Board of Directors

SUMMARY REPORT	Meeting Date:	23 November 2022
	Agenda Item:	23

Report Title:	**Board Assurance Framework (BAF)**	
Author(s):	Amber Wild, Head of Corporate Assurance and Deborah Lawrenson, Director of Corporate Governance	
Accountable Director:	Deborah Lawrenson, Director of Corporate Governance	
Other Meetings presented to or previously agreed at:	**Committee/Group:**	The relevant sections of the BAF for 2022-23 were last received at the Board sub-committees for review in advance of Board on the following dates: • Finance and Performance Committee -10 November 2022 • People Committee – 8 November 2022 • Quality Assurance Committee – 9 November 2022 • Audit and Risk Committee – 18 October 2022
	Date:	See above
Key Points recommendations to or previously agreed at:	The Board Assurance Framework (BAF) risks are presented in full and attached at **appendix 1.**	

Summary of key points in report

The updated detailed Board Assurance Framework (BAF) risks overseen by the committees are attached for reference at **appendix 1**.

Risks that have been updated by Executive leads since the last discussion at the Board in September 2022 are presented in blue text in the full BAF.

For all BAF risks work has taken place to identify actions, now closed which can move to controls and work is underway to look at inclusion of the trajectory for moving the risks to their target scores.

Below is a summary of the BAF risks overseen by each Board sub-committees with key updates provided:

FINANCE AND PERFORMANCE COMMITTEE OVERSIGHT

BAF.0021

AIM 3: Effective Use of Resources
STRATEGIC PRIORITY: Transformation: Changing things that will make a difference
Exec Lead: Phillip Easthope

DETAILS: There is a risk of failure to ensure digital systems are in place to meet current and future business needs by failing to effectively address inadequate legacy systems and technology caused by complex historic system issues requiring on-going maintenance, inadequate system monitoring, testing and maintenance, failure to address cyber security weaknesses, delays in procurement and roll out of new systems resulting in negative impact on patient safety and clinical effectiveness due to loss of access to key systems and processes and potential increase in cyber security and data protection incidents

Summary update:
Committee discussed and agreed

- As the committee previously agreed that the risks should be separated out to one for digital solutions with a risk appetite of MODERATE and to one for Cybersecurity with a risk appetite of LOW– it was noted this was discussed at the November Data Information Governance Group (DIGG) with work now taking place by the operational leads for review of the separated BAF risks in December – a specific request has also been made in respect of an update on the DPST actions.
- There were no changes proposed to the residual or target risk scores at this time pending this further work.
- It is recognised sources of assurance and actions are unlikely to change until Q1/Q2 2022/23 on the retirement of the Insight system
- In its next discussion the committee will look at separated risks and at the trajectory for moving to target risk scores

BAF.0022

AIM3: Effective Use of Resources
STRATEGIC PRIORITY: Transformation: Changing things that will make a difference
Exec Lead: Phillip Easthope

DETAILS: There is a risk that we fail to deliver the break-even position agreed for 2022/23 caused by factors including non-delivery of the financial plan or CIP targets and increased cost pressures resulting in a threat to both our financial sustainability and delivery of our statutory financial duties.

Summary update
Committee discussed, agreed and noted:

- The risk will be kept under close review noting it is possible if the position worsens that the residual risk score will rise, given there is increasing risk in respect of delivery of the Cost Improvement Plans which are not as progressed as they need to be and therefore progress status has moved to 'some slippage'
- At the October FPC meeting it was agreed the target score should change to 4 x 2 = 6 – **Board to endorse this change**
- Work is taking place to refine detail around recurrent/non-recurrent schemes in budget lines – to be in place by December 2022 aligned with budget setting and to look at actions to mitigate forecast overspend – likelihood scores will be reconsidered at the review in December and to consider if there is any movement from actions to controls.

BAF.0026

AIM 3: Effective Use of Resources
STRATEGIC PRIORITY: Transformation: Changing things that will make a difference
Exec Lead: Pat Keeling

DETAILS: There is a risk of slippage or failure in projects comprising our transformation plans caused by factors including non-delivery of targets by milestones, unanticipated costs arising or lack of sufficient capacity to deliver within the timeframes agreed or availability of capital funds resulting in service quality and safety being compromised by the non-delivery of key strategic projects.

Summary update

Committee discussed and agreed and noted:

- Milestones for 3 programmes - PCMH, LD and Community Facilities were being updated in Oct and Nov to be reflected in the Transformation report to the committee
- No changes were proposed to Residual risk or target scores
- Progress has been made with some actions which are now marked for closure and some completed actions have been moved to controls

BAF: 0027

AIM 3: Effective Use of Resources
STRATEGIC PRIORITY: Transformation: Changing things that will make a difference
Exec Lead: Pat Keeling

DETAILS: There is a risk of failure to engage effectively with system partners as new system arrangements are developed caused by non-participation in partnership forums, capacity issues (focus on Trust), difficulty in meeting increased requirement to provide evidence/data potentially at pace and volume, lack of clarity around governance and decision making arrangements resulting in poorer quality of services, missed opportunities to participate or lead on elements of system change and potential increase in costs

Summary update

Committee discussed and agreed and noted:

- We may now start to see changes following establishment of the Integrated Care Board (ICB) on 1 July 2022 . There is national guidance on how ICB and ICP will develop their strategies and plans by May 2023.
- The SHSC Engagement Map is being updated with latest changes
- No changes were proposed to residual or target scores
- Note – as previously reported additional BAF risks will need to be added to reflect system BAF risks when developed and we will in turn have to escalated Risk to those BAFs where appropriate

AIM 4 - **ENSURE SERVICES ARE INCLUSIVE**

STRATEGIC PRIORITY: Transformation: Changing things that will make a difference and Partnership Working (PLACE (equality) addressing deprivation, Provider Alliance (forensic and specialist services) ICS and University (improving outcome measures)

RISK REF: No specific risks identified at this time
Cross References to risks which cover inclusivity and the ones relevant to this committee are highlighted below:

- Aim 1 - Deliver Outstanding care BAF risks 0023, 0024, 0025, 0029
- Aim 2 - Create Great Place to Work BAF risks 0013,0014,0020
- **Aim 3 - Effective Use of Resources BAF risks 0027**

PEOPLE COMMITTEE OVERSIGHT

BAF.0013

AIM 3: Effective use of resources

STRATEGIC PRIORITY: Transformation: Changing things that will make a difference
Exec Lead: Executive Director of People

DETAILS: There is a risk that we fail to identify key cultural and work pressures impacting on staff health and wellbeing and delivery of services, leading to ineffective interventions; caused by failure to engage with staff in a meaningful way around concerns raised in the staff and pulse surveys as well as through engagement with, and demonstration of the values; and failure to implement demonstrable changes resulting in low scores on the staff survey (low morale), high sickness absence levels and negative indicators for quality of care.

Summary update
Committee discussed, agreed and noted:

- the risk type for this should be 'workforce'.
- the risk appetite should remain as LOW.
- the current risk score should remain 3 x 4 = 12
- the target risk should be changed to 3 (severity) x2 (likelihood) =6 (given for a LOW appetite it should be between 5 and 8) **Board to endorse this change**
- Actions have been reviewed and there has been some movement of assurances to the controls section

BAF. 0014

AIM 2: CREATE A GREAT PLACE TO WORK
STRATEGIC PRIORITY: Transformation – Changing things that will make a difference
Exec Lead: Executive Director People

DETAILS: There is a risk of failure to undertake effective workforce planning to support recruiting, attracting and retaining staff to meet current and future needs caused by ineffective workforce planning, insufficiently attractive flexible working offer, competition, limited availability through international recruitment, reluctance of staff to remain in the NHS post Covid19, any national ICS requirements resulting in a negative impact on delivery of our strategic and operational objectives and provision of high-quality safe care.

Summary update
Committee discussed and agreed:

- The risk appetite should move to MODERATE from LOW
- The current score to remain 4 x 4 = 16
- Approved movement of the target risk score to 3 (severity) x3 (likelihood) =9 to fit with target risk requirements for a MODERATE score. **Board to endorse this change**
- Progress status has moved from some slippage to on track' for example progress with international recruitment and work to develop the workforce planning dashboard progressing.
- Some actions for gaps in controls and assurances have been clarified and work is ongoing to clarify remaining gaps.Gaps and assurances have been reviewed and a new control has been added with some movement of assurances to the controls section
- The committee noted the need for access to more detailed data to fully understand the vacancy factor; the roll out of the roster early the new year is expected to have a positive impact on data quality and it was agreed at the committee the data presented will be separated by service line in the future which will provide a further control and assurance.

BAF. 0020

AIM 2: CREATE A GREAT PLACE TO WORK
STRATEGIC PRIORITY: Transformation – Changing things that will make a difference
Exec Lead: Executive Director of People

DETAILS: There is a risk of failure to enable a paradigm shift in our culture through delivery of the overarching cultural change programme, caused by a lack of engagement in the wide range of leadership activity and opportunities for development provided, inability to adapt and engage to enable organisational

change, resulting in failure to improve the culture of the organisation, ineffective leadership development, application of learning, engagement with our values, emergence of closed subcultures and low staff morale which in turn impacts negatively on service quality and service user feedback.

Summary update
Committee discussed and agreed

- The risk appetite should move to MODERATE from LOW.
- That the current risk score of 4 x 3 = 12 should remain unchanged
- The target score was updated to 3 x3 =9 to fit revised risk appetite which was approved by the committee. **Board to endorse this change**
- That the risk type 'Workforce' is most appropriate
- Actions have been reviewed and there has been some movement of assurances to the controls section

QUALITY ASSURANCE COMMITTEE OVERSIGHT

BAF.0023

AIM 1: Deliver outstanding care
STRATEGIC PRIORITY: COVID19 – Recovering Effectively

DETAILS: There is a risk that service users and staff are exposed to an avoidable spread of infectious diseases caused by a failure to consistently maintain appropriate Infection Prevention Control arrangements and safe working practices.

Summary update
Committee discussed and agreed

- the updated description of the risk – **Board are asked to endorse this change**
- Noted receipt of the HSE inspection looking at sharps safety and been issued with an improvement notices around consistently applying safe working practices to ensure staff are protected from needle stick injuries and prevent spread of infection
- The Winter 2022/23 Flu and Covid vaccination campaign has commenced
- The risk rating is not proposed to change - it was noted that although impact is being mitigated; likelihood does not reduce at the current time under circumstances of rising background levels of air borne infection.
- It was confirmed the target risk score should be 3 x 3 = 9 - **Board to endorse this change.**

BAF.0024

AIM 1: Deliver outstanding care
STRATEGIC PRIORITY: COVID19 – Recovering Effectively
Exec Lead: Beverley Murphy

DETAILS: There is a risk of failure to anticipate issues with, and achieve, maintain and evidence compliance with fundamental standards of care, caused by capacity and capability issues, cultural challenges, high use of agency and vacancy in some teams, use of out of area placements, lead in time for major estate changes, resulting in avoidable harm or negative impact on service user outcomes and experience, staff wellbeing, reputation, future sustainability of particular services which could result in regulatory action.

Summary update
Committee discussed, agreed and noted:

- Ownership of this risk should be shared by the Director of Nursing, Professions and Operations with the Medical Director as SRO for 'Back to Good' – **Board to endorse this change.**
- Back to Good – 6 improvement actions are in exception – two are proposed for closure following PMO Board.

