Board of Directors

SUMMARY REPORT	Meeting Date:	24 July 2024
	Agenda Item:	24

Report Title:	**Board Assurance Framework 2024/25**	
Author(s):	Director of Corporate Governance with input from Executive leads.	
Accountable Director:	Deborah Lawrenson, Director of Corporate Governance (Trust Secretary)	
Other Meetings presented to or previously agreed at:	**Committee/Group:**	Executive Management Team (EMT) Board of Directors
	Date:	Executive Management Team (20 June 2024) People Committee (09 July 2024) Quality Assurance Committee (10 July 2024) Finance and Performance Committee (11 July 2024) Audit and Risk Committee (16 July 2024)
Key Points recommendations to or previously agreed at:	The updated BAF for 2024/25 is presented for approval following receipt through the assurance committees. Changes from those discussions have been reflected and are indicated in blue text on the document.	

Summary of key points in report

Alert

The full draft BAF is attached for discussion and approval:

Appendix 1 – Quality Assurance Committee BAF risks
Appendix 2 – Finance and Performance BAF risks
Appendix 3 – People Committee BAF risks

Advise

The document has been developed following engagement with Executive Leads and receipt at Executive Management Team and post earlier discussion on the outline by the Board of Directors.

Following discussion at Quality and Assurance Committee and Audit and Risk Committee

- Discussions took place in particular on BAF risks 0024 and 0025B in relation to scoring where it had

been suggested by the Executive that the score for 0025B be reduced from 16 to 12 given the recent move of Maple Ward which was a key milestone in addressing Ligature Anchor Point risks in acute ward environments. It was agreed given further work is taking place to identify further milestones in respect of ligature anchor points in non-acute areas in line with the risk assessments for those areas, this should remain at the current score of 16.

- A cross referral has been made to Finance and Performance Committee in respect of BAF risk 0025B noting further work will take place to strengthen BAF risk 0025B in respect of transformation work to provide timescales and expected route for delivery of milestones and progress with meeting the target score. This will include reference to milestones to address remaining non-acute ligation risks. FPC are asked to discuss this in terms of potential impact on approach to the scoring of this risk; deliverability of milestones and clarity on their impact on reaching the target score.

Following discussion at Quality Assurance Committee and confirmed at Audit and Risk Committee:

- The wording for BAF risk 0029 has been slightly amended to provide clarity however the wording of this risk will be looked at in more detail with the Executive lead to ensure it is sufficiently clear

Assure

Audit and Risk Committee were assured around work which had taken place to develop the document and the demonstrable movement which takes place on it following discussions through the assurance committees, in keeping the document live.

The document has also been updated since receipt at the Assurance Committee to ensure it reflects the revised appetite scoring approach agreed through the Board. These changes are highlighted in blue text for ease of reference.

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

The Board of Directors is asked to receive for **assurance, discussion and approval** the draft BAF for 2024/25.

Please identify which strategic priorities will be impacted by this report:				
Effective Use of Resources	*Yes*	***X***	*No*	
Deliver Outstanding Care	*Yes*	***X***	*No*	
Great Place to Work	*Yes*	***X***	*No*	
Ensuring our services are inclusive	*Yes*	***X***	*No*	

Is this report relevant to compliance with any key standards ?					**State specific standard**
Care Quality Commission Fundamental Standards	*Yes*	***X***	*No*		Potentially in relation to risks overseen at QAC in relation to fundamental standards of care.
Data Security and Protection Toolkit	*Yes*	***X***	*No*		Potentially in relation to risks overseen at FPC in terms of digital capability and cross referral from People Committee
Any other specific standard	*Yes*		*No*	***X***	

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, Engagement and Experience	*Yes*	***X***	*No*		Specific detail is covered within the BAF
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 2024/25 DRAFT FOR APPROVAL
As at 17.07.24
Appendix 1

BAF RISKS OVERSEEN BY QUALITY ASSURANCE COMMITTEE

<table>
<tr><td colspan="6">BAF RISK 0024 - Proposed wording - Risk of failing to meet fundamental standards of care with the regulatory body caused by lack of appropriate systems and auditing of compliance with standards, resulting in avoidable harm and negative impact on service user outcomes and experience staff wellbeing, development of closed cultures, reputation, future sustainability of particular services which could result in potential for regulatory action.</td></tr>
<tr><td colspan="2">STRATEGIC AIMS
- Deliver outstanding care
- Ensure our services are inclusive</td><td colspan="3">STRATEGIC PRIORITIES
- Deliver our quality and safety objectives</td><td>Executive lead: Executive Director – Nursing and Professions /Medical Director
Board oversight: Quality Assurance Committee
Last reviewed – July 2024. Next review – September 204
Risk type: Quality
Risk appetite: Low (minimal and cautious)
Risk rating impact v likelihood
- Current 4 x 3 = 12
- Target 4 x 1 = 4
- Movement ⟺
• Corresponding Corporate Risks: 4513, 5026, 5047,5220, 5124 and 3679</td></tr>
<tr><td><u>On track</u></td><td>Some slippage</td><td>At risk</td><td>Completed</td><td>Assurance level</td><td>Amber</td></tr>
<tr><td colspan="3"><u>Summary Update</u>
• The wording of the risk has been updated for approval.
• Teams are working together to demonstrate the link between Fundamental Standards visits and PLACE visits and actions. This will be reflected in the next PLACE report.</td><td colspan="3"><u>Progress against Milestones for 2024/25</u>
Completion of outstanding actions from the Back to Good programme –
• Completion of the Fixed Ligature Anchor Point programme for acute adult in patient services - the risk to service users will be mitigated through the planned decant of Maple ward to Dovedale 2 following its move to Burbage – this is completed with the Maple move completed 27</td></tr>
</table>

• The risk type is both Quality and Statutory – the risk score would therefore be either Low (1-3) or Moderate (5-6) and the score has changed therefore to 4 x 1 = 4 • The rewording of BAF risk 0024 replaces the need for former BAF risk 0025A • The Director of Nursing has requested an updated assessment of the LAP risks to support identifying milestones required and if necessary to reflect in the scoring and actions required. • There will be milestones to be identified around the capital programme which will also be reflected on BAF risk 0025B.	June 2024. Cross reference to BAF risks 0025a and 0025b. **Milestone achieved.** • **New milestone to be added around addressing LAP risk in the remainder of the estate (beyond the acute ward programme) as this is currently behind requirements and remains a risk. See BAF risk 0025B** • **Progression of improvements related to supervision and training –** overseen through BAU post closure of the B2G programme, at People Committee. New dashboard in place. Expected to improve post PDRs.

Controls

- Established quality governance mechanisms including fundamental standards of care, culture and quality visits and quality audit programme.
- Monitoring of performance and Quality through governance structure which can result in request for improvement plans monitored through QAC e.g. recovery teams, SAANs.
- Ongoing recruitment and workforce planning processes including clinical establishment reviews, reviewed via People committee with robust workforce dashboard
- Service lines and IPQR embedded ensuring oversight.
- Management and leadership structure in place – Ward to Board with increased grip and control around management of establishments.
- Clinical and Social Care strategy implemented.
- Robust incident and investigation governance in place, PSIRF implemented from November 2023.
- Co-production standards launched and a range of patient experience measures in place.
- Range of leadership offers completed and ongoing across SHSC corporate and clinical teams.
- Quality and Equality impact assessment reporting to QAC.
- Ligature anchor point removal plan phase 1 and 2 are completed, phase 3 in progress. Clinical Environmental Risk Group reviews all LAP assessments and reports to clinical quality and safety group. Exceptions reported to Therapeutic Environment Board.

Gaps in controls 2024/25 (those addressed in 2023/24 have been removed)	**Actions to address gaps in controls**
1. Phase 3 plan for reducing ligature anchor points will depend on decant solution and take place over an 18-month period see action.	• Maple ward will decant to refurbished Stanage ward Dovedale 2 ward 27 June 2024 **Owner Director of Strategy** • Full business case for Maple improvements was submitted to Board in April 2024 - **Owner Director of Strategy Action closed**
2. Maple ward and PICU remain mixed gender- Maple work will move the ward to single gender' closed at September Board as plan in place see update in actions.	• Current Maple ward became single gender in February 2024 to support repatriating out of area patients. This was temporary pending approval of the full business case for Maple. Maple business case has been approved subject to capital allocation. Maple ward is closed as of 27/06/24 and is now located on DD2 ward. **Owner Director of Operations – action closed** • Plans are being worked up to explore options for the management of mixed sex gender on PICU. **Owner Director of Operations** • Report on sexual safety received at QAC in March 2024. Sexual safety lead in place. **Owner Executive Director of Nursing, Professions and Quality - action closed**
3. We are restricted on our capital spend each year and we have a large programme	• Updated Capital Plan received at Board April 2024. **Owners Director of Finance and**

of estates improvements which means that they have to be phased over the next two years. **GAP closed**	**Director of Strategy. Action closed**
4. Poor compliance with Supervision in clinical teams	• Supervision rates remain a concern in some areas this continues to be monitored at the People Committee. Dashboard received at EMT in June 2024 and monthly thereafter. Recovery plans in place will be overseen at OMG prior to receipt at assurance committee. Moving to ESR for recording. Line management supervision training pilot in place. Update to be provided in September 2024 **Owner Executive Director of People**
5. Flow plan is not impacting at a pace we had hoped.	• Flow planning in place with improved flow evident in recent months. Consideration will be given to actions required for BAF 2024/25 around flow. Despite improvements up to April 2024, there has been an increase of OOA spot purchase beds mainly for female service users, which is now subject to a revised flow plan. Monthly monitoring in place. **Owner Director of Operations.**
6. Use of 136 suite rooms to accommodate people awaiting admission – still required at the current time	• New HBPOS (136 suite) opened January 2024. There has been some re-purposing continuing and this remains under regular review and is reported weekly to EMT and through to the assurance committees. There has been some improvement in breaches since March 24 and this is subject to the revised flow plan for OOA. Monthly monitoring in place. **Owner Director of Operations.**
7. Recovery plans to date are not having sufficient impact waiting times this is being addressed through the Community Transformation which will be completed in January 2024. **GAP closed**	• Recovery plans were received at QAC and have now stopped. We continue to see a downward trajectory of people waiting for the newly transformed recovery services. **Owners Head of Service, Greg Hackney/Director of Operations Neil Robertson.** Action closed.
Internal assurance • Back to Good —Closure report received at Board November 2023 – ongoing reporting through Quality Assurance Report on embeddedness and outstanding elements overseen by relevant assurance committees. • Tendable being utilised consistently. • Regular reporting through governance routes including learning lessons, safeguarding reports, staffing reports, transformation programme reports. • Successful international recruitment with new recruits in post • The 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. Outstanding actions in respect of Maple ward LAPs will be mitigated when Maple decants to Dovedale 2. • New EPR plan approved by the Board in April 2024.	**External assurance** • 2023 CQC relationship visits – positive verbal feedback received. • Section 11 Audit with safeguarding partnerships. • Positive engagement around S42's in 2023/24 in terms of Trust responsiveness. • CQC reinspection – Dec 2021 - Outcome of December 2021 acute and PICU inspection by CQC – reported Jan 2022. • Regularly reviewed by the Clinical Environment review group on a monthly basis. • Engagement with safeguarding partnerships at Executive level • NHSE funding required external reporting
Gaps in assurance (those addressed in 2023/24 have been removed) None currently	**Actions to address gaps:** N/A

RISK REF: BAF.025B - There is a risk of failure to deliver 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 unacceptable service user safety, more restrictive care and a poor staff and service user experience.

