Board of Directors

SUMMARY REPORT	Meeting Date:	25 September 2024
	Agenda Item:	23

Report Title:	**Board Assurance Framework 2024/25**	
Author(s):	Director of Corporate Governance with input from Executive leads.	
Accountable Director:	Deborah Lawrenson, Director of Corporate Governance	
Other Meetings presented to or previously agreed at:	**Committee/Group:**	Executive Management Team (EMT) Board of Directors and the Board Assurance Committees in September 2024
	Date:	Executive Management Team (5 September 2024)
Key Points recommendations to or previously agreed at:	The updated BAF for 2024/25 is presented for assurance and agreement of changes.	

Summary of key points in report

Introduction

The BAF has been through its review process at EMT and the Assurance Committees in August and September. In their deep dive on the Corporate Risk Register in August the Executive team confirmed changes to propose to the BAF risk descriptions which have subsequently gone through the relevant assurance committees and been adapted for recommendation to the Board. EMT have not at this stage recommended any additional strategic risks for reflection on the BAF. Cross references to relevant risks on the Corporate Risk Register are included. All changes are proposed in blue or strike through.

Alert

The Board is specifically asked to agree changes to the risk descriptions to the following BAF risks as recommended by EMT and the Assurance Committees this included a request by committees to ensure the descriptions follow the principles of *'risk of….caused by…. resulting in….*' :

Overseen at Quality and Assurance Committee

- **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 impact on service user safety, more restrictive care and a

poor staff and service user experience.

- **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

- **BAF RISK 31** 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.

Overseen at People Committee

- **BAF RISK 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.

Overseen at Finance and Performance Committee

- **BAF RISK 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 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.

- **BAF RISK 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.

Advise

- Refinement has taken place on appetite, cross references to risks and to confirm if any changes on scoring is required (none currently proposed). Milestones, actions, controls and assurances have been updated. At the request of the committees a further review took place post discussion to ensure any closed actions or milestones have been reflected where appropriate in the controls or assurances and that the risk descriptions for some risks be updated to ensure '*caused by... and resulting in…'* is sufficiently clear.

Assure

- The Board can take assurance the BAF has gone through its regular review process with Executive leads, collectively with EMT and then received at the Assurance Committees.

The Full BAF is attached as follows:

- **Appendix 1** – BAF risks received at Quality Assurance Committee
- **Appendix 2** – BAF risks received at People Committee
- **Appendix 3** – BAF risks received at Finance and Performance Committee

Recommendation for the Board/Committee to consider:							
Consider for Action		**Approval**	**X**	**Assurance**	**X**	**Information**	
The Board is asked to receive for **assurance, discussion and comment** the updated BAF for 2024/25 and to **approve changes** to the risk descriptions as outlined.							

Please identify which strategic priorities will be impacted by this report:				
Effective Use of Resources	*Yes*	***X***	*No*	

Deliver Outstanding Care	*Yes*	***X***	*No*	
Great Place to Work	*Yes*	***X***	*No*	
Ensuring our services are inclusive	*Yes*	***X***	*No*	

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

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

BOARD ASSURANCE FRAMEWORK 2024/25
Appendix 1
As at 13.09.24 post Quality Assurance Committee

BAF RISKS OVERSEEN BY QUALITY ASSURANCE COMMITTEE

Following EMT review of the CRR and the BAF in August and receipt at QAC in September it is recommended all current BAF risks sitting beneath Quality Assurance Committee be retained and amended where indicated.

The Board is asked to approve changes to the Risk Descriptions of BAF risks 025b, 029 and 031.

<table>
<tr><td colspan="6">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.</td></tr>
<tr><td colspan="2">STRATEGIC AIMS
- Deliver outstanding care
- Ensure our services are inclusive</td><td colspan="2">STRATEGIC PRIORITIES
- Deliver our quality and safety objectives</td><td colspan="2">Executive lead: Executive Director – Nursing and Professions /Medical Director
Board oversight: Quality Assurance Committee
Last reviewed – September 2024. Next review – November 2024 for receipt at EMT in December 2024 and QAC in January 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: 4513, 5026, 5047, 5124</td></tr>
<tr><td><u>On track</u></td><td>Some slippage</td><td>At risk</td><td>Completed</td><td>Assurance level</td><td>Amber</td></tr>
<tr><td colspan="3"><u>Summary Update</u></td><td colspan="3"><u>Progress against Milestones for 2024/25</u></td></tr>
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• The Director of Nursing has requested an updated assessment of the LAP risks to support identifying milestones required and if necessary to reflect in the scoring and actions required and work to complete this is underway. • The Organsiational Managmnent Group and EMT are provoiding additional oversight of supervision and mandatory training compliance.	Completion of outstanding actions from the Back to Good programme – • New milestone to be added around addressing LAP risk in the remainder of the estate (beyond the acute ward programme) as this is currently behind requirements and remains a risk. See BAF risk 0025B **- proposed wording -** Planning to ensure that LAP review is going to be held by TEP Board – to take place by the 31 December 2024**.** • **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. **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 oversight.
- Management and leadership structure in place – Ward to Board with increased grip and control around management of establishments.
- Clinical and Social Care strategy implemented.
- Robust incident and investigation governance in place, PSIRF implemented from November 2023.
- Co-production standards launched and a range of patient experience measures in place.
- Range of leadership offers completed and ongoing across SHSC corporate and clinical teams.
- Quality and Equality impact assessment reporting to QAC.
- Ligature anchor point removal plan phase 1 and 2 are completed, phase 3 in progress. Clinical Environmental Risk Group reviews all LAP assessments and reports to clinical quality and safety group. Exceptions reported to Therapeutic Environment Board.
- Establishment of OMG which consists of leaders from all directorates.
- Updated Capital Plan received at Board in April 2024.
- Full business case for Maple improvements were received at Board in April 2024

