Board of Directors (Open)

Date:	11 March 2020	Item Ref:	

TITLE OF PAPER	Board Assurance Framework 2019/20
TO BE PRESENTED BY	Samantha Harrison, Interim Director of Corporate Governance
ACTION REQUIRED	For discussion and assurance

OUTCOME	To provide assurance that through the Board Assurance Framework (BAF), complemented by the risk management Strategy, the Trust has systematically managed the principal risks identified in achieving its objectives.
TIMETABLE FOR DECISION	11 March 2020
LINKS TO OTHER KEY REPORTS/DECISIONS	Internal Audit Reports covering Risk Management Directorate Risk Registers Risk Management Strategy Shaping the Future, the Trust Strategy & Strategic Planning Framework 2017-2020 Corporate (organisational) Risk Register Care Network and Directorate Risk Registers
STRATEGIC AIM **STRATEGIC OBJECTIVE** **BAF RISK NUMBER** **BAF RISK DESCRIPTION**	Quality & Safety A101 Effective governance, quality assurance and improvement will underpin all we do A101iii Trust governance systems are not sufficiently embedded which may reduce the effective means by which executive directors can consistently and continually be held to account for the delivery of sound strategies, effective risk management of risk and service quality.
LINKS TO NHS CONSTITUTION/OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	Provider Licence Annual Governance Statement NHS Foundation Trust Code of Governance
IMPLICATIONS FOR SERVICE DELIVERY & FINANCIAL IMPACT	Implications of individual risks are highlighted in the BAF. The BAF enables the Trust to satisfy its regulatory requirements and provides assurance for the Chief Executive to sign the Annual Governance Statement.
CONSIDERATION OF LEGAL ISSUES	Breach of SHSC Constitution Standing Orders Breach of NHS Improvement's Governance regulations and Provider Licence.

Author of Report	Sam Stoddart
Designation	Deputy Board Secretary
Date of Report	3 March 2020

Sheffield Health and Social Care NHS Foundation Trust

Summary Report

1. Purpose

For approval	For assurance	For collective decision	To seek input from	To report progress	For information	Other (please state)
	x		x			

2. Summary

The Trust aspires to be outstanding in relation to its corporate governance. Evidence that would support achievement of this would be:

a) Meeting the requirements of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-17-good-governance

b) Having a board assurance framework (BAF) and risk registers in place which are assessed by the board on a quarterly basis as a minimum as set down in the development reviews of leadership and governance using the well-led framework, https://improvement.nhs.uk/uploads/documents/Well-led_guidance_June_2017.pdf

c) Securing a significant Head of Internal Audit Opinion (HIAO)

The Trust now has all three in place and work will continue to maintain this.

2.1 Board Assurance Framework Purpose

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

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

Within Shaping the Future, the Trust Strategy & Strategic Planning Framework 2017-2020 operational priorities are identified and reviewed annually. Strategic objectives for 2019/20 were reviewed and revisions made. The Trust has refreshed its strategic objectives for 2020/21 and will undertake a comprehensive review of its strategy in the first half of 2020/21.

2.2 BAF Operation

The BAF is fully automated via the Ulysses Risk Management System (URMS) and risks are updated by risk owners and are quality assured by Executive Directors. Each BAF risk is assigned and presented to the appropriate Board Committee for consideration and review on a quarterly basis. In order to help Committees determine the level of management and assurance received from the BAF risks, report front sheets require the author to identify the relevant BAF risk. Any concerns Board Committees have in relation to the BAF are recorded in the 'significant issues' report they present to the Board.

2.3 Risk Appetite

The Trust reviews its risk appetite annually. The risk appetite for each risk is shown on the BAF report.

2.4 2019/20 BAF

The last iteration of the 2019/20 BAF was presented to Board in December 2019 following which it was received and discussed by each board committee in January 2020. Comments from those committees have been incorporated into this iteration and have been reported to Board from each committee's significant issues report.

2.5 2020/21 BAF

On 19 February 2020, the Board met to review its risk appetite for 2020 and consider the principle risks aligned to the draft revised strategic objectives. The Board acknowledged the continued improvement of the BAF, but highlighted that accountability for risks needs to be and owned at all levels. The need to develop effective communication between committees where risks may fall into the oversight of both was highlighted. Committee Chairs also proposed to work within their committees to take a proactive role in identifying assurances and to address assurance gaps. They also cited the need for BAF actions to be time focused with clear milestones and for actions to clearly mitigate the risks through their impact.

It was agreed that the Chair of each board committee would meet with two executive directors to agree principle risks for the strategic areas for which the committee has oversight. This is to be completed by the end of March 2020 following which all risks will be shared with EDG for collective review. In April, each committee will receive their 2020/21 BAF risks for approval, whilst also having sight of all other risks. Final approval of all BAF risks will be given by the Board of Directors in May 2020.

2.6 Changes to BAF since last presentation in December 2019

There are 16 principle risks contained in the BAF.

The Board can review all changes since December 2019 in Appendix 1. Appendix 2 details those Committees to which BAF risks are linked and links with risks on the Corporate Risk Register (CRR).

2.7 Closed Risks

There are no closed risks but EDG is recommending that risks A204 and A403ii are closed. This will be considered by WODC and FPC respectively in April following which a recommendation will be made to Board.

2.8 Assurances

Assurance ratings are as follows:

Green	Effective controls definitely in place and Board is satisfied that appropriate assurances are available
Amber	Effective controls thought to be in place but assurances are uncertain and/or possibly insufficient
Red	Effective controls may not be in place and/or appropriate assurances are not available to Board

However, Board members are asked to note that the BAF report does not provide an *overall* assurance rating for each risk. Assurance ratings are assigned to each control within a risk.

Following the CQC inspection in January and February, the Trust has received feedback in which a number of areas of concern were highlighted. These have been incorporated into the BAF and a number of risks have increased residual risk scores to reflect the feedback and increase the number of controls in place. However, action will will remain ongoing to address issues raised and this will be reflected in future iterations of the BAF.

In order to provide the Board with some indication of assurance, the table below shows the assurance ratings for each control within a risk and any change therein. The Board is asked to note the addition of the risk appetite for each risk.

Risk N°	Risk appetite	Assurance Level for controls	Change in Assurance Ratings	Risk N°	Risk Appetite	Assurance Level for controls	Change in Assurance Ratings
A101i	Failure to meet regulatory standards (registration and compliance).			**A101ii**	Inability to improve the quality of patient care.		
	Low (Quality)	Residual risk score increased to 15 from 6 Control 1: red Control 2: green (new) Control 3: green (new)	↓		**Low (Quality)**	Residual risk score increased to 15 from 6 Control 1: red Control 2: amber Control 3: amber Control 4: amber Control 5: green Control 6: amber	↓
A101iii	Trust governance systems are not sufficiently embedded.			**A102i**	Failure to deliver safe care due to insufficient numbers of appropriately trained registered professionals.		
	Zero (Statutory)	Residual risk score increased to 15 from 9 Control 1: red (was green) Control 2: green Control 3: amber Control 4: green	↓		**Zero (Safety)**	Control 1: amber Control 2: amber (new)	↔

