Public Board of directors
Item number: 24
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Confidential/public paper:	Public
Report Title:	**Board Assurance Framework (BAF) 2025-2026 and risk appetite review**
Author(s)	Amber Wild, Head of corporate assurance Dawn Pearson, Associate director of communications and corporate governance
Accountable Director:	Dawn Pearson, Associate director of communications and corporate governance James Drury, director of strategy
Presented by:	Dawn Pearson, Associate director of communications and corporate governance
Vision and values:	The Trust vision is to ensure we **work together for service users**. The BAF helps to assure us that any identified risks are managed, so we can continue to **improve the lives** of the people we serve, through safe and effective services and demonstrate our **commitment to quality**.
Purpose:	The board assurance framework (BAF) identifies risks in relation to each of the Trust's strategic objectives along with the controls in place and assurances available on their operation. The revised BAF risk descriptions and scores have been aligned to corporate risks to ensure an overview and are presented for final approval by the Board of directors in July 2025 following changes to BAF risk descriptions and scores approved by the committee responsible for oversight.
Executive summary:	The **development of the 2025-2026 BAF risk descriptions and score** are aligned to the refreshed Trust strategy, following discussions at the executive management team and Trust Board development sessions in June 2025. In addition to the risks being reviewed the risk appetite score was also discussed; the new risks and risk appetite table are detailed within the report. The updated risk BAF risk descriptions, numbering and scoring for 2025-2026 have been reviewed through the relevant committees in readiness for sign off by the Board of directors. The full draft BAF 2025-2026 is now attached for discussion and approval: Appendix 1 – Quality assurance committee BAF risks Appendix 2 – Finance and performance BAF risks Appendix 3 – People committee BAF risks Appendix 4 – Draft BAF

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*		
Reduce inequalities	*Yes*	**X**	*No*		

What is the contribution to the delivery of standards, legal obligations and/or wider system and partnership working.	
An efficient and effective board assurance framework (BAF) is a fundamental component of good governance, providing a tool for the Board to identify risks to the achievement of its strategic objectives and ensure that there is sufficient and reliable assurance regarding the effective management of strategic risk. 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.	
Board assurance framework (BAF) and corporate risk(s):	All BAF risks are noted within the report.
Any background papers/items previously considered:	The Board of directors' development session on 30 April started the process for executive leads to start to think about and consider BAF updates for 2025-2026 and further discussions took place at EMT and the Board during June 2025. The risk appetite for 2025-2026 was also agreed by the Board of directors in June 2025 and all Trust committees have now reviewed and commented on the revisions which are now presented in full. The BAF is continues to be reviewed quarterly by each executive director lead prior to EMT and relevant committee. All changes to the BAF are approved by Trust Board as part of the annual work programme.
Recommendation:	The Board of directors are asked to: • **Discuss and approve** all BAF risks and updates for 2025-2026.

Board of Directors
Board assurance framework (BAF) 2025-2026
30 July 2025

1. Purpose of the paper

The board assurance framework (BAF) identifies risks in relation to each of the Trust's strategic objectives along with the controls in place and assurances available on their operation. The revised BAF risk descriptions, scores and aligned corporate risks are presented for final approval by the Board of directors.

Set out below are the final and revised BAF risk descriptions, scores and aligned corporate risks. These risks have been developed following discussions at Executive Management team and Trust Board development sessions in June 2025 and finalised through relevant committees during July 2025.

In addition to the risks being reviewed the risk appetite score has also been discussed and the new risk appetite table is set out below:

Category	**Low** (minimal)	**Moderate** (cautious)	**High** (open)	**Extreme risk** (eager)
	1-3	4-6	8-12	15-25
Clinical Quality and Safety Board agreed to keep these combined and to develop sub statements with different targets				
Statutory/ Compliance No change				
Financial Sustainability No change				
Business No change				
Reputation Changed from high to moderate				
Workforce No change				

Environment No change				
Strategic No change				

2. BAF risks 2025-2026

The table set out below the new risk description for all BAF risks. There are now:

- **16 BAF risks for the period 2025-2026** aligned to 19 corporate risks (with 2 additional corporate risks awaiting approval)

