Front Sheet: Public Board of Directors
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Private/ public paper:	Public
Report Title:	**Board Assurance Framework 2024/25**
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Vision and values:	The Trust vision is to ensure we **work together for service users**. The BAF helps to assure us that any identified risks are managed, so we can continue to **improve the lives** of the people we serve, through safe and effective services and demonstrate our **commitment to quality**.
Purpose and key actions:	The purpose of this report is to share the updated BAF reports following review by all executive director leads and EMT and to note that relevant committees were assured that these now reflect the current position and scores. All updates are appended as follows: Appendix 1: Quality Appendix 2: People Appendix 3: Finance and performance The purpose of the report is to provide the final updates of the BAF for approval.
Executive summary:	The paper includes in each appendix the most up to date board assurance framework (BAF). All confirmed **proposed changes to the BAF risk descriptions are highlighted in blue text.** The relevant **summary updates are indicated in blue text** for each risk in the appendices. All **scores have been reviewed,** and the changes are noted below and in the appendices. **Actions and milestones have been updated** where appropriate to reflect the impact of action taken to mitigate the risk and to ensure the wording of actions **reflects the current programmes**. The following BAF risks have been updated for **quarter 4:**

1. Quality:

Risk	Description summary	Risk rating impact v likelihood
0024	Risk of failing to meet fundamental standards of care with the regulatory body caused by lack of appropriate systems and auditing of compliance with standards.	Current 4 x 3 = 12 Target 4 x 1 = 4 Movement ⟷
0025B	There is a risk of failure to deliver the therapeutic environments programme at the required pace caused by difficulty in accessing capital funds	**Current 4 x 2 = 8** Target 3 x 2 = 6 Movement ↓
0029	There is a risk of a delay in people accessing core mental health services caused by issues with models of care, access to beds, flow, crisis care management	Current 4 x 4 = 16 Target 3 x 1 = 3 Movement ⟷
0031	There is a risk we fail to deliver on national inequalities priorities and our strategic aim to deliver inclusive services, caused by failure to adopt an inequalities-based approach to care resulting in poorer access, later presentations and risk of poorer outcomes.	Current **3 x 3 = 9** Target 3 x 2 = 6 Movement ↓

2. People:

Risk	Description summary	Risk rating impact

		v likelihood
0013	Risk that our staff do not feel well supported, caused by a lack of appropriate measures and mechanisms in place to support staff wellbeing resulting in a poor experience for staff.	Current 4 X 3 = 12 Target 4 x 2 = 8 Movement ⟷
0014	There is a risk of failure to undertake effective workforce planning (train, retain and reform) to support recruiting, attracting and retaining staff to meet current and future needs.	Current 4 x 3 = 12 Target 4 x 2 = 8 Movement ⟷
0020	Risk of failure as an organisation to live by our values caused by not addressing closed cultures poor behavioural issues and lack of respect for equality diversity and inclusion.	Current 4 x 3 = 12 Target 4 x 2 = 6 Movement ⟷

3. Finance and performance:

Risk	Description summary	Risk rating impact v likelihood
0021A	There is a risk of failure to ensure digital systems are in place to meet current and future business needs.	Current 4 x 3 = 12 Target 3 x 2 = 6 Movement ⟷
0021B	There is a risk of cyber security breach caused by inadequate arrangements for mitigating increasingly sophisticated cyber security threat and attacks and increased data protection incidents	Current 4 x 3 = 12 Target 3 x 2 = 6 Movement ⟷
0022	There is a risk we fail to deliver the break-even position in the medium term caused by factors including failure to develop and deliver robust financial plans	Current 4 x 4 = 16 Target 3 x 1 = 3 Movement ⟷
0026	There is a risk that we fail to take evidence led approach to change and improvement	Current 3 x 4 = 12 Target 4 x 2 = 8 Movement ↓
0027	There is a risk of failure to ensure effective stakeholder management and communication with our partners and the wider population and to effectively engage in the complex partnership landscape	Current 4 x 3 = 12 Target 4 x 2 = 8 Movement ⟷
0030	There is a risk of failure to maintain and deliver on the SHSC Green Plan.	Current 3 x 4 = 12 Target 2 x 4= 8 Movement ⟷
0032	There is a risk that our estate does not enable the delivery of our strategic priorities.	Current 3 x 3 = 9 Target 3 x 2= 6 Movement: ↓

Which strategic objective does the item primarily contribute to:					
Effective Use of Resources	*Yes*	**X**	*No*		
Deliver Outstanding Care	*Yes*	**X**	*No*		
Great Place to Work	*Yes*	**X**	*No*		
Ensuring our services are inclusive	*Yes*	**X**	*No*		

What is the contribution to the delivery of standards, legal obligations and/or wider system and partnership working.	
The BAF is the main tool by which the Board overall responsibility for internal control. Owned by the Board, it is a key tool to assure and evidence the delivery of strategic objectives.	
BAF and corporate risk/s:	The paper provides assurance for all BAF risks and corresponding corporate risks are noted within the report.
Any background papers/ items previously considered:	All changes to the BAF are noted and approved by Board of Directors and this was last received in January 2025.
Recommendation:	The Board of Directors are asked to: • **Approve** the updates • **Approve** the review of **scoring** where this has changed • **Note** for assurance that updates reflect the impact of action taken to mitigate the risk

BOARD ASSURANCE FRAMEWORK 2024/25
For receipt in March 2025

BAF RISKS OVERSEEN BY QUALITY ASSURANCE COMMITTEE

BAF RISK 0024 – Risk of failing to meet fundamental standards of care with the regulatory body caused by lack of appropriate systems and auditing of compliance with standards, resulting in avoidable harm and negative impact on service user outcomes and experience staff wellbeing, development of closed cultures, reputation, future sustainability of particular services which could result in potential for regulatory action.

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	**Executive lead:** Executive Director – Nursing and Professions /Medical Director **Board oversight:** Quality Assurance Committee **Last reviewed** – February 2025. **Next review** – April 2025 **Risk type:** Quality **Risk appetite:** Low (minimal and cautious) **Risk rating impact v likelihood** - Current 4 x 3 = 12 no change - Target 4 x 1 = 4 - Movement ⟺ • **Corresponding Corporate Risks:** 5026, 5124
- Deliver outstanding care - Ensure our services are inclusive	- Deliver our quality and safety objectives	

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

Summary Update

- The risk has not changed and it is therofre proposed that the risk score remains unchanged.
- There are a number of hotspot areas that are not meeting fundamtnal standards of care (FSoC)
- The audit systmen is beinf streanghthed and FSoC visits are back on track.
- An external reviw of quality governacne is planned for April 2025.

Progress against Milestones for 2024/25

- A programme of targeted audits to ensure the embeddedness of actions that took place during the back to good programme will be complete by the end of Q1 2025-2026.
- Planning to ensure that LAP review is going to be held by the Therapeutics Environment Board (TEP) Board – to take place by the 31 December 2024**.** This is ongoing and is on track to be achieved by the 31 December LAP assessments are ongoing as a continual loop and any issues report into the LAP oversight group and then TEP Board.
- **Progression of improvements related to supervision and training –** overseen through BAU post closure of the B2G programme, at People Committee. New dashboard in place. Expected to improve post PDRs. This is currently being overseen by the Operational Management Group (OMG) and reports to EMT on a monthly basis. Work with inputting supervision into ESR will take place early 2025. This will be embedded in governance at all levels for monitoring and training compliance, which will feed into the quality governance review that is being planned. A review of the supervision policy and the associated supervision tree for both directorates is underway and

	will be completed by the end of Q1 2025-26. An evaluation of the supervision training that was completed by Sheffield Hallam university will inform ongoing procurement of supervision training. A non-medical training oversight group is planned to start March 2025. Supervision compliance will continue to be monitored through operational management group and the People Committee • Fundamental Standards visits – the programme will be reviewed for the forthcoming financial year with a review of the templates/ audit tool. in line with the new CQC standards. By April 2025 for the templates and programme. All fundamental standards visits have now been completed and the template is being reviewed in line with the CQC standards - a new framework will be implemented by the end of Q1 2025-26. • Development of record audits tool by Jan 2025 and an improvement action plan by March 2025 to be able to provide assurance of open cultures in key areas. An audit tool has been developed and is being piloted at Forest lodge during April 2025. A full roll out is planned by the end of Q1 2025-26. **Milestones completed** • **Completion of the Fixed Ligature Anchor Point programme for acute adult in patient services** - the risk to service users will be mitigated through the planned decant of Maple ward to Dovedale 2 following its move to Burbage – this is completed with the Maple move completed 27 June 2024. Cross reference to BAF risks 0025a and 0025b **completed.**

