Front Sheet: Public Board of Directors
Item number: 21
Date: 29 January 2025

Private/ public paper:	Public
Report Title:	**Board Assurance Framework 2024/25**
Author(s) Accountable Director:	Dawn Pearson, Associate Director of Communications and Corporate Governance
Presented by:	Dawn Pearson, Associate Director of Communications and Corporate Governance
Vision and values:	The Trust vision is to ensure we **work together for service users**. The BAF helps to assure us that any identified risks are managed, so we can continue to **improve the lives** of the people we serve, through safe and effective services and demonstrate our **commitment to quality**.
Purpose and key actions:	The purpose of this report is to share the updated BAF reports following review by all executive director leads and EMT and to note that relevant Committees were assured that these now reflect the current position and scores. ARC who has oversight of all risks have also provided additional assurance. All updates are appended as follows: Appendix 1: Quality Appendix 2: People Appendix 3: Finance and performance The purpose of the report is to provide the final updates of the BAF for approval.
Executive summary:	The paper includes in each appendix the most up to date board assurance framework (BAF). All confirmed **proposed changes to the BAF risk descriptions are highlighted in blue text.** The updates are also reflected in the summary which describe the impact and progress, including a review of the risk score. The following BAF risks have been updated **for quarter 3:**

1. Quality:

Risk	Description summary	Risk rating impact v likelihood
0024	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.	Current 4 x 3 = 12 Target 4 x 1 = 4 Movement ⟷
0025B	There is a risk of failure to deliver the therapeutic environments programme at the required pace caused by difficulty in accessing capital funds	Current 4 x 4 = 16 Target 3 x 2 = 6 Movement ⟷
0029	There is a risk of a delay in people accessing core mental health services caused by issues with models of care, access to beds, flow, crisis care management	Current 4 x 4 = 16 Target 3 x 1 = 3 Movement ⟷
0031	There is a risk we fail to deliver on national inequalities priorities and our strategic aim to deliver inclusive services, caused by failure to adopt an inequalities-based approach to care resulting in poorer access, later presentations and risk of poorer outcomes.	Current 4 x 3 = 12 Target 3 x 2 = 6 Movement ⟷

2. People:

Risk	Description summary	Risk rating impact v likelihood

0013	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.	Current 4 X 3 = 12 Target 4 x 2 = 8 Movement ⟷
0014	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.	Current 4 x 3 = 12 Target 4 x 2 = 8 Movement ⟷
0020	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.	Current 4 x 3 = 12 Target 4 x 2 = 8 Movement ⟷

3. Finance and performance:

Risk	Description summary	Risk rating impact v likelihood
0021A	There is a risk of failure to ensure digital systems are in place to meet current and future business needs.	Current 4 x 3 = 12 Target 3 x 2 = 6 Movement ⟷
0021B	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	Current 4 x 3 = 12 Target 3 x 2 = 6 Movement ⟷
0022	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	Current 4 x 4 = 16 Target 3 x 1 = 3 Movement ⟷
0026	There is a risk that we fail to take evidence led approach to change and improvement	Current 4 x 4 = 16 Target 4 x 2 = 8 Movement ⟷
0027	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	Current 4 x 3 = 12 Target 4 x 2 = 8 Movement ⟷
0030	There is a risk of failure to maintain and deliver on the SHSC Green Plan.	Current 3 x 4 = 12 Target 2 x 4= 8 Movement ⟷

Which strategic objective does the item primarily contribute to:					
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*		

What is the contribution to the delivery of standards, legal obligations and/or wider system and partnership working.	
The BAF is the main tool by which the Board overall responsibility for internal control. Owned by the Board, it is a key tool to assure and evidence the delivery of strategic objectives.	
BAF and corporate risk/s:	The paper provides assurance for all BAF risks and corresponding corporate risks are noted within the report.
Any background papers/ items previously considered:	All changes to the BAF are noted and approved by Trust Board. It was agreed at the Board in September 2024 that review discussions of the Board Assurance framework (BAF) should now focus on the gap between the current score and the target score.
Recommendation:	The Trust Board are asked to: • **Approve** the updates • Ensure updates identify gaps to achieve the required target score

BOARD ASSURANCE FRAMEWORK 2024/25
Appendix 1 for receipt in January 2025

BAF RISKS OVERSEEN BY QUALITY ASSURANCE COMMITTEE

BAF RISK 0024 – 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.

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	**Executive lead:** Executive Director – Nursing and Professions /Medical Director **Board oversight:** Quality Assurance Committee **Last reviewed** – December 2024. **Next review** – February 2025 for receipt at EMT and the Board in March 2025. **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:** 5026, 5124
- Deliver outstanding care - Ensure our services are inclusive	- Deliver our quality and safety objectives	

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

Summary Update

- Robust actions have been put in place to address the gaps in quality governance which will support the risk in moving towards the target score.
- Diagnostic work and improvement work is being put in place and the impact of these is expected to address the risk score moving.