- No proposed change to risk scores

BAF.0025

AIM 1: Deliver outstanding care
STRATEGIC PRIORITY: CQC Continuous Improvement and Transformation - Changing things that will make a difference
Exec Lead: Beverley Murphy

DETAILS: There is a risk of failure to effectively deliver essential environmental improvements including the reduction of ligature anchor points in inpatient settings (the therapeutics environment programme) at the required pace caused by difficulty in accessing capital funds required, the revenue requirements of the programme, supply chain issues (people and materials), and capacity of skills staff to deliver works to timeframe required resulting in more restrictive care and a poor staff and service user experience and unacceptable service user safety risks

Summary update
Committee discussed, agreed and noted:
- Committee agreed that there should be a separation of the risk into one around Ligature anchor points (LAP) for which the appetite should be LOW and Therapeutic environments for which the appetite should be MODERATE. This is to be taken forward – for reporting to QAC in January 2023
- The current score 4 x 4 = 16 is unchanged. Committee agreed that the current and target risk score should be reviewed following the separation of these risks.
- Some closed actions had been moved into controls

BAF: 0029

AIM 1: Deliver outstanding care
STRATEGIC PRIORITY: COVID19 – Recovering Effectively and Transformation: Changing things that will make a difference
Exec Lead: Beverley Murphy

DETAILS: There is a risk of a delay in people accessing the right community care at the right time caused by issues with models of care, contractual issues and the impact of practice changes during Covid resulting in poor experience of care and potential harm to service users

Summary update
Committee discussed and agreed
- No proposed change to risk scores
- Additional Strategic priority added- Transformation

AIM 4 - **ENSURE SERVICES ARE INCLUSIVE**

STRATEGIC OBJECTIVE: Transformation: Changing things that will make a difference and Partnership Working (PLACE (equality) addressing deprivation, Provider Alliance (forensic and specialist services) ICS and University (improving outcome measures)

RISK REF: No specific risks identified at this time
Cross References to risks which cover inclusivity and the ones relevant to this committee are highlighted below:

- **Aim 1 - Deliver Outstanding care BAF risks 0023, 0024, 0025, 0029**
- Aim 2 - Create Great Place to Work BAF risks 0013,**0014**,0020
- Aim 3 - Effective Use of Resources BAF risks 0027

Recommendation for the Board/Committee to consider:							
Consider for Action		**Approval**	**X**	**Assurance**	**X**	**Information**	

The Board of Directors is asked to:

- receive the Board Assurance Framework (BAF)
- note updates provided post discussion at board sub-committees and
- agree changes to the risk descriptor of BAF risk 0023 and the sharing of Executive leadership of BAF risk 0024.
- Agree to changes to target risk scores for BAF risks 0013, 0014, 0020, 0023 to fit with revised risk appetite levels.

Please identify which strategic priorities will be impacted by this report:				
Covid-19 Recovering Effectively	*Yes*		*No*	
CQC Getting Back to Good Continuous Improvement	*Yes*		*No*	
Transformation – Changing things that will make a difference	*Yes*	***X***	*No*	
Partnerships – working together to make a bigger impact	*Yes*	***X***	*No*	

Is this report relevant to compliance with any key standards ?					**State specific standard**
Care Quality Commission Fundamental Standards	*Yes*	***X***	*No*		"Systems and processes must be established to ensure compliance with the fundamental standards" See individual BAF risks for detail.
Data Security and Protection Governance Toolkit	*Yes*	***X***	*No*		
Any other specific standard	*Yes*	***X***	*No*		

Have these areas been considered ? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Service User and Carer Safety and Experience	*Yes*	***X***	*No*		Specific detail is covered within the BAF for each area
Financial (revenue &capital)	*Yes*	***X***	*No*		
Organisational Development/Workforce	*Yes*	***X***	*No*		
Equality, Diversity & Inclusion	*Yes*	***X***	*No*		
Legal	*Yes*	***X***	*No*		
Environmental Sustainability	*Yes*	***X***	*No*		

Board Assurance Framework

Section 1: Analysis and supporting detail

BAF Snapshot

1.1 Risks are ordered from highest to lowest, where the gulf between current risk rating and target risk rating the next denominator where scores are equal.

The BAF is a key aspect of good governance in all organisations and a properly functioning BAF provides Board members with an understanding of the principal risks to achieving its strategic objectives. It also provides assurance regarding controls in place or actions being taken to mitigate risks to an acceptable level within the Board's risk appetite.

The BAF is dynamic document and enables risks to evolve to reflect changing external and internal environments. As such, it is expected that some risks will close over the course of a year once controlled to an acceptable level, or risks may change to reflect emerging issues and priorities.

1.2 The Risk Appetite was reviewed at the Board in its meeting in August. Below is the snapshot of risks overseen at Finance and Performance Committee, Quality Assurance Committee and People Committee. Arrows to showing movement since the risks were last discussed at the Board are included.

1.3 The Board is asked to consider BAF risk scores alongside the other sources of information presented as part of triangulation.

1.4 Movement on target scores to meet revised appetite are drawn out below:

- BAF 0014 going up from 3 x 2 = 6 to 3 x 3 = 9
- BAF 0022 going down from 4 x 3 = 12 to 4 x 2 = 8
- BAF 0020 going up from 3 x 2 = 6 to 3 x 3 = 9
- BAF 0013 going up from 2 x 2 = 4 to 3 x 2 = 6
- BAF 0023 going up from 4 x 2 = 8 to 3 x 3 = 9

Current Risk Score			**Target Risk Score require discussion**		
Severity	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**
BAF.0029 NEW - There is a risk of a delay in people accessing the right community care at the right time caused by issues with models of care, contractual issues and the impact of practice changes during Covid resulting in poor experience of care and potential harm to service users					
4	4	16 ⟺	4	2	8 ⟺
BAF0014: There is a risk of failure to undertake effective workforce planning to support recruiting, attracting and retaining staff to meet current and future needs caused by ineffective workforce planning, insufficiently attractive flexible working offer, competition, limited availability through international recruitment, reluctance of staff to remain in the NHS post Covid19, any national ICS requirements resulting in a negative impact on					

delivery of our strategic and operational objectives and provision of high-quality safe care.					
4	4	16 ⟺	3	3	9 ⇧
BAF.0025 - There is a risk of failure to effectively deliver essential environmental improvements including the reduction of ligature anchor points in inpatient settings (the therapeutics environment programme) at the required pace caused by difficulty in accessing capital funds required, the revenue requirements of the programme, supply chain issues (people and materials), and capacity of skills staff to deliver works to timeframe required resulting in more restrictive care and a poor staff and service user experience and unacceptable service user safety risks					
4	4	16 ⟺	3	2	6 ⟺
BAF0022: there is a risk that we fail to deliver the break-even position agreed for 2022/2023 caused by factors including non-delivery of the financial plan or CIP targets and increased cost pressures resulting in a threat to both our financial sustainability and delivery of our statutory financial duties.					
5	3	15 ⟺	4	2	8 ⇩
BAF0020: There is a risk of failure to enable a paradigm shift in our culture through delivery of the overarching cultural change programme, caused by a lack of engagement in the wide range of leadership activity and opportunities for development provided, inability to adapt and engage to enable organisational change, resulting in failure to improve the culture of the organisation, ineffective leadership development, application of learning, engagement with our values, emergence of closed subcultures and low staff morale which in turn impacts negatively on service quality and service user feedback.					
4	3	12 ⟺	3	3	9 ⇧
BAF0013: There is a risk that we fail to identify key cultural and work pressures impacting on staff health and wellbeing and delivery of services, leading to ineffective interventions; caused by failure to engage with staff in a meaningful way around concerns raised in the staff and pulse surveys as well as through engagement with, and demonstration of the values; and failure to implement demonstrable changes resulting in low scores on the staff survey (low morale), high sickness absence levels and negative indicators for quality of care.					
3	4	12 ⟺	3	2	6 ⇧
BAF0027: there is a risk of failure to engage effectively with system partners as new system arrangements are developed caused by non-participation in partnership forums, capacity issues (focus on Trust), difficulty in meeting increased requirements to provide evidence/data potentially at pace and volume, lack of clarity around governance and decision-making arrangements resulting in poorer quality of services, missed opportunities to participate or lead on elements of system change and potential increase in costs					
4	3	12 ⟺	4	3	12 ⟺
BAF. 0024 - There is a risk of failure to anticipate issues with, and achieve, maintain and evidence compliance with fundamental standards of care, caused by capacity and capability issues, cultural challenges, high use of agency and vacancy in some teams, use of out of area placements, lead in time for major estate changes, resulting in avoidable harm or negative impact on service user outcomes and experience, staff wellbeing, reputation, future sustainability of particular services *which could result in* regulatory action.					
4	3	12 ⟺	4	2	8 ⟺
BAF.0023 There is a risk that service users and staff are exposed to an avoidable spread of infectious diseases caused by a failure to consistently maintain appropriate Infection					

Prevention Control arrangements and safe working practices.					
4	3	12 ⟺	3	3	9 ⇧
BAF 0021: there is a risk of failure to ensure digital systems are in place to meet current and future business needs by failing to effectively address inadequate legacy systems and technology caused by complex historic system issues requiring on-going maintenance, inadequate system monitoring, testing and maintenance, failure to address cyber security weaknesses, delays in procurement and roll out of new systems resulting in negative impact on patient safety and clinical effectiveness due to loss of access to key systems and processes and potential increase in cyber security and data protection incidents					
4	3	12 ⟺	1	3	⟺ 3
BAF0026: there is a risk of slippage or failure in projects comprising our transformation plans caused by factors including non-delivery of targets by milestones, unanticipated costs arising or lack of sufficient capacity to deliver within the timeframes agreed or availability of capital funds resulting in service quality and safety being compromised by the non-delivery of key strategic projects					
3	3	9 ⟺	3	2	⟺ 6

Section 2: Risks

2.1 Failure to properly review the BAF could result in Board or its committees not being fully sighted on key risks to the delivery of our strategic aims and objectives.

2.2 There are no specific corporate risks around usage of the BAF.

Section 3: Assurance

3.1 The information provided within the BAF is 'owned' by Executive Directors and reviewed/revised by colleagues within their directorates under their leadership.

3.2 For the most effective assurance, information provided within the BAF should be considered alongside other sources of information provided to Board and its committees, including other reports received, discussions held and observations at visits. This triangulation will ensure that the BAF represents the assurance that Board and Committee members believe they have received.

Section 4: Implications

Strategic Aims and Board Assurance Framework

4.1 All apply

Equalities, diversity and inclusion

4.2 See People Committee BAF risks

Culture and People

4.3 See People Committee BAF risks

Integration and system thinking

4.4 See Finance Committee BAF risks

Financial

4.5 See Finance Committee BAF risks

Compliance - Legal/Regulatory

4.6 See BAF risk 22 regarding regulatory requirement to break even.

The Trust received an HSE enforcement notice in respect of sharps management and this was discussed at Quality Assurance Committee in the context of risk management.

