Public Board of Directors **Item 13**

03 September 2025

Title	Board Assurance Framework 2025-26
Lead Director	Alison Hughes, Director of Corporate Affairs
Author	Alison Hughes, Director of Corporate Affairs
Report for	Approval

Executive Summary and Report Recommendations

The purpose of this report is to provide the Board of Directors with an update and assurance on the management of strategic risks through the Board Assurance Framework for 2025-26.

This update provides the position following detailed review through July and August 2025.

It is recommended that the Board:

- Receives the update provided on the current position in relation to the strategic risks
- Approves the proposal to change the risk appetite for ID06 from Cautious to Moderate, as recommended by the Finance & Performance Committee

Key Risks

This report relates to the following key risks:

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.

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

Contribution to WCHC strategic objectives:	
Populations	
Safe care and support every time	Yes
People and communities guiding care	Yes
Groundbreaking innovation and research	Yes
People	
Improve the wellbeing of our employees	Yes
Better employee experience to attract and retain talent	Yes
Grow, develop and realise employee potential	Yes
Place	
Improve the health of our population and actively contribute to tackle health inequalities	Yes
Increase our social value offer as an Anchor Institution	Yes
Make most efficient use of resources to ensure value for money	Yes

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
16/10/24	Board of Directors	BAF	The Board of Directors was assured of the oversight and management of strategic risks in the BAF through the sub-committees of the Board and noted the current risk ratings and ID04 as the highest scoring risk.
11/12/24	Board of Directors	BAF	The Board of Directors approved the position reported for each of the strategic risks included in the BAF for 2024-25, noting that ID04 remained the highest scoring risk. The Board of Directors also approved the recommendation from the Finance & Performance Committee that ID06 had achieved its target risk rating and would be kept under review for the remainder of the financial year.
19/02/25	Board of Directors	BAF	The Board of Directors approved the position reported for each of the strategic risks included in the BAF for 2024-25, noting that ID04 remained the highest scoring risk. The Board of Directors also

			approved the MIAA Assurance Framework Report 2024/25.
19/03/25	Informal Board	BAF	The members of the Board supported an informal discussion to review current and emerging risks for 2025-26 and to inform the position presented to the committees and the Board in April and May 2025.
23/04/25	Board of Directors	BAF	The Board of Directors approved the recommendation for new risks for 2025-26.
04/06/25	Board of Directors	BAF	The Board of Directors received the update provided on the current position in relation to the strategic risks, noting that the sub-committees of the Board will continue to track and monitor progress. It was noted in particular that the meeting of the Finance & Performance Committee and the People & Culture Committee would take place (the following week) to review relevant risks.

1	**Narrative**
1.1	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.
1.2	At the meeting of the Board of Directors in June 2025 an update was provided on each of the strategic risks for the start of the new financial year.
1.3	The summary table at **appendix 1** confirms the current position of strategic risks as reviewed by committees of the Board during July and August 2025. This includes a new risk (ID05) associated with cyber security and EPRR which is monitored via the Finance & Performance Committee.
1.4	A revised risk description for ID11 is being developed to reflect the Partnership Agreement established between both WCHC and WUTH and the risk of failing to develop a Joint Strategy and deliver the 2-year plan to realise the benefits of integration. This will be considered by the Integration Management Board in September 2025 and reported as appropriate to the Board of Directors.
1.5	The BAF now includes 8 strategic risks, none of which is currently scoring at a high-level.

	The highest scoring risks are RR12. No risk has achieved its target risk rating.
1.6	Through each of the committees of the Board a review of the risk appetite for strategic risks also has been completed. This also included a review of equivalent strategic risks on the WUTH BAF recognising alignment and variance where appropriate. The Finance & Performance Committee supported an amendment to the risk appetite for ID06 - *Failure to effectively embed service transformation and change will impact on the Trust's ability to deliver sustainable efficiency gains and the CIP plan for 2025-26* from Cautious to Moderate - *Tending always towards exposure to only modest levels of risk*, recognising the opportunity to deliver and transform services differently to effect efficiency gains and improved patient experience, which ensuring a robust EQIA/QIA process. The People & Culture Committee completed a review of workforce strategic risks in each Trust including risk appetite and target risk scores, which demonstrated a level of alignment and resulted in no current changes to WCHC strategic workforce risks.
1.7	It is anticipated that as the development of the Joint Strategy progresses, shared strategic risks and Board Assurance Frameworks between WCHC and WUTH will emerge.
1.8	**Wirral Place Delivery Assurance Framework** The Wirral Place Based Partnership Board manages key system strategic risks through the Place Delivery Assurance Framework. The PDAF was last presented to the Place Based Partnership Board in March 2025, and can be accessed via the following link - Agenda for Wirral Place Based Partnership Board on Thursday, 27th March 2025, 10.00 a.m. | Wirral Council

2	**Implications**
2.1	**Quality/Inclusion** The quality impact assessments and equality impact assessments are undertaken through the work streams that underpin the BAF.
2.2	**Finance** Any financial or resource implications are detailed in the BAF for each strategic risk.
2.3	**Compliance** The BAF is key to effective governance and is subject to an annual Assurance Framework Review as per internal audit standards in order to inform the Head of Internal Audit Opinion (HOIA) each year. The strategic risks tracked through the BAF are reported annually through the Annual Governance Statement.

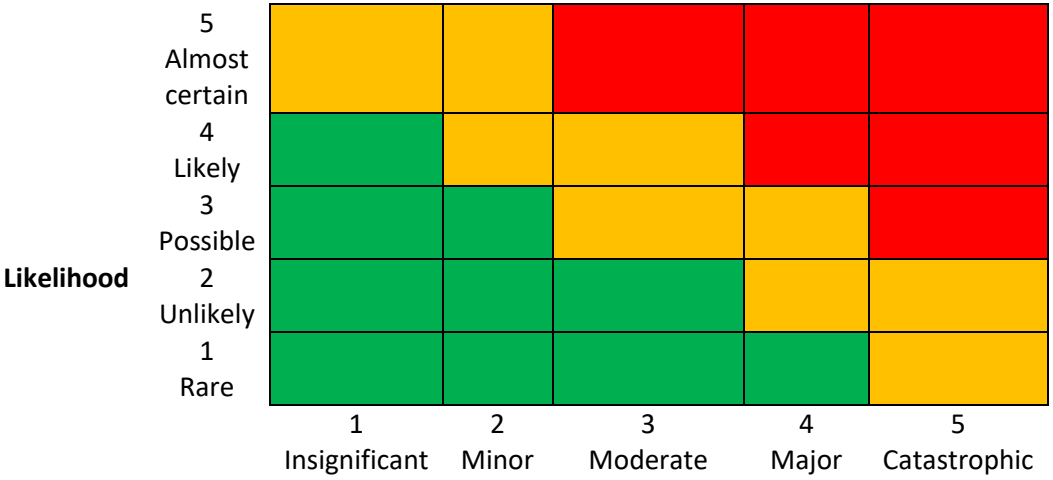
3	**The Trust Social Value Intentions**
3.1	Does this report align with the Trust's social value intentions? Not applicable