Progress against Milestones for 2024/25

Completion of outstanding actions from the Back to Good programme –

- Planning to ensure that LAP review is going to be held by the Therapeutics Environment Board (TEP) Board – to take place by the 31 December 2024**.** This is ongoing and is on track to be achieved by the 31 December
- **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. This is currently being overseen by the Operational Management Group (OMG) and reports to EMT on a monthly basis. Work with inputting supervision into ESR will take place early 2025. This will be embedded in governance at all levels for monitoring and training compliance, which will feed into the quality governance review that is being planned.
- Fundamental Standards visits – the programme will be reviewed for the forthcoming financial

	year with a review of the templates/ audit tool. in line with the new CQC standards. By April 2025 for the templates and programme. • Development of record audits tool by Jan 2025 and an improvement action plan by March 2025 to be able to provide assurance of open cultures in key areas, **Milestones completed** • **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 June 2024. Cross reference to BAF risks 0025a and 0025b **completed.**

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 a level of 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 patient experience measures are 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.
- Establishment of OMG which consists of leaders from all directorates.
- Updated Capital Plan received at Board in April 2024 with updates received at subsequent Board meetings.
- Full business case for Maple improvements were received at Board in April 2024 and an update received in December 2024. This approved and in waiting to be inacted when funding steams are aligned

Internal assurance	**External 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.	• 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

• New EPR plan approved by the Board in April 2024. • OMG oversight with reporting to EMT • Completion of the Fixed Ligature Anchor Point programme for acute adult in patient services - the risk to service users has been mitigated through the planned decant of Maple ward to Dovedale 2 following its move to Burbage - at the end of June 2024.	
Gaps in assurance (those addressed in 2023/24 have been removed)	**Actions to address gaps in assurance:**
1. Tendable is not being used consistently	• A Module on Ulyssess is being developed, and the audits from Tendable will be moved across by Jan 2025. Executive Director of Nursing, Quality and Professions
2. Regular reporting through governance routes including learning lessons, safeguarding reports, staffing reports, transformation programme reports.	• Further improvement to governance processes required to strengthen assurance and learning is shared across the organisation. An review of the Quality Governance architecture has been commissioned and will be undertaken during Q4 2024-25.
3. Completion of the Fixed Ligature Anchor Point programme	• Scoping of work that is required in the Older Adults acute wards to eradicate LAP is taking place. There is some outstanding work on Forest Lodge low secure unit which is currently being planned for essential works. This is subject to the capital plan prioritisation by end of March 25. The LAP won't be complete until Maple ward complete, but people have been decanted from Maple which addresses this problem. Grenoside is on the capital plan. Owner Director of Operations.
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. **GAP closed.**	• Maple ward has been decanted to refurbished Stanage ward Dovedale 2 ward 27 June 2024 **Owner Director of Strategy Action closed** • 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. Only PICU is mixed gender now.	• Plans are being worked up to explore options for the management of mixed sex gender on PICU. Maple ward has closed. Currently undertaking an options appraisal of the future of delivery if mixed gender care in PICU – by the end of Nov 2024 for the options paper **Owner Director of Operations** • The Sexual Safety working group is in place reporting into QAC 6 monthly.
3. We are restricted on our capital spend each year and we have a large programme of estates improvements which means that they have to be phased over the next two years. **GAP closed**	• Updated Capital Plan received at Board April 2024. **Owners Director of Finance and 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.The plan is still to move to ESR for recording. This and reporting frequency is being reviewed by OMG 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. Meeting with leaders from all clinical areas on a weekly basis to deliver a rapid improvement plan. We are working with GIRFT who have provided initial feedback which will be used to support rapid improvement. Commissioned external support with medium term improvement. We have established a programme board to oversee flow and effective working between service lines – this will be in place by the end of September 2024 and will report into EMT, QAC, FPC. **Owner Director of Operations.** The Home First programme has been established to oversee flow. Teams have received feedback from the assessment from GIRFT, and Real World Health have been commissioned to review flow pathways. They will be providing a digital platform so that resolution of the challenges can be data driven – March 25
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 breaching 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. There continues to be some breaching and this remains under regular review. **Owner Director of Operations.** There was further deterioration in Quarter 3, in relation to breach of use of the 136 beds. It is a priory of the Home First Programme to prevent this.
7. Recovery plans to date are not having sufficient impact on waiting times, this is being addressed through the Community Transformation which will be completed in January 2024. **GAP CLOSED (July 2024)**	• Recovery plans have been received through QAC. We continue to see a downward trajectory of people waiting for the newly transformed recovery services. **Action closed.**
8. Establishment of OMG which consists of leaders from all directorates.	• The reporting framework and work programme of governance structures will be reviewed by Director of Operations and Associate Director of Communications and Operations- January 2025. There are a number of Tier 2 committees that report into Quality Assurance Committee and provide assurances at the present time.
9. Patient experience measures are in place but Friends and Family test (FFT) data is low, and the care opinion subscription no longer in place.	• The FFT has now gone live on Qualtrics which provides an online way to give feedback this is accessible via QR code and marketed on Jarvis, SHSC external website, and posters circulated to services. The engagement team will work with services to raise awareness of Qualtrics and encourage services to embed this work and understand the barriers faced. FFT performance will continue to be monitored through LECAG and the IPQR

RISK REF: BAF.025B - There is a risk of failure to deliver the therapeutic environments 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~~ impact on 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** – December 2024. **Next review** – February 2025 for receipt at EMT and the Board in March 2025. **Risk type:** Safety **Risk appetite:** Moderate (cautious) **Risk rating impact v likelihood** - Current 4 x 4 = 16 For discussion at EMT in February - Target 3 x 2 = 6 - Movement ⟺ - **Assurance rating** –Amber - **Corresponding Corporate risks – 5344**
- 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

- **Due to the availability of in year capital slippage from the system in Dec 2024 capital work can progress Maple ward refurbishment can now commence in Q4 24/25 and will form part of capital planning in 25/26.**
- **Fulwood estate position continues into Q4**
- **Several milestones have now been achieved with LAP risk milestones covered in next phase for TEP.**
- **Discussion to reduce risk score to take place in Feb EMT.**

Milestones in 2024/25 to support reaching target score:

- Commence refurbishment of Maple during 2024 – dependent upon availability of Capital funds. Business case approved in principle by Board in April 2024. Update December 2024. Delays in receipt of funds mean no longer possible to commence Maple Ward works in 2024. To be re-planned as part of capital planning for 25/26 in Q4 of 24/25
- Milestones around addressing the remaining LAP risks in the estate is covered in the scope for next phase of TEP
- Agree revisions to the capital plan and mitigations for schemes that are delayed, reflecting latest position with regard to the Fulwood receipt – September 2024 update December 2024, dynamic revision of capital plan undertaken in response to possible availability of in-year capital slippage from system. Will be in position to clarify the outcome of bids made in Q4 24/25
- Strategic Outline business case for a new hospital – December 2024 update December 2024, work continues into Q4

