supervision policy - Deputy Chief Nurse - **30 September 2023 - COMPLETE** - 90% of clinical staff receiving supervision - **31 March 2024** - Implementation of PSIRF - ~~**April 2023**~~ quality goal 2 actions identified for June (complete) and **31 March**

including any trends or areas for improvement *(MiAA recommendation completed)* - Trust engaged in national pilot of Community Nursing Safer Staffing Tool (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	*IPB in April 2023 and included in EDS action plan re: domain 1).* - 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** - Complete full implementation and testing of PSIRF across the Trust - **Deputy Chief Nurse**		**2024** *(see Quality Strategy delivery plan)* - Successful implementation of waiting list stratification tool - **2023-24** - 6-monthly staffing audit using SNCT - The first formal data collection period in the Trust was completed between 17 – 23 July 2023 - **COMPLETE.** - Initial findings from CNSST data collection (to PCC) - ~~October 2023~~ **PENDING** (data collection complete, analysis and interpretation in progress - reported to PCC) - Lancashire Healthy Child Programme - **1 April 2024**

- 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. - PSIRF policies and procedures developed and implemented to promote sustainability. - 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 published with key achievements and progress to deliver quality goals highlighted. - 20% baseline of staff trained in Quality Improvement curriculum. - Baseline completed to determine a clear denominator and criteria for eligible staff for the national patient safety curriculum *(detailed in Quality Strategy delivery plan)* - Training compliance visible on TIG for L1 & L2 of the national patient safety curriculum. - Current compliance L1 & L2 - 94.26%, L1 for board and senior management - 93.33%, L1 for other staff (agreed cohort) - 95.76%			

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. - SRO and Project Lead identified. - Workstreams and relevant leads identified and work now underway. **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. - 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 - achieving across all	- Satisfactory completion of mobilisation plan to support safe launch and delivery of Lancashire Healthy Child Programme from 1 October 2024 - **Executive Leadership Team/Board of Directors**	- Safe mobilisation of Lancashire Healthy Child Programme contract from 1 October 2024 - 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	

areas including Domain 1 commissioned services (community cardiology and bladder and bowel) - AIS template available in S1 for all services. Performance against completion rates tracked via locality SAFE/OPG meetings with increased oversight at IPB. Included as an action from EDS domain 1. - Development of waiting list stratification tool aligned to CORE20PLUS5 (in pilot phase) - FFT (YTD) = 21,262 responses with 92.5% recommending Trust services **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**

RISK TO BE CARRIED FORWARD FOR 2024-25. **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. - CQC rating (published 13 December 2023) - GOOD with outstanding areas. - EDI training compliance - 98.2% - ~~CQC inspection completed - draft report pending.~~ - 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.	- ~~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 report - **October 2023 - COMPLETE** - 10% of eligible staff to be trained in inclusion and health inequalities curriculum by **September 2022 - ON-GOING** - Recruit 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*

- 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 - Partner Safety Partners recruited - Re-balancing of resources in community nursing to support caseload in PCNs underway **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. - Quality Strategy Delivery Plan details care pathways identified for co-design. **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.	across all services - **Deputy COO/Service Directors** - *see ID01 work on-going to improve AIS compliance (raised at IPB in April 2023 and included in EDS action plan domain 1).* - 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) - **COMPLETE.** - 4 care pathways across the trust that will be co-developed with patients - **31 March 2024** - 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)*

- EDS 2022-23 published on public website with actions identified. - 92% of staff completed comprehensive learning disability and autism e-learning (Oliver McGowan Level 1) **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			

Board Assurance Framework 2023-24 year-end position.

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 August 2023)
- The committee completes a self-assessment against its work in respect of the agreed Terms of Reference (last completed in September/October 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
- CQC inspection published December 2023 with overall rating of Good.