	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** ☐

Strategic risk summary 2025-26

Risk Description	Committee oversight	Link to 5-year strategy	Initial risk rating (LxC)	Current risk rating (LxC) (August 2025)	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
Previous ID03 archived at end of 2023-24.						
ID04 - Inability to achieve the financial plan including CIP will impact on the Trust's financial sustainability and service delivery and the system financial plan.	Finance & Performance Committee	Make most efficient use of resources to ensure value for money	3 x 3 (12)	3 x 4 (12)	2 x 4 (8)	Cautious
NEW ID05 - Inability to effectively implement business continuity and EPRR arrangements due to a failure in critical infrastructure or a cyber-attack impacting on the quality of patient care	Finance & Performance Committee	Safe care and support every time Make most efficient use of resources to ensure value for money	3 x 3 (12)	3 x 4 (12)	2 x 4 (8)	Cautious
ID06 - Failure to effectively embed service transformation and change will impact on the Trust's ability to deliver sustainable efficiency gains and the CIP plan for 2025-26.	Finance & Performance Committee	Make most efficient use of resources to ensure value for money	3 x 4 (12)	3 x 4 (12) ↔	2 x 4 (8)	Moderate
ID07 - Our people do not feel looked after, their employee experience is poor, and their health and wellbeing is not prioritised.	People & Culture Committee	Improve the wellbeing of our employees Better employee experience to attract and retain talent	2 x 4 (8)	2 x 4 (8) ↔	1 x 4 (4)	Moderate

Risk Description	Committee oversight	Link to 5-year strategy	Initial risk rating (LxC)	Current risk rating (LxC) (August 2025)	Target risk rating (LxC)	Risk Appetite
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.	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
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	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
~~ID11 - Failure to achieve the Trust's 5-year strategy due to the absence of effective partnership working resulting in damaged external relations, failure to deliver the financial plan 24-25 and the recommendations from the Wirral Review, with poorer outcomes for patients and a threat to service sustainability.~~	Board of Directors	Make most efficient use of resources and ensure value for money	New risk to be developed between WCHC and WUTH to have oversight via the Integration Management Board.			



Consequence

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 2025-26

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 of oversight groups reporting to IPB tested through internal audit in 2023-24 providing Substantial Assurance.

Quality Governance

- Year 1 and Year 2 of the Quality Strategy Delivery Plan implemented successfully with committee oversight.
- 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 and minutes/ decisions from the groups for noting.
- The committee contributes to the development of the annual quality strategy delivery plan and priorities and receives bi-monthly assurance on implementation.
- The committee contributes to the development of and maintains oversight of 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.
- The fortnightly Clinical Risk Management Group (CRMG) meetings are in place to monitor incidents and learning.
- SAFE system in use trust-wide for audits (e.g., hand hygiene, medicines management, IG, team leader)
- SAFE Operations Group (SOG) reports directly to the Integrated Performance Board
- Regular formal and informal engagement with CQC
- CQC inspection rating of Good with Outstanding areas.

- The Trust has implemented a health inequalities stratification waiting list tool - Joint AIS and Health Inequalities Waiting List Tool questionnaire now live in System one with all fields mandated
- Just and Learning culture supported by FTSU framework allowing staff to openly raise concerns.

PSIRF

- Patient Safety Lead in post and two Patient Safety Partners recruited as per national guidance.
- PSIRF implementation reported to the committee
- 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.
- High-level of compliance with patient safety training.
- Clinical protocol for Clinical Supervision (CP95)
- Patient Safety Incident Response Plan (GP60) approved

FTSU

- 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.

Safeguarding governance

- Safeguarding executive lead is member of committee
- Quarterly Safeguarding Assurance Group established to oversee compliance with legislative and regulatory safeguarding standards reporting directly to QSC
- Place based Safeguarding Assurance Partnership Boards and subgroups are supported through strong presentation of WCHC safeguarding specialists
- Safeguarding Supervision Policy (SG04)

Infection prevention and control governance

- Director of Infection Prevention and Control is member of committee
- Quarterly IPC group established to oversee compliance with legislative and regulatory IPC standards reporting directly to QSC
- Place based IPC and Health Protection Boards attended by IPC specialists
- Member of NW IPC forum

Medicines governance

- Executive lead for medicines governance and Controlled Drugs Accountable Officer is member of committee
- Medicines governance group established which reports directly to QSC

Safe Staffing (the following mitigations have been moved from the detail of ID01 recognising implementation during 2023-24)

- Safe staffing model on CICC supports professional judgement by maximising use of available staffing resource, implementing a holistic multidisciplinary team model including the use of therapies staff.
- Enhanced reporting through the governance agreed via PCC and QSC.
- Metrics and measures developed to monitor, analyse and review and report against e-rostering system use and performance *(MiAA recommendation completed)*
- Reporting timetable developed to ensure regular, timely updating to PCOG and SOG including any trends or areas for improvement *(MiAA recommendation completed)*
- Trust engaged in national pilot of Community Nursing Safer Staffing Tool (CNSST) - the first cohort of community trusts to collect safe staffing data

System Governance

- Wirral Place Quality Performance Group established with CNO as member
- 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
- Joint Establishment & Pay Control Panel established with WUTH (weekly)
- Chief Nurse participating in system recovery meetings with turnaround Director

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.
- SAFE mechanism for recording clinical and professional supervision captures method of delivery to include peer, group and 1:1 delivery
- Management Supervision procedure (HRP07)
- Transferrable learning from Shanley Review to WCHC identified across 7 recommendations
- Assurance review process of the recommendations from the Shanley Review focused on 1) Assurance Tools, 2) Governance Processes, 3) Alignment to Trust Strategies

QEIA process

- Standard Operating Procedure for the completion and approval of QEIA/EIA/QIA in place and available on Staff Zone
- Stage 1 and stage 2 templates available on Staff Zone

<table>
<tr><td colspan="5">ID01 Failure to deliver services safely and responsively to inclusively meet the needs of the population.</td><td>Quality & Safety Committee oversight</td></tr>
<tr><td colspan="6">Link to 5-year strategy - Safe care and support every time