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.	• 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

• Regular reporting through governance routes including learning lessons, safeguarding reports, staffing reports, transformation programme reports. • Successful international recruitment with new recruits in post • The CQC report that was published on 16 February 2022 demonstrated we had delivered actions against the section 29a warning. Significant progress was noticed. New improvement actions are in place. Outstanding actions in respect of Maple ward LAPs will be mitigated when Maple decants to Dovedale 2. • New EPR plan approved by the Board in April 2024. • 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.	inspection by CQC – reported Jan 2022. • Regularly reviewed by the Clinical Environment review group on a monthly basis. • Engagement with safeguarding partnerships at Executive level • NHSE funding required external reporting
Gaps in assurance (those addressed in 2023/24 have been removed) None currently	**Actions to address gaps:** N/A
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 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.**
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.**
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.**

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** – September 2024. **Next review** – November 2024 for receipt at EMT in December 2024 and QAC in January 2025. **Risk type:** Safety **Risk appetite:** Moderate (cautious) **Risk rating impact v likelihood** - Current 4 x 4 = 16 - Target 3 x 2 = 6 - Movement ⟺ - **Assurance rating** –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	**Milestones in 2024/25 to support reaching target score:**
• Clinical Environmental Risk Group (CERG) confirmed further LAP	• Commence refurbishment of Maple during 2024 ~~– end of January 2025~~ – dependent upon availability of

work to inform scope of next phase of TEP – July 2024. • Scope of older people's and rehab and forensic therapeutic environment programme received at TEP board – August 2024. • Estates strategy – report received at FPC July 2024 and to be received at BoD in September 2024. • ICS infrastructure strategy including TEP work submitted July 2024 • Addressed in recent EMT review of risk register - August 2024. A deep dive by the Executive Team to sense check the risks and scoring on the Corporate Risk Register alongside the Board Assurance Framework too place in August 2024. The EMT recommendation is that this BAF risk needs to be retained • The target score for this BAF risk has been changed from 3 x 3 to 3 x 2 to meet the requirements of 'moderate' risk appetite under the new scoring. • These remain strategic risks until modifiable LAP risks are removed from all in-patient environments which is dependent upon access to capital funding. • The Assurance rating is proposed to remain at 'amber' • **Board are asked to approve the change to the risk description**	Capital funds. Business case approved in principle by Board in April 2024. • ~~As noted under BAF risk 0024 New milestone to be added around addressing LAP risk in the remainder of the estate (beyond the acute ward programme) as this is currently behind requirements. There are milestones to be identified around the capital programme to support addressing remaining LAPs in the estate beyond acute wards.~~ 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 • Outline business case for a new hospital – December 2024 **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 ~~updated strategy - October 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)	• Evidence based approach to Reducing Restrictive practice implementation (note there is

• 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 which SHSC has contributed to	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).	• ~~Timeline for the Older People element of the TEP. Agreed at Therapeutic environments programme board in July 2024 to ask EMT to commission a strategic outline case for DD1 and G1 – due early 2025/26 – Owner Director of Operations~~. 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.
	• LAP work taking place to capture outstanding ligature anchor point work through the Clinical Environmental Risk Group **Owner Exec Dir of Nursing, Professions and Quality** - has undertaken analysis ~~and remains ongoing~~. 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. ~~Dovedale 1 now subject to a new feasibility plan that is exploring other estate options, which will be delivered on in 12-18months. We are managing the risk during this process with increased CCTV coverage and refresh of managed risks~~ **GAP removed as duplication**	• ~~Dovedale 1 requires extensive work and we are scoping the best environment to improve quality on the ward – we have identified a possible new location for Dovedale 1 and improvements will require a full business case and wide engagement. Due to the CDEL limits on capital we will prioritise this for 2024/25 Capital Plan. We are exploring opportunities to begin the design phase in 2023/24. Completion anticipated December 2024. Reflected in reporting to FBC to Board in April 2024. Agreed at Transformation Board in July 2024 to ask EMT to commission a strategic outline case for DDI and G1 – due early 2025/26 with a view to undertake refurbishment by the end of this financial year. **Owner Director of Strategy**.~~ **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 ~~through the requirements of 'Right Care Right Place'~~ caused by issues with models of care, access to beds, flow, crisis care management, and contractual issues resulting in poor experience of care and potential harm to service users