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	**Executive lead:** Director of Strategy **Board oversight:** Finance and Performance Committee **Last reviewed** – July 2024. **Next review** – September 2024. **Risk type:** Safety **Risk appetite:** Moderate (cautious) **Risk rating impact v likelihood** - Current 4 x 4 = 16 - Target 3 x 2 = 6 - Movement ⟺ - **Assurance rating** – Proposed to move from Red to Amber - **Corresponding Corporate risks – 3679**
- Deliver outstanding care - Effective use of resources - Ensure our services are inclusive	- Deliver our quality and safety objectives - Deliver therapeutic environment	

On track	Some slippage	At risk	Completed	**Assurance level**	**Amber**

Summary update

- Maple Ward decant to DD2 has taken place. This element of the risk has reduced
- Scoping of older people's environment programme is now underway.
- Following Maple Ward decant wording of the risk to be considered to focus on remaining LAP risks in the older people's inpatient estate – this is longer term strategic risk and we anticipate it will remain a BAF risk until capital is identified and works completed. It would be replaced with an overarching fitness of the estate risk for modern healthcare delivery, that supports effective delivery of services with greater alignment of co-located/adjacent services where required, NHSE recommend focus on enabling future models of care through a green and sustainable approach.
- The Director of Nursing has requested an updated assessment of the LAPs risks to support identifying milestones required and if necessary to reflect in the scoring and actions required.

Milestones in 2024/25 to support reaching target score:

- Stanage refurbishment – The Stanage ward re-opened in April 2024. Achieved.
- Dovedale 2 moved to Burbage – May 2024 – achieved
- Maple Ward decant to Dovedale 2 –27 June 2024 – achieved.
- Refurbishment of Maple June 2024 – end of January 2025 – dependent upon availability of Capital funds. Business case approved in principle by Board in April 2024.
- Clinical Environmental Risk Group to include detail on any outstanding works – by July 2024.
- Estates strategy – Interim report July 2024 updated strategy - October 2024
- Outline business case for a new hospital – December 2024
- ICS infrastructure strategy – July 2024
- As noted under BAF risk 0024 New milestone to be added around addressing LAP risk in the remainder of the estate (beyond the acute ward programme) as this is currently behind requirements. There are milestones to be identified around the capital programme to support addressing remaining LAPs in the estate beyond acute wards.

• Corporate Risk 3679 related to LAP was recently reduced from 15 to 12 and discussed at QAC in July QAC agreed that this should be seen alongside the BAF risks to determine if the reduction should take place. • Following discussion at both QAC and ARC it has been agreed to keep this BAF risk at 16 for the timebeing whilst further milestones are identified. The Board will need to agree at that stage what reduction might be able to take on the scoring incrementally as the milestones are achieved. • The target score for this BAF risk has been changed from 3 x 3 to 3 x 2 to meet the requirements of 'moderate' under the new scoring. • Lines to sit under this new risk would be -safety i.e. inc the current 25b LAP risk - compliance with standards required for buildings - backlog maintenance - efficiency and sustainability - effectiveness of care pathway delivery • These remain strategic risks until the decant of Maple ward (which has taken place) and completion of the refurbishment programme which is dependent upon access to capital funding. • It is proposed if the 25a and 25 b risks remain separate this risk score should reduce from 16 to 12 upon the decant of Maple to Dovedale 2. **Committee to discuss whether this reduction can now take place.** • The Assurance rating is proposed to remain at red until capital funding is secured.	

Control

- Governance in place to oversee Maple and associated moves
- Quality team have assessed the impact of ligature assessments and tightened controls and processes with mitigations identified and monitored – LAP heat maps in place on all wards.
- Enhanced nursing to manage environmental risks.
- Estate strategy that determines future need for community and ward estates that enables therapeutic and safe care. Being reviewed in 2024.
- Board and Executive visits.
- PLACE visits programme and Fundamental Standards visits.
- Capital investment in 136 provision achieved.
- Successful move of inpatient wards.
- LAP assurance group which is led by the programme manager for therapeutic environments and the clinical risk and patient safety advisor. Governance arrangements will be picked up through the revised approach to managing Transformation Programmes in Q1 of 2024/25.

• Clinical Environmental Risk Group should include detail on any outstanding works. Was expected c June 2024 and is completed.	
Internal assurance • Regular reporting (Capital Group; Therapeutic Environment Programme Board; Transformation Board) • Operational Structure presentation to People Committee • Health and Safety audits • IPQR monthly reports – statutory and mandatory training • Board and Executive visits to all wards and teams • Recruitment forecast confirmed • Completion of Stanage and Burbage refurbishments. • Opening of the new HBPOS in January 2024 • In February and March 2023 Registered Nurse and Healthcare Support Workers were onboarded covering many vacancies across acute wards. Systems are in place for rolling Registered Nurse and Healthcare Support Workers led by the Lead Nurse for recruitment.	**External assurance** • Evidence based approach to Reducing Restrictive practice implementation (note there is evidence of continuing improvement around use of restricted practice)
Gaps in control (those addressed in 2023/24 have been removed)	
1. Use of temporary staffing leading to potential inconsistencies in the application of practice standards – **GAP Closed.**	**Actions to address gaps in control** • Need to confirm current actions to address this gap. • Maple business case approved April 2024. **Owner Director of Strategy**. Actions related to this are closed. • The recent review of Maple has ensured staff induction and bite size training is in place to manage the risks of fixed ligature anchor points. No target date required. **Owner Director of Operations** – **Action and gap closed.**
2. Delays in the delivery of Therapeutic Environment Programme (TEP).	• LAP work taking place to capture outstanding ligature anchor point work through the Clinical Environmental Risk Group **Owner Exec Dir of Nursing, Professions and Quality** - has undertaken analysis and remains ongoing. • Maple business case Full Business case approved in April 2024**. Owner Director of Strategy**. **Action closed** • Timeline for the Older People element of the TEP. Agreed at transformation board in July 2024 to ask EMT to commission a strategic outline case for DD1 and G1 – due early 2025/26 – Owner Director of Operations.
3. Dovedale 1 now subject to a new feasibility plan that is exploring other estate options, which will be delivered on in 12-18months. We are managing the risk during this process with increased CCTV coverage and refresh of managed risks	• Dovedale 1 requires extensive work and we are scoping the best environment to improve quality on the ward– we have identified a possible new location for Dovedale 1 and improvements will require a full business case and wide engagement. Due to the CDEL limits on capital we will prioritise this for 2024/25 Capital Plan. We are exploring opportunities to begin the design phase in 2023/24. Completion anticipated December 2024. Reflected in reporting to FBC to Board in April 2024. Agreed at Transformation Board in July 2024 to ask EMT to commission a strategic outline case for DDI and G1 – due early 2025/26 with a view to

	undertake refurbishment by the end of this financial year. **Owner Director of Strategy.**
Gaps in assurance (those addressed in 2023/24 have been removed) No current gaps	**Actions to address gaps in assurance** N/A

RISK REF: BAF.0029 Proposed wording - There is a risk of a delay in people accessing core mental health services through the requirements of 'Right Care Right Place' caused by issues with models of care, access to beds, flow, crisis care management, and contractual issues resulting in poor experience of care and potential harm to service users

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	**Executive lead: Director of Operations** **Board oversight: Quality Assurance Committee** **Last reviewed** – July 2024. **Next review** – September 2024. **Risk type: Safety** **Risk appetite:** Low (minimal) **Risk rating impact v likelihood** - Current 4 x 4 = 16 - Target 3 x 1 = 3 - Movement ⟺ - Corresponding Corporate Risks: 4697, 5001
- Deliver outstanding care - Ensure our services are inclusive	- Deliver our quality and safety objectives - Work in partnership to address health inequalities	

On track	Some slippage	**At risk**	Completed	**Assurance level**	**Red**

Summary update	**Milestones in 2024/25 to support reaching target score:**
• The wording of the risk has been changed to remove reference to Covid, and to focus on core mental health services – note any specific reference to issues related to specialist services are reflected in recovery plans and on the Corporate Risk Register. • Work is taking place to refresh the wording of the associated risks – covered in the CRR once approved will be reflected on the BAF reported to July Board. • Following discussion at QAC the Director of Operations has agreed to give further consideration to the wording of this risk to ensure clarity. • The target score has been changed from 4 x 2 to 3 x 1 to meet the new scoring requirements	• Agreement of Gender service investment – this remains a challenge in terms of demand and capacity – issues have been escalated to NHSE. • CMHT transformation – current lifestyle stage implementation is on track for completion by July 2024
Control	**Internal assurance**
• EWS and SPA service has been transformed with Primary Care Sheffield. • Waiting Well Programme - Waiting list management initiatives in place to support people while they wait and respond to risk and supporting them to 'wait well'.	• Regular reporting in place through governance structure including Learning lessons quarterly report; IPQR, Complaints report; Quarterly reports to Quality Assurance Committee; Quarterly reports to Finance and Performance Committee.