Organisational risk - ID3137 (RR16 - 4 x 4) - CICC call bells, ID3201 (RR16 - 4 x 4) - CICC non-registered staffing and ID2830 (RR15 - 5 x 3) - resource to meet demand for EHCPs
Patient safety incident / emerging issue reported to private Board - 02.07.25</td></tr>
<tr><td colspan="6">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</td></tr>
<tr><td colspan="2">Current risk rating (LxC)
(by month of committee)</td><td colspan="2">Risk appetite</td><td colspan="2">Target risk rating (LxC)</td></tr>
<tr><td>May 25</td><td>July 25</td><td>Sept 25</td><td>Nov 25</td><td>Jan 26</td><td>Mar 26</td><td colspan="2" rowspan="2">Averse</td><td colspan="2" rowspan="2">2 x 4 (8)</td></tr>
<tr><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="2">Mitigations
(i.e., processes in place, controls in place)</td><td colspan="2">Gaps
(Including an identified lead to address the gap and link to relevant action plan)</td><td>Outcomes/Outputs
(i.e., proof points that the risk has been mitigated)</td><td>Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="2">Actions to ensure safe care and support every time to prevent variation of standards across localities and teams.
Headline measures in-month (M02)
- 0 never events - QUAL05
- 0 MRSA incidents - QUAL16
- 0 C.Diff incidents - QUAL15
- 1 fall (moderate & above harm) - QUAL17
- 91.7% FFT - QUAL22 YTD
- 3 complaints received (3 YTD) - QUAL08</td><td colspan="2">- Supervision Training Strategy - Head of L&OD
- PSIRF learning cafes roll-out Q4 - delayed to 25-26 (included in Delivery Plan - wider roll out to teams will commence during 2025/26 and have an emphasis on system learning with WUTH and beyond) - Head of Quality & Patient Experience</td><td>- NOF rating / segmentation
- Sustained performance against quality metrics
- FFT response rate and satisfaction rate
- Low number of complaints
- Mandatory training sustained compliance maintained at 90%
- Delivery of all actions in Quality Strategy Delivery Plan, or</td><td>- Supervision Training Strategy approved - TBC
- Reporting on expected outcomes from 4 joint high priority clinical risk areas (based on PSIRF analysis) - October 2025
- Delivery of 4 joint QI programmes based on high</td></tr>
</table>

- 421 incidents reported - QUAL02 *(2.1% moderate and above harm - QUAL18)*
- 190 patient safety incidents (M9) - QUAL03
- Mandatory training compliance trust-wide achieved target - 95.2% (vs 90% target)
- Indicators within the Quality Dashboard have been refreshed to reflect the Patient Safety Incident Response Framework and systems-learning
- The following indicators have been added;
  - QUAL25: Number of reported no and low harm patient safety incidents
  - QUAL26: Number of After-Action Reviews (AAR) requested
  - QUAL27: Number of patient safety incident investigations (PSII) requested
  - QUAL28: Number of patient safety incident investigations (PSII) completed in 3 months
- Quality Strategy Delivery Plan including quality goals for 2025-26 reviewed and approved and tracked at QSC
- 4 agreed clinical safety improvement priorities for 2025-26 agreed with WUTH aligned to shared priorities (Quality Goal 1)
- LFPSE (Learning from Patient Safety Events) launched.
- Enhanced PSIRF training delivered (over 425 staff trained exceeding target of 250) (Quality Goal 2)
- PSIRF champions identified and communicated on Staff Zone (Quality Goal 2)
	- QI programme to address waiting lists in specialist speech and language and ND assessments *(aligned to Ofsted/CQC Wirral SEND inspection report established) (Quality Goal 4)* - **Deputy Chief Nurse**	mitigated position agreed with committee
		~~- Role essential training compliance achieved and maintained at 90%~~
		~~- 12% of staff to be trained in Tier 2 Oliver McGowan mandatory training~~
		~~- QI summary reports with measured impacts from 4 x QI programmes and with actions for improvement~~
		~~- 20 members of staff trained in QSIR-P (5-day course now concluded with positive evaluation)~~
		~~- 80 members of staff trained in QSIR-F *(2 session for Quality Champions in Q4)*~~
		~~- Quarterly patient safety champions meetings with attendance monitored to ensure continued appropriate staff engagement across services~~
		~~- PSIRF learning cafes~~
			priority clinical risks - **March 2026**
			- Quarterly patient safety champion meetings - **December 2025**
			- Delivery of two patient safety champion training sessions - **March 2026**
			- Implement 'What matters to you' campaign in 2 more WCHC services **- December 2025**
			- 'What matters to you' campaign day - **March 2026**
			- 12% of eligible staff trained in Tier 2 Oliver McGowan mandatory training - **June 2025**
			- 65% of eligible staff trained in QI - **July 2025**
			~~- PSIRF actions to further embed in the process and culture *(quality goal 2)* - **Q1, 2025-26**~~

- 'What matters to you' campaign launched at Commitment to Carers conference (Quality Goal 3) - Collaborative working with system partners to co-produce a minimum of two care pathways (Quality Goal 4) - Internal governance structure to support collaborative working *(aligned to Ofsted/CQC Wirral SEND inspection report established)* (Quality Goal 4) - 25-26 plan for QI curriculum training with focus on foundation training including flexible options to support compliance (Quality Goal 5) - District nursing development work underway, including engagement with frontline rearms to take forward improvement ideas - currently PAUSED awaiting consultation to commence. - 8 cohorts of staff trained in Tier 2 Oliver McGowan (n=125 staff) resulting in year end position of 8.6% of eligible staff trained against a target of 12%. 1 session planned for June 2025 and if all staff attend, this will take position to 10.1%. - Professional Nurse Advocate (PNA) programme in place - Joint AIS and Health Inequalities Waiting List Tool questionnaire live in System one with all fields mandated **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. - New tender evaluation process agreed at private Board (July 2025) including the establishment of new BDIG with WUTH - Business Development & Investment Group **Actions to ensure equitable outcomes across our population based on the Core20PLUS5 principles.** - Health Inequalities & Inclusion Strategy developed and approved. - Quality Strategy Delivery Plan including quality goals for 2025-26 reviewed and approved and tracked at QSC – see mitigations above related to each quality goal. - 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	- Review of the NHS Providers guide on reducing health inequalities will be undertaken, resulting in a clear plan for delivery of health inequalities data analysis and intelligence reporting to Board.	- Sustained performance against inclusion metrics - Delivery of all actions in Quality Strategy Delivery Plan, or mitigated position agreed with committee - 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	