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	**Executive lead: Director of Operations** **Board oversight: Quality Assurance Committee** **Last reviewed** – September 2024 **Next review** – November 2024 for receipt at EMT in December 2024 and QAC in January 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

- At EMT discussion in August it was suggested 'right care right place' be taken out int e risk description as it is too specific, and this has been confirmed by the Executive lead.
- Additional milestones relating to ADHD and PCMHT have been added.
- A recent review by NHSE provided positive feedback on service model and delivery for ADHD services
- It has been confirmed by the Executive Lead that there is no change to the scoring currently.
- **Board are asked to approve the change to the risk description**

Milestones in 2024/25 to support reaching target score:

- 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 December 2024
- 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.

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

Internal assurance

- Regular reporting in place through governance structure including Learning lessons

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.	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. • Culture and quality visits • Contracting updates as required. • Improved oversight of people waiting in recovery teams ~~and EWS and SPA~~. Rag rating system provides oversight of people waiting, and where VCSE support is needed this is identified. • Improvement Plan for Gender services in place and being implemented. • CMHT transformation – current lifestyle stage implementation completed July 2024 • NHSE regional deep dive on Gender Services – positive feedback received actions identified and addressed. **External assurance** • Gender services agreements re funding remain pending - Negotiation and escalation through commissioning forums at place, ICB and NHSE. • Adherence to the NHS Long Term Plan and the community team framework. • Relevant adherence to NICE guidance. • Adherence to the 4-week waiting standard for relevant core services.
Gaps in control (Gaps in controls addressed in 2023/24 have been removed) 1. Where there are large numbers of people waiting for a service, we cannot reach out to every person on a regular basis, so are reliant on people contacting us if their presentation deteriorates or circumstances change. Each service has a protocol to regularly review people's needs whilst waiting and apply a RAG rating to prioritise contact.	**Actions to address gaps in controls** • Investment was prioritised in 23/24 in our recovery services and perinatal mental health. For ADHD we are working through the Provider Collaborative to resolve long waits for the service and progress is expected by the end of the financial year 2024/25 in terms of a reduction of up to c50%. This remains ongoing. • 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.
	• **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
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 31 There is a risk we fail to deliver on national inequalities priorities and our strategic aim to deliver inclusive services ~~clinical and social care strategy which aims to deliver personalised and trauma informed care~~, caused by failure to adopt an inequalities based approach to care resulting in poorer access, later presentations and risk of poorer outcomes.

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	
- Ensuring services are Inclusive	- **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** – September 2024. **Next review** – November 2024 for receipt at EMT in December 2024 and QAC in January 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	**Milestones in 2024/25 to support reaching target score:**
• Health Inequalities Annual Report (addressing NHSE statement on information on health inequalities) to be published by October. • Risk description updated to align more closely with strategic priorities • Current risk scoring of 12 has been confirmed.	• ~~Improving our data and analytics health inequalities measures and recording of personalised characteristics of those we serve in line with the NHS Statement on information on health inequalities (duty under section 13SA of the national health service act 2006) – by October 2024~~ This milestone is replaced with a new milestone indicated in blue text below • 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

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- Milestones have been updated
- **Board are asked to approve the change to the risk description**

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- Following June Board session draft self-assessment to be presented back to Board for approval by September 2024 – **Director of Strategy**
- Following June Board session lead officers for inequalities to create a proposed action plan for inequalities, including the strategic objectives above – by September 2024 – **Director of Strategy**
- Trust Strategy refresh to strengthen focus on tackling inequalities by October 2024 – **Director of Strategy**
- 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.**

Milestones completed

- Board development session and around MHA QI, health inequalities self-assessment and PCREF – June 2024 – **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.**

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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

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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

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External assurance

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

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Gaps in controls

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

</td><td>

Actions to address gaps in controls

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

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

Gaps in assurance

- The level of recording of personal characteristics of service users

</td><td>

Actions to address gaps in assurance

- Improvement activity to increase the level of recording of personal characteristics – This remains a gap and is

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

remains low. Increasing the percentage of records with complete demographic information will strengthen the effectiveness of our assurance mechanisms.	owned by Operations- Greg Hackney, Senior head of Service and is reported monthly through the IPQR.