• Duty systems in place for relevant teams to respond to immediate risks. • We will continue to monitor the improvements in waiting times in our core services and ensure initiatives are in place where there is an increase in waiting times. Monitoring takes place through the directorate and executive IPQR process. • Well established General manager and service manager development session utilised to promote new practice and share learning. • An improved plan in place to have understanding of risks to people waiting for allocation from 1 November 2022. Achieved for our core services and Gender Identify services. • Moving forward ICB place discussions will continue 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. This is a delivery group reporting to the PLACE performance and quality committee and PLACE board.	• Leadership Recovery plans • Community recovery plans for relevant services. • Culture and quality visits • Contracting updates as required. • Improved oversight of people waiting in recovery teams and EWS and SPA. Rag rating system provides oversight of people waiting, and where VCSE support is needed this is identified. • Improvement Plan for Gender services in place and being implemented. **External assurance** • Gender services agreements re funding remain pending - Negotiation and escalation through commissioning 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.
Gaps in control (Gaps in controls addressed in 2023/24 have been removed) 1. Where there are large numbers of people waiting for a service, we cannot reach out to every person on a regular basis, so are reliant on people contacting us if their presentation deteriorates or circumstances change. Each service has a protocol to regularly review people's needs whilst waiting and apply a RAG rating to prioritise contact.	**Actions to address gaps in controls** • Investment was prioritised in 23/24 in our recovery services and perinatal mental health. For ADHD we are working through the Provider Collaborative to resolve long waits for the service and progress is expected by the end of the financial year 2024/15 in terms of a reduction of up to c50%. • Following reporting to committees our QI team has been working with services to ensure initiatives are in place around 'waiting well'. Commissioning priorities for Mental Health with the ICB and other partners have been fed into the 2024/25 planning process. Completed however we continue to engage about unmet commissioning priorities. Owners Executive Director of Operations and Executive Director of Finance. Completed. **Action closed** • There has been no further movement on Gender Services around investment and the Trust is continuing to engage and escalate. • An NHSE regional deep dive was undertaken (on the Gender Service) and positive feedback was received about the system put in place to manage waits. Actions were identified by NHSE, which we have put in place. Completed. **Action closed** • We are working with NHSE about their requirement for us see 17 year-olds as part of the changes to children's clinic nationally. This needs a governance review. There is no new investment being provided by NHSE at this time. This again may continue into the next financial year (2023/24). Guidance received from NHSE and protocol being put in place and expected to be completed by end of September 2023. We are contractually obliged to take 17 year olds and are working with NHSE and EMT about next steps. Completed. **Action closed**
2. All areas require clear commissioning specification, which require a review and process implemented by Sheffield place, helping us to really understand who a	• We are assertively following up with our strategic planners about resolving this very outstanding issue. This is now subject to Executive level escalation through Director of Operations. This is still ongoing and is also being escalated by the Deputy Director of

service is for This is still on going and is an action led by Place.	Finance. Further update on progress to be provided in September. **Owner – Senior Head of Services**
Gaps in assurance (Gaps in assurance addressed in 2023/24 have been removed)	**Actions to address gaps in assurance**
1. 'Not having finalised the primary care, recovery teams and SAANS transformation plans' reported to Board as closed as plan has been mobilised – see updates on actions. **Gap closed.**	• In 2023/24 it was reported work was in place to design a crisis and urgent response team in line with PCMH transformation programme which would take 12 months to implement timing subject to formal consultation. This was delivered in Q1 2024/25 and the service is now in place. Owners Medical Director and Executive Director of Nursing, Professions and Quality for PCMHT and Director of Operations for CMHT. Completed. Service in place. **Action closed**
2. Staff vacancies and turnover remains high in some areas. **Gap closed as no current issues.**	• In 2023/24 it was reported as part of workforce planning we were identifying new ways of working by looking at alternative staffing groups for filling vacancies and looking at ways to work differently in many of our community services due to the abolition of the care programme approach which means that we can use peer support workers, recovery workers and the VCSE to support service delivery. This was due for delivery by the end of 2023/24) – Owner Senior Head of Services Completed. **Action closed** • There are no current issues with Community nursing recruitment Owner Executive Director of Nursing, Professions and Quality. **Action closed.**
3. Lack of agile technology to maintain a high level of contact with people waiting.	• Part of revised Digital Strategy and road map to be developed in 2025/26 following implementation of RIO and the data warehouse **Owner CDIO**
4. Number and nature of complaints from recovery service users. **GAP closed**	• In 2023/24 it was reported work was taking place to identify services where a realistic trajectory could be achieved to reduce waits. See above. This is ongoing and capacity resource is being brought in to look demand and capacity modelling expected to be completed by end of Q4 2023/24– owner Director of Operations Completed. The number of complaints has not changed. No further action required currently. **Action closed**

NEW RISK REF – BAF 31 Proposed wording - There is a risk we fail to deliver on national inequalities priorities and our clinical and social care strategy which aims to deliver personalised and trauma informed care, caused by failure to adopt an inequalities based approach to care resulting in poorer access, later presentations and risk of poorer outcomes.

STRATEGIC AIMS - Ensuring services are Inclusive	**STRATEGIC PRIORITIES** - **Deliver our patient and carer race equality framework** - **Work in partnership to address health inequalities** - **Deliver our equality objectives**	**Executive lead:** Executive Director of Strategy **Board oversight:** Quality Assurance Committee **Last reviewed** – July 2024. **Next review** – Sept 2024. **Risk type:** strategic/ quality **Risk appetite:** Moderate (cautious) **Risk rating impact v likelihood –** Scoring is still to be confirmed - Current 4 x 3 = 12 - Target 3 x 2 = 6 - Movement – NA as new risk Corresponding corporate risks: no corresponding Corporate Risks currently.

On track	Some slippage	At risk	Completed	**Assurance level**	**AMBER**

Summary update

- Board development session took place in June 2024 including work to support a self-assessment which will support the Board to identify gaps and next steps
- Health Inequalities Annual Report to be in place by October and to be reflected alongside planning for the Annual Report and Quality Account.
- Target score has been changed from 4 x 2 to 3 x 2 to meet the new scoring requirements for a moderate appetite (5-6)

Milestones in 2024/25 to support reaching target score:

- Board development session and around MHA QI, health inequalities self-assessment and PCREF – June 2024 – completed
- Improving our data and analytics health inequalities measures and recording of personalised characteristics of those we serve in line with the NHS Statement on information on health inequalities (duty under section 13SA of the national health service act 2006) – by October 2024
- Deliver the 4th year objectives in the Clinical and Social Care Strategy demonstrating delivery being well embedded in the organisation by end of financial year 2024/25
- All projects with the 'waiting well QI collaborative' have a health inequalities element by July 2024. **Head of Quality Improvement**
- Following June Board session draft self-assessment to be presented back to Board for approval by September 2024 – **Director of Strategy**
- Following June Board session lead officers for inequalities to create a proposed action plan for inequalities, including the strategic objectives above – by September 2024 – **Director of Strategy**
- Trust Strategy refresh to strengthen focus on tackling inequalities by October 2024 – **Director of Strategy**
- Health Inequalities Annual Report due by October 2024 – **Head of Health Inequalities and Director of Strategy/Medical Director.**

Controls

- Programme of work to deliver the clinical and social care strategy includes actions to embed trauma informed practice, and PROMs, rolling out across services over 24/25 and beyond
- Inequalities community of practice established June 2024. Exact focus tbc but will contribute to culture change providing mutual support for colleagues seeking to tackle inequalities through small scale QI initiatives in their areas of work.
- Leadership roles for inequalities established by June 2024 – in place.

Internal assurance

- Inequalities reporting to Board – details tbc following June development session
- Inequalities measures in IPQR, plus breakdown of key metrics by personal characteristics in IPQR and workforce reports

External assurance

- Reporting of nationally mandated inequalities measures in October 2024 and beyond in line with NHSE Statement on Inequalities

Gaps in controls

None identified at present time. Need to embed the new controls detailed above and review their effectiveness

Actions to address gaps in controls

- Schedule a review of the effectiveness of the controls in June 2025 (12 months in)

Gaps in assurance • The level of recording of personal characteristics of service users remains low. Increasing the percentage of records with complete demographic information will strengthen the effectiveness of our assurance mechanisms.	**Actions to address gaps in assurance** • Improvement activity to increase the level of recording of personal characteristics – date and owner to be confirmed by the Director of Strategy

BOARD ASSURANCE FRAMEWORK 2024/25 DRAFT FOR APPROVAL
As at 17.07.24
Appendix 2

BAF RISKS OVERSEEN BY FINANCE AND PERFORMANCE COMMITTEE

The Director of Strategy is considering risks for inclusion around innovation, service sustainability and Growth and around the appropriateness and sustainability of our Estate in the wider strategic context. The majority of these when drafted would sit under Finance and Performance Committee.

<table>
<tr><td colspan="5">RISK REF BAF: 21A Proposed wording - Previous description - There is a risk of failure to ensure digital systems are in place to meet current and future business needs, caused by failure to develop and deliver an up-to-date modern digital strategy and systems and processes to support its delivery, resulting in poorer clinical safety, quality, efficiency and effectiveness.</td></tr>
<tr><td colspan="2">STRATEGIC AIMS
- Effective use of resources
- Deliver outstanding care</td><td>STRATEGIC PRIORITIES
- Implement RIO safely</td><td colspan="2">Executive lead: Executive Director of Finance
Board oversight: Finance and Performance Committee & Audit and Risk Committee
Last reviewed – July 2024. Next review – September 2024.
Risk type: Quality & Digital (data) Clinical, Quality and Safety
Risk appetite: Moderate Low to Moderate (minimal and cautious)
Risk rating impact v likelihood
- Current 4 x 3 = 12
- Target 3 x 2 = 6
- Movement ⟺
Corresponding corporate risks: 4795, 5224</td></tr>
<tr><td>On track</td><td><u>Some slippage</u></td><td>At risk</td><td>Completed</td><td>Assurance Level Red</td></tr>
<tr><td colspan="2"><u>Summary update</u>
• The Board approved an updated plan for EPR in Q1 of the financial year 2023/24 and updates on progress are received at each Board meeting.
• Given agreement of the plan discussion is asked on whether the assurance rating can change to Amber.
• Target score updated from 3 x 3 to 3 x 2 to meet the new scoring requirements for its risk appetite</td><td colspan="3"><u>Milestones in 2024/25 to support reaching target score:</u>
• Retire Insight – currently EPR is expected to complete in Q4 of 2024/25
• As noted previously, sources of assurance and actions are unlikely to change until the full retirement of Insight.
• Address data reporting gaps for services in the Tranche 1 stage of EPR implementation - for services that have moved to RIO in Tranche 1 there are some data reporting gaps these are being followed through as part of the stabilization works.
• Development of revised Digital Strategy and roadmap for delivery of the digital strategy in 2025/26</td></tr>
<tr><td colspan="5"><u>Controls</u>
• Governance (EPR programme board structure, EMT oversight, reports to assurance committee FPC and Board, external support sitting on EPR programme board)
• DAG Governance controls - providing operational oversight through EMT and to assurance committees - ARC/FPC need to embed routine reporting into EMT. NEW GAP
• Need to refresh strategy and identify plan for delivery. The Digital Strategy approved by Trust Board on 4/11/2021 defines a plan for improved technology services and</td></tr>
</table>