Sustainability

4.7 See BAF risks 26 and 27

Section 5: List of Appendices

1. Full Board Assurance Framework as at 14 November 2022

BOARD ASSURANCE FRAMEWORK 2022/2023 – risks overseen by Finance and Performance Committee updated for receipt at November 2022 BOARD

AIM 3: EFFECTIVE USE OF RESOURCES	**STRATEGIC PRIORITY:** Transformation: Changing things that will make a difference
RISK REF: BAF.0021 **RISK CREATED:** 07/05/2021 *re-worded June – approved at July 2022 Finance and Performance Committee for submission to Audit & Risk Committee and Board*	**DETAILS:** There is a risk of failure to ensure digital systems are in place to meet current and future business needs by failing to effectively address inadequate legacy systems and technology caused by complex historic system issues requiring on-going maintenance, inadequate system monitoring, testing and maintenance, failure to address cyber security weaknesses, delays in procurement and roll out of new systems resulting in negative impact on patient safety and clinical effectiveness due to loss of access to key systems and processes and potential increase in cyber security and data protection incidents

Executive lead: Executive Director of Finance **Board sub – committee oversight:** Finance and Performance				**Risk type:** Quality & *Digital (data)*		**Risk appetite:**			**LOW –** cyber **MODERATE –** digital
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	**4**	**3**	**12**	**Last Review:**	02.11.2022	**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**1**	**3**	**3**	**Next Review:**	December – date to be confirmed	**X**			

Summary update

- *Changes are in blue*
- *As the FPC committee previously agreed that the risks should be separated out to one for digital solutions with a risk appetite of MODERATE and to one for Cybersecurity with a risk appetite of LOW– it was noted this was discussed at the November Data Information Governance Group (DIGG) with work now taking place by the operational leads for review of the separated BAF risks in December – a specific request has also been made in respect of an update on the DPST actions.*
- *There were no changes proposed to the residual or target risk scores at this time pending this further work.*
- *It is recognised sources of assurance and actions are unlikely to change until Q1/Q2 2022/23 on the retirement of the Insight system*
- *In its next discussion the committee will look at separated risks and at the trajectory for moving to target risk scores*

CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
1 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**GREEN**
Control • Governance controls in place via new EPR Programme Board which meets monthly • Board membership of EPR Programme includes 3rd party EPR supplier, 3rd party deployment consultations, CCIO, CSO and Chair of ICS Digital Delivery Board.	**Gaps in control** None **Actions** None	**Internal assurance** • Reporting into Programme Board with oversight by Trust Transformation Board. EPR system has been procured with contracts signed in January 2022. Trust wide go live will be via a number of phases and is due to commence in April 2023 **External assurance**	**Gaps in assurance** None **Actions** • Full retirement of Insight in Q1/Q2 2023	

		• New EPR consultancy engaged to take us through implementation phase. Unified Tech Fund commits Trust to provide 'blueprints' (good practice for EPR functionality) as part of implementation.		
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
2 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**GREEN**
Control • Governance controls in place via Data and Information Governance Group (DIGG) which meets every 2 months	**Gaps in control** None **Actions** None	**Internal assurance** • *Reporting to DIGG and onward* reporting to Audit and Risk Committee **External assurance** • Annual Data Security Protection Toolkit (DSPT) audit moderate assurance rating received.	**Gaps in assurance** None **Actions** • Implement DSPT action plan to achieve 'Standards met' at June 2023 (Actions Jul, Aug, Sep 22 Jun 23)	
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
3 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Controls • Digital Strategy approved by Trust Board on 4/11/2021 defines a plan and roadmap for improved technology services and sustainability	**Gaps** • Assessment and plan for full resourcing and affordability not currently in place **Actions**	**Internal assurance** • Digital Strategy Group - meets every 2 months and reports to FPC **External assurance** None	**Gaps in assurance** • Committee oversight **Actions** • Resource plan to be received at Oct 2022 ARC, as part of update to committee.	

	Mandate and business case for increased staffing resource in IMST in progress. Target date 30/6/2022 (Andrew Male) **Progress** Decisions through business planning process still pending. Final decisions by BPG still pending.			
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
4 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Controls • IMST continue to retire old systems and improve cyber security in line with the guidance provided by the data protection and security toolkit making good progress to meeting the standard.	**Gaps** • Four elements of DSPT still to be achieved, the relevant risks are being tracked. **Actions** • The relevant risks are being tracked At DIGG and reported through to ARC. **Progress** • Last Windows 2008 server retired	**Internal assurance** • DSPT audit. Internal audit have provided support around penetration testing. **External assurance** • DSPT submission as part of national reporting	**Gaps in assurance** None **Actions** • Implement DSPT action plan to achieve 'Standards met' at June 23 (Actions Jul, Aug, Sep 22 Jun 23)	

AIM3: EFFECTIVE USE OF RESOURCES	**STRATEGIC *PRIORITY*:** Transformation: Changing things that will make a difference
RISK REF: BAF.0022 **RISK CREATED:** 07/05/2021 – *re-worded – June - approved at July 2022 Finance and Investment Committee for submission to Audit & Risk Committee and Board*	**DETAILS:** There is a risk that we fail to deliver the break-even position agreed for 2022/23 caused by factors including non-delivery of the financial plan or CIP targets and increased cost pressures resulting in a threat to both our financial sustainability and delivery of our statutory financial duties.

Executive lead: Executive Director of Finance **Board sub – committee oversight:** Finance and Performance				**Risk type:** Finance		**Risk appetite:**			***LOW***
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	**5**	**3**	**15**	**Last Review:**	04/10/2022	**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**4**	**2**	**8**	**Next Review:**	December date to be confirmed		X		

Summary update

- *Changes are in blue italics*
- *The risk will be kept under close review noting it is possible if the position worsens that the residual risk score will rise, given there is increasing risk in respect of delivery of the Cost Improvement Plans which are not as progressed as they need to be and therefore progress status has moved to 'some slippage'*
- *At the October FPC meeting it was agreed the target score should change to 4 x 2 = 6 – **Board to endorse this change***
- *Work is taking place to refine detail around recurrent/non-recurrent schemes in budget lines – to be in place by December 2022 aligned with budget setting and to look at actions to mitigate forecast overspend – likelihood scores will be reconsidered at the review in December and to consider if there is any movement from actions to controls.*

CONTROLS & MITIGATIONS		ASSURANCES/EVIDENCE (how do we know we are making an impact)		Assurance rating
1 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Control • Operational plan; financial planning; including CIP planning, processes and delivery monitoring • CIP programme Board established with more sophisticated CIP planning processes	**Gaps in control** • *Identification of a full recurrent CIP plan* • *CIP delivery groups to be fully established (2nd tier reporting to CIP programme Board)* **Actions** 2022/23 CIP plan including QEIA to be in place by the end of Quarter 3 2021/22. **Progress** - Programme Board established, some CIP scheme identified, Key areas identified and plan progressing.	**Internal assurance** • Monthly financial reporting to Team and Programme Board, Assurance report to FPC and Board. • Performance Framework meetings and recovery plans **External assurance** • NHSE&I Financial Review *2021/22* and ongoing support as required	**Gaps in assurance** • Full CIP plan 100% recurrently identified. **Actions** • Number of schemes identified full plans yet to be provided. Target date for full plans needs to be agreed as Q3 to keep this work on track. There is some risk this target will not be reached. • Identify actions to mitigate forecast overspend – due for discussion at November FPC • Work taking place to refine capture of recurrent/non-recurrent detail in budget lines – by December 2022 will be aligned with budget setting.	

AIM 3: EFFECTIVE USE OF RESOURCES	**STRATEGIC PRIORITY:** Transformation: Changing things that will make a difference
RISK REF: BAF.0026 **RISK CREATED:** 12/05/2021 re-*worded – June - approved at July 2022 Finance and Performance Committee for submission to Audit & Risk Committee and Board*	**DETAILS:** There is a risk of slippage or failure in projects comprising our transformation plans caused by factors including non-delivery of targets by milestones, unanticipated costs arising or lack of sufficient capacity to deliver within the timeframes agreed or availability of capital funds resulting in service quality and safety being compromised by the non-delivery of key strategic projects.

Executive lead: Director of Strategy **Board sub – committee oversight:** Finance and Performance				**Risk type:** Quality		**Risk appetite:**			**LOW**
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	**3**	**3**	**9**	**Last Review:**	**2/11/22**	**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**3**	**2**	**6**	**Next Review:**	December date to be confirmed		**X**		

Summary update

- *Changes are blue*
- *Milestones for 3 programmes - PCMH, LD and Community Facilities were being updated in Oct and Nov to be reflected in the Transformation report to the committee*
- *No changes were proposed to Residual risk or target scores*
- *Progress has been made with some actions which are now marked for closure and some completed actions have been moved to controls*

CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
1 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/**	**AMBER**

			Actions to address gaps

Control
• Members of the Executive team as SRO's for all projects and programmes
• Joint board with Primary Care Sheffield for the PCMHT programme
• Resource issues are being addressed. Additional consultancy support to therapeutic environments programme and additional £2 m capital allocated from National programme. We have an external resource to support drafting of the SOC, have strengthened capacity and capability across our capital and construction projects (including within procurement)
	Gaps in control
	• To ensure skilled and experienced Project/Programme Managers in role for People Plan and CMHT project – additional resource (from within the Trust) has been brought into to work on e roster data and increased skills to support that programme. A replacement to an existing role has been brought in (consultancy support) and have increased capacity as working in parallel for a month. With CMHT project we have improved project management support.
	• Portfolio risk and issue register and milestone plan to be embedded within the work and assurance activities of the Transformation Board – we have these in place for all programmes – highlighted risks are received at the Transformation Board. We are updating the milestones for 3 programmes in Oct and Nov: PCMH, LD and Community Facilities.PK tomorrow – milestones will be provided in the Transformation report issued to FPC in November
	• Dependencies register to be redefined and implemented into work and assurance of the Transformation Board -
	• Change control process to be implemented across all programmes to ensure changes to scope, quality and plans are visible and agreed at the appropriate level of authority – going well in terms of the capital projects so change controls in three of the projects so far (Fulwood, Therapeutics environment and community facilities)
	• Lack of formally assigning colleagues to programmes with acknowledgement of amount of time required to dedicate to the programme –programme manager allocation taking place in
		Internal assurance
		• Triangulation of information between Back to Good programme and Transformation Portfolio via PMO.
		• Reporting from programmes to relevant committees and Transformation Board to Finance and Performance Committee.
		• Programme Highlight reports.
		