BOARD ASSURANCE FRAMEWORK 2024/25
Appendix 2
As at 13.09.24 post receipt at People Committee

Following EMT review of the CRR and the BAF in August and receipt at People Committee in September it is recommended all current BAF risks sitting beneath People Committee are retained.

BAF RISKS OVERSEEN AT PEOPLE COMMITTEE

<table>
<tr><td colspan="5">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 gaps in health inequalities which in turn impacts negatively on service user/patient care.</td></tr>
<tr><td colspan="2">STRATEGIC AIMS
- Deliver outstanding care
- Create a Great Place to Work</td><td colspan="2">STRATEGIC PRIORITIES
- Deliver our quality and safety objectives
- Live our values, improving experience and wellbeing
- Improving staff engagement and involvement</td><td>Executive lead: Executive Director of People
Board oversight: People Committee
Last reviewed – September 2024. Next review – November 2024 for receipt at EMT in December and People Committee and Board in January 2024.
Risk type: Workforce
Risk appetite: High (open)
Risk rating impact v likelihood
- Current 4 X 3 = 12
- Target 4 x 2 = 8
- Movement ⟺
Corresponding risks on the Corporate Risk Register: 5385</td></tr>
<tr><td>On track</td><td>Some slippage</td><td>At risk</td><td>Completed</td><td>Assurance level Amber</td></tr>
<tr><td colspan="2"><u>Summary update</u>
• Sexual safety awareness raising activity will take place in September and improvements to reporting incidents relating to staff will be in place from September 2024.
• A corporate risk relating to sexual safety has been added to the register and will taken through take RoG/ People Committee in September.
• Wellbeing Champion roles are in place and provides assurance on staff experience this has moved over to controls.</td><td colspan="3"><u>Milestones in 2024/25 to support reaching target score:</u>
▪ 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.
▪ 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.
▪ Complete diagnostic self-assessment of the health and well-being self-assessment (7 key areas) –dynamic</td></tr>
</table>

• Milestone achievement dates have been updated and there is no change to the scoring at this review.	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. • 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 • Team sessions will be put in place to support managers with occupational health referrals from June 2024.Reduction target for V & A to be identified with the Chair of the V & A reduction group by the end of September 2024. • 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 • 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. • Flu vaccination 60% target for uptake – by end of December 2024. • 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**

Controls

- Governance – ICS HRD Deputy Network, ICS staff Health and Wellbeing Group, National Wellbeing Guardian Network, People Strategy Delivery Plan in place April 2023 and reviewed through tier II groups into People Committee, Regular reporting to committees and to SHWB group, Reporting to the ICS (including on HWB)
- NHSEI National Wellbeing lead and ICS Wellbeing Group
- HWB Framework in place
- NHS People Plan and actions for HR and OD
- South Yorkshire People leaders meeting (multi agency) which provides a system view around a range of areas to support people related issues in work.
- The ICS have established a wellbeing roadmap and there are three ICS groups around people, partnerships, prevention and proof [the Trust has nominated a lead to work alongside colleagues to influence the development of this]
- Board level Wellbeing Guardian in place
- Supporting staff with complex long-term conditions. - special interest group (ICS)

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

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.
~~OD function incorporates wellbeing support~~.
~~Staff Health and Wellbeing group in place with expanded membership having been reviewed. Group monitors delivery of the People strategy reporting to People Committee~~.
~~New OH provider in place from Jan 23 with review arrangements in place~~.

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

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

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.
</td></tr>
<tr><td><u>Gaps in control</u> Gaps in controls addressed in 2023/24 have been removed.

Lack of systems to check quality well-being conversations are happening (although guidance has been issued)
</td><td><u>Actions to address gaps in controls</u>

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 Head of OD~~ Owner Deputy Director of People
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
</td></tr>
<tr><td>2. Review of new Occupational Health Contract – GAP closed.</td><td>• 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</td></tr>
</table>

3. Wellbeing Self-assessment has limited clinical operations input	• Annual Wellbeing assessment– September 2024 Wellbeing champions network and the cross trust development of a wellbeing plan – 24 Sept. **Deputy Director of People** • HWB network to be established - Priority for 24/25 (as above) – September 2024 Update as above. **Deputy Director of People**
Gaps in assurance **Gaps in assurance addressed in 2023/24 have been removed)** • None currently identified.	**Actions to address gaps in assurance** N/A

RISK REF –BAF.0014 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** – November 2024 for receipt at EMT in December and People Committee and Board in January 2024. **Risk type:** Workforce **Risk appetite:** High (open) **Risk rating impact v likelihood** - Current 4 x 3 = 12 - Target 4 x 2 = 8 - Movement ⟺ Corresponding risks on the Corporate Risk Register: 5321 -

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

Summary update • Vacancy Control Panel (VCP) – a new process is in place to monitor and manage workforce changes. These are expected to complement workforce plans but accepting some deviation where VIP are brought in. • Workforce plans are being updated in conjunction with the completion of the professional plans and will be. • Milestones have been updated and there are no changes to the scoring at this review.	**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 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. • 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 • 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. • Next Review of flexible working policy is due by October 2024. • Data Warehouse development sits with IMST –December 2024.