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

System Governance

- Wirral Place Finance, Investment and Resources Group established with CFO as member
- Trust involvement in system planning sessions for 2024-25

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 with TIG dashboards allowing tracking of performance
- The members of the committee have access to the Trust Information Gateway to monitor performance

TARGET RISK RATING ACHIEVED. **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)**	
2 x 2 (4)	Open	2 x 2 (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**
• 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) • WCHC NED appointed as NED representative on MHLDC Leadership Board	• ~~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~~ *(post workshop with Chair(s))* - **December 2023** • Chair and NED attending workshop on 18 October 2023 - **COMPLETE**

RISK TO BE ARCHIVED AND REPLACED BY NEW ID04 FOR 2024-25 **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 = L2 x C4 = RR8 Organisational risk ID2917 = ~~L5 x C3 = RR15~~ L1 x C3 = RR3 (reduced January 2024) ***Agreed at Board of Directors that this remains a high-level strategic risk given the underlying financial position.***	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)**
4 x 4 (16)	Cautious	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**
• CFO engagement in Place peer-review of financial position reporting to the Board and ICB • Briefing to Board of Directors via extraordinary board on 23/11/23 on latest position with the ICB and collaborative work at Place to reivew and improve overall financial position • CFO engagement in all ICB discussions as and when required on financial pressures across C&M	• ~~P&E gap and slippage on delivery at M9 - **Chief Strategy Officer and IPB** *(link to risk ID2917)*~~ • ~~Achievement of financial plan reported at M5 (£253k surplus achieving plan)~~ - **Chief Finance Officer and IPB** • ~~Productivity & Efficiency programme ideas / PIDs in development - **Chief Strategy Officer** *(link to risk ID2917)*~~	• Delivery of financial plan 2023-24 • Delivery of Productivity & Efficiency programme target for 2023-24 *(link to risk ID2917)* • Compliance with all necessary and relevant system expenditure controls • Mitigated position in relation to ID2935 and reduction in risk rating. • Agreement of financial plan for 2024-25	• P&E target of £5.3m delivered - March 2024 *(link to risk ID2917)* - **COMPLETE.** • Financial plan delivered or mitigated position with ICB - March 2024 - **COMPLETE.**

• Achievement of financial plan reported at M7 (achieving plan) supported by non-recurrent means • 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 • Financial pressures for 2023-24 reviewed and reduced, funded or mitigated • Monthly monitoring of financial position (including P&E) at FROG, POG 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 • Weekly P&E tracking meetings • MIAA report providing **Substantial Assurance** on CIP identification and tracking processeS **P&E target** | **£ and % projects approved against target** | **£ and % delivered against plan**	• ~~Emerging budget pressures - **Chief Finance Officer and IPB**~~ • A Third of the P&E delivery is recurrent. There is reliance on non-recurrent means to balance the budget this year, and this results in future pressures	• Clarity of strategic risk focus for 2024-25 aligned to organisational in-year risks and strategic longer-term risks	

	5.3m	£1.142m (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)		
		£2.79m (53%) Additional transformation schemes approved to a notional value of £212.5 (6%)	£988.223 (45% of M5 plan)		
		£3.451m (65%)	£1.85m (60% of plan for M7)		
		£3.57m (67%)	100% of target met (M9)		
		£4.9m (92%)	100% of target met (M11)		
• 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)					

• 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 • ELT review of all 23-24 schemes by portfolio to determine delays, deferrarls or rejections and confirm revised position. • FROG conducting deep dives of overspending and underspending cost centres			

TARGET RISK RATING ACHIEVED. **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 Link to PDAF - Poor financial performance in the Wirral health and care system leads to a negative impact and increased monitoring and regulation (RR20)	
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)**
~~3 x 4 (12)~~ 2 X 4 = (8)	Cautious	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**
• CFO engagement in Place peer-review of financial position reporting to the Board and ICB • Briefing to Board of Directors via extraordinary board on 23/11/23 on latest position with the ICB and collaborative work at Place to reivew and improve overall financial position • Place-based governance arrangements established following approval by CEOs including Finance, Investment and Resources Group (FIRG) • FIRG collectively reviewing P&E and financial position across all providers	- 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** (Place Delivery Assurance Framework PDAF developed)~~ - Place accountability and performance framework to be	• Delivery of financial plans • 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	• Quarterly review of financial performance at Place to confirm trajectory - **July, October, January, April -** IN PROGRESS (see CFO engagement in peer-review of financial position) • 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 -** IN PROGRESS (see CFO

