NHS
Wirral Community Health and Care
NHS Foundation Trust

# Board Assurance Framework (BAF) – year-end 2021-22

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| **Meeting** | Board of Directors | | |
| **Date** | 13/04/2022 | **Agenda item** | **11** |
| **Lead Director** | Alison Hughes, Director of Corporate Affairs | | |
| **Author(s)** | Karen Lees, Head of Corporate Governance | | |

**Action required** (please tick the appropriate box)

**To Approve** ☑ **To Discuss** ☐ **To Assure** ☐

**Purpose**

The purpose of this paper is to provide an update on the strategic risks managed through the Board Assurance Framework following oversight at each of the sub-committees of the Board during March and April 2022.

**Executive Summary**

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

Following review by the Board of Directors in February 2022 and during March and April 2022 each committee of the Board has discussed the relevant strategic risks aligned to the duties and responsibilities of the committee and considered the year-end position.

A high-level summary of the risks is included at appendix 1 and further detail on each strategic risk is included at appendix 2.

Each of the committees of the Board have the BAF as a standing agenda item on their bi-monthly agendas, and this work is focused on monitoring the following.

- Risk mitigations (based on processes and structures in place across the Trust)
- Outcomes and trajectories to determine risk reduction
- Target risk ratings
- Gaps in mitigations
- Cumulative impact of organisational risks as reported through Risk Reports
- Any new or emerging strategic risks to escalate to the Board of Directors

The BAF includes 9 strategic risks, and the year-end position reflects no risk scoring above RR12, and no risk having achieved its target risk rating.

At the meeting of the Quality & Safety Committee in March 2022, members considered an increase in risk rating for ID03 - *Non-compliance with statutory, regulatory and professional standards* to RR12 (from RR9) due to an increase in the likelihood as a result of the impact of the NHS Level 4 incident on the delivery of services and particularly related to an increase in ID10 - *The optimum workforce level is not achieved resulting in gaps in service provision* agreed in February 2022. This recognises the importance of workforce levels supporting the delivery of safe, caring, responsive and effective care.

The Education & Workforce Committee considered the strategic workforce risks following the recommendation supported at the last Board of Directors and agreed the year-end position as reflected in appendix 2. The members of the committee recognised the regular review of strategic workforce risks during the financial year and therefore anticipated themes for 2022-23 to ensure continued oversight and effective management in line with the Trust's strategy.

At the meeting of the Finance & Performance Committee in April 2022, members considered a reduction in risk rating for ID04 - *The right partnerships are not developed and maintained to support the success of Provider Collaboratives within the place where the Trust operates i.e., Wirral and other (e.g., St Helens, Cheshire East and Knowsley (from 2022)),* to RR4 (2 x 2) reflecting the progress made to determine the Trust's position in place-based arrangements in Wirral and other geographies. This proposed reduction does not achieve the target risk rating and therefore recognises further work once the ICS/ICP are formally established, with a consideration therefore of the risk description.

The Finance & Performance Committee also considered the position in respect of ID05 and ID06 and the year-end position is reflected in appendix 2. In respect of ID05 the committee acknowledged the future funding regime both at place and system level. In recognising the anticipated financial plan for 22-23, the committee considered future risk areas both in terms of system funding and any potential impact on quality, and the future financial sustainability of the Trust.

The Board Assurance Framework is reviewed annually to reflect the strategic priorities of the Trust and at the next informal board session, the Board of Directors will review the strategic risks for the new financial year.

**Phase 2 Assurance Framework Review**

Mersey Internal Audit Agency (MiAA) has completed a phase 2 review of the Trust's Assurance Framework.

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

- The structure of the BAF meets the NHS requirements
- There has been Board / Governing Body 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.

**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 Impact Assessment completed and attached No
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.

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

| Our Populations - outstanding, safe care every time | Our People - enhancing staff development | Our Performance - increase efficiency of all services |
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**Board of Directors is asked to consider the following action**

To receive the update provided in relation to the strategic risks managed through the Board Assurance Framework, noting the current risk rating, mitigations in place and identified gaps.
To approve the proposed increase in risk rating for ID03
To approve the reduced risk rating for ID04

**Report history**

| Submitted to | Date | Brief summary of outcome |
|---|---|---|
| Board of Directors | 14/04/21 | The Board of Directors received the year-end position for all strategic risks in the BAF. An update was also provided on the recommendations from the annual Assurance Framework Review with an agreed to provide greater oversight of the relevant risks at the committees of the Board. |
| Board of Directors | 09/06/21 | The Board of Directors<br>- was assured of the review and focus on principal risks at the committees of the Board<br>- received the summary of risk themes for 2021-22 as determined by the committees<br>- was assured of the process to finalise these through the committees and the Informal Board session in July 2021 |
| Informal Board | 07/07/21 | All members of the Board participated in a series of workshops to define risk descriptions, discuss risk ratings, risk appetite and mitigations, outcomes and gaps for referral back to committees. |
| Board of Directors | 04/08/21 | The Board of Directors received the strategic risks and approved them for tracking through the BAF during 2021-22, with each committee taking appropriate oversight.<br>The Board of Directors agreed to discuss organisational design risk at the next Informal Board (see update in matters arising). |
| Board of Directors | 06/10/21 | The Board of Directors received the update provided in relation to the strategic risks managed through the BAF and noted the current risk rating, mitigations in place and identified gaps. The Board of Directors was assured of the oversight and management of strategic risks through the sub committees of the Board. |
| Informal Board | 03/11/21 | An interim review of the Board Assurance Framework was completed with the Director of Corporate Affairs noting the findings from the phase 1 internal audit Assurance Framework Review. |
| Board of Directors | 08/12/21 | The Board of Directors received the update provided in relation to the strategic risks managed through the BAF and noted the current risk rating, mitigations in place and identified gaps.<br>The Board of Directors approved the revised risk description for ID10 and supported the recommendation from the Education & Workforce Committee to review the workforce strategic risks through an informal board session. |

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| Informal Board | 05/01/22 | The informal board session reviewed and agreed revisions to the strategic workforce risks managed through the BAF to be formally reported to EWC in February 2022. |
| Board of Directors | 09/02/22 | The Board of Directors was assured by the oversight and management of strategic risks through the sub-committees of the Board and approved the proposed increase in risk rating for ID01, the revised strategic workforce risks and the increased risk rating for ID10. |