Milestones Completed

- Stanage refurbishment – The Stanage ward re-opened in April 2024. Achieved.
- Dovedale 2 moved to Burbage – May 2024 – **completed.**
- Maple Ward decant to Dovedale 2 –27 June 2024 –**completed.**
- Clinical Environmental Risk Group to include detail on any outstanding works – by July 2024 - **completed.**

	• Estates strategy – Interim report July 2024 **completed.** • ICS infrastructure strategy – July 2024 **– completed.**

Control

- Governance was in place to oversee Maple and associated moves
- Maple full business case received at Board April 2024.
- 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 confirmed remaining LAP works for wards was completed in June 2024 and the group receives detail on any outstanding works.
- Estates Strategy interim review – September 2024
- ICS infrastructure strategy – to which SHSC has inputted.

Internal assurance	**External 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 Dovedale 2 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. • Maple Ward decant to Dovedale June 2024 • Clinical Environmental Risk Group receives detail on any outstanding works • Estates Strategy interim review received at Board September 2024 • ICS Infrastructure Strategy (SHSC has contributed to its development)	• 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 (July 2024)**	
2. Delays in the delivery of Therapeutic Environment Programme (TEP).	• The scope of the work for the next phase of the Therapeutics Environment programme (TEP) has been drafted by the programme team and will go through the approval process by November 2024. Owner Director of Strategy. Report received at EMT December 2024
	• 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. Addressed through work to close the Maple ward – completed June 2024 **Action Closed**
	• Maple business case Full Business case approved in April 2024**. Owner Director of Strategy**. **Action closed**
3. **GAP removed as duplication**	**Action removed as duplication.**
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 There is a risk of a delay in people accessing core mental health services 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** – December 2024 **Next review** – February 2025 for receipt at EMT and the Board in March 2025. **Risk type: Safety** **Risk appetite:** Low (minimal) **Risk rating impact v likelihood** - Current 4 x 4 = 16 risk - Target 3 x 1 = 3 - Movement ⟺ - Corresponding Corporate Risks: 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:**
• We continue to make good progress with our waits for core mental health service and Sheffield Psychological Therapy Service and are benchmarking favorably • Our challenge core area for waiting is the Sheffield Memory Service, which is subject	• Agreement of Gender service investment – this remains a challenge in terms of demand and capacity – issues have been escalated to NHSE. No change • ADHD – a review of ADHD pathway to support the reduction of current of waits by 31

to a recovery plan. • ADHD and Gender Service continue to be significantly challenged with waits. Although, the Gender Service us meeting contracted activity, this will not impact on those waiting in a meaningful way. This is a national challenge. ADHD assessments have recommenced, however, we are still working with the ICB Sheffield Place and the Mental Health Collalborative to ensure a sustainable service offer	December 2024 No change • PCMHT and Urgent and Crisis Care - currently being embedded and governing programme set to end in November 2024, after which this will go to BAU. No change **Milestones completed** • CMHT transformation – current lifestyle stage implementation is on track for completion by July 2024. This has been implemented - **completed.**
Control • 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'. • 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. • Continuing to engage with ICB and other partners around unmet commissioning priorities • Guidance from NHSE around requirements for support to 17 year olds received and being followed.	**Internal assurance** • 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. • ~~Leadership Recovery plans~~ • ~~Community recovery plans for relevant services~~. Allocation to named worker recovery plan. • Memory Service recovery plan • Culture and quality visits • Contracting updates as required. • Improved oversight of people waiting in CMHT's and Crisis and Urgent Team ~~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. • CMHT transformation – current lifestyle stage implementation completed July 2024 completed now bedding in • NHSE regional deep dive on Gender Services – positive feedback received actions identified and addressed. Implemented changes and have recently been assessed by the Levy Review team and awaiting feedback. **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~~ Attempting to move close to the 4-week waiting standard for relevant core services funding dependent
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	**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 2024/25 in terms of a reduction of up to c50%. This remains ongoing.

protocol to regularly review people's needs whilst waiting and apply a RAG rating to prioritise contact.	• There has been no further movement on Gender Services around investment and the Trust is continuing to engage and escalate. However, a recent review by NHSE provided positive feedback on service model and delivery and we have implemented the feedback. We now await the feedback from the Levy Review in early Q4 24/25 .
	• **Other actions were closed at the July 2024 Board.**
2. All areas require clear commissioning specification, which require a review and process implemented by Sheffield place, helping us to really understand who a service is for This is still on going and is an action led by Place.	• 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 Finance. Further update on progress to be provided in September. This remains ongoing **Owner – Senior Head of Services** and Chris Cotton, Deputy Dir of Finance This is being worked on with Sheffield Place and Our contract team. There are still a significant numbers of service specs outstanding – completion October 2025.
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. **GAP CLOSED – confirmed at July 2024 Board**	
2. Staff vacancies and turnover remains high in some areas **GAP CLOSED as no current issues –at July 2024 Board**	
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 service users - no further action needed currently **GAP closed – at July 2024 Board**	

BAF 0031 There is a risk we fail to deliver on national inequalities priorities and our strategic aim to deliver inclusive services, 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** – December 2024. **Next review** – February 2025 for receipt at EMT and the Board in March 2025. **Risk type:** strategic/ quality **Risk appetite:** Moderate (cautious) **Risk rating impact v likelihood –** Scoring 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