- 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 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. **Actions to ensure safe demobilisation of services.** - ~~Demobilisation plan in progress for Lancashire 0-19+ contract.~~ - ~~Long COVID services demobilisation in progress~~ - School aged immunisation service demobilisation			

<table>
<tr><td colspan="6">ID02 Failure to deliver services inclusively with people and communities guiding care, supporting learning and influencing change</td><td>Quality & Safety Committee oversight</td></tr>
<tr><td colspan="7">Link to 5-year strategy - Safe care and support every time</td></tr>
<tr><td colspan="7">Consequence;
• Inequity of access and experience and outcomes for all groups in our community
• Poor outcomes due to failure to listen to people accessing services
• Reputation impact leading to poor health and care outcomes</td></tr>
<tr><td colspan="6">Current risk rating (LxC)</td><td>Risk appetite</td></tr>
<tr><td>Apr 25</td><td>June 25</td><td>Aug 25</td><td>Oct 25</td><td>Dec 25</td><td>Feb 26</td><td rowspan="2">Averse</td></tr>
<tr><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="6">Mitigations
(i.e., processes in place, controls in place)</td><td>Gaps
(Including an identified lead to address the gap and link to relevant action plan)</td></tr>
<tr><td colspan="6">Actions to ensure collaboration and co-design with community partners.
- EDI training compliance - 96.8%
- Quality Strategy Delivery Plan including quality goals for 2025-26 reviewed and approved and tracked at QSC
- ‘What matters to you’ campaign launched at Commitment to Carers conference (Quality Goal 3)
- Collaborative working with system partners to co-produce a minimum of two care pathways (Quality Goal 4)</td><td>- Lack of staff confidence in accessing and interpreting health inequalities data - Head of Inclusion
- Digital version of AIS and Health Inequalities Waiting List Tool questionnaire in multiple languages - Head of Inclusion
- Embed use of paper forms of questionnaire for those impacted by digital</td></tr>
<tr><td colspan="6"></td><td>Outcomes/Outputs
(i.e., proof points that the risk has been mitigated)

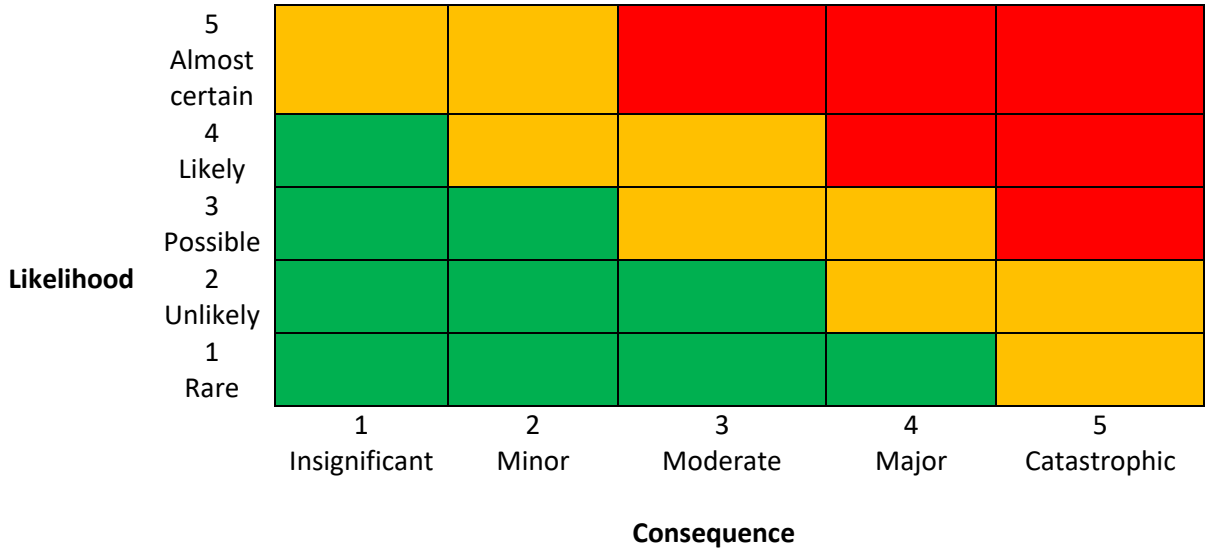
NOTE: ensuring clear alignment of the outcome to the gap it addresses</td></tr>
<tr><td colspan="6"></td><td>- Sustained performance against inclusion metrics
- Delivery of all actions in Quality Strategy Delivery Plan, or mitigated position agreed with committee
- Measures of equity of access demonstrated through patient/service user data and experience.
- Staff confident in delivering culturally sensitive care.</td></tr>
<tr><td colspan="6"></td><td>Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="6"></td><td>- Implement ‘What matters to you’ campaign in 2 more WCHC services - December 2025
- ‘What matters to you’ campaign day - March 2026
- 12% of eligible staff trained in Tier 2 Oliver McGowan mandatory training - June 2025
- 65% of eligible staff trained in QI - July 2025</td></tr>
</table>

- Inclusion Principle 1 - Positive action for inclusive access. Joint AIS and Health Inequalities Waiting List Tool questionnaire live in System one with all fields mandated. - 6000 public members sharing their experience and inspiring improvement. - Level 1 Always Events accreditation focussing on what good looks like and replicating it every time. - Complaint's process putting people at the heart of learning. - QIA and EIA SOP refreshed and approved - Recruitment of Population Health Fellow role - Experience dashboard built on TIG. - Partner Safety Partners recruited. - Re-balancing of resources in community nursing to support caseload in PCNs underway. - 5 community partners recruited. - Completion of all actions agreed following MIAA review to address variation in practice and incomplete data. **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.	exclusion - **Head of Inclusion**	- All reasonable adjustments are made to facilitate most effective care delivery. - Staff will report increased skill, knowledge and confidence in quality improvement methodology. - Further embed health inequalities waiting list tool - Regular reporting to the Trust Board on health inequalities data through the Integrated Performance Report.	- Achievement of 90% completion rate of AIS and inclusion template across all services - **March 2025** *(Inclusion principle 1)* - locality completion rates range from 47% - 80%; monitoring at SOG.