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# Appendix 1 - Principal risks for 2021-22

| Principal Risk Description | Committee oversight | Consequence | Link to Work Plan 2021-22 | Current risk rating (LxC) | Target risk rating (LxC) | Risk Appetite |
|---|---|---|---|---|---|---|
| ID01 Failure to restore and evolve community services safely and responsively to reflect the needs of the population as we move out of the pandemic and understand its impact better | Quality & Safety Committee | • Poor experience of care resulting in deterioration and poor health and care outcomes | Safe Care & Support every time | 3 x 3 (9) | 1 x 3 (3) | Averse |
| ID02 Inability to restore NHS services inclusively with the aim of protecting the most vulnerable people in our communities | Quality & Safety Committee | • Inequity of access and experience and outcomes for all groups in our community resulting in exacerbation of health inequalities | Engaged Populations<br><br>Safe Care & Support every time | 3 x 4 (12) | 2 x 4 (8) | Averse |
| ID03 Non-compliance with statutory, regulatory and professional standards | Quality & Safety Committee | • Harm to people<br>• Reputational damage and lack of public confidence | Engaged Populations<br><br>Effective & Innovative<br><br>Safe Care & Support every time | ~~2 x 4 (8)~~<br><br>**3 x 4 (12)** | 1 x 4 (4) | Averse |
| ID04 The right partnerships are not developed and maintained to support the success of Provider Collaboratives within the place where the Trust operates i.e. Wirral and other (e.g. St Helens, Mid-Cheshire) | Finance & Performance Committee | • Poor service user access, experience and outcomes<br>• Non-compliance with Duty to Collaborate | Align the Trust's structure with current national policy | **2 x 2 (4)** | 1 x 2 (2) | Cautious |

| Principal Risk Description | Committee oversight | Consequence | Link to Work Plan 2021-22 | Current risk rating (LxC) | Target risk rating (LxC) | Risk Appetite |
|---|---|---|---|---|---|---|
| | | • Negative reputational impact across ICPs and in wider ICS<br>• Poor contract performance - financial implications (Trust and system) | | | | |
| ID05 Future system funding regime negatively impacts on system and Trust financial position and sustainability | Finance & Performance Committee | • Financial sustainability impact<br>• Negative reputational impact | Align the Trust's structure with current national policy | 3 x 3 (9) | 2 x 3 (6) | Cautious |
| ID06 IM&T infrastructure fails to maintain effective cyber defences affecting Trust security and reputation | Finance & Performance Committee | • Cyber attack<br>• Negative reputational impact<br>• IG breaches - loss of data<br>• Regulatory action<br>• Financial | Ensure core infrastructure is performant, resilient and complies with relevant cyber standards | 3 x 3 (9) | 1 x 3 (3) | Averse |
| ID07 Our people's health, wellbeing and morale are significantly affected by the long-term impact of the pandemic. | Education & Workforce Committee | • Increase in sickness absence levels, lack of availability of staff, reduced staff engagement<br>• reputation impact leading to poor health and care outcomes<br>• Poor staff survey results | Wellbeing & Recovery | 3 x 4 (12) | 2 x 4 (8) | Cautious |
| ***Risk suspended following EWC on 2.2.22 and a review of strategic workforce risks.<br>Focus of ID08 identified as a gap to ID10.***<br><br>ID08 Lack of collaboration across the ICP *(health & social care providers)* to implement an effective and complimentary workforce plan | Education & Workforce Committee | • Increase in sickness absence levels, lack of availability of staff, reduced staff engagement, reputation impact leading to poor health and care outcomes | Transformation of the organisation | 3 x 4 (12) | 1 x 4 (4) | Cautious |

| Principal Risk Description | Committee oversight | Consequence | Link to Work Plan 2021-22 | Current risk rating (LxC) | Target risk rating (LxC) | Risk Appetite |
|---|---|---|---|---|---|---|
| resulting in modern, agile, integrated working practices not being established | | • Poor staff survey results<br>• Poor staff retention<br>• Inability to attract new workforce | | | | |
| ID09 The Trust's Inclusion intentions are not delivered; the workforce is not representative of its communities and people are not able to thrive as employees of our Trust | Education & Workforce Committee | • Poor outcomes for the people working in the Trust<br>• Poor working environment for staff<br>• Failure to meet the requirements of the Equality Act 2010 | Culture | 3 x 3 (9) | 1 x 3 (3) | Averse |
| ID10 The optimum workforce level is not achieved resulting in gaps in service provision | Education & Workforce Committee | • Poor staff retention<br>• Inability to attract and recruit appropriately skilled staff<br>• Low staff morale | Develop Capability and Talent | 4 x 3 (12) | 2 x 3 (6) | Averse |
| ***Risk suspended as Place-Based Partnership governance arrangements are confirmed to determine the specific scope of the risk for the Trust.***<br>ID11 The Trust's corporate governance does not remain effective in providing a framework for the Trust's business, within the developing governance framework of the system | Board of Directors | • Poor quality or slow decisions are made<br>• Poor reputation and losing appropriate influence in the system | All | (2x4) 8 | | Open |

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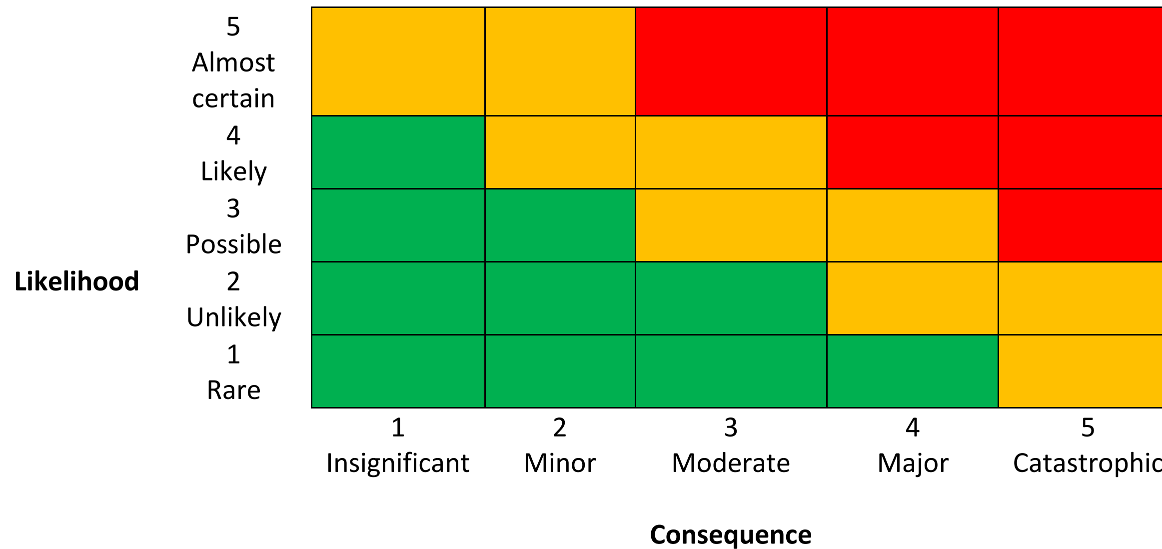
| Averse | Prepared to accept only the very lowest levels of risk |
| **Cautious** | Willing to accept some low risks |
| **Moderate** | Tending always towards exposure to only modest levels of risk |
| **Open** | Prepared to consider all delivery options even when there are elevated levels of associated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



## Appendix 2 - Board Assurance Framework

As of January 2022, the Trust established streamlined governance arrangements in response to the Level 4 incident declared across the NHS. The quality governance framework has remained in place but with meetings having a focused agenda and membership where appropriate. This should be considered when reviewing strategic risks.