Risk N°	Risk appetite	Assurance Level for controls	Change in Assurance Ratings	Risk N°	Risk Appetite	Assurance Level for controls	Change in Assurance Ratings
A102ii	Inability to improve the safety of patient care.			A103	Failure to systematically and adequately measure service user experience and outcomes		
	Zero (Safety)	Residual risk score increased to 15 from 8 Control 1: red Control 2: green Control 3: amber Control 4: amber (was green) Control 5: green Control 6: green			**Low (Quality)**	Control 1: amber Control 2: amber Control 3: amber Control 4: amber Control 5: amber	
A104	Inability to deliver services in accordance with defined access standards.			A201	Failure to address culture and morale through implementation of the Trust's OD and Engagement Plan		
	Low (Quality)	Control 1: amber Control 2: green			**Moderate (Workforce)**	Control 1: amber Control 2: amber Control 3: amber (was green) Control 4: amber	
A202	Risk the Trust does not develop new roles to meet current and future workforce needs.			A203	Insufficient skills and systems in place to enable transformation of recruitment within the Trust		
	Moderate (Workforce)	Control 1: amber (was red) Control 2: amber Control 3: green			**Moderate (Workforce)**	Control 1: green Control 2: amber (was green) Control 3: amber Control 4: green (new)	
A204	Risk the Trust fails to properly recognise what is significant for the health and wellbeing of its staff and take prompt action.			A302	Insufficient capacity to maintain service quality in recovery services		
	Moderate (Workforce)	Control 1: green Control 2: green Control 3: green (new)			**Low (Quality)**	Control 1: amber Control 2: green Control 3: green	
A401	Inability to deliver a break-even position resulting in a failure to deliver financial sustainability.			A403i	Affordability of the Acute Care Modernisation (ACM) project as it progresses through to final business case (FBC) and procurement stages		
	Moderate (Financial)	Control 1: amber			**Moderate (Financial)**	Control 1: green Control 2: green Control 3: green	
A403ii	Delays in the disposal of Fulwood site impact on the capital programme, i.e. Acute Care Modernisation			A404	The programmes for delivery are not developed or require additional resources not within plan and/or require significant reprioritisation once developed		
	Moderate (Financial)	Control 1: green Control 2: green Residual risk score reduced			**High (Business)**	Control 1: green Control 2: amber Control 3: green Control 4: green	

Risk N^{o}	Risk appetite	Assurance Level for controls	Change in Assurance Ratings	Risk N^{o}	Risk Appetite	Assurance Level for controls	Change in Assurance Ratings
						Control 5: amber (new)	

3. Next Steps

Following presentation to the board, the final iteration of the 2019/20 BAF will be presented to all Board committees in April 2020. Comments from these committees will be incorporated into the BAF and further reviews will be undertaken by risk owners before the next and final presentation of the 2019/20 BAF to board in June 2020.

4. Required Actions

The Board is asked to:

a) Consider papers presented at today's meeting with a view to identifying how assurance can be gained from them that actions on the BAF are being sufficiently mitigated and:

- record and minute any assurance that has been provided (or not) during the meeting regarding the relevant risks;
- provide the Director of Corporate Governance (Board Secretary) with any updates that are required to the BAF following the Committee.

b) Receive and approve the BAF.

5. Monitoring Arrangements

The BAF and Corporate Risk Register are monitored by the Director of Corporate Governance (Board Secretary). However, it is the responsibility of Board to have due oversight of it and that the papers which are brought before them provide sufficient assurance that risks are being addressed and managed.

6. Contact Details

Samantha Harrison, Interim Director of Corporate Governance (Board Secretary)
Email: samantha.harrison@shsc.nhs.uk

Risk Number	Changes and Assurance Provided
A101i	**Executive Lead: Executive Medical Director**
	"Failure to meet regulatory standards (registration and compliance)"
	Residual risk score increased to 15 from 6 Control 1: Revised description, 5 internal assurances removed, 1 new added, gap in assurance amended Control 2: new Control 3: new Action 1: new Action 2: new Action 3: description expanded, progress update added, timescale + 5 months
A101ii	**Executive Lead: Executive Medical Director**
	"Inability to improve in the quality of patient care"
	Residual risk score increased to 15 from 6 Control 1: additional gap in assurance added Control 2-6: no change Action 1: new Action 2: progress update added, timescale + 5 months Action 3: new
A101iii	**Executive Lead: Chief Executive (Director of Corporate Governance)**
	"Trust governance systems are not sufficiently embedded which may reduce the effective means by which executive directors can consistently and continually be held to account for the delivery of sound strategies, effective management of risk and the quality of service provided by the organisation."
	Residual risk score increased to 15 from 9 Control 1: gap in control added, 2 new internal assurances, 2nd external assurance updated, 3rd and 4th external assurances added, gap in assurance added, assurance rating reduced to red from green Control 2: no change Control 3: no change Control 4: new Actions 1-4: new
A102i	**Executive Lead: Executive Director of Nursing & Professions**
	"Failure to deliver safe care due to insufficient numbers of appropriately trained registered professionals"
	Control 1: no change Control 2: new Action 1: description expanded, progress added, timescale + 3 months Action 2: description expanded, progress added Action 3: progress added, timescale + 2 months Action 4: progress added, timescale + 2 months Action closed as duplicate of action 1
A102ii	**Executive Lead: Executive Medical Director**
	"Inability to improve the safety of patient care"
	Residual risk score increased to 15 from 8 Controls 1: additional gap in assurance added Controls 2-3: no change

Risk Number	Changes and Assurance Provided
	Control 4: gap in control added, additional internal assurance added, assurance rating reduced to amber from green Control 5: no change Control 6: new Action 1: new Action 2: no change Action 3: new
A103	**Executive Lead: Executive Medical Director**
	"Failure to adequately measure service user experience and outcomes"
	No change to risk
A104	**Executive Lead: Executive Director of Operational Delivery**
	"Inability to deliver services in accordance with defined access standards"
	Control 1: no change Control 2: amended and gap updated Action 1: revised to be more specific Action 2: new
A201	**Executive Lead: Director of Human Resources**
	"Failure to address culture and morale through implementation of the Trust's OD and Engagement Plan"
	Control 1: revised, gap in control revised Control 2: updated Control 3: revised, gap in control revised, assurance rating reduced to amber from green (WODC instructed) Control 4: updated, internal assurance updated Action 1: revised, progress update added, timescale + 1 month Action 2: new
A202	**Executive Lead: Director of Human Resources**
	"There is a risk that the Trust does not develop new roles to meet current and future workforce needs"
	Control 1: gap in control revised, new external assurance, one external assurance as out of date, assurance rating increased to amber from red Control 2: revised, 1st gap in control updated, 2nd gap in control new Control 3: gap in control new Action 1: progress update added, timescale + 4 months Action 2: progress update added, timescale + 4 months
A203	**Executive Lead: Director of Human Resources**
	"Insufficient skills and system in place to enable transformation of recruitment within the Trust"
	Control 1: no change Control 2: gap in control added, assurance rating reduced to amber from green Control 3: description expanded Control 4: new Action 1: progress update added, timescale + 4 months Action 2: new
A204	**Executive Lead: Director of Human Resources**
	"Risk the Trust fails to properly recognise what is significant for the health and wellbeing of its staff and take prompt action"

Risk Number	Changes and Assurance Provided
	Control 1: no change Control 2: no change Control 3: new Action 1: progress update added Action 2: progress update added
A302	**Executive Lead: Executive Director of Operational Delivery**
	"Insufficient capacity to maintain service quality in recovery services"
	Control 1: 2nd gap in control added, 2 new internal assurance, 1 new external assurance Control 2: no change Control 3: no change Action 1: no change Action 2: progress update dated, timescale + 4 months
A401	**Executive Lead: Executive Director of Finance**
	"Inability to deliver a break-even position resulting in a failure to deliver financial sustainability"
	Control 1: 6th point in control is new, gap in assurance updated Action 1: progress update added, timescale + 3 months
A403i	**Executive Lead: Executive Director of Finance**
	"Affordability of the Acute Care Modernisation (ACM) project as it progresses through to final business case and procurement stages"
	Controls 1-3: no change Action 1: progress update added, timescale + 2 months Action 2: progress update added, timescale + 4 months
A403ii	**Executive Lead: Executive Director of Finance**
	"Delays in the disposal of Fulwood site impacts on the capital programme, i.e. ACM"
	Residual risk score reduced to 4 from 6 Control 1: gap in assurance removed Control 2: no change Action 1: progress update added
A404	**Executive Lead: Executive Director of Finance**
	"The programmes for delivery are not developed or require additional resources not within plan and/or require significant re-prioritisation once developed"
	Control 1-4: no change Control 5: new Action 1: progress update added, timescale + 3 months Action 2: progress update added 2 actions completed and closed referencing new governance arrangements - these have been approved by DTB, notably the combining of CSSG and BSSG into an overall Digital Systems Strategy Group. Development underway to implement Portfolio Management per best practice across the Digital Transformation Strategy and associated delivery portfolio. INSIGHT2 FBC now approved and NHSD have accepted formally the Trust onto the Fast Follower programme.

Appendix 2

Links between Board Assurance Framework, Corporate Risk Register and Board Committees 2019/20 – areas shaded amber highlight strategic objectives without a principal risk.