- **Several milestones are complete with other milestones on track for end of financial year 2024/25**
- **Trust strategy refresh will have a baseline EIA and a focus on addressing health inequalities.**
- **Recording of protected characteristics remains static and an approach to increase is being supported through communication and a dedicated strand of work which includes RIO.**

Milestones in 2024/25 to support reaching target score:

- 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
- Trust Strategy refresh to strengthen focus on tackling inequalities by October 2024 – **Director of Strategy –** update December 2024 – this is underway

Milestones completed

- Board development session and around MHA QI, health inequalities self-assessment and PCREF – June 2024 – **completed**.
- 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 Completed
- All projects with the 'waiting well QI collaborative' have a health inequalities element by July 2024. All teams are being supported to consider health inequalities throughout their work with their coaches **Head of Quality Improvement – completed.**
- Following June Board session draft self-assessment to be presented back to Board for approval by September 2024 – **Director of Strategy completed**
- Publish alongside the Trust's Annual Report key information on health inequalities and details of how the Trust has responded to it, in accordance with NHS England's statement on information on health inequalities by October 2024 – **Head of Health Inequalities and Director of Strategy/Medical Director. completed**
-

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.
- All projects with the 'waiting well QI collaborative' have a health inequalities element was in place by July 2024. All teams are being supported to consider health inequalities throughout their work with their coaches

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 • Board development session and around MHA QI, health inequalities self-assessment and PCREF – June 2024	**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 – This remains a gap and is owned by Operations- Greg Hackney, Senior head of Service and is reported monthly through the IPQR.

BOARD ASSURANCE FRAMEWORK 2024/25
Appendix 3
post September Board for review in December for CP/SB

BAF RISKS OVERSEEN AT PEOPLE COMMITTEE

RISK REF – BAF 0013 – 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 failure to address 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** – September 2024. **Next review** – December 2024 for receipt at EMT in December 2024 and QAC/ Board in January 2025 **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: 5385
- 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

- Sickness rates remain high, and vaccination rates remain low.
- Partnership agreement is now in place
- 40+ champions on the health and wellbeing group
- Diagnostic self-assessment complete and task and finish group to develop a wellbeing plan, including comms to promote the offer
- Values into behaviors work in now in mobilisation phase.
- Continue to monitor violence and aggression through effective baseline data and reporting.

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. Going to JCF in September 2024, and ongoing partnership workshops to be planned for the Autumn – Oct 2024. Achieved - Went to JCF in Sept and Nov 2024, and final agreement has been confirmed.
- ~~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. Update – there are over 40 now in place, and induction sessions have been held. Achieved – move to controls~~. Provide assurance on staff experience. -staff survey results (wellbeing) and regular feedback through wellbeing champion grpu.
- 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. Diagnostic assessment has been completed several times, and it has been agreed at WODAG to set up a Task and Finish group to look at a wellbeing plan with a workshop planned for 26 Sept 2024. A task and finish group has been established and following its initial meeting it has been agreed to expand the membership to include key stakeholders and support co-production. Work to understand how to communicate the offer will take place – March 2025. • 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. Various events have been held and they will continue throughout the year and advertised through the organisation comms – remains ongoing and Involvement plans will be developed for the new financial year - April 2025. • ~~Reduction target~~ Improved reporting systems for Violence & Aggression ~~to be identified with the Chair of the V & A reduction group by the end of September 2024.~~ This remains ongoing – an update has been provided at EMT. Baseline data is available in the IPQR, SB ~~to take to V&A group for discussion and then to update these next 2 bullet points and conder whether an action is required in the 'actions to address gaps'~~ ~~Corpo~~rate risk 5385 updated with an action plan • Reduction target for V & A to be identified with the Chair of the V & A reduction group – by September 2024. Update for EMT rescheduled from August to September 2024 and this will include decision making on the target. • Values into behaviours work – ~~implementation phase to be completed by the end of August 2024~~. Workshop sessions have been held throughout August. Further workshops, open sessions and tools to take forward conversations are available on Jarvis. Phase 2 engagement to be completed by the end of September 2024 – achieved in Oct 2024 and the Values delivery group has been established. ~~Behaviours framework~~ • Creation of a wellbeing hub by the end of September 2024 –a bid is being developed for additional funding and exploring ways to co-locate workplace wellbeing. Implementation delayed and awaiting the outcome of the bid and potential estates – March 2025. • Flu vaccination 60% target for uptake – by end of December 2024. Flu vaccination uptake from the organisation has been lower during this financial year and the campaign has been extended into 2025.(• Establishment of cross Trust Sickness absence review group - by the end of September 2024. **Milestones completed** • 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. This is completed and the support/ training sessions are available for people to access on Jarvis**. Achieved**
Controls • Governance – ICS HRD Deputy Network, ICS staff Health and Wellbeing Group, National Wellbeing Guardian Network, People Strategy Delivery Plan in place and refreshed in April 2024 and reviewed through tier II groups into People Committee, Regular reporting to committees and to WODAG 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
- 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
- Vaccination planning
- Wellbeing Champions
- Now Wellbeing and OD Assurance group (WODAG) overseeing wellbeing support
- OH Contract in place and regular OH contract review meetings in place – quarterly.
- Violence and Aggression Group
- Sexual Safety Charter

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
- Sexual safety charter- the associated implementation plan is in place

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. Findings have informed the plans for 2024-25.
- 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.
- Sexual safety charter –development and oversight provided in partnership with NHS sexual safety and domestic abuse team