• 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 • 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	implemented (from ICB) - **Chief Executive** (via CEOs forum) - System financial recovery plan 24-25 to be developed through the planning round - Chief Finance Officer	• Staff satisfaction and feedback (i.e., staff reporting ability to collaborate, 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	engagement in peer-review of financial position)

TARGET RISK RATING ACHIEVED. **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 Link to PDAF - Wirral system partners are unable to deliver the priority programmes within the Wirral Health and Care Plan which will result in poorer outcomes and greater inequalities for our population (RR8).	
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)**
~~3 x 4 (12)~~ 2 x 4 =(8)	Cautious	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**
• CQC report providing overall rating of 'Good' • Achievement of financial plan reported at M9 (achieving plan) supported by non-recurrent means • Strong operational performance reported at ~~M9 - 61 Green, 12 Amber, 13 Red~~ M11 = 64 Green, 13 Amber, 9 Red • Strong and sustained performance against operational system metrics • All KPIs have been revised and updated to ensure they are relevant, consistent with other providers locally and nationally, and with appropriate RAG thresholds.	• ~~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	• 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)	• 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 - COMPLETE** • Staff survey results - **March 2024 - COMPLETE** • ~~Adult Social Care contract transfer - **Q1, 23/24**~~

• Waiting list management process developed (also aligned to health inequalities) • All waiting lists are clinically triaged • At M11 all services (except paediatric and adult SLT) continue to report under 52 weeks for first appointments • 10 out of 18 services achieved quarterly stretch targets for reducing waiting time for first appointment during Q2, 23-24 - updated position shared at FPC (February 2024) • Strategic COOs meeting weekly • 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 • Sustained monthly performance with FFT feedback (~~M9 = 91.8%~~ M11 = 91.6% recommending services) • 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 - activity increasing and expansion trajectory on track • Sustained improvements in LoS at CICC	demographics - **Chief 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**~~	• ~~Smooth return of Adult Social Care contract to the Local Authority~~ • ~~Good CQC inspection outcome~~	

• 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 • ~~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) • Agency use below 3.7% ICB cap (~~M9 = 1.4%~~ M11 = 1.7%)			

Board Assurance Framework 2023-24 year-end position.

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 August 2023)
- The committee completes a self-assessment against its work in respect of the agreed Terms of Reference (last completed in September/October 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.

System Governance

- Wirral Place Workforce Group established with CPO as member

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

RISK TO BE CARRIED FORWARD FOR 2024-25. **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)~~ 2 x 4 (8)	**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**
• NHS staff survey 2023 results published with improvements across all areas (significantly improve in 8 of the 9 scores compared to 2022) • 2023 uptake for national staff survey = 60% (1,047 responses) • Trust turnover rate of 11.1% has achieved target as per People Delivery Plan for Year 2 - ≤12% average over 12 months by March 2024.	• ~~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~~	• CQC rated GOOD Trust • 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%	• ~~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 – COMPLETE.** *(presented to IPB in November 2023 and policy development underway)*

