Wirral Community Health and Care NHS Foundation Trust

Board Assurance Framework (BAF)

Meeting	Board of Directors		
Date	19/10/2022	**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 cover paper is to provide the Board of Directors with an update and assurance on the development the underpinning risk templates for the strategic risks that were agreed at the Board of Directors meeting in June 2022. These risks are monitored through the Board Assurance Framework (BAF).

Executive Summary

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

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

During September and October 2022, the committees of the board have completed a further review of the strategic risks in order to provide a full update to the Board of Directors, included at appendix 1.

The committee have reviewed mitigation, gaps, outcomes and trajectories to mitigate risks and also had some useful discussions regarding risk ratings and in some instances refinements of risk descriptions, to reflect the changing landscape. The changes are summarised as follows;

Quality & safety strategic risks (ID01 and ID02)

- Risk descriptions reviewed to reflect committee members feedback
- In populating the strategic risk template, existing mitigations have been segmented according to some key areas in either the Quality or Health Inequalities and Inclusion strategies. The members of the committee are asked to review this approach and provide any further comments, additions or amends prior to presentation to the Board of Directors in October 2022.

Finance & performance strategic risks (ID03, ID04, ID05 and ID06)

- At its meeting on 3 August 2022, the committee reviewed all relevant risks but specifically the detail of ***ID03 - The constitution and governance of the Provider Collaborative (member/stakeholder) Board and clarity on the establishment of a Lead Provider for some or all services is not exacted.*** It was agreed that whilst it remains a potential risk, the specific risk to the organisation was not clear and as such the risk was temporarily suspended until further progress was confirmed. At the meeting of the committee in October 2022, the status of the risk was reconsidered and subsequently the Chief Executive and Director of Corporate Affairs are reviewing proposals to share with the board at the informal session on 2

November 2022 for further debate and discussion. The position will be reviewed at the Finance & Performance Committee in December and subsequently to the Board of Directors.
- Risk descriptions reviewed for ID05 and ID06 to reflect committee members feedback
- In respect of ID05 the revision to the risk description recognises that there is a strategic risk on service delivery which has oversight at QSC (ID01). The proposed revision therefore ensures a focus on poor financial performance at place.

Strategic workforce risks (ID07, ID08 and ID09)
- The risk rating for ID08 has increased to RR12 with an increase in likelihood to 3 (from 2) given the results and further action required following a review of the WDES data
- The risk rating for ID09 has decreased to RR12 with a likelihood of 3 (reduced from 4) recognising the work completed and updates provided

Of the 8 strategic risks being actively tracked through the Board Assurance Framework none are scoring more than RR12.

There is one high-level organisational risks which has oversight at the Quality & Safety Committee; this relates to the Knowsley 0-25 service and whilst high-level does not impact on the current scoring of any strategic risk.

Through formal and informal meetings, the Board of Directors will continue to discuss the Board Assurance Framework including the identification of any new or emerging risks particularly in the context of legislative changes and arrangements at Place level.

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

Board of Directors is asked to consider the following action
- Approve the revised risk descriptions for ID01 and ID02 based on a recommendation from the Quality & Safety Committee
- Note the position regarding ID03
- Approve the revised risk descriptions for ID05 and ID06 based on a recommendation from the Finance & Performance Committee
- Approve the increase in risk rating for ID08 to RR12 (from RR8)
- Approve the decrease in risk rating for ID09 to RR12 (from RR16)
- To be assured by the progress with the development of the strategic risk template for Board Assurance Framework through the sub-committees of the Board .

Report history

Submitted to	Date	Brief summary of outcome
Board of Directors	09/06/21	The Board of Directors - was assured of the review and focus on principal risks at the committees of the Board

		- received the summary of risk themes for 2021-22 as determined by the committees - 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. 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. 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.
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.
Board of Directors	13/04/22	The Board of Directors received the update provided in relation to the