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

1. Lack of systems to check quality well-being conversations are happening (although guidance has been issued)

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) Group established ongoing monitoring taking place no end date currently. Absence Review Group to be established by end of Sept –**Owner Deputy Director of People** **Action closed with the appointment of the wellbeing and engagement lead, and the implementation of the champions**
- 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 40 plus champions now in place. **Owner Executive Director of People** **Action closed. Wellbeing champions recruited and**

	embedded.
2. Review of new Occupational Health Contract – **GAP closed.**	• 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* Achieved and regular reviews (quarterly) are in place. **Deputy Director of People** – **Action closed**
3. Wellbeing Self-assessment has limited clinical operations input	• Annual Wellbeing assessment– September 2024 Wellbeing champions network is established and the cross trust development of a wellbeing plan – 24 Sept. **Deputy Director of People** There is ongoing work with coproduction and stakeholder groups to develop the wellbeing plan by end of March 2025 - • HWB network to be established - Priority for 24/25 (as above) – September 2024 Update as above. **Deputy Director of People** The Health and Wellbeing network has been set up and this action is closed.
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 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 - Create a Great Place to Work - Effective Use of Resources	**STRATEGIC PRIORITIES** - 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** – September 2024. **Next review** – December 2024 for receipt at EMT in December 2024 and QAC/ Board in January 2025. **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 • Workforce planning has been integrated into the business planning process to ensure completion in all services and teams.		**Milestones in 2024/25 to support reaching target score:** • 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			

• Professions plans have been developed AHP, Nursing, trainee Doctors, PSW, Psychology all reporting to People Committee.	VIP programme of work. Refinement will continue to take place through the remainder of the financial year. It has been agreed that Annual workforce plans will be integrated into business planning. Workforce plan to be reviewed and compared to professions plan to ensure feasibility and delivery - October/ November 2024.52% of workforce plans have been received back as part of the ongoing business and operational oplanning process • 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. Psychology and medical plans going to EMT in September, and at People Committee in November 2024 Psychology has been signed off November 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 – a review has taken place to determine what can be done aligned with ICS colleagues for contractual benefits. Non-contractual benefits will fall as part of the wellbeing plan – draft plan by October 2024.On hold pending priority setting. • Next Review of flexible working policy is due by October 2024. • Data Warehouse development sits with IMST –December 2024. Go live planned for in house workforce dashboard

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**.**
- All new starters and all establishment change requests have to go through defined approval processes

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]*
- Retention review at People Committee bi-monthly.
- People Delivery plan in place for 2024-25.
- 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 vacancies (funded establishment – Staff in post) and

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.
- NHSE~~I~~ Performance workforce returns + direct support
- NHSE~~I~~ and People workforce return (PWR) reporting which triangulates and checks our data
- PWR reporting and NHSEI governance for international recruitment
- Internal Audit significant assurance received for Data Quality – July 2024.

means vacancy data can be updated on a daily basis. • Internal audit on workforce data quality – received with significant assurance in 2024/25	
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 – target date September 2024. A High-level Annual Needs analysis is scheduled to go to EMT – October 2024.**Owner Head of Workforce Development and Training by the end of March 2025.** • 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. Update as above **Owner Head of Workforce Development and Training –** target date end of March Priority setting for Q4 in Jan to confirm at this point •
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. **Action closed.**

RISK REF – 0020 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 resulting in negative impact 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** – September 2024. **Next review** – December 2024 for receipt at EMT in December 2024 and QAC/ Board in January 2025. **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: 5385	
On track	**Some slippage**	At risk	Completed	**Assurance level**	**Amber**

<table>
<tr>
<td><u>Summary update</u>

• Good progress is being made on the mobilisation
• Management and development offer is being launched
• Developing as leaders cohort 5 is now being delivered starting Jan 2025
• Staff survey complete – now analysing survey results and a plan is in place to share results.</td>
<td><u>Milestones in 2024/25 to support reaching target score:</u>
• Consultation on Living Our Values conversation, engagement and development happened in August 2024. Phase 2 to be complete by the end of September 2024/Values Delivery Group to be in place from October 2024 onwards.
• 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 Managers development offer engagement session happened in August 2024. Review of outputs will take place and next steps planned and expected to deliver a programme by the 31 December 2024.
• 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. As above
• Developing As Leaders (DAL) Alumni event planned for the Autumn 2024 – date tbc
• Staff survey launch 2024 – September 2024. Results received December 2024</td>
</tr>
<tr>
<td colspan="2"><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.
• 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)
• Workforce and Organisational Assurance group (WODAG) receives regular reports (monthly) on performance against expected outcomes</td>
</tr>
<tr>
<td><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</td>
<td><u>External assurance</u>

• Quality Improvement Group (ICS)
• 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.</td>
</tr>
</table>

• Team SHSC: Developing as Leaders (DAL) cohorts have taken place - Cohort 4 completed in July 2024. • People Pulse July 2024 results showed an increase in Mood in all 9 Engagement scores. People Pulse surveys quarterly – frequency to be reviewed.	
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.	• Have been developing mechanisms such as heatmap to give indicator of the health of an area received at EMT and further development taking place as part of the People Committee Dashboard. Owner Sarah Bawden – To be received at People Committee November 2024.Heatmap now part of dashboard as of Jan 2025 ~~Previous actions were closed in July.~~
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	• **Owner Head of OD and Deputy Director of People Staff survey Engagement 2024 increased by 12 % results released to organisations under embargo and plans will be developed in conjunction**

BOARD ASSURANCE FRAMEWORK 2024/25
Appendix 3 for receipt in January 2025

BAF RISKS OVERSEEN BY FINANCE AND PERFORMANCE COMMITTEE

RISK REF BAF: 21A 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.