Controls

- Established quality governance mechanisms including fundamental standards of care, culture and quality visits and quality audit programme.
- Monitoring of performance and Quality through governance structure which can result in request for improvement plans monitored through QAC e.g. recovery teams, SAANs.
- Ongoing recruitment and workforce planning processes including clinical establishment reviews, reviewed via People committee with robust workforce dashboard
- Service lines and IPQR embedded ensuring a level of oversight.
- Management and leadership structure in place – Ward to Board with increased grip and control around management of establishments.
- Clinical and Social Care strategy implemented.
- Robust incident and investigation governance in place, PSIRF implemented from November 2023.
- Co-production standards launched and patient experience measures are in place.
- Range of leadership offers completed and ongoing across SHSC corporate and clinical teams.
- Quality and Equality impact assessment reporting to QAC.
- Ligature anchor point removal plan phase 1 and 2 are completed, phase 3 in progress. Clinical Environmental Risk Group reviews all LAP assessments and reports to clinical quality and safety group. Exceptions reported to Therapeutic Environment Board.
- Establishment of OMG which consists of leaders from all directorates.
- Updated Capital Plan received at Board in April 2024 with updates received at subsequent Board meetings.
- Full business case for Maple improvements were received at Board in April 2024 and an update received in December 2024. This approved and in waiting to be inacted when funding steams are aligned

Internal assurance	**External assurance**
• Back to Good – Closure report received at Board November 2023 – ongoing reporting through Quality Assurance Report on embeddedness and outstanding	• 2023 CQC relationship visits – positive verbal feedback received. • Section 11 Audit with safeguarding partnerships.

elements overseen by relevant assurance committees. • Tendable being utilised consistently. • Regular reporting through governance routes including learning lessons, safeguarding reports, staffing reports, transformation programme reports. • Successful international recruitment with new recruits in post • The CQC report that was published on 16 February 2022 demonstrated we had delivered actions against the section 29a warning. Significant progress was noticed. New improvement actions are in place. Outstanding actions in respect of Maple ward LAPs will be mitigated when Maple decants to Dovedale 2. • New EPR plan approved by the Board in April 2024. • 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.	• Positive engagement around S42's in 2023/24 in terms of Trust responsiveness. • CQC reinspection – Dec 2021 - Outcome of December 2021 acute and PICU inspection by CQC – reported Jan 2022. • Regularly reviewed by the Clinical Environment review group on a monthly basis. • Engagement with safeguarding partnerships at Executive level • NHSE funding required external reporting
Gaps in assurance (those addressed in 2023/24 have been removed)	**Actions to address gaps in assurance:**
1. Tendable is not being used consistently	• A Module on Ulyssess is being developed, and the audits from Tendable will be moved across by Jan 2025. **Executive Director of Nursing, Quality and Professions** Tendable is no longer in use, and module is being built on Ulysses, this is in progress – to be ready by the end of April 2025.
2. Regular reporting through governance routes including learning lessons, safeguarding reports, staffing reports, transformation programme reports.	• Further improvement to governance processes required to strengthen assurance and learning is shared across the organisation. A review of the Quality Governance architecture has been commissioned and will be undertaken during Q4 2024-25. **Executive Director of Nursing, Quality and Professions** An external review of quality governance is commencing in April 2025.
3. Completion of the Fixed Ligature Anchor Point programme	• Scoping of work that is required in the Older Adults acute wards to eradicate LAP is taking place. There is some outstanding work on Forest Lodge low secure unit which is currently being planned for essential works. This is subject to the capital plan prioritisation by end of March 25. The LAP won't be complete until Maple ward complete, but people have been decanted from Maple which addresses this problem. Grenoside is on the capital plan. **Owner Director of Operations.** Project in scoping phase and a kick off stakeholder engagement has taken place. A milestone plan has been requested for April 2025 programme board.
Gaps in controls 2024/25 (those addressed in 2023/24 have been removed)	**Actions to address gaps in controls**
1. Phase 3 plan for reducing ligature anchor points will depend on decant solution and take place over an 18-month period see action. **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	• 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

	gender now.	appraisal of the future for delivery of mixed gender care in PICU – by the end of Nov 2024 for the options paper **Owner Director of Operations** An outline case was presented in November 2025 to the programme board and an updated outline case will be presented to the programme board on 12 March 2025. • The Sexual Safety working group is in place reporting into QAC 6 monthly.
3.	We are restricted on our capital spend each year and we have a large programme of estates improvements which means that they have to be phased over the next two years. **GAP closed**	• Updated Capital Plan received at Board April 2024. **Owners Director of Finance and Director of Strategy. Action closed**
4.	Poor compliance with Supervision in clinical teams	• Supervision rates remain a concern in some areas this continues to be monitored at the People Committee. Dashboard received at EMT in June 2024 and monthly thereafter. Recovery plans in place will be overseen at OMG prior to receipt at assurance committee. Moving to ESR for recording. Line management supervision training pilot in place. Update to be provided in September 2024.The plan is still to move to ESR for recording. This and reporting frequency is being reviewed by OMG in September 2024. **Owner Executive Director of People** Supervision recording has moved to manager self-service (ESR) from January 2025 and the impact of this is expected to be seen in Q1 of 2025-26. Operational management group will continue to have oversight of compliance levels.
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.** Our Home First Programme and insights from Real World Health have identified the capability and capacity of community and crisis services, the efficiency of hospital care (length of stay), and social care delayed discharge as key drivers. Changes to operational and clinical governance structures and improvements to patient information flow have now been implemented. The Home First Programme launched under a revised structure and terms of reference in February 2025 and has since achieved its trajectory milestones to reduce out of area hospital care.
6.	Use of 136 suite rooms to accommodate people awaiting admission – still required at the current time	• New HBPOS (136 suite) opened January 2024. There has been some breaching continuing and this remains under regular review and is reported weekly to EMT and through to the assurance committees. There has been some improvement in breaches since March 24 and this is subject to the revised flow plan for OOA. Monthly monitoring in place. There continues to be some breaching and this remains under regular review. **Owner Director of Operations.** There was further deterioration in Quarter 3, in relation to breach of use of the 136 beds. It is a priory

	of the Home First Programme to prevent this. The regional Health Based place of Safety (Third HBPOS at the Longley Site) opened in January 2025, following work by the Provider Collaborative to improve HBPOS capacity. Operational and clinical leadership is provided by our Crisis Service, who work in close partnership with Sheffield City Council and South Yorkshire Police. Cross organisational procedures are now operational which require us to operate a maximum length of stay of 24 hours within a HBPOS, whilst also avoiding out of area hospital care. This forms part of the objectives of the Home First Programme.
7. Recovery plans to date are not having sufficient impact on waiting times, this is being addressed through the Community Transformation which will be completed in January 2024. **GAP CLOSED (July 2024)**	• Recovery plans have been received through QAC. We continue to see a downward trajectory of people waiting for the newly transformed recovery services. **Action closed.**
8. Establishment of OMG which consists of leaders from all directorates.	• The reporting framework and work programme of governance structures will be reviewed by **Director of Operations** and Associate Director of Communications and Operations- January 2025. There are a number of Tier 2 committees that report into Quality Assurance Committee and provide assurances at the present time. An external governance review has been completed and a final report is expected at the Board of Directors April 2025.
9. Patient experience measures are in place but Friends and Family test (FFT) data is low, and the care opinion subscription no longer in place.	• The FFT has now gone live on Qualtrics which provides an online way to give feedback this is accessible via QR code and marketed on Jarvis, SHSC external website, and posters circulated to services. The engagement team will work with services to raise awareness of Qualtrics and encourage services to embed this work and understand the barriers faced. FFT performance will continue to be monitored through LECAG and the IPQR There is now a feedback improvement plan in place which is starting to demonstrate improvements in feedback performance. Safe to share is also in place, which is showing in increase in engagement.

RISK REF: BAF 0025B - 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.

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	**Executive lead:** Director of Strategy **Board oversight:** Finance and Performance Committee **Last reviewed** – February 2025. **Next review** – April 2025 **Risk type:** Safety **Risk appetite:** Moderate (cautious) **Risk rating impact v likelihood** - Current ~~4 x 4 = 16~~ **4 x 2 = 8** - 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**	**Green**

Summary update

Successfully increased 24/25 capital budget through bids for system year end slippage. Enabled start of Maple Ward project, and a number of other critical capital projects - thereby enabling the 25/26 capital plan to be focused on addressing next tranche of priorities.

Maple Ward project on track for completion in 25/26 year.

Sign of progress towards the imminent sale of Fulwood meaning that more likely to be able to increase the available capital investment in 25/26. If realised this will accelerate delivery of next phase of TEP.

Nature of this risk may change to become more focused on clarity of strategic intent with regard to specific sites, and ability to clarify schemes and confirm viable business cases, rather than focused on availability of capital.

As each specific site is addressed, we expect the impact rating to be reduced further.