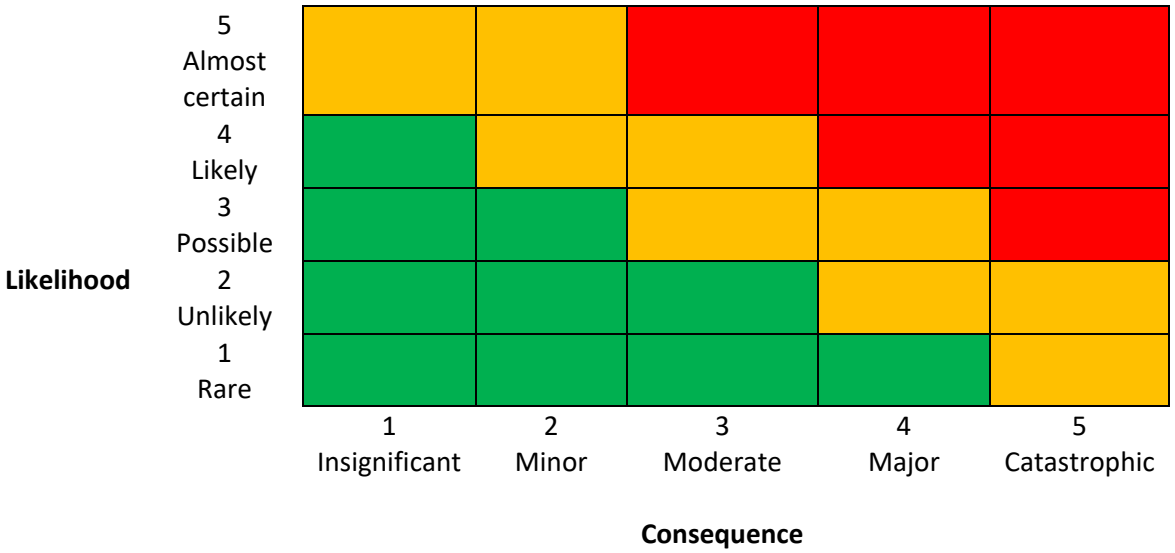
		strategic risks, noting the current risk rating, mitigations in place and identified gaps and approved the reduced risk rating for ID04 The Board of Directors received the BAF as the year-end position.
Informal Board	11/05/22	The members of the Board considered the strategic risks for 2022-23 reflecting on the risks tracked through the BAF in 2021-22 and the Trust's 5-year strategy.
Board of Directors	15/06/22	The members of the Board received and approve recommendations from the committees of the Board on the proposed strategic risks for tracking through the Board Assurance Framework during 2022-23; and approved the strategic risk structure template.
Board of Directors	17/08/22	The Board received an update following review of all strategic risks at the committees of the Board.

Strategic risk summary 2022-23

Risk Description	Committee oversight	Link to 5-year strategy	Current risk rating (LxC)	Target risk rating (LxC)	Risk Appetite
ID01 - Failure to deliver services safely and responsively to inclusively meet the needs of the population	Quality & Safety Committee	Safe Care & Support every time	3 x 4 (12)	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)	2 x 4 (8)	Averse
ID03 The constitution and governance of the Provider Collaborative (member/stakeholder) Board and clarity on the establishment of a Lead Provider for some or all services is not exacted **Risk temporarily suspended as further arrangements around the Providers Collaborative are defined and the system risk framework established.**	Finance & Performance Committee				
ID04 - The financial settlement requires an unachievable efficiency target creating a risk to the financial sustainability of the organisation	Finance & Performance Committee	Make most efficient use of resources to ensure value for money	3 x 4 (12)	2 x 4 (8)	Averse
ID05 - Poor financial performance at Place creates a negative impact on the Trust and leads to increased monitoring and regulation	Finance & Performance Committee	Deliver sustainable health and care services	3 x 4 (12)	1 x 4 (4)	Averse
ID06 Trust operational and financial performance is poor and has an impact on Place	Finance & Performance Committee	Deliver sustainable health and care services	2 x 4 (8)	1 x 4 (4)	Averse

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

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



Board Assurance Framework 2022-23

Strategic risks with oversight at Quality & Safety Committee

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

Corporate Governance

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

Quality Governance

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

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

Monitoring quality performance

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

~~**ID01 Failure to deliver services safely and responsively to meet the needs of the population contributing to the reduction of health inequalities**~~ **Proposed revised risk description - ID01 Failure to deliver services safely and responsively to inclusively meet the needs of the population**	Quality & Safety Committee oversight
Link to 5-year strategy - Poor experience of care resulting in deterioration and poor health and care outcomes	
Consequence; • Poor experience of care resulting in deterioration and poor health and care outcomes • Non-compliance with regulatory standards and conditions • Widening of health inequalities	