<table>
<tr><td colspan="2">sustainability provides control and assurance. Given EPR delay this impacts on the delivery of the strategy and need to develop and continue to refine the digital roadmap and strategy for delivery now in 2025/26.
• New Target Operating Model for Digital under development
• SHSC Digital 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. Ongoing until legacy system is retired.</td></tr>
<tr><td><u>Internal assurance</u>
• Governance reporting in place - reporting into Programme Board with oversight by Trust Transformation Board and EMT. Governance arrangements updated and received through the revised EPR implementation plan approved at Board in April 2024.
• Additional support is in place should Insight do down.
• External independent expertise has been in place to support development of the new plan (from January 2024)
• DSPT audit. Internal audit have provided support and assurance around penetration testing.</td><td><u>External assurance</u>
• Annual Data Security Protection Toolkit (DSPT) audit moderate assurance rating received in 2023 and in 2024.
• DSPT submission as part of national reporting
• External review –report received on EPR at Board in February 2024 with recommendations on actions required.</td></tr>
<tr><td><u>Gaps in controls</u> (Gaps in controls addressed in 2023/24 have been removed)</td><td><u>Actions to address gaps in controls</u></td></tr>
<tr><td>1. Put in place assessment and plan for full resourcing and affordability (for IMST).</td><td>• Target Operating Model to be in place by July 2024 –with the new CDIO as part of development of the revised plan – Owner CDIO/Exec Director of Finance.</td></tr>
<tr><td>2. Address elements of DSPT still to be achieved, the relevant risks are being tracked.</td><td>• Data Security Standards - issue regarding password criteria on Insight will be resolved when Insight is decommissioned following RIO implementation, currently planned for end of January 2025. Owner CDIO/Exec Director of Finance January 2025.</td></tr>
<tr><td>3. The need to develop a new Digital Roadmap and Target Operating Model.</td><td>• Digital Roadmap– Owner CDIO/Exec Director of Finance timing to be confirmed for delivery this will be after the strategy refresh later in the financial year and will be by the end of March 2025</td></tr>
<tr><td><u>Gaps in assurance</u> (Gaps in assurance addressed in 2023/24 have been removed)</td><td><u>Actions to address gaps in assurance</u></td></tr>
<tr><td>Insight still being used – delays with EPR</td><td>• Retirement of Insight delayed to Q4 2024/25 Owner CDIO/Director of Finance.
• Revised plan for Implementation of RIO (EPR) received and approved at Board April 2024.</td></tr>
</table>

RISK REF BAF 0021B - Proposed wording - There is a risk of cyber security breach caused by inadequate arrangements for mitigating increasingly sophisticated cyber security threat and attacks and increased data protection incidents resulting in loss of access to business critical systems and potential clinical risk.

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	
- Effective use of resources	- Deliver our financial plan and efficiency programme - Deliver our quality and safety objectives	**Executive lead:** Executive Director of Finance **Board oversight:** Finance and Performance/Audit and Risk Committee **Last reviewed** – July 2024. **Next review** – September 2024. **Risk type:** Quality & *Digital (data)* Clinical Quality and Safety, Business and reputation **Risk appetite:** Low to Medium (minimal and cautious) **Risk rating impact v likelihood** - Current 4 x 3 = 12 - Target 3 x 2 = 6 - Movement ⟺ - Corresponding corporate risks: none currently

On track	**Some slippage**	At risk	Completed	**Assurance level**	**Amber**	**Green**

Summary update

- It is felt this remains a strategic risk.
- It is suggested reference to low IG training levels be removed given current performance
- It is suggested reference be made to needing to be able to respond to moving with pace of threat in terms of how attacks take place and changes in approach. The pace of change is significant.
- To note in 2025/25 the DSPT is changing so standards will change and this will need to be taken into consideration.
- New milestones be linked with revised delivery of EPR and decommissioning of Insight and actions from the DPST audit received at the end of June 2024
- Target score changed from 4 x 2 to 3 x 2 to meet the new scoring requirements for Low – Moderate appetite.

Milestones in 2024/25 to support reaching target score:

- DSPT compliance aligned with all DSPT work – June 2024 On track
- Rebasing and understanding new requirements of the changes to DSPT to be reflected in due course

Controls

- Governance controls in place via monthly DAG meetings and reporting via EMT and into assurance committee (ARC)
- SHSC CAB use of Sunrise Service management Desk to record time to act following receipt of notifications in accordance with ITIL processes (i.e. necessary standards)
- SHSC Change Advisory Board (CAB) and Emergency CAB meetings reviewing and responding appropriately to NHSD Care Certification notices.
- Supplier engagement to ensure system patches are notified where vulnerabilities are known. Supplier engagement meetings as part of Service Review Management process, in accordance with ITIL process model Risk only applies if system is hosted locally, strategic shift to cloud hosting for application.

<table>
<tr><td colspan="2">
• Mandatory IG Training to be monitored and reported across all Trust areas, with staff mandated to ensure compliancy as part of supervision. Monitored through DAG and through reporting on mandatory training compliance to committees.
• Phishing tests in accordance with requirements of DSP Toolkit is being undertaken annually.
</td></tr>
<tr><td>
<u>Internal Assurance</u>
Governance reporting:
• Reports on patching reports are received at-DAG and will be reflected in the Service Management report received at DAG which reports onward to ARC and EMT (which is additional reporting in 2024/25).
• Service management reports include supplier engagement relating to system patching for key suppliers for locally hosted systems.
• Monthly performance reporting across all Teams for mandatory IG training.
• Oversight via reporting to DAG which has been in place since April 2023.
</td><td>
<u>External assurance</u>
• Confirmation provided to NHSD in accordance with prescribed national process.
• DSPT compliance – key indicator - Annual Data Security Protection Toolkit (DSPT) audit moderate assurance rating received.
</td></tr>
<tr><td>
<u>Gaps in controls</u>

Gaps in controls addressed in 2023/24 have been removed.
- None currently
</td><td>
<u>Actions to address gaps in controls</u>

N/A
</td></tr>
<tr><td>
<u>Gaps in assurance (Gaps in assurance addressed in 2023/24 have been removed)</u>

System Asset register functionality within Sunrise not yet enabled.
</td><td>
<u>Actions to address gaps in assurance</u>
• Asset register to be specified and developed in 2024/25 starting with hardware assets. Owner Head of Service Delivery and Infrastructure Digital.
• Clinical system owners to be identified and BCP's to be confirmed by clinical leads. (April 2024) – BCP's are being confirmed to SHSC EPO still under development. The EPPR manager has confirmed each service has a Business Continuity Plan and a SOP has been prepared to support them in respect of RiO being unavailable. Owner CDIO Action closed
</td></tr>
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<tr><td colspan="3">
RISK REF BAF 0022 Proposed wording - There is a risk we fail to deliver the break-even position in the medium term caused by factors including failure to develop and deliver robust financial plans based on delivery of operational, transformation and efficiency plans resulting in a reduction in our financial sustainability and delivery of our statutory duties.
</td></tr>
<tr><td>
STRATEGIC AIMS
- EFFECTIVE USE OF RESOURCES
</td><td>
STRATEGIC PRIORITIES
- Deliver our financial plan and efficiency programme
</td><td>
Executive lead: Executive Director of Finance
Board oversight: Finance and Performance Committee
Last reviewed – May 2024. Next review – July 2024
Risk type: Finance
Risk appetite: Low (minimal)
Risk rating impact v likelihood
- Current 4 x 4 = 16
- Target 3 x 1 = 3
</td></tr>
</table>

				- Movement ⟺ Corresponding corporate risks: 5051	
On track	Some slippage	At risk	Completed	**Assurance level**	**Amber**

Summary update

- As part of financial planning 2 – 3 year break even plans were considered
- For the final financial plan of break even delivered over 3 years with internal financial targets to give headroom on VIP delivery and potential to over achieve.
- New wording to the risk description proposed.
- Given plans are in place and being further developed to deliver the financial plans for 2024/25 the work could be described as on track to meet the requirements in the current financial year, as at this stage – will be kept under review.
- Target score changed from 4 x 2 to 3 x 1 to meet new scoring requirements for Low risk appetite

Milestones in 2024/25 to support reaching target score:

- Develop Financial Plan and Value Improvement plans for 2024/25 – to be received at the Board April 2024 – plans received – completed.
- Development of action plans for 2024/25 and completion of QEIA screening tool by end of May 2024 – plans in place and being monitored.
- Develop Financial Plan and Value Improvement plans for 2025/26 – plans to be developed aligned to medium term plan good draft completed by December 2024 for receipt of final plans in April 2025 post EMT and FPC in March 2025.

Controls

- Operational plan; financial planning; including CIP planning, processes and delivery monitoring
- CIP programme Board established with more sophisticated CIP planning processes.
- Strengthened governance arrangements have been in place since September 2023, with EMT additional weekly oversight meeting in place since end of November 2023.

Internal assurance

- Governance reporting in place through - monthly financial reporting to Team and Programme Board, Assurance report to EMT, FPC and Board.
- Performance Framework meetings and recovery plans and review processes.
- Value Improvement Plan in place for 2024/25 with a number of costed plans identified and some delivered by onset of Q1.
- Strengthened arrangements in place to develop and challenge VIP plans weekly meetings with Exec leads.

External assurance

- NHSE Financial Review *2021/22* and ongoing support as required.
- Internal audit on CIP received June 2023 - split opinion overall (significant on processes and limited on improvements already in place) it was recognised the gap had already been closed in 2023/24 CIP planning and no further action was needed.

Gaps in controls **Gaps in controls addressed in 2023/24 have been removed.**

1. Identification of a full recurrent VIP plan over the medium term

Actions to address gaps in controls

- Strengthened arrangements are in place to develop and challenge VIP plans. From April 2024 and Ongoing **Action closed moved to assurance.**
- Value Improvement Plan received for 2023/24 – received April 2024 FPC and Board. VIP plans continue to be developed and part of financial planning for future years – **owner Executive Director of Finance.**
- 3 year VIP plan not yet fully developed. Good plans to be in place by December 2024 and final plans by April

	2025. **Owner Executive Director of Finance**
Gaps in assurances Gaps in assurance addressed in 2023/24 have been removed 1. Development of medium term VIP plan	**Actions to address gaps in assurances** • **See above**

RISK REF - BAF.0026 Proposed revised wording - There is a risk that we fail to take an evidence led approach to change and improvement caused by a failure to implement our integrated change framework effectively resulting in failure to deliver our strategy, improve outcomes, address inequalities and deliver value, growth and sustainability.

Elements which would underpin this are:

- Research
- Innovation
- Capability capacity and processes
- Quality Improvement

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	**Executive lead:** Director of Strategy **Board oversight**: Finance and Performance Committee **Last reviewed** – July 2024. **Next review** – September 2024. **Risk type:** Strategic **Risk appetite:** High (open) **Risk rating impact v likelihood** - Current 4 x 4 = 16 - Target 4 x 2 = 8 - Movement ⟺ Corresponding corporate risks: 4795, 5224
- Effective use of resources - Deliver outstanding care	- Deliver Therapeutic environments - Delivery our quality and safety objectives - Implement Rio safely	

On track	**Some slippage**	**At risk**	**Completed**	**Assurance level**	**Amber**

Summary update	**Milestones in 2024/25 to support reaching target score:**
• It is proposed this risk remain separate from the overarching estates risk which is about fitness of purpose of the estate. • Updating risk description proposed for discussion • It is proposed assurance remains amber due to some slippage. • Target score changed from 3 x 2 to 4 x 2 to meet the new scoring requirements for a High appetite	• Integrated change framework delivery arrangements to commence from June 2024. • Revised approach to reporting to Board for transformation programmes through the IPQR from July 2024. • TEP Board to make a proposal regarding revisions to portfolio by July 2024 to support re-prioritisation. • Therapeutic environments – Maple decant 27 June 2024 completed works by end of January 2025. Older peoples [see note above re scoping] • The EPR programme - has been updated and approved at the April 2024 Board. Achievement of required resources identified to Board by September 2024. EPR to be delivered to be delivered by the end of the financial year.