Controls

- Governance - WPG monitoring delivery and reporting to People Committee, Recruitment and Retention Group for all professions in place, External ICS retention group, Workforce Recruitment and Retention Group to support identification of gaps – see new Gap in control will be addressed once merged group in place,
- From April 2023 the Workforce Transformation and Recruitment and Retention groups merged to one group now called Workforce Recruitment and Transformation group to support new merged BAF risk, Education and Training group governing apprenticeship levy, Recruitment delivery group for all professions put in place from March 2023
- Monthly reporting to NHSE, and ICS
- Health care support worker regional community of practice group hosted by NHSE
- TRAC reports feed into R & R group to oversee People delivery plan – recruitment reporting through the workforce dashboard goes to People Committee
- People Plan in place
- Annual learning needs analysis undertaken to inform Trust training plan priorities for workforce transformation and CPD funding investment *[from BAF risk 0019]*
- Ensuring the apprenticeship level is fully utilised and prioritised for new roles/progression pathways for existing staff and that we meet our public sector apprenticeship targets *[from BAF risk 0019]*
- Workforce data dashboard
- TRAC system in place to manage ALL recruitment. Tracked and reported to People Committee
- Training and further guidance for recruiting managers on TRAC. Rolling programme of training is in place**.**
- 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]*
- ~~Deep dive took place into retention at People Committee in April 2022~~ Retention review at People Committee bi-monthly.
- ~~People Delivery plan final version presented to People Committee. This is set and reviewed annually over the three year strategy~~. People Delivery plan in place for 2024-25.
- Improved data and systems to support accurate vacancy in

External assurance

- ICS Recruitment and Retention group attended by Deputy Director of People
- Bi-monthly reporting to Quality Board (external group i.e. NHSE/I, CQC, CCG *as was*)
- National People Plan reporting to ICS – we are required to provide evidence on meeting priorities so ICS can respond on national level.
- ICS partnership working on workforce dashboard [from BAF risk 0019]
- Quarterly data benchmarking report (apprenticeship levy data collection) to Health Education England on behalf of ICS [from BAF risk 0019]
- National People Plan reports into ICS.
- Progress with international recruitment 15 International nurses arriving this year (2023/24).
- NHSEI Performance workforce returns + direct support
- NHSEI and People workforce return (PWR) reporting which triangulates and checks our data
- PWR reporting and NHSEI governance for international recruitment
- Internal Audit significant assurance received for Data Quality – July 2024.

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 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** • 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 2025
Gaps in assurance Gaps in assurance addressed in 2023/24 have been removed) 1. ESR data poor quality GAP 4 closed for poor quality but open for vulnerability of the data as multiple dependencies. **GAP closed.**	**Actions to address gaps in assurance** • Building on work which took place in 2023/24 which included cleansing data to maintain the data integrity all contractual changes to ESR, all new starters and all establishment change requests have to be approved by both finance and Workforce before any amendments to ESR or the ledger are made Owner Interim Workforce Systems Lead (Steven Sellars) – **Actions to improve data quality ongoing as part of manager self-service roll out April 2024**. **Achieved and will be ongoing** – it is recognised given there are smaller teams for quality control monitoring there are vulnerabilities around quality control checking – mitigations are in place. However, positively the internal audit on data quality has been received with significant assurance. **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** – November 2024 for receipt at EMT in December and People Committee and Board in January 2024. **Risk type:** Clinical Quality and Safety **Risk appetite:** Low to Moderate (minimal and cautious) **Risk rating impact v likelihood** - Current 4 x 3 = 12 - Target 3 x 2 = 6 - Movement ⟺

				Corresponding risks on the Corporate Risk Register: 5385	
On track	**Some slippage**	At risk	Completed	**Assurance level**	**Amber**

Summary update

- Values into Behaviours work is underway and sessions have been held over Augst 2024.
- Milestones have been updated.
- There is no change to the scoring at this review.

Milestones in 2024/25 to support reaching target score:

- 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.
- ~~Values into behaviours consultation and launch of outcomes – April to December 2023 now in implementation phase. In August 2023 engaged external consultants to contribute to the communications structures and this work. A revised approach has been developed to ensure a larger number of the workforce are engaged through this programme of work. Consultation and engagement on values into behaviours commenced outlined in People Delivery plan and outputs received at Board of Directors in Q1 of 2024/25~~.

