Board Assurance Framework (BAF) 2024-25

Meeting Title	Board of Directors		
Date	19/06/2024	**Agenda Item**	11
Lead Director	Alison Hughes, Director of Corporate Affairs		
Author(s)	Alison Hughes, Director of Corporate Affairs		

Action required (please select the appropriate box)

To Approve ☒	**To Discuss** ☐	**To Assure** ☐

Purpose

The purpose of this paper is to provide the Board of Directors with an update and assurance on the management of strategic risks through the Board Assurance Framework for 2024-25

This update provides the position following the committees of the Board who have reviewed relevant strategic risks during May and June 2024 and follows informal board discussions on 15 May 2024.

Executive Summary

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

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

The Board of Directors received the year-end position for 2023-24 in April 2024 and subsequently an informal board session has considered strategic risks for the new financial year and each of the committees of the Board have reviewed the position.

There are currently 7 strategic risks included in the BAF for 2024-25. Each risk is aligned to the duties and responsibilities of a committee for oversight, and all are detailed in **appendix 1**.

The following risks have been carried forward from 2023-24 to 2024-25 for on-going tracking in line with Year 3 of the organisational and enabling strategies;

ID01 - Failure to deliver services safely and responsively to inclusively meet the needs of the population.
ID02 - Failure to deliver services inclusively with people and communities guiding care, supporting learning and influencing change.

ID07 - Our people do not feel looked after, their employee experience is poor, and their health and wellbeing is not prioritised.
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.
ID10 - We are not able to attract, grow and develop our talent sufficiently to ensure the right numbers of engaged, motivated and skilled staff to meet activity and operational demand levels.

The previous risk ID03 was archived at the end of 2023-24.

The Finance & Performance Committee has considered the position in relation to relevant financial and operational strategic risks and following discussions at informal board and at the most recent meeting of the committee on 5 June 2024 the following is proposed to the Board of Directors for approval;

ID04 - *NEW RISK DESCRIPTION* - Failure to deliver the Trust's agreed financial plan for 2024-25 has an impact on future monitoring and regulation and on Place performance.

ID05 - *CLOSE THE RISK* - recognising that the risk as previously described is sufficiently addressed in terms of the Trust's ability to mitigate ID04.

ID06 - *NEW RISK DESCRIPTION* - Trust operational performance declines resulting poorer outcomes and greater inequalities for our population.

Each of the risks has been reviewed and aligned to key actions and measures included in the relevant strategy delivery plans for outcomes and trajectories to mitigate. The risk ratings and risk appetites for each have also been reviewed.

The highest scoring risk is ID04 with a current risk rating of RR16.

All other risks are scored between RR12 and RR8.

Wirral Place Delivery Assurance Framework

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

The effective management of strategic risks also requires oversight of relevant organisational risks. The committee receives a regular risk report which provides oversight of the management of high-level (>15) organisational risks. There are no high-level risks reporting to the People & Culture Committee.

Strategic (Board Assurance Framework - BAF) and operational Risks and opportunities:

The BAF records the principal risks that could impact on the Trust's ability in achieving its strategic objectives. Therefore, failure to correctly develop and maintain the BAF could lead to the Trust not being able to achieve its strategic objectives or its statutory obligations. There are opportunities through the effective development and use of the BAF, to enhance the delivery of the Trust's strategic objectives and effectively mitigate the impact of the principal risks contained within the BAF.

Quality/inclusion considerations:

Quality & Equality Impact Assessment completed and attached No.

The quality impact assessments and equality impact assessments are undertaken through the work streams that underpin the BAF.

Financial/resource implications:

Any financial or resources implications are detailed in the BAF for each strategic risk.

The Trust Vision - To be a population health focused organisation specialising in supporting people to live independent and healthy lives. The Trust Objectives are:

- Populations - We will support our populations to thrive by optimising wellbeing and independence
- People - We will support our people to create a place they are proud and excited to work
- Place - We will deliver sustainable health and care services within our communities enabling the creation of healthy places

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

People - Improve the wellbeing of our employees	Populations - Safe care and support every time	Place - Make most efficient use of resources to ensure value for money

The Trust Social Value Intentions

Does this report align with the Trust social value intentions? Not applicable

If Yes, please select all of the social value themes that apply:

Community engagement and support ☐

Purchasing and investing locally for social benefit ☐

Representative workforce and access to quality work ☐

Increasing wellbeing and health equity ☐

Reducing environmental impact ☐

Board of Directors is asked to consider the following action

To review and approve the position reported for each of the strategic risks included in the BAF for 2024-25.

Report history (Please include details of the last meeting that received this paper, including the title of the meeting, the date, and a summary of the outcome). This provides the audit trail through the governance structure.

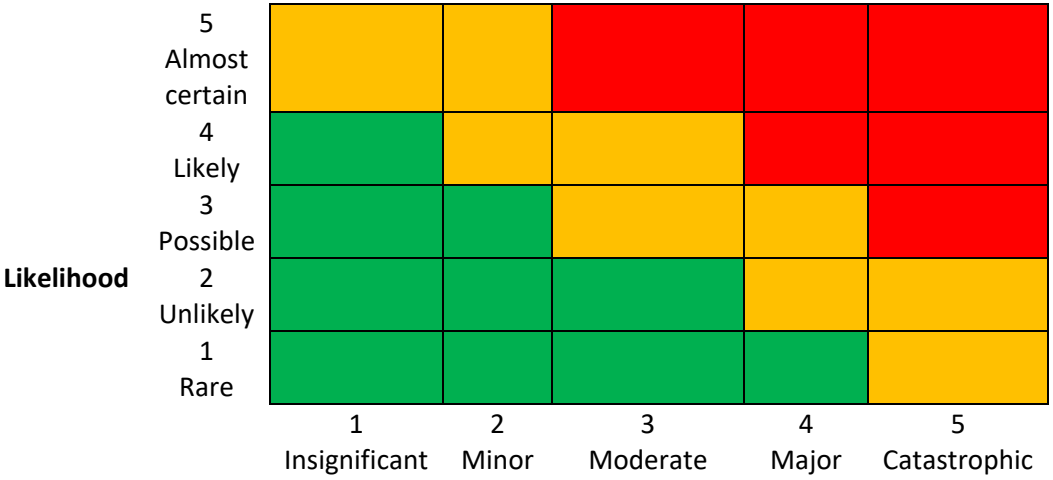
Submitted to	Date	Brief summary of outcome
Board of Directors	21/06/23	The Board of Directors - reviewed the mitigations, gaps, outcomes and actions already populated for each of the strategic risks. - approved the proposed rewording of ID04 related to the financial plan 2023-24. - approved the recommendation that ID03 has achieved its target risk rating. - noted that the Quality & Safety Committee would review ID09 in the context of ID01.
Board of Directors	16/08/23	The Board of Directors - considered the mitigations, gaps, outcomes and actions already populated for each of the strategic risks. - approved the recommendation that ID09 is archived, and safe staffing processes are incorporated as core mitigations to ID01. - noted ID04 as a high-level strategic risk at RR16 with on-going monitoring at the Finance & Performance Committee. approved the increase in current risk rating for ID06 following the amendment to the target risk rating.
Board of Directors	17/10/23	The Board of Directors reviewed the mitigations, gaps, outcomes and actions for each of the strategic risks and noted ID04 as a high-level strategic risk at RR16 with on-going monitoring at the Finance & Performance Committee. The Board of Directors also supported a recommendation from the People & Culture Committee to consider a strategic risk in relation to retaining talent and growth of the workforce.
Board of Directors	13/12/23	The Board of Directors approved the recommendations in the report and was assured of the oversight and management of strategic risks in the BAF through the sub-committees of the Board. In particular, the Board noted