Milestones in 2024/25 and 2025/26 to support reaching target score:

- Milestones around addressing the remaining LAP risks in the estate is covered in the scope for next phase of TEP
- Short term capital projects delivered using capital slippage from system by end of March 2025.
- Strategic Outline business case for a new hospital – December 2024 update December 2024, work paused in Q4 24/25 to focus on delivery of short term projects utilising slippage – to re-commence in 25/26
- review of effectiveness of operational mitigations of risks at sites that form part of next phase of TEP (Forest Lodge and Grenoside) in view of likely length of time until building work can be completed – Q1 25/26
- Clarify strategic intent with regard to sites in next phase of TEP - Q1 25/26

Milestones Completed

- Stanage refurbishment – The Stanage ward re-opened in April 2024. Achieved.
- Dovedale 2 moved to Burbage – May 2024 – **completed.**
- Maple Ward decant to Dovedale 2 –27 June 2024 –**completed.**
- Clinical Environmental Risk Group to include detail on any outstanding works – by July 2024 - **completed.**
- Estates strategy – Interim report July 2024 **completed.**
- ICS infrastructure strategy – July 2024 **– completed.**
- Maple Ward refurbishment commenced in early 2025 – **completed**
- Capital plan for 25/26 revised dynamically in light of progress and income achieved – **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 provisions 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 • Regular reporting (Capital Group; Therapeutic Environment Programme Board; Transformation Board) • Operational Structure presentation to People Committee • Health and Safety audits • IPQR monthly reports – statutory and mandatory training • Board and Executive visits to all wards and teams • Recruitment forecast confirmed • Completion of Stanage Dovedale 2 and Burbage refurbishments. • Opening of the new HBPOS in January 2024 • In February and March 2023 Registered Nurse and Healthcare Support Workers were onboarded covering many vacancies across acute wards. Systems are in place for rolling Registered Nurse and Healthcare Support Workers led by the Lead Nurse for recruitment. • Maple Ward decant to Dovedale June 2024 • Clinical Environmental Risk Group receives details on any outstanding works • Estates Strategy interim review received at Board September 2024 • ICS Infrastructure Strategy (SHSC has contributed to its development)	**External assurance** • Evidence based approach to Reducing Restrictive practice implementation (note there is evidence of continuing improvement around use of restricted practice)
Gaps in control (those addressed in 2023/24 have been removed)	
1. Use of temporary staffing leading to potential inconsistencies in the application of practice standards **- GAP Closed (July 2024)**	
2. Delays in the delivery of Therapeutic Environment Programme (TEP).	• The scope of the work for the next phase of the Therapeutics Environment programme (TEP) has been drafted by the programme team and will go through the approval process

	by November 2024. Owner Director of Strategy. Report received at EMT December 2024 **Action closed**
	• LAP work taking place to capture outstanding ligature anchor point work through the Clinical Environmental Risk Group **Owner Exec Dir of Nursing, Professions and Quality** - has undertaken analysis. Addressed through work to close the Maple ward – completed June 2024 **Action Closed**
	• Maple business case Full Business case approved in April 2024**. Owner Director of Strategy**. **Action closed**
3. **GAP removed as duplication**	**Action removed as duplication.**
Gaps in assurance (those addressed in 2023/24 have been removed) No current gaps	**Actions to address gaps in assurance** N/A

RISK REF: BAF 0029 There is a risk of a delay in people accessing core mental health services caused by issues with models of care, access to beds, flow, crisis care management, and contractual issues resulting in poor experience of care and potential harm to service users

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	**Executive lead: Director of Operations** **Board oversight: Quality Assurance Committee** **Last reviewed** – February 2025 **Next review** April 2025 **Risk type: Safety** **Risk appetite:** Low (minimal) **Risk rating impact v likelihood** - Current 4 x 4 = 16 risk no change - Target 3 x 1 = 3 - Movement ⟺ - Corresponding Corporate Risks: 5001
- Deliver outstanding care - Ensure our services are inclusive	- Deliver our quality and safety objectives - Work in partnership to address health inequalities	

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

Summary update	**Milestones in 2024/25 to support reaching target score:**
• The capability and capacity of community and crisis services, the efficiency of hospital care (length of stay), and social care delayed discharge as key drivers to the continuing challenging operational context. • As such, there are no plans to reduce the risk score at this stage. • Changes to operational and clinical governance structures and improvements to patient information flow have now been implemented. The Home First Programme launched under a revised structure and terms of reference in February 2025.	• Agreement of Gender service investment – this remains a challenge in terms of demand and capacity – issues have been escalated to NHSE. March 2025 - Gender and ADHD service now delivering against a trajectory to meet commissioned activity. • ADHD – a review of ADHD pathway to support the reduction of current of waits by 31 December 2024 No change • PCMHT and Urgent and Crisis Care - currently being embedded and governing

	programme set to end in November 2024, after which this will go to BAU. March 2025 – PCMH and Crisis Care in Business as usual following transformation. Mitigation is being developed in response to emergent risks around excessive demand into CMHT. • March 2025 - PCMH meeting target trajectory against the birth rate. **Milestones completed** • CMHT transformation – current lifestyle stage implementation is on track for completion by July 2024. This has been implemented - **completed.**
Control • Home First programme • Waiting Well Programme - Waiting list management initiatives in place to support people while they wait and respond to risk and supporting them to 'wait well'. • Duty systems in place for relevant teams to respond to immediate risks. • We will continue to monitor the improvements in waiting times in our core services and ensure initiatives are in place where there is an increase in waiting times. Monitoring takes place through the directorate and executive IPQR process. • Well established General manager and service manager development session utilised to promote new practice and share learning. • An improved plan in place to have understanding of risks to people waiting for allocation from 1 November 2022. Achieved for our core services and Gender Identify services. • Moving forward ICB place discussions will continue to address waits, re-set service specifications, and explore investment opportunities. • Raising challenges and issues in strategic places, such as, SY NHSE, Autism Learning Disability Board, Place Mental Health Learning Disability Autism and Dementia Board at place. This is a delivery group reporting to the PLACE performance and quality committee and PLACE board. • Continuing to engage with ICB and other partners around unmet commissioning priorities • Guidance from NHSE around requirements for support to 17 year olds received and being followed.	**Internal assurance** • Regular reporting in place through governance structure including Learning lessons quarterly report; IPQR, Complaints report; Quarterly reports to Quality Assurance Committee; Quarterly reports to Finance and Performance Committee. • Allocation to named worker recovery plan. • Memory Service recovery plan • Culture and quality visits • Contracting updates as required. • Improved oversight of people waiting in CMHT's and Crisis and Urgent recovery teams. Rag rating system provides oversight of people waiting, and where VCSE support is needed this is identified. • Improvement Plan for Gender services in place and being implemented. • CMHT transformation – current lifestyle stage implementation completed July 2024 completed now bedding in • NHSE regional deep dive on Gender Services – positive feedback received actions identified and addressed. Implemented changes and have recently been assessed by the Levy Review team and awaiting feedback. **External assurance** • Gender services agreements re-funding remain pending - Negotiation and escalation through commissioning forums at NHSE. • Adherence to the NHS Long Term Plan and the community team framework. • Relevant adherence to NICE guidance. • Attempting to move close to the 4-week waiting standard for relevant core services funding dependent
Gaps in control (Gaps in controls addressed in 2023/24 have been removed) 1. Where there are large numbers of people waiting for a service, we cannot reach out to every person on a regular basis, so are reliant on people contacting us if their presentation deteriorates or circumstances change. Each service has a protocol to regularly review people's needs whilst waiting and apply a RAG rating	**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. Completion of workforce plan and job plans to enable agreement of performance trajectory for increased

to prioritise contact.	activity. Further discussions are ongoing to consider whether there are further operational efficiencies that can be made that will increase the available number of assessment slots – April 2025 • There has been no further movement on Gender Services around investment and the Trust is continuing to engage and escalate. However, a recent review by NHSE provided positive feedback on service model and delivery and we have implemented the feedback. We now await the feedback from the Levy Review in early Q4 24/25. Deep dive from NHS England has been completed. Formal report expected latter part of Q4. Once received will review actionsRecruitment to new workforce plan for GIC to address single points of failure within operational delivery and support increased throughput - April 2025
	• **Other actions were closed at the July 2024 Board.**
2. All areas require clear commissioning specification, which require a review and process implemented by Sheffield place, helping us to really understand who a service is for This is still on going and is an action led by Place.	• We are assertively following up with our strategic planners about resolving this very outstanding issue. This is now subject to Executive level escalation through Director of Operations. This is still ongoing and is also being escalated by the Deputy Director of Finance. Further update on progress to be provided in September. This remains ongoing **Owner – Senior Head of Services** and Chris Cotton, Deputy Dir of Finance This is being worked on with Sheffield Place and Our contract team. There are still a significant numbers of service specs outstanding – completion October 2025.
Gaps in assurance (Gaps in assurance addressed in 2023/24 have been removed)	**Actions to address gaps in assurance**
1. Not having finalised the primary care, recovery teams and SAANs transformation plans reported to Board as closed as plan has been mobilised. **GAP CLOSED – confirmed at July 2024 Board**	
2. Staff vacancies and turnover remains high in some areas **GAP CLOSED as no current issues –at July 2024 Board**	
3. Lack of agile technology to maintain a high level of contact with people waiting.	• Part of revised Digital Strategy and road map to be developed in 2025/26 following implementation of RIO and the data warehouse **Owner CDIO** this will be completed following the implementation of RIO during 2025/26
4. Number and nature of complaints from service users - no further action needed currently **GAP closed – at July 2024 Board**	

BAF 0031 There is a risk we fail to deliver on national inequalities priorities and our strategic aim to reduce inequalities ~~deliver inclusive services~~, caused by failure to adopt an inequalities based approach to care resulting in poorer access, later presentations and risk of poorer outcomes.