• 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 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 (281 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%)	~~**Officer** - plan approved and 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**~~	• Q18 in NSS - *'My organisation treats staff who are involved in an error, near miss or incident fairly'.* • Improve staff retention <12% over 12 months. • We work flexibly NHS People Promise score in NSS = 6.7 • Positive position overall from appraisal audit and recommendations to PCOG. • 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.	• Amendments to LQF - LQF under review and proposed amendments to PCOG - ~~March 2023 October 2023 January 2024~~ March 2024 (as amended in delivery plan) complete and replaced by actions around the behavioural standards framework • Behavioural standards framework launched - ~~July 2023 October 2023 January 2024~~ March 2024 (as amended in delivery plan) – **COMPLETE.** • Adult Social Care contract transfer - **Q1, 2023/24 (30 June 2023) – COMPLETE.** • Comprehensive review of senior management leadership development (to date) - **COMPLETE.** • Review and refresh of Leadership Forum - **August 2023** - **COMPLETE.** • Appraisal audit - **COMPLETE.** • Staff engagement score in the National Staff Survey (NSS) > 7.2 – **March 2024** (quarterly monitoring via NQPS) - **ACHIEVED** • NSS uptake > 50% - **March 2024** (quarterly monitoring via NQPS) - **ACHIEVED** • Q23c in NSS *"I would recommend my organisation as a place to work"* > 63.9% - **March 2024**

• 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 Voice Forum • 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) • Annual appraisals with focus on health and wellbeing and inclusion of career conversation in 2023 • Appraisal 2023 completion rate exceeding 95% • Highest performing community trust in the country for the quality of appraisals (NSS 2023) • Training packages in place via ESR to support managers to undertake more effective appraisals. • Freedom To Speak Up Guardian connecting across the Trust and excellent engagement during FTSU month (October 2023) • Organisational-wide recruitment and retention (R&R) group reporting to PCOG • R&R group developed Exit Plan to ensure coherent approach.	• ~~Behavioural standards framework linked to values and LQF - **Head of L&OD**~~ • Review of LQF to identify any gaps in current behavioural statements and develop support materials - **Head of L&OD** development in 24/25 of Behavioural Standards Framework to be launched and embedded in 24/25, action in year 3 HR delivery plan • ~~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**~~	• Smooth transfer of Adult Social Care contract to the Local Authority with good employee experience	(quarterly monitoring via NQPS) - **ACHIEVED** • Q24a in NSS "I often think about leaving the organisation" (lower % is better) $\leq$ 28.0% - **March 2024** (quarterly monitoring via NQPS) - **ACHIEVED** • Improve staff retention $\leq$12% over 12 months by **March 2024 - ACHIEVED** • We work flexibly NHS People Promise score in NSS = 6.7 - **March 2024 - ACHIEVED** • 'Morale' theme score in NSS $\geq$6.1 - **March 2024 - ACHIEVED** • 'Inclusion' sub-score of 'We are compassionate and inclusive' NHS People Promise score in NSS $\geq$7.3 - **March 2024 - ACHIEVED** • Launch of behavioural standards framework - **Q1, 2024-25**

• R&R group developed recruitment and retention action plan ~~(due for completion March 2024)~~ with improved monitoring of leaver data and improved exit processes. • ~~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 rates (data on TIG) • Refresh and relaunch of MDT preceptorship programme. • Shadow board programme secured and underway for Deputies • Leadership Forums for Band 7 managers and Band 8 senior leaders established. • July 2023 People Pulse Survey 22% uptake = 410 headcount resulting in an overall engagement score of 7.00 *(up from 6.68 and just above the national average for staff engagement, an improvement from the April figures).* • January 2024 Pulse Survey 20.7% uptake = 379 headcount resulting in an overall engagement score of 7.16 *(up from 7.00 in July 2023).* • Festival of Leadership delivered successfully	• ~~Review and refresh of Leadership Forum - **Head of L&OD**~~ • Alignment to ICB cultural tool *(in development)* to provide targeted support to teams - **Head of L&OD** this is an action in year 3 HR delivery plan • ~~Appraisal audit to verify quality and experience of staff - **Deputy HRD**~~ • Design, commission and implement a trust wide team development methodology - **Head of L&OD** this is an action (changed slightly) in year 3 HR delivery plan • Launch of behavioural standards framework - **Head of L&OD**		