		ID04 remained the highest scoring strategic risk.
Board of Directors	21/02/24	The Board of Directors reviewed the mitigations, gaps, outcomes and actions already populated for each of the strategic risks. The Board of Directors noted the detail provided in relation to the new risk ID10 and approved a revised risk description for 2024-25 for ID04.
Board of Directors	17/04/24	The Board of Directors reviewed the mitigations, gaps, outcomes and actions already populated for each of the strategic risks and approved the position reported for the year-end 2023-24 for each of the strategic risks. The Board of Directors also welcomed the Annual Assurance Framework Review from Mersey Internal Audit Agency (MIAA).

Strategic risk summary 2024-25

Risk Description	Committee oversight	Link to 5-year strategy	Initial risk rating (LxC) (April 2024)	Current risk rating (LxC) (May/June 2024)	Target risk rating (LxC)	Risk Appetite
ID01 - Failure to deliver services safely and responsively to inclusively meet the needs of the population.	Quality & Safety Committee	Safe Care & Support every time	3 x 4 (12)	3 x 4 (12)	2 x 4 (8)	Averse
ID02 - Failure to deliver services inclusively with people and communities guiding care, supporting learning and influencing change.	Quality & Safety Committee	Inequity of access and experience and outcomes for all groups in our community resulting in exacerbation of health inequalities	3 x 4 (12)	3 x 4 (12)	2 x 4 (8)	Averse
Previous ID03 archived at end of 2023-24.						
(Revised risk description) ID04 - Failure to deliver the Trust's agreed financial plan for 2024-25 has an impact on future monitoring and regulation and on Place performance.	Finance & Performance Committee	Make most efficient use of resources to ensure value for money	4 x 3 (12)	4 x 4 (16)	2 x 4 (8)	Cautious
Previous ID05 recommended for closure for 2024-25. See detail in cover paper.						
(Revised risk description) ID06 - Trust operational performance declines resulting in poorer outcomes and greater inequalities for our population.	Finance & Performance Committee	Deliver sustainable health and care services	2 x 4 (8)	2 x 4 (8)	1 x 4 (4)	Cautious
ID07 - Our people do not feel looked after, their employee experience is poor, and their health and wellbeing is not prioritised.	People & Culture Committee	Improve the wellbeing of our employees Better employee experience to attract and retain talent	2 x 4 (8)	2 x 4 (8)	1 x 4 (4)	Moderate
ID08 - Our People Inclusion intentions are not delivered; people are not able to thrive as employees of our Trust and the workforce is not representative of our population.	People & Culture Committee	Improve the wellbeing of our employees Better employee experience to attract and retain talent	3 x 4 (12)	3 x 4 (12)	1 x 4 (4)	Moderate

Risk Description	Committee oversight	Link to 5-year strategy	Initial risk rating (LxC) (April 2024)	Current risk rating (LxC) (May/June 2024)	Target risk rating (LxC)	Risk Appetite
Previous ID09 archived during 2023-24 and included in ID01.						
ID10 - We are not able to attract, grow and develop our talent sufficiently to ensure the right numbers of engaged, motivated and skilled staff to meet activity and operational demand levels.	People & Culture Committee	Grow, develop and realise employee potential Better employee experience to attract and retain talent	2 x 4 (8)	2 x 4 (8)	1 x 4 (4)	Open



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 2024-25

Strategic risks with oversight at Quality & Safety Committee

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

Corporate Governance

- The Quality & Safety Committee meets on a bi-monthly schedule with an agreed annual workplan in place.
- The committee has Terms of Reference in place, reviewed annually.
- The Chief Nurse is the Executive Lead for the committee.
- The Chief Nurse is also the Trust Lead for addressing health inequalities.
- The Integrated Performance Board is the highest operational group in the Trust and maintains oversight and scrutiny of performance to provide assurance to the committee.
- The committee completes a self-assessment against its work in respect of the agreed Terms of Reference
- In accordance with the Trust's Risk Policy, the committee receives a report on high-level organisational risks to monitor actions to mitigate risks and determine any impact on strategic risks being managed through the BAF.
- The committee receives an update on trust-wide policies related to the duties of the committee and on the implementation of recommendations from internal audit reviews
- The Chair of the committee meets with the governor chair of the Governor Quality Forum to provide a briefing after each meeting of the committee.
- Governance arrangements of oversight groups reporting to IPB tested through internal audit in 2023-24 providing Substantial Assurance.

Quality Governance

- Year 1 and Year 2 of the Quality Strategy Delivery Plan implemented successfully with committee oversight.
- The quality governance structure in place provides clarity on the groups reporting to the committee.
- The committee receives the Terms of Reference for the groups reporting to it and minutes/ decisions from the groups for noting.
- The committee contributes to the development of the annual quality plan and priorities and receives bi-monthly assurance on implementation.
- The committee contributes to the development of and maintains oversight of the implementation of the annual quality priorities.
- The committee reviews and approves the Trust's annual quality report.
- The committee ensures that processes are in place to systematically and effectively respond to reflective learning from incidents, complaints, patient/client feedback and learning from deaths.
- The weekly Clinical Risk Management Group (CRMG) meetings are in place to monitor incidents and learning.
- SAFE system in use trust-wide for audits (e.g., hand hygiene, medicines management, IG, team leader)
- SAFE Operations Group (SOG) reports directly to the Integrated Performance Board
- Regular formal and informal engagement with CQC
- CQC inspection rating of Good with Outstanding areas.
- The Trust has implemented a health inequalities stratification waiting list tool.

- Just and Learning culture supported by FTSU framework allowing staff to openly raise concerns.

PSIRF

- Patient Safety Lead in post and two Patient Safety Partners recruited as per national guidance.
- PSIRF implementation reported to the committee
- PSIRF policies and procedures developed and implemented to promote sustainability.
- PSIRF stakeholder group established.
- Robust gantt chart aligned to the national PSIRF implementation timeframes, reporting to POG monthly by exception.
- High-level of compliance with patient safety training.