Controls

- 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
- ~~Agile mindsets & behaviours leadership programme (contracted programme)~~

Internal assurance	**External assurance**
• Staff engagement steering group reports monthly to Organisational Development Assurance Group which reporting into People Committee bi- monthly • People Plan 23 -24 received at May People committee (contains all OD activity) • People Committee received refreshed deliverables in 2022 • People Pulse survey • OD actions were refreshed as part of the People Plan update for 2022-23 NEW assurance following closure of action in March • Team SHSC: Developing as Leaders (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. • ~~developing as Leaders Cohort 3 recruited to with line manager and Exec support. 30 participants. Will run June 2023 to December 2023. Day 1 held 12.6.23 and Day 2 19.07.23. Positive evaluation received from both days. Called in nominees for the next cohort.~~ • ~~Agile Mindset & Behaviours leadership programme - 3 Cohorts completed now 30 leaders trained in Agile Mindset & Behaviours methodology and tools. Cohort 4 underway 11 participants working through the 20 week programme. Two learning events have been held to embed knowledge. Consideration taking place on future approach for embedding learning~~.	• ~~Quality Board bi-monthly report~~ 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.
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. • 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	• Action planning at service level in progress, staff engagement included as part of the triannual Performance review meetings with the Exec team, with services reporting progress on action plans

	(based on people promise themes). Templates have gone out. Confirmation required that the templates are being fully utilized before the gap can be closed down for the next review of the BAF risk (October) will be tested through performance review process - Reviewing the approach, templates shared but not fully utilized. Improvement in staff survey response rates for substantive and bank staff in 2023, but People Pulse response rates variable. Reviewing change of use of People Pulse survey from 3 times a year to possibly 1 in order that we have an interim measure for staff survey and reduce ask of staff. Being explored in line with national requirements. Update received at People Committee in May. No further update at this time. **Owner Head of OD and Deputy Director of People**

BOARD ASSURANCE FRAMEWORK 2024/25
Appendix 3
As at 13.09.24 post receipt at Finance and Performance Committee

BAF RISKS OVERSEEN BY FINANCE AND PERFORMANCE COMMITTEE

Following EMT review of the CRR and the BAF in August, and receipt at FPC in September it is recommended all current BAF risks sitting beneath Finance and Performance Committee are retained and amended where indicated.

<table>
<tr><td colspan="6">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.</td></tr>
<tr><td colspan="2">STRATEGIC AIMS
- Effective use of resources
- Deliver outstanding care</td><td colspan="2">STRATEGIC PRIORITIES
- Implement RIO safely</td><td colspan="2">Executive lead: Executive Director of Finance
Board oversight: Finance and Performance Committee & Audit and Risk Committee
Last reviewed – September 2024. Next review – November 2024 for receipt at EMT in December and FPC and Board in January 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</td></tr>
<tr><td>On track</td><td><u>Some slippage</u></td><td>At risk</td><td>Completed</td><td>Assurance Level</td><td>Red</td></tr>
<tr><td colspan="2"><u>Summary update</u>
• The assurance level remains red whilst we retain the infrastructure risk of Insight.
• There are no changes to the milestones to report at this time.</td><td colspan="4"><u>Milestones in 2024/25 to support reaching target score:</u>
• Retire Insight – currently EPR is expected to complete in Q4 of 2024/25
• As noted previously, sources of assurance and actions are unlikely to change until the full retirement of Insight.
• Address data reporting gaps for services in the Tranche 1 stage of EPR implementation - for services that have moved to RIO in Tranche 1 there are some data reporting gaps these are being followed through as</td></tr>
</table>

	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) • 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.	
Internal assurance • 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.	**External assurance** • 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.
Gaps in controls (Gaps in controls addressed in 2023/24 have been removed)	**Actions to address gaps in controls**
1. Put in place assessment and plan for full resourcing and affordability (for IMST).	• 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**.
2. Address elements of DSPT still to be achieved, the relevant risks are being tracked.	• 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.
3. The need to develop a new Digital Roadmap and Target Operating Model.	• 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
Gaps in assurance (Gaps in assurance addressed in 2023/24 have been removed)	**Actions to address gaps in assurance**
Insight still being used – delays with EPR	• 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.

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** – September 2024. **Next review** – November 2024 for receipt at EMT in December and FPC and Board in January 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

- It is suggested reference to low IG training levels be removed given current performance
- To note in 2024/25 the DSPT is changing so standards will change and this will need to be taken into consideration.
- Additional risks are being developed to be reflected in the corporate risk register around a cyber security risk linked to this strategic risk. These are expected to be in place in September 2024, for reporting in October 2024.