STRATEGIC AIMS - Ensuring services are Inclusive		**STRATEGIC PRIORITIES** - **Deliver our patient and carer race equality framework** - **Work in partnership to address health inequalities** - **Deliver our equality objectives**		**Executive lead:** ~~Executive~~ Director of Strategy **Board oversight:** Quality Assurance Committee **Last reviewed** – February 2025. **Next review** – April 2025 **Risk type:** strategic/ quality **Risk appetite:** Moderate (cautious) **Risk rating impact v likelihood –** Scoring confirmed - Current ~~4 x 3 = 12~~ 3 x 3 = 9 - Target 3 x 2 = 6 - Movement – ⇩ Corresponding corporate risks: no corresponding Corporate Risks currently.	
On track	Some slippage	At risk	Completed	**Assurance level**	**AMBER**

Summary update

- Increasing evidence of strategic alignment, and focus in operational plans.
- Increasing momentum with movement of staff acting on inequalities. In the year ahead anticipate delivering a number of tactical improvements that further demonstrate practical progress to build on strategic intent.
- Strategic priorities for 25/26 include reducing inequalities and specifically progress with improving recording of personal characteristics.

Milestones in 2024/25 and 2025/26 to support reaching target score:

- Annual Report 24/25 includes refreshed health inequalities statement – Q1 25/26
- Trust strategy agreed and published in Q1 2025/26

Milestones completed

- Board development session and around MHA QI, health inequalities self-assessment and PCREF – June 2024 – **completed**.
- Following June Board session lead officers for inequalities to create a proposed action plan for inequalities, including the strategic objectives above – by September 2024 – Director of Strategy Completed
- All projects with the 'waiting well QI collaborative' have a health inequalities element by July 2024. All teams are being supported to consider health inequalities throughout their work with their coaches **Head of Quality Improvement – completed.**
- Following June Board session draft self-assessment to be presented back to Board for approval by September 2024 – **Director of Strategy completed**
- Publish alongside the Trust's Annual Report key information on health inequalities and details of how the Trust has responded to it, in accordance with NHS England's statement on information on health inequalities by October 2024 – **Head of Health Inequalities and Director of Strategy/Medical Director. completed**
- Board considered its role in delivering the Fair and Healthy Sheffield Plan and agreed organisation specific actions – December 2024 – **completed**
- Trust Strategy refresh strengthens focus on tackling inequalities – summary agreed January 2025 - **completed**

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

- Operational plan 25/26 includes focus on tackling inequalities. Service Level business plans all include inequalities focused objectives
- 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

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

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

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

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

</td><td>

External assurance

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

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<tr><td>

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 remains low. Increasing the percentage of records with complete demographic information will strengthen the effectiveness of our assurance mechanisms.

</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 owned by Operations- Greg Hackney, Senior head of Service and is reported monthly through the IPQR. A recovery plan related to recording of protected characteristics is in place and reports to the Quality Assurance committee. Further work is required to detail evidence of the impact with data. – April 2025.

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

BOARD ASSURANCE FRAMEWORK 2024/25
For receipt March 2025

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 failure to address 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 – February 2025. Next review – April 2025
Risk type: Workforce
Risk appetite: High (open)
Risk rating impact v likelihood
- Current 4 X 3 = 12 no change
- 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</td><td>Amber</td></tr>
<tr><td colspan="3"><u>Summary update</u>
• There is still a lot of work ongoing to refine the well-being offer and reduce sickness absence levels which have not come down enough to support a reduction in the score.
• The milestones and actions have been refreshed to reflect the impact of further actions being taken to mitigate the risk.
• The Board has agreed the development of the wellbeing hub, and a work plan will be created to support the implementation of this work in the new financial year 2025/2026 with some support identified from Charitable funds.</td><td colspan="3"><u>Milestones in 2024/25 to support reaching target score:</u>
• Health and wellbeing assessment model is in place which informs the scoping and prioritisation of the health and wellbeing work. This will support focus for the new financial year – People Plan 2025/26.
• The Board have agreed the development of the wellbeing hub and a work plan will be created to support the implementation of this work in the new financial year 2025/2026 with some support identified from Charitable funds.
• A Violence and aggression reduction plan is being developed by the end of March 2025, and this will report to EMT, People Committee, via WODAG and the health and safety group.
• Reduction targets and parameters need to be confirmed aligned to the national violence and aggression reduction standards and linked to the least restrictive practice work – a draft was completed end of February, and the final version will be completed by the end of March 2025.
• Values into behaviours work -workshop sessions were held throughout August. Further workshops, open sessions and tools to take forward conversations are available on Jarvis. Phase 2 engagement to be completed by the end of September 2024 – achieved in Oct 2024 and the Values delivery group has been established. The draft behaviors framework was received at the Board in Jan 2025 and a delivery group is in place to support implementation during 2025-26. This will be tracked through the</td></tr>
</table>

	transformation programme board as a Trust programme priority, and progress will be reported to PC • Flu vaccination 60% target for uptake – by end of December 2024. Flu vaccination uptake from the organisation has been lower during this financial year and the campaign is being considered for extension into 2025. Flu vaccination update is 37.59 (38%) as of February 2025. The campaign has been extended until end of March 2025. Campaign management will be led by nursing from April 2025. • **Milestones completed** • Completion of review of Occupational Health Contract – Annual contract meeting against SLAs held with STH in May 2024. **Achieved** • Team sessions will be put in place to support managers with occupational health referrals from June 2024. This is completed and the support/ training sessions are available for people to access on Jarvis**. Achieved** • Staff side Recognition agreement – refreshed agreement to be in place and launched in May 2024 after JCF. Going to JCF in September 2024, and ongoing partnership workshops to be planned for the Autumn – Oct 2024. Achieved - Went to JCF in Sept and Nov 2024, and final agreement has been confirmed. **Completed** • Provide assurance on staff experience. -staff survey results (wellbeing) and regular feedback through wellbeing champion group. – wellbeing champion network is established to provide hub and spoke model for sharing feedback, engagement and signposting. Staff survey results report have been issued under embargo to take actions/ plan around wellbeing results. **Completed** • Completion of the wellbeing engagement events and development of the network which is a 2024/25 priority. Roadshows are underway with a programme across the financial year. Various events have been held and they will continue throughout the year and advertised through the organisation comms – remains ongoing and Involvement plans will be developed for the new financial year. **Closed** – revised milestone relating to wellbeing hub development has been added. • Improved reporting systems for Violence & Aggression. This remains ongoing – an update has been provided at EMT and baseline data is available in the IPQR, the associated corporate risk 5385 updated with an action plan – closed. This milestone has been revised with an update on the violence and aggression reduction plan. • Establishment of cross Trust Sickness absence review group - by the end of September 2024. This action has been closed. Approach will be refreshed for the new financial year.

Controls

- Governance – ICS HRD Deputy Network, ICS staff Health and Wellbeing Group, National Wellbeing Guardian Network, People Strategy Delivery Plan in place and refreshed in April 2024 and reviewed through tier II groups into People Committee, Regular reporting to committees and to WODAG group, reporting to the ICS (including on HWB)
- NHSEI National Wellbeing lead and ICS Wellbeing Group
- HWB Framework in place
- NHS People Plan and actions for HR and OD
- South Yorkshire People leaders meeting (multi agency) which provides a system view around a range of areas to support people related issues in work.
- The ICS have established a wellbeing roadmap and there are three ICS groups around people, partnerships, prevention and proof [the Trust has nominated a lead to work alongside colleagues to influence the development of this]
- Board level Wellbeing Guardian in place
- Supporting staff with complex long-term conditions. - special interest group (ICS)
- Professional nurse advocates in place (nurses) now extended a restorative supervision offer to all staff
- Vaccination planning

<table>
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Now Wellbeing and OD Assurance group (WODAG) overseeing wellbeing support
OH Contract in place and regular OH contract review meetings in place – quarterly.
Violence and Aggression Group
Sexual Safety Charter
Staff side Recognition refreshed agreement in place.
Wellbeing champion network is established to provide hub and spoke model for sharing feedback, engagement and signposting
National violence and aggression reduction standards

</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.
Health and wellbeing network in place.
Wellbeing and Engagement lead in place.
Wellbeing champions recruited and embedded
Return to work meetings monitored through eRoster.
Wellbeing conversation guidance now embedded in revised Supervision Policy.
Reports to People Committee include progress on milestones.
Diagnostic undertaken against national wellbeing framework (informed People strategy review and delivery plan) – updates received at People Committee
Sexual safety charter- the associated implementation plan is in place
Occupational health contract with quarterly reviews contract monitoring data/information in place.
</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.
Sexual safety charter –development and oversight provided in partnership with NHS sexual safety and domestic abuse team
</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 Deputy Director of People Action closed with the appointment of the wellbeing and engagement lead, and the implementation of the champions
Wellbeing champions and the networks being established (this will now be undertaken by the HWB lead) – progressing expecting increase in expression of interest following roadshows. Roadshows completed and plan to develop network included in 24/25 priority 40 plus champions now in place. Owner Executive Director of People Action closed. Wellbeing champions recruited and embedded.
</td></tr>
</table>