		External assurance
		• Significant Assurance rating received by 360 Assurance to Audit and Risk Committee in January 2022 for the Transformation Board and PMO.
		• Some programmes have external assurance mechanisms, as follows:
		  ○ Adult Forensic New Care
		  ○ Models via (tbc)
		• Primary and Committee Mental Health via (tbc)
			Gaps in assurance
			Some programmes have external ~~assurance mechanisms as hosted elsewhere (primary and community mental health). There are programme boards overseeing those. Governance appropriate – no further action.~~
			
			Actions
			• No further action required at this stage

	PMO and through the PIDs and refreshing PIDs paperwork and TORs as part of the audit which is almost completed. **Actions** • Work taking place to look at what is required from a dependency register – by end October 2022 The dependency register is now specified and therefore this action is complete. Will be built using MS Office products. It has been specified in Monday.com to commence implementation in January 2023 • Change controls for the remaining projects to be in place by end of November 2022. This will not be achieved by this timeframe it is linked with the above action for delivery in January. • outlined above to be completed by end of September 2022. This action is complete			
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
2 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	***AMBER***
Control • Transformation Board in place to provide read across between programmes (including Back to Good) and operational areas, manage dependencies and provide guidance and support	**Gaps in control** • Dependencies register to be embedded into everyday use. **Actions** • See comment against control above. The actions are with the PMO to put in place by end of October 2022 The dependency register is now specified and therefore this action is complete. Will be built using MS Office products. It has been specified in Monday.com to commence implementation in January 2023	**Internal assurance** • Reporting takes place via PMO. The SRO/Chair of the Back to Good Programme Board is a member of the Transformation Board. **External assurance** • NHSE/I representation on the Transformation Board and Back to Good Programme Board.	**Gaps in assurance** None **Actions** **None**	
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**

3 - Controls	Gaps in control/Actions to address gaps	Internal/External assurance	Negative assurances or Gaps in assurance/ Actions to address gaps	*AMBER*
Controls • Programme/Project Boards in place	**Gaps** • People Plan does not have a Programme Board. It reports to People Committee. It has a project group for E-roster which is the element outstanding – this will report into People Committee and Transformation Board. • For each of the strategies there will be implementation groups feeding into the relevant board sub committees. This is being reviewed to ensure clear governance flows up from the tier II groups. **Action** • Implementation reporting to be confirmed by end of November and reflected into Tier I forward planners.	**Internal assurance** • Programme and Project Boards are in place *for the majority of areas*. • Activity to standardise the Terms of Reference and agendas. All in place • Highlight reports already standardised. **External assurance** • EPR – External representative on Programme Board to advise on procurement. • Primary and Community Mental Health Transformation Programme – representation from Primary Care and external organisations.	**Gaps in assurance** None **Actions** None	
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
4 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**GREEN**
Controls • Reporting structures in place from Programme Manager to Programme Board, through to Transformation Board and Finance and Performance Committee	**Gaps** None **Action** None	**Internal assurance** • Board, meeting minutes, report to Finance and Performance committee **External assurance** None	**Gaps in assurance** None **Actions** None	

CONTROLS & MITIGATIONS		ASSURANCES/EVIDENCE (how do we know we are making an impact)		Assurance rating
5 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**GREEN**
Controls • Standardised highlight reports produced which include milestone plans, financial information and roles and responsibilities	**Gaps** None **Action** None	**Internal assurance** • Highlight reports in place and stored on SharePoint going back to January 2021 **External assurance** None	**Gaps in assurance** None **Actions** None	
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
6 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Controls • Developing maturity of PMO to support, check and challenge of reporting	**Gaps** • Lack of resource within PMO to complete fully. There has been a review and an increase in programme managers supported by our clinical directorates (through provision of 8a resources through a partnering approach). **Action** • Gap addressed no further action. Gap and action to be closed.	**Internal assurance** • Business case approved to recruit to team to fulfil action. **External assurance** None	**Gaps in assurance** None **Actions** None	
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
7 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/**	**AMBER**

			Actions to address gaps	
Controls • External specialist resource is being brought in where appropriate to provide necessary skills, knowledge and capacity	**Gaps** • CMHT Programme Manager/Project Lead position – has been recruited to and relates to the update on the gap under control 6. **Action** • None	**Internal assurance** • Job description being reviewed by People Directorate prior to advertising. **External assurance** None	**Gaps in assurance** None **Actions** None	
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
8 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Controls • Key project documentation templates in place	**Gaps** • Suite of templates in place but not effectively rolled out across the Transformation Portfolio due to when the programmes were started **Action** • The FPC TOR should be revised to include responsibilities for the Committee for: -Receiving reports from Transformation Board - -Delivery and oversight of the transformation programme (although it does reference the Digital Transformation Strategy). Target date 31/05/22 – **Progress** - *FPC TORs updated approved at FPC July 2022 for onward sharing at Board.* Action closed	**Internal assurance** • Suite of templates available. All new projects and programmes use the new templates. **External assurance** None	**Gaps in assurance** None **Actions** None	

	• Improve project/programme document management including:
	  • Expectations for maintenance and storage of project and programme documentation that is considered core (both operationally and strategically). This should include which documents should be stored where, version control arrangements.
	  • Operational responsibility for programme staff for maintaining and storing documents
	
	• **Progress -**Document management system is under review – due date 31/5/2022 (Zoe Sibeko) *interim arrangement put in place as per update to Audit Committee.*
	• Complete the roll-out of common core agenda elements to all programme boards . **Progress -** All completed by 30/06/2022		

CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
9 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
<u>Controls</u> • Portfolio Risk and issue register and milestone in place	**<u>Gaps</u>** • Risk and issue register for portfolio is not kept up to date. The individual risks are recorded and managed and highlighted to the Transformation Board and Finance ad Performance Committee. Activity to take place to bring this up to date. They are received at each of the meetings and are on Ullyses and updates are provided in the monthly highlight reports in a section on top risks. Risks are also flagged on the summary page of the Transformation report to FPC and Board as a golden thread. **<u>Action</u>**	**<u>Internal assurance</u>** • *To be identified* **<u>External assurance</u>** None	**<u>Gaps in assurance</u>** None **<u>Actions</u>** None	

	• None			
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
10 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Controls • Community of Practice in place to share knowledge and experiences between the Transformation Programme/Project Managers • Programme Board TORs all reviewed against new standard and revised where necessary	**Gaps** No current gaps	**Internal assurance** • Evidence of monthly meetings **External assurance** • None	**Gaps in assurance** None **Actions** None	

AIM 3: EFFECTIVE USE OF RESOURCES	**STRATEGIC PRIORITY:** Transformation: Changing things that will make a difference
RISK REF: 0027 **RISK CREATED:** 19/11/2021 – re-worded – June - approved at July 2022 Finance and Performance Committee for submission to Audit & Risk Committee and Board	**DETAILS:** There is a risk of failure to engage effectively with system partners as new system arrangements are developed caused by non-participation in partnership forums, capacity issues (focus on Trust), difficulty in meeting increased requirement to provide evidence/data potentially at pace and volume, lack of clarity around governance and decision making arrangements resulting in poorer quality of services, missed opportunities to participate or lead on elements of system change and potential increase in costs

Executive lead: Director of Strategy **Board sub – committee oversight:** Finance and Performance				**Risk type:** Business		**Risk appetite:**			**MODERATE**
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	**4**	**3**	**12**	**Last Review:**	2/11/22	**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**4**	**3**	**12**	**Next Review:**	30/11/2022	**X**			

Summary update

- Changes in blue
- *We may now start to see changes following establishment of the Integrated Care Board (ICB) on 1 July 2022 . There is national guidance on how ICB and ICP will develop their strategies and plans by May 2023.*
- *The SHSC Engagement Map is being updated with latest changes*
- *No changes were proposed to residual or target scores*
- *Note – as previously reported additional BAF risks will need to be added to reflect system BAF risks when developed and we will in turn have to escalated Risk to those BAFs where appropriate*

CONTROLS & MITIGATIONS		ASSURANCES/EVIDENCE (how do we know we are making an impact)		Assurance rating
1 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Control • Trust Board members engaged with and part of system-wide governance, delivery and partnership boards at system and place level. We have mapped out the external meetings already attended by Chair and CEO engagement meetings, Executive Directors, continuously updated as arrangements change. As part of the strategic priorities there is partnership working with Sheffield PLACE, Provider Alliance, SYICS and the University	**Gaps in control** • Some gaps remain in our engagement of Trust Board members for external forums related to housing, education and employment services. We have been engaging with the Sheffield Health and Care Partnership group. PK is linked into Housing. HRD meetings link in on some of these issues • Need to determine if there are further system-wide partnership forums (ICS, PLACE and Collaborative) that the Trust should be equally engaging with to support delivery of plans. • System governance infrastructure is also going through a period of transition. **Actions** • Continue to proactively engage – as part of new place arrangements which are developing as part of the whole ICS change • The engagement map is being updated to reflect the latest changes by the end of November 2022. • Map the system governance on a page to support NEDS in understanding how Place , Collaborative, ICB and special commissioning operates by the end of November	**Internal assurance** • CEO and Chair's briefing and report to Board provides an overview of system and system governance arrangements. • All reports to Committees and Board are prompted to consider the partnership implications arising from the report. • Regular meetings with Sheffield LA, PLACE, ICS and Provider Alliance **External assurance** • Future review from CQC and NHSE/I will seek views from system partners. • Link into Outcomes group in PLACE. • New arrangements are now emerging • Priorities workshop took place in October	**Gaps in assurance** Future CQC and NHSE/I reviews will not be as frequent. • Orientation of enquiry from CQC will be whether partnership working is effective. • Not all reports include sufficient consideration of partnership working. **Actions** • Reflect in planning for CQC visit ongoing.	

CONTROLS & MITIGATIONS		ASSURANCES/EVIDENCE (how do we know we are making an impact)		Assurance rating
2 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/**	**AMBER**

			Actions to address gaps	
Control • Programme in place to review and update core strategies by June 2022. • Each strategy will develop and agree a programme of work to implement each strategy. There will be an agreed reporting cycle to report progress to each of the responsible committees and Board.	**Gaps in control** None **Actions** None	**Internal assurance** • Agreed timeline for development and delivery of the strategies was regularly reported to Board up to March 2022 and triangulated with the Board forward plan. Completion is due in June 2022. Is this finished? • Strategies and associated implementation work plans are in place. **External assurance** • NHSEE/I and CQC Well-Led monitoring	**Gaps in assurance** None **Actions** None	
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
3 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Controls • Stakeholder analysis matrix and engagement plan will form part of each strategy implementation plan.	**Gaps** • Still under development for the final strategies not yet approved by the Board. **Actions** • PIDs are being developed for each of the strategies – some are in place and others to be finalised following gap analysis – to be completed in December 2023.	**Internal assurance** • Board sub-committee review of each strategy prior to approval. • Engagement with the Council of Governors. • Quality Accounts **External assurance** • CQC and NHSE/I Well-Led monitoring.	**Gaps in assurance** • Detailed implementation plans have yet to be finalised for every strategy therefore stakeholder and engagement plans are yet to be fully completed **Action** • Standardised implementation plans for Trust strategies and	

			operational plan to actively consider and identify how partnership working will support delivery of the objective – due date 30/06/2022 (Jason Rowlands) • **Progress –**implementation plans are being finalised for each of the eight enabling strategies, scheduled for end of November/ early December. • Stakeholder engagement plans are being completed as part of the PID for each strategy – to be completed by end of November/ early December. [JR]
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**	**Assurance rating**
4 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps** **AMBER**
Controls • Transformation Board oversees delivery of strategic transformation priorities and reviews effectiveness and outcomes from system engagement and impact on programmes. • Monthly highlight reports from each strategic transformation programme.	**Gaps** • Identifying the explicit interaction with the ACP/HCP and the new ICS governance strategy **Action** • Transformation Board to consider the most effective way to progress a strategic appraisal of ongoing partner relationships **Progress** – Strategic appraisal of ongoing partnerships is underway and will be brought back to Board as part of the strategic direction refresh – original due date 30/6/2022 (Jason Rowlands) this will link in with the 5 year plan and strategic direction and context of the 5yr plan will go to the FPC in November and the Board in December	**Internal assurance** • Project Initiation Document (PID) setting out the engagement arrangements including the stakeholder analysis. • *Report to Board in June 2022 included detail on stakeholder engagement by project.* **External assurance** • Significant assurance received from Internal Audit of transformation programme.	**Gaps in assurance** None **Actions** None

	(workshop) and then Board for approval in January 2023		

BOARD ASSURANCE FRAMEWORK 2022/2023 – Risks overseen by People Committee updated for receipt at the November 2022 BOARD

AIM 2: CREATE A GREAT PLACE TO WORK	**STRATEGIC PRIORITY:** Transformation – Changing things that will make a difference
RISK REF: BAF.0013 **RISK CREATED:** 07/05/2021 – *re-worded June 2022 approved at July People Committee for submission to Audit & Risk Committee and Board*	**DETAILS:** There is a risk that we fail to identify key cultural and work pressures impacting on staff health and wellbeing and delivery of services, leading to ineffective interventions; caused by failure to engage with staff in a meaningful way around concerns raised in the staff and pulse surveys as well as through engagement with, and demonstration of the values; and failure to implement demonstrable changes resulting in low scores on the staff survey (low morale), high sickness absence levels and negative indicators for quality of care.