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

Mitigations (i.e., processes in place, controls in place)	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs (i.e., proof points that the risk has been mitigated)**	**Trajectory to mitigate and achieve target risk rating**

Actions to ensure safe care and support every time to prevent variation of standards across localities and teams - Psychological safety of staff prioritised to enable delivery of the safest care and support - Clinical and professional supervision recorded on SAFE with improving position (74.5% vs 90% target) - Mandatory training compliance trust-wide achieved 92.1% target - Quality Strategy delivery plan monitored via Quality & Safety Committee - Safe Staffing project group established *(see link to risk ID09)* - New operational structure reflected in governance arrangements to allow focus on locality-based incidents, risks and learning - Wide-ranging clinical audit programme in place leading to improvements in care and support - Policy review processes in place and regular reporting of SitRep to Quality & Safety Committee (all policies available on Staff Zone) - Timely identification and management of risk as described in Risk Policy (GP45) - Professional Nurse Advocate (PNA) programme commenced - Deputy Director of Adult Social Care leading implementation of Schwartz rounds - SAFE/OOG highlight reports providing oversight	- Role essential training compliance below 80% - **Service Directors (July 2022)** *(reference SAFE/OOG action log)* - Clinical and professional supervision compliance sustained 90% - **Team Leaders** - Develop plan for roll out of Professional Nurse Advocate Programme across Nursing services **- Deputy Chief Nurse (see Quality Strategy delivery plan)** - Supervision Training Strategy - **Head of L&OD** - Re-establish Schwartz Round steering group with supporting communications plan - **Deputy Director of Adult Social Care** - Mobilisation specific gap analysis to evaluate resources required for mobilisation - Availability of health inequalities data aligned to service provision and as part of personalised care assessment processes - **Head**	- CQC rating of Good or Outstanding - Mandatory training compliance maintained at 90%	- CQC inspection - 2022/23 - System-wide harm prevention group to be established - **June 2022** - Implementation of training strategy for the National Patient Safety Strategy - **May 2022 - ON-GOING** - Role essential training compliance to achieve target 90% - **July 2022** - Full delivery of the Quality Strategy delivery plan - **March 2023** - Embedding of health inequalities/AIS dashboard across all services - **July 2022** - Recruitment of Patient Safety Partner (as per national guidance) - **November 2022** - Supervision Training Strategy approved - **July 2022**

- Monitoring of new services in St Helens and Knowsley through existing governance arrangements **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 PMG **Actions to ensure equitable outcomes across our population based on the Core20PLUS5 principles** - Health Inequalities & Inclusion Strategy developed and approved - Mechanism in place to ensure involvement of people always included within RCA's (agreed at CRMG) - Participation in C&M prevention pledge programme agreed with identified Executive lead – Chief Nurse - Inclusion dashboard developed - Partnership forum established - Rainbow badge assessment underway	**of Inclusion and Service Directors (September 2022)**	- Successful and safe mobilisation of new services - Availability and use of AIS data for all core services - Inclusion metrics - High % of patient feedback via FFT is maintained and feedback is representative of the community tested through equality data	

~~**ID02 Failure to deliver services inclusively with people and communities leading care, supporting learning and influencing change**~~ **Proposed revised risk description - ID02 Failure to deliver services inclusively with people and communities guiding care, supporting learning and influencing change**	Quality & Safety Committee oversight
Link to 5-year strategy - Inequity of access and experience and outcomes for all groups in our community resulting in exacerbation of health inequalities	
Consequence; • Inequity of access and experience and outcomes for all groups in our community • Poor outcomes due to failure to listen to people accessing services • Reputation impact leading to poor health and care outcomes	