FTSU

- FTSU Guardian appointed.
- FTSU Executive Lead is a member of the committee.
- FTSU NED Lead identified and attends committee (pending appointment of new Audit Chair - July 2024).
- FTSU Steering Group reporting to the committee.

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

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

System Governance

- Wirral Place Quality Performance Group established with CNO as member
- Partnership working with Local Authorities and other stakeholder organisations via Place (e.g., Quality & Performance Group, Safeguarding Children Partnerships, Safeguarding Adults Partnership Board) and regional (e.g., C&M Chief Nurse Network, MHLDC Provider Collaborative) meetings

Monitoring quality performance

- The committee receives a quality report from TIG providing a YTD summary (via SPC charts) of all quality performance metrics at each meeting.
- The members of the committee have access to the Trust Information Gateway to monitor quality performance and to access the Audit Tracker Tool to monitor progress.
- The committee contributes to and receives the annual quality improvement audit programme and tracks implementation.
- The committee receives updates live from the system on regulatory compliance including local audits and procedural documents.

ID01 Failure to deliver services safely and responsively to inclusively meet the needs of the population.			Quality & Safety Committee oversight
Link to 5-year strategy - Safe care and support every time			
Consequence; • Poor experience of care resulting in deterioration and poor health and care outcomes • Non-compliance with regulatory standards and conditions • Widening of health inequalities			
Current risk rating (LxC)	**Risk appetite**		**Target risk rating (LxC)**
3 x 4 (12)	**Averse**		2 x 4 (8)
Mitigations **(i.e., processes in place, controls in place)**	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs** **(i.e., proof points that the risk has been mitigated)**	**Trajectory to mitigate and achieve target risk rating**
Actions to ensure safe care and support every time to prevent variation of standards across localities and teams. - SAFE mechanism for recording clinical and professional supervision captures method of delivery to include peer, group and 1:1 delivery ~~- 85.5% at M3 92.2% at M6, 92.7% at M8, 85.5% at M10~~ M12 89% (vs 90% target with average annual compliance of 88%) - Quality of supervision audit completed, and feedback used to improve processes - Clinical protocol for Clinical Supervision (CP95) - Safeguarding Supervision Policy (SG04) - Management Supervision procedure (HRP07)	- Clinical and professional supervision compliance sustained at 90% - **Team Leaders** *(trust-wide trajectory on TIG and set trajectory for Q2, Q3 and Q4 aiming for above 90%)* ~~- Relaunch of supervision policy - **Deputy Chief Nurse**~~ - Supervision Training Strategy - **Head of L&OD** ~~- Roll-out of waiting list stratification tool to services (phased approach) - **Deputy Chief Operating Officer**~~ - ~~Access the Safer Nursing Care Tool to validate workforce establishment setting - **Deputy~~	- CQC rating GOOD with Outstanding elements - FFT response rate and satisfaction rate - Low number of complaints - Publication of Quality Account 2023-24 published with key achievements and progress to deliver quality goals highlighted. - Safe mobilisation of Lancashire 0-19 service. - Mandatory training sustained compliance maintained at 90% - Role essential training compliance achieved and maintained at 90%	~~- System-wide harm prevention group to be established - COMPLETE with Deputy Chief Nurse attendance.~~ - Lancashire 0-19 contract mobilisation - **1 October 2024**. - 90% of eligible staff trained in national patient safety curriculum per annum - 31 March 2024 - **COMPLETE** - ~~40% of eligible staff trained in QI curriculum - 31 March 2024 - **COMPLETE**~~ - 60% of eligible staff trained in QI curriculum - **March 2025** *(quality goal 7)*

- Mandatory training compliance trust-wide achieved target - ~~M3 = 94.5% 95.2% at M6, 95.1% at M8, 95.1% at M10~~ M12 94.2% (vs 90% target with average annual compliance of 95.0%) - Role essential training compliance - ~~91.6% at M7,~~ ~~92.2% at M8, 92.8% at M10~~ M12 92.6% (vs 90% target with average annual compliance of 90.5%) - 2024-25 clinical audit programme agreed - Patient Safety Incident Response Plan (GP60) approved - LFPSE (Learning from Patient Safety Events) launched - Professional Nurse Advocate (PNA) programme in place - Development of waiting list stratification tool aligned to CORE20PLUS5 (in pilot phase) - 20% baseline of staff trained in Quality Improvement curriculum. - Quality goal 4 - 4 QI programmes focusing on high-priority clinical risks (see Y3 delivery plan) - Baseline completed to determine a clear denominator and criteria for eligible staff for the national patient safety curriculum - Training compliance visible on TIG for L1 & L2 of the national patient safety curriculum. - Current compliance L1 & L2 - ~~94.26%,~~ 95.1% L1 for board and senior management - ~~93.33%,~~ 95.3%, L1 for other staff (agreed cohort) - ~~95.76%,~~ 97.5%	~~**Chief Nurse**~~ - in April 2024 the CNSST was suspended pending further development work at a national level. - Tier 2 Oliver McGowan training to be rolled out to eligible staff - **OMMT lead trainer** - Further embed PSIRF principles through process and culture – **Deputy Chief Nurse**	- Clinical and professional supervision sustained compliance at 90% *(quality goal 3).* - 20% of staff to be trained in Tier 2 Oliver McGowan mandatory training *(quality goal 4)* - QI summary reports from 4 x QI programmes with actions for improvement - Audits on the quality of supervision (end of Q2 and Q4) - 20 members of staff trained in QSIR-P - 80 members of staff trained in QSIR-F - Quarterly patient safety champions meetings - PSIRF learning cafes	- Supervision Training Strategy approved - **November 2023 -** (Extension for action approved by QSC) - 90% of clinical staff receiving supervision - **31 June 2024** (*quality goal 3 reset for 24/25* - targeted approach to set trajectories for improvement if below 85%) - Implementation of PSIRF - quality goal 2 - **31 March 2024** - **COMPLETE.** - 20% of eligible staff trained in Tier 2 Oliver McGowan mandatory training - **31 March 2025** *(quality goal 4)* - ~~Successful implementation of waiting list stratification tool - **2023-24**~~ - ~~Initial findings from CNSST data collection (to PCC) - October 2023 **PENDING** (data collection complete, analysis and interpretation in progress - reported to PCC)~~ - 4 x QI programmes delivered - **March 2025** *(quality goal 1)* - PSIRF actions to further embed in the process and culture *(quality goal 2)* - **March 2025**