Previous risk: **2024-2025 risk 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. **2025-2026 risk BAF 0030** **There is a risk that the failure to deliver the Trust Green Plan will have an impact on the local environment, workforce and population and lead to legal and regulatory action and reputational damage.** **Lead:** Executive director of finance, performance and digital	3 x 4 =12
Previous risk: **2024-2025 risk BAF 0032** 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. **2025-2026 risk BAF 0032** **There is a risk that our estates do not adequately enable the delivery of our strategic priorities, which includes community models of care and care closer to home.** **Lead:** Director of strategy To note: no corporate risk aligned currently.	4 x 3 = 12
Previous risk: **2024-2025 BAF 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.	4 x 3 = 12

2025-2026 risk BAF 0024 **Risk to both staff and service users, culture and reputation when failing to meet the fundamental standards of care, legal, regulatory and safety requirements.** **Lead:** Executive director of nursing, quality and profession **Corporate risks aligned:** • **Risk 5026** There is a risk that patients who come under the Deprivation of Liberty Safeguards (DOLS) framework are detained on SHSC staffed premises with no legal authority in place to authorise this. This is caused by significant delays and backlogs within the Local Authority (who are responsible for conducting such assessments and authorisations). This could result in patient's legal rights being breached by the Trust, and the Trust potentially being challenged legally by a patient or their representative **(risk score 3 x 4 =12).** • **Risk 5124** There is a risk that the Trust is not compliant with s132/132A Mental Health Act (the requirement to provide information to patients). This is caused by a lack of assurance that the legally required information is being provided to patients in a timely manner. This could result in the Trust breaching patients' rights and exposes the Trust to potential regulatory action. (**risk score 4 x 3 = 12).** • **Risk 5344** There is a risk that the integrity and safety of the fire doors have been compromised caused by inadequate maintenance through a sufficient Planned Preventative Maintenance (PPM) regime resulting in reduced effectiveness in minimising the spread of fire and smoke. **(risk score 5 x 3 = 15).** • **Risk 5429** Section 42 Enquiries are not currently being allocated and completed within statutory timeframes as stated in the Care Act 2014. SHSC is at risk of further breach of statutory timeframes caused by ongoing delays in allocation and staff capacity to complete in a timely manner. This results in a delay in sharing safeguarding information with Sheffield Adult Social Care and we are not working within the principles of Making Safeguarding Personal **(risk score 3 x 4 = 12)**	
Previous risk: **2024-2025 risk 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. **2025-2026 risk BAF 0025B** **There is a risk of failure to deliver essential programmes of work to environments in a time frame required, caused by limited availability of capital investment, resulting in an impact on safety and experience for both service users and staff.** **Lead:** Director of strategy To note: no corporate risk aligned currently.	4 x 2 =8