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

Mitigations **(i.e., processes in place, controls in place)**	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs** **(i.e., proof points that the risk has been mitigated)** NOTE: ensuring clear alignment of the outcome to the gap it addresses	**Trajectory to mitigate and achieve target risk rating**
Actions to ensure collaboration and co-design with community partners - Quality Strategy ambition *"People and communities guiding care"* - 6000 public members sharing their experience and inspiring improvement - Level 1 Always Events accreditation focussing on what good looks like and replicating it every time - Complaint's process putting people at the heart of learning - QIA and EIA SOP refreshed and approved - Recruitment of Population Health Fellow role - Quality Improvement sharing and celebration event planned for July 2022	- Review of health inequalities and inclusion training to support delivery of culturally sensitive care - **Head of Inclusion** - Agree workplan for Population Health Fellow including implementation of brief interventions - **Head of Inclusion** - Poor compliance and completion of accessibility	- CQC rating of Good or Outstanding - Measures of equity of access demonstrated through patient/service user data and experience - Staff confident in delivering culturally sensitive care - All reasonable adjustments are made to facilitate most effective care delivery	- CQC inspection - 2022/23 - 10% of eligible staff to be trained in inclusion and health inequalities curriculum by **September 2022** - Recruit 10 Community Partners to support and influence change as part of our engagement/participation groups - **September 2022** - Model/framework to focus on the 20+5 model developed - **March 2023**

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

Board Assurance Framework 2022-23

Strategic risks with oversight at Finance & Performance Committee

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

Corporate Governance

- The Finance & Performance Committee meets on a bi-monthly schedule with an agreed annual workplan in place
- The committee has Terms of Reference in place, reviewed annually
- The committee completes a self-assessment against its work in respect of the agreed Terms of Reference
- 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
- The committee receives an update on trust-wide policies related to the duties of the committee (via SAFE) and on the implementation of recommendations from internal audit reviews (via TIG - Audit Tracker Tool)

Financial and Operational Governance

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

Monitoring performance

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

~~ID03 The constitution and governance of the Provider Collaborative (member/stakeholder) Board and clarity on the establishment of a Lead Provider for some or all services is not exacted~~ **Risk temporarily suspended as further arrangements around the Providers Collaborative are defined and the system risk framework established.**	Finance & Performance Committee oversight

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

~~Consequence;~~

- ~~Non-compliance with Duty to Collaborate~~
- ~~Negative reputational impact across ICPs and in wider ICS~~

~~Current risk rating (LxC)~~	~~Risk appetite~~	~~Target risk rating (LxC)~~
~~3x3 (9)~~	~~Cautious~~	~~1x3 (3)~~

~~Mitigations (i.e. processes in place, controls in place)~~	~~Gaps~~ ~~(Including an identified lead to address the gap and link to relevant action plan)~~	~~Outcomes/Outputs (i.e. proof points that the risk has been mitigated)~~ ~~NOTE: ensuring clear alignment of the outcome to the gap it addresses~~	~~Trajectory to mitigate and achieve target risk rating~~
• ~~MHLDC membership agreed - members act as a voice of the MHLDC PC in Place, and as a voice of Place in MHLDC~~ • ~~MHLDC statement of case and MoU in place~~ • ~~MHLDC governance defined with collaborative board and joint committee arrangements with collaborative members board~~ • ~~MHLDC vision *"to plan and deliver connected pathways of care for people in their communities, especially those with multiple physical and mental health needs, where a system-wide approach is needed to achieve the best outcomes"* agreed~~	• ~~Still outstanding formal agreement with ICB although in principle agreed~~ • ~~Governance architecture yet to be operationalised due to some discontent concerning full membership and associated membership of the collaborative~~	• ~~Agreed and formal governance process for commissioning spend at ICB level~~ • ~~Formal ICB approach to collaborative research and innovation~~ • ~~Agreed process for workforce strategy across the ICB for services~~ • ~~Agreed governance communication arrangements with CMAST and the wider NorthWest ICBs~~	• ~~Aim to be in place Q4 22-23~~

• ~~Nominated partner representation on ICB Board~~ • ~~Planned workshop (w/c 25 July) with CEOs and DASS to formalise new working relationships at Place and ICP level~~			

ID04 The financial settlement requires an unachievable efficiency target creating a risk to the financial sustainability of the organisation	Finance & Performance Committee oversight
Link to 5-year strategy - Make most efficient use of resources to ensure value for money	
Consequence; • Financial sustainability impact • Negative reputational impact	