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	**Executive lead:** Executive Director of Finance **Board oversight: Finance and Performance Committee & Audit and Risk Committee** **Last reviewed** – December 2024. **Next review** – February 2025 for receipt at EMT and the Board in March 2025 **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, 5224,5366, 5367,5368 5369, 5370
- Effective use of resources - Deliver outstanding care	- Implement RIO safely	

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

Summary update

•

Milestones in 2024/25 to support reaching target score:

- 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

Controls

- Governance (EPR programme board structure, EMT oversight, reports to assurance committee FPC and Board, external support sitting on EPR programme board)

<table>
<tr><td colspan="2">

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 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 (TOM) to be in place by July 2024 –with the new CDIO as part of development of the revised plan – The draft TOM is in progress. This has been to Operational Management Group (OMG) and financial implications have yet to be finalised. A revised timeline will be brought to EMT in September 2024. Owner CDIO/Exec Director of Finance. Revised TOM and financial implications are incorporated into draft financial plan and will be agreed as part of planning process. Deadline 31st March 2025</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 –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**	**Executive lead:** Executive Director of Finance **Board oversight:** Finance and Performance/Audit and Risk Committee **Last reviewed** – December 2024. **Next review** – February 2025 for receipt at EMT and the Board in March 2025 **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
- Effective use of resources	- Deliver our financial plan and efficiency programme - Deliver our quality and safety objectives	

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

Summary update	**Milestones in 2024/25 to support reaching target score:**
Review of risk completed and reflected on directorate and corporate risk register as appropriate.	• DSPT compliance aligned with all DSPT work – June 2024 New DSPT aligned to the annual audit programme received. Regular monitoring of the Internal Audit action tracker takes place with regular reporting received at ARC. **Completed**

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.
- 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.

Internal Assurance	**External assurance**
Governance reporting: • Reports on patching reports are received at-DAG and will be	• Confirmation provided to NHSD in accordance with prescribed national process.

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. • DSPT compliance aligned with DPST work confirmed June 2024. The new DSPT is aligned to the annual audit programme and monitoring of internal audit actions takes place through the tracker received at ARC. • Internal governance amended to re-instate IG, cyber and AI group reporting into ARC. ARC received cyber security posture review in October.	• DSPT compliance – key indicator - Annual Data Security Protection Toolkit (DSPT) audit moderate assurance rating received.
Gaps in controls **Gaps in controls addressed in 2023/24 have been removed.** - None currently	**Actions to address gaps in controls** N/A
Gaps in assurance (Gaps in assurance addressed in 2023/24 have been removed) System Asset register functionality within Sunrise not yet enabled.	**Actions to address gaps in assurance** • Asset register to be specified and developed in 2024/25 starting with hardware assets. **Owner Head of Service Delivery and Infrastructure Digital.** The timeline for completion of the audit is October 2024, and work on the register will be completed by 31 December 2024. • Asset integration between hardware discovery system (LANSweeper) and IT Service Management system (Sunrise) is complete. Population of assets and processes to be completed. Conducting physical hardware audits across all SHSC sites to support population of hardware assets into system including replacement of legacy hardware to support going live with Rio. Timeline for completion April 2025. Owner Head of Service Delivery and Infrastructure Digital.

RISK REF BAF 0022 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.

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	**Executive lead:** Executive Director of Finance **Board oversight:** Finance and Performance Committee **Last reviewed** – December 2024. **Next review** – February 2025 for receipt at EMT and the Board in March 2025. **Risk type: Finance** **Risk appetite:** Low (minimal) **Risk rating impact v likelihood** - Current 4 x 4 = 16 - Target 3 x 1 = 3 - Movement ⟺ Corresponding corporate risks: 5051
- EFFECTIVE USE OF RESOURCES	- Deliver our financial plan and efficiency programme	

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

Summary update

- VIP of 7.3 million expected to be delivered for 24/25. Additional mitigation of 0.9m required to meet additional cost pressures in relation to increased out-of-area expenditure.
- The system financial position is challenging and SY is under the national Investigation and Intervention (I&I) process.
- We are engaging to improve financial controls across the system to ensure delivery of individual organisational plans.
- As part of system planning SHSC have confirmed delivery of plan requires mitigation against significant risk and we cannot contribute reduce our deficit further to contribute to the system gap to deliver plan

Milestones in 2024/25 to support reaching target score:

- ~~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~~.
- ~~Engaging in the I&I process and considering strengthening controls for implementation – Sept 2024~~
- Engage at Mental Health Provider collaborative to consider further plans to contribute to a system gap of £48 million.
- Engaging in I&I process, controls have been strengthen to mitigate financial position, contributing to non-recurrent delivery of VIP. Will continue to review monthly and as required by the system.
- Development of additional mitigations to be reviewed by EMT in January 2025

Milestones completed

- Develop Financial Plan and Value Improvement plans for 2024/25 – to be received at the Board April 2024 – plans received – completed.

Controls

- Operational plan; financial planning; including CIP planning, processes and delivery monitoring
- Financial plan and value improvement plans for 2024/25 in place.
- 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.
- Consideration is being given to an additional programme board for VIP to oversee VIP planning and delivery for 25/26 to be established in late January / February 2025.

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** • 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 to be in place 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 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. Is this the right description? For further discussion in EMT.

Elements which would underpin this are:

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

STRATEGIC AIMS - Effective use of resources - Deliver outstanding care	**STRATEGIC PRIORITIES** - Deliver Therapeutic environments - Delivery our quality and safety objectives - Implement Rio safely	**Executive lead:** Director of Strategy **Board oversight**: Finance and Performance Committee **Last reviewed** – December 2024. **Next review** – February 2025 for receipt at and the Board in March 2025.

				Risk type: Strategic **Risk appetite:** High (open) **Risk rating impact v likelihood** - Current 4 x 4 = 16 scoring likelihood to be reduced to 3? Discuss at EMT - Target 4 x 2 = 8 - Movement ⟺ Corresponding corporate risks: ~~5367~~, 5051	
On track	**Some slippage**	**At risk**	**Completed**	**Assurance level**	**Amber**

Summary update

- Integrated change framework workshops held in July, ~~and~~ August and December 2024, with good participation across change-enabling teams
- Launched at collective leadership group in December
- Assurance remains amber due to some slippage.
- Milestones have been updated to reflect the implementation of change rather than delivery specific programmes.