Executive lead: Executive Director of Workforce **Board sub – committee oversight:** People				**Risk type:** Workforce		**Risk appetite:**			**LOW**
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	**3**	**4**	**12**	**Last Review:**	31/10/22	**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**3**	**2**	**6**	**Next Review:**	December date to be confirmed	**X**			

Summary update

Changes are in blue

- Committee reaffirmed and agreed
  - the risk type for this should be 'workforce'.
  - the risk appetite should remain as LOW.
  - the current risk score should remain 3 x 4 = 12
  - the target risk should be changed to 3 (severity) x2 (likelihood) =6 (given for a LOW appetite it should be between 5 and 8) **Board to endorse this change**
  - Actions have been reviewed and there has been some movement of assurances to the controls section

CONTROLS & MITIGATIONS		ASSURANCES/EVIDENCE (how do we know we are making an impact)		Assurance rating
1 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	***AMBER***
Control • Staff Health and Wellbeing group monitoring delivery of the People strategy and reporting to the People Committee. • ICS HRD Deputy Network • ICS staff Health and Wellbeing Group • National Wellbeing Guardian Network • Flu and Covid 19 campaigns • Regular reporting to committees • Reporting to the ICS (including on HWB) • Long Covid support available virtually (by demand from participants) at SHSC and via the ICS	**Gaps in control** **Action** • Embed well being conversations target date 31/8/2022 (Sarah Bawden) **Progress** –The first wellbeing champions network is planned for 8 November to embed wellbeing training and wellbeing conversations. • Revisit membership of HWB to ensure all groups represented **Progress** – Invites to extend the group issued to review membership at next meeting. To be reviewed at HWB Assurance group 19/5/22 – Co-Chair from WWB had been appointed and in process of identifying who invite should be extended to include clinical operational staff to take effect by the ned of November. Sub-group will be started bi-monthly from December.	**Internal assurance** • Report to People Committee • ~~Report to Transformation Board~~ [people plan no longer goes to Transformation Board therefore this has been removed] **External assurance** • Model Hospital and NHSE/I returns • CQC Well-Led • Internal audit 360 staff wellbeing audit - *Significant assurance*	**Gaps in assurance** None **Actions** None	
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
2 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/**	**AMBER**

			Actions to address gaps	
Control • People Delivery Plan in place • Reports to SHWB group • NHS People Plan and actions for HR and OD • People Plan actions have been refreshed for 2022/23 focussed on the Assurance Group with progress reported to People Committee	**Gaps in control** • Inpatient area focus **Action** • OH Health re-specification (engagement with staff and specification development and tender (previously in action 9174) – Target date 31/07/2022 (Sarah Bawden) **Progress** • Update - Tender process completed successful bidder notified, plan for standard contractual 12 week transition from October 2022. STH to commence delivery from 1 January 2023.	**Internal assurance** • Reports to People Committee **External assurance** • CQC Well-Led • Internal Audit (360 assurance) focussing on wellbeing - Significant assurance	**Gaps in assurance** • Recommendations on governance to record completion of action milestones (people delivery plan which *was* being refreshed February 2022) **Actions** • Assurance groups to report on completion of milestones as part of scheduled update reports to People Committee. Confirmed this is in place.	
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
3 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Control • HWB Framework in place • NHSEI National Wellbeing lead and ICS Wellbeing Group • Reports to committee • Trailblazer community of practice framework is in place	**Gaps in control** • Self-assessment has limited clinical operations input **Action** • HWB network to be established proposal to HWB group February 2022 – target date 31/08/2022 (Sarah Bawden) **Progress** - Survey issued, some champions appointed, further work to establish network ongoing as part of a HWB system. In progress of reviewing leadership support to staff wellbeing. **Action**	**Internal assurance** **External Assurance** • We participated as a trailblazer to test out the HWB framework trailblazer (NHSEI) community of good practice • National NHS HWB framework diagnostic – this is an assessment tool and was reported into HWB assurance group and fed into the refreshed delivery plan from 2022/23.	**Gaps in assurance** None **Actions** None	

	• Undertake diagnostic against wellbeing framework to inform the People Strategy review.		

AIM 2: CREATE A GREAT PLACE TO WORK	**STRATEGIC PRIORITY:** Transformation – Changing things that will make a difference

RISK REF: BAF.0014 **RISK CREATED:** 07/05/2021 – *re-worded June 2022 approved at July People committee for submission to Audit & Risk Committee and Board*	**DETAILS:** There is a risk of failure to undertake effective workforce planning to support recruiting, attracting and retaining staff to meet current and future needs caused by ineffective workforce planning, insufficiently attractive flexible working offer, competition, limited availability through international recruitment, reluctance of staff to remain in the NHS post Covid19, any national ICS requirements resulting in a negative impact on delivery of our strategic and operational objectives and provision of high-quality safe care.

Executive lead: Executive Director of People **Board sub – committee oversight:** People				**Risk type:** Workforce		**Risk appetite:**			**MODERATE**
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	**4**	**4**	**16**	**Last Review:**	31/10/22	**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**3**	**3**	**9**	**Next Review:**	December – date to be confirmed	**X**			

Summary update

Changes are in blue

Committee reaffirmed and agreed that

- The risk appetite should move to MODERATE from LOW
- The current score to remain 4 x 4 = 16
- Approved movement of the target risk score to 3 (severity) x3 (likelihood) =9 to fit with target risk requirements for a MODERATE score. **Board to endorse this change**
- Progress status has moved from some slippage to on track' for example progress with international recruitment and work to develop the workforce planning dashboard progressing.
- Some actions for gaps in controls and assurances have been clarified and work is ongoing to clarify remaining gaps. Gaps and assurances have been reviewed and a new control has been added with some movement of assurances to the controls section
- The committee noted the need for access to more detailed data to fully understand the vacancy factor; the roll out of the roster early the new year is expected to have a positive impact on data quality and it was agreed at the committee the data presented will be separated by service line in the future which will provide a further control and assurance.

CONTROLS & MITIGATIONS	ASSURANCES/EVIDENCE (how do we know we are making an impact)	Assurance rating

1 - Controls	Gaps in control/Actions to address gaps	Internal/External assurance	Negative assurances or Gaps in assurance/ Actions to address gaps	AMBER
Control • WPG monitoring delivery and reporting to People Committee • GAP Recruitment group (nursing) • Weekly reporting on vacancies for HCSW to meet funding specification • TRAC reports feed into R & R group to oversee delivery plan • People Delivery Plan for 2020/23 signed off at People Committee March 2022 due for re-approval March 2023 • Annual learning needs analysis undertaken to inform Trust training plan priorities for investment *[from BAF risk 0019]* • Developing a career pathway for support workers – business case agreed September 2021. Project Board in place and membership and TOR agreed *[from BAF risk 0019]* • Ensure the apprenticeship level is fully utilised and prioritised for new roles/progression pathways for existing staff and that we meet our public sector apprenticeship targets *[from BAF risk 0019]* • Recruitment optimisation workstream reporting into the agency reduction project	**Gaps in control** • Recruitment group focussed on nursing and HCSW only. • Study leave policy with all relevant changes has been updated and approved July 2022 to support new process for learning needs analysis. *[from BAF risk 0019] study leave policy with all relevant changes updated and approved – Action closed* • Failure to recruit a suitable candidate for the Project Officer role at the third attempt for the support worker career pathway work – JD/Ps amended. *[from BAF risk 0019]* **Actions** • Implement performance report for workforce planning and transformation group. Progress – regional dashboard in development. SHSC work commenced June. Attain commissioned to develop the dashboard (work commenced April) *[from BAF risk 0019* Demo of dashboard going to Workforce Transformation group September - Sept to Dec 2022 timeframe. Demo of dashboard has been completed and testing to be clear about requirement to be included in the dashboard to take place by end of Dec 22.	**Internal assurance** • Bi-monthly reporting to People Committee and Board • HR team have engaged with services to support completion of Training Needs Analysis templates to identify their needs *[from BAF risk 0019]* • Project Boards report to workforce assurance group *[from BAF risk 0019]* • Workforce assurance group apprenticeship levy reported through the Workforce Assurance Group *[from BAF risk 0019]* • Now reporting full use of the levy and no unused funds into People Committee. **External assurance** • ICS Recruitment and Retention group attended by Deputy Director of People • Bi-monthly reporting to Quality Board (external group i.e. NHSE/I, CQC, CCG *as was*) • National People Plan reporting to ICS – we are required to provide evidence on meeting priorities so ICS can respond on national level.	**Gaps in assurance** • Dashboard information needs to reflect KPIs • Action log and planner still to be fully implemented for workforce planning and transformation group – aiming to use AAA approach. Will be fully in place from July 2022 [*from BAF risk 0019]* • **Actions** Recruited external consultancy support 'Attain' using improvement monies to support development of a dashboard. Similar work underway at the ICS so the new system will align with work on system level. [*from BAF risk 0019]*	