Current risk rating (LxC)	**Risk appetite**	**Target risk rating (LxC)**
3x4 (12)	Averse	2x4 (8)

Mitigations **(i.e. processes in place, controls in place)**	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs** **(i.e. proof points that the risk has been mitigated)** NOTE: ensuring clear alignment of the outcome to the gap it addresses	**Trajectory to mitigate and achieve target risk rating**
• Financial plan 2022-23 reviewed and supported by Board of Directors with acknowledgement of best endeavours • Robust CIP governance processes in place with oversight at Programme Management Group • Capital expenditure plan reviewed monthly at Programme Management Group • Productivity & Efficiency programme status well monitored (as at mid-September 2022) – Target: £4.1m – PIDs approved at PMG: £3.3m Current Gap: £0.8m – PIDS in train with high confidence £0.2m – 80% approved against £4.1m target	• Slippage on financial plan reported at M5 - **Chief Finance Officer / ELT** • Productivity & Efficiency programme ideas / PIDs in development reduced since June 22 - **Chief Strategy Officer**	• Delivery of financial plan 2022-23 • Delivery of Productivity & Efficiency programme target for 2022-23	• Financial plan delivered or mitigated position with ICS - **March 2023**

• Monthly monitoring of financial position at IPB and bi-monthly at FPC • Finance, Resources & Oversight Group (FROG) established to strengthen financial governance sub-IPB • Focused work at Senior Development Forum on areas of financial pressure in Q1 followed up at ELT with action plans/impact on run rates to be monitored at FROG • Quarterly meetings of CFO with ICB CFO commencing in October 2022			

ID05 Poor ~~service delivery and/or~~ financial performance at Place creates a negative impact on the Trust and leads to increased monitoring and regulation	Finance & Performance Committee oversight
Link to 5-year strategy - Deliver sustainable health and care services	
Consequence; • Poor service user access, experience and outcomes • Poor contract performance - financial implications (system) • System regulatory action	

Current risk rating (LxC)	**Risk appetite**	**Target risk rating (LxC)**
3x4 (12)	Averse	1x4 (4)

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

• Financial plan 2022-23 reviewed and supported by Board of Directors with acknowledgement of best endeavours • Robust CIP governance processes in place with oversight at Programme Management Group • Service contracts in place, approved and with strengthened scrutiny and governance arrangements	**Executive/Deputy Chief Executive** • As at the end of Sept 2022 there is no formal monitoring of Wirral Place combined Financial Performance		

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

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

Consequence;

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

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

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

• Strategic COOs meeting established weekly • Trust position clear in place governance - *see ID03 and ID05* • Wirral CFOs meetings regularly • Wirral Provider Partnership accountable to the Place-based Partnership Board • Service contracts in place, approved and with strengthened scrutiny and governance arrangements • Finance, Resources & Oversight Group established to strengthen financial governance sub-IPB • Waiting list oversight workshops established through Deputy COO leadership	• Redesign of Operational Performance dashboard in TIG to include SPC charts and trajectories for improved performance, as required - **Chief Operating Officer** • Reduction in agency usage across core services - **HRD**		

Board Assurance Framework 2022-23

Strategic risks with oversight at Education & Workforce 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 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 committee completes a self-assessment against its work in respect of the agreed Terms of Reference
- 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
- The committee receives an update on trust-wide policies related to the duties of the committee (via SAFE) and on the implementation of recommendations from internal audit reviews (via TIG - Audit Tracker Tool)
- The Chair of the committee is the NED health and wellbeing lead for the Trust

Workforce Governance

- The governance structure in place provides clarity on the groups reporting to the committee
- The committee contributes to the development of the annual People Strategy Delivery Plan and priorities and receives bi-monthly assurance on implementation
- The committee receives the Terms of Reference for the groups reporting to it
- The committee receives the minutes from group meetings for noting
- The committee contributes to the development of, and maintains oversight on the implementation of the annual people/workforce priorities
- The committee reviews and approves the EDS2, 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 People & Culture Oversight Group (being established in October 2022) will report to the Integrated Performance on key people governance matters
- FTSU Guardian appointed
- FTSU Executive Lead is a member of the committee