Milestones in 2024/25 to support reaching target score:

- 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)

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

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.

</td></tr>
<tr><td><u>Internal Assurance</u>
Governance reporting:
Reports on patching reports are received at-DAG and will be reflected in the Service Management report received at DAG which reports onward to ARC and EMT (which is additional reporting in 2024/25).
Service management reports include supplier engagement relating to system patching for key suppliers for locally hosted systems.
Monthly performance reporting across all Teams for mandatory IG training.
Oversight via reporting to DAG which has been in place since April 2023.
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.
</td><td><u>External assurance</u>
Confirmation provided to NHSD in accordance with prescribed national process.
DSPT compliance – key indicator - Annual Data Security Protection Toolkit (DSPT) audit moderate assurance rating received.
</td></tr>
<tr><td><u>Gaps in controls</u>

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

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

System Asset register functionality within Sunrise not yet enabled.</td><td><u>Actions to address gaps in assurance</u>
Asset register to be specified and developed in 2024/25 starting with hardware assets. Owner Head of Service Delivery and Infrastructure Digital. The timeline for completion of the audit is October 2024, and work on the register will be completed by 31 December 2024.
</td></tr>
</table>

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	
- EFFECTIVE USE OF RESOURCES	- Deliver our financial plan and efficiency programme	**Executive lead:** Executive Director of Finance **Board oversight:** Finance and Performance Committee **Last reviewed** – September 2024. **Next review** – November 2024 for receipt at EMT in December and FPC and Board in January 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

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

Summary update

- Continuing to develop further plans to close the CIP gap 2024-25 of 0.7 million.
- 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.
- A plan is being developed for the system gap not included in plans of £48 million.

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.

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.

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

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.

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.	
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.

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** – September 2024. **Next review** – November 2024 for receipt at EMT in December and FPC and Board in January 2025. **Risk type:** Strategic **Risk appetite:** High (open) **Risk rating impact v likelihood** - Current 4 x 4 = 16 - Target 4 x 2 = 8 - Movement ⟺ Corresponding corporate risks: 5367, 5051

On track	Some slippage	At risk	Completed	Assurance level	Amber

Summary update

- Integrated change framework workshops held in July and August 2024, with good participation across change-enabling teams
- 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
  - Develop Integrated change support 'offer' for the 'do and share' category – by October 2024
  - Test Integrated Change framework with operational colleagues – by end of September 2024
  - Launch Integrated Change Framework with Collective Leadership Group – by October 2024
- Revised approach to reporting to Board for transformation programmes ~~through the IPQR~~ from July 2024.
- ~~TEP~~ 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
- Organisation wide comms and launch of Integrated change framework – by October 2024
- ~~Therapeutic environments – Maple decant 27 June 2024 completed works by end of January 2025. Older peoples [see note above re scoping]~~
- ~~The EPR programme – has been updated and approved at the April 2024 Board. Achievement of required resources identified to Board by September 2024. EPR to be delivered to be delivered by the end of the financial year.~~
- ~~Community Facilities – see comment about estates strategy refresh.~~
- ~~Fullwood capital receipts – The February 2024 strategy Board agreed to pursue revised phasing of receipts of the sale over 2024/25 and 2025/26. Receipt remains delayed due to delays with the submission of planning application by the buyer and approval of planning permission by the Local Authority. Planning meeting now delayed until after the July election. Updates on progress are received at the Board.~~
- ~~CMHT delivery January 2024 and LD delivery – The LD programme on track with operational model agreed, moving into implementation, with full programme completion expected Summer 2024. CMHT programme and PCMH programmes have April milestones, and complex inter dependencies.~~

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.
  Business cases and capital expenditure approved in accordance with Trust wide governance processes. ~~Business case reviews and change control activity by Programme Boards recorded within the programme and conducted in line with wider governance processes if outside of agreed tolerances.~~

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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.

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

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

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

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

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<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.

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<tr><td>
<u>Gaps in assurance</u>

Gaps in assurance addressed in 2023/24 have been removed

None currently

</td><td>
<u>Actions to address gaps in assurance</u>

N/A
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</table>

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 ~~resulting in~~ missed opportunities to add value for our service users and to meet population needs that require a partnership approach, resulting in potential to ~~This may mean that we~~ miss opportunities to also safeguard the sustainability of the organisation longer term and ultimately may fail to deliver our strategic priorities and operational plan.

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	**Executive lead:** Director of Strategy **Board oversight:** Finance and Performance Committee **Last reviewed** – September 2024. **Next review** – November 2024 for receipt at EMT in December and FPC and Board in January 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
- Deliver outstanding care - Effective use of resources - Ensure our services are inclusive	- 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	

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

Summary update

- Place- based partnership (Sheffield Heath and Care Partnership) – SHSC directors are playing an active role and leading on several workstreams in the partnership.
- Milestones and target dates have been updated to reflect this.