		• ICS partnership working on workforce dashboard [from BAF risk 0019] • Quarterly data benchmarking report (apprenticeship levy data collection) to Health Education England on behalf of ICS [from BAF risk 0019]		
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
2 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Control • Recruitment and Retention Group to support identification of gaps – see new Gap in control will be addressed once merged group in place	**Gaps in control** • Data to support accurate vacancy reporting being addressed with People Directorate and Finance • Workforce Transformation and Recruitment and Retention groups to merge to support new merged BAF risk. **Action** • Improve workforce data quality. Create a robust system that monitors vacancy rates. Workforce review process commenced data issued for review by services by 31 10 22. Next phase is updating changes to ESR. • Recruit first cohorts of International nurses (x20) by February 2023 at the latest – target date 28/2/2023 (Sarah Bawden) **Progress –** Recruited nurse recruitment lead. Contracted with NHSP to recruit nurses. Interviews planned for March *2022.* OSCE training packages sourced. Paper to BPG 15.2.2022 and costs approved. Monthly	**Internal assurance** • Recruitment and Retention Group reports to People committee quarterly and additionally as requested. • Deep dive took place into retention at People Committee in April 2022 **External assurance** • National People Plan reports into ICS	**Gaps in assurance** • Dashboard information **Actions** • SB to look at actions required around addressing gaps related to dashboard information (to be identified Dec 2022)	

	meetings with NHSEI to review progress. Progress has been made with offers to 17 international nurses. Confirmation for 7 still progressing.			
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
3 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	***AMBER***
Controls • HCSW and Recruitment Cell weekly meeting with NHSEI (+direct support)	**Gaps** • Not all staff covered at this stage **Action** • SB to identify action to address gap (to be identified Dec 2022)	**Internal assurance** • Recruitment and retention group **External assurance** • NHSEI Performance workforce returns + direct support	**Gaps in assurance** None **Actions** None	
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
4 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Controls • TRAC system in place to manage ALL recruitment. Tracked and reported to People Committee	**Gaps** • Users require additional training and support **Action** • Review of transactional processes using established microsystem looking at onboarding and Day One Ready initiative – target date 30/6/200 (Sarah Bawden)	**Internal assurance** • Reports to Recruitment and Retention Assurance Group and to each People Committee meeting **External assurance** • NHSEI and People workforce return (PWR) reporting which	**Gaps in assurance** ESR data poor quality **Actions** • Interim support engaged 18/7/22 to progress plan of action to address data quality (engaged for 6 months –	

	Progress – Day One Ready Microsystem will now encompass all employee lifecycle activities and renamed Employee Lifecycle microsystem. Transactional process workshop October 2021. Input to People Directorate review to align transactional processes with directorate and provide greater clarity of sight. Continue use of microsystem and focus/timescales to be confirmed Action closed. • Training and further guidance for recruiting managers on TRAC – target date 30/6/200 (Sarah Bawden) Confirmation to be provided if this is closed given rolling programme of training is in place. **Progress –** Training provided by Recruitment Manager. Ongoing and rolling programme of bitesize training and review of training so far being undertaken as part of benefits realisation programme. Costs for training being sought from TRAC.	triangulates and checks our data	timeline on data quality to be confirmed)	
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
5 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	***AMBER***
Controls • Nurse Recruitment Group established to review attraction initiatives	**Gaps** • Membership needs to be reviewed **Action** • SB to confirm action (to be confirmed Dec 2022)	**Internal assurance** • Reports to Recruitment and Retention Group **External assurance** • PWR reporting and NHSEI governance for international recruitment	**Gaps in assurance** None **Actions** None	

AIM 2: CREATE A GREAT PLACE TO WORK	**STRATEGIC PRIORITY:** Transformation – Changing things that will make a difference
RISK REF: BAF.0020 **RISK CREATED:** 01/04/2021 re-*worded – June - approved at July 2022 People Committee for submission to Audit & Risk Committee and Board*	**DETAILS:** There is a risk of failure to enable a paradigm shift in our culture through delivery of the overarching cultural change programme, caused by a lack of engagement in the wide range of leadership activity and opportunities for development provided, inability to adapt and engage to enable organisational change, resulting in failure to improve the culture of the organisation, ineffective leadership development, application of learning, engagement with our values, emergence of closed subcultures and low staff morale which in turn impacts negatively on service quality and service user feedback.

Executive lead: Executive Director of People **Board sub – committee oversight:** People				**Risk type:** Quality & *Workforce*		**Risk appetite:**			**MODERATE**
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	**4**	**3**	**12**	**Last Review:**	31/10/22	**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**3**	**3**	**9**	**Next Review:**	December date to be confirmed		**X**		

Summary update

Changes in blue

Committee reaffirmed and agreed that:

- The risk appetite should move to MODERATE from LOW.
- That the current risk score of 4 x 3 = 12 should remain unchanged
- The target score was updated to 3 x3 =9 to fit revised risk appetite which was approved by the committee. **Board to endorse this change**
- That the risk type 'Workforce' is most appropriate
- Actions have been reviewed and there has been *some movement of assurances to the controls section*

CONTROLS & MITIGATIONS		ASSURANCES/EVIDENCE (how do we know we are making an impact)		Assurance rating
1 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Control • NHSEI Culture and Leadership framework (CLP) to underpin SHSC Leadership and Culture Development programmes • Reporting to People Committee • Staff Engagement Steering Group established to increase engagement and reporting to People Committee • NHSEI National and regional People Plan	**Gaps in control** • Culture champions *need* to be aligned with NHSEI Culture and Leadership programme • Mechanism needs to be in place to gather and consolidate (triangulate) all staff data and themes. **Action** • Develop a framework for Organisational Development– Target date 30/06/2022 (Caroline Parry) **Progress –** Head of OD commenced 10 January 2022. Recruitment to OD and Leadership team has commenced. Refreshed delivery plan proposes key elements of OD Framework: Leadership development, management development, team development, talent development, refreshed values rollout, Just and Learning culture and staff engagement. People Committee March 2022. Development of a framework is being progressed by Head of Organisational Development and a Board workshop is currently planned for October final date to be confirmed. Confirmation to be provided on date for completion of the framework (post Board workshop session to reflect feedback) and framework on a page summarising key component. OD assurance group 15.8 to sign off objectives for framework and then People Committee (progress updated to be provided in Dec 2022)	**Internal assurance** • Organisational Assurance Group reporting into People Committee bi-monthly • Transformation Board Report monthly **External assurance** • Quality Board bi-monthly report • ICS HR Directors Group (NHS HR Futures report) – this is a long term 10 year strategy to make improvements in HR and OD in the NHS to support delivery of the NHS people plan	**Gaps in assurance** None **Actions** None	

	• Refreshed SHSC values to underpin cultural vision – Target date 31/05/2022 (Sarah Bawden) **Progress –** Values were approved by the Board In September 2021 and communicated via JARVIS *(intranet)* and discussed at Autumn away days. Staff side session held January 2022. Implementation plan to be developed to embed refreshed values within core People Directorate functions. For example recruitment and PDR. • Refreshed values included in updated PDR documentation for 2022 PDR window. Values included in SHSC developing as leaders, will develop further for cohort 2. • Using 'Big Conversation' methodology to explore what our values mean in practice to our staff, will use this establish a shared set of behaviours to support our values.			
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
2 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**GREEN**
Control • 2022-23 Refreshed People Delivery Plan (OD Framework)	**Gaps in control** Plan to be presented for final approval at People Committee **Actions** • OD actions refreshed as part of the update of the People Plan for 2022/23, presented to People Committee May 2022.	**Internal assurance** • People Committee received refreshed deliverables in 2022 • People Pulse survey **External assurance** • NHS National Survey – amalgamated benchmarking across sector • NHS People Plan – provides assurance that SHSC People Strategy was developed taking	**Gaps in assurance** None **Actions** None	

		account of the NHS people plan		
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
3 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Controls • Team SHSC Developing as Leaders (Leadership Development Programme)	**Gaps** • Maximum capacity 30 per cohort. First cohort 28 and roll out will follow • Lack of data to identify eligible leaders **Action** • Co design leadership development programme with Arden and GEM (these are part of a Commissioning Support Unit, delivering leadership development)– Target data 31/08/2022 (Caroline Parry) **Progress –** Co design group will track alongside delivery until July 2022 when group will reform to an internal delivery group. Evaluation of co-design and other information in August to inform future group TOR. The TOR would go to the OD Assurance Group, and People Committee and would close as they would be used for future roll out of the programme. Will engage line managers as we did with the first cohort to identify participants, ensure diversity and achieve target of 30. Improvements in data in progress, will support accurate identification of eligible leaders (also use participants targeted for the monthly leaders calls). • Cohort 1 completed 11.7.22. Arden and GEM contribution concluded 19.7.22 follow on review in September 2022.	**Internal assurance** • Led by and agenda approved by CEO **External assurance** • National staff survey results 2021 – staff engagement scores • External benchmarking report	**Gaps in assurance** • Low engagement scores – confirming with operational lead this is from staff survey and pulse survey data **Actions** • If as above, action planning at service level in progress, staff engagement as a KPI as part of the Performance review meetings with the Exec team with services reporting progress on action plans (based on people promise themes).	

	• Agile Mindset & Behaviours leadership programme – Chief Executive is the senior sponsor. Cohorts 1 & 2 underway with Cohort 3 starting 7.09.22. • Team SHSC: Developing as leaders Cohort 2 - Approval received to recruit to Cohort 2 Developing as Leaders Faculty to be formed - first meeting 16.9.22. Planned 6 Day programme 12 October start until April 2023		

AIM 4: ENSURE SERVICES ARE INCLUSIVE	***STRATEGIC OBJECTIVE:*** *Transformation: Changing things that will make a difference and Partnership Working (PLACE (equality) addressing deprivation, Provider Alliance (forensic and specialist services) ICS and University (improving outcome measures)*
RISK REF: No specific risks identified at this time	***Cross References to risks which cover inclusivity – Those covered at this committee are in bold*** • *Aim 1 - Deliver Outstanding care BAF risks 0023, 0024, 0025, 0029* • *Aim 2 - Create Great Place to Work BAF risks* ***0013,0014,0020*** • *Aim 3 - Effective Use of Resources BAF risks 0027*

BOARD ASSURANCE FRAMEWORK 2022/2023 – BAF risks overseen at Quality Assurance Committee updated for receipt at November 2022 BOARD

AIM 1: DELIVER OUTSTANDING CARE	**STRATEGIC PRIORITY: COVID19 –** Recovering Effectively
RISK REF: BAF.0023 **RISK CREATED:** *Risk re-worded June 2022 – approved at July 2022 Quality Assurance Committee for submission to Audit & Risk Committee and Board*	**DETAILS:** There is a risk that service users and staff are exposed to an avoidable spread of infectious diseases caused by a failure to consistently maintain appropriate Infection Prevention Control arrangements and safe working practices.

Executive lead: Executive Director – Nursing and Professions **Board sub – committee oversight:** Quality Assurance				**Risk type:** Safety		**Risk appetite:**			**MODERATE**
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	**4**	**3**	**12**	**Last Review:**	02/11/22	**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**3**	**3**	**9**	**Next Review:**	December date to be confirmed	**X**			

Summary update

Changes are in blue.