# Principal risks for 2021-22 with oversight at Quality & Safety Committee

The Quality & Safety Committee has oversight of three strategic risks managed through the Board Assurance Framework and provides updates to the Board of Directors at each meeting for further discussion on the mitigations and controls in place.

At each meeting of the committee, a review of the strategic risks is considered particularly in the context of escalated organisational risks and other agenda items.

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

**Corporate Governance**

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

**Quality Governance**

- The quality governance structure in place provides clarity on the groups reporting to the committee
- The committee receives the Terms of Reference for the groups reporting to it
- The committee contributes to the development of the annual quality plan and priorities and receives quarterly assurance on implementation
- The committee receives the minutes from group meetings for noting
- The committee receives a briefing from the trust-wide Standards Assurance Framework for Excellence (SAFE) Assurance group at each meeting
- 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

**Monitoring quality performance**

- The committee receives a quality report providing a summary of all quality performance metrics at each meeting
- The members of the committee have access to the Trust Information Gateway, which covers Trust health and social care services, to monitor quality performance and to access the Audit Tracker Tool to monitor progress
- The committee contributes to, and receives the annual quality improvement audit programme and tracks implementation
- The committee receives regular updates live from the SAFE on-line (compliance) system on regulatory compliance including local audits and procedural documents

| **ID01 Failure to restore and evolve community services safely and responsively to reflect the needs of the population as we move out of the pandemic and understand its impact better** | | | Quality & Safety Committee oversight |
|---|---|---|---|
| Link to Work Plan 2021-22 - Safe Care & Support every time | | | |
| Consequence;<br>- Poor experience of care resulting in deterioration and poor health and care outcomes | | | |
| **Current risk rating (LxC)** | **Risk appetite** | | **Target risk rating (LxC)** |
| **3 x 3 (9)** | Averse | | 1 x 3 (3) |
| **Mitigations<br>(i.e., processes in place, controls in place)** | **Gaps** | **Outcomes/Outputs<br>(i.e., proof points that the risk has been mitigated)** | **Trajectory to mitigate and achieve target risk rating** |
| - All services completed reset and restore assessments, documenting evidence of completion in SAFE<br>- Tracking of waiting lists and any associated safety risks through Operational Performance Groups at local level and Operational Oversight Group (OOG)<br>- All incidents of deterioration are reported via the Datix system and an appropriate review is undertaken<br>- All complaints associated with waiting lists and restored services are tracked | - Impact of new Level 4 incident declared on service delivery and restoration of services (i.e., prioritisation of community services) - i.e waiting lists position<br>- Delays in implementation of organisational design<br>Availability of:<br>- quality outcomes framework to measure impact of safe restoration of all community | - Testing and auditing of reset and restore assessments reporting to SAFE<br>- Effective waiting list management<br>- Positive and representative patient and service user feedback<br>- Reduction in complaints and concerns associated with access to services/waiting lists<br>- Organisational design implementation demonstrably responding to staff concerns and suggestions | - Assurance provided to SAFE following testing of reset and restore assessments by December 2021 - pending<br>- Tracking of waiting lists against trajectory at IPB by January 2022 – pending due to streamlined governance arrangements<br>- End of year review of patient experience and complaints associated with the restoration of services by April 2022 |

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| through Clinical Risk Management Group to identify any learning<br>- Waiting list management oversight at OOG and IPB - pending due to Level 4 impact<br>- Patient experience volunteer recruitment to support waiting list management - NHS funding support<br>- Streamlined governance arrangements in response to Level 4 incident maintain quality governance framework to ensure safe delivery of services<br>- Prioritisation of service delivery across Cheshire & Merseyside to respond to current population needs (i.e., admission avoidance, discharge, urgent care) | services *(mitigation through development of IPR)*<br>- health inequalities data and evaluation aligned to service provision in the context of COVID-19 (link to ID02)<br>- Target for FFT responses (total number and % positive feedback) | | - Health Inequalities & Inclusion Strategy 2022-27 - by April 2022<br>- Quality Strategy 2022-27 - by April 2022<br>- FFT target to align with Quality Strategy - by April 2022 |

<table>
<tr><td colspan="6">ID02 Inability to restore NHS services inclusively with the aim of protecting the most vulnerable people in our communities</td><td colspan="2">Quality & Safety Committee oversight</td></tr>
<tr><td colspan="8">Link to Work Plan 2021-22 - Engaged Populations, Safe Care & Support every time</td></tr>
<tr><td colspan="8">Consequence;<br>- Inequity of access and experience and outcomes for all groups in our community resulting in exacerbation of health inequalities</td></tr>
<tr><td colspan="2">Current risk rating (LxC)</td><td colspan="3">Risk appetite</td><td colspan="3">Target risk rating (LxC)</td></tr>
<tr><td colspan="2">3 x 4 (12)</td><td colspan="3">Averse</td><td colspan="3">2 x 4 (8)</td></tr>
<tr><td>Mitigations<br>(i.e., processes in place, controls in place)</td><td colspan="2">Gaps</td><td colspan="3">Outcomes/Outputs<br>(i.e., proof points that the risk has been mitigated)</td><td colspan="2">Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td>- 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<br>- Restoration of services is aligned to appropriate capacity to areas of the Borough that have the most actual and potential need - pending due to Level 4 impact<br>- Effective engagement between public health colleagues and senior Trust staff leading to a review of priorities for the Health Inequalities and Inclusion strategy</td><td colspan="2">- Impact of new Level 4 incident declared on the restoration of services (i.e., prioritisation of community services)<br>- Delays in implementation of organisational design<br>- Availability of health inequalities data aligned to service provision and as part of personalised care assessment processes<br>- Lack of staff confidence in accessing and interpreting health inequalities data<br>- Review of health inequalities and inclusion training to support delivery of culturally sensitive care</td><td colspan="3">- Measures of equity of access demonstrated through patient/service user data and experience<br>- Staff confident in delivering culturally sensitive care<br>- All reasonable adjustments are made to facilitate most effective care delivery<br>- Reset and restore QIA and EIA assessments completed for all services with evidence documented on SAFE<br>- Assurance from QIA/EIA panel to QSC and EWC</td><td colspan="2">- Embedding of health inequalities dashboard across all services and testing through performance framework - Q4 2021-22 - pending<br>- Health Inequalities and Inclusion Strategy by April 2022<br>- QIA and EIA processes, updated SOP and approval processes - Q3 2021-22 - pending</td></tr>
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| - Restoration of services and refresh of health inequalities data through TIG dashboard (in development) evidences the delivery of culturally sensitive care - pending due to Level 4 impact<br>- 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<br>- Waiting list management takes account of health inequalities and vulnerability<br>- Organisational design is based on addressing health inequalities by deploying capacity appropriately across the localities<br>- Streamlined governance arrangements in response to Level 4 incident maintain quality governance framework to ensure safe delivery of services<br>- Prioritisation of service delivery across Cheshire & Merseyside to respond to current population needs (i.e., admission avoidance, discharge, urgent care) | | | |