Previous risk: **2024-2025 risk 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 **2025-2026 risk BAF 0029** **There is a risk to quality, safety and patient care due to delayed access to timely crisis support and mental health services, which could result in poor experience of care and potential harm to service users.** **Lead:** Director of operations **Corporate risks aligned:** • **Risk 4100** There is a risk of deterioration in mental health and safety of patients and carers, caused by a lack of access to available mental health beds, resulting in patients being supported in the community by the older adult (OA) home treatment team impacting on the quality and safety of care, and staff wellbeing. (**risk score 4 x 4 =16**). • **Risk 4756** Demand for the ADHD pathway greatly outweighs the resource and capacity of the service. This is resulting in increasing wait times and high numbers of people not being screened and waiting for assessment and diagnosis. Sheffield has an extreme length of waits and there is a risk to the reputation of the Trust. However, national waiting times are referral numbers are universally high. There is no city-wide strategy or proposed clinical model to address the issue. (**risk score 4 x 4 =16**). • **Risk 4757** There is a risk to patient health and wellbeing due to the exponential increase in demand on services that is resulting in very long waiting times. Waiting list length and waiting time increases in excess of commissioned targets have been exacerbated by historic staff absence, recruitment issues, and national specification requirements that combine to create inefficient system flow. (**risk score 4 x 4 =16).** • **Risk 5001** There is a risk that patients are delayed in accessing an acute hospital bed in Sheffield caused by reduced patient flow through our acute, crisis and community services resulting in a risk to the quality and safety of patient care. **(risk score 4 x 4 =16).** • **Risk 5438** There is a risk of serious incidents occurring at Forest Lodge evidenced by a range of recent risk incidents impacting staff and service user safety. This has led to the service being referred into organisational safeguarding with the introduction of a programme of improvement and enhanced monitoring by commissioners which could lead to reputational damage (**risk score 4 x 3 = 12).** • **Risk 5410** There is a risk that the hospital discharge of restricted patients is delayed due to administration by the Ministry of Justice (**risk score 3 x 4 = 12).** • **TBC NEW Risk 5351** There is a risk that patients in the health-based place of safety (HBPoS) will not have adequate medical oversight due to no medical budget and registered consultant (RC) cover (**risk score 3 x 5 = 15).** • **TBC NEW Risk 5474** There is a significant risk of clinical harm, data breaches, and loss of public trust caused by staff using AI tools to support or influence clinical decision-making without appropriate governance, (**risk score 4 x 3 = 12).**	4 x 4 =16
Previous risk: **2024-2025 risk BAF 0031** There is a risk we fail to deliver on national inequalities priorities and our strategic aim to reduce inequalities, caused by failure to adopt an inequalities-based approach to care resulting in poorer access, later presentations and risk of poorer outcomes. **2025-2026 risk BAF 0031** **There is a risk that the Trust fails to maximize its contribution to reducing inequalities caused by a failure to adopt a population health management approach including a focus on prevention, leading to poorer outcomes and unfair differences in outcomes.**	4 x 4 =16

Lead: Director of strategy To note: no corporate risk aligned currently.	
Previous risk: **2024-2025 risk 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. **2025-2026 risk BAF 0013** **Risk that staff well-being and absence is impacted by the workplace environment, lack of support and failure to provide a workplace environment that is free from violence, aggression, bullying, abuse, racism and promotes sexual safety.** **Lead:** Executive director of people **Corporate risks aligned:** • **Risk 5385** There is a risk that reporting systems do not support an effective response to sexual safety, racism and violence caused by the culture of reporting resulting in low staff morale, wellbeing and quality of care**. (risk score 3 x 4 = 12).**	4 x 4 = 16
Previous risk: **2024-2025 risk BAF0014** 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. **2025-2026 risk BAF 0014** **There is an increasing risk of ensuring a flexible modern workforce that reflects the workforce market, community we serve to ensure skill mix and retention as well as alignment with strategic priorities and finances.** **Lead:** Executive director of people **Corporate risks aligned:** • **Risk 5321** There is a risk that we are unable to meet mandatory training compliance levels caused by a variety of factors impacting on one or more training subjects including lack of suitable training space for delivery of training; trainer capacity, access to computers for e learning, and difficulties in staff release resulting in targets and CQC requirements not being met. **(risk score 3 x 4 = 12).** • **Risk 5409** A risk to patient safety due medical staffing and recruitment challenges resulting in a sub-optimal level of medical capacity in inpatient and community services **(risk score 3 x 4 = 12).** • **Risk 5410** There is a risk that the hospital discharge of restricted patients is delayed due to administration by the Ministry of Justice. This may adversely affect patient experience and outcomes and may significantly reduce our hospital bed capacity, causing delays in arranging hospital admission for other patients (**risk score 3 x 4 = 12)**	4 x 3 = 12
Previous risk: **2024-2025 risk BAF 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,	4 x 3 = 12