Strategic Objective	BAF Risk Number	Risk Description	Corporate Risk Register Number(s)	Board/ Committee (s)
A101 Effective governance, quality assurance & improvement will underpin all we do	**A101i**	Failure to meet regulatory standards (registration & compliance)	3679 4189 4284	QAC QAC QAC
	A101ii	Inability to improve the quality of patient care	3916 4140 4324 4330	QAC QAC QAC QAC
	A101iii	Trust governance systems are not sufficiently embedded which may reduce the effective means by which executive directors can consistently and continually be held to account	4264	QAC
A102 We will deliver safe care at all times	**A102i**	Failure to deliver safe care due to insufficient numbers of appropriately trained registered professionals.	3831 4021	WODC WODC
	A102ii	Inability to provide assurance regarding improvement in the safety of patient care.	4079 4190 4223 4276	QAC QAC WODC QAC
A103 We will provide a positive experience and improve outcomes for service users	**A103**	Failure to adequately measure service user experience and outcomes		QAC
A104 We will ensure timely access to effective care	**A104**	Inability to deliver services in accordance with defined access standards		QAC
A201 We will implement a revised OD & Engagement Plan	**A201**	Failure to address culture and improve morale through implementation of the Trust's OD and Engagement Plan		WODC
A202 We will implement a programme to establish and expand new roles	**A202**	There is a risk that the Trust does not develop new roles to meet current and future workforce needs.		WODC
A203 We will revamp and improve our approach to recruitment and retention	**A203**	Insufficient skills and systems in place to enable transformation of recruitment within the Trust		WODC

Strategic Objective	BAF Risk Number	Risk Description	Corporate Risk Register Number(s)	Board/ Committee (s)
A204 We will prioritise the health, wellbeing & welfare of our employees	**A204**	Risk the Trust fails to properly recognise what is significant for the health and wellbeing of its staff and take prompt action.	4078 4124 4325	WODC QAC WODC
A301 We will deliver primary mental health and neighbourhood services	**NONE**			BoD
A302 We will deliver effective recovery services	**A302**	Insufficient capacity to maintain service quality in recovery services		QAC
A303 We will develop new care models for secure care	**NONE**			QAC
A304 We will deliver effective crisis care pathways and services	**NONE**			QAC
A401 We will ensure the financial sustainability of our services	**A401**	Inability to deliver a break-even position resulting in a failure to deliver financial sustainability	2175	FPC
A402 We will take a clear procurement-led approach to reducing costs	**NONE**			FPC
A403 We will implement our estate plan to meet our service needs	**A403i**	Affordability of the Acute Care Modernisation project as it progresses through to final business case and procurement stages		FPC
	A403ii	Delays in the disposal of Fulwood site impact on the capital programme, i.e. Acute Care Modernisation		FPC
A404 We will use technology to deliver new ways of working and new care models	**A404**	The programmes for delivery are not developed or require additional resources not within plan and/or require significant re-prioritisation once developed	4121 4326 4327	FPC FPC FPC

Key:
BoD: Board of Directors
QAC: Quality Assurance Committee
FPC: Finance and Performance Committee
ARC: Audit & Risk Committee
WODC: Workforce and Organisation Development Committee

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 1. QUALITY AND SAFETY | Strategic Objective: 1. Effective Governance, Quality Assurance And Improvement Will Underpin All We Do.

Risk Ref: A1O1I Details: Failure to meet regulatory standards (registration and compliance).

Executive Lead:	Executive Medical Director
Risk Type:	Quality
Risk Appetite:	Low

Risk Rating:	Impact	Likelihood	Score
Residual Risk (with current controls):	5	3	15
Target Risk (after improved controls):	3	1	3

BAF Risk Review Date:	
Last Review:	03/03/2020
Next Review:	01/06/2020

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Executive Director led working groups established to oversee areas requiring significant improvement.		Working group meeting minutes.	CQC Well Led inspection July 2018, outcome 'Requires Improvement' ('Good' in Caring, Effective and Responsive) Wainwright Crescent CQC inspection December 2018 - rated 'Good' in all domains Clover Group (General Practice) CQC Announced Inspection 25th Sept 17. Final Report received in December '17 = Rated Good in all five domains & population groups. Clover City Practice inspected in November 2017. Final Report received December '17 = Rated Good in all five domains &	Feedback received from CQC highlights areas requiring significant improvements.	RED

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 1. QUALITY AND SAFETY | Strategic Objective: 1. Effective Governance, Quality Assurance And Improvement Will Underpin All We Do.

Risk Ref: A1O1I Details: Failure to meet regulatory standards (registration and compliance).

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
			population groups. Quarterly CQC Formal Engagement meetings Bi-monthly CQC 'Insight' Reports bring together intelligence about the Trust's performance from a range of external data sources such as MHMDS CQC well-led inspection February 2020.		
Weekly monitoring of progress against remedial actions at Executive Directors Group, with escalation to Board in place.		Regular updates from Clinical Operations into Executive Directors Group. Executive Directors Group meeting papers. Progress monitored at each level of Clinical Operations governance structure. Quality Assurance Committee meeting papers.			GREEN

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 1. QUALITY AND SAFETY | Strategic Objective: 1. Effective Governance, Quality Assurance And Improvement Will Underpin All We Do.

Risk Ref: A1O1I Details: Failure to meet regulatory standards (registration and compliance).

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
		Board of Directors meeting papers.			
Regular oversight of progress at all levels of Clinical Operations.		Clinical Operations governance meeting minutes. Clinical Operations reporting into Executive Directors Group.			GREEN

Target Date: 13/03/2020	Responsible Person: Andrea Wilson
Action Details	Action Progress
● Remedial action plan to address the areas outlined as requiring significant improvement is being developed.	

Target Date: 29/05/2020	Responsible Person: Michelle Fearon
Action Details	Action Progress
● When action plan has been developed to address areas requiring significant improvement, implementation is required to rectify the issues.	

Target Date: 31/05/2020	Responsible Person: Andrea Wilson
Action Details	Action Progress
● 2018 action plan - where actions are not yet completed: Clinical supervision,	Three areas remain outstanding from the 2018 well-led CQC action plan. Of these target dates for

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 1. QUALITY AND SAFETY | Strategic Objective: 1. Effective Governance, Quality Assurance And Improvement Will Underpin All We Do.

Risk Ref: A1O1I Details: Failure to meet regulatory standards (registration and compliance).

telephony, physical health checks, need to focus efforts in these areas in order to evidence completion and ensure embeddedness in practice.	completion are proposed for two of these (Forest Close Bungalow 3 refurbishment completion by May 2020 and nurse call alarm system at Forest Lodge and Maple Ward by January 2020, then rolling out trust wide). Work is underway to revise the action plan and agree timescales for the third (physical health monitoring). ---------- 360 Assurance carrying out audit to test the embedding of actions. This is due for Q3, hence the target date has been revised accordingly.

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 1. QUALITY AND SAFETY | Strategic Objective: 1. Effective Governance, Quality Assurance And Improvement Will Underpin All We Do.

Risk Ref: A1O1II Details: Inability to improve the quality of patient care.

Executive Lead:	Executive Medical Director
Risk Type:	Quality
Risk Appetite:	Low

Risk Rating:	Impact	Likelihood	Score
Residual Risk (with current controls):	5	3	15
Target Risk (after improved controls):	3	1	3

BAF Risk Review Date:	
Last Review:	03/03/2020
Next Review:	01/06/2020

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Quality Improvement and Assurance (QI&A) Strategy in place, which covers experience, effectiveness and safety, together with appropriate resources to implement.		Progress reports on QI&A strategy implementation to QAC (bi-annual). This includes updates on the impact of Microsystems. Quarterly Clinical Effectiveness Group assurance reports to QAC which include progress on quality improvement projects. Quarterly assurance reports from Service User Safety Group provided to QAC. Quarterly assurance reports from Service User Engagement Group provided to QAC.	Annual Quality Report. CQC inspection report October 2018.	CQC rated as 'Requires Improvement' overall and within the 'Safe' and 'Well-Led' domains. Feedback from the CQC following February 2020 well-led inspection highlights areas requiring significant improvement.	RED
Quality schedule in place as part of national contract with NHS		Targets within the Quality Schedule are incorporated	Quality is monitored by NHS Sheffield CCG via quarterly	Grading of serious incident investigation reports does	AMBER

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 1. QUALITY AND SAFETY | Strategic Objective: 1. Effective Governance, Quality Assurance And Improvement Will Underpin All We Do.