2. Review of new Occupational Health Contract – **GAP closed.**	• OH new contract in place QEIA completed for review. Evaluation of OH contract overdue. Timeframe for contract monitoring data/information to support the review has not been made available by STH to inform the review, delays being addressed robustly with STH – 24/25 improvement plan for OH service Q2 Achieved and regular reviews (quarterly) are in place. **Deputy Director of People** – **Action closed**
3. Wellbeing Self-assessment has limited clinical operations input	• Annual Wellbeing assessment– September 2024 Wellbeing champions network is established and the cross trust development of a wellbeing plan – 24 Sept. **Deputy Director of People There** is ongoing work with coproduction and stakeholder groups to develop the wellbeing plan - March 2025 This has been completed March 2025. HWB network to be established - Priority for 24/25 (as above) – September 2024 Update as above. **Deputy Director of People. T**he Health and Wellbeing network has been set up and this **action is closed.**
4. Development of the wellbeing hub aligned to the priorities of the NHS wellbeing framework assessment	• The wellbeing plan development group has met and will be reporting into PC through WODAG report in March 2025. Reporting will highlight how the plan will continue to provide oversight of the development of the wellbeing hub.
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	**STRATEGIC PRIORITIES**	**Executive lead:** Executive Director of People **Board oversight:** People Committee **Last reviewed** – February 2025. **Next review** April 2025 **Risk type:** Workforce **Risk appetite:** High (open) **Risk rating impact v likelihood** - Current 4 x 3 = 12 no change - Target 4 x 2 = 8 - Movement ⟺ Corresponding risks on the Corporate Risk Register: 5321, 5409 -
- Create a Great Place to Work - Effective Use of Resources	- Live our values, improving experience and wellbeing - Improving staff engagement and involvement - Deliver our financial plan and efficiency programme	

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

Summary update

- Professions plans have been completed and progress reported into the workforce recruitment and transformation group and People Committee.
- 54% of 3-year service led workforce plans have been updated as part of the business planning process, and support offered to enable full completion.
- Hosting of new in-house workforce dashboard creating savings and additional reporting capability to support workforce planning

Milestones in 2024/25 to support reaching target score:

- Service-led 3-year workforce plan in place for all areas –to be delivered through the business planning process and will need to be reviewed as part of the VIP programme of work.. Professions plans now in place, and updates on progress provided through the Workforce Recruitment and Transformation group and reported via the people strategy and plan updates into People Committee. Service led 3 year plans = total of 54% have been updated (70) The outstanding 60 plans are across Acute and Community (22), Rehab & Specialist (18), Professions plans (7), Digital (8), Clinical management team (4) and Transformation projects (1).
- Review of local reward and benefits offer – March 2024. Included in the 24/25 priority with a target date for Q1. Update expected and of June 2024 – a review has taken place to determine what can be done aligned with ICS colleagues for contractual benefits. Non-contractual benefits will fall as part of the wellbeing plan – draft plan by October 2024.On hold pending priority setting.
- Next Review of flexible working policy is due by ~~October 2024~~.April 2027
- Data Warehouse development sits with IMST –December 2024. In House Dashboard complete. Full Launch planned for May 2025

Controls

- Governance
- 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
- 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.
- Manager self-service (ESR) in place

Internal assurance

Governance reporting:

- Bi-monthly reporting to People Committee and Board; Project Boards report to workforce assurance group *[from BAF risk 0019]* Workforce assurance group apprenticeship levy reported through the Workforce Assurance Group *[from BAF risk 0019]* Recruitment and Retention Group reports to People and Recruitment and retention group (and reports received at People Committee). A set of subgroups has been established reporting to the newly formed Workforce Recruitment and Transformation group. A medical recruitment and engagement group (a subgroup of the assurance group) has been in place since December 2022
- HR team have engaged with services to support completion of Training Needs Analysis templates to identify their needs *[from BAF risk 0019]*
- Retention review at People Committee bi-monthly.
- People Delivery plan in place for 2024-25.
- Improved data and systems to support accurate vacancy in place following work by People and Finance directorates. ESR has been updated with funded establishments. This gives workforce the ability to accurately report on vacancies (funded establishment – Staff in post) and means vacancy data can be updated on a daily basis.

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).
- NHSE Performance workforce returns + direct support
- NHSE 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.

• 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.** Training needs analysis scheduled for EMT end April • Consideration is being given as to how best to do a full organisation high level learning needs analysis. Timing of this is to be confirmed as to whether it is deliverable in the current financial year. Update as above **Owner Head of Workforce Development and Training –** target date end of March Priority setting for Q4 in Jan to confirm at this point The only external funding that remains available is the Nursing and AHP CPD funding – expected again for 2026. A new non-medical training group chaired by the Executive director of nursing and professions begin in March 2025 and will take responsibility for creating a high-level training plan. A separate list of all staff high level learning needs is required by 30/4/25 •
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	**STRATEGIC PRIORITIES**	**Executive lead:** Executive Director of People **Board oversight:** People Committee **Last reviewed** –February 2025. **Next review** — April 2025 . **Risk type:** Clinical Quality and Safety **Risk appetite:** Low to Moderate (minimal and cautious) **Risk rating impact v likelihood** - Current 4 x 3 = 12 no change - Target 3 x 2 = 6 - Movement ⟺ Corresponding risks on the Corporate Risk Register: 5385
CREATE A GREAT PLACE TO WORK	- Live our values, improving experience and wellbeing - Improving staff engagement and involvement	

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

Summary update

- SHSC manager launched in December 2024
- Staff Survey 2024 organisational response rate (engagement measure) increased by 12% (which is a 20% year on year increase from 2023).
- Staff survey data analysis and team level reports shared with senior leaders to commence early action planning pending lifting of the embargo.
- Values into behaviours report and recommendations presented to Board, and Values delivery group in place to drive action, launch event April 2025.
- Potential to reduce the risk scores towards the end of the year pending good results after 6-month evaluation following the launch of the new values/framework in April 2025

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. SHSC Manager launched December 2024. Monthly range of modules on offer. SHSC Community of Practice established and operating.
- Developing As Leaders (DAL) Alumni event planned for the Autumn 2024 – date tbc Completed. Held on 09.10.24
- Staff survey launch 2024 – September 2024. Results received December 2024
- First cut data analysis completed with reports to EMT and session with Collective Leadership Group 04.02.24 all under embargo.
- Team level summary report out to all senior leaders and team leave February /March 2025.
- National embargo will be lifted 13.03.25
- Board approval of Values report and recommendations 29.01.25. Co-chairs of Values Delivery Group confirmed and leads on working group established with OD and PMO to drive action. Workstream renamed 'We are our values' and will report to Transformation Portfolio Board. Launch event of refreshed values and behaviours framework planned for April 2025.

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 • Values work to be report to Transformation Portfolio Board from March 2025 – title of 'We are our values' • Established Co-chairs for the Values Delivery Group and working with OD and PMO to progress the 'We are our values' workstream.	
Internal 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.	**External assurance** • 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. • New NHS leadership and management framework under development
Gaps in control **Gaps in controls addressed in 2023/24 have been removed.**	**Actions to address gaps in controls** N/A

1. Mechanism needs to be in place to gather and consolidate (triangulate) all staff data and themes.	• Have been developing mechanisms such as heatmap to give indicator of the health of an area received at EMT and further development taking place as part of the People Committee Dashboard. Owner Sarah Bawden – To be received at People Committee November 2024.Heatmap now part of dashboard as of Jan 2025 • Staff Survey2024 results provided in heatmap format for SHSC level and team level and used to triangulate the people metrics heatmaps.
Gaps in assurance **Gaps in assurance addressed in 2023/24 have been removed)**	**Actions to address gaps in assurance** N/A
1. Low engagement scores – confirming with operational lead this is from staff survey and pulse survey data	• **Owner Head of OD and Deputy Director of People** Staff Survey 2024 organisational response rate (engagement measure) increased by 12% (which is a 20% year on year increase from 2023). Continued increase in participation from ethnically diverse staff within this. Results released to leaders across the organisations in line with national embargo to support preparatory action including analysis of results and being local team action plans prior to full national release on 13.03.25.

BOARD ASSURANCE FRAMEWORK 2024/25
For receipt in March 2025

BAF RISKS OVERSEEN BY FINANCE AND PERFORMANCE COMMITTEE

RISK REF BAF: 21A There is a risk of failure to ensure digital systems are in place to meet current and future business needs, caused by failure to develop and deliver an up-to-date modern digital strategy and systems and processes to support its delivery, resulting in poorer clinical safety, quality, efficiency and effectiveness.

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	**Executive lead:** Executive Director of Finance **Board oversight: Finance and Performance Committee & Audit and Risk Committee** **Last reviewed** – February 2025. **Next review** – April 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 no change - Target 3 x 2 = 6 - Movement ⟺ Corresponding corporate risks: 5401, 5399
- Effective use of resources - Deliver outstanding care	- Implement RIO safely	

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

Summary update

- The risk score has been reviewed and there will be no change until Insight has been retired.
- Following the implementation of RIO, development of a revised digital plan and roadmap for delivery will take place.
- The corresponding corporate risk currently remain unchanged.