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. **2025-2026 risk BAF 0020** **Risk of failure to the organisation of embedding an open culture, and a sense of belonging driven by Trust values and behaviours which result in a lack of inclusion, poor staff experience and negative feedback.** **Lead:** Executive director of people To note: no corporate risk aligned currently.	
Previous risk: **2024-2025 risk BAF 0021A** 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. **2025-2026 risk BAF 0023** **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.** **Lead:** Executive director of finance, performance and digital **Corporate risk aligned:** • **Risk 5462** There is a risk that the Rio optimisation phase does not deliver the expected benefits or introduces additional safety and efficiency challenges to existing clinical pathways. This could result in unsafe changes that put service users at risk, an unacceptable burden on staff and/or additional costs. **(risk score 4 x 3 = 12)**	4 x 3 = 12
Previous risk: **2024-2025 risk 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. **2025-2026 risk BAF 0021** **The is a risk of a 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 system, and potential clinical risk that will have an impact on staff, people who use or have used services and the wider system.** **Lead:** Executive director of finance, performance and digital **Corporate risk aligned:** • **Risk 5401** There is a risk that all corporate and clinical services cannot operate safely because technology is unavailable due to a cyber security incident **(risk score 4 x 3 = 12).**	5 x 4 = 20

Previous risk: **2024-2025 risk 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. **2025-2026 risk 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.** **Lead:** Executive director of finance, performance and digital **Corporate risk aligned:** • **Risk 5051** There is a risk of failure to deliver the required level of savings for 2025/26 will result in the planned deficit not being met. **(risk score 5 x 3 = 15).**	4 x 4 = 16
Previous risk: **2024-2025 risk 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. **2025-2026 risk BAF 0026** **There is a risk that we fail to take an evidence led approach to change and improvement supported by staff who are prepared, skilled and trained in delivering the integrated change framework approach.** **Lead:** Director of strategy **Corporate risk aligned:** • **Risk 5344:** There is a risk that the integrity and safety of the fire doors have been compromised caused by inadequate maintenance through a sufficient Planned Preventative Maintenance (PPM) regime **(risk score 5 x 3 = 15).**	4 x 3 =12
Previous risk: **2024-2025 risk 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. **2025-2026 risk BAF 0027** **There is a risk that we do not ensure effective and timely stakeholder involvement and partnership working, which would have a negative impact on addressing population health and/ or sustainability of the organisation resulting in a failure to meet our strategic objectives.**	4 x 3 = 12

Lead: Director of strategy **Corporate risk aligned:** • **NEW Risk 5461** There is a risk that service users from Rotherham, Barnsley and Doncaster open to the Sheffield Eating Disorder Service cannot access specialist medical emergency in eating disorders (MEED) support in their locality. **(risk score 3 x 4 = 12).**	
BAF 0028 NEW RISK 2025-2026 **A risk that we fail to recognise, challenge or respond to tackling all forms of racism and racial inequality and micro-aggression which would mean the Trust is not truly inclusive resulting in racial inequity for people who work in or use Trust services.** **Lead:** Executive director of people **Corporate risk aligned:** • **Risk 5385** There is a risk that reporting systems do not support an effective response to sexual safety, racism and violence caused by the culture of reporting resulting in low staff morale, wellbeing and quality of care. **(risks score 3 x 4 = 12)**	**Proposed score: 4 x 4 = 16**
BAF 0033 NEW RISK 2025-2026 **There is a risk that unresolved ligature anchor points in patient-accessible areas may lead to incidents of self-harm or suicide, due to delays in capital programme works required to remove or mitigate these risks. This could result in serious harm to service users, regulatory breaches, reputational damage, and potential legal consequences.** **Lead:** Executive director of nursing, quality and profession To note: no corporate risk aligned currently.	**Proposed score: 5 x 4 = 20**

3. Recommendation:

The Board of directors are asked to:

- **Discuss and approve** all BAF risks and updates for 2025-2026.

Appendices:

Appendix 1 – Quality assurance committee BAF risks
Appendix 2 – Finance and performance BAF risks
Appendix 3 – People committee BAF risks

BOARD ASSURANCE FRAMEWORK 2025/26
For receipt in July 2025

BAF RISKS OVERSEEN BY QUALITY ASSURANCE COMMITTEE

BAF Risk 0024
Risk to both staff and service users, culture and reputation when failing to meet the fundamental standards of care, legal, regulatory and safety requirements.