| **ID03 Non-compliance with statutory, regulatory and professional standards** | Quality & Safety Committee oversight |
|---|---|
| Link to Work Plan 2021-22 - Engaged Populations, Effective & Innovative and Safe Care & Support every time | |
| Consequence;<br>- Harm to people<br>- Reputational damage and lack of public confidence | |

| **Current risk rating (LxC)** | **Risk appetite** | **Target risk rating (LxC)** |
|---|---|---|
| ~~2 x 4 (8)~~<br>**3 x 4 (12)** | Averse | 1 x 4 (4) |

| **Mitigations (i.e., processes in place, controls in place)** | **Gaps** | **Outcomes/Outputs (i.e., proof points that the risk has been mitigated)** | **Trajectory to mitigate and achieve target risk rating** |
|---|---|---|---|
| - Robust programme of work implemented through the Quality Strategy and Regulatory Delivery Group (QSRDG), reporting to SAFE Assurance Group to ensure consistent full compliance of CQC regulations and Social Care Employer Standards<br>- Bi-weekly position and assurance report to ELT<br>- Risk policy updated with enhanced risk management processes<br>- Targeted mitigation in place with quality, governance and dedicated operational support for areas that require strengthening<br>- External well led review commissioned<br>- Systems of assurance adapted to on-going operational design | - Impact of new Level 4 incident declared on the restoration of services (i.e., prioritisation of community services)<br>- Workforce levels impacting on service delivery and safe staffing regulations *(see ID10 with an increased risk rating agreed to RR12)*<br>- External evaluation has not yet been undertaken<br>- External validation of well-led through developmental review (in progress) | - Full delivery of quality strategy priorities to enhance regulatory compliance<br>- Staff awareness and confidence in evidencing all regulatory requirements - tested through service reviews<br>- CQC reinspection with overall Good or Outstanding rating<br>- Governance reset effectively embedded from Board to local level, from September 2021<br>- Full implementation of action plan from well-led review | - Revised Risk Policy approved and published<br>- External well-led review completing in Q4 2021-22 - delayed due to impact of Level 4 incident<br>- Well-led action plan implementation by end of Q1 22-23<br>- By March 2022 quality strategy priorities to be reported in Quality Report<br>- Quality Strategy 2022-27 - by April 2022<br>- Trust-wide and local governance reset from September 2021 and by end of Q3 2021-22 – completed but testing required and impact of Level 4 incident and streamlining of governance to be considered |

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| - Ensure full delivery of quality strategy priorities to enhance regulatory compliance<br>- On-going engagement with CQC in response to Level 4 incident to understand regulatory process activity<br>- SAFE Assurance Group renewed focus on self-assessments and regulatory compliance | | | |

# Principal risks for 2021-22 with oversight at Finance & Performance Committee

The Finance & Performance Committee has oversight of three strategic risks managed through the Board Assurance Framework and provides updates to the Board of Directors at each meeting for further discussion on the mitigations and controls in place. At each meeting of the committee, a review of the strategic risks is considered particularly in the context of escalated organisational risks and other agenda items.

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

**Corporate Governance**

- The Finance & Performance Committee meets on a bi-monthly schedule with an agreed annual workplan in place
- The committee has Terms of Reference in place, reviewed annually
- 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
- 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
- All operational risks associated with finance & performance are also monitored through the Programme Management Group before the Integrated Performance Board
- The committee receives an update on trust-wide policies related to the duties of the committee (via SAFE) and on the implementation of recommendations from internal audit reviews (via TIG - Audit Tracker Tool)
- The committee completes a self-assessment against its work in respect of the agreed Terms of Reference (following emergency governance arrangements and the re-establishment of the committee, this self-assessment will be completed in January 2022)

**Financial and Operational Governance**

- The governance structure in place provides clarity on the groups reporting to the committee
- The committee receives the Terms of Reference for the groups reporting to it
- The committee contributes to the development of the annual financial plan (including oversight of CIP) and the IM&T workplan and receives quarterly assurance on implementation
- The committee receives the minutes from group meetings for noting
- The committee reviews and approves the Trust's financial and operational plans prior to submission to the regulators

**Monitoring performance**

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

| **ID04 The right partnerships are not developed and maintained to support the success of Provider Collaboratives within the place where the Trust operates i.e., Wirral and other (e.g., St Helens, Cheshire East and Knowsley (from 2022))** | Finance & Performance Committee oversight |
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Link to Work Plan 2021-22 - Align the Trust's structure with current national policy

Consequence;

- Poor service user access, experience and outcomes
- Non-compliance with Duty to Collaborate
- Negative reputational impact across ICPs and in wider ICS
- Poor contract performance - financial implications (Trust and system)

| **Current risk rating (LxC)** | **Risk appetite** | **Target risk rating (LxC)** |
|---|---|---|
| ~~6 (3 x 2)~~<br>4 (2 x 2) | Cautious | 2 (1 x 2) |

| **Mitigations<br>(i.e., processes in place, controls in place)** | **Gaps** | **Outcomes/Outputs<br>(i.e., proof points that the risk has been mitigated)** | **Trajectory to mitigate and achieve target risk rating** |
|---|---|---|---|
| - Healthy Wirral Partnership Board with Chair, CEO and CFO attendance linking to wider system governance<br>- Wirral ICP Delivery Group (CFO leadership); finalising governance infrastructure for the new ICP - progressing well with shadow arrangements forming for Q1, 2022-23<br>- Joint CEO sponsor of the ICP Delivery Group with WUTH CEO<br>- C&M Provider CEOs<br>- Task and finish group looking at system pressures, and the formation of Provider Collaboratives across C&M<br>- Memorandum of Understanding for the C&M Mental Health, Learning Disability and Community (MHLDC) Provider Collaborative (formerly C&M Out of Hospital CEOs) | - Delay in national legislation impacting on date for formal establishment of ICS<br>- Recommendations from internal audit stakeholder engagement review - delayed. | - Establishment of ICP (place) governance across the Wirral system (in shadow form from Q1, 2022-23)<br>- Clarity on ICP governance arrangements in Cheshire East, St Helens and Knowsley to determine Trust position - emerging with Trust representation at key forums - complete. | - Governance workshop across the system in October 2021 (complete)<br>- Internal Audit Plan - stakeholder engagement review October - December 2021 - delayed<br>- Trust 5-year strategy - April 2022<br>- Internal Audit Plan 22/23 - place-based governance arrangements - Q2<br>- Establishment of ICP (place) governance across the Wirral system - in shadow form from Q1, 2022-23 |