- Quality Strategy - *quality goal 6* - 5 co-designed care pathways identified - *NPOP and referral pathway to memory clinic, translation and interpretation, Long Covid and rehabilitation, Rehab @ Home and home hazards checklist, FNP-Improving accessibility of information for first time parents.* **Actions to ensure that all voices, including under-represented groups can be heard and encouraged to influence change.** - Active engagement through the Partnership Forum with multiple groups/agencies across Wirral (e.g., Wirral Change, Mencap, LGBT, veterans) supporting close links with our communities and positively influencing participation and involvement. - Veteran Aware accreditation (Bronze and Silver) achieved for the Trust. ~~- EDS 2022-23 published on public website with actions identified.~~ - 8 cohorts of staff trained in Tier 2 Oliver McGowan (n=125 staff) resulting in year-end position of 8.6% of eligible staff trained against a target of 12%. 1 session planned for June 2025 and if all staff attend, this will take position to 10.1%. - 'What matters to you' campaign launched at Commitment to Carers conference (Quality Goal 3) ~~- Trust active involvement in system-wide preparation for re-inspection of SEND.~~			

- TIG dashboard updated to show new AIS compliance monitoring, targets and agreed trajectories **Actions to ensure children and families living in poverty in all our places 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 - Locality governance reflects trust-wide governance across different geographies with any variation related to specific service specification (i.e., different 0-19 services)			

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 2025-26

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.

Financial 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 2024)
- The committee completes a self-assessment against its work in respect of the agreed Terms of Reference (last completed in August 2024)
- The interim 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
- 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 CIP 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
- Joint governance arrangements established between WCHC and WUTH for CIP tracking, monitoring and oversight (including WCHC CIP assurance group and joint Programme Improvement Board)

System Governance

- Wirral Place Finance, Investment and Resources Group established with CFO as member
- Trust involvement in system planning sessions for 2025-26
- Integration Management Board (IMB) established between WCHC and WUTH to oversee integration

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 CIP 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

<table>
<tr><td colspan="6">ID04 - Inability to achieve the financial plan including CIP will impact on the Trust's financial sustainability and service delivery and the system financial plan.</td><td>Finance & Performance Committee oversight</td></tr>
<tr><td colspan="7">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

Organisational risk - ID3192 (RR9 - 3 x 3) - Insufficient agreed projects to recurrently deliver WCHC's efficiency target for 25-26 and potential for identified projects not delivered in full and ID3186 (RR12 - 3 x 4) - A significant underlying deficit financial position at both North West and C&M ICB has been reported. The ask of each system is to deliver financial balance within 3 years. C&M currently has a deficit plan of £178m. The Trust has submitted a £0.9m surplus plan for 25-26 which includes at £5.7m CIP that will be challenging making the delivery of the 25-26 financial plan a risk.</td></tr>
<tr><td colspan="7">Consequence;
Financial sustainability impact
Negative reputational impact for the Trust and system
Enhanced financial control from ICB and NHSE</td></tr>
<tr><td colspan="3">Current risk rating (LxC)
(by month of committee)</td><td colspan="2">Risk appetite</td><td colspan="2">Target risk rating (LxC)</td></tr>
<tr><td>April 25</td><td>June 25</td><td>Aug 25</td><td>Oct 25</td><td>Dec 25</td><td>Feb 26</td><td colspan="2" rowspan="2">Cautious</td><td colspan="2" rowspan="2">2 x 4 (8)</td></tr>
<tr><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td></td><td></td><td></td></tr>
<tr><td colspan="3">Mitigations
(i.e. processes in place, controls in place)</td><td colspan="2">Gaps
(Including an identified lead to address the gap and link to relevant action plan)</td><td>Outcomes/Outputs
(i.e. proof points that the risk has been mitigated)

NOTE: ensuring clear alignment of the outcome to the gap it addresses</td><td>Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="3">Board approval of financial plan 2025-26 and subsequent revised forecast (18.7.25) linked back to current run rate and extrapolates current financial position to year-end
Full participation in C&M ICS reviews - ICS Director Turnaround, NHSE review</td><td colspan="2">Impact of ICB turnaround process is not clear - expectation to improve forecast to mitigate the risk associated with WUTH forecast.
NHSE approval of C&M financial plan</td><td>Delivery of recurrent CIP to achieve the target for 2025-26
Delivery of revised financial forecast 2025-26</td><td>CIP target delivered - March 2026
Financial plan delivered or mitigated position with ICB - March 2026</td></tr>
</table>

of CIP and establishing forecast risk for 25-26 and PWC/Stephen Hay diagnostic / financial governance • Bi-monthly updates to Finance & Performance Committee • Monthly oversight at Finance, Resources Oversight Group, chaired by interim CFO • Financial plan delivery (at M4) in line with plan • Robust CIP plan in place for 2025-26 with identification of recurrent schemes • Robust CIP governance in place including joint reporting with WUTH to Programme Improvement Board • CIP workstreams established with SRO Leads at Executive level • Trust continued engagement in ICB turnaround process (NOTED as an emerging issue at private board on 4.6.25) • M3 financial plan - reported deficit of £489k against a planned deficit of £493k • M3 CIP position - £1,220k delivered against plan of £1,213k • Membership and participation in Place Finance and Investment Group • System collaboration across NHS provider organisations	• CIP delivery to support delivery of improved position - **Interim Chief Finance Officer** • Further implementation and use of model health data in clinical and corporate services - **Chief Strategy Officer / Interim Chief Finance Officer** • Develop 3-year rolling capital programme - **interim Chief Finance Officer**		

• Relevant organisational risks (e.g., CIP, Capital, Financial Performance) tracked on Datix and through governance structures (as per Risk Policy) • EPCP process established jointly between WCHC and WUTH • Enhanced controls established for vacancy control and non-pay discretionary spend and communicated trust-wide with supporting SOP - improved position reported in two months since established.			

<table>
<tr><td colspan="6">NEW ID06 - Failure to effectively embed service transformation and change will impact on the Trust’s ability to deliver sustainable efficiency gains and the CIP plan for 2025-26.</td><td>Finance & Performance Committee oversight</td></tr>
<tr><td colspan="7">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).