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	
• Deliver outstanding care • Reduce inequalities	• Realise the benefits of implementing RIO safely • Become a digitally enabled organisation, including patient engagement portals and access to shared records • Become a more productive in all parts of out Trust, including undertaking a corporate support services review • Home first – reducing out of area placements, improving productivity and flow. • Deliver our quality and safety objectives, including culture of care, risk assessments, care planning and restrictive practice. • Implement neighbourhood mental health centre pilot. Therapeutic environments – refurbish Maple ward	**Executive lead:** Executive Director – Nursing and Professions /Medical Director **Board oversight:** Quality Assurance Committee **Last reviewed** – July 2025. **Next review** – September 2025 **Risk type:** Clinical quality and safety. **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 , 5344, 5429

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

Summary Update	
BAF risk was reviewed by EMT in June 2025 and risk agreed to remain the same – 12. Significant progress made with the LAP being addressed across in-patient estate with Maple refurbishment due to comclude October 2025.	• **Review of Quality Governance –** Full review of Quality Governance by Good Governance Institute – due to conclude August 2025. Revised structure to be implemented by October 2025 • **Progression of improvements related to supervision and training –** Supervision overseen through SLT and reported to EMT and People Committee. A review of the supervision policy and the associated supervision tree for both directorates is underway and will be completed by the end of Q2 2025-26.

Home First Programme continues to implement pathway improvements to address out of area placement use. However, the use of out of area placements continues to occur. RIO was implemented successfully in March 2025, the optimisation and benefits realisation phase has commenced. Least Restrictive practice continues to be a focus with February 2025 having no episodes of seclusion. Focused QI being undertaken to ensure protected characteristics are accurately and consistently recorded. Impact in the pilot teams has been significant, with some teams achieving 100%. Culture of Care (CoC) Programme is established across in-patient wards with ward QI initiatives being presented to the CoC group. Personalised approach to Risk assessment being implemented, with the template agreed and being built into RiO. Training underway. PCREF Stakeholder group established to oversee the Trust approach to the Delivery of PCREF Establsihment of an Enhanced Support SOP to provide enhanced support to areas experinencing quality concerns.	• The non-medical training oversight group are considering the ongoing procurement of supervision training from Sheffield Hallam university after a positive evaluation of the programme (August 2025). • Non-Medical Education and Training Group has been established and will ensure that as clinical models/pathways of care are developed the associated raining needs are reviewed and funding streams explored (e.g. NHSE CPD funding). • Regulatory Compliance - A new group to develop the approach to assurance in relation to the CQC assessment framework. This will include a refresh of the Fundamental Standards visits programme. Q3 2025/26. • Implementation of the new Ulysses Quality Audit programme to take place across in-patient services August 2025. This includes a record keeping audit. **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
- 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 and mainstreamed into Quality Governance oversight
- Robust incident and investigation governance in place in line with PSIRF
- Co-production standards implemented patient experience measures are in place including Care Opinion relaunched July 2025
- 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 SLT which consists of leaders from all directorates and receives a quality report.
- Updated Capital Plan received at Board in April 2025 with updates received at subsequent Board meetings.

Internal assurance	**External assurance**
• Clinical Quality & Safety Group, SLT and EMT oversight of Enhanced Support	• CQC Inspection – acute in-patient wards (awaiting feedback)

• Regular reporting through governance routes including learning lessons, safeguarding reports, staffing reports, transformation programme reports. • • 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. • SLT 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 – Maple refurbishment concludes October 2025.	• CQC relationship visits • Provider Collaborative Quality Visits • Section 11 Audit with safeguarding partnerships. • Regularly reviewed by the Clinical Environment review group on a monthly basis. • Engagement with safeguarding partnerships at Executive level
Gaps in assurance	**Actions to address gaps in assurance:**
1. Tendable was not consistently used and was removed in September 2025. The Ulysses replacement was delayed due to the RIO roll out.	• A Module on Ulyssess has been developed to replace Ulysses which is being launched August 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.~~ **Has been completed by the Good Governance Institute** ~~**Executive Director of Nursing, Quality and Professions** An external review of quality governance is commencing in April 2025~~ and will conclude August 2025 with new structure implemented October 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 Update 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.**	**Actions to address gaps in controls actions must address identified gaps in control or assurance and must have assigned owners and target dates.** S**trikethrough any that are no longer relevant** • 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 remains mixed gender- ~~Maple work will move the ward to single gender' closed at September Board as plan in place see update in actions. Only PICU is mixed gender now.~~	• Plans are being worked up to explore options for the management of mixed sex gender on PICU. ~~Maple ward has closed. Currently undertaking an options appraisal of the future 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.~~ Senior Leadership Team is overseeing compliance improvement and Compliance is expected to reach required levels within Q2.
~~5. Flow plan is not impacting at a pace we had hoped.~~ Current Length of stay and out of area bed use is above trajectory	• ~~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~~.Director of Performance and Delivery** 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.~~ The Home First programme is expected to achieve out of area trajectories across Q2.
6. Use of 136 suite rooms to accommodate people awaiting admission – still required at the	• New HBPOS (136 suite) opened January 2024. There has been some breaching