Actions to ensure safe mobilisation of new services. - Business decision making process aligned to strategic objectives. - Establishment of mobilisation project at the commencement of new contracts - Mobilisation projects monitored at POG. - SRO and Project Lead identified. - Workstreams and relevant leads identified and work underway to mobilise Lancashire 0-19 contract for 1 October 2024. - Successful launch of Wirral Sexual Health Service from 1 April 2024 **Actions to ensure equitable outcomes across our population based on the Core20PLUS5 principles.** - Health Inequalities & Inclusion Strategy developed and approved. - Mechanism in place to ensure involvement of people always included within RCA's (agreed at CRMG) - Participation in C&M Prevention Pledge programme agreed with identified. - Chief Nurse = Prevention Pledge Executive Lead - Inclusion dashboard developed. - Partnership forum established. - Bronze Status in the NHS Rainbow Pin Badge accreditation scheme - Silver award in the Armed Forces Covenant Employer Recognition Scheme	- Satisfactory completion of mobilisation plan to support safe launch and delivery of Lancashire Healthy Child Programme from 1 October 2024 - **Executive Leadership Team/Board of Directors** - Availability of health inequalities data aligned to service provision and as part of personalised care assessment processes - **Head of Inclusion and Service Directors (September 2022) -** *see trajectory for improvement to address the gap but work on-going to improve AIS compliance (raised at IPB in April 2023 and included in EDS action plan re: domain 1).*	- Safe mobilisation of Lancashire Healthy Child Programme contract from 1 October 2024 - Availability and use of AIS data for all core services - Inclusion metrics - High % of patient feedback via FFT is maintained and feedback is representative of the community tested through equality data - 4 co-designed care pathways aimed at reducing health inequalities *(quality goal 6)* - Successful launch of 'what matters to you?' campaign *(quality goal 5)*	~~- Launch of Sexual Health Wirral Service - 1 April 2024 - **COMPLETE**~~ - Safe mobilisation of Lancashire Healthy Child Programme contract - 1 October 2024 - Embedding of health inequalities/AIS dashboard across all services - **July 2023 - COMPLETE** - Summary report from 4 co-designed care pathways - **March 2025** *(quality goal 6)* - 'What matters to you?' question embedded into 1 service as part of routine care planning and personalised care - **March 2025** *(quality goal 5)*

- Veteran Aware accreditation achieved for the Trust. - EDS2 assessment criteria agreed and completed for 2022-23 - achieving across all areas including Domain 1 commissioned services (community cardiology and bladder and bowel) - AIS template available in S1 for all services. Performance against completion rates tracked via locality SAFE/OPG meetings with increased oversight at IPB. Included as an action from EDS domain 1. - FFT (YTD) = 21,262 responses with 92.5% recommending Trust services **Actions to ensure safe demobilisation of services.** No current demobilisation projects in process.			

ID02 Failure to deliver services inclusively with people and communities guiding care, supporting learning and influencing change	Quality & Safety Committee oversight

Link to 5-year strategy - Safe care and support every time

Consequence;

- Inequity of access and experience and outcomes for all groups in our community
- Poor outcomes due to failure to listen to people accessing services
- Reputation impact leading to poor health and care outcomes

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

Mitigations (i.e., processes in place, controls in place)	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs (i.e., proof points that the risk has been mitigated)** NOTE: ensuring clear alignment of the outcome to the gap it addresses	**Trajectory to mitigate and achieve target risk rating**
Actions to ensure collaboration and co-design with community partners. - EDI training compliance - 98.2% - Quality Strategy ambition *"People and communities guiding care".* - Inclusion Principle 1 - Positive action for inclusive access - 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	- Poor compliance and completion of AIS template across all services - **Deputy COO/Service Directors** *(Inclusion principle 1)* - Lack of staff confidence in accessing and interpreting health inequalities data - **Head of Inclusion** - Established engagement with stakeholders and partners in Lancashire to understand communities – **Head of Inclusion / Service Lead**	- 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. - 20% of staff to be trained in Tier 2 Oliver McGowan mandatory training *(quality goal 4)* - 60% of eligible staff trained in QI curriculum *(quality goal 7)*	~~- 10% of eligible staff to be trained in inclusion and health inequalities curriculum by **September 2022 - ON-GOING**~~ - 20% of eligible staff trained in Tier 2 Oliver McGowan mandatory training - **31 March 2025** *(quality goal 4)* ~~- Recruit 8 Community Partners **- 31 March 2024**~~ ~~- Model/framework to focus on the 20+5 model developed - **March 2023**~~ ~~- Improved completion of AIS template across all services (supporting waiting list~~

- Quality Improvement sharing and celebration events - Experience dashboard built on TIG - Partner Safety Partners recruited - Re-balancing of resources in community nursing to support caseload in PCNs underway - 5 community partners recruited - Lancashire mobilisation governance includes Service Delivery workstream **Actions to address health inequalities by hearing from those with poorer health outcomes, learning and understanding the context of people's lives and what the barriers to better health might be** - On-going work with system partners (system health inequalities group) to improve identification of minority and vulnerable groups within the population, ensuring that we reach into these communities and make it as easy as possible for people to access appropriate care when required. - Quality Strategy - *quality goal 6* - implementation of 4 co-designed care pathways aimed at reducing health inequalities and evidencing sustainability and spread. **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	- Further embed health inequalities waiting list tool evidencing outcomes and ensuring equitable access *(inclusion principle 1)* - **Deputy Chief Operating Officer / Deputy Chief Nurse / Head of Inclusion** - Tier 2 Oliver McGowan training to be rolled out to eligible staff - **OMMT lead trainer**	- Staff will report increased skill, knowledge and confidence in quality improvement methodology - 4 co-designed care pathways aimed at reducing health inequalities with stakeholder engagement *(quality goal 6)* - Successful launch of 'what matters to you?' campaign *(quality goal 5)* - Further embed health inequalities waiting list tool	~~management) - *see ID01 work on-going to improve AIS compliance*~~ - Achievement of 90% completion rate of AIS and inclusion template across all services - **March 2025** *(Inclusion principle 1)* - ~~4 Always Events coproduced alongside people with lived experience - **March 2023** (1 completed, 2 on-going and a further event planned) – **COMPLETE.**~~ - Summary report from 4 co-designed care pathways - **March 2025** *(quality goal 6)*

communities and positively influencing participation and involvement. - Veteran Aware accreditation (Bronze and Silver) achieved for the Trust. - EDS 2022-23 published on public website with actions identified. - 94.6% of staff completed comprehensive learning disability and autism e-learning (Oliver McGowan Level 1) **Actions to ensure children and families living in poverty are engaged to improve outcomes and life chances.** - Established service user groups including Involve, Your Voice and Inclusion Forum with a commitment to co-design. - Participation in Local Safeguarding Children Partnerships across all Boroughs where 0-19/25 services are delivered. - Good partnerships with other agencies - Lancashire mobilisation governance includes Service Delivery workstream			

Board Assurance Framework 2024-25

Strategic risks with oversight at Finance & Performance Committee

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

Corporate Governance

- The Finance & Performance Committee meets on a bi-monthly schedule with an agreed annual workplan in place
- The committee has Terms of Reference in place, reviewed annually (last reviewed in August 2023)
- The committee completes a self-assessment against its work in respect of the agreed Terms of Reference (last completed in September/October 2023)
- The Chief Finance Officer is the Executive Lead for the committee
- The Integrated Performance Board is the highest operational group in the Trust and maintains oversight and scrutiny of performance to provide assurance to the committee
- The Finance & Resources Oversight Group (FROG) reports to the IPB on all matters associated with financial and contractual performance and the Safe Operations Group (SOG) reports to the IPB on all matters associated with operational performance
- In accordance with the Trust's Risk Policy, the committee receives a report on high-level organisational risks, and can access all operational risk status through the TIG on-line system, to monitor actions to mitigate risks and determine any impact on strategic risks being managed through the BAF
- The committee receives an update on the status of trust-wide policies (related to the duties of the committee) at every meeting
- The committee receives an update on the implementation of recommendations from internal audit reviews (via TIG - Audit Tracker Tool) at every meeting
- The committee receives assurance reports in respect of the Data Security & Protection Toolkit submission
- The committee receives an IG /SIRO Annual Report
- CQC inspection published December 2023 with overall rating of Good.