• Legacy mentor in post • HR involvement in PSIRF project • 'Intention to leave' question from the staff survey is included in quarterly pulse checks and follow up with services where this data shows outliers. January PP = 63% would recommend WCHC as a place to work *(increase from 58.9% in July 2023)* • Behavioural standards framework developed and approved *(shared at informal board in March 2024)* - pending launch in Q1 24-25. • Funding for People Promise Manager secured and recruitment in progress			

RISK TO BE CARRIED FORWARD FOR 2024-25. **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**
• NHS staff survey 2023 results published with improvements across all areas (significantly improve in 8 of the 9 scores compared to 2022) • 2023 uptake for national staff survey = 60% (1,047 responses) • 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)~~	• 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	• CQC rated GOOD Trust • 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~~ - pilot by March 2024 with roll out in Q1 2024/25 (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.

• 96.3% compliance with mandatory equality, diversity & human rights training (as at 3 April 2024) target 90% • 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. • Executive sponsorship of all staff networks refreshed and agreed. • Staff Voice Forum • 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	network - **Head of HR/Head of Inclusion** • 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/ Widening Participation Lead** this is an action in year 3 HR delivery plan • Increased diversity at senior roles in the trust and at Trust Board - **Chief People Officer** this is an action in year 3 HR delivery plan • ~~Implement Recruitment and Retention Action Plan (inc. improved leaver data, improved exit processes) - **Deputy Director of HR and L&OD**~~	• 'Compassionate culture' sub-score of 'We are compassionate and inclusive' from NHS People Promise in NSS ≥7.2. • 'We are safe and healthy' from NHS People Promise in NSS ≥6.3. • 'Morale' theme score in NSS ≥6.1. • 'Inclusion' sub-score of 'We are compassionate and inclusive' NHS People Promise score in NSS ≥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	• Deliver all actions from the WRES action plan - ~~July 2023~~ **June 2024** *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 December 2023 (Associate NED role in progress)~~ **this is an action in year 3 HR delivery plan.** • Associate NED role(s) to be recruited to - **Q4,23-24** this is an action in year 3 HR delivery plan • Development of pre-employment programmes - ~~September 2023 November 2023~~ ~~March 2024 (as amended in delivery plan)~~ **this is an action in year 3 HR delivery plan.** • Implement the WCHC approach to Widening Participation - ~~December 2023~~ ~~March 2024 (as amended in delivery plan)~~ **this is an action in year 3 HR delivery plan.** • Staff engagement score in the National Staff Survey (NSS) ≥ 7.2 – **March 2024** (quarterly monitoring via NQPS) - **ACHIEVED**

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 • R&R group developed Exit Plan to ensure coherent approach • R&R group developed recruitment and retention action plan with improved monitoring of leaver data and improved exit processes • 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% • Legacy mentor in post • Widening participation lead in post	• Further develop staff networks as active partners in decision making processes - **Head of HR** Have developed the staff voice forum and engaging Board • Targeted recruitment for entry level roles/ career pathways, in areas of high deprivation according to CORE20Plus5 - **Head of L&OD -** *The infrastructure for Widening Participation has been established during 23/24 and delivery will be actioned under Year 3 HR Delivery Plan* • Further data analysis of community demographics linked to widening participation workstreams (to support targeted recruitment for entry level roles) - **Head of L&OD/ Widening Participation Lead** this is an action in year 3 HR delivery plan • Development of pre-employment programmes as part of Trust Widening Participation approach - **Head of L&OD/ Widening Participation Lead** *The infrastructure for Widening*		• NSS uptake $\geq$ 50% - **March 2024** (quarterly monitoring via NQPS) - **ACHIEVED** • Q23c in NSS *"I would recommend my organisation as a place to work"* $\geq$ 63.9% - **March 2024** (quarterly monitoring via NQPS) - **ACHIEVED** • Q24a in NSS "I often think about leaving the organisation" (lower % is better) $\leq$ 28.0% - **March 2024** (quarterly monitoring via NQPS) - **ACHIEVED** • Improve staff retention $\leq$12% over 12 months by **March 2024** - **ACHIEVED** • 'Compassionate culture' sub-score of 'We are compassionate and inclusive' from NHS People Promise in NSS $\geq$7.2 - **March 2024** - **ACHIEVED** • 'We are safe and healthy' from NHS People Promise in NSS $\geq$6.3 - **March 2024** - **ACHIEVED** • 'Morale' theme score in NSS $\geq$6.1 - **March 2024** - **ACHIEVED** • 'Inclusion' sub-score of 'We are compassionate and inclusive' NHS People Promise score in NSS $\geq$7.3 - **March 2024** - **ACHIEVED**