Milestones in 2024/25 to support reaching target score:

- Integrated change framework delivery arrangements to commence from June 2024. A workshop to agree the arrangements took place in July and August with new milestones for implementation as:
  - Develop Integrated Change 'front door' and 'triage' arrangements - by end of September 2024 Process in place and will start in January 2025
  - Develop Integrated change support 'offer' for the 'do and share' category – by October 2024 completed in December through publication of ICF Guide on Jarvis
  - Test Integrated Change framework with operational colleagues – by end of September 2024 completed in December
  - Launch Integrated Change Framework with Collective Leadership Group – by October 2024 completed in December
- Revised approach to reporting to Board for transformation programmes from July 2024.
- Transformation Portfolio Board to make a proposal regarding revisions to portfolio by July 2024 to support re-prioritisation. Meeting deferred, now taking place in September Revised portfolio confirmed and reporting underway – December 2024.
- Organisation wide comms and launch of Integrated change framework – by October 2024 Comms launch started in December – ongoing through Q4

Controls

- 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.

<table>
<tr><td colspan="2">Business cases and capital expenditure approved in accordance with Trust wide governance processes.
• 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.
• Regular deep dive reports on each transformation programme at EMT
• Integrated change framework includes ‘phased approach with gateways’ – to start January 2025</td></tr>
<tr><td><u>Internal assurance</u>
• ~~Through former Back to Good programme, currently received through~~ Individual programme highlight reports received at Transformation Portfolio Board. Portfolio report received monthly at Transformation portfolio board, EMT and Finance and Performance Committee. These highlighted risks and issues.
• Schedule of deep dive reports on specific programmes at EMT
• 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 Therapeutic Environments programme.
• Suite of templates available. All new projects and programmes use the new templates including TORs.
• People Plan reports into people Committee and has a project group for e-roster project group reports into People Committee and Transformation Board. 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
• Programme Managers were engaged in roadmap and development work, sharing learning and experiences on specific projects.</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:
o Adult Forensic New Care
o 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. External assurance role adapted but ongoing at December 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>
<tr><td><u>Gaps in controls</u>
Gaps in controls addressed in 2023/24 have been removed.
• ~~Gateway reviews~~</td><td><u>Actions to address gaps in controls</u>
• Process and timetable for gateway reviews to be developed for all programmes and will be confirmed by October 2024. Owner Director of Strategy. Included in Integrated change guide in December 24</td></tr>
</table>

Gaps in assurance	**Actions to address gaps in assurance**
Gaps in assurance addressed in 2023/24 have been removed • None currently	N/A

RISK REF – BAF 0027 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, ~~caused by~~ leading to missed opportunities to add value for our service users and to meet population needs that require a partnership approach, resulting in potential to 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** – December 2024. **Next review** – February 2025 for receipt at EMT and the Board in March 2025. **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		**Milestones in 2024/25 to support reaching target score:** • Community forensic team tender – successfully moved into collaborative commissioning approach -service governance to be proposed by partners by October 2024. Negotiations ongoing December 2024 • Establish eating disorder joint committee (in shadow form) for South Yorkshire. Initial meeting in September 2024. December 2024 progress being made towards go-live in April 2025 • Develop action plan for delivery of GGI findings by October 2024 with implementation thereafter. Project team assembled due to start January 2025 • Establishment of Trust 'partnerships group' and some form of CRM (Customer Relations Manager) system by March 2025. Initial discussion due September 2024 - December 2024 - this rolled into the stakeholder management project above **Milestones completed** • 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 - **completed.** • Desire Code Communications Strategy work will feed into the strategy refresh work in October 2024 (on track) Quick wins identified for delivery in advance of August 2024 – **completed.** • 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~~. Funding confirmed December 2024 **completed** **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 Sheffield health care partnership, ICB and SY MHLDA Collaborative to participate in the planning of priorities for 2023/24 and worked together with colleagues in Sheffield, SY MHLDA 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 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, Sheffield Health and Care Partnership, 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) • Advisory Group in place for mother and baby and associated perinatal service development to ensure provision mees the needs of the population and connects effectively with local services.	
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 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	**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 • Externally supported (GGI) stakeholder review outcome received at Board in April 2024.

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. • Quick wins developed and in place in support of the Desire Code work in advance of finalisation of the Communications Strategy (due to complete in October 2024)	
Gaps in controls (Gaps in assurance addressed in 2023/24 have been removed)	**Actions to address gaps in controls**
~~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).~~ Up to date and agreed Trust Strategy for 2025 onwards	• ~~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~~ Project underway to revise Trust Strategy by April 2025. **Owner Director of Strategy**
Gaps in assurance 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.~~ Revised CQC approach and revised performance management roles for NHSE (less ICB) require monitoring to understand implications for SHSC. Once clearer this needs to be reflected in our assurance	**Actions to address gaps in assurance** • ~~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~~.** Monitor and evaluate the implications of changing approach of CQC **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~~ Trust approach is not to have many strategies, but there will be a small number of key board level enabling strategies linked to the main trust strategy. This framework needs to be clear and agreed by Trust Board	• ~~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~~.** Develop framework of enabling strategies and plans, and agree with Board in January 2025 – Director of Strategy

RISK REF – BAF 0030 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 - Effective use of resources	**STRATEGIC PRIORITIES** - None specifically attached	**Executive lead:** Executive Director of Finance **Board oversight:** Finance and Performance Committee **Last reviewed** – December 2024 **Next review** – February 2025 for receipt at EMT and the Board in March 2025.