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| approved by Boards of member organisations<br>- C&M MHLDC Provider Collaborative proposals to ICB - April 2022<br>- Board level representation at system meetings (e.g., Chief Strategy Officer attendance at PLACE forum in St Helens, Cheshire East and engagement with commissioners and stakeholders in Knowsley) across places we serve<br>- Alignment of Service Directors to localities and PCNs<br>- 5-year strategy development plan included partners and stakeholders feedback<br>- Trust attendance at Health & Wellbeing Boards in St Helens, Cheshire East and Knowsley<br>- Executive attendance (CSO and COO) agreed at Knowsley's Shadow Integrated Partnership Board and St Helen's People Board.<br>- Place-lead for Wirral confirmed<br>- Internal Audit Plan for 22/23 includes an Integrated Health and Social Care review with the objective to provide an opinion on the governance arrangements developed within the integrated health and social care services to effectively manage the delivery of strategic objectives, contractual requirements, key performance indicators and statutory assurances.<br>- CSO acts as partnership lead connecting the Trust with places to ensure we can be | | | |

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| proactive if there are any areas of concern and to receive positive feedback on how services at place are progressing.<br>- Reintroduction of contract meetings with commissioners. | | | |

<table>
<tr><td colspan="5">ID05 Future system funding regime negatively impacts on system and Trust financial position and sustainability</td><td colspan="2">Finance & Performance Committee oversight</td></tr>
<tr><td colspan="7">Link to Work Plan 2021-22 - Align the Trust’s structure with current national policy</td></tr>
<tr><td colspan="7">Consequence.<br>• Financial sustainability impact<br>• Negative reputational impact</td></tr>
<tr><td colspan="2">Current risk rating (LxC)</td><td colspan="3">Risk appetite</td><td colspan="2">Target risk rating (LxC)</td></tr>
<tr><td colspan="2">9 (3 x 3)</td><td colspan="3">Cautious</td><td colspan="2">6 (2 x 3)</td></tr>
<tr><td>Mitigations<br>(i.e., processes in place, controls in place)</td><td colspan="2">Gaps</td><td colspan="2">Outcomes/Outputs<br>(i.e., proof points that the risk has been mitigated)</td><td colspan="2">Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td>- CFO local, regional and national forums<br>- Sound financial controls for H1 achieved position<br>- H2 funding position received, and guidance implemented locally and at system-level<br>- Board approval for break-even position for H2 (November 2021) - on track to deliver<br>- Oversight of CIP for 2021-22 through Chief Operating Officer and ELT - all Deputy Directors and Heads of Service taking collective responsibility for working together to develop achievable plans<br>- On target to achieve CIP 21-22 - achieved</td><td colspan="2">- Final submission of financial plan 22-23 (by end of April 2022)<br>-</td><td colspan="2">- Delivery of H2 (21-22) break-even financial plan<br>- Delivery of required CIP for 21-22<br>- Unqualified audit opinion - achieved for 20-21<br>- Agreement of financial plan for 22-23 locally and at system-level (by end of April 2022)</td><td colspan="2">- Current and projected position to be reported regularly to FPC up to year-end (December 2021, February 2022) - complete<br>- Confirmation of H2 funding due in <u>September 2021</u> - received 30 September 2021 - complete<br>- H2 financial plan approved by Board of Directors and submitted to ICS and NHSE/I - complete<br>- From November 2021 COO established working group with Deputy Directors and Heads of Service for collective working on unidentified gap for 2021-22 and plan for 22-23 - report to FPC up to year-end and beyond (December 2021, February 2022) - group will be re-established from end of January 2022 following pause due to Level 4 incident - complete</td></tr>
</table>

| | | | |
|---|---|---|---|
| - Robust CIP governance arrangements in place for 22-23 CIP programme<br>- Chief Strategy Officer identified as Accountable Lead for CIP with each Director taking portfolio responsibility<br>- Strong progress on CIP identification for 22-23 | | | - Final submission of financial plan 22-23 (by end of April 2022) |

<table>
<tr><td colspan="3">ID06 IM&T infrastructure fails to maintain effective cyber defences affecting Trust security and reputation</td><td>Finance & Performance Committee oversight</td></tr>
<tr><td colspan="4">Link to Work Plan 2021-22 - Ensure core infrastructure is performant, resilient and complies with relevant cyber standards</td></tr>
<tr><td colspan="4">Consequence;<br>• Cyber attack<br>• Negative reputational impact<br>• IG breaches - loss of data<br>• Regulatory action<br>• Financial</td></tr>
<tr><td>Current risk rating (LxC)</td><td colspan="2">Risk appetite</td><td>Target risk rating (LxC)</td></tr>
<tr><td>9 (3 x 3)</td><td colspan="2">Averse</td><td>3 (1 x 3)</td></tr>
<tr><td>Mitigations<br>(i.e., processes in place, controls in place)</td><td>Gaps</td><td>Outcomes/Outputs<br>(i.e., proof points that the risk has been mitigated)</td><td>Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td>- DSPT 20-21 submission completed<br>- DSPT assertion 7.3.6 workplan agreed and delivered ahead of plan<br>- DSPT 21-22 submission action plan in place and tracking through IGDS and FPC<br>- MiAA testing of DSPT 21-22 assertions - ToR agreed<br>- Investment in IM&T infrastructure and delivery of upgrade programmes monitored through PMG<br>- Oversight at IGDS<br>- IGDS reporting to FPC</td><td>- Unsupported Windows Operating software with a remediation plan in place<br><br>- Full test of IT Business Continuity plans<br><br>- Independent on-site assessment of Data Security & Protection Toolkit (DSPT) to secure Cyber Essentials Plus</td><td>- Implementation of solution for immutable backups by end of December 2021 - completed<br><br>- Unsupported software remediation following successful delivery of upgrade programmes.<br><br>- IT Continuity test plans tested and documented.<br><br>- Substantial assurance from onsite assessment of DSPT to secure Cyber Essentials.</td><td>- DSPT assertion 7.3.6 improvement plan to be delivered by 31 December 2021 - complete<br><br>- Unsupported Operating System by March 2022<br><br>- Business continuity testing - Q4 2021-22<br><br>- DSPT on-site assessment - March 2022 (ToRs agreed) - in progress</td></tr>
</table>

| | | | |
|---|---|---|---|
| - IM&T network infrastructure plan to improve resilience across the Trust<br>- Robust security patching in place across the estate<br>- Strengthened skill and capability of IM&T service (new Head of IT and IT Cyber Security Assurance role).<br>- IT Security group established to monitor operational improvement plan.<br>- Annual penetration tests<br>- Infrastructure monitoring in place<br>- Vendor support of hardware and software<br>- Standardisation of security platforms (Anti-virus / Advanced TP).<br>- Improved external collaboration with C&M Cyber security group<br>- Increased cyber awareness through regular training and communication<br>- Existing business continuity plans in place across the Trust<br>- Emergency Planning Resilience and Response (EPRR) self-assessment completed, and substantial assurance received (submitted in accordance with national deadline).<br>- Refreshed IT security policies - IG23 General Security Policy | | | |

| | | | |
|---|---|---|---|
| - Data Security and Protection Training Needs Analysis completed<br>- Regular System Audits - Legitimacy and Same Surname Access BEST, SOEL Health, Excelicare, SystmOne, Liquid Logic reported to IGDS<br>- Board level cyber security training delivered March 2022 | | | |

# Principal risks for 2021-22 with oversight at Education & Workforce Committee

The Education & Workforce Committee has oversight of three strategic risks managed through the Board Assurance Framework and provides updates to the Board of Directors at each meeting for further discussion on the mitigations and controls in place.