<table>
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Community Facilities – see comment about estates strategy refresh.
Fullwood capital receipts – The February 2024 strategy Board agreed to pursue revised phasing of receipts of the sale over 2024/25 and 2025/26. Receipt remains delayed due to delays with the submission of planning application by the buyer and approval of planning permission by the Local Authority. Planning meeting now delayed until after the July election. Updates on progress are received at the Board.
CMHT delivery January 2024 and LD delivery - The LD programme on track with operational model agreed, moving into implementation, with full programme completion expected Summer 2024. CMHT programme and PCMH programmes have April milestones, and complex inter dependencies.

</td></tr>
<tr><td colspan="2"><u>Controls</u>

Governance - EMT oversight in place. Effective programme management in place including governance infrastructure aligned to Prince II and Managing Successful Programmes standards.
Reporting through Programme Boards to Transformation Board and onwards to Board sub committees.
Monthly escalation reporting.
Health Card and Financial Health Card developed and reviewed monthly at transformation board and bi- monthly at FPC from March 2023 providing overview of all programmes.
Members of the Executive team as SRO’s for all projects and programmes.
Joint board with Primary Care Sheffield for the PCMHT programme.
Monthly review of programme health card by the Transformation Board to support governance.
Use of QEIA’s to support change control within projects.
Risks and issues reviewed monthly by programme boards and escalated to Transformation Board and assurance committees when appropriate.
Milestone plans in place for each programme and monitored through highlight reports.
Procurement process; Project change control on capital and business case visibility.
Can this be changed to ‘Business cases and capital expenditure approved in accordance with Trust wide governance processes. Business case reviews and change control activity by Programme Boards recorded within the programme and conducted in line with wider governance processes if outside of agreed tolerances.
Programme Board TORs all reviewed against new standard and revised where necessary.
All programme stakeholder maps have been updated.
Monthly meetings in place with programme managers to review highlight reports, risks and issues.

</td></tr>
<tr><td><u>Internal assurance</u>

Through former Back to Good programme, currently received through reporting received through Transformation Board and Finance and Performance Committee. These highlighted risks and issues.
Standardised approach in place for all Programme Boards and have been available on sharepoint since January 2021; review schedule in place – the approach is currently under review.
Board, meeting minutes, report to Finance and Performance committee.
Business case approved to recruit to team to fulfil action. All posts within PMO filled. PMO Analyst in place to focus on check and challenge activities.
External resources were secured to support the completion of the Strategic Outline Case for the

</td><td><u>External assurance</u>

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 in place, as follows:

Adult Forensic New Care
Health based place of safety bid – monitoring arrangements were in place by ICB (this opened in January 2024)

Primary and Community Mental Health via joint programme board with Primary Care Sheffield.
EPR – External representative on Programme Board to advise on procurement. External review of the programme commissioned and reported through FPC and Board in February 2024.
Primary and Community Mental Health Transformation Programme – has representation from Primary Care and external organisations and the Learning disability programme and CMHT project boards have representation from external organisations.
360 Assurance have reviewed all TOR’s.
External specialist resource is brought in where required e.g. EPR

</td></tr>
</table>

Therapeutic Environments programme. • Suite of templates available. All new projects and programmes use the new templates including TORs. • Programme Managers were engaged in roadmap and development work, sharing learning and experiences on specific projects.	
Gaps in controls **Gaps in controls addressed in 2023/24 have been removed.** • None currently	**Actions to address gaps in controls** N/A
• 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. **GAP closed**	• The focus in 2023/24 was on the embedding and optimisation of eRoster, including connectivity with other systems, to support delivery of people plan action for 23/24 to implement manager self-service by March 2024. A range of workshops have taken place to support staff with this. Head of workforce systems (Stephen Sellars) who is attending a range of forums. **Action closed.** • Governance arrangements - The progress on the people plan (which is refreshed annually to ensure delivery of the People Strategy and KPIs) is reported into People Committee and Board on a quarterly basis, this is based on inputs from the Tier 2 groups and other routes. The Roster work reported into the Transformation portfolio board previously as it was a specific project. **Action closed**
Gaps in assurance **Gaps in assurance addressed in 2023/24 have been removed** • None currently	**Actions to address gaps in assurance** N/A

RISK REF – BAF 0027 Proposed re-wording - There is a risk of failure to ensure effective stakeholder management and communication with our partners and the wider population and to effectively engage in the complex partnership landscape, resulting in missed opportunities to add value for our service users and to meet population needs that require a partnership approach, This may mean that we miss opportunities to also safeguard the sustainability of the organisation longer term and ultimately may fail to deliver our strategic priorities and operational plan.		
STRATEGIC AIMS - Deliver outstanding care - Effective use of resources - Ensure our services are inclusive	**STRATEGIC PRIORITIES** - Work in partnership to address health inequalities - Improve access to crisis care - Improve access so people wait less and wait well - Deliver our quality and safety objectives	**Executive lead:** Director of Strategy **Board oversight:** Finance and Performance Committee **Last reviewed** – July 2024. **Next review** – September 2024. **Risk type:** Business/Strategic **Risk appetite:** High (open) **Risk rating impact v likelihood** • Current 4 x 3 = 12 • Target 4 x 2 = 8 • Movement ⟺ Corresponding corporate risks: None specifically though see risks linked to transformation programmes

On track	Some slippage	At risk	Completed	**Assurance level**	**Amber**

Summary update

- Target risk is likely to reduce to a 4 x 2 = 8 by the end of 2024/25
- Cover sheet for Board papers updated to request any associated mitigation of this BAF risk in papers which refer to system and partnership activity.

Milestones in 2024/25 to support reaching target score:

- Mother and baby and associated perinatal service development – by the end of 2023/24 March 2024 ongoing development through SY MHLDA provider collaboration. Contract management arrangements between NHSE and LYPFT for mother and baby unit have been confirmed (June '24). These include an advisory group that includes SHSC, through which the Trusts that are served by the Unit ensure the provision is meeting the needs of their populations and connecting effectively with local services. **Milestone complete.**
- Community forensic team tender – due to meet with other interested parties and the commissioner before August 2024.
- Agreeing South Yorkshire integrated approach to access for Health Based Place of Safety – approach has been approved by Provider Collaborative Board in May and is expected to be delivered by the end of 2024/25.
- Eating disorder service co-located with VSCE – the proposal for eating disorder joint committee (in shadow form) has been approved by the Collaborative Board and respective Boards in May for implementation in 2024/25.
- Staff bank enhanced with students from Sheffield Universities – by the end of 2023/24 – Update – recruitment was paused after Christmas as we had enough resource, so not actively sought applications from students however we do currently have some students on the bank and numbers are being captured.
- Develop action plan for delivery of GGI findings by August 2024 with implementation thereafter.
- Desire Code Communications Strategy work will feed into the strategy refresh work in October 2024. Quick wins identified for delivery in advance of August 2024.

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

- We were fully engaged at PLACE, ICB and Collaborative to participate in the planning of priorities for 2023/24 and worked together with colleagues in PLACE, collaborative and ICB through board workshop and with our senior leaders to support us in ensuring the priorities are reflected in SHSCs annual operating plan – approved by the Board in May 2023
- Sheffield Health and Care Partnership regularly attended by Chair and CEO and other Executives linking into appropriate delivery groups.
- All core Trust strategies are in place with annual reviews process.
- Regular meetings with Sheffield LA, PLACE, ICS and Provider Alliance (moved from assurance)
- All reports to Committees and Board are prompted to consider the partnership implications arising from the report (moved from assurance)

Internal assurance

- CEO and Chair's briefing and reports to Board provides an overview of system and system governance arrangements.
- SHSC Chair is lead Chair for the MHLDA Collaborative (effective from July 2023)
- Business opportunities, risks (PESTLE AND SWOT) received

External assurance

- Link into Outcomes Group in PLACE
- New partnership arrangements are bedding in for PLACE, System and Collaboratives.
- NHSE Well Led feedback on self assessment December 2022
- System quality oversight meetings post inspection
- Significant assurance received from Internal Audit on the transformation programme 2022/23

at Board in February 2024 and ongoing updating in place. • Active engagement taking place – SROs are engaging as part of new ICS arrangements. • Engagement with the Council of Governors. • Strategies and associated implementation work plans are in place with reviews reflected in committee/Board planners. • Enabling strategies in place. • Quality Accounts reflects engagement. • Annual Report reflects engagement. • Project Initiation Document (PID) setting out the engagement arrangements including the stakeholder analysis. • Report to Board in June 2022 included detail on stakeholder engagement for each project. Work underway to refresh the approach in 2024/25 • 5-year plan and strategic direction received at FPC (Nov 2022) and Board workshop (Dec 2022) approved by Board Jan 2023. Revised priorities agreed in 2023 and Refreshed Strategy discussion planned at Board October 2024.	• Externally supported (GGI) stakeholder review outcome received at Board in April 2024.
<u>Gaps in controls</u> (Gaps in assurance addressed in 2023/24 have been removed)	**<u>Actions to address gaps in controls</u>**
1. Digital roadmap not yet in place	• Revised Digital Strategy and road map developed in 2025/26 following implementation of RIO and the data warehouse. **Owner CDIO**
2. Still under development for the final strategies not yet approved by the Board (PIDs).	• Review of approach to strategy planning and reporting by Director of Strategy and is planned to be progressed for 2024/25. This gap is likely to be closed and replaced as appropriate. Approach will be updated post Board strategy refresh discussions in October 2024. **Owner Director of Strategy**
<u>Gaps in assurance</u> 1. Future CQC and NHSE 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.	**<u>Actions to address gaps in assurance</u>** • Reflect in planning for CQC visit - timing for visit not yet known therefore the work to prepare is continuing - Executive Team **therefore no date attached. Owner Director of Nursing.**
2. Detailed implementation plans have yet to be finalised for every strategy therefore stakeholder and engagement plans are yet to be fully completed	• See update against Gap in controls 2. Work also taking place to reflect on feedback received from the stakeholder engagement review by GGI which will impact on plans. **See comment above under gaps in controls.**

RISK REF – BAF 0030 Proposed wording - There is a risk of failure to maintain and deliver on the SHSC Green Plan, caused by lack of robust plans capability and capacity to deliver targets required resulting in potential to lead to poor patient outcomes, worsening of existing health inequalities, poor service delivery, disruption to services, inefficient use of resource and energy/higher operating costs, legal and regulatory action, missed opportunities for innovation, reputational damage, reduced productivity and increased environmental impact.