Organisational risk - ID3192 (RR9 - 3 x 3) - Insufficient agreed projects to recurrently deliver WCHC’s efficiency target for 25-26 and potential for identified projects not delivered in full</td></tr>
<tr><td colspan="7">Consequence;
Poor service user access, experience and outcomes
Poor contract performance - financial implications (Trust and system)
Negative reputational impact</td></tr>
<tr><td colspan="6">Current risk rating (LxC)
(by month of committee)</td><td colspan="2">Risk appetite</td><td colspan="2">Target risk rating (LxC)</td></tr>
<tr><td>April 25</td><td>June 25</td><td>Aug 25</td><td>Oct 25</td><td>Dec 25</td><td>Feb 26</td><td colspan="2" rowspan="2">Moderate</td><td colspan="2" rowspan="2">2 x 4 (8)</td></tr>
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NOTE: ensuring clear alignment of the outcome to the gap it addresses</td><td colspan="2">Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="6">Robust CIP governance in place including joint reporting with WUTH to Programme Improvement Board
CIP workstreams established with SRO Leads at Executive level</td><td>CIP delivery to support delivery of improved position - Interim Chief Finance Officer
Community Nursing Development Programme to</td><td>Delivery of the benefits of integration as described for each service
Staff experience and staff morale</td><td colspan="2">Implementation of new Community Nursing model - Q4 2025-26
Key deliverables for Y1 of 2-year integration plan achieved - March 2026</td></tr>
</table>

• Programme of Quality Improvement Training and Events available across the Trust (including WUTH staff) • Community Nursing Development Programme determined and scoped • WCHC COO / Director of Integration & Partnerships leading programmes of work associated with clinical services integration • 2-year integration plan developed for clinical and corporate services with oversight at Integration Management Group (IMG) and Integration Management Board (IMB) • MSK clinical service review in progress between WCHC and WUTH as part of the 2-year integration plan • UEC service review in progress between WCHC and WUTH as part of the 2-year integration plan • Workforce Sharing Agreement in place to support flexibility of wokforce between Trusts *(to maximise transformation opportunities)*	commence consultation and progress - **Chief Nurse** • Phase Two MSK clinical services review - **Chief Strategy Officer** (to IMG) • UEC integration programme - **COO/Director of Integration & Parternships** (to IMG)	• Patient experience and feedback • Delivery of recurrent CIP to achieve the target for 2025-26 • Delivery of revised financial forecast 2025-26	• CIP target delivered - **March 2026** • Financial plan delivered or mitigated position with ICB - **March 2026**

<table>
<tr><td colspan="5">NEW ID05 - Inability to effectively implement business continuity and EPRR arrangements due to a failure in critical infrastructure or a cyber attack impacting on the quality of patient care</td><td>Finance & Performance Committee oversight</td></tr>
<tr><td colspan="6">Link to 5-year strategy - (Populations) Safe care and support every time, (Place) Make most efficient use of resources to ensure value for money</td></tr>
<tr><td colspan="6">Consequence;
• Delivery of patient care and patient experience
• Staff morale
• Financial impact
• Negative reputational impact for the Trust and system</td></tr>
<tr><td colspan="3">Current risk rating (LxC)
(by month of committee)</td><td colspan="2">Risk appetite</td><td>Target risk rating (LxC)</td></tr>
<tr><td>April 25</td><td>June 25</td><td>Aug 25</td><td>Oct 25</td><td>Dec 25</td><td>Feb 26</td><td rowspan="2">Cautious</td><td rowspan="2">2 x 4 (8)</td></tr>
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NOTE: ensuring clear alignment of the outcome to the gap it addresses</td><td>Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="3">• EPRR arrangements in place including business continuity plans for all services
• EPRR lead reporting to COO
• Annual EPRR report presented to Board with regular monitoring at FPC
• Major Incident Plan approved by Board
• EPRR work plan agreed and endorsed by Board</td><td>• Achievement of substantial compliance against the EPRR core standards self-assessment - Chief Operating Officer
• Alignment of EPRR functions with WUTH - Chief Operating Officer
• Implementation of recommendations from DSPT/CAF</td><td>• EPRR core standards self-assessment - substantial compliance</td><td>• EPRR core standards self-assessment - substantial compliance - March 2026
• Implementation of all recommendations from DSPT/CAF audit review - Q1, 26-27</td></tr>
</table>

• 2024 EPRR core standards self-assessment confirmed 86% compliance (partial compliance)
• MiAA audit provided 'substantial assurance'
• EPRR governance through HSSR group reporting to FPC
• SIRO appointed
• DSPT/CAF completed and submitted to NHSE, following audit review
• 12 outcomes reviewed across the 5 objectives, including 8 NHSE mandated outcome and 4 identified by the Trust
  - *11 outcomes = met the minimum achievement level*
  - *1 outcome = not meeting the minimum achievement level*
  - *Overall assurance rating = moderate risk.*
  - *Overall assessment of the veracity of self-assessment = High confidence*
• Action plan developed to track implementation of recommendations from DSPT/CAF
• Cyber and IG governance through IGDS reporting to FPC
• Multi-Factor Authentication in place across the Trust
	audit review - **Chief Digital Information Officer**		

Board Assurance Framework 2025-26

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 2024)
- The committee completes a self-assessment against its work in respect of the agreed Terms of Reference
- The Chief People Officer is the Executive Lead for the committee. A Joint CPO has been appointed between WUTH and WCHC as part of the recommendations from the Wirral Review.
- 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 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 is also the NED health and wellbeing lead for the Trust.

Workforce Governance

- Year 1, 2 and 3 of the People Strategy Delivery Plan implemented successfully with committee oversight.
- The PSDP has been reviewed and actions consolidated with a focus on management training and development, clinical career pathways and apprenticeships, rotational posts and RPA.
- Other actions have been held as paused and will be carried over into future plans under a joint WCHC/WUTH People Team which will address the capacity issues preventing delivery.
- 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.
- People Governance structure reviewed during 2023-24 to ensure effective monitoring of workforce and L&OD metrics.
- Quarterly People Pulse Survey process embedded with reporting to PCC and to staff via Get Together

- National NHS Staff Survey reporting via PCC and to Board of Directors.

System Governance

- Wirral Place Workforce Group established with CPO as member
- CPO Chair of NHS national community providers COP meeting
- Workforce Sharing Agreement approved between WCHC and WUTH
- Integration Management Board (IMB) established between WCHC and WUTH to oversee integration

Monitoring workforce performance

- The committee receives a workforce report from TIG providing a YTD summary (via SPC charts) of all workforce performance metrics at each meeting.
- The members of the committee have access to the Trust Information Gateway, to monitor workforce performance and to access the Audit Tracker Tool to monitor progress
- Recruitment and Retention Group established
- Recruitment and retention action plan delivered with improved tracking of key metrics
- The committee receives updates on regulatory and legislative compliance including procedural documents