Milestones in 2024/25 to support reaching target score:

- Retire Insight – currently EPR is expected to complete in Q4 of 2024/25 no change, this remains on track for delivery.
- As noted previously, sources of assurance and actions are unlikely to change until the full retirement of Insight.
- Address data reporting gaps for services in the Tranche 1 stage of EPR implementation - for services that have moved to RIO in Tranche 1 there are some data reporting gaps these are being followed through as part of the stabilization works. A full list of minimum reporting requests signed off by Rio Programme Board in Jan 2025. These to be delivered by March for RIO.
- Development of revised Digital Strategy and roadmap for delivery of the digital strategy in 2025/26 this will be completed following the implementation of RIO during 2025/26

<table>
<tr><td colspan="2"><u>Controls</u>
• Governance (EPR programme board structure, EMT oversight, reports to assurance committee FPC and Board, Board oversight, 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 these impacts on the delivery of the strategy and need to develop and continue to refine the digital roadmap and strategy for delivery now in 2025/26.
• New Target Operating Model for Digital under development
• SHSC Digital continue to retire old systems and improve cyber security in line with the guidance provided by the data protection and security toolkit. Making good progress to meeting the standard. Ongoing until legacy system is retired.</td></tr>
<tr><td><u>Internal assurance</u>
• Governance reporting in place - reporting into Programme Board with oversight by Trust Transformation Board and EMT. Governance arrangements updated and received through the revised EPR implementation plan approved at Board in April 2024.
• Additional support is in place should Insight do down.
• External independent expertise has been in place to support development of the new plan (from January 2024)
• DSPT audit. Internal audit has provided support and assurance around penetration testing.</td><td><u>External assurance</u>
• Annual Data Security Protection Toolkit (DSPT) audit moderate assurance rating received in 2023 and in 2024.
• DSPT submission as part of national reporting
• External review –report received on EPR at Board in February 2024 with recommendations on actions required.</td></tr>
<tr><td><u>Gaps in controls</u> (Gaps in controls addressed in 2023/24 have been removed)</td><td><u>Actions to address gaps in controls</u></td></tr>
<tr><td>1. Put in place assessment and plan for full resourcing and affordability (for IMST).</td><td>• Target Operating Model (TOM) to be in place by July 2024 –with the new CDIO as part of development of the revised plan – The draft TOM is in progress. This has been to Operational Management Group (OMG) and financial implications have yet to be finalised. A revised timeline will be brought to EMT in September 2024. Owner CDIO/Exec Director of Finance. Revised TOM and financial implications are incorporated into draft financial plan and will be agreed as part of planning process. Deadline 31st March 2025 JCF committee in mid-March. Money confirmed within business planning cycle. Likely that corporate VIP will be greater, and more capitalisation of staff will take place.</td></tr>
<tr><td>2. Address elements of DSPT still to be achieved, the relevant risks are being tracked.</td><td>• Data Security Standards - issue regarding password criteria on Insight will be resolved when Insight is decommissioned following RIO implementation, currently planned for end of ~~January 2025~~. Insight will be decommissioned following EPR implementation – timescale will be confirmed in the new financial year as part of the cutover planning. Owner CDIO/Exec Director of Finance January 2025.</td></tr>
<tr><td>3. The need to develop a new Digital Roadmap and Target Operating Model.</td><td>• Digital Roadmap– Owner CDIO/Exec Director of Finance timing to be confirmed for delivery this will be after the strategy refresh later in the financial year and will be by the end of March 2025 This is linked to timescales of the new strategy and will be confirmed in the new financial year.</td></tr>
<tr><td><u>Gaps in assurance</u> (Gaps in assurance addressed in 2023/24 have been removed)</td><td><u>Actions to address gaps in assurance</u></td></tr>
<tr><td>Insight still being used – delays with EPR</td><td>• Retirement of Insight delayed to Q4 2024/25 Owner CDIO/Director of Finance. Insight will be retired in Q1 2025/26.
• Revised plan for Implementation of RIO (EPR) received and approved at Board April 2024. Monthly updates</td></tr>
</table>

	have been received at Board and planning is on track for go live in March 2025.

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** – February 2025. **Next review** – April 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: 5401
- Effective use of resources	- Deliver our financial plan and efficiency programme - Deliver our quality and safety objectives	

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

Summary update

- New Information Governance, Cyber Security & Artificial Intelligence Group has met twice and deal with use of aliases in clinical
- systems for staff who are patients
- Use of passwords for device encryption.
- Four policies have been reviewed and approved
- No change of scoring is recommended until the new annual DSPT work has been discussed at the Information Governance, Cyber Security & Artificial Intelligence Group

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** New annual DSPT work is being prepared for June 2025

Controls

- Governance controls in place via bi-monthly Information Governance, Cyber Security & Artificial Intelligence Group meetings and reporting via EMT and into the Audit and Risk Committee.
- 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.
- New DSPT aligned to the annual audit programme received.

Internal Assurance

Governance reporting:

- Reports on patching reports are received at-DAG and will be

External assurance

- Confirmation provided to NHSD in accordance with prescribed national process.

reflected in the Service Management report received at DAG which reports onward to ARC and EMT (which is additional reporting in 2024/25). • Service management reports include supplier engagement relating to system patching for key suppliers for locally hosted systems. • Monthly performance reporting across all Teams for mandatory IG training. • Oversight via reporting to DAG which has been in place since April 2023. • DSPT compliance aligned with DPST work confirmed June 2024. The new DSPT is aligned to the annual audit programme and monitoring of internal audit actions takes place through the tracker received at ARC. • Internal governance amended to re-instate IG, cyber and AI group reporting into ARC. ARC received cyber security posture review in October. • Monitoring of the Internal Audit action tracker takes place with regular reporting received at ARC	• DSPT compliance – key indicator - Annual Data Security Protection Toolkit (DSPT) audit moderate assurance rating received.
Gaps in controls **Gaps in controls addressed in 2023/24 have been removed.** - None currently	**Actions to address gaps in controls** N/A
Gaps in assurance (Gaps in assurance addressed in 2023/24 have been removed) System Asset register functionality within Sunrise not yet enabled.	**Actions to address gaps in assurance** • Asset register to be specified and developed in 2024/25 starting with hardware assets. **Owner Head of Service Delivery and Infrastructure Digital.** The timeline for completion of the audit is October 2024, and work on the register will be completed by 31 December 2024. Completed • Asset integration between hardware discovery system (LANSweeper) and IT Service Management system (Sunrise) is complete. Population of assets and processes to be completed. Conducting physical hardware audits across all SHSC sites to support population of hardware assets into system including • replacement of legacy hardware to support going live with Rio. Timeline for completion April 2025. Owner Head of Service Delivery and Infrastructure Digital. Improvements continue to support asset management. Purchasing page has been developed on the new self-service page to support the transition to a centralised funding approach to support the management of assets. Creation of SOPs continue to support Digital staff and managers to manage assets effectively.

RISK REF BAF 0022 There is a risk we fail to deliver the break-even position in the medium term caused by factors including failure to develop and deliver robust financial plans based on delivery of operational, transformation and efficiency plans resulting in a reduction in our financial sustainability and delivery of our statutory duties.

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

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

Summary update

- Financial context is very challenging over the medium-term plan
- VIP plans are underdeveloped, and the risk score therefore remains unchanged.

Milestones in 2024/25 to support reaching target score:

- Engage at Mental Health Provider collaborative to consider further plans to contribute to a system gap of £48 million**.** Discussions are ongoing about the system position including with NHS England on where the expected year end position and additional actions being taken across the system to reduce the deficit as much as possible
- Engaging in I&I process, controls have been strengthened to mitigate financial position, contributing to non-recurrent delivery of VIP. Will continue to review monthly and as required by the system. Ongoing and subject to I&I process for a further 12 months
- Development of additional mitigations to be reviewed by EMT in January 2025. Mitigations have been reviewed in January and February at EMT.

Milestones completed

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

Controls

- Operational plan; financial planning; including CIP planning, processes and delivery monitoring
- Financial plan and value improvement plans for 2024/25 in place.
- CIP programme Board established with more sophisticated CIP planning processes.
- Strengthened governance arrangements have been in place since September 2023, with EMT additional weekly oversight meeting in place since end of November 2023.
- Consideration is being given to an additional programme board for VIP to oversee VIP planning and delivery for 25/26 to be established in late January / February 2025.
- Programme board for VIP to oversee VIP planning and delivery for 25/26 has been established in late January / February 2025.

Internal assurance	**External 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 several 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.	• NHSE Financial Review *2021/22* and ongoing support as required. • Internal audit on CIP received June 2023 - split opinion overall (significant on processes and limited on improvements already in place) it was recognised the gap had already been closed in 2023/24 CIP planning and no further action was needed.
Gaps in controls Gaps in controls addressed in 2023/24 have been removed. 1. Identification of a full recurrent VIP plan over the medium term	**Actions to address gaps in controls** • Value Improvement Plan received for 2023/24 – received April 2024 FPC and Board. VIP plans continue to be developed and part of financial planning for future years – **owner Executive Director of Finance.** VIP plans continue to be reviewed at OMG, EMT and the newly established VIP programme Board. • 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** VIP plans continue to be developed. These are behind plan regarding 2025/26 plans and future years.
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 evidence led approach to change and improvement caused by a failure to implement our integrated change framework effectively resulting in failure to deliver our strategy, improve outcomes, address inequalities and deliver value, growth and sustainability.