	Participation has been established during 23/24 and delivery will be actioned under Year 3 HR Delivery Plan • Implement the WCHC approach to Widening Participation *(incorporating Work Experience, pre-employment programmes and an engagement programme with schools and FE providers) – The infrastructure for Widening Participation has been established during 23/24 and delivery will be actioned under Year 3 HR Delivery Plan*		

RISK TO BE CARRIED FORWARD FOR 2024-25. **ID10 - We are not able to attract, grow and develop our talent sufficiently to ensure the right numbers of engaged, motivated and skilled staff to meet activity and operational demand levels.**	People & Culture Committee oversight
Link to 5-year strategy - Grow, develop and realise employee potential Better employee experience to attract and retain talent Link to PDAF - The Wirral health and care system is unable to recruit, develop and retain staff to create a diverse health and care workforce with the skills and experience required to deliver the strategic objectives (RR12).	
Consequence; • Poor outcomes for the people working in the Trust • Reduced staff engagement • Increase in staff turnover and recruitment challenges	

Current risk rating (LxC)	**Risk appetite**	**Target risk rating (LxC)**
2 x 4 (8)	**Open**	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**
• CQC rated GOOD Trust • Trust turnover rate of 11.1% has achieved target as per People Delivery Plan for Year 2 - ≤12% average over 12 months by March 2024. *(12-month average 10.5%)* • Agency use reduced and below the cap • Positive student experience and methods of fast-track recruitment • Time to recruit new staff monitored via PCOG and improving • Apprenticeship plan in progress (task & finish group established) - *'grow our own'* - clinical career pathways	• Hard to recruit roles in the Trust - **Chief People Officer** this is an action in year 3 HR delivery plan and covered in more detail in Recruitment & Retention action plan; and as part of developing clinical career pathways to "grow our own" • Not currently recruiting sufficiently from deprived areas - **Chief People Officer**	• Achieve target rate for turnover • Optimisation of bank and agency use • Staff engagement score in the National Staff Survey (NSS) ≥ 7.2 • NSS uptake ≥ 50% (quarterly monitoring via NQPS) • Reduced vacancy rate • Reduced sickness absence • Launch of clinical career pathways • We work flexibly NHS People Promise score in NSS = 6.7	• Launch of clinical career pathways - **April 2024** this is an action in year 3 HR delivery plan • Trust turnover rate ≤12% average over 12 months - **March 2024 ACHIEVED at 10.5%** • Staff engagement score in the National Staff Survey (NSS) ≥ 7.2 - **March 2024** (quarterly monitoring via NQPS) - **ACHIEVED**

• Social value metrics related to recruitment agreed • Widening participation lead in post • Behavioural standards framework developed and approved *(shared at informal board in March 2024)* – pending launch in Q1 24-25. • Refresh of flexible working policy in progress	this is an action in year 3 HR delivery plan • Not currently using the right proportion of apprenticeship levy for entry-level roles - **Chief People Officer / Head of L&OD** this is an action in year 3 HR delivery plan		• NSS uptake ≥ 50% - **March 2024** (quarterly monitoring via NQPS) - **ACHIEVED** • We work flexibly NHS People Promise score in NSS = 6.7 - **March 2024** - **ACHIEVED** • Launch of behavioural standards framework - **Q1, 2024-25**

Assurance Framework

Assignment Report 2023/24 (Final)

Wirral Community Health and Care NHS Foundation Trust

133WIRRCFT_2324_002

Contents

MIAA would like to thank all staff for their co-operation and assistance in completing this review.