Risk Ref: A1O1II Details: Inability to improve the quality of patient care.

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Sheffield CCG.		into relevant quarterly assurance reports to QAC. Quarterly Impact Assessment (QIA) assurance reports to QAC. All CIP QIAs considered by Clinical/Corporate panel and signed off by EDG.	Quality Performance Reviews. Any issues are escalated to the monthly Contract Monitoring Group and/or Contract Monitoring Board.	not always meet the CCG target.	
Service user and carer feedback is captured through various mechanisms, monitored through the Quality Assurance Committee.	Lack of systematic approach to dissemination of learning from feedback.	Service User Engagement group monitors performance in service user and carer feedback. Quality Assurance Committee monitors performance in formal and informal complaints and compliments.	360 Assurance audit reports on service user engagement and service user experience. (Limited assurance provided for service user experience. Significant assurance provided for service user engagement).		AMBER
Service User Engagement and Experience Strategy is in place together with the appropriate resources to implement.	Improvements required in the uptake of Friends and Family Test and Care Opinion and to adequately manage and learn from this feedback.	Service User Engagement Group monitors progress against strategy implementation plan. Quarterly Service User Engagement Group assurance reports (including FFT data) to QAC	CQC Inspection Report - October 2018 Monthly national benchmarking data from FFT Continuous Care Opinion Feedback	Service user feedback is limited in volume.	AMBER

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 1. QUALITY AND SAFETY | Strategic Objective: 1. Effective Governance, Quality Assurance And Improvement Will Underpin All We Do.

Risk Ref: A1O1II Details: Inability to improve the quality of patient care.

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
		Quarterly complaints and compliments report to QAC	360 Assurance given significant assurance on service user engagement.		
Service users involved in Microsystem projects within teams.		Quarterly assurance reports from Clinical Effectiveness to Quality Assurance Committee.			GREEN
Robust monitoring of CQUIN performance is in place via both operational and corporate governance structures.		Monthly CQUINs meeting monitors performance and agrees remedial actions where required. Quarterly reports to EDG and Quality Assurance Committee.	Quarterly reports from NHS Sheffield CCG regarding performance.	Under-performance on an number of CQUIN areas (physical health, alcohol & tobacco).	AMBER

Target Date: 13/03/2020 Responsible Person: Andrea Wilson

Action Details	Action Progress
Remedial action plan to address the areas requiring significant improvement, highlighted in CQC feedback, being developed.	

Target Date: 31/05/2020 Responsible Person: Andrea Wilson

Action Details	Action Progress
Where actions are not yet completed following 2018 inspection: Clinical supervision, telephony, physical health checks, need to focus efforts in these areas in order to evidence completion and ensure embeddedness in practice.	Three areas remain outstanding from the 2018 CQC action plan. Of these target dates for completion are proposed for two of these (Forest Close Bungalow 3 refurbishment completion by May 2020 and nurse call alarms in Forest Lodge and Maple Ward by January 2020 and then rolling out trust wide). Work is underway to revise the action plan and agree timescales for the third (physical health monitoring).

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 1. QUALITY AND SAFETY | Strategic Objective: 1. Effective Governance, Quality Assurance And Improvement Will Underpin All We Do.

Risk Ref: A1O1II Details: Inability to improve the quality of patient care.

Target Date: 29/05/2020 Responsible Person: Michelle Fearon

Action Details	Action Progress
Following development of remedial action plan, implement actions.	

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 1. QUALITY AND SAFETY | Strategic Objective: 1. Effective Governance, Quality Assurance And Improvement Will Underpin All We Do.

Risk Ref: A1O1III Details: Trust governance systems are not sufficiently embedded which may reduce the effective means by which executive directors can consistently and continually be held to account for the delivery of sound strategies, effective management of risk and the quality of service provided by the organisation.

Executive Lead:	Chief Executive
Risk Type:	Statutory
Risk Appetite:	Zero

Risk Rating:	Impact	Likelihood	Score
Residual Risk (with current controls):	5	3	15
Target Risk (after improved controls):	3	2	6

BAF Risk Review Date:	
Last Review:	03/03/2020
Next Review:	01/06/2020

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Governance structure in place from Board to operational group level	Governance failure in relation to complaints management	Committee/Group minutes and reports to Board Committees Significant issues report to Board from each Board Committee Monthly Clinical Operations, Performance & Governance Meeting reports to EDG Complaints performance reporting to QAC on a quarterly basis as part of patient experience report. Monthly reporting to EDG on complaints performance.	Annual Head of Audit Opinion (Significant for 2018/19) Committee Governance & Risk Management Audit Oct 2019 - significant assurance Internal Audit benchmarking report on implementation of complaints policy within remit of review. Internal Audit Advisory Report on Complaints Management (Jan 2020) - actions incorporated into Complaints Improvement Action Plan.	CQC Feedback Feb 2020 highlighted areas requiring significant improvement.	RED
Risk Management Strategy refreshed and in place		Annual Governance Statement	360 Internal Audit of Operational Risk		GREEN

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 1. QUALITY AND SAFETY | Strategic Objective: 1. Effective Governance, Quality Assurance And Improvement Will Underpin All We Do.

Risk Ref: A1O1III Details: Trust governance systems are not sufficiently embedded which may reduce the effective means by which executive directors can consistently and continually be held to account for the delivery of sound strategies, effective management of risk and the quality of service provided by the organisation.

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
		Corporate Governance Statement	Management (Mar 19) significant assurance 360 Internal Audit of Governance and Risk Management (Oct 19) significant assurance		
Policy system management in place.	Policy System Management process insufficiently embedded in the organisation.	Policy Governance Group reports to EDG and CQC Task and Finish Group.	Internal Audit 360 Assurance Policy Management report Sept 17 provides limited assurance. Follow up report (July 2018) shows progress made. CQC Well-Led Inspection (July 2018) identifies policies as a must-be-done (review/updating/reflecting national guidance and best practice).		AMBER
Executive Director led working group established to oversee progress against CQC feedback.					GREEN

Target Date: 30/06/2020 Responsible Person: Joanne Slater

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 1. QUALITY AND SAFETY | Strategic Objective: 1. Effective Governance, Quality Assurance And Improvement Will Underpin All We Do.

Risk Ref: A1O1III Details: Trust governance systems are not sufficiently embedded which may reduce the effective means by which executive directors can consistently and continually be held to account for the delivery of sound strategies, effective management of risk and the quality of service provided by the organisation.

Action Details	Action Progress
Action plan to address complaints issues and achieve agreed with performance levels agreed with NHS Sheffield CCG and under regular review.	

Target Date: 30/06/2020 Responsible Person: Joanne Slater

Action Details	Action Progress
Following Serious Incident review in complaints handling within the Corporate Affairs department, action plan agreed and in place. Under regular review.	

Target Date: 13/03/2020 Responsible Person: Michelle Fearon

Action Details	Action Progress
Remedial action plan to address CQC feedback is being developed.	

Target Date: 29/05/2020 Responsible Person: Michelle Fearon

Action Details	Action Progress
When remedial action plan is developed to address CQC feedback, implement actions.	

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 1. QUALITY AND SAFETY | Strategic Objective: 2. We Will Deliver Safe Care At All Times.

Risk Ref: A1O2I Details: Failure to deliver safe care due to insufficient numbers of appropriately trained registered professionals.