Elements which would underpin this are:

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

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

				Risk type: Strategic **Risk appetite:** High (open) **Risk rating impact v likelihood** - Current ~~4 x 4 = 16~~ 3 x 4 = 12 - Target 4 x 2 = 8 - Movement ⇩ Corresponding corporate risks: 5051, 5001, 4100, 4756,4757	
On track	**Some slippages**	**At risk**	**Completed**	**Assurance level**	**Amber**

Summary update

- Major programmes are progressing to BAU and benefits realisation. Where programmes become stuck, remedial action is taken.
- Key deliverables – EPR and TEP showing good progress towards delivery
- Integrated Change Framework now live and being used. Improvement and iteration of the approach evident (as per the plan)
- Further work to do in 25/26 to focus on all levels of change beyond the most complex programmes, and to build capability for improvement
- A reduction in the risk score is proposed from 16 to 12, **for approval.**

Milestones in 2024/25 and 2025/26 to support reaching target score:

- Further revision of portfolio of complex change in line with 25/26 operational plan and strategy refresh – March 25
- Development of appropriate central oversight arrangements for all three levels of the change framework (beyond the most complex major programmes) – Quarter 1 25/26
- Implementation of EPR by March 25 and optimisation and benefits realisation throughout 25/26
- Open Maple Ward by Q3 25 26 – key deliverable of TEP

Milestones completed:

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

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 SROs for all 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.
- Programme Board TORs all reviewed against new standard and revised where necessary.
- All programme stakeholder maps have been updated.
- Monthly meetings in place with programme managers to review highlight reports, risks and issues.
- Regular deep dive reports on each transformation programme at EMT
- Integrated change framework includes 'phased approach with gateways' – to start ~~January 2025~~ April 2025

Internal assurance	**External assurance**

• Individual programme highlights reports received at Transformation Portfolio Board. Portfolio report received monthly at Transformation portfolio board, EMT and Finance and Performance Committee. These highlighted risks and issues.
• Schedule of deep dive reports on specific programmes at EMT
• Standardised approach in place for all Programme Boards and have been available on SharePoint since January 2021; review schedule in place – the approach is currently under review.
• Board, meeting minutes, report to Finance and Performance committee.
• Business case approved to recruit to team to fulfil action. All posts within PMO filled. PMO Analyst in place to focus on check and challenge activities.
• External resources were secured to support the completion of the Strategic Outline Case for the Therapeutic Environments programme.
• Suite of templates available. All new projects and programmes use the new templates including TORs.
• People Plan reports into people Committee and has a project group for e-roster project group reports into People Committee and Transformation Board. The progress on the people plans (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.
	• 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. External assurance role adapted but ongoing in December 2024
	• Primary and Community Mental Health Transformation Programme – has representation from Primary Care and external organisations and the Learning disability programme and CMHT project boards have representation from external organisations.
	• 360 Assurance have reviewed all TOR's.
	• External specialist resource is brought in where required e.g. EPR

Gaps in controls **Gaps in controls addressed in 2023/24 have been removed.** • Gateway reviews	**Actions to address gaps in controls** • Process and timetable for gateway reviews to be developed for all programmes and will be confirmed by October 2024. Owner Director of Strategy. Included in Integrated change guide in December 24 – update Feb 25 – proposed approach to Gateways being engaged upon with colleagues by April 2025

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

RISK REF – BAF 0027 There is a risk of failure to ensure effective stakeholder management and communication with our partners and the wider population and to effectively engage in the complex partnership landscape, leading to missed opportunities to add value for our service users and to meet population needs that require a partnership approach, resulting in potential to miss opportunities to safeguard the sustainability of the organisation and fail to deliver our strategic priorities and operational plan.

STRATEGIC AIMS	STRATEGIC PRIORITIES	
- 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	**Executive lead:** Director of Strategy **Board oversight:** Finance and Performance Committee **Last reviewed** – February 2025. **Next review** – April 2025 **Risk type:** Business/Strategic **Risk appetite:** High (open) **Risk rating impact v likelihood** • Current 4 x 3 = 12 • Target 4 x 2 = 8 • Movement ⟺ Corresponding corporate risks: None specifically though see risks linked to transformation programmes

On track	Some slippages	At risk	Completed	Assurance level	Amber

Summary update

- No change in assessment of risk rating – remains a critical area to focus attention.
- Progress on proactive visible participation by the Trust is good
- Success is increasingly linked to our ability to effectively deliver change (not just the top-level programmes), and to demonstrate effective operational delivery.
- Ability to provide data and analysis remains a critical success factor which should be improved through the EPR implementation and related initiatives.
- Emerging need to enhance coordination and support for a wider range of Trust representatives participating in external partnerships 'CRM' to support a distributed leadership model.

Milestones in 2024/25 to support reaching target score:

- Community forensic team tender – successfully moved into collaborative commissioning approach -service governance to be proposed by partners by October 2024. Negotiations ongoing December 2024. Commissioning process stopped due to funding February 25
- Develop action plan for delivery of GGI findings by October 2024 with implementation thereafter. Project team assembled due to start January 2025 – continuing February 25 slowed due to annual planning
- Establishment of Trust 'partnerships group' and some form of CRM (Customer Relations Manager) system by March 2025. Initial discussion due September 2024 - December 2024 - **this rolled into the stakeholder management project above**

Milestones completed

- Mother and baby and associated perinatal service development – by the end of 2023/24 March 2024 ongoing development through SY MHLDA provider collaboration. Contract management arrangements

	between NHSE and LYPFT for mother and baby unit have been confirmed (June '24). These include an advisory group that includes SHSC, through which the Trusts that are served by the Unit ensure the provision is meeting the needs of their populations and connecting effectively with local services - **completed.** • Desire Code Communications Strategy work will feed into the strategy refresh work in October 2024 (on track) Quick wins identified for delivery in advance of August 2024 – **completed.** • Agreeing South Yorkshire integrated approach to access for Health Based Place of Safety – approach has been approved by Provider Collaborative Board in May Funding confirmed December 2024 **completed** • Establish eating disorder joint committee (in shadow form) for South Yorkshire. Initial meeting in September 2024. February 25 progress being made towards go-live in April 2025 **completed** **Note** – as previously reported additional BAF risks will need to be added to reflect system BAF risks when developed and we will in turn have to escalated Risk to those BAFs where appropriate.
Controls • We were fully engaged at Sheffield health care partnership, ICB and SY MHLDA Collaborative to participate in the planning of priorities for 2023/24 and worked together with colleagues in Sheffield, SY MHLDA collaborative and ICB through board workshop and with our senior leaders to support us in ensuring the priorities are reflected in SHSCs annual operating plan – approved by the Board in May 2023 • Sheffield Health and Care Partnership regularly attended by CEO and other Executives linking into appropriate delivery groups. • All core Trust strategies are in place with annual reviews process. • Regular meetings with Sheffield LA, Sheffield Health and Care Partnership, ICS and Provider Alliance (moved from assurance) • All reports to Committees and Board are prompted to consider the partnership implications arising from the report (moved from assurance) • Advisory Group in place for mother and baby and associated perinatal service development to ensure provision mees the needs of the population and connects effectively with local services.	

Internal assurance	**External 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	• Link into Outcomes Group in PLACE • New partnership arrangements are bedding in for PLACE, System and Collaboratives. • NHSE Well Led feedback on self-assessment December 2022 • System quality oversight meetings post inspection • Significant assurance received from Internal Audit on the transformation programme 2022/23 • Externally supported (GGI) stakeholder review outcome received at Board in April 2024.

approach in 2024/25 • 5-year plan and strategic direction received at FPC (Nov 2022), and Board workshop (Dec 2022) approved by Board Jan 2023. Revised priorities agreed in 2023, and Refreshed Strategy discussion planned at Board October 2024. • Quick wins developed and in place in support of the Desire Code work in advance of finalisation of the Communications Strategy (due to complete in October 2024)	
Gaps in controls (Gaps in assurance addressed in 2023/24 have been removed)	**Actions to address gaps in controls**
2. Up to date and agreed Trust Strategy for 2025 onwards	• Project underway to revise Trust Strategy by April 2025. **Owner Director of Strategy**
Gaps in assurance 1. Revised CQC approach and revised performance management roles for NHSE (less ICB) require monitoring to understand implications for SHSC. Once clearer this needs to be reflected in our assurance	**Actions to address gaps in assurance** • Monitor and evaluate the implications of changing approach of CQC **Owner Director of Nursing.**
2. Trust approach is not to have many strategies, but there will be a small number of key board level enabling strategies linked to the main trust strategy. This framework needs to be clear and agreed by Trust Board	• Develop framework of enabling strategies and plans, and agree with Board in January 2025 – Director of Strategy - update February 25 enabling strategy leads workshop completed and alignment underway as part of strategy refresh – April 2025

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** – February 2025 **Next review** – April 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 slippages	At risk	Completed	**Assurance level**	**Amber**

Summary update

- Delivery of green plan actions remains challenging and score therefore remains unchanged. However, it is anticipated greater controls and assurance will be gained as Green Plan has been refreshed and simplified to provide a focused, time bound and measurable action plan for green plan delivery. This is being coordinated by the sustainability lead with input from sustainable development group members.
- This is backed up with external assurance of new statutory green plan refresh guidance issued by the Greener NHS Feb 25 and a refresh of the SY ICS Green Plan which is anticipated to include more robust governance and reporting mechanisms to support Trust green plan delivery. (Further update anticipated by the July 25.)