Monitoring workforce performance

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

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

ID07 Our people do not feel looked after, their employee experience is poor, and their health and wellbeing is not prioritised	Education & Workforce Committee oversight

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

Consequence;

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

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

Mitigations (i.e. processes in place, controls in place)	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs (i.e. proof points that the risk has been mitigated)** NOTE: ensuring clear alignment of the outcome to the gap it addresses	**Trajectory to mitigate and achieve target risk rating**
• People Strategy published with clear alignment to the NHS People Promise and ambition 1 'Looking after our people' • Wellbeing Champions in services across the Trust • Quarterly pulse survey embedded across the Trust (11% completion rate for Q2 - 52.2% of respondents 'feeling calm', 39.2% of respondents 'feeling anxious')	• Pulse survey engagement score tracking through Trust governance - **Deputy Director of HR and L&OD** • Effective exit processes to ensure learning and improve retention - **Deputy Director of HR and L&OD**	• Improved levels of staff engagement and satisfaction in national and local surveys - *see mitigations for on-going tracking* • Improvement in quarterly pulse survey engagement score • Reduction in staff turnover rates (@ M5 an increasing position YTD to 14.5%)	• Team WCHC values embedded and visible - **March 2023** • Health and wellbeing is personalised for all staff - **March 2023** • Embedding of e-roster - **March 2023**

• Q2 pulse survey results saw an improvement in scores for feeling proactively supported in health and wellbeing and feeling supported as a team - higher than NHS overall
• Q2 engagement score = 6.47%
  – Motivation = 6.41
  – Involvement = 6.47
  – Advocacy = 6.54
• Staff survey team intentions at local level
• Team WCHC staff recognition scheme & Staff Awards successfully delivered
• Health and wellbeing conversation training for managers
• Wellbeing (including financial wellbeing) information on Staff Zone for all staff
• FFT results providing high satisfaction levels from service users (>90%)
• Leadership Qualities Framework in place and supporting development of leadership skills
• System Leadership Training for senior leaders
• Staff Council
• Agile working principles developed with JUSS and Staff Council for pilot (Q2)
• Managers briefings in place and issued to support with the dissemination of key messages
• Annual appraisals with focus on health and wellbeing
	• Greener grass conversations when staff are considering leaving - **Deputy Director of HR and L&OD**
	• Trust-wide retention plan - **interim Director of HR & L&OD**
		• Reduction in staff sickness rates (M5 reduction to 6.9% from 8.5% in M4)
		• Health and wellbeing conversation training is delivered to all managers
		• Reduction in staffing related risks on Datix
		• Team WCHC values are visible in all people practices (recruitment, appraisal, supervision) and at all levels
			• Outcome of insight work following pilot of agile working principles - **October 2022**
			• ~~Increase in % of responses to quarterly pulse survey - **October 2022**~~ (Q2 achieved 11% against an NHSE benchmark of 10%)
			• Annual Staff Survey results - **March 2023**

• Staff benefits platform approved and being implemented • Freedom To Speak Up Guardian connecting across the Trust • Revised People Governance arrangements establishing to support tracking and monitoring of metrics - People and Culture Oversight Group			

ID08 Our People Inclusion intentions are not delivered; people are not able to thrive as employees of our Trust and the workforce is not representative of our population	Education & Workforce Committee oversight

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

Consequence;

- Poor outcomes for the people working in the Trust
- Reduced staff engagement
- Failure to meet the requirements of the Equality Act 2010
- Increase in staff turnover and recruitment challenges