<table>
<tr><td colspan="6">ID07 Our people do not feel looked after, their employee experience is poor, and their health and wellbeing is not prioritised</td><td>People & Culture Committee oversight</td></tr>
<tr><td colspan="7">Link to 5-Year strategy - Improve the wellbeing of our employees
Better employee experience to attract and retain talent</td></tr>
<tr><td colspan="7">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</td></tr>
<tr><td colspan="6">Current risk rating (LxC)
(by committee by month)</td><td colspan="2">Risk appetite</td><td>Target risk rating (LxC)</td></tr>
<tr><td>April 25</td><td>June 25</td><td>Aug 25</td><td>Oct 25</td><td>Dec 25</td><td>Feb 26</td><td colspan="2" rowspan="2">Moderate</td><td rowspan="2">1 x 4 (4)</td></tr>
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(Including an identified lead to address the gap and link to relevant action plan)</td><td>Outcomes/Outputs
(i.e., proof points that the risk has been mitigated)
NOTE: ensuring clear alignment of the outcome to the gap it addresses</td><td>Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="3">People Strategy Delivery Plan Year 4 developed and includes;
Actions deferred from Year 3
Alignment to existing national priorities
Key themes of the People Promise
9 x actions in Year 4 delivery plan aligned to ambition 1 ‘Looking after our people’
NHS staff survey 2024 results published</td><td colspan="2">Impact of AFC review of nursing role profiles to be reviewed - Chief People Officer
Sickness absence rates increasing - flagged in IPR at Board of Directors and monthly Get Together - Chief People Officer</td><td>Staff engagement score in the National Staff Survey (NSS) Year 4 target ≥ 7.2 v’s 2024 results 7.02
NSS uptake Year 4 target ≥ 55% v’s 2024 result 51%
Q25c in NSS “I would recommend my organisation as a place to work” Year 4 target ≥ 63% v’s 2024 result 63.21%</td><td>See outcome column for outcomes to be measured via the NSS in March 2026 and strategy measures of success.
- Completion of actions in Year 4 PSDP ‘Looking after our people’ - March 2026
- Roll-out of OD programme to support integration of services between WCHC and WUTH - on-</td></tr>
</table>

– Overall, a decline in all 9 scores, only two decreases were statistically significant – Best score for Community Trusts for *staff having an appraisal* – Key overview - comparison to 2023 - 1 significantly better, 8 significantly worse, 91 no significant difference. • Wellbeing Champions in services across the Trust • Wellbeing conversation training for managers and uptake monitored at PCOG. • Wellbeing (including financial wellbeing) information on Staff Zone for all staff. – Wagestream available for all staff – Vivup staff benefits platform launched. • FFT results providing high satisfaction levels from service users (>90%) • Leadership Qualities Framework in place and supporting development of leadership skills *(LQF under review to identify any gaps in current behavioural statements)* • System Leadership Training for senior leaders • Staff Voice Forum • Managers briefings in place and issued to support with the dissemination of key messages (to be enhanced through staff engagement plan)	• Implementation of workplace sexual safety measures - **Head of HR** • Appraisal compliance 2025 - currently reporting low at half-way point **- Deputy Chief People Officer** • Manager training to support staff mental health and wellbeing **- Head of HR** • Delivery of People Management Skills **- L&OD** • Deliver Leadership for All programmes with alignment between WCHC and WUTH **- L&OD**	• Q26a in NSS *"I often think about leaving the organisation"* (lower % is better) Year 4 target <u>≤</u> 28.0% v's 2024 result 33.23% • Improve staff retention Year 4 target <u>≤</u>12% v's 8.9% in 2024-25 • We work flexibly NHS People Promise score in NSS Year 4 target 6.7 v's 2024 result 6.63% • Positive FFT results at 'very good' or 'good' Year 4 target 93% • 'Morale' sub-score in NSS Year 4 target <u>≥</u>6.1 v's 2024 result 5.84% • 'Inclusion' sub-score of *'We are compassionate and inclusive'* NHS People Promise score in NSS Year 4 target <u>≥</u>7.30 v's 2024 result 7.30 • 'Compassionate culture' sub-score of 'We are compassionate and inclusive' Year 4 target <u>≥</u>7.20 v's 2024 result 7.28 • Targeted culture interventions *'We are safe and healthy'* Year 4 target <u>≥</u>6.3 v's 2024 result 6.20	**going and aligned to 2-year integration plan**

• Senior Leaders Briefings established monthly to support dissemination of messages • Appraisal window 2025 opened and extended to September 2025 • Training packages in place via ESR to support managers to undertake effective appraisals. • Freedom To Speak Up Guardian and >100 champions. • Organisational-wide recruitment and retention (R&R) group reporting to PCOG • Reduction in vacancy rates (data on TIG) • Refresh and relaunch of MDT preceptorship programme. • Behavioural standards framework launched trust-wide • Internal and external communications plans to support integration developed - Better Together branding launched • Workforce Sharing Agreement agreed between both Trusts • Engagement plan developed for staff as part of the integration plan • OD plan developed including managers 'toolkit' to support service integration • Joint Strategy development between WCHC and WUTH to include staff engagement • Better Together - case for change document published internally and externally			

• Multiple channels for staff to ask questions - Ask ELT, monthly Get Together, monthly Leaders In Touch, Senior Leaders Briefing			

<table>
<tr><td colspan="6">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</td><td>People & Culture Committee oversight</td></tr>
<tr><td colspan="7">Link to 5-Year strategy - Improve the wellbeing of our employees
Better employee experience to attract and retain talent</td></tr>
<tr><td colspan="7">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</td></tr>
<tr><td colspan="6">Current risk rating (LxC)
(by committee by month)</td><td>Risk appetite</td><td>Target risk rating (LxC)</td></tr>
<tr><td>April 25</td><td>June 25</td><td>Aug 25</td><td>Oct 25</td><td>Dec 25</td><td>Feb 26</td><td rowspan="2">Moderate</td><td rowspan="2">1 x 4 (4)</td></tr>
<tr><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td>3 x 4 (12)</td><td></td><td></td><td></td></tr>
<tr><td colspan="8">Measures remain under review and in development following committee discussions in August 2024.</td></tr>
<tr><td colspan="2">Mitigations
(i.e., processes in place, controls in place)</td><td colspan="2">Gaps
(Including an identified lead to address the gap and link to relevant action plan)</td><td colspan="2">Outcomes/Outputs
(i.e., proof points that the risk has been mitigated)

NOTE: ensuring clear alignment of the outcome to the gap it addresses</td><td colspan="2">Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="2">People Strategy Delivery Plan Year 4 developed and includes;
Actions deferred from Year 3
Alignment to existing national priorities
Key themes of the People Promise
8 x actions in Year 4 delivery plan aligned to ambition 1 ‘Culture and Belonging’</td><td colspan="2">Roll out cultural competence training - Head of Inclusion
EDI dashboard to PCC - Head of Inclusion
Implement regular cultural assessment at Trust and divisional level - Deputy CPO</td><td colspan="2">Staff engagement score in the National Staff Survey (NSS) Year 4 target ≥ 7.2 v’s 2024 results 7.02
NSS uptake Year 4 target ≥ 55% v’s 2024 result 51%
Q25c in NSS “I would recommend my organisation as a place to</td><td colspan="2">See outcome column for outcomes to be measured via the NSS in March 2026 and strategy measures of success.
Completion of actions in Year 4 PSDP ‘Culture and Belonging’ - March 2026</td></tr>
</table>