At each meeting of the committee, a review of the strategic risks is considered particularly in the context of escalated organisational risks and other agenda items.

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 Education & Workforce 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 Director of HR & Organisational Development is the Executive Lead for the committee
- The Integrated Performance Board is the highest operational group in the Trust and maintains oversight and scrutiny of performance to provide assurance to the committee
- 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
- All operational risks associated with workforce are also monitored through the Programme Management Group before the Integrated Performance Board
- The committee receives an update on trust-wide policies related to the duties of the committee (via SAFE) and on the implementation of recommendations from internal audit reviews (via TIG - Audit Tracker Tool)
- The Chair of the committee is the NED health and wellbeing lead for the Trust
- The committee completes a self-assessment against its work in respect of the agreed Terms of Reference (following emergency governance arrangements and the re-establishment of the committee, this self-assessment will be completed in January 2022)

**Workforce Governance**

- The governance structure in place provides clarity on the groups reporting to the committee
- The committee receives the Terms of Reference for the groups reporting to it
- The committee receives the minutes from group meetings for noting
- The committee contributes to the development of the annual people plan and priorities and receives quarterly assurance on implementation
- The committee receives a briefing from the trust-wide Standards Assurance Framework for Excellence (SAFE) Assurance group at each meeting in relation to specific workforce metrics (i.e., safe staffing, mandatory and role essential training)
- The committee contributes to the development of, and maintains oversight on the implementation of the annual people/workforce priorities
- The committee reviews and approves the 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

**Monitoring workforce performance**

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

<table>
<tr><td colspan="4">ID07 Our people's health, wellbeing and morale are significantly affected by the long-term impact of the pandemic</td><td colspan="2">Education & Workforce Committee oversight</td></tr>
<tr><td colspan="6">Link to Work Plan 2021-22 - Wellbeing & Recovery</td></tr>
<tr><td colspan="6">Consequence;<br>• Increase in sickness absence levels, lack of availability of staff, reduced staff engagement<br>• Reputation impact leading to poor health and care outcomes<br>• Poor staff survey results</td></tr>
<tr><td colspan="2">Current risk rating (LxC)</td><td colspan="2">Risk appetite</td><td colspan="2">Target risk rating (LxC)</td></tr>
<tr><td colspan="2">12 (3 x 4)</td><td colspan="2">Cautious</td><td colspan="2">8 (2 x 4)</td></tr>
<tr><td>Mitigations<br>(i.e., processes in place, controls in place)</td><td colspan="2">Gaps</td><td colspan="2">Outcomes/Outputs<br>(i.e., proof points that the risk has been mitigated)</td><td>Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td>- Wellbeing pledges signed off at Board of Directors in December 2021<br>- People Plan approved<br>- Tracking of Staff Survey Team Intentions in SAFE on-line system<br>- Workforce metrics agreed and tracked through TIG, Integrated Performance Board and reported to committee<br>- Monthly pulse survey and Get Together - January Sli.do question on health and wellbeing actions (Pulse survey resumed in December 2021)<br>- Health and wellbeing support available for all staff<br>- Team Intentions (from national staff survey) developed through service Plans on a Page<br>- Appraisal completion rate 87.3%</td><td colspan="2">- Increase in pulse survey response rate to provide greater depth of representation (December = 203 responses) NOTE: Pulse Survey moving to quarterly position from April 2022<br>- Availability of qualitative data on the quality of wellbeing conversations - pending<br>- Impact of Level 4 incident and subsequent reassignment of staff - return to substantive roles from 31 March 2022<br>- Action plan for 2021-22 national staff survey to be agreed</td><td colspan="2">- Improvement on pulse survey response on wellbeing and motivation<br>- Increase in pulse survey responses (quarterly)<br>- Annual national staff survey - improvement on health & wellbeing question responses<br>- Reduction in % staff absence due to stress & anxiety (overall sickness reduction from 8.7% in Jan to 7.8% in Feb; YTD 6.9%))<br>- Achieving key milestones on Organisational Design - phase 1 from 1 April 2022<br>- Agreed actions from Sickness Absence Task & Finish group - T&F group delayed due to Level 4 incident</td><td>- Implementation of People Plan actions - regular reports to EWC and by March 2022<br>- By February/March 2022, national staff survey results and tracking of responses on health and wellbeing<br>- Evidence (qualitative and quantitative) to support that wellbeing conversations are taking place - February 2022 (action from EWC) - pending due to impact of Level 4<br>- Quarterly monitoring of progress to achieve NW well-being pledges at EWC - e.g., February, June, October - pending due to impact of Level 4<br>- Implementation of actions from Sickness Absence Task & Finish group - Q4 2021/22 - pending due to impact of Level 4</td></tr>
</table>

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|---|---|---|---|
| - Wellbeing Champions to support wellbeing pledges<br>- Wellbeing Guardian - NED lead appointed<br>- Weekly pay option implemented for bank staff (Wagestream)<br>- Staff Zone resources to support health and wellbeing<br>- Associated risks for Knowsley TUPE transfer being managed through risk registers | | | |

<table>
<tr><td colspan="4">ID09 The Trust’s Inclusion intentions are not delivered; the workforce is not representative of its communities and people are not able to thrive as employees of our Trust</td><td colspan="2">Education & Workforce Committee oversight</td></tr>
<tr><td colspan="6">Link to Work Plan 2021-22 - Culture</td></tr>
<tr><td colspan="6">Consequence;<br>• Poor outcomes for the people working in the Trust<br>• Poor working environment for staff<br>• Failure to meet the requirements of the Equality Act 2010</td></tr>
<tr><td colspan="2">Current risk rating (LxC)</td><td colspan="2">Risk appetite</td><td colspan="2">Target risk rating (LxC)</td></tr>
<tr><td colspan="2">9 (3 x 3)</td><td colspan="2">Averse</td><td colspan="2">3 (1 x 3)</td></tr>
<tr><td>Mitigations<br>(i.e., processes in place, controls in place)</td><td colspan="2">Gaps</td><td>Outcomes/Outputs<br>(i.e., proof points that the risk has been mitigated)</td><td colspan="2">Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td>- People Plan and accompanying action plan - inclusive culture theme<br>- EDS2 assessment - inclusive leadership<br>- WRES and WDES action plans<br>- Staff network groups with Exec sponsorship agreed<br>- Reciprocal mentoring programme<br>- Development of new Inclusion and Health Inequalities Strategy<br>- New values and common purpose embedded through HR processes<br>- Leadership Qualities Framework and Development Programme<br>- Learning & Organisational Development workplan</td><td colspan="2">- Trust/divisional Inclusion dashboards to include workforce KPIs e.g., numbers of discrimination ER cases and minority ethnic staff levels (in development)<br>- Improved data capture to assist monitoring</td><td>- EDS2 assessment report and outcomes<br>- Staff Survey results - improvement in inclusion questions in comparison to 2020<br>- Action plan for 2021-22 national staff survey to be agreed<br>- Delivery of the WRES and WDES action plans e.g., increase in representation in workforce<br>- Inclusion dashboard to be embedded in local governance arrangements e.g., SAFE, Operational Performance Groups providing evidence of data capture and analysis</td><td colspan="2">- By February/March 2022, national staff survey results - published.<br>- By March 2022 - increase in representation of protected groups in workforce e.g., BAME, Disabled<br>- By April 2022 Inclusion and Health Inequalities Strategy - on track.<br>- Inclusion and Health Inequalities dashboard - Q1, 2022/23</td></tr>
</table>