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

Mitigations (i.e. processes in place, controls in place)	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs (i.e. proof points that the risk has been mitigated)** NOTE: ensuring clear alignment of the outcome to the gap it addresses	**Trajectory to mitigate and achieve target risk rating**
• Inclusion and Health Inequalities Strategy published with a commitment to empowering and upskilling our people • People Strategy published with clear alignment to the NHS People Promise and ambition 1 'Looking after our people' • Staff network groups established for BAME, LGBTQ, (Dis)Ability and Carers • Staff Council • Leadership Qualities Framework in place and supporting development of leadership skills	• WDES and WRES actions to improve the experience of disabled staff and BAME workforce have not achieved the intended outcome - **Deputy HRD/Head of HR/Head of Inclusion** • Trust to raise awareness of reasonable adjustments, sharing lived experiences, increasing declaration rates and membership of the (Dis)Ability network - **Head of HR/Head of Inclusion**	• Improved staff experience for disabled staff (WDES) • Improved levels of staff engagement in national and local surveys • Reduction in staff turnover rates • Improvement in quarterly pulse survey engagement score (by equality groups) • Increased numbers of people joining the organisation from currently underrepresented groups including those from Core20Plus5 communities	• Deliver cultural awareness training - **March 2023** • Further develop staff networks - **March 2023** • Deliver all actions from the WDES action plan - **June 2023** • Deliver all actions from the WRES action plan - **July 2023** • Increased diversity at senior roles in the trust and at Trust Board

• WRES and EDS completion with oversight at EWC • Gender pay gap report to EWC • Wellbeing Champions in services across the Trust • Inclusion Champions in services across the Trust • WDES reporting increase in number of staff reporting they are disabled • WDES reporting increase in the likelihood of being appointed as a disabled member of staff • A more representative board in comparison to the rest of the workforce • Implementation of the reverse mentoring scheme with BAME staff • WRES reporting an increase in the percentage of the workforce from a BAME background	• Reverse mentoring scheme to be set up with directors and disabled staff - **Head of HR/ Head of Inclusion** • Race Disparity Ratio data pending from NHS England - **Head of HR** • Involvement in widening participation initiatives and share lived experiences to encourage BAME applicants to the Trust - **Head of HR/ Head of Inclusion** • Increased diversity at senior roles in the trust and at Trust Board	• Development of multiple career pathways • Training is delivered to senior leaders and line managers in culture, equality, inclusion, fairness and justice • Targets are set and monitored to ensure workforce is more representative of the local community at all levels • Further develop staff networks as active partners in decision making processes • Improved and sustained levels of staff satisfaction and feedback	

ID09 Safe Staffing levels are not maintained across the Trust impacting on the safe delivery of services, staff morale and regulatory compliance	Education & Workforce Committee oversight

Link to 5-year strategy - Grow, develop and realise potential

Consequence;

- Inability to attract and recruit appropriately skilled staff
- Poor staff retention
- Low staff morale
- Reputation impact leading to poor health and care outcomes

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

Mitigations **(i.e. processes in place, controls in place)**	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs** **(i.e. proof points that the risk has been mitigated)** NOTE: ensuring clear alignment of the outcome to the gap it addresses	**Trajectory to mitigate and achieve target risk rating**
• Establishment of Safe Staffing Project Group • Safe Staffing Project tracked through PMO with PID approved at PMG • Core Services Oversight Group established to support regulatory compliance across core services • SAFE/OOG combined with oversight of key safe staffing metrics • Mandatory training compliance high and stable • Safe Staffing on CICC - safe staffing model supports professional judgement by maximising use of available staffing resource, implementing a holistic	• Full roll-out of E-roster including SafeCare facility - **Deputy Director of HR & L&OD** • Role essential training compliance - **Service Directors & Quality Leads** • Sustained reporting of supervision levels - **Service Directors & Quality Leads** • Trust-wide retention plan - **interim Director of HR & L&OD** • Mitigation of risk ID2784 (RR12) - Lack of availability of	• Full roll-out of E-roster across the Trust • Improved and sustained role essential training and clinical/professional supervision levels • Reduction in staffing incidents and risks • Staff satisfaction and feedback	• Future presentation of safe staffing data from automated system - Q4 2022-23 • E-rostering utilisation is optimised to support safe care delivery - **March 2023** • SNCT training delivered - Q4 2022-23 • 6-monthly staffing audit using SNCT - Q1 2023-24

multidisciplinary team model including the use of therapies staff •	Safe Staffing Dashboard to provide best management of staffing resource and high-quality assurance to Board of Directors • Triangulation of safe staffing data with quality and safety metrics - **Deputy HRD and Deputy Chief Nurse** • Access the Safer Nursing Care Tool to validate workforce establishment setting - **Deputy Chief Nurse**		