current time	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.

BAF 0025 - There is a risk of failure to deliver essential programmes of work to environments in a time frame required, caused by limited availability of capital investment, resulting in an impact on safety, ~~reducing restrictive practice~~ and ~~a poor~~ experience for both service users and staff.

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	**Executive lead:** Director of Strategy **Board oversight:** Finance and Performance Committee **Last reviewed** – July 2025. **Next review** – September 2025 **Risk type:** Safety **Risk appetite:** Moderate (cautious) **Risk rating impact v likelihood**
• Deliver outstanding care • Effective use of resources • Reduce inequalities • Great place to work	• Therapeutic environments – refurbish Maple ward. • Home first – reducing out of area placements, improving productivity and flow. • Deliver our quality and safety objectives, including culture of care, risk assessments, care planning and restrictive practice. • ~~Home first – reducing out of area placements, improving productivity and flow. Implement neighborhood mental health center pilot.~~ • ~~Therapeutic environments – refurbish Male ward.~~ • Improve the safety of our staff by reducing violence and aggression and sexual safety incidents	• Current **4 x 2 = 8 (reduced)** • Target 3 x 2 = 6 • Movement • **Assurance rating** –Amber • **Corresponding Corporate risks – 5344**

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

Summary update

- ~~articulate the key messages, action and movement in risk score here.~~
- ~~Include that the BAF risk scores has been reviewed and updated where appropriate to reflect the impact of action taken to mitigate the risk.~~ The Therapeutic Environments Programme is the Trust's capital programme designed to respond to safety and quality risks identified by CQC and subsequently by the Trust's own reviews. There is good progress with the second phase of the programme (Maple ward, and small-scale enhancements at DD2) which has been accelerated through bids to secure additional system capital. The final phase of TEP (OPMH and Forensic) is likely to take multiple years to reach

Milestones in 2025/26 to support reaching target score: EMT review of capital plan prioritisation – August 2025

- EMT review of Forest Lodge environmental assessment – August 2025
- TEP final phase scoping (OPMH and Forensic) – subject to capital plan re-prioritisation – December 2025
- Revised plans for sale of Fulwood - September 2025
- Delivery of phase 1 of programme of investment in fire doors and compartmentation – March 2026

- ~~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~~

delivery due to limited availability of capital. This situation has recently been exacerbated by delays in the sale of Fulwood. • Key actions being taken in 2025 to address this include a) review capital plan prioritization, b) consider additional sources of investment for the options/ design phase to be ready for system capital slippage opportunities, and c) revise Fulwood sales strategy. • Additionally, it is important that we maintain effective mitigations and monitoring of risk. Key to this is a) Trust LAP group reviews risks, and b) effective implementation of operational protocols for management of risk at relevant units. • Steps that will trigger a review of current risk ratings are: a) completion of Maple and DD2 projects, b) completion of OPMH and Forensic options work, c) securing additional capital, and d) completion of projects in OPMH and Forensic.	• 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.
- 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
- Use of temporary staffing leading to potential inconsistencies in the application of practice standards - GAP Closed (July 2024)
- Clinical Environmental Risk Group confirmed remaining LAP works for wards was completed in June 2024 and the group receives detail on any outstanding works.
- ~~Estates Strategy interim review – September 2024~~
- ~~ICS infrastructure strategy – to which SHSC has inputted.~~

Internal assurance	**External assurance**
• Forensic internal rapid review – to **EMT July 2025** • Regular reporting (Capital Group; Therapeutic Environment Programme Board; Improvement and Change ~~Transformation~~ Board)	• Evidence based approach to Reducing Restrictive practice implementation (note there is evidence of continuing improvement around use of restricted practice)

~~• 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)	
Gaps in control	
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**~~
Gaps in assurance	**Actions to address gaps in assurance**

BAF 0029 There is a risk to quality, safety and patient care due to delayed access to timely crisis support and mental health services, which could result in poor experience of care and potential harm to service users.