STRATEGIC AIMS	STRATEGIC PRIORITIES	
- Effective use of resources	- None specifically attached	**Executive lead:** Executive Director of Finance **Board oversight:** Finance and Performance Committee **Last reviewed** – July 2024. **Next review** – September 2024. **Risk type:** Environmental **Risk appetite:** High (open) **Risk rating impact v likelihood** - Current 3 x 4 = 12 - Target 2 x 4 = 8 - Movement ⟺ Corresponding corporate risks: None specifically

On track	Some slippage	At risk	Completed	**Assurance level**	**Amber**

Summary update

- It is felt this remains a strategic risk and there is a legal imperative to plan for delivery of the targets.
- The risk description has been updated for discussion
- The CCRRA is not yet complete and working group not yet established to manage risk assessment and to report into SDG it is anticipated this will be completed by October 2024 in order to inform the updated version of the Green Plan due for Board approval in January 2025.

Milestones in 2024/25 to support reaching target score:

- Reviewing and revising the plan for 2025/26 in line with new requirements later in the financial year – by 31 March 2025
- Monitoring delivery of the action plan – quarterly at FPC.

Controls

- Governance - Sustainable Development Group, delegated Board oversite via the FPC linked to partnership and collaboration in place through Place and system.
- Green Plan Approved by SHSC Board and refreshed annually in line with revised requirements due to be in place in the new financial year 2025/26.
- Strategic intent (Green Plan Implemented under SHSC Strategic priority Continuous Quality Improvement, 2023.2026.
- Climate change and the need for continuous sustainable quality embedded with Quality strategy, strategic priorities and annual objectives.
- Supporting EPPR Policies and minimum annual review of BCPs
- Engagement with wider NHS Sustainability Program (GNHS), for best practice, guidance and support.t
- SHSC Committee report templates include reference to sustainable development
- Green plan pick list of service objectives 24/25 (Current voluntary uptake of Green Plan objectives).
- Sustainable Development included in SHSC QEIA (Limited feedback on effectiveness)

Internal assurance

Governance reporting:

- Annual Reports on Strategy delivery to the Board
- Quality Strategy Sustainable Development Priorities progress reported into QAC.
- Executive Lead identified for Net zero (Green Plan) in

External assurance

- Greener NHS – Quarterly data submission
- Greener NHS Fleet Data submission

place (Director of Finance, Performance and IMST)	
Gaps in controls Gaps in controls addressed in 2023/24 have been removed.	**Actions to address gaps in controls** **Note** - For those actions currently without dates please note plans are to be progressed throughout the remainder of 2023/24 and 2024/2. Will be updated as plans are developed and key dates confirmed.
• No Climate Change Risk Assessment (CCRA) in place to address gaps in BCPs and support delivery of SHSC Adaptation Plan. **GAP Closed**	• CCRA is under development and an outline plan in place to produce a placed based Adaptation plan with STH and SCH. Need to set up a working group to review CCRA and develop risk assessment action plan to inform Adaptation plan. (Membership to include EPRR, Operational Leads, Estates etc.) CCRRA not yet complete and working group not yet established to manage risk assessment and to report into SDG it is anticipated this will be completed by October 2024 in order to inform the updated version of the Green Plan due for Board approval in January 2025. **Sustainability Lead**
• Consistent carbon footprint performance and projection reporting (Restraints due to data assurance and capacity) **GAP Closed.**	• Work continues at ICS level to peer review carbon foot printing approach. Sustainability Lead scoping potential for adopting an external provider/ platform to support carbon footprint development and reporting (In addition to providing some external assurance for our approach) Sustainability Lead **timing dependent on planning for 2024/25 –** The Sustainability Lead has advised this **action can be closed** noting after peer review it has been identified that the approach SHSC are taking is aligned to most NHS trusts (using Defra emission factors) so we will continue to use this approach until advised otherwise by Greener NHS.
• Awareness and education training on sustainable development and climate change of SHSC workforce (including Board and Senior Leadership) **GAP Closed,**	• Reflected in Leadership and Management course. **Action closed.**
• Capital and business planning processes aligned to green plan strategy and wider Grener NHS net zero goals. **GAP Closed.**	• Sustainability lead is working with Strategy and Business Planning team to embed Sustainable Development and where appropriate a Sustainable Impact Assessment into business case templates. Sustainability lead to support Capital Team to develop a Sustainable Capital Policy, aligning to Green Plan Ambitions and wider GNHS Strategic Plans (E.g. NZC Building standard, NZC Estates Delivery Plan, NHS NZ Supplier Roadmap) Draft Sustainable Capital Policy 31st Jan 24, Business case Template is in place and to be used from May 2024 with feedback to be gathered**. Sustainability Lead/ Business Planning lead Action closed.**
• Further integration of sustainable development and Climate change risk into SHSC governance structures and performance reviews (Risk management, SHSC Committee's and compliance groups)	• Reporting takes place through FPC post working groups. Will consider route into BPG – to ensure it is reflected into business planning with a sustainability objective for all areas for 2025/26 planning - November 2024. **Sustainability Lead** Update Jul 24- Sarah Ellison is now attending AIPG, BPG and Capital Planning Group to ensure Sustainable development is considered in proposed/ ongoing business cases etc.
• Current Capacity of Sustainable Development Lead (and wider Green Plan Focus Area leads) could be insufficient to deliver green plan aims and meet statutory targets at pace	• Sustainability Lead to scope what additional roles could support delivery of the Green Plan in the longer Term. In the short term the establishment of further sub-working groups to take operational control of Green Plan actions/ Focus Areas with no-predetermined lead or multi-stakeholder

required.	implications (E.g. Sustainable Travel and Transport Working Group, Climate Change Risk/ Adaptation Planning Group, Sustainable Models of Care Delivery Group, Green Network etc) **Owner Sustainability Lead**
• Limited access to/ understand of which KPIs/ metrics can be used to monitor and disclose our performance. (SHSC Sustainability Dashboard Required)	• Monitoring of KPIs is reflected in the Annual Report 2023/24 and will be captured for 2024/25. The timing for development of an internal sustainability dashboard – the first version will be in place by October 2024. This will be a work in progress as we gain more clarity on what data we have to report on and what data is useful to include in the dashboard. The Sustainability Lead has confirmed the Greener NHS Dashboard is a national data collection for all NHS Trusts which will support us to benchmark progress and Trust data can be used to develop National outlook for net zero emissions target delivery and Delivering a Greener NHS Delivery plan delivery. **Owner Sustainability Lead.**
Gaps in assurance (Gaps in assurance addressed in 2023/24 have been removed) • Greener NHS Dashboard (benchmarking Trusts against each other, by service type e.g. acute/mental health, by ICS and by Region).	**Actions to address gaps in assurance** • Greener NHS Dashboard- Need to continue to improve input into the Greener NHS Data and analytics tools, including the Green Plan Support Tool to pull out benchmarking data. Some scrutiny required of carbon footprint output for each Trust in case variable proxies or apportionment assigned. Data reflected in the Annual Report for 2023/24. See above. **Owner Sustainability Lead**
• Gaps in representation of clinical and medical directorates at Sustainable Development Group and to take ownership of Green Plan Action Plan Actions under the Sustainable Models of Care Area of Focus. **GAP closed.**	• A review and plan will be developed to establish a "Sustainable Models of Care" sub group to the Sustainable Development Group to provide ownership of the Sustainable Models of Care Green Plan Actions. **31st March 24 Sustainability Lead in place. Action closed.**
• More assurance required on how funding to deliver the Green Plan will be sourced/ assigned.	• Assurance gap funding: Continue to identify opportunities and apply for bids/funding submitting applications, e.g. Low Carbon Skills Funding, Public Sector Decarbonisation Scheme. Continue work/ upskills Finance/ Procurement Teams to ensure whole life costing is applied to revenue/ capital spend so ROI can be determined on opportunities to embed/ enhance sustainable development. **Sustainability Lead** – application for low carbon skills funding submitted in Q1 2024/25 – outcome pending. We will respond to future opportunities as they emerge. **Action proposed to be closed after funding has been confirmed.**
• Gaps in representation from Service Users or those with Lived experience in Sustainable Development Group.	• Work is ongoing to make links with Service User Engagement team to review what engagement with Sustainable Development Group could involve including the intent to make clearer and more meaningful links with service users to support co-**production of the next Green Plan strategy (Due 2025/26) – Sustainability Lead**

NEW RISK REF – BAF 32 Proposed wording – There Is a risk that our estate does not enable the delivery of our strategic priorities and meet the quality and safety needs of our service users and appropriate working environment for our staff resulting in suboptimal effectiveness, efficiency, experience and quality of care.

STRATEGIC AIMS	STRATEGIC PRIORITIES	Executive lead: Executive Director of Strategy Board oversight: Finance and Performance Committee Last reviewed – July 2024 . Next review – September 2024. Risk type: Quality and Safety Risk appetite: Low to Moderate (minimal and cautious) Risk rating impact v likelihood - Current 4 x 3 = 12 - Target 3 x 2 = 6 - Movement – NA as new risk Corresponding corporate risks: 3679
- Deliver Outstanding Care - Effective use of resources - Ensuring services are Inclusive - Create a great place to work	- Deliver therapeutic environments - Improve access so people wait well and wait less - Deliver our financial plan and efficiency programme - Work in partnership to address health inequalities - Live our values improving experience and wellbeing	

On track	Some slippage	At risk	Completed	Assurance level	Amber

Summary update

- The space utilisation project is due to commence in July 2024. This has a significant contribution to make to our VIP plans. Work is underway to address the findings of the 23/24 PLACE assessment. Engagement with Sheffield HCP partners and SY ICS partners is ongoing, focused on identifying short term efficiency gains and building the case for longer term strategic investments.
- The TEP programme is in the final stage of delivery of the adult acute phase and is commencing scoping of the next phase to address older adult and rehab requirements.
- In July work has commenced on estates strategy refresh and developing a vision for a fit for purpose estate including 'new hospital'.
- Work remains ongoing to deliver asset disposals that contribute to space utilisation, and generate capital for re-investment.
- It was noted at FPC that the risk on Fire Doors remains as was – the doors on acute wards were changed. Current risk relates to G1 and Care Homes – the independent review will provide a verified status for all doors and then the risk can be re looked at.
- Target score changed from 4 x 2 to 3 x 2 to meet the new scoring requirements for a Low to Moderate risk appetite

Milestones in 2024/25 to support reaching target score:

- Opportunities for colocation and estate efficiency with Sheffield HCP partners explored by September 2024.
- Scope and timeline for next phase of Therapeutic Environments Programme confirmed by September 2024
- Opportunities from improved space utilisation quantified by November 2024
- Estates strategy refresh – December 2024
- Strategic outline case for new hospital (incl multi-site options) by December 2024

Controls

- Governance - Working as part of Place Estates priority to optimise use of the NHS estate. Reporting through FPC, Business Planning Group, Capital Planning.
- Checks through estate work – such as water safety, fire safety, lifts, electrical and gas
- PLACE audit – provide benchmarking information and support identifying areas for action.