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 revised green plan agreed at the Board in January 2025
- Monitoring delivery of the action plan – quarterly at FPC. Additional periodic reporting is planned through EMT.

Controls

- Governance - Sustainable Development Group, delegated Board oversite via the FPC linked to partnership and collaboration in place through Place and system. There is currently a review of governance and reporting on net zero and sustainable development ay SY ICS in conjunction with the ICS Green Plan Refresh. This may lead to more defined governance and reporting processes. (More information to follow)
- 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. Green plan is reviewed annually. All NHS Trusts must refresh, get Board approval and publish their Green Plans, refreshed in line with new Green Plan Refresh Guidance (published4th Feb 25) by the 31st July 2025. Our Green plan has been refreshed and final word content has been approved by Board January 25. We are aiming to have the final publishable version of the Green Plan available by the end of April 25.
- ~~Strategic intent (Green Plan Implemented under SHSC Strategic priority Continuous Quality Improvement, 2023.2026.~~ The Green Plan underpins our approach to delivering our strategic priorities.
- 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). Green Plan Service Objectives 25/26- each Service/Team must pick 1 minimum of 3 Green Plan pick list objectives.
- Sustainable Development included in SHSC QEIA (Limited feedback on effectiveness) In addition Sustainability Lead is a member of the QEIA Panel.
- Carbon footprint performance and projection reporting using Defra emission factors 25/26 Aiming for Quarterly carbon footprint reporting to support development of an SHSC Sustainability dashboard of metrics/targets and KPIs.
- 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. . Estates and Facilities Sustainability Steering Group has been established and first meeting held December 2024.
- Sustainability is embedded within the SHSC Improvement and Change Framework for consideration within change projects and as a signpost for support ensuring change projects align to Green Plan.
- Sustainability has been embedded into our Quality Improvement Approach. (included in Full Day QI training and a question on how projects align to the principles of sustainable healthcare included in QI project form so we can log how many projects impact our sustainability goals)
- Supply Chain and Procurement- Sustainability considerations are included in Purchasing Officer Non-Pay script, minimum 10% weighting on Net Zero and Social Value in every tender and work is progressing to embed sustainability and our net zero goals in the SHSC Invitation to Tender template documents

Internal assurance

Governance reporting:

- Annual Reports on Strategy delivery to the Board
- Quality Strategy Sustainable Development Priorities progress reported into QAC.
- Executive Lead identified for Net zero (Green Plan) in place (Director of Finance, Performance and IMST)
- Awareness and education training on sustainable development and climate change reflected in Leadership

External assurance

- Greener NHS – Quarterly data submission
- Greener NHS Fleet Data submission
- Greener NHS Green Plan Support Tool, Self-Assessment Questionnaire

and Management course • ~~Establishment of a Sustainable Models of Care" sub group to the Sustainable Development Group~~ This has been stood down until a core membership can be established. • Greener NHS Dashboard data has been reflected in the Annual Report for 2023/24 • Greener NHS Green Plan Support Tool Assessment Questions included in the refreshed Green Plan Action Plan. **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	**Actions to address gaps in controls**
• 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~~ 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** • CCRA to be complete by the 31st March 2025 and a delivery group set up for climate risk and adaptation
• 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. This has not been progressed – discussions are taking place with the deputy director of strategy and planning to confirm the timing for this which will be in the new financial year.
• 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** This action has been delayed due to work refreshing green plan. Now Green plan refresh is complete and in conjunction to review of refreshed Green Plan against new Greener NHS Green Plan Refresh Statutory Guidance (published 4th Feb 25) work can continue to review priorities, capacity to deliver and additional resource required - April 2025
• 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 must 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.** Development of sustainability dashboard has been delayed as sustainability lead did not have capacity to progress alongside green plan refresh work. However, within green plan refresh as clear list of metrics/targets/KPIs have been developed which will be integrated into a sustainability dashboard. Aim is for dashboard to be made available by June/July 2025 and to be updated quarterly initially as a minimum, alongside quarterly carbon foot print updates.
• 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** A limited amount of engagement has taken place in the form of engagement with the Peer support network leads and Engagement and Experience team. Next steps, in conjunction of development of updated Green Plan Action Plan development is for each staff network group, including those with lived experience to review the green plan action plan and the equality impact considerations to offer feedback and input into our approach for action plan delivery. Sustainability Lead is working with Dasal Abayaratne to development opportunities to engage with our service users on this subject in the form of a climate cafes/ focus groups

BAF 32 There is a risk that our estate does not enable the delivery of our strategic priorities and meet the quality and safety needs of our service users and appropriate working environment for our staff caused by failure to effectively reflect requirements resulting in suboptimal effectiveness, efficiency, experience and quality of care.

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	**Executive lead:** Director of Strategy **Board oversight:** Finance and Performance Committee **Last reviewed** – February 2025. **Next review** – April 2025 **Risk type:** Quality and Safety **Risk appetite:** Low to Moderate (minimal and cautious) **Risk rating impact v likelihood** - Current ~~4 x 3 = 12~~ 3 x 3 = 9 - Target 3 x 2 = 6 - Movement – ⇩ Corresponding corporate risks: 5344
- Deliver Outstanding Care - Effective use of resources - Ensuring services are Inclusive - Create a great place to work	- Deliver therapeutic environments - Improve access so people wait well and wait less - Deliver our financial plan and efficiency programme - Work in partnership to address health inequalities - Live our values improving experience and wellbeing	

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

Summary update

- Significant progress made with delivery of TEP specifically related to Maple Ward, and in securing additional capital to enable delivery of capital priorities for safety and effectiveness.
- Estates and facilities assurance mechanisms enhanced with the establishment of the Estates and Facilities Oversight Group
- PLACE audit results demonstrate year on year improvement
- Fire safety risks much more thoroughly understood, and programme of work to address approved by Board for implementation over next 2-3 years, with significant progress enabled by funding for 25/26.
- A reduction in the risk score is proposed from 12 to 9, for approval.

Milestones in 2024/25 to support reaching target score:

- Opportunities for colocation and estate efficiency with Sheffield HCP partners has been explored and is on track for September 2024. December 2024 – ongoing, visits to LIFT buildings still planned. – February 25 no further progress
- Scope and timeline for next phase of Therapeutic Environments Programme confirmed by November 2024 – slide deck prepared for EMT December 2024 **complete**
- Opportunities from improved space utilisation quantified by November 2024 – initial tranche of opportunities identified at Wardsend Rd, Distington House and Netherthorpe House**.** Initial tranche **complete**
- Estates strategy annual review was received at FPC in July and is due for receipt at Board in September 2024 - **complete**
- Strategic outline case for new hospital (including multi-site options) by December 2024 project continuing into Q4 – February 25 no further progress

Competed milestones:

- Estates and Facilities Oversight Group established January 25 - **complete**
- PLACE audit results demonstrate improvement year on year - Q4 **complete**
- Independent audit of fire doors and fire compartmentation delivered, programme of work to address agreed by Board December 24, and included in capital plan for 25/26 and beyond.

<table>
<tr><td colspan="2"><u>Controls</u>
• Governance - Working as part of Place Estates priority to optimise use of the NHS estate. Reporting through FPC, Business Planning Group, Capital Planning.
• Checks through estate work – such as water safety, fire safety, lifts, electrical and gas
• PLACE audit – provide benchmarking information and support identifying areas for action.
• ERIC returns – provide benchmarking information.
• PAM returns – provide benchmarking information
• Authorised Engineers all in place.
• Maintenance programme of work in place
• Capital plan
• Contracting arrangements in place for buildings leased and not owned.
• Estates and Facilities Oversight Group established January 25
• Independent audit of fire doors and fire compartmentation delivered</td></tr>
<tr><td><u>Internal assurance</u>
• Annual PLACE report and associated action plan
• 7 facet survey report
• Annual Health and Safety Report (and quarterly updates received at Assurance Committees)</td><td><u>External assurance</u>
• Authorised Engineers Annual Audit including of the competencies required of internal teams
• ERIC returns and benchmarking
• Annual Premises Assurance Model (PAM)
• Sircle independent review of fire doors and compartmentation at all in-patient locations</td></tr>
<tr><td><u>Gaps in controls</u>
• External review of our fire doors and our systems for monitoring.</td><td><u>Actions to address gaps in controls</u>
• Commission independent external review – received at EMT in June 2024 and reported thereafter at FPC and in AAA reporting Board in July 2024 – Owner Director of Strategy – complete</td></tr>
<tr><td><u>Gaps in assurance</u>
• See above re Fire Safety – need to see Sircle report to confirm any gaps in assurance</td><td><u>Actions to address gaps in assurance</u>
• Receive and evaluate Sircle report in January 2025 – owner Director of Strategy - complete</td></tr>
</table>