Executive Lead:	Executive Director - Nursing & Professions
Risk Type:	Safety
Risk Appetite:	Zero

Risk Rating:	Impact	Likelihood	Score
Residual Risk (with current controls):	4	3	12
Target Risk (after improved controls):	3	2	6

BAF Risk Review Date:	
Last Review:	19/02/2020
Next Review:	20/03/2020

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Deputy Director of Nursing led recruitment & retention programme for the Inpatient Wards. Development of New Roles: trainee Nursing Associate (tNA) trainee Advanced Clinical Practitioner (tACP) Nurse Apprenticeships & Clinical Associate Psychologist. Funding secured for additional trainees in 19/20. Guaranteed job offers for all undergraduate students who graduate/register with their professional body. Resource secured to increase E-Rostering Capacity: Band 4 Administrator & Band 8a Workforce Systems & Information	Insufficient numbers of Psychological Practitioners across the Inpatient Wards. Limited capacity / coverage of AHPs in all the inpatient areas. Registered Nurse Vacancies in the inpatient areas. Meeting all E-Rostering implementation requirements as per National Good Practice Guidance (Auto Roster, A/L, Safety, Compliance). Implementation of the Clinical Establishment Review (CERs) Requirements (NQB). Full implementation of the newly Published Mental Health Optimal Staffing Tool (MHOST). Do not have an E-Rostering Reporting	Acute Care Wards AFE Reviews conducted March 2019 in line with NQB Guidance and Safe Care Module (Acuity & Dependency) Monthly Safer Staffing Reports to EDG & BoD. Monthly E-Rostering Operational Performance Report reviewed at Safer Staffing & Care Network Governance meetings.	CQC Well Led Inspection (July 2018) Acute Care Wards received a regulatory breach in respect of staffing levels and an overall rating of Requires Improvement. Internal Audit Report on E-Rostering (July 2019) = Significant Assurance Internal Audit Report on Workforce Utilisation (January 2019) = Significant Assurance	EDG & Board Safer Staffing Reports provide partial / limited assurance as they do not yet include staff or patient experience measures.	AMBER

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 1. QUALITY AND SAFETY | Strategic Objective: 2. We Will Deliver Safe Care At All Times.

Risk Ref: A1O2I Details: Failure to deliver safe care due to insufficient numbers of appropriately trained registered professionals.

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Manager (Oct '19). Monthly Safer Staffing Group Monthly E Rostering Confirm & Challenge Group overseeing e-rostering performance management. Monthly Bank, Agency & E-Rostering Steering Group. Band 7 Senior Nurse 24/7 Patient flow Co-ordinators in post, manage staffing deployment across wards in response to patient need /demand. Shift by shift reporting on patient demand & staffing capacity & escalation in place.	Management System (all reports are manually generated from multiple internal systems).				
Experienced senior nurses available in clinical areas to support staff teams. Recruitment ongoing and skill mix & safe staffing review to be completed before end of financial year.					AMBER

Target Date: 31/03/2020 Responsible Person: Liz Lightbown

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 1. QUALITY AND SAFETY | Strategic Objective: 2. We Will Deliver Safe Care At All Times.

Risk Ref: A1O2I Details: Failure to deliver safe care due to insufficient numbers of appropriately trained registered professionals.

Action Details	Action Progress
To produce a new report on compliance with / monitoring of all E-- Rostering requirements / attainment standards (national & local policy / procedure) in conjunction with MHOST requirements.	Workforce Systems & Information Manager currently in progress reviewing all E-rostering. Timescale extended to end of financial year to ensure completed in comprehensive manner and within governance processes. ---------- Executive Director of Nursing & Professions has met with the new Workforce Systems & Information Manager (Aimee Hatchman) who starts 7/10/19 to fully brief her on this action, what is required & by when.

Target Date: 29/02/2020 Responsible Person: Liz Lightbown

Action Details	Action Progress
Introduce Clinical Establishment Reviews (to ensure we have the right staff, with the right skills providing the right care at the right time /place in response to identified patient need within available resources) in conjunction with MHOST national guidelines.	MHOST roll out (clinical establishment review) has begun, starting in forensic and rehabilitation units. Workshop booked for 13.01.2020 to facilitate. ---------- A workshop to agree how to introduce CERs, with Senior Clinicians & Directors/Deputies, has been set for 28th October.

Target Date: 31/03/2020 Responsible Person: Linda Wilkinson

Action Details	Action Progress
To produce a Business Case to increase the capacity of Psychological Practitioners on the Inpatient Wards	Outline business case agreed in principle. Full business case to be presented to March 2020 Board of Directors. ---------- It has been agreed that further work needs to be undertaken, specifically relating to finances. Therefore the business case will be presented to BPG in January 2020 together with the business case for AHPs. The timescale has been extended to reflect this.

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 1. QUALITY AND SAFETY | Strategic Objective: 2. We Will Deliver Safe Care At All Times.

Risk Ref: A1O2I Details: Failure to deliver safe care due to insufficient numbers of appropriately trained registered professionals.

Target Date: 31/03/2020 Responsible Person: Julie Edwards

Action Details	Action Progress
To produce a Business Case to increase the capacity of Allied Health Professionals in the Inpatient Wards	Outline business case has been agreed in principle. Full business case to be presented to March 2020 Board of Directors. ---------- It has been agreed that further work needs to be undertaken, specifically relating to finances. Therefore the business case will be presented to BPG in January 2020 therefore the timescale has been extended to reflect.

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 1. QUALITY AND SAFETY | Strategic Objective: 2. We Will Deliver Safe Care At All Times.

Risk Ref: A1O2II Details: Inability to improve the safety of patient care.

Executive Lead:	Executive Medical Director
Risk Type:	Safety
Risk Appetite:	Zero

Risk Rating:	Impact	Likelihood	Score
Residual Risk (with current controls):	5	3	15
Target Risk (after improved controls):	2	2	4

BAF Risk Review Date:	
Last Review:	03/03/2020
Next Review:	01/06/2020

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Patient Safety Improvement approach refreshed for 2018/19.		Quarterly assurance reports from the Service User Safety Group to the Quality Assurance Committee. Quarterly learning events take place within clinical operations. Safety huddles in operation. Annual safer care event.	CQC inspection report (October 18).	CQC rating of 'requires improvement' for patient safety. Feedback from the CQC following February 2020 well-led inspection highlights areas for significant improvement.	RED
Service User Safety Group monitors patient safety.		Quarterly assurance reports from Service User Safety Group to QAC. Learning from incidents reported to QAC on a quarterly basis. Quarterly mortality reports to QAC.	Bi-annual patient safety incident data from National Reporting Learning System (NRLS).		GREEN

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 1. QUALITY AND SAFETY | Strategic Objective: 2. We Will Deliver Safe Care At All Times.

Risk Ref: A1O2II Details: Inability to improve the safety of patient care.

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
		Quarterly learning events take place within Clinical Operations.			
Lessons learned from investigations/reviews of care/mortality reviews are shared across the Trust in a variety of ways.		Connect Learning events Staff debriefs Clinical operations governance meeting minutes. Quarterly incident management report Quarterly mortality report Structured Judgement Reviews flowchart	CCG reviews on serious incident investigation reports. HM Coroner reviews of care provision during inquests. Serious Case Reviews, Child Death Overviews and domestic homicide reviews. CQC inspections (report October 2018	'Should do' gap identified by CQC around inconsistency of learning lessons.	AMBER
Appropriate training is in place for staff to ensure they are practising safely.	Not all mandatory training targets being met	Training compliance rates monitored monthly, escalated to EDG when necessary Suite of training on offer to staff to support ongoing development.	CQC Inspections. Internal Audit Report: Infection Control December 2018 - significant assurance Internal Audit Report: Mandatory Training 2nd Follow Up Report January 18		AMBER
Patient Safety and Experience Groups established and overseeing patient safety within Clinical Operations.					GREEN
Exeucitve Director led working groups established to oversee					GREEN

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 1. QUALITY AND SAFETY | Strategic Objective: 2. We Will Deliver Safe Care At All Times.

Risk Ref: A1O2II Details: Inability to improve the safety of patient care.

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
areas requiring significant imrprovement, following CQC feedback.					

Target Date: 13/03/2020 Responsible Person: Andrea Wilson

Action Details	Action Progress
Remedial action plan to address the areas requiring significant improvement being developed.	

Target Date: 30/05/2020 Responsible Person: Andrea Wilson

Action Details	Action Progress
Where actions are not yet completed from 2018 inspection, need to provide appropriate evidence to demonstrate completion and that these are embedded into practice.	Three areas remain outstanding from the CQC action plan. Of these target dates for completion are proposed for two of these (Forest Close Bungalow 3 refurbishment completion by May 2020, and Nurse Call alarms in Forest Lodge and Maple Ward by January 2020 then rolling out trust wide) Work is underway to revise the action plan and agree timescales for the third (physical health monitoring following RI)

Target Date: 29/05/2020 Responsible Person: Andrea Wilson

Action Details	Action Progress
Following development of remedial action plan, implement actions.	