				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 • Sub groups required have been established. This will support development of the updated Green Plan due for receipt at the Board 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)
- Carbon footprint performance and projection reporting using Defra emission factors
- Capital and business planning processes aligned to green plan strategy and wider Greener NHS net zero goals
- Improved governance for the integration of sustainable development and Climate change risk into SHSC governance structures and performance reviews
- The Sustainability Lead and the Lead for Estates and Facilities are exploring establishment of an Estates Sustainability Steering Group reporting into Facilities Leadership meetings to develop and drive forward heat decarbonisation planning and to provide ownership for subsequent estates funding applications.

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 place (Director of Finance, Performance and IMST) • Awareness and education training on sustainable development and climate change reflected in Leadership	**External assurance** • Greener NHS – Quarterly data submission • Greener NHS Fleet Data submission

and Management course • Establishment of a Sustainable Models of Care" sub group to the Sustainable Development Group • Greener NHS Dashboard data has been reflected in the Annual Report for 2023/24 **Negative Assurance** • We were unsuccessful in our bid for additional resources through low carbon skills funding however we are seeking feedback on our bid will continue to seek funding opportunities as they become available and are creating a control to support in responding to opportunities.	
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 reported as closed to FPC however it has been re-opened by the sustainability lead as work is continuing.**	• 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. Work has commenced and the risk assessment template is under review with the EPPR lead. **Sustainability Lead**
• Further integration of sustainable development and Climate change risk into SHSC governance structures and performance reviews (Risk management, SHSC Committee's and compliance groups) **GAP reported as closed at FPC in September but re-opened following further update from the Sustainability Lead. However significant progress has been made.**	• 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. Sustainability Lead is now a member of the QEIAP and work continues to develop and improve the sustainability impact assessment within the QEIP alongside supporting guidance to aid those completing the document and for reviewing. In addition, sustainability considerations are now included in the SHSC Capital Programme Policy which is due for receipt at Policy Governance Group in September 2024. Work remains outstanding to make the sustainability content embedded within the business case template easier to assess business case sustainable value (negative/neutral/positive) update on progress to be provided in November 2024.
• 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 required.	• 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 implications (E.g. Sustainable Travel and Transport Working Group, Climate Change Risk/ Adaptation Planning Group, Sustainable Models of Care Delivery Group, Green Network etc) Relevant

	subgroups have been set up. Plans for additional resources will be considered, aligned to the revision of the green plan will be put in place by the end of the financial year. **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). **GAP CLOSED**	**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 Action closed**
• More assurance required on how funding to deliver the Green Plan will be sourced/ assigned. **GAP CLOSED.**	Assurance gap funding: Continue to identify opportunities and apply for bids/funding submitting applications, e.g. Low Carbon Skills Funding, Public Sector De-carbonisation 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.** Funding bid not successful. Still awaiting feedback from Salix on whether this was due to application not meeting criteria or not making the cut for applications to be reviewed as funds had been allocated. Will continue to seek funding opportunities as they become available**.** In the meantime the Sustainability Lead is working with the Estates and Facilities directorate to set up an Estates Sustainability Steering group, reporting into Facilities Leadership meetings to develop and drive forward heat decarbonisation planning and provide ownership for subsequent estates funding applications. **Action closed**.
• 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**

BAF 32 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 caused by failure to effectively reflect requirements 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** – December 2024. **Next review** – February 2025 for receipt at EMT and the Board in March 2025 **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: 5344
- 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 EMT discussion in August confirmed this BAF risk should be retained however it was felt it is the same as the therapeutic environments risks and should that one be a subset of this BAF risk – TEP is a sub-set of 'effective estates'
- Work continues to address the findings of the 23/24 PLACE assessment
- Engagement with Sheffield HCP partners and SY ICS partners is ongoing through quarterly meetings, focused on identifying short term efficiency gains and building the case for longer term strategic investments.
- Work remains ongoing to deliver asset disposals that contribute to space utilisation, and generate capital for re-investment.
- 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 will be ready for agreement in November 2024.
- In July work has commenced on estates strategy refresh and developing a vision for a fit for purpose estate including 'new hospital'. The annual review of the Estates strategy is due for receipt at the September 2024 Board

Milestones in 2024/25 to support reaching target score:

- Opportunities for colocation and estate efficiency with Sheffield HCP partners has been explored and is on track for September 2024. December 2024 – ongoing, visits to LIFT buildings still planned.
- Scope and timeline for next phase of Therapeutic Environments Programme confirmed by November 2024 – slide deck prepared for EMT December 2024
- Opportunities from improved space utilisation quantified by November 2024 – initial tranche of opportunities identified at Wardsend Rd, Distington House and Netherthorpe House. Initial tranche complete
- Estates strategy annual review was received at FPC in July and is due for receipt at Board in September 2024 - complete
- Strategic outline case for new hospital (incl multi-site options) by December 2024 project continuing into Q4

<table>
<tr><td>

- 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. The review is expected by the end of September 2024
- Changes to risk description approved at Board in September 2024

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

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.
- ERIC returns – provide benchmarking information.
- PAM 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>

Internal assurance

- Annual PLACE report and associated action plan
- 7 facet survey report
- Annual Health and Safety Report (and quarterly updates received at Assurance Committees)

</td><td>

External assurance

- Authorised Engineers Annual Audit including of the competencies required of internal teams
- ERIC returns and benchmarking
- Annual Premises Assurance Model (PAM)
- Sircle independent review of fire doors and compartmentation at all in-patient locations

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

Gaps in controls

- ~~Require an additional external review of our fire doors and our systems for monitoring.~~

</td><td>

Actions to address gaps in controls

- 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>

Gaps in assurance

- See above re Fire Safety – need to see Sircle report to confirm any gaps in assurance

</td><td>

Actions to address gaps in assurance

- ~~Commission AE assessment of the competencies required of internal teams. Report by September 2024 – **Owner Director of Strategy**~~
- Receive and evaluate Sircle report in January 2025 – **owner Director of Strategy**

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