Financial and Operational Governance

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

System Governance

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

Monitoring performance

- The committee receives a finance report providing a summary of YTD financial performance metrics at each meeting (via TIG)
- The committee receives a report on progress to achieve Productivity & Efficiency targets across the Trust

- The committee receives a YTD operational performance report providing a summary of all operational performance metrics (national, regional and local) at each meeting with TIG dashboards allowing tracking of performance
- The members of the committee have access to the Trust Information Gateway to monitor performance

REVISED ID04 Failure to deliver the Trust's agreed financial plan for 2024-25 has an impact on future monitoring and regulation and on Place performance.	Finance & Performance Committee oversight
Link to 5-year strategy - Make most efficient use of resources to ensure value for money Link to PDAF - Poor financial performance in the Wirral health and care system leads to a negative impact and increased monitoring and regulation (RR20)	
Consequence; • Financial sustainability impact • Negative reputational impact	

Current risk rating (LxC)	**Risk appetite**	**Target risk rating (LxC)**
4 x 4 (16)	Cautious	2 x 4 (8)

Mitigations **(i.e. processes in place, controls in place)**	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs** **(i.e. proof points that the risk has been mitigated)** NOTE: ensuring clear alignment of the outcome to the gap it addresses	**Trajectory to mitigate and achieve target risk rating**
• Regular CFO engagement with ICB CFO to negotiate and agree financial position for 2024-25 • Board briefings on draft financial plan submissions and approval on each iteration of the financial planning process • Capital plan 2024-25 developed via Capital Monitoring Group and discussed with IPB • ELT review of financial pressures for 2024-25 • Financial governance arrangements in place and tested by MIAA through Key Financial Controls audit providing ***Substantial Assurance***	• Robust CIP schemes to deliver target - **Chief Strategy Officer** • Delivery of identified transformation / developmental programmes of work - **Chief Strategy Office (SRO) / ELT** • Further implementation and use of model health data in clinical and corporate services - **Chief Strategy Officer / Interim Chief Finance Officer** • Recommendations from Wirral system review - **Interim CEO** • ~~Availability of planning guidance for 2024-25 to determine impact~~	• ~~Agreement of financial plan 2024-25.~~ • Delivery of financial plan 2024-25 • Delivery of CIP target for 2024-25 • Compliance with all necessary and relevant system expenditure controls	• Submission of FINAL financial plan for 2024-25 - May 2024 • CIP target delivered - March 2025 • Financial plan delivered or mitigated position with ICB - March 2025 • Conclusion of Wirral system review - Q3, 2024-25

• Senior Leadership Forum (March 2024) focused on CIP target and opportunities / confidence level to deliver savings • Transformation /developmental programmes of work identified with Chief Strategy Officer as SRO • Model health data available and in use across clinical and corporate services • Membership and participation in Place Finance and Investment Group • System collaboration across NHS provider organisations • Contribution to system Financial Recovery Plan • Relevant organisational risks (e.g., CIP, Capital, Financial Performance) tracked on Datix and through governance structures (as per Risk Policy)	~~on financial position for 2024-25 - **Chief Finance Officer / FPC**~~ • ~~Confirmation of continued funding of system investments e.g. HomeFirst - **Chief Finance Officer / Chief Operating Officer**~~ • ~~Clarity on expenditure controls from the ICB - **Chief Finance Officer / Chief Executive**~~		

REVISED ID06 - Trust operational performance declines resulting in poorer outcomes and greater inequalities for our population.	Finance & Performance Committee oversight
Link to 5-year strategy - Make most efficient use of resources to ensure value for money Link to PDAF - Wirral system partners are unable to deliver the priority programmes within the Wirral Health and Care Plan which will result in poorer outcomes and greater inequalities for our population (RR8).	
Consequence; • Poor service user access, experience and outcomes • Poor contract performance - financial implications (Trust) • Negative reputational impact	

Current risk rating (LxC)	**Risk appetite**	**Target risk rating (LxC)**
2 x 4 (8)	Cautious	2 x 4 (8)

Mitigations **(i.e. processes in place, controls in place)**	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs** **(i.e. proof points that the risk has been mitigated)** NOTE: ensuring clear alignment of the outcome to the gap it addresses	**Trajectory to mitigate and achieve target risk rating**
• CQC report providing overall rating of 'Good' • Strong operational performance reported M01 = 67 Green, 10 Amber, 11 Red • ICB contracts 24-25 signed • Strong and sustained performance against operational system metrics • All KPIs have been revised and updated to ensure they are relevant, consistent with other providers locally and nationally, and with appropriate RAG thresholds. • Waiting list management process developed (also aligned to health inequalities)	• Waiting lists performance to be within 52 weeks - **Chief Operating Officer** • Evidence and assurance on performance according to population need and demographics - **Chief Operating Officer, Chief Nurse and EDI Lead**	• Improved position on red KPIs • Reduction in agency usage across the Trust • Sustained strong patient satisfaction and feedback (average 92% recommending Trust services) • Stakeholder satisfaction and feedback through Place Based Partnership Board • Positive impact on health inequalities demonstrated through service provision (waiting list data and patient experience)	• Reduction in number of red KPIs • Full roll-out of waiting list stratification tool to all services - **COMPLETE** • Staff survey results - **March 2025**

• All waiting lists are clinically triaged • At M11 all services (except paediatric and adult SLT) continue to report under 52 weeks for first appointments • 10 out of 18 services achieved quarterly stretch targets for reducing waiting time for first appointment during Q2, 23-24 - updated position shared at FPC (February 2024) • Strategic COOs meeting weekly • Service contracts in place, approved and with strengthened scrutiny and governance arrangements • Sustained monthly performance with FFT feedback (M01 = 94.1% recommending services) • COO is SRO for Home First across the system - activity increasing and expansion trajectory on track • Sustained improvements in LoS at CICC • Downward trajectory in turnover rates, vacancy rates, temporary staffing levels and sickness absence rates across the Trust (i.e., resilience in workforce) • Waiting list stratification tool in services demonstrating positive impact • TIG waiting list dashboard with targets visible with RAG status against performance compared to previous quarter (methodology reported to IPB)			