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 1. QUALITY AND SAFETY | Strategic Objective: 3. We Will Provide A Positive Experience And Improve Outcomes For Service Users.

Risk Ref: A1O3 Details: Failure to systematically and adequately measure service user experience and outcomes.

Executive Lead:	Executive Medical Director
Risk Type:	Quality
Risk Appetite:	Low

Risk Rating:	Impact	Likelihood	Score
Residual Risk (with current controls):	2	3	6
Target Risk (after improved controls):	2	1	2

BAF Risk Review Date:	
Last Review:	03/01/2020
Next Review:	02/04/2020

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Clinical Effectiveness Group oversee use of patient outcome measures.		Reports to QAC on quarterly basis	FFT data from NHS England		AMBER
Trust's Operational Plan mandates increase in services using outcome measures.		Progress against objectives within Operational Plan reported to BPG			AMBER
Service User Engagement Group oversees experience and engagement across the Trust.		Reports quarterly to QAC			AMBER
Carers and Young Carers Strategy Implementation Group oversees plans to increase level of carer engagement and feedback.		Bi-annual assurance report to QAC re progress against strategy.			AMBER
Number of mechanisms in place to gather patient and carer feedback.		Methods of feedback, emerging themes and actions taken included in quarterly assurance report to QAC.		Mechanisms not in place consistently across all services and low uptake in volume.	AMBER

Target Date: 31/03/2020 Responsible Person: Jo Evans

Action Details	Action Progress
Plan developed to increase number of responses received re Friends and Family	

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 1. QUALITY AND SAFETY | Strategic Objective: 3. We Will Provide A Positive Experience And Improve Outcomes For Service Users.

Risk Ref: A1O3 Details: Failure to systematically and adequately measure service user experience and outcomes.

Test, Care Opinion and Quality of Experience survey and to extend into areas not currently reaching.

Target Date: 31/03/2020 Responsible Person: Jonathan Burleigh

Action Details	Action Progress
Increase use of appropriate outcome measures across services.	

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 1. QUALITY AND SAFETY | Strategic Objective: 4. We Will Ensure Timely Access To Effective Care.

Risk Ref: A1O4 Details: Inability to deliver services in accordance with defined access standards.

Executive Lead:	Executive Director - Operational Delivery
Risk Type:	Quality
Risk Appetite:	Low

Risk Rating:	Impact	Likelihood	Score
Residual Risk (with current controls):	4	3	12
Target Risk (after improved controls):	2	3	6

BAF Risk Review Date:
Last Review: 24/02/2020
Next Review: 25/03/2020

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Standard for receiving crisis assessment defined and monitored regularly.	Standard not being consistently met in Liaison Service and increased demand in SPA	Quarterly Performance Reviews with teams Clinical Operations Governance meetings.	Mental Health Services Data Set returns.		AMBER
Contract awarded 2020 for drug and alcohol service with amended access standards and targets.	Target for DNA rate and Psycho-Social Interventions not being met 2019/20; however Commissioner accepts performance. With new contract and amended targets, gap should be closed in 2020/21.	Clinical and corporate performance report to FIPC, QAC, EDG and BoD.	Reporting to DACT		GREEN

Target Date: 31/03/2020 Responsible Person: Michelle Fearon

Action Details	Action Progress
Extend operating hours of Home Treatment Service to meet access standards	Bid for additional monies awarded (£500k). Extension of Home Treatment Service to 10pm now being mobilised.

Target Date: 01/04/2020 Responsible Person: Michelle Fearon

Action Details	Action Progress
Contract negotiations to enable Trust to meet mental health access standards and ensure fidelity to Mental Health Long Term Plan.	Contract negotiations underway to provide a 24/7 service.

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 1. QUALITY AND SAFETY | Strategic Objective: 4. We Will Ensure Timely Access To Effective Care.

Risk Ref: A1O4 Details: Inability to deliver services in accordance with defined access standards.

	---------- Contract negotiations underway.

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 2. PEOPLE	Strategic Objective: 1. Implement A Revised OD And Engagement Plan.

Risk Ref: A2O1 Details: Failure to address culture and morale through implementation of the Trust's OD and Engagement Plan.

Executive Lead:	Director Of Human Resources
Risk Type:	Workforce
Risk Appetite:	Moderate

Risk Rating:	Impact	Likelihood	Score
Residual Risk (with current controls):	4	4	16
Target Risk (after improved controls):	3	2	6

BAF Risk Review Date:	
Last Review:	20/02/2020
Next Review:	21/03/2020

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Workforce Strategy delivery plan in place.	Organisational Development strategy to be developed	Progress on delivery plan reported to WODC quarterly.			AMBER
LIA adopted by the Trust in March 2019.Cilnical lead and LIA teams in post and second pulse check due March 2020.		Governance structure in place. Reporting to EDG.			AMBER
Organisation Development (OD) Priorities agreed	OD strategy in development Reporting on Priorities to WODC	EDG and WODC			AMBER
Staff Survey Steering Group in place to address priorities raised in staff survey		Accountable to EDG with quarterly reports to WODC			AMBER

Target Date: 30/04/2020 Responsible Person: Caroline Parry

Action Details	Action Progress
Review of Workforce Strategy (People Strategy)	Final draft of People Strategy presented to WODC, EDG and Board 12/2/20 Accepted as final strategy subject to minor amends from SUSEG and BAME network consultation. Delivery Plan and KPI metrics to Board April 2020 ---------- Refresh of Workforce strategy in line with Trust refersh

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 2. PEOPLE	Strategic Objective: 1. Implement A Revised OD And Engagement Plan.

Risk Ref: A2O1 Details: Failure to address culture and morale through implementation of the Trust's OD and Engagement Plan.

Target Date: 31/07/2020 Responsible Person: Rita Evans

Action Details	Action Progress
Develop standalone OD strategy for Trust	OD Partners in place on 6 month FTC. Organisational Diagnostic underway to be complete by July 2020

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 2. PEOPLE	Strategic Objective: 2. Implement A Programme To Establish And Expand New Roles.

Risk Ref: A2O2	Details: Risk the Trust does not develop new roles to meet current and future workforce needs.

Executive Lead:	Director Of Human Resources
Risk Type:	Workforce
Risk Appetite:	Moderate

Risk Rating:	Impact	Likelihood	Score
Residual Risk (with current controls):	4	2	8
Target Risk (after improved controls):	2	2	4

BAF Risk Review Date:	
Last Review:	25/02/2020
Next Review:	25/05/2020

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Effective Staffing Group oversees Workforce Planning Group, Medical Staffing Group, Bank , Agency and E rostering Group, Safer Staffing Group, Education & Training Steering Group.	Effectiveness of Effective Staffing Group	Workforce In-Year monitoring return to NHS Improvement (monthly) Monthly report to NHS Improvement on nursing agency/bank usage. NHSi/E E-workforce Data collection	IA 360 assurance report on workforce utilisation January 2019 - significant assurance IA 360 assurance E-Rostering Review June 2019 - significant assurance		AMBER
New People Strategy to be in place March 2020.	Board approved subject to minor amends. People Strategy Delivery Plan in place from April 2020.	Quarterly delivery plan progress reports to WODC.			AMBER
Workforce Plan (forecast / demand) for 19/20 approved and in place	Workforce numbers will be refreshed for 20/21	Monthly reports to workforce planning group	Monthly workforce report submissions to NHSi 5 year plan and forecast demand submitted		GREEN

Target Date: 30/04/2020	Responsible Person: Karen Dickinson

Action Details	Action Progress
Ensure the reconciliation of information between HR and Finance systems.	Work is progressing now new HR position is in post. Timescale extended by 2 months.

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 2. PEOPLE	Strategic Objective: 2. Implement A Programme To Establish And Expand New Roles.

Risk Ref: A2O2 Details: Risk the Trust does not develop new roles to meet current and future workforce needs.