- *the updated description of the risk – **Board are asked to endorse this change***
- *Noted receipt of the HSE inspection looking at sharps safety and been issued with an improvement notices around consistently applying safe working practices to ensure staff are protected from needle stick injuries and prevent spread of infection*
- *The Winter 2022/23 Flu and Covid vaccination campaign has commenced*
- *The risk rating is not proposed to change - it was noted that although impact is being mitigated; likelihood does not reduce at the current time under circumstances of rising background levels of air borne infection.*
- *It was confirmed the target risk score should be 3 x 3 = 9 - **Board to endorse this change.***

CONTROLS & MITIGATIONS		ASSURANCES/EVIDENCE (how do we know we are making an impact)		Assurance rating
1 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Controls • Early implementation of the occupational health contract in relation to sharps injuries to support ensuring full compliance • We have put in place a sharps management group to meet on a weekly basis to ensure we deliver the HSE improvement plan • IPC committee in place with annual work plan attached • Support from the Director of Infection Prevention Control for the IPC nurse • Highly accessible vaccine clinics for all staff made available • Reporting and decision making through Bronze, Silver and Gold command structure • Procurement cell that monitors PPE on a daily basis to ensure a ready supply and to meet Trust needs • Implementation of the operational command structure (Bronze, Silver, Gold) • Adherence to national guidance for the prevention and control of infection including the guidance on testing,	**Gaps** • Variable adherence to fundamental standards of hand hygiene • *Some service* Users refusal to wear PPE (masks) • When in outbreak not all Service Users agree to isolate • In-patient estate does not facilitate adequate ventilation • *Ina*bility to influence the uptake of vaccine in some staff • Limited capacity to fill staffing gaps in the event of major outbreak • Lack of confidence in available staff data in respect of Covid vaccination from Winter 2022 • Complacency caused by an ongoing global pandemic • Lack of consistent staffing with right IPC training **Actions** • Stepped up hand hygiene training with use of light box in inpatient units. New and not yet embedded • We continue to talk to service users in circumstances where isolation and mask wearing is recommended. • We continue to advise on 'hands, space, face' • We continued to use influencers to land the message for vaccine hesitant groups that are recognised as such	**Internal assurance** • Review following Covid19 wave to reflect on learning • Infection Control Lead Nurses will lead activity, in the event of an outbreak to mitigate and prevent further spread of infection • Reporting on recovery from Covid to Board of directors • Vaccination performance reporting • IPC mandatory training • On site presence of senior and executive leaders • Improvement plan in relation to HSE inspection • IPC BAF refreshed and presented to the IPC committee meeting in October • New Infection Prevention Control Lead has reviewed all IPC arrangements **External assurance** • Daily situation Report to NHSE/I covering staff absence, number of beds and number of patients with Covid19 • Outbreaks and deaths in Trust reported to NHSE/I • Learning from review reported to NHSE/I • Planned internal audit – scope has been agreed **Negative assurance** • HSE inspection improvement notice	**Gaps in assurance** • Not all staff eligible staff will take up the 4th vaccine offer **Actions** • Continued communication to underscore the benefit of the vaccine	

management and treatment of patients. • Implementation of robust cleaning schedules • Assessments for staff, vaccine availability and monitoring of uptake • Covid19 clinical advisory group operational • Working Safely Group in place • Robust supply of PPE updated daily • Agile working place to enable work from home • Reduced physical contact between staff and patients • Implementation of current guidance to support visiting in line with national guidance • Incident control centre operational in line with national guidance • Robust reporting and management of any outbreaks • 24hr staff absence report to inform resource decisions • Individual risk assessments monitored by HR • Environmental Risk assessments monitored by H & S team • Ability to move to enhanced cleaning when in outbreak or risk of infection incrases – newly added • Fully recruited IPC team – newly added • IPC practices and approach to Covid is embedded – newly added	• We have a recruitment plan for temporary and substantive staff and we have improved the bank pay offer and band 5 payments to increase retention • Critical areas identified and being reviewed as part of business continuity planning in response to potential industrial action. • We continue to review the national guidance and follow this and uptake of vaccines being monitored; additional controls in place with the autumn 2022 vaccination programme.		

• Latest Flu and Covid vaccination programme – commencing October 2022				
Controls & Mitigations		**Internal/External assurance**		**Assurance rating**
2 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**GREEN**
• Covid risk register in place • *Command structure* • Access to health surveillance data for Sheffield and South Yorkshire to inform necessary next steps	**Gaps in control** None **Actions** None	**Internal assurance** • Coronavirus weekly Sit Rep dashboard reported in Silver and Gold group meetings • Risk score is reviewed with every change in guidance and legislation • Shared with Audit and Risk Committee and Board **External assurance** • Weekly sit rep is reported externally to ICS and Local Authority. • Risk score is reviewed with every change in guidance and legislation	**Gaps in assurance** None **Actions** None	

AIM 1: DELIVER OUTSTANDING CARE	STRATEGIC PRIORITY: CQC - Getting back to good continuing to improve
RISK REF: BAF.0024 **RISK CREATED:** *June 2022 Risk re-worded June 2022 – approved at July 2022 Quality Assurance Committee for submission to Audit & Risk Committee and Board*	**DETAILS:** There is a risk of failure to anticipate issues with, and achieve, maintain and evidence compliance with fundamental standards of care, caused by capacity and capability issues, cultural challenges, high use of agency and vacancy in some teams, use of out of area placements, lead in time for major estate changes, resulting in avoidable harm or negative impact on service user outcomes and experience, staff wellbeing, reputation, future sustainability of particular services *which could result in* regulatory action.

Executive lead: Executive Director – Nursing and Professions /Medical Director **Board sub – committee oversight:** Quality Assurance				**Risk type:** Quality		**Risk appetite:**			**LOW**
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		***PROGRESS STATUS***			
Residual Risk (with current controls)	**4**	**3**	**12**	**Last Review:**	**03/11/12**	***On track***	***Some Slippage***	***At risk***	***Completed***
Target Risk (after improved controls)	**4**	**2**	**8**	**Next Review:**	December date to be confirmed		**X**		

Summary update

Changes are in blue

- *Ownership of this risk should be shared by the Director of Nursing, Professions and Operations with the Medical Director as SRO for 'Back to Good' –* ***Board to endorse this change.***
- *Back to Good – 6 improvement actions are in exception – two are proposed for closure following PMO Board.*
- *No proposed change to risk scores*

CONTROLS & MITIGATIONS		ASSURANCES/EVIDENCE (how do we know we are making an impact)		Assurance rating
1 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Control • Recovery teams improvement plan • Back to Good improvement actions • Active recruitment plan with Clinical Lead for recruitment in post from January 2022 we have a forecast for posts recruited to February 2023 • Clinical Establishment reviews 2022/23 is being conducted • HCSW regional employment programme • Implementation of current People Plan • Service lines and IPQR embedded ensuring oversight • Clinical Directorate leadership oversight with additional nursing and clinical lead to support pace of improvements • Daily safety huddles in quality team • Experts by experience • OD plan implemented • Removal of two seclusion rooms on two wards • Reducing restrictive intervention strategy implemented with evidence of impact • Safe wards in place • Ward Manager and Matron development plan completed	**Gaps in control** • *Back to Good – Back to Good – 6 improvement actions are in exception (as at 03/11/22 but are expected to reduce in time for verbal updating at QAC)* • Reliance on temporary workforce to cover vacancies, maternity leave and sickness. Delay in new starters • Lead in time for international recruitment longer than anticipated. • Number of people applying for posts does not match vacancies • Increasing rate of turnover in some teams • Not all ward manager posts are filled by substantive appointments • We are now consulting on the outcome of the establishment reviews and therefore the new establishments are not fully implemented • Lack of reliable workforce data by team • Tendable not being utilised consistently • Difficulty in keeping pace with recruiting to new posts created by investment • Covid19 driven absence and exhaustion and low morale following a long running pandemic creating some burnout • Lack of impact of the HCSW employment programme. • Additional capacity for nursing will take time to have impact • Experts by experience have found making an impact in wards a challenge • Two wards continue to utilise seclusion until new ward environments are available	**Internal assurance** • Back to Good monthly reports • EPR monthly programme Board reports • ACM monthly Board reports • Transformation Board monthly reports • Staffing reports to People Committee • IPQR monthly report • Progress report on Clinical Establishment Reviews to People and Finance Committees • Leadership Recovery plans • Learning lessons quarterly report • Complaints report • Staffing report to People Committee • Safeguarding Q1 & 2 reports 2020-21 • Safeguarding development plan progress reports to Quality Assurance Committee • Policy review by Quality Assurance Committee • Quarterly reports to Quality Assurance Committee	**Gaps in assurance** • Use of 136 suite rooms to accommodate people awaiting admission • Delays in community transformation • Recovery plans not impacting waiting times in EWS/SPA and Recovery for allocation • Flow plan is not impacting at a pace we had hoped • Turnover remains high • Outcome of Culture and Quality visit to recovery team July 2022 **Actions** • Flow plan revised and being led by the Clinical Director • Community transformation programme • Utilising a UEC dashboard to understand the blocks in progress – started from July 2022. • Additional focus needed on delayed care – September 2022 • Revised recovery plan for community recovery	

• Safeguarding rapid development plan delivered • Clinical and Social Care strategy implemented • Co-production standards launched • Quality and Equality impact assessment process in place • Ligature anchor point removal plan phase 1 and 2 are completed, phase 3 in planning • Daily operational management of safer staffing • New EPR implementation underway and timescale agreed • Human Rights training • SHSC leadership development plan is being implemented with the first co-designed programme cohort commencing on 28 February 2022 until 11 July 2022. Programme progress is reported into Transformation Board. Commenced as planned • Fundamental standards of care visits underway • Tendable reporting into Clinical Safety • Focus on reducing number of open incident actions	• Phase 3 plan for reducing ligature anchor points will depend on decant solution and take place over an 18 month period • New EPR not yet implemented • Responsible Clinician vacancies • Safe wards not fully embedded • Two acute wards remain mixed gender • Granular team base data not yet embedded • Lack of data on the accessible information standards • Lack of capital to support essential environmental improvements • Slight delay in move of Stanage ward into the refurbished Burbage ward due for occupation on the 28 November **Actions** • Ligature Anchor point removal proramme is continuing and progress reported to therapeutic environment board. • Maple ward will decant to refurbished Stanage ward – date to be confirmed. • International recruitment plan continues. Progress: 2 new starts December 2022 confirmed. Progress is slower than anticipated. • Ward manager and matron development plan agreed for Q4 20/21 and Q1 21/22 to enhance leadership skills and cultural development – Target date 30/06/2022 (Salli Midgley) **Progress** – Programme completed September 2022. • Renewed recruitment plan of national job fairs with 4 sessions planned on 12 March 2022, 26 March 2022, 19 April 2022 and 23 April 2022 – Target date 31/10/2022 (Joanne Simms) **Progress** – four recruitment fairs completed, very few people appointed. Planning for the year ahead underway. Looking to RGN recruitment for support in Nursing Homes.	• Safer staffing report to Board September 2022 • Dormitories removed • Community recovery plans for waits in two teams showing progress • Supervision rate increasing in some teams • Completion of the Safeguarding rapid development plan reported to QAC • Medicines management rapid dev plan completed and reported to QAC • EPR implementation progressing to plan • Experienced EPR implementation partner appointed • Improving performance with incident actions reported in the IPQR • Culture and quality visits **External assurance** • Outcome of December 2021 acute and PICU inspection by CQC – reported Jan 2022 • Section 11 Audit with safeguarding partnerships • Engagement with safeguarding partnerships at Executive level	services presented to Director of Nursing and Medical Director 1 November 2022

	• Commitment to develop team based workforce metrics has been given, this action requires a detailed timeline for delivery – December 2022			
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
2 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Control • Year One Back to Good actions delivered (exception of 3 items rolled into year two) • CQC reinspection demonstrated improvements across Well Led and Older People's services	**Gaps in control** • Acute and PICU services subject to further rapid improvements for reassessment during December. This is now being reassessed following Edenfield. Outcome awaited. • Leadership vacancies at Michael Carlisle Centre **Actions** • Back to Good year two programme underway to complete delivery of action plan to maintain improvements and deliver rapid improvements across Acute and PICU – Target date 31/03/2023 (Salli Midgley) **Progress** – CQC report that was published on 16 February 2022 demonstrated we had delivered actions against the section 29a warning. Significant progress was noticed. New improvement actions are in place. • Matron and substantive Modern Matron appointed to Michael Carlisle.	**Internal assurance** • Fundamental standards visits to take place across PICU and Adult wards • IPQR data **External assurance** • CQC reinspection – Dec 2021	**Gaps in assurance** • Impact of staffing/covid to deliver on actions • Limited progress on team based workforce data. **Actions** • Recruitment plan in place, daily management of staffing resource • Impact of recruitment plan being reviewed by Executive lead further update to be provided in November.	
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
3 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**GREEN**