This report has been prepared as commissioned by the organisation, and is for your sole use. If you have any queries regarding this review please contact the Engagement Manager. To discuss any other issues then please contact the Director.

1 Executive Summary

Overall Audit Objective: 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.

This report provides assessment of the following sub objectives:

- The structure of the AF meets the NHS requirements;
- The organisation considers risk appetite and risk appetite is used to inform the management of 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.

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

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.**

2 Detailed Assessment and Management Action

2.1 Structure – Desktop review of the Assurance Framework (Date on AF Provided: February 2024)		
Requirement	Conclusion	Wider Commentary
2.1.1 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 (included on both the summary AF and the detailed AF). Initial risk scores have included on the summary AF. • The AF includes consideration of risk appetite. • The organisation's AF does provide updates of progress against actions. The way that the AF is structured, the gaps within the AF are worded as "actions". A review of the gaps and "trajectory to mitigate and achieve risk rating" columns of the AF identified that a responsible lead and implementation due dates/deadlines have been allocated to the actions. • **The organisation's AF does not use dashboards / graphs to provide visual**
2.1.2 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.	
2.1.3 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.	
2.1.4 The format of the AF provides and action plan to address the gaps.	The AF includes actions to address gaps.	

		overviews although this is not a mandatory requirement.

2.2 Risk Appetite		
Requirement	Conclusion	Wider Commentary
2.2.1 The organisation has a high level risk appetite statement in place.	The organisation's risk appetite was clearly defined and communicated.	The risk appetite statements were agreed (as part of the review of the Trust's strategic objectives for 2023/24) at an informal Board in May 2023. An update in relation to the risk appetite review was reported at the following Board of Directors meeting in June 2023. The risk appetite had been reviewed for system risks that are the same or similar to partnering Trusts / organisations in the context of shared objectives. Risk responses are reflective of the corresponding risk appetite. No risk has a target risk rating of more than 8, and 5 of the 9 have a risk appetite of "adverse" or "cautious". For the remaining 4 risks, the Trust is willing to accept more risk, however believe that they can achieve a target risk rating of 4.
2.2.2 The organisation's risk appetite is reviewed and updated at least annually.	Board minutes demonstrated review of the risk appetite. The risk appetite had updated and re-agreed within the period under review.	
2.2.3 The organisation has defined its risk 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.	
2.2.4 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.	

2.3 Engagement – Review of Board minutes for April 2023 to December 2023 (Dates on meetings when the AF was presented: April 2023, June 2023, August 2023, October 2023, December 2023 and February 2024).		
Requirement	Conclusion	Wider Commentary
2.3.1 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 2023; • June 2023; • August 2023; • October 2023; • December 2023; and, • February 2024 (as per meeting papers). Examples of Board discussion of the AF include: • June 2023 – Board approved proposed rewording of AF risk reference ID04 related to the financial plan 2023/24. • August 2023 – Board noted safe staffing processes incorporated as core mitigations for AF risk reference ID01. • December 2023 – Board highlighted that AF risk reference ID04 remained the highest strategic risk score and considered
2.3.2 The minutes of the Board clearly demonstrate discussion, review and update of the AF.	Board minutes clearly demonstrate discussion and update of the AF.	
2.3.3 The AF is regularly presented to the relevant committees of Board.	The AF was regularly presented to committee / subcommittees.	
2.3.4 The minutes of Board 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.	