	---------- HR, Workforce Systems and Information Manager due in post Oct 2019 to support achievement of this action. However, delays due to challenges presented by how the systems are operated in HR and Finance and dialogue continues to identify ways forward. Timescale extend by four months to reflect the complexity of the issue.

Target Date: 30/04/2020 Responsible Person: Dean Wilson

Action Details	Action Progress
Review of effective staffing group TOR and remit as required by IA audit report.	Jan 2020 Effective Staffing Group meeting cancelled therefore ToRs yet to be approved. Chair of Effective Staffing Group to transfer to Director of Human Resources. ---------- Chair of Effective staffing to transfer back to DW

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 2. PEOPLE	Strategic Objective: 3. Revamp And Improve Our Approach To Recruitment And Retention.

Risk Ref: A2O3 Details: Insufficient skills and systems in place to enable transformation of recruitment within the Trust.

Executive Lead:	Director Of Human Resources
Risk Type:	Workforce
Risk Appetite:	Moderate

Risk Rating:	Impact	Likelihood	Score
Residual Risk (with current controls):	3	4	12
Target Risk (after improved controls):	3	2	6

BAF Risk Review Date:	
Last Review:	25/02/2020
Next Review:	26/03/2020

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Integrated resource for management of recruitment		HRBP reports to HR SMT			GREEN
Action plan and KPI's	Delivery plan in development by April 2020	HR SMT, Workforce Planning Group, Medical Workforce Planning group			AMBER
Review of systems and practices within the HR team resulting in improvements to service delivery					AMBER
ACP Workforce Strategy (Brand Sheffield) regional recruitment and retention collaboration		TOG	ACP		GREEN

Target Date: 30/04/2020 Responsible Person: Caroline Parry

Action Details	Action Progress
Submit a business case for TRAC system to improve quality and efficiency of recruitment process	Procurement requirements extend business case process ---------- Business case still in development due to procurement queries. Timescale extended to reflect this.

Target Date: 30/04/2020 Responsible Person: Caroline Parry

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 2. PEOPLE	Strategic Objective: 3. Revamp And Improve Our Approach To Recruitment And Retention.

Risk Ref: A2O3 Details: Insufficient skills and systems in place to enable transformation of recruitment within the Trust.

Action Details	Action Progress
Recruitment and Retention Delivery Plan (part of People Strategy Delivery Plan) to be developed.	Recruitment and retention workstream to People Strategy Appointment of a Recruitment Manager Transactional review of activities of the recruitment team

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 2. PEOPLE	Strategic Objective: 4. We Will Prioritise The Health, Wellbeing And Welfare Of Our Employees.

Risk Ref: A2O4 Details: Risk the Trust fails to properly recognise what is significant for the health and wellbeing of its staff and take prompt action.

Executive Lead:	Director Of Human Resources
Risk Type:	Workforce
Risk Appetite:	Moderate

Risk Rating:	Impact	Likelihood	Score
Residual Risk (with current controls):	3	2	6
Target Risk (after improved controls):	2	2	4

BAF Risk Review Date:	
Last Review:	25/02/2020
Next Review:	25/05/2020

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Effective staff wellbeing support functions in place		Workforce plan reporting to WODC Listening into Action Governance			GREEN
Wellbeing plan in place		Health and Wellbeing Group monitor progress against plan bi-monthly basis			GREEN
Revised Promoting Attendance Policy in place	Programme of promotion taking place	Staff attendance reported to WODC, EDG and Board			GREEN

Target Date: 31/03/2020	Responsible Person: Caroline Parry
Action Details	Action Progress
Roll out wellbeing action plan to support delivery of the wellbeing plan	Reduction in absence levels due to MSK issues Progress being made in provision of healthy food for staff Increase in absence rates due to work-related stress Reduction in flu uptake in 2019/20

Target Date: 31/03/2020	Responsible Person: Dean Wilson
Action Details	Action Progress
Working with LiA using crowdfix to address wellbeing priorities	increasing mental Health First Aid training Roll Out HWB Roadshows

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 2. PEOPLE	Strategic Objective: 4. We Will Prioritise The Health, Wellbeing And Welfare Of Our Employees.

Risk Ref: A2O4	Details: Risk the Trust fails to properly recognise what is significant for the health and wellbeing of its staff and take prompt action.

	Mindfulness App development in line with National NHS mindfulness APP

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 3. FUTURE SERVICES	Strategic Objective: 2. Deliver Effective Recovery Services.

Risk Ref: A3O2 Details: Insufficient capacity to maintain service quality in recovery services.

Executive Lead:	Executive Director - Operational Delivery
Risk Type:	Quality
Risk Appetite:	Low

Risk Rating:	Impact	Likelihood	Score
Residual Risk (with current controls):	3	2	6
Target Risk (after improved controls):	2	2	4

BAF Risk Review Date:	
Last Review:	19/12/2019
Next Review:	18/03/2020

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Maximum caseload size of 35 agreed in line with CMHT accreditation standards	Traction in discharging appropriate people linked to industrial dispute. Unions no longer accepting previously agreed maximum caseload size.	Team Dashboards used for caseload oversight Reports to QAC and Board Monitoring reports to relevant clinical operations governance meetings. Community Flow Group reporting to Scheduled & Planned Care Network	ACAS arbitration		AMBER
Additional 8 care co-ordinators in post from August/September 2019					GREEN
Four bank care co-ordinators to remain in post to Autumn 2019					GREEN

Target Date: 31/03/2020 Responsible Person: Clive Clarke

Action Details	Action Progress
Negotiation for additional funding for 2019/20 and beyond with NHS Sheffield CCG via Contract Management Group and Board.	Negotiations remain ongoing and will continue until year end therefore timescale amended to reflect this.

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 3. FUTURE SERVICES | Strategic Objective: 2. Deliver Effective Recovery Services.

Risk Ref: A3O2 Details: Insufficient capacity to maintain service quality in recovery services.

Target Date: 31/07/2020 Responsible Person: Michelle Fearon

Action Details	Action Progress
2nd stage of admin support infrastructures beginning in December. Outcome of review to be shared with staff in order to seek feedback. Following this a gap analysis will take place to identify investment needs.	Implementation paused following the request from Staffside to include within the review of the CMHT service.

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 4. VALUE FOR MONEY	Strategic Objective: 1. Ensure The Financial Sustainability Of Our Services.

Risk Ref: A4O1	Details: Inability to deliver a break-even position resulting in a failure to deliver financial sustainability.

Executive Lead:	Executive Director Of Finance
Risk Type:	Financial
Risk Appetite:	Moderate

Risk Rating:	Impact	Likelihood	Score
Residual Risk (with current controls):	5	2	10
Target Risk (after improved controls):	5	2	10

BAF Risk Review Date:	
Last Review:	21/02/2020
Next Review:	21/05/2020

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Monthly Finance Reporting, incorporating CIP plans and performance. 5 year long term financial model, which will be formally refreshed again as part of the long term planning by NHSi planned for the summer of 2019. Financial planning, including control total consideration and CIP plans Strong financial governance and management in place at Trust , divisional and service level and with key partners Risk share in place with commissioners within Sheffield Updated operational plan for 20/21	Need to move CIP planning process from "salami slice" approach to a more informed allocation method. Need to conclude the budget setting sign off process for 2020/21.	Monthly finance report to Board, FIPC and EDG. Summary reports to TOG, TMG and EDG Financial Performance Framework and DOF level intervention meetings.	NHSI monitoring against Single Oversight Framework NHSI quarterly review meeting (QRM) & letter Head of Internal Audit Opinion. and significant positive assurance re financial audits	CIP plans for 19/20 now include a modest CIP gap of c£24k within HR which is the only unidentified element. IMST and Estates have solutions in place but elements only achieved non recurrently. Within the clinical directorate there has been vacancy factors applied but c£324k remains only non recurrently achieved. Other demand pressures has resulted in net overspends across the clinical directorate despite CIP progress.	AMBER

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 4. VALUE FOR MONEY | Strategic Objective: 1. Ensure The Financial Sustainability Of Our Services.

Risk Ref: A4O1 Details: Inability to deliver a break-even position resulting in a failure to deliver financial sustainability.