Controls	Gaps	Internal assurance	Gaps in assurance
• Contract in place and programme established to implement a new commercially supported EPR	None **Actions** – none	• EPR Programme Board chaired by Director of Nursing, Profession and Operations • Programme Board reports to Transformation Board **External assurance** • NHSE/I funding required external reporting	None **Actions** None

AIM 1: DELIVER OUTSTANDING CARE	**STRATEGIC PRORITY:** CQC Continuous Improvement and Transformation - Changing things that will make a difference
RISK REF: BAF.0025 **RISK CREATED:** *11/05/2021 – re-worded June 2022 – approved at Quality Assurance Committee for submission to Audit Committee and Board*	**DETAILS:** There is a risk of failure to effectively deliver essential environmental improvements including the reduction of ligature anchor points in inpatient settings (the therapeutics environment programme) at the required pace caused by difficulty in accessing capital funds required, the revenue requirements of the programme, supply chain issues (people and materials), and capacity of skills staff to deliver works to timeframe required resulting in more restrictive care and a poor staff and service user experience and unacceptable service user safety risks

Executive lead: Executive Director – Nursing and Professions **Board sub – committee oversight:** Quality Assurance				**Risk type:** Safety		**Risk appetite:**			**LOW – MEDIUM**
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	**4**	**4**	**16**	**Last Review:**	02/11/22	**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**3**	**2**	**6**	**Next Review:**	December date to be confirmed		**x**		

Summary update - *Cross reference with BAF.0026*
Updates are in blue

- Committee agreed that there should be a separation of the risk into one around Ligature anchor points (LAP) for which the appetite should be LOW and Therapeutic environments for which the appetite should be MODERATE. This is to be taken forward – for reporting to QAC in January 2023
- The current score 4 x 4 = 16 is unchanged. Committee agreed that the current and target risk score should be reviewed following the separation of these risks.
- Some closed actions had been moved into controls

CONTROLS & MITIGATIONS		ASSURANCES/EVIDENCE (how do we know we are making an impact)		Assurance rating
1 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**RED**
Control • Quality team have assessed the impact of ligature assessments and tightened controls and processes. • Enhanced nursing to manage environmental risks • Implementation of Least Restrictive Strategy 2021 • Revised approach to Clinical Risk Management • Investment in preceptorship to develop the skills of newly registered nurses • Ligature anchor point assessments in place for all environments • Risk heat map implemented for all inpatient wards • Ward managers for all wards • Ward manager and Matron development programme • Implementation of Matrons and Team managers with a focussed span and clear responsibilities April 2021 • Planned environmental improvements to the acute wards	**Gaps in control** • High levels of Band 5 vacancies in some wards with a lack of workforce data to rapidly identify staffing risks • Use of temporary staffing leading to potential inconsistencies in the application of practice standards • Clinical establishments not being worked to and a revised skill mix that has not yet been implemented • Least restrictive Strategy not yet embedded • New Clinical Risk Management Policy and training not yet implemented • Variance in staff understanding of ligature anchor point assessment • Use of temporary staff • Limitations in current approach to clinical risk assessments and management • Environmental safety at work not yet completed • Variance in management capability and experience • Vacancies for responsible clinicians • Delays in the delivery of Therapeutic Environment Programme (TEP) • Vacancies in substantive nurse leadership at Michael Carlisle Centre Lack of outcomes from expressions of interest to the new hospitals bid and the bid for additional capital for the 136 reprovision • Lack of de-escalation space on Endcliffe ward • Stanage Ward team lack of confidence to work without seclusion • Provision of 136 suite not yet completed. **Actions** • The ward works improvement programme (overseen by the Therapeutic Environments Programme Board) commenced w/c July	**Internal assurance** • Capital Group reports • Operational Structure presentation to People Committee • Therapeutic Environment Programme Board reports • Transformation Board reports • Health and Safety audits • IPQR monthly reports – statutory and mandatory training • Board and Executive visits to all wards and teams • Crisis Pathway presentation to Quality Assurance Committee March 2021 • Recruitment forecast confirmed **External assurance** • Evidence based approach to Reducing Restrictive practice implementation	**Gaps in assurance** • Feb 2020 CQC inspection report • CQC inspection reports - August 2020, May and December 2021 (in respect of the environment) **Actions** • Implementation of Back to Good programme and the Therapeutic Environments programme	

• Estate strategy that determines future need for community and ward estates that enables therapeutic and safe care • IPQR used to identify emerging risks • On site presence of senior and executive leadership • Board visits • Matron for 4 acute wards in place July 2022. • Executive team visits on site. • Capital investment in 136 provision achieved.	2021. Consideration was taken on how to accelerate the ward improvement programme. The method chosen was to work on live wards for the programme which covered Stanage, Maple and Dovedale 1 wards. **Progress –** The refurbishment works on Burbage ward have been extended due to unplanned roof works which are necessary. Relocation date is November 2022. As part of this programme of works Stanage dormitories have been eradicated, completed on 3 December 2021. Phase 3 work will be undertaken on a closed ward and will target items such as en-suites, ceilings and a new de-escalation room. Gaps in controls amended as 1) Dovedale 2 war was reopened for admissions, and 2) the Trust now has a Board approved Estates Strategy. • Forecast of new starters in place improving vacancy gap for registered nurses to 6% by February 2022. • Plan to relocate Stanage to a ward without seclusion now agreed.		

AIM 1: DELIVER OUTSTANDING CARE	***STRATEGIC PRIORITY: COVID19 –*** *Recovering Effectively* ***and Transformation: Changing things that will make a difference***
RISK REF: *BAF.0029* ***RISK CREATED: new risk*** *descriptor approved at Quality Assurance Committee for submission to Audit & Risk Committee and Board*	***DETAILS:*** *There is a risk of a delay in people accessing the right community care at the right time caused by, issues with models of care, contractual issues and the impact of practice changes during Covid resulting in poor experience of care and potential harm to service users*
Summary update - *Cross reference BAF.0014* *Changes in blue* • *No proposed change to risk scores* • *Additional strategic priority added – Transformation*	

Executive lead: Executive Director – Nursing and Professions **Board sub – committee oversight:** Quality Assurance				**Risk type:** Safety	**Risk appetite:**	**LOW**
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**	**PROGRESS STATUS**	

Residual Risk (with current controls)	**4**	**4**	**16**	**Last Review:**	02/11/22	**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**4**	**2**	**8**	**Next Review:**	December date to be confirmed			**X**	

CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
1 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**RED**
<u>Control</u> • EWS and SPA service being transformed with PCS • Care for change recovery teams being consulted on • Revised plan to oversee performance of recovery teams presented to Director of Nursing and medical Director 1 November 2022. • Waiting list management initiatives in place to support people while they wait and respond to risk. • Information shared with service users about their waits and what to do if their situation worsens. • Use of the Voluntary Community and Social Enterprise sector to support people who are waiting. • Duty systems for relevant teams respond to immediate risks.	**<u>Gaps in control</u>** • Where there are large numbers of people waiting for a service, we can not reach out to every person on a regular basis, so are reliant on people contacting us if their presentation deteriorates or circumstances change. • Key areas where people are waiting require service transformation (SPA/EWS Recovery and SANNS), so we need to deliver this to resolve the issues, which is taking time. • People waiting for the gender service are required to be seen by a specialist doctor, which are not available due to sickness and recruitment challenges. • Where areas need investment, clear commissioning intentions are required by the ICB to move waits forward. • All areas require clear commissioning specification, which require a review and process implemented by Sheffield place, helping us to really understand who a service is for. **Actions** • Improved oversight of people waiting in recovery teams and EWS and SPA. • This will be progressed by the 31st October 2022. • Identify and deliver early adoption initiatives between primary care mental health and the SPA/EWS to reduce waiting time whilst we prepare the system transformation by 30th November 2022.	**<u>Internal assurance</u>** • Back to Good monthly reports • EPR monthly programme Board reports • Transformation Board monthly reports • IPQR monthly report • Leadership Recovery plans • Learning lessons quarterly report • Complaints report • Quarterly reports to Quality Assurance Committee • Quarterly reports to Finance and Performance Committee. • Community recovery plans for relevant services. • Culture and quality visits • Contracting updates as required. **<u>External assurance</u>** • Negotiation and escalation through commissioning	**<u>Gaps in assurance</u>** • August QAC Waiting Times Paper (also to be sent to FPC) • Recovery plans not delivering downward trajectory in waits. • Not finalised the primary care, recovery teams and SANS transformation plans • Staff vacancies and turnover remains high in some areas. • Lack of agile technology to maintain a high level of contact with people waiting. • Long terms sickness in Gender Service. **<u>Actions</u>** • Clear strategic plan on moving forward the issues raised in the waiting times paper to move forward priorities by 31st October 2022. • Identify services where a realistic trajectory can be achieved to reduce waits by 30th September 2022.	

• Transformation programmes in place to resolve waiting in key services – recovery teams and the single point of access and emotional wellbeing service and Learning Disability. • General manager and service manager development session utilise to promote new practice and share learning. • An improved plan in place to have understanding of risks to people waiting for allocation 1 November 2022. • All staff forums held with the recovery team to find solutions in managing people waiting. • Moving forward ICB place discussions to address waits, re-set service specifications, and explore investment opportunities. • Raising challenges and issues in strategic places, such as, SY NHSE, Autism Learning Disability Board, Place Mental Health Learning Disability Autism and Dementia Board at place. • IPQR framework used to monitor waits of services and review mitigation processes in place. • Undertaking waiting list reviews for key services to	• Continue to work with strategic planners about commissioning intentions that address key wait areas and ensure service specification are finalised for each service by 30th September 2022. • Work with NHSE about the support needed for the Gender Service.	forums at place, ICB and NHSE. • Adherence to the NHS Long Term Plan and the community team framework. • Relevant adherence to NICE guidance. • Adherence to the 4-week waiting standard for relevant core services. **Negative Assurance** • Number and nature of complaints from recovery service users	• Identify contract vehicles that enables us to mobilise VCSE resources to support initiatives and where appropriate workforce gaps by 31st October 2022. • Develop and implement an improvement plan for Gender services by 30th September 2022.

ensure people are in the right place for care.			

AIM 4: ENSURE SERVICES ARE INCLUSIVE	***STRATEGIC OBJECTIVE:*** *Transformation: Changing things that will make a difference and Partnership Working (PLACE (equality) addressing deprivation, Provider Alliance (forensic and specialist services) ICS and University (improving outcome measures)*
RISK REF: No specific risks identified at this time	***Cross References to risks which cover inclusivity*** • *Aim 1 - Deliver Outstanding care BAF risks* ***0023, 0024, 0025, 0029*** • *Aim 2 - Create Great Place to Work BAF risks 0013,0014,0020* • *Aim 3 - Effective Use of Resources BAF risks 0027*