STRATEGIC AIMS	STRATEGIC PRIORITIES	Executive lead: Director of Operations Board oversight: Quality Assurance Committee Last reviewed – July 2025 Next review September 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: 5001,4100, 4756, 4747, 5438
• Deliver outstanding care • Reduce inequalities	• **Deliver our quality and safety objectives including our culture of care, risk assessments, care planning and restrictive practice.** • **Home First – reducing out of area placements, improving productivity and flow.** • **Implement neighborhood mental health Centre pilot.** • **Therapeutic environments – refurbish Maple ward.**	

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

Summary update

- The BAF risk description has been updated to reflect the risk to quality, safety and patint care due to delayed access to crsis support and menta halth servces.
- The milestones have been updated to reflect progress in improving access to crisis and mental health services
- Th risk score remains unchanged.
-

Milestones in 2025/2026 to support reaching target score:

- Agreement of Gender service investment – this remains a challenge in terms of demand and capacity – issues have been escalated to NHSE. March 2025 - Gender and ADHD service now delivering against a trajectory to meet commissioned activity.
- Heeley and Gleedless MH Centre to launch in July 2025.
- ADHD – a review of ADHD pathway to support the reduction of current of waits ~~by 31 December 2024 No change~~
- PCMHT and CMHT pathway alignment and improved operational delivery – October 2025
- ~~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 – Perinatal Mental Health 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.**
- NHS 111 MH option April 2024 - **completed**

Control

Internal assurance

• 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.~~ • DLT, SLT and EMT governance established from July 2025 • 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.	• 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 1. Where there are large numbers of people waiting for a service, we cannot reach out to every person on a regular basis, so are reliant on people contacting us if their presentation deteriorates or circumstances change. Each service has a protocol to regularly review people's needs whilst waiting and apply a RAG rating to prioritise contact.	**Actions to address gaps in controls** Investment was prioritised in 23/24 in our recovery services and perinatal mental health. For ADHD we are working through the Provider Collaborative to resolve long waits for the service and progress is expected by the end of the financial year 2025/26 in terms ~~of a reduction of up to c50~~ a regional development. This remains ongoing. Completion of workforce plan and job plans to enable agreement of performance trajectory for increased activity. Further work has been progressed to increase operational efficacy through a nurse-led model. ~~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
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	**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 that the Trust fails to maximize its contribution to reducing ~~there are widening~~ inequalities ~~in our system~~ caused by a failure to adopt a population health management ~~based~~ approach including a focus on prevention, leading to ~~to reduce disparity, resulting in~~ poorer outcomes and unfair differences in outcomes.

STRATEGIC AIMS • Reduce inequalities • Deliver outstanding care • Effective use of resources •	**STRATEGIC PRIORITIES** Implement our inequalities and population health plan, starting by increasing the recording of personal data. • Improve pathways to work and access to housing through local partnerships. • Implement our Patient and Carer Race Equality Framework. • Deliver out equality objectives • Implement neighbourhood mental health centre pilot. • Develop university trust strategy and	**Executive lead:** Director of Strategy **Board oversight:** Quality Assurance Committee **Last reviewed** – July 2025. **Next review** – September 2025 **Risk type:** strategic **Risk appetite:** Moderate (cautious) **Risk rating impact v likelihood –** Scoring confirmed • Current 4x 4=16 • Target 3 x 2 = 6 • Movement – Corresponding corporate risks: no corresponding Corporate Risks

		partnerships with our universities ~~• Deliver the SY MHLDA partnership priorities~~		currently.	
On track	Some slippage	At risk	Completed	**Assurance level**	**AMBER**