• NHS staff survey 2024 results published
  - Key overview - comparison to 2023 - 1 significantly better, 8 significantly worse, 91 no significant difference.
• Inclusion and Health Inequalities Strategy published with a commitment to empowering and upskilling our people.
• Staff network groups established for BAME, LGBTQ, Ability and Carers, Menopause and Armed Forces
  - Executive sponsorship of all staff networks refreshed and agreed.
• Staff Voice Forum
• WRES and EDS completion with oversight at PCC
• Trust adopted NorthWest BAME Assembly anti-racist statement
• Gender pay gap report to PCC
• Wellbeing and Inclusion Champions in services across the Trust
• 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 recruitment and retention action plan with improved monitoring of leaver data and improved exit processes. Plan closed following sustained decrease in turnover to below target levels.
	• Further develop staff network - **Head of Inclusion**
	• Increase coaching activity
		work" Year 4 target ≥ 63% v's 2024 result 63.21%
		• Q26a in NSS *"I often think about leaving the organisation"* (lower % is better) Year 4 target ≤ 28.0% v's 2024 result 33.23%
		• Improve staff retention Year 4 target ≤12% v's 8.9% in 2024-25
		• We work flexibly NHS People Promise score in NSS Year 4 target 6.7 v's 2024 result 6.63%
		• Positive FFT results at 'very good' or 'good' Year 4 target 93%
		• 'Morale' sub-score in NSS Year 4 target ≥6.1 v's 2024 result 5.84%
		• 'Inclusion' sub-score of *'We are compassionate and inclusive'* NHS People Promise score in NSS Year 4 target ≥7.30 v's 2024 result 7.30
		• 'Compassionate culture' sub-score of 'We are compassionate and inclusive' Year 4 target ≥7.20 v's 2024 result 7.28
		• Targeted culture interventions *'We are safe and healthy'* Year 4 target ≥6.3 v's 2024 result 6.20
		• Number of people supported on pre-employment programmes Year 4 target 10 v's 2024 achievement of 9
			• Deliver all actions from the WDES action plan - **April 2026**
			• Deliver all actions from WRES action plan - **April 2026**

• NHS Rainbow Pin Badge scheme - achieved bronze status • Armed Forces Covenant community inclusion initiatives - covenant signed, silver DERS achieved and VCHA accreditation achieved • Recruitment and Retention Policy includes positive action in respect of increasing diversity at senior roles (8a and above). • Chief executives, chairs and board members have specific and measurable EDI objectives to which they are individually and collectively accountable (6 high impact actions for EDI) • Behavioural standards framework launched trust-wide • EDS 2024 completed (jointly with WUTH) with Board approval in February 2025 - Overall attainment level = **Achieving**		• Delivery of NHSE EDI High Impact Actions • Achieve Bronze Level status for the NW BAME Assembly Anti-Racist Framework	

<table>
<tr><td colspan="6">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.</td><td>People & Culture Committee oversight</td></tr>
<tr><td colspan="7">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).</td></tr>
<tr><td colspan="7">Consequence;
Poor outcomes for the people working in the Trust
Reduced staff engagement
Increase in staff turnover and recruitment challenges</td></tr>
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(Including an identified lead to address the gap and link to relevant action plan)</td><td colspan="2">Outcomes/Outputs
(i.e., proof points that the risk has been mitigated)

NOTE: ensuring clear alignment of the outcome to the gap it addresses</td><td colspan="2">Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td colspan="2">People Strategy Delivery Plan Year 4 developed and includes;
Actions deferred from Year 3
Alignment to existing national priorities
Key themes of the People Promise
4 x actions in Year 4 delivery plan aligned to ambition 1 ‘Growing for the Future’</td><td>Review operational service requirements in relation to career pathways, clinical apprenticeships and advanced practice - L&OD</td><td colspan="2">Staff engagement score in the National Staff Survey (NSS) Year 4 target ≥ 7.2 v’s 2024 results 7.02
NSS uptake Year 4 target ≥ 55% v’s 2024 result 51%
Q25c in NSS “I would recommend my organisation as a place to work” Year 4 target ≥ 63% v’s 2024 result 63.21%</td><td colspan="2">See outcome column for outcomes to be measured via the NSS in March 2026 and strategy measures of success.
Completion of actions in Year 4 PSDP ‘Growing for the Future’ - March 2026</td></tr>
</table>

• Positive student experience and methods of fast-track recruitment • Low staff turnover • Apprenticeship plan in progress (task & finish group established) - *'grow our own'* - clinical career pathways • Social value metrics related to recruitment agreed • Internal and external communications plans to support integration developed - Better Together branding launched • Workforce Sharing Agreement agreed between both Trusts • Engagement plan developed for staff as part of the integration plan • OD plan developed including managers 'toolkit' to support service integration • Joint Strategy development between WCHC and WUTH to include staff engagement		• Q26a in NSS *"I often think about leaving the organisation"* (lower % is better) Year 4 target ≤ 28.0% v's 2024 result 33.23% • Improve staff retention Year 4 target ≤12% v's 8.9% in 2024-25 • We work flexibly NHS People Promise score in NSS Year 4 target 6.7 v's 2024 result 6.63% • Positive FFT results at 'very good' or 'good' Year 4 target 93% • 'Morale' sub-score in NSS Year 4 target ≥6.1 v's 2024 result 5.84% • 'Inclusion' sub-score of *'We are compassionate and inclusive'* NHS People Promise score in NSS Year 4 target ≥7.30 v's 2024 result 7.30 • 'Compassionate culture' sub-score of 'We are compassionate and inclusive' Year 4 target ≥7.20 v's 2024 result 7.28 • Targeted culture interventions *'We are safe and healthy'* Year 4 target ≥6.3 v's 2024 result 6.20 • 'Development' sub-score 'We are always learning' Year 4 target ≥6.6% v's 2024 result 6.33% • Social value metric - % of apprenticeship levy used for entry level roles Year 4 target ≥5% v's	

		2024 position 5.7% (90 live apprenticeships) • Social value metric - % of workforce on an apprenticeship programme Year 4 target ≥5% • Number of people supported on pre-employment programmes Year 4 target 10 v's 2024 achievement of 9 • Develop and pilot at least 1 pre-employment programme	