<table>
<tr><td colspan="2">
• ERIC returns – provide benchmarking information.
• Authorised Engineers all in place.
• Maintenance programme of work in place
• Capital plan
• Contracting arrangements in place for buildings leased and not owned.
</td></tr>
<tr><td><u>Internal assurance</u>
• Annual PLACE report and associated action plan
• Annual Premises Assurance Model (PAM)
• 7 facet survey report
• Annual Health and Safety Report (and quarterly updates received at Assurance Committees)</td><td><u>External assurance</u>
• Authorised Engineers Annual Audit
• ERIC returns and benchmarking</td></tr>
<tr><td><u>Gaps in controls</u>
• Require an additional external review of our fire doors and our systems for monitoring.</td><td><u>Actions to address gaps in controls</u>
• Commission independent external review – received at EMT in June 2024 and reported thereafter at FPC and in AAA reporting Board in July 2024 – Owner Director of Strategy</td></tr>
<tr><td><u>Gaps in assurance</u>
• See above re Fire Safety</td><td><u>Actions to address gaps in assurance</u>
• Commission AE assessment of the competencies required of internal teams. Report by September 2024 – Owner Director of Strategy</td></tr>
</table>

BOARD ASSURANCE FRAMEWORK 2024/25 DRAFT FOR APPROVAL
As at 17.07.24
Appendix 3

BAF RISKS OVERSEEN AT PEOPLE COMMITTEE

RISK REF – BAF 0013 - Proposed wording - Risk that our staff do not feel well supported, caused by a lack of appropriate measures and mechanisms in place to support staff wellbeing resulting in a poor experience for staff, failure to provide a positive working environment and potential for increase in absence and gaps in health inequalities which in turn impacts negatively on service user/patient care.

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	**Executive lead:** Executive Director of People **Board oversight:** People Committee **Last reviewed** – July 2024. **Next review** – September 2024. **Risk type:** Workforce **Risk appetite:** High (open) **Risk rating impact v likelihood** - Current 4 X 3 = 12 - Target 4 x 2 = 8 - Movement ⟺ Corresponding risks on the Corporate Risk Register: none currently
- Deliver outstanding care - Create a Great Place to Work	- Deliver our quality and safety objectives - Live our values, improving experience and wellbeing - Improving staff engagement and involvement	

On track	Some slippage	At risk	Completed	**Assurance level**	**Amber**

Summary update

- It is considered there remains a strategic risk around not ensuring we have good support mechanisms in place for staff that address the staff experience and working environment noting we need to make changes to address trends and absences which are continuing to rise.
- **Updated risk description for discussion and approval.**
- There are actions identified in work covered under the existing milestones that will have a positive impact on the work environment such as raising awareness and increasing reporting. Supporting managers to more effectively embed a safe and health culture (which is one of our People Promise themes)
- Will take place across the year. Wellbeing champions being recruited – 20 to date.
- V & A levels are monitored and sexual safety dashboard has been developed
- Have confirmed SLAs and performance targets which are being achieved and contract performance has improved.

Milestones in 2024/25 to support reaching target score:

- Staff side Recognition agreement – refreshed agreement to be in place and launched in May 2024 after JCF.
- Dedicated Wellbeing champion roles in place – original target June 2023 – 6 are in post, revised plan to develop wellbeing champions network target expected in Q2 – on track
- Complete diagnostic self-assessment of the health and well-being self-assessment (7 key areas) –dynamic tool. At the last Health and Wellbeing meeting it was recognised there are things being taken forward across the organisation which are not formally reflected and learned from through the health and wellbeing work. It identified overlap with OD work and the dedicated wellbeing practitioner is working across the organisation to look at where the other work will be taken forward – linking up our wellbeing champion network roles so they have a better understanding of everything happening. Reporting through the merged assurance group reporting into People committee. We will repeat the assessment in January 2025 and it will be repeated annually.
- Completion of the wellbeing engagement events and development of the network which is a 2024/25 priority. Roadshows are underway with a programme across the financial year.
- Completion of review of Occupational Health Contract – Annual contract meeting against SLAs held with STH in May 2024. **Achieved**
- Team sessions will be put in place to support managers with occupational health referrals from June 2024.

• Target score updated from 3 x 2 to 4 x 2 to meet the new scoring requirements for risk appetite.	• Reduction target for V & A to be identified with the Chair of the V & A reduction group – by September 2024. • Values into behaviours work – implementation phase to be completed by the end of August 2024.
Controls • Governance – ICS HRD Deputy Network, ICS staff Health and Wellbeing Group, National Wellbeing Guardian Network, People Strategy Delivery Plan in place April 2023 and reviewed through tier II groups into People Committee, Regular reporting to committees and to SHWB group, Reporting to the ICS (including on HWB) • NHSEI National Wellbeing lead and ICS Wellbeing Group • HWB Framework in place • NHS People Plan and actions for HR and OD • South Yorkshire People leaders meeting (multi agency) which provides a system view around a range of areas to support people related issues in work. • The ICS have established a wellbeing roadmap and there are three ICS groups around people, partnerships, prevention and proof [the Trust has nominated a lead to work alongside colleagues to influence the development of this] • Board level Wellbeing Guardian in place • OD function incorporates wellbeing support. • Supporting staff with complex long-term conditions. - special interest group (ICS) • Professional nurse advocates in place (nurses) now extended a restorative supervision offer to all staff • Staff Health and Wellbeing group in place with expanded membership having been reviewed. Group monitors delivery of the People strategy reporting to People Committee. • Vaccination planning • New OH provider in place from Jan 23 with review arrangements in place.	
Internal assurance • Menopause accreditation in place from September 2023 • People strategy (approved March 2023) – has a deliverable to support managers to deliver team and individual wellbeing. • Governance reporting to People Committee • Service-led IPQR's monitoring. • Health and Wellbeing self- assessment toolkit. • Wellbeing and Engagement lead in place. • Return to work meetings monitored through eRoster. • Wellbeing conversation guidance now embedded in revised Supervision Policy. • Reports to People Committee include progress on milestones. • Diagnostic undertaken against national wellbeing framework (informed People strategy review and delivery plan) – updates received at People Committee	**External assurance** • Model Hospital and NHSE/I returns. • CQC Well-Led. • Internal audit 360 staff wellbeing audit - *Significant 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. • The ICS have established a wellbeing roadmap and there are three elements around people, prevention and partnerships this will support the delivery of our health and Wellbeing priorities in the People plan.
Gaps in control Gaps in controls addressed in 2023/24 have been removed. 1. Lack of systems to check quality well-being conversations are	**Actions to address gaps in controls** • Wellbeing focus group to establish factors impacting on wellbeing and tailor support where it is needed from September 2023 (new post in place and work progressing – it was agreed at wellbeing group to use the framework to set priorities – monitored through Tier III group and reported into People Committee) **Owner Head of OD**– Group established ongoing monitoring taking place no end

happening (although guidance has been issued)	date currently. • Wellbeing champions and the networks being established (this will now be undertaken by the HWB lead) – progressing expecting increase in expression of interest following roadshows. Roadshows completed and plan to develop network included in 24/25 priority. **Owner Executive Director of People**
2. Review of new Occupational Health Contract	• OH new contract in place QEIA completed for review. Evaluation of OH contract overdue. Timeframe for contract monitoring data/information to support the review has not been made available by STH to inform the review, delays being addressed robustly with STH – 24/25 improvement plan for OH service *Q2* **Deputy Director of People**
3. Wellbeing Self-assessment has limited clinical operations input	• Annual Wellbeing assessment– September 2024 **Deputy Director of People** • HWB network to be established - Priority for 24/25 (as above) – September 2024 **Deputy Director of People**
Gaps in assurance **Gaps in assurance addressed in 2023/24 have been removed)** • None currently identified.	**Actions to address gaps in assurance** N/A

RISK REF –BAF.0014 Proposed wording - There is a risk of failure to undertake effective workforce planning (train, retain and reform) to support recruiting, attracting and retaining staff to meet current and future needs caused by the absence of a long-term workforce plan that considers training requirements, flexible working and development of new roles resulting in failure to deliver a modern fit for purpose workforce.

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	
- Create a Great Place to Work - Effective Use of Resources	- Live our values, improving experience and wellbeing - Improving staff engagement and involvement - Deliver our financial plan and efficiency programme	**Executive lead:** Executive Director of People **Board oversight:** People Committee **Last reviewed** – July 2024. **Next review** – September 2024. **Risk type:** Workforce **Risk appetite:** High (open) **Risk rating impact v likelihood** - Current 4 x 3 = 12 - Target 4 x 2 = 8 - Movement ⟺ Corresponding risks on the Corporate Risk Register: 5321 -

On track	Some slippage	At risk	Completed	**Assurance level**	**Amber**

Summary update	**Milestones in 2024/25 to support reaching target score:**
• It is felt this remains a strategic risk whilst we have workforce plans in place, not all are delivered and some require further work however we have identified how workforce plans can be better	• Service-led 3-year workforce plan in place for all areas – whilst we have workforce plans in place, not all are delivered and some require further work however we have identified how workforce plans can be better integrated. To be delivered through the business planning process and will need to be reviewed as part of the

integrated. • We report to NHSE on workforce trajectories based on a range of conversations however we need to link this with what we really think our workforce will be like and to link this with the VIP work and with recovery plans to make the workforce plans effective and impactful. • It is recommended the risk appetite remain moderate as we need to be open to innovation. • Action planning is taking place to reflect on the staff survey from 2023. • Workforce and operational planning for the ICS is supporting development of our plans and making best use of ESR and reporting on establishment. There is ongoing significant focus on use of ESR as a single source of establishment data. There is a major dependency on Finance, People and IMST colleagues working together on this. • There is a financial risk around the data warehouse hosting and cost implications as IMST have not yet picked up hosting given EPR delay – this has resulted in financial implications as this is not currently deliverable in house and has been picked up in financial planning discussions. • In terms of meeting target score this will be confirmed as we need to collate finalise and review workforce plans. • Target score changed from 3 x 3 to 4 x 2 to meet new scoring requirements for risk appetite	VIP programme of work. Refinement will continue to take place through the remainder of the financial year. • SHSC recruitment plan (derived from the three-year workforce plan – how we do it) – we have professions plans which support the People Strategy which is helpful but need all of the profession plans to have a recruitment plan. AHP, Nursing Trainee docs and are completed as well as Peer Support. Plans outstanding and timeframes needed for Pharmacy and Medical. The plan for Psychology will be received in September 2024 meeting. The professional trajectories and pipelines are needed to support development of the recruitment plan for SHSC and detail on risks and opportunities from the workforce plans. This is therefore going to be delayed into Q3 potentially Q4 of the current 2024/25 financial year. The medical plan is currently paused whilst we are completing the medical establishment review but will be completed by October 2024. • Review of local reward and benefits offer – March 2024. Included in the 24/25 priority with a target date for Q1. Update expected and of June 2024 • Next Review of flexible working policy is due by October 2024.