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
under development					

Target Date: 31/03/2020 Responsible Person: James Sabin

Action Details	Action Progress
Develop a new process as part of financial planning to better target future CIPs. Move away from traditional salami slice approach.	Work ongoing but prioritisation of investments is being impacted by emerging CQC needs and ACM tenders now being back. Timeline agreed to take financial plan to March board post EDG. The final version will go to FPC on the 30th March (delegated sign off) and Board post submission on the 8th April 2020. ---------- As part of CIP planning for 20/21 alternative CIP methodology will be explored for consideration. One option proposed includes a CFO led negotiated approach but bringing in various metrics linking in performance, benchmarking and evidenced based resourcing. This will be progressed throughout January and February via EDG, FIPC and Board.

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 4. VALUE FOR MONEY | Strategic Objective: 3. Implement Our Estate Plan To Meet Our Service Needs.

Risk Ref: A4O3I Details: Affordability of the Acute Care Modernisation (ACM) project as it progresses through to final business case (FBC) and procurement stages

Executive Lead:	Executive Director Of Finance
Risk Type:	Financial
Risk Appetite:	Moderate

Risk Rating:	Impact	Likelihood	Score
Residual Risk (with current controls):	4	3	12
Target Risk (after improved controls):	4	2	8

BAF Risk Review Date:	
Last Review:	24/02/2020
Next Review:	25/03/2020

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
General Management and Clinical Programme Leads are now in place. ACM Programme Board is now established in addition to an operational steering group. Routine Governance and reporting arrangements in place through EDG via TOG/BPG.		ACM Programme Board meetings and minutes, are fed into EDG. Steering Group minutes are fed into the Programme Board. Highlight reports are being produced. Programme risk registers are in place and being reviewed regularly.	Forms part of the CAPEX plan submitted as part of the 2019/20 financial plan. Material Transaction and no loan required simplified the process and now has NHSi support.	Needs to progress to FBC and final tender stage.	GREEN
Stakeholder meetings held with all relevant community and inpatient service managers. Outcomes have informed the development of the plan to deliver the estates strategy.		Updated estate strategy completed and progressing via Governance.	Forms part of the NHSi plan submission.	Engagement is ongoing and plans being developed (for medium-term and long-term), but not yet finalised.	GREEN
5 Case model / compliant business case developed, Affordability of Plan at outline business case (OBC) stage	Risks will remain whilst this progresses to FBC and tender is awarded.	ACM OBC, ACM Programme Board.	No longer deemed a significant transaction and no longer requires external borrowing. NHSi restrictions		GREEN

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 4. VALUE FOR MONEY | Strategic Objective: 3. Implement Our Estate Plan To Meet Our Service Needs.

Risk Ref: A4O3I Details: Affordability of the Acute Care Modernisation (ACM) project as it progresses through to final business case (FBC) and procurement stages

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
			removed and now supported as part of the annual plan sign off process.		

Target Date: 31/05/2020 Responsible Person: Phillip Easthope

Action Details	Action Progress
Progress to Full Business Case and pass through the required governance route.	FBC production timetable updated to reflect latest programme, following extension of tender period

Target Date: 06/03/2020 Responsible Person: Phillip Easthope

Action Details	Action Progress
Progress to stage 2 tender.	Stage 2 tender period, evaluation and sign-off expected 2/3/20

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 4. VALUE FOR MONEY | Strategic Objective: 3. Implement Our Estate Plan To Meet Our Service Needs.

Risk Ref: A4O3II Details: Delays in the disposal of Fulwood site impact on the capital programme, i.e. Acute Care Modernisation

Executive Lead:	Executive Director Of Finance
Risk Type:	Financial
Risk Appetite:	Moderate

Risk Rating:	Impact	Likelihood	Score
Residual Risk (with current controls):	2	2	4
Target Risk (after improved controls):	2	2	4

BAF Risk Review Date:	
Last Review:	25/02/2020
Next Review:	25/05/2020

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Robust governance including leaving Fulwood project and ACM programme board		Programme Board reporting to EDG			GREEN
Financial Planning		Financial reporting through EDG & FIPC and Capital oversight through capital Board, and BPG	NHSI oversight of Annual plan		GREEN

Target Date: 04/03/2020 Responsible Person: Helen Payne

Action Details	Action Progress
Secure planning permission for Fulwood site, to reduce likelihood of slippage	Outline planning permission approved. ---------- Advised by Consultancy (DLP) acting on behalf of the Trust to secure Outline Planning Consent, that the senior responsible officer in the Local Authority had initially delayed this for submission to full planning committee in December, and there has then been a further delay until possible February 2020. This is to enable the planning committee to consider Affordable Housing provision related to the redevelopment of the site. There is very little the Trust can do to influence this scenario and consequently the competitive marketing exercise cannot start until Quarter 4 assuming no further planning consent delays. Capital receipt will be delayed by approximately 6 months.

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 4. VALUE FOR MONEY	Strategic Objective: 4. Use Technology To Deliver New Ways Of Working And New Care Models.

Risk Ref: A4O4	Details: The programmes for delivery are not developed or require additional resources not within plan and/or require significant reprioritisation once developed

Executive Lead:	Executive Director Of Finance
Risk Type:	Business
Risk Appetite:	High

Risk Rating:	Impact	Likelihood	Score
Residual Risk (with current controls):	4	4	16
Target Risk (after improved controls):	2	3	6

BAF Risk Review Date:	
Last Review:	19/02/2020
Next Review:	20/03/2020

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
Compliance with IT Strategy (dynamic).		Data and Information Governance Board (DIGB) Business Planning Group (BPG). Updated IT strategy approved by BoD May 2018.	Internal Audit Report on IT Strategy (October 2017) and NHS England Digital Maturity Toolkit.		GREEN
Business planning processes, including relevant resource requirements included in business cases	Portfolio Management Office (PMO) capabilitites / maturity re overall oversight of all portfolios, projects and programmes and associated control and decsion making			PMO assurance reporting	AMBER
Revised governance arrangements in place to manage the IMST / Digital transformation strategy and associated delivery portfolio.					GREEN
Portfolio of IMST projects and programmes now developed utilising PM3. Development of a resource allocation tool underway to compliment.					GREEN
Implementation of a resource demand / capacity model in IMST		Existing governance boards used to monitor priorities			AMBER

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 4. VALUE FOR MONEY | Strategic Objective: 4. Use Technology To Deliver New Ways Of Working And New Care Models.

Risk Ref: A4O4 Details: The programmes for delivery are not developed or require additional resources not within plan and/or require significant reprioritisation once developed

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	Gaps in Control	Internal Assurance	External Assurance	Negative Assurance OR Gaps in Assurance	Assurance Rating
in early stages. CAB to be introduced to review IMST capacity and feasibility of changes.		(BPG; Clinical Ops Change and Improvement Board) - introduction of CAB will add additional level of assurance.			

Target Date: 31/03/2020 Responsible Person: Nick Gillott

Action Details	Action Progress
● Contact management solution business case to be produced.	Programme is underway and resourced with a strong programme manager and appropriate governance in place. Brief agreed by the programme board and stakeholders engaged - SRO in place. Phase one (process and people) to be completed Q4. ---------- Contact Centre Manager appointed to the trust, with a successful appointment to an IMST Programme manager to help develop the programme brief, and future business case.

Target Date: 31/03/2020 Responsible Person: Nick Gillott

Action Details	Action Progress
● Development of a resource capacity and allocation tool underway within IMST to compliment the portfolio management tool.	Initial development completed and baseline data added. Initial usage has started to help provide analysis of capacity across IMST to complete major change work. Baseline structure paper completed and submitted through finance for budget planning with new roles identified for future business case to assist in working with Trust directorates to better understand and plan requirements. ---------- Tool currently being updated with capacity. Aligned with BAU and change activity and now reviewed monthly by extended SMT. PM3 used to monitor all IMST change activity as part of the PM3 pilot.

BOARD ASSURANCE FRAMEWORK 2019/20

AIM: 4. VALUE FOR MONEY	Strategic Objective: 4. Use Technology To Deliver New Ways Of Working And New Care Models.

Risk Ref: A4O4	Details:	The programmes for delivery are not developed or require additional resources not within plan and/or require significant reprioritisation once developed