		a new strategic risk in relation to retaining talent and growth of the workforce. It was also noted that AF risk reference ID03 was achieving the target risk rating. The AF was presented to Committees / Sub-Committees in the following months: • Quality and Safety Committee – May 2023, July 2023, September 2023, November 2023 and January 2024. • Finance and Performance Committee – April 2023, June 2023, August 2023, October 2023, November 2023 and February 2024. • People and Culture Committee – May 2023, June 2023, August 2023, October 2023 and December 2023. Examples of Committee / Sub-Committee consideration of the AF include: <u>Quality and Safety Committee:</u> • September 2023 – The Committee considered AF risk references ID01 and ID02. It was suggested that ID01 should of focus more on the clinical risk including

		the implementation of the Patient Safety Incident Response Framework (PSIRF). Finance and Performance Committee: • October 2023 - The Committee considered AF risk references ID03, ID04 and ID05. The Committee discussed the financial settlement for 2023/24 (together with the financial plan negotiated with the ICB) which related to AF risk reference ID03 and that poses a challenging financial target which could result in a risk to the financial sustainability of the organisation. People and Culture Committee: • August 2023 – AF risk reference ID09 was discussed. It was noted that safe staffing would continue to be managed through the Trust's risk register and monitored as part of the quarterly safe staffing report.

2.4 Quality and Alignment – Review against Board minutes and Benchmarking (Dates of last three Board meetings October 2023, December 2023 and February 2024)		
Requirement	Conclusion	Wider Commentary
2.4.1 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 deliver services safely and responsively 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. • ID06 – Trust operational and financial performance is poor and has an impact on Place performance and future monitoring and regulation. System risks are clearly articulated and consider Trust and system wide position (set out in controls, gaps in controls and assurances). There is evidence of the Board connecting risks in papers and discussions to the AF, examples include:
2.4.2 The risks identified within the Board minutes are reflected in the AF.	Risks identified by the Board were reflected in the AF.	
2.4.3 Board assurances are clearly identified within the AF.	Assurances were clearly identified.	
2.4.4 Controls are clearly defined within the AF.	Controls were clearly defined.	
2.4.5 Gaps are clearly identified within the AF and actions detailed.	Gaps were clearly identified and mitigating actions were in place.	

		• In August 2023, the Annual Health Inequalities and Inclusion report included a set of priorities for 2023/24 which links to AF risk reference ID01; and, • In October 2023, as part of the Workforce Dashboard, it was reported that there had been a slight increase in sickness absence which links to AF risk reference ID07. **It is recommended that the cover sheets used for reporting to the Board and sub-committees are updated to include a link to the corresponding BAF risk.** The assurances detailed within the AF were clear in terms of scope, frequency and reporting routes to the Board.

2.5 Action Plan:

No	Requirement	Recommendation	Management Response / Responsibility for Action / Date
1.	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.	The Trust notes this recommendation and also that it is not a mandatory requirement, the Trust will continue to evolve the BAF. Responsible Officer – Director of Corporate Affairs Implementation Date – July 2024
2.	Quality and Alignment	Cover sheets for the Board of Directors and Sub-Committees should link to the corresponding BAF risk.	The cover sheet template is being refreshed and this recommendation will be included as part of this refresh. Responsible Officer – Head of Corporate Governance Implementation Date – July 2024

Appendix A: Engagement Scope

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 consisted of an assessment of the following sub objectives:

- 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.

Scope Limitations

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..

Limitations

The matters raised in this report are only those which came to our attention during our internal audit work and are not necessarily a comprehensive statement of all the weaknesses that exist, or of all the improvements that may be required. Whilst every care has been taken to ensure that the information in this report is as accurate as possible, based on the information provided and documentation reviewed, no complete guarantee or warranty can be given with regards to the advice and information contained herein. Our work does not provide absolute assurance that material errors, loss or fraud do not exist.

Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management and work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, nor relied upon to identify all circumstances of fraud or irregularity. Effective and timely implementation of our recommendations by management is important for the maintenance of a reliable internal control system

Appendix B: Report Distribution

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Our work was completed in accordance with Public Sector Internal Audit Standards and conforms with the International Standards for the Professional Practice of Internal Auditing.