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 ~~due to meet with other interested parties and the commissioner before August 2024.~~
- Agreeing South Yorkshire integrated approach to access for Health Based Place of Safety – approach has been approved by Provider Collaborative Board in May and is expected to be delivered by the end of 2024/25.
- ~~Eating disorder service co-located with VSCE – the proposal for~~ Establish eating disorder joint committee (in shadow form) for South Yorkshire. Initial meeting in September 2024. ~~has been approved by the Collaborative Board and respective Boards in May for implementation in 2024/25.~~
- ~~Staff bank enhanced with students from Sheffield Universities – by the end of 2023/24 – Update – recruitment was paused after Christmas as we had enough resource, so not actively sought applications from students however we do currently have some students on the bank and numbers are being captured.~~
- Develop action plan for delivery of GGI findings by ~~August 2024~~ October 2024 with implementation thereafter.
- Establishment of Trust 'partnerships group' and some form of CRM (Customer Relations Manager) system by March 2025. Initial discussion due September 2024

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.** **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 ~~PLACE~~, ICB and SY MHLDA Collaborative to participate in the planning of priorities for 2023/24 and worked together with colleagues in Sheffield ~~PLACE~~, 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 ~~Chair and~~ CEO and other Executives linking into appropriate delivery groups. • All core Trust strategies are in place with annual reviews process. • Regular meetings with Sheffield LA, Sheffield Health and Care Partnership ~~PLACE~~, ICS and Provider Alliance (moved from assurance) • All reports to Committees and Board are prompted to consider the partnership implications arising from the report (moved from assurance) • 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 approach in 2024/25 • 5-year plan and strategic direction received at FPC (Nov 2022)	**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.

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).	• Review of approach to strategy planning and reporting by Director of Strategy and is planned to be progressed for 2024/25. This gap is likely to be closed and replaced as appropriate. Approach will be updated post Board strategy refresh discussions in October 2024. **Owner Director of Strategy**
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.	**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. Owner Director of Nursing.**
2. Detailed implementation plans have yet to be finalised for every strategy therefore stakeholder and engagement plans are yet to be fully completed	• See update against Gap in controls 2. Work also taking place to reflect on feedback received from the stakeholder engagement review by GGI which will impact on plans. **See comment above under gaps in controls.**

RISK REF – BAF 0030 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** – September 2024 . **Next review** – November 2024 for receipt at EMT in December and FPC and Board in January 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 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

External assurance

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

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 - Deliver Outstanding Care - Effective use of resources	**STRATEGIC PRIORITIES** - Deliver therapeutic environments - Improve access so people wait well and wait less - Deliver our financial plan and efficiency programme	**Executive lead:** Executive Director of Strategy **Board oversight:** Finance and Performance Committee **Last reviewed** – September 2024. **Next review** – November 2024 for

- Ensuring services are Inclusive - Create a great place to work		- Work in partnership to address health inequalities - Live our values improving experience and wellbeing		receipt at EMT in December 2024 and FPC and Board in January 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	
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
- 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

Milestones in 2024/25 to support reaching target score:

- Opportunities for colocation and estate efficiency with Sheffield HCP partners has been explored ~~by September 2024~~ and is on track for September 2024.
- Scope and timeline for next phase of Therapeutic Environments Programme confirmed by ~~September~~ November 2024
- Opportunities from improved space utilisation quantified by November 2024
- Estates strategy ~~refresh~~ annual review was received at FPC in July and is due for receipt at Board in September 2024~~. December 2024~~
- Strategic outline case for new hospital (incl multi-site options) by December 2024

Controls • Governance - Working as part of Place Estates priority to optimise use of the NHS estate. Reporting through FPC, Business Planning Group, Capital Planning. • Checks through estate work – such as water safety, fire safety, lifts, electrical and gas • PLACE audit – provide benchmarking information and support identifying areas for action. • ERIC returns – provide benchmarking information. • Authorised Engineers all in place. • Maintenance programme of work in place • Capital plan • Contracting arrangements in place for buildings leased and not owned.	
Internal assurance • Annual PLACE report and associated action plan • Annual Premises Assurance Model (PAM) • 7 facet survey report • Annual Health and Safety Report (and quarterly updates received at Assurance Committees)	**External assurance** • Authorised Engineers Annual Audit • ERIC returns and benchmarking
Gaps in controls • Require an additional external review of our fire doors and our systems for monitoring.	**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**
Gaps in assurance • See above re Fire Safety	**Actions to address gaps in assurance** • Commission AE assessment of the competencies required of internal teams. Report by September 2024 – **Owner Director of Strategy**