• TIG functionality allowing drill down for full caseload and new patient waiting list (SLT) • Agency use below 3.7% ICB cap (M01 = 0.1%)			

Board Assurance Framework 2024-25

Strategic risks with oversight at People & Culture Committee

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

Corporate Governance

- The People & Culture Committee meets on a bi-monthly schedule with an agreed annual workplan in place.
- The committee has Terms of Reference in place, reviewed annually.
- The Chief People Officer is the Executive Lead for the committee.
- The Integrated Performance Board is the highest operational group in the Trust and maintains oversight and scrutiny of performance to provide assurance to the committee.
- The committee completes a self-assessment against its work in respect of the agreed Terms of Reference.
- The PCOG (People & Culture Oversight Group) reports to the IPB on all matters associated with people and workforce performance.
- In accordance with the Trust's Risk Policy, the committee receives a report on high-level organisational risks, and can access all operational risk status through the Datix on-line system, to monitor actions to mitigate risks and determine any impact on strategic risks being managed through the BAF.
- The committee receives an update on trust-wide policies (related to the duties of the committee and on the implementation of recommendations from internal audit reviews.
- The Chair of the committee is also the NED health and wellbeing lead for the Trust.
- Governance arrangements of oversight groups reporting to IPB were tested through internal audit in 2023-24 providing Substantial Assurance.
- CQC inspection rating of Good with Outstanding areas

Workforce Governance

- Year 1 and Year 2 of the People Strategy Delivery Plan implemented successfully with committee oversight.
- The governance structure in place provides clarity on the groups reporting to the committee.
- The committee contributes to the development of the annual People Strategy Delivery Plan and priorities and receives bi-monthly assurance on implementation.
- The committee receives the Terms of Reference for the groups reporting to it and decision and action logs from each meeting for noting.
- The committee reviews and approves the EDS (workforce domains), WRES and WDES annual reports and associated action plans.
- The committee ensures that processes are in place to systematically and effectively respond to reflective learning from staffing incidents and employee relations cases.
- The committee receives and approves the Trust's workforce plan.
- The FTSU Executive Lead is a member of the committee.
- People Governance structure reviewed during 2023-24 to ensure effective monitoring of workforce and L&OD metrics.
- NHS national staff survey 2023 overall improved position with increased response rate to 60%.
- Quarterly People Pulse Survey process embedded with reporting to PCC and to staff via Get Together

System Governance

- Wirral Place Workforce Group established with CPO as member
- CPO Chair of NHS national community providers COP meeting

Monitoring workforce performance

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

ID07 Our people do not feel looked after, their employee experience is poor, and their health and wellbeing is not prioritised	People & Culture 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)**
2 x 4 (8)	**Moderate**	1 x 4 (4)

Mitigations **(i.e., processes in place, controls in place)**	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs** **(i.e., proof points that the risk has been mitigated)** NOTE: ensuring clear alignment of the outcome to the gap it addresses	**Trajectory to mitigate and achieve target risk rating**
• People Promise Manager appointed and in post. • NHS staff survey 2023 results published with improvements across all areas (significantly improve in 8 of the 9 scores compared to 2022) • 2023 uptake for national staff survey = 60% (1,047 responses) • Trust turnover rate of 11.1% has achieved target as per People Delivery Plan for Year 2 - ≤12% average over 12 months by March 2024.	• Launch new Flexible Working Policy - **Head of HR** • Embed updated Managing Attendance Policy - **Head of HR** • ~~Review of LQF to identify any gaps in current behavioural statements and develop support materials - **Head of L&OD**~~ • Alignment to ICB cultural tool *(in development)* to provide	• CQC rated GOOD Trust • Staff engagement score in the National Staff Survey (NSS) ≥ 7.30 • NSS uptake ≥ 62% • Q23c in NSS *"I would recommend my organisation as a place to work"* ≥ 65.0% • Q24a in NSS *"I often think about leaving the organisation"* (lower % is better) ≤ 27.0%	• Staff engagement score in the National Staff Survey (NSS) ≥ 7.30 - **March 2025** (quarterly monitoring via NQPS) • NSS uptake ≥ 62% - **March 20245** (quarterly monitoring via NQPS) • Q23c in NSS *"I would recommend my organisation as a place to work"* ≥ 65.0% - **March 2025** (quarterly monitoring via NQPS)

• People Strategy published with clear alignment to the NHS People Promise and ambition 1 'Looking after our people'. • People Strategy Delivery Plan 2023-24 developed, and progress reviewed bi-monthly by committee. • Wellbeing Champions in services across the Trust • Enhanced monitoring and reporting on progress against Trust and locality level staff survey action plans (via PCOG) • Improved monitoring of national quarterly pulse survey (NQPS)) via TIG • Team WCHC staff recognition scheme & Staff Awards successfully delivered • Wellbeing conversation training for managers (281 staff received training to date) and uptake monitored at PCOG • Wellbeing (including financial wellbeing) information on Staff Zone for all staff • Wagestream available for all staff • Vivup staff benefits platform launched • FFT results providing high satisfaction levels from service users (>90%) • Leadership Qualities Framework in place and supporting development of leadership skills *(LQF under review to identify any gaps in current behavioural statements)* • System Leadership Training for senior leaders • Staff Voice Forum	targeted support to teams - **Head of L&OD** • Design, commission and implement a trust wide team development methodology - **Head of L&OD** Delivery Pan • ~~Launch of behavioural standards framework - **Head of L&OD**~~ • Define allyship for all protected characteristics to support staff in being allies - **Head of Equity & Inclusion** • Manager Essentials Programme for newly appointed managers - **Head of L&OD** • Delivery of People Promise Project to support consistently lower turnover - **Deputy Director of HR&OD, People Promise Manager** • Evolution of WCHC Leadership Forum framework - **Head of L&OD** • Successfully onboard and integrated new staff from Lancashire 0-19 contract - **Deputy Director of HR&OD**	• Improve staff retention ≤10% over 12 months. • We work flexibly NHS People Promise score in NSS = 6.90 • Positive position overall from appraisal audit and recommendations to PCOG. • Positive FFT results at 'very good' or 'good' ≥92.6% • 'Morale' sub-score in NSS ≥6.30 • 'Inclusion' sub-score of *'We are compassionate and inclusive'* NHS People Promise score in NSS ≥7.40 • 'Compassionate culture' sub-score of 'We are compassionate and inclusive' ≥7.50 • Targeted culture interventions *'We are safe and healthy'* ≥6.40 • Team WCHC values are visible in all people practices (recruitment, appraisal, supervision) and at all levels • Wellbeing conversations achieved according to target in People Strategy Delivery Plan (n=100) • ~~Leadership Quality Framework embedded across the Trust including refreshed Leadership Forum.~~ • Behavioural standards framework (BSF) embedded across the Trust	• Q24a in NSS "I often think about leaving the organisation" (lower % is better) ≤ 27.0% - **March 2025** • Improve staff retention ≤10% over 12 months by **March 2025 -** • We work flexibly NHS People Promise score in NSS - ≥ 6.90 - **March 2025 -** • 'Morale' sub-score in NSS ≥ 6.30 - **March 2025** • 'Inclusion' sub-score of 'We are compassionate and inclusive' NHS People Promise score in NSS ≥ 7.40 - **March 2025** • 'Compassionate culture' sub-score of 'We are compassionate and inclusive' ≥7.50 - **March 2025** • Launch of behavioural standards framework - **Q1, 2024-25 - COMPLETE.** • Embed the behavioural standards framework **- Q4 March 2025** • Lancashire contract mobilisation **- 1 October 2024**