Controls

- Governance - WPG monitoring delivery and reporting to People Committee, Recruitment and Retention Group for all professions in place, External ICS retention group, Workforce Recruitment and Retention Group to support identification of gaps – see new Gap in control will be addressed once merged group in place,
- From April 2023 the Workforce Transformation and Recruitment and Retention groups merged to one group now called Workforce Recruitment and Transformation group to support new merged BAF risk, Education and Training group governing apprenticeship levy, Recruitment delivery group for all professions put in place from March 2023
- Monthly reporting to NHSE, and ICS
- Health care support worker regional community of practice group hosted by NHSE
- TRAC reports feed into R & R group to oversee People delivery plan – recruitment reporting through the workforce dashboard goes to People Committee
- People Plan in place
- Annual learning needs analysis undertaken to inform Trust training plan priorities for workforce transformation and CPD funding investment *[from BAF risk 0019]*
- Ensuring 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]*
- Workforce data dashboard
- TRAC system in place to manage ALL recruitment. Tracked and reported to People Committee
- Training and further guidance for recruiting managers on TRAC. Rolling programme of training is in place**.**

Internal assurance

Governance reporting:

- Bi-monthly reporting to People Committee and Board; 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]* Recruitment and Retention Group reports to People and Recruitment and retention group (and reports received at People Committee). A set of subgroups has been established reporting to the newly formed Workforce Recruitment and Transformation group. A medical recruitment and engagement group (a subgroup of the assurance group) has been in place since December 2022
- HR team have engaged with services to support completion of Training Needs Analysis templates to identify their needs *[from BAF risk 0019]*
- Deep dive took place into retention at People Committee in April 2022
- People Delivery plan final version presented to People Committee. This is set and reviewed annually over the three year strategy.
- Improved data and systems to support accurate vacancy in place following work by People and Finance directorates. ESR has been updated with funded establishments. This gives workforce the ability to accurately report on

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.
- 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]
- National People Plan reports into ICS.
- Progress with international recruitment 15 International nurses arriving this year (2023/24).
- NHSEI Performance workforce returns + direct support
- NHSEI and People workforce return (PWR) reporting which triangulates and checks our data
- PWR reporting and NHSEI governance for international recruitment

vacancies (funded establishment – Staff in post) and means vacancy data can be updated on a daily basis.	
Gaps in control Gaps in controls addressed in 2023/24 have been removed. 1. Annual learning needs analysis undertaken to inform training plan priorities for investment (completed at high level for external funding only some gaps in process)	**Actions to address gaps in controls** • The plan for supporting usage was reviewed in 2023/24. The process for collecting high level learning needs has been improved with ownership and engagement from senior nurses and Deputy AHP Lead and governance through the education contract group. Continuing to identify funding available for CPD **Owner Head of Workforce Development and Training** – target date September 2024. • Consideration is being given as to how best to do a full organisation high level learning needs analysis. Timing of this is to be confirmed as to whether it is deliverable in the current financial year. **Owner Head of Workforce Development and Training –** target date end of March 2025
Gaps in assurance Gaps in assurance addressed in 2023/24 have been removed) 1. ESR data poor quality GAP 4 closed for poor quality but open for vulnerability of the data as multiple dependencies. **GAP closed.**	**Actions to address gaps in assurance** • Building on work which took place in 2023/24 which included cleansing data to maintain the data integrity all contractual changes to ESR, all new starters and all establishment change requests have to be approved by both finance and Workforce before any amendments to ESR or the ledger are made Owner Interim Workforce Systems Lead (Steven Sellars) – **Actions to improve data quality ongoing as part of manager self-service roll out April 2024**. **Achieved and will be ongoing** – it is recognised given there are smaller teams for quality control monitoring there are vulnerabilities around quality control checking – mitigations are in place. However, positively the internal audit on data quality has been received with significant assurance.

RISK REF – 0020 Proposed wording - Risk of failure as an organisation to live by our values caused by not addressing closed cultures poor behavioural issues and lack of respect for equality diversity and inclusion, resulting in poor engagement and communication, ineffective leadership and poor staff experience in turn impacting on our staff survey results, quality of service user experience and attracting and retaining high quality staff.					
STRATEGIC AIMS CREATE A GREAT PLACE TO WORK		**STRATEGIC PRIORITIES** - Live our values, improving experience and wellbeing - Improving staff engagement and involvement		**Executive lead:** Executive Director of People **Board oversight:** People Committee **Last reviewed** – July 2024. **Next review** – September 2024. **Risk type:** Clinical Quality and Safety **Risk appetite:** Low to Moderate (minimal and cautious) **Risk rating impact v likelihood** - Current 4 x 3 = 12 - Target 3 x 2 = 6 - Movement ⟺ Corresponding risks on the Corporate Risk Register: None currently	
On track	**Some slippage**	At risk	Completed	**Assurance level**	**Amber**
Summary update • It is felt this remains a strategic risk – work has begun and is directly linked to the Values into Behaviour work and through that work similar issues continue to be raised. • EDI could be covered through this risk in terms of identifying controls, gaps and actions and with additional wording added to		**Milestones in 2024/25 to support reaching target score:** • Values into behaviours consultation and launch of outcomes – April to December 2023 now in implementation phase. In August 2023 engaged external consultants to contribute to the communications structures and this work. A revised approach has been developed to ensure a larger number of the workforce are engaged through this programme of work. Consultation and engagement on values into behaviours commenced outlined in People Delivery plan and outputs received at Board of Directors in Q1			

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the description. This is being followed up by the Deputy Director of People with the EDI lead to provide a view.
• Consideration being given as to whether a TNA is needed around training (mandatory) and beyond mandatory.
• Should consideration be given to including a BAF risk around staff having access to the right skills and training to deliver care overseen at People Committee or Quality Assurance Committee? A milestone for this would be a high level TNA for each directorate for the next 2 – 3 years.
• Target score changed from 3 x 3 to 3 x 2 to meet the new scoring requirements for Low to Moderate risk appetite
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of 2024/25.
• Expectations of SHSC Managers and Leaders – consultation on expectations of managers and leaders will be part of our values into behaviours consultation. Outcomes will define our leadership and management development offers – development of SHSC manager commenced Launch 24/25 – will be delivered in Q3/Q4 of 2024/25
• SHSC Manager Development offer – new offer defined to be launch 24/25 –in progress and is a priority for this financial year – to be in place by end of September 2024.
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<u>Controls</u>
• Governance - Reporting to People Committee, Staff Engagement Steering Group established to increase engagement and reporting to People Committee
• NHSEI National and regional People Plan
• 2023 -26 People Strategy approved at Board in March 23.
• OD framework in place and detailed within People strategy delivery plan
• Board visits programme (15 steps)
• Restorative Just and Learning process
• FTSUG processes
• Refreshed People Delivery Plan
• Leadership development offer in place – Team SHSC – Developing as Leaders programme.
• Agile mindsets & behaviours leadership programme (contracted programme)
• Fundamental standards of care visits completed across inpatient. Action plans in place. Culture and Quality visit programme in place for community services.
• Transformation Board reports (monthly)
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<u>Internal assurance</u>
• Staff engagement steering group reports monthly to Organisational Development Assurance Group which reporting into People Committee bi- monthly
• People Plan 23 -24 received at May People committee (contains all OD activity)
• People Committee received refreshed deliverables in 2022
• People Pulse survey
• OD actions were refreshed as part of the People Plan update for 2022-23 NEW assurance following closure of action in March
• Team SHSC: developing as Leaders Cohort 3 recruited to with line manager and Exec support. 30 participants. Will run June 2023 to December 2023. Day 1 held 12.6.23 and Day 2 19.07.23. Positive evaluation received from both days. Called in nominees for the next cohort.
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<u>External assurance</u>
• Quality Board bi-monthly report
• ICS HR Directors Group (NHS HR Futures report) – long term 10 year strategy to make improvements in HR and OD in the NHS to support delivery of the NHS People Plan
• NHS National Survey – amalgamated benchmarking across sector
• NHS People Plan provides assurance that SHSC People Strategy was developed taking account of this.
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• Agile Mindset & Behaviours leadership programme –3 Cohorts completed now 30 leaders trained in Agile Mindset & Behaviours methodology and tools. Cohort 4 underway 11 participants working through the 20 week programme. Two learning events have been held to embed knowledge. Consideration taking place on future approach for embedding learning. • People Pulse July results showed an increase in Mood in all 9 Engagement scores.	
Gaps in control **Gaps in controls addressed in 2023/24 have been removed.**	**Actions to address gaps in controls** N/A
1. Mechanism needs to be in place to gather and consolidate (triangulate) all staff data and themes.	• Framework on a page is being developed – July 2023. Head of OD (Charlotte Turnbull) – **Action closed July 2023** • Exploratory meeting with Quality, Service Improvement, Business Performance, IT held to see how different data areas could work together more effectively to support our managers/leaders took place on 08.08.23 – confirmation taking place with the lead to ascertain if anything further is required before this gap/and associated action is closed down. People committee and JCF and the FTSUG receive casework info further consideration to take place around where and what should be shared for example in the Public Learning Lessons Report at QAC and the IPQR [note – we also have the confidential report to the Board]. **This action is closed as staff survey data and arising action plans will be included within reporting to EPQR process wef May 2024- Owner Head of OD.**
Gaps in assurance **Gaps in assurance addressed in 2023/24 have been removed)**	**Actions to address gaps in assurance** N/A
1. Low engagement scores – confirming with operational lead this is from staff survey and pulse survey data	• Action planning at service level in progress, staff engagement included as part of the triannual Performance review meetings with the Exec team with services reporting progress on action plans (based on people promise themes). Templates have gone out. Confirmation required that the templates are being fully utilized before the gap can be closed down for the next review of the BAF risk (October) will be tested through performance review process - Reviewing the approach, templates shared but not fully utilized. Improvement in staff survey response rates for substantive and bank staff in 2023, but People Pulse response rates variable. Reviewing change of use of People Pulse survey from 3 times a year to possibly 1 in order that we have an ~~interim measure for staff sur~~vey and reduce ask of staff. Being explored in line with national requirements. **Update received at People Committee in May**. **Owner Head of OD and Deputy Director of People**