| | | | |
|---|---|---|---|
| - Organisational Design Oversight Group with HR attendance and leadership<br>- Rising Through the Ranks event<br>- Health Inequalities Task & Finish Group<br>- Revised AIS format to improve data collection implemented on system1<br>- Exec Team meeting with Director of Public Health to discuss approach to focus on Health Inequalities<br>- Partnership Forum with system partners and staff representatives<br>- Health Inequalities & Inclusion Strategy developed *(pending board approval on 13.4.22)* | | | |

<table>
<tr><td colspan="3">ID10 The optimum workforce level is not achieved resulting in gaps in service provision</td><td>Education & Workforce Committee oversight</td></tr>
<tr><td colspan="4">Link to Work Plan 2021-22 - Develop Capability and Talent</td></tr>
<tr><td colspan="4">Consequence;<br>• Lack of availability of staff with the right skills<br>• Inability to attract and recruit appropriately skilled staff<br>• Low staff morale</td></tr>
<tr><td>Current risk rating (LxC)</td><td colspan="2">Risk appetite</td><td>Target risk rating (LxC)</td></tr>
<tr><td>12 (4 x 3)</td><td colspan="2">Averse</td><td>6 (2 x 3)</td></tr>
<tr><td>Mitigations<br>(i.e., processes in place, controls in place)</td><td>Gaps</td><td>Outcomes/Outputs<br>(i.e., proof points that the risk has been mitigated)</td><td>Trajectory to mitigate and achieve target risk rating</td></tr>
<tr><td>- NHSE/I guidance for community services implemented with appropriate staff reassignments enacted<br>- International nurses recruited and in post from February 2022 (CICC initially)<br>- People Plan<br>- L&OD plan<br>- Recruitment action plans in areas with identified recruitment challenges<br>- Apprenticeship target<br>- Organisational Design - phase 1 launched on 1 April 2022 with new organisational structure<br>- Pulse survey focus on Trust as a place to work and discussion at Get Together<br>- Weekly pay for bank staff to address challenges of filling shifts</td><td>- Place-based workforce plan to address key workforce priorities<br>- Speed of recruitment<br>- Workforce supply chain is compromised - lack of availability of staff with the right skills<br>- Changing age profile of workforce based on increase in retirement<br>- High sickness levels<br>- Robust monitoring of safe staffing metrics (Reg 18) - ref: MiAA internal audit review with Limited Assurance<br>- Lack of collaboration across the ICP (health & social care providers) to implement an effective and complimentary workforce plan resulting in modern, agile, integrated working practices not being established</td><td>- Development of a place-based workforce plan identifying and addressing key workforce challenges<br>- Reduction in staff turnover rates and sickness absence levels<br>- Increase in staff satisfaction response in national NHS staff survey - decrease in morale and engagement (as per national trend)<br>- Increased availability of bank staff due to weekly pay option<br>- Reduction in organisational risks related to workforce and staffing issues - relevant risks remain under review via monthly OOG and IPB. 21 risks on risk register related to staffing and competence - NO high-level</td><td>- Evidence of Safe Staffing metrics through SAFE Assurance Group - Q1, 22/23 - on-going (presentation to EWC on 6.4.22)</td></tr>
</table>

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|---|---|---|---|
| - Programme of support and challenge to improve teams’ use of rostering to improve efficiency and staff experience<br>- Improved feedback and intelligence from exit interviews and other relevant data<br>- Turnover rates benchmark well against system and community trusts<br>- Reg 18 Safe Staffing focus at SAFE Assurance Group | | | |
| **Organisational risks**<br>Previously mapped to ID10 and reported in February 2022. Risk rating reduced to RR8.<br>- **ID2733 -** Delayed recruitment in CICC and increase in sickness absence (RR16)<br>- Reviewed via CICC programme board and Silver Command (under streamlined governance arrangements)<br>- Considered at EWC in the context of reviewing the risk rating. | | | |

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

**From:** Ann Ellis – Senior Audit Manager
Charles Black – Principal Auditor

**Date:** 22nd March 2022

**Re:** **Assurance Framework Review – Phase 2**

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# 1 Introduction and Background

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

The principles of assurance frameworks have been in place for a number of years, and there has been a continued focus on ensuring the embeddedness of these processes and the extent they are used by the Board. Whilst traditionally the AF focused on risks, controls and assurances within the organisation, we are starting to see a wider focus across organisational boundaries and an increase in external risks to reflect the environment within which organisations are operating.

The Covid-19 pandemic has had an enormous impact on the risk landscape for NHS organisations, and has provided a difficult challenge for organisations to balance managing pre-existing strategic risks and new risks emerging or changing as a result of the pandemic.

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

# 2 Objectives & Scope

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

The review was conducted in two stages:

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

- The structure of the AF meets the NHS requirements;
- There has been Board / Governing Body 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.

This review also followed up on actions raised as part of the Assurance Framework Phase 1 review.