• Agile working principles developed with JUSS and Staff Council • Managers briefings in place and issued to support with the dissemination of key messages (to be enhanced through staff engagement plan) • Senior Leadership Forum and Leadership Forum in place and established across (twice per year). • Annual appraisals with focus on health and wellbeing and inclusion of career conversation in 2023 • Appraisal 2023 completion rate exceeding 95% • Highest performing community trust in the country for the quality of appraisals (NSS 2023) • Training packages in place via ESR to support managers to undertake effective appraisals. • Freedom To Speak Up Guardian connecting across the Trust • Organisational-wide recruitment and retention (R&R) group reporting to PCOG • R&R group developed Exit Plan to ensure coherent approach. • R&R group developed recruitment and retention action plan with improved monitoring of leaver data and improved exit processes. • Reduction in vacancy rates (data on TIG)	• Deliver aims of the Sexual Safety Charter in line with national guidance - **Head of HR** • Delivery of recruitment and retention plan including objectives relating to positive action for under-represented groups - **Deputy Director of HR & OD**	• Managers confident to support the wellbeing of their staff (PS1) fully and compassionately	

• Refresh and relaunch of MDT preceptorship programme. • Shadow board programme delivered for Deputies • Leadership Forums for Band 7 managers and Band 8 senior leaders established. • Festival of Leadership 2023 delivered successfully • Legacy mentor in post • HR involvement in PSIRF project • Behavioural standards framework launched at Leadership Forum (April 2024)			

ID08 Our People Inclusion intentions are not delivered; people are not able to thrive as employees of our Trust and the workforce is not representative of our population	People & Culture Committee oversight
Link to 5-Year strategy - Improve the wellbeing of our employees Better employee experience to attract and retain talent	
Consequence; • Poor outcomes for the people working in the Trust • Reduced staff engagement • Failure to meet the requirements of the Equality Act 2010 • Increase in staff turnover and recruitment challenges	

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

Mitigations **(i.e., processes in place, controls in place)**	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs** **(i.e., proof points that the risk has been mitigated)** NOTE: ensuring clear alignment of the outcome to the gap it addresses	**Trajectory to mitigate and achieve target risk rating**
• People Promise Manager appointed and in post. • NHS staff survey 2023 results published with improvements across all areas (significantly improve in 8 of the 9 scores compared to 2022) • 2023 uptake for national staff survey = 60% (1,047 responses) • Inclusion and Health Inequalities Strategy published with a commitment to empowering and upskilling our people.	• Achievement of WDES and WRES actions to improve the experience of disabled staff and BAME workforce - **Deputy HRD/Head of HR/Head of Inclusion** • Raise awareness of reasonable adjustments, sharing lived experiences, increasing declaration rates and membership of the Ability network - **Head of HR/Head of Inclusion**	• CQC rated GOOD Trust • Staff engagement score in the National Staff Survey (NSS) $\geq$ 7.30 • NSS uptake $\geq$ 62% • Q23c in NSS *"I would recommend my organisation as a place to work"* $\geq$ 65.0% • Q24a in NSS *"I often think about leaving the organisation"* (lower % is better) $\leq$ 27.0% • Improve staff retention $\leq$10% over 12 months.	• Cultural awareness training for staff and managers - roll out in Q2 2024/25 (as amended in delivery plan) • Deliver all actions from the WDES action plan - **June 2024** *of the 5 actions, 3 were completed, 1 reframed and 1 carried forward to 2023-24 action plan. • Deliver all actions from the WRES action plan - **June 2024** *action plan for 2022-23 notes completed

• 97.5% compliance with mandatory equality, diversity & human rights training (as of 7 June 2024) target 90% • People Strategy published with clear alignment to the NHS People Promise and ambition 1 'Looking after our people'. • Staff network groups established for BAME, LGBTQ, Ability and Carers. New Menopause Network. • Executive sponsorship of all staff networks refreshed and agreed. • Staff Voice Forum • ~~Leadership Qualities Framework in place and supporting development of leadership skills *(LQF under review to identify any gaps in current behavioural statements)*~~ • WRES and EDS completion with oversight at PCC • Gender pay gap report to PCC • Wellbeing Champions in services across the Trust • Inclusion Champions in services across the Trust • WDES reporting increase in number of staff reporting they are disabled • WDES reporting increase in the likelihood of being appointed as a disabled member of staff • WRES reporting an increase in the percentage of the workforce from a BAME background. WRES action plan rated a '3' (best score) by the national team.	• Define allyship for all protected characteristics to support staff in being allies - **Head of Equity & Inclusion** • ~~Allyship support between directors and disabled staff - **Head of HR/ Head of Inclusion**~~ • Involvement in widening participation initiatives and share lived experiences to encourage BAME applicants to the Trust - **Head of HR/ Head of Inclusion/ Widening Participation Lead** this is an action in Year 3 People Strategy Delivery Plan • ~~Increased diversity at senior roles in the trust and at Trust Board - **Chief People Officer**~~ *(see reference R&R plan below with 'positive action')* • Further develop staff networks as active partners in decision making processes - **Head of HR** • Targeted recruitment for entry level roles/ career pathways, in areas of high deprivation according to CORE20Plus5 - **Head of L&OD -**	• We work flexibly NHS People Promise score in NSS = 6.90 • Positive position overall from appraisal audit and recommendations to PCOG. • Positive FFT results at 'very good' or 'good' ≥92.6% • 'Morale' sub-score in NSS ≥6.30 • 'Inclusion' sub-score of *'We are compassionate and inclusive'* NHS People Promise score in NSS ≥7.40 • 'Compassionate culture' sub-score of 'We are compassionate and inclusive' ≥7.50 • Targeted culture interventions *'We are safe and healthy'* ≥6.40 • Improved staff experience for disabled staff (WDES) • Increased numbers of people joining the organisation from currently underrepresented groups including those from Core20Plus5 communities • Development of multiple career pathways • Launch of cultural awareness training for managers and staff • Targets are set and monitored to ensure workforce is more representative of the local community at all levels	actions with some carried forward to 2023-24 • Increased diversity at senior roles in the trust - **this is an action in Year 3 People Strategy Delivery Plan.** • Associate NED role(s) to be recruited to - **Q4,23-24** - **COMPLETE** • ~~Development of pre-employment programmes - **September 2023** **November 2023** March 2024 (as amended in delivery plan) **this is an action in Year 3 People Strategy Delivery Plan.**~~ • Implement the WCHC approach to Widening Participation (including work experience, pre-employment and engagement with FE and schools) - **January 2025** • Staff engagement score in the National Staff Survey (NSS) ≥ 7.30 - **March 2025** (quarterly monitoring via NQPS) • NSS uptake ≥ 62% - **March 20245** (quarterly monitoring via NQPS) • Q23c in NSS *"I would recommend my organisation as a place to work"* ≥ 65.0% - **March 2025** (quarterly monitoring via NQPS)

• Representatives of BAME staff network supporting the development of more inclusive recruitment practices. • Organisational-wide recruitment and retention (R&R) group reporting to PCOG • R&R group developed Exit Plan to ensure coherent approach • R&R group developed recruitment and retention action plan with improved monitoring of leaver data and improved exit processes • NHS Rainbow Pin Badge scheme - achieved bronze status • Armed Forces Covenant community inclusion initiatives - covenant signed, silver DERS achieved and VCHA accreditation achieved • E-Learning sourced to support Armed Forces Community inclusion • Recruitment and Retention Policy includes positive action in respect of increasing diversity at senior roles (8a and above). • WRES data 2022-23 - BAME staff in the Trust increased from 3.6% to 4.1% • Legacy mentor in post • Widening participation lead in post • Chief executives, chairs and board members have specific and measurable EDI objectives to which they are individually and	• Further data analysis of community demographics linked to widening participation workstreams (to support targeted recruitment for entry level roles) - **Head of L&OD/ Widening Participation Lead** • ~~Development of pre-employment programmes as part of Trust Widening Participation approach - **Head of L&OD/ Widening Participation Lead**~~ • Implement the WCHC approach to Widening Participation *(incorporating Work Experience, pre-employment programmes and an engagement programme with schools and FE providers)* • Delivery of recruitment and retention plan including objectives relating to positive action for under-represented groups - **Deputy Director of HR & OD** • Successfully onboard and integrated new staff from	• Behavioural standards framework (BSF) embedded across the Trust	• Q24a in NSS "I often think about leaving the organisation" (lower % is better) $\leq$ 27.0% - **March 2025** • Improve staff retention $\leq$10% over 12 months by **March 2025 -** • We work flexibly NHS People Promise score in NSS - $\geq$ 6.90 - **March 2025 -** • 'Morale' sub-score in NSS $\geq$6.30 - **March 2025** • 'Inclusion' sub-score of 'We are compassionate and inclusive' NHS People Promise score in NSS $\geq$7.40 - **March 2025** • 'Compassionate culture' sub-score of 'We are compassionate and inclusive' $\geq$7.50 - **March 2025**

collectively accountable (6 high impact actions for EDI) • Behavioural standards framework launched at Leadership Forum (April 2024)	Lancashire 0-19 contract - **Deputy Director of HR&OD**		

ID10 - We are not able to attract, grow and develop our talent sufficiently to ensure the right numbers of engaged, motivated and skilled staff to meet activity and operational demand levels.	People & Culture Committee oversight

Link to 5-Year strategy - Grow, develop and realise employee potential
Better employee experience to attract and retain talent
Link to PDAF - The Wirral health and care system is unable to recruit, develop and retain staff to create a diverse health and care workforce with the skills and experience required to deliver the strategic objectives (RR12).

Consequence;

- Poor outcomes for the people working in the Trust
- Reduced staff engagement
- Increase in staff turnover and recruitment challenges

Current risk rating (LxC)	**Risk appetite**	**Target risk rating (LxC)**
2 x 4 (8)	**Open**	1 x 4 (4)

Mitigations (i.e., processes in place, controls in place)	**Gaps** (Including an identified lead to address the gap and link to relevant action plan)	**Outcomes/Outputs (i.e., proof points that the risk has been mitigated)** NOTE: ensuring clear alignment of the outcome to the gap it addresses	**Trajectory to mitigate and achieve target risk rating**
• People Promise Manager appointed and in post. • CQC rated GOOD Trust • Trust turnover rate achieved target as per People Delivery Plan for Year 2 - ≤12% • Agency use reduced and below the cap • Positive student experience and methods of fast-track recruitment • Time to recruit new staff monitored via PCOG and improving • Apprenticeship plan in progress (task & finish group established) - *'grow our own'* - clinical career pathways	• Launch new Flexible Working Policy - **Head of HR** • Delivery of recruitment and retention plan including objectives relating to positive action for under-represented groups - **Deputy Director of HR & OD** • ~~Not currently recruiting sufficiently from deprived areas - **Chief People Officer** this is an action in Year 3 People Strategy Delivery Plan~~	• Achieve target rate for turnover • Optimisation of bank and agency use • Staff engagement score in the National Staff Survey (NSS) $\geq$ 7.30 • NSS uptake $\geq$ 62% • Reduced vacancy rate • Reduced sickness absence • Launch of clinical career pathways • We work flexibly NHS People Promise score in NSS = 6.7 • Behavioural standards framework (BSF) embedded across the Trust	• Launch of clinical career pathways - **September 2024** • Trust turnover rate ≤10% average over 12 months - **March 2025** • Staff engagement score in the National Staff Survey (NSS) $\geq$ 7.30 - **March 2025** • NSS uptake $\geq$ 62% - **March 2025** (quarterly monitoring via NQPS) • We work flexibly NHS People Promise score in NSS = $\geq$ 6.90 - **March 2025**

• Social value metrics related to recruitment agreed • Widening participation lead in post • Behavioural standards framework (BSF) launched at Leadership Forum (April 2024) • Refresh of flexible working policy in progress • Proactive work with HE, Proactive recruitment of Y3 nursing and therapy students.	• ~~Not currently using the right proportion of apprenticeship levy for entry level roles - **Chief People Officer / Head of L&OD** this is an action in Year 3 People Strategy Delivery Plan~~ • Further embed clinical apprenticeships within 'grow our own' pathways and increase the number of entry-level apprenticeships - **Head of L&OD** • Consider the impact of smaller services on workforce resilience - **Deputy Director of HR&OD** • Successfully onboard and integrated new staff from Lancashire 0-19 contract - **Deputy Director of HR&OD**	• Student evaluations, rotational posts working with system partners	• Launch of behavioural standards framework - **Q1, 2024-25 - COMPLETE.** • Embed the behavioural standards framework **- Q4 March 2025** • Lancashire contract mobilisation **- 1 October 2024**