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

# 3 Objectives & Assurance Statement

## Opinion

| | |
|---|---|
| **Structure** | **The organisation's AF is structured to meet the NHS requirements.** |
| **Engagement** | **The AF is visibly used by the organisation.** |
| **Quality & Alignment** | **The AF clearly reflects the risks discussed by the Board.** |

# 4 Detailed Assessment

## 4.1 Structure

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

<table>
<tr><th>Requirement</th><th>Conclusion</th><th>Wider Commentary</th></tr>
<tr><td>4.1.1 The structure of the AF meets the NHS requirements in respect of defining objectives, risks, controls, assurances and gaps.</td><td>The structure of the AF does meet the NHS requirements.</td><td rowspan="4"><ul><li>The AF strategic risks (an overarching document) includes details such as the Committee of which has oversight, current and target risks scores for each principal risk.</li><li>The AF strategic risks (overarching document) should be updated to include initial risk scores to determine movement of risks.</li><li>The AF strategic risks (overarching document) includes consideration of risk appetite / target risks.</li><li>The mitigations (controls in place), assurances (outcomes/outputs), gaps and actions to be taken (the trajectory to mitigate and achieve target risk ratings) are included in the segmented AF. The AF is segmented for each Committee of the Board (such as the Quality and Safety Committee has duties and responsibilities aligned to strategic risks reference ID01, ID02 and ID03.</li><li>We confirmed that the AF strategic risks (overarching document) along with the supporting segmented AF (that is aligned to each Committee) had been reported to the Board of Directors in February 2021.</li></ul></td></tr>
<tr><td>4.1.2 The objectives within the AF align with those in the strategic plan.</td><td>The objectives within the AF do align with those in the strategic plan.</td></tr>
<tr><td>4.1.3 The AF includes risk scoring, i.e. initial, current and target risk scores.</td><td>The organisation's AF does include reference to the movement of risks / risk profile.</td></tr>
<tr><td>4.1.4 The format of the AF provides an action plan to address the gaps.</td><td>The AF includes actions to address gaps.</td></tr>
</table>

| | | |
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| | | • The segmented AF does provide updates of progress against actions to address the identified gaps.<br>• **The Trust should consider enhancing the segmented AF to include responsible leads for each individual action identified from the gaps. Each identified gap should also have a supporting action in place.**<br>• The organisation’s AF does not use dashboards / graphs to provide visual overviews. |

## 4.2. Engagement

Review of Board minutes for April 2021 to December 2021 (Dates on meetings when the AF was presented: April 2021, August 2021, October 2021, December 2021 and February 2022)

<table>
<tr><th>Requirement</th><th>Conclusion</th><th>Wider Commentary</th></tr>
<tr><td>4.2.1 The AF is regularly presented to the Board.</td><td>The AF was regularly presented to the Board.</td><td rowspan="4">The AF was presented to the Board in the following months:<ul><li>April 2021;</li><li>August 2021;</li><li>October 2021;</li><li>December 2021; and,</li><li>February 2022.</li></ul>Examples of Board discussion of the AF include:<ul><li>October 2021 – an update was provided to the Board on the work completed by the Committees during June and July 2021. It was noted that the AF would be included as a standing agenda item on each committee agenda and the committees would continue the ongoing work on the monitoring of strategic risk.</li><li>December 2021 – the risks were considered in the context of the wider agenda and it was recommended that at the next Informal Board meeting, the full Board of Directors test the strategic workforce risks in the wider context to ensure they remained fit for purpose.</li></ul></td></tr>
<tr><td>4.2.2 The minutes of the Board clearly demonstrate discussion, review and update of the AF.</td><td>Board minutes clearly demonstrate discussion and update of the AF.</td></tr>
<tr><td>4.2.3 Where the AF is regularly presented to the relevant committees of Board.</td><td>The AF was regularly presented to committees/subcommittees.</td></tr>
<tr><td>4.2.4 The minutes of Board Committees clearly demonstrate consideration of the AF and associated risks.</td><td>Committee minutes received by the Board demonstrate the use of AF by the Committees.</td></tr>
</table>

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| | | The accuracy of risk reference ID10 was discussed and challenged, particularly in the context of the delivery of the People Plan.<br>The AF was presented to Committees/Sub-committees in the following months:<br>• Quality and Safety Committee – September 2021, November 2021 and January 2022.<br>• Finance and Performance Committee – October 2021, November 2021 and February 2022.<br>• Education and Workforce Committee – December 2021 and February 2022.<br>Examples of committee / sub-committee consideration of the AF include:<br>• Quality and Safety Committee – In January 2022, increase in risk rating ID01 from 9 to 6 was discussed due to increase in the likelihood as a result of the impact of the NHS level 4 incident on the restoration of services.<br>• Education and Workforce Committee – In February 2022, the scoring of ID01 was considered and subsequently the risk rating score was changed to 12.<br>• Finance and Performance Committee – In February 2022, the trajectory of risk reference ID06 as considered (relating to IMT infrastructure with consideration given to the completion of actions in relation to assertion 7.3.6. |

## 4.3. Quality and Alignment

Review against Board minutes and Benchmarking (February 2022, December 2021 and October 2021).

| Requirement | Conclusion | Wider Commentary |
|---|---|---|
| **4.3.1 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:<br>• Failure to restore and evolve community services safely and responsively;<br>• Inability to restore NHS services;<br>• The right partnerships are not developed and maintained to support the success of Provider Collaboratives; and,<br>• Future system funding regime negatively impacts on system and Trust financial position and sustainability.<br>There is evidence of the Board connecting risks in papers and discussions to the AF, examples include:<br>• In December 2021 – as part of the Integrated Performance Report it was reported that there has been an increase in staff turnover and sickness |
| **4.3.2 The risks identified within the Board minutes are reflected in the AF.** | Risks identified by the Board were reflected in the AF. | |
| **4.3.3 Board assurances are clearly identified within the AF.** | Assurances were clearly identified. | |
| **4.3.4 Controls are clearly defined within the AF.** | Controls were clearly defined. | |
| **4.3.5 Gaps are clearly identified within the AF and actions detailed.** | Gaps were clearly identified and mitigating actions were in place. However, some areas for improvement were identified. | |

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| | | absence which links to AF risk reference ID10.<br>• In addition, the accuracy of the risk description for risk reference ID10 was discussed following reporting of the heath and wellbeing pledges paper.<br>The assurances detailed within the AF were clear in terms of scope, frequency and reporting routes to the Board.<br>**As noted in the structure section above, although work is still underway to identify the gaps and required actions, the segmented AF should be enhanced to include responsible leads for each individual action identified from the gaps. The AF should be clearly mapped to ensure that each identified gap has a supporting action in place.** |

## 4.4. Action Plan:

| No | Requirement | Recommendation | Management Response / Responsibility for Action / Date |
|---|---|---|---|
| **1.** | Structure | The AF strategic risks (overarching document) should be updated to include initial risk scores to determine movement of risks. | This will be incorporated into the review of the BAF for the new financial year. The BAF 22/23 will be discussed at informal board in May 2022 and formal Board of Directors in June 2022.<br>Responsibility for Action – Director of Corporate Affairs |
| **2.** | Structure | The Trust should consider enhancing the segmented AF to include responsible leads for each individual action identified from the gaps. Each identified gap should also have a supporting action in place. | This will be considered as part of further enhancement of the BAF for 22/23. The revised BAF will be presented to the Board of Directors in June 2022 where this will be addressed for any identified gaps. Any further gaps identified throughout the financial year will be approached in the same way.<br>Responsibility for Action – Director of Corporate Affairs |
| **3.** | Quality and Alignment | As noted in the structure section above, although work is still underway to identify the gaps and required | See above. |

| | | | |
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| | | actions, the segmented AF should be enhanced to include responsible leads for each individual action identified from the gaps. The AF should be clearly mapped to ensure that each identified gap has a supporting action in place. | |