Summary update

- ~~articulate the key messages, action and movement in risk score here.~~
- ~~Include that the BAF risk scores has been reviewed and updated where appropriate to reflect the impact of action taken to mitigate the risk~~
- The Trust has a dedicated lead for reducing inequalities and population health who has been effective in establishing active networks in the Trust and local system and ensuring that the Board is conscious of its responsibilities, with regular consideration of the topic on agendas. A prioritised plan has been agreed and reducing inequalities is prominent in our refreshed strategy. There is progress on the key measure of recording of personal data, but our current level of recording is not acceptable.
- There is a risk that the current means and resourcing of this strategic aim will not achieve the level of change required at the pace that is expected.

Milestones in 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
- QI projects with pathfinder services to improve recording of personal data – reporting learning by **September 2025**
- Board self assessment repeated - **September 2025**
- Charitable bids for funds to build capacity - outcome of bids known **August 2025**
- HWB development of inequalities fellowship scheme – would grow capacity – dates tbc

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**
- 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~~
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~~ • Annual Board self assessment • NHSE statement on Inequalities - publication annually • IPQR data showing level of recording of personal characteristics by service • Twice yearly progress reports to Board • Inequalities community of practice established June 2024. ~~Exact focus tbc but will contribute to culture change providing mutual support for colleagues seeking to tackle inequalities through small scale QI initiatives in their areas of work.~~ • Leadership roles for inequalities established by June 2024 – in place. • All projects with the 'waiting well QI collaborative' have a health inequalities element was in place by July 2024. All teams are being supported to consider health inequalities throughout their work with their coaches	
Internal assurance • Inequalities reporting to Board – details tbc following June development session • Inequalities measures in IPQR, plus breakdown of key metrics by personal characteristics in IPQR and workforce reports • Board development session and around MHA QI, health inequalities self-assessment and PCREF – June 2024	**External assurance** • Reporting of nationally mandated inequalities measures in October 2024 and beyond in line with NHSE Statement on Inequalities
Gaps in controls	**Actions to address gaps in controls** • ~~Schedule a review of the effectiveness of the controls in June 2025 (12 months in)~~
Gaps in assurance • The level of recording of personal characteristics of service users remains low. Increasing the percentage of records with complete demographic information will strengthen the effectiveness of our assurance mechanisms.	**Actions to address gaps in assurance** • Improvement activity to increase the level of recording of personal characteristics – This remains a gap and is owned by Operations- Greg Hackney, Senior head of Service and is reported monthly through the IPQR. 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.

NEW BAF 0033

There is a risk that unresolved ligature anchor points in patient-accessible areas may lead to incidents of self-harm or suicide, due to delays in capital programme works required to remove or mitigate these risks. This could result in serious harm to service users, regulatory breaches, reputational damage, and potential legal consequences.

STRATEGIC AIMS	STRATEGIC PRIORITIES	Executive lead: Executive director of nursing, quality and profession Board oversight: Quality Assurance Committee Last reviewed – July 2025. Next review – September 2025 Risk type: clinical quality and safety Risk appetite: Moderate (cautious) Risk rating impact v likelihood – Scoring confirmed • Current 5x 4=20 • Target 3 x 2 = 6 • Movement – Corresponding corporate risks: no corresponding Corporate Risks currently.
• Deliver outstanding care	• Deliver our quality and safety objectives, including culture of care, risk assessments, care planning and restrictive practice. • Therapeutic environments – refurbish Maple ward.	

On track	Some slippage	At risk	Completed	Assurance level	AMBER

Summary update

- LAP assessments are all up to date and available to staff
- BAF risk was agreed at EMT and Board Development Session in June 2025

Ligature Anchor Points (LAP) have been addressed across the adult acute units. However, LAPs remain on older people's wards and Forest Lodge, but are well understood and included in the LAP assessments for each ward

Milestones in 2025/26 to support reaching target score:

- Capital works prioritisation to address higher risk LAPs in 2025/26
- Personalised approach to risk assessment training to be delivered across all wards – end Q3 2025/26
- Launch of Ulysses audits to include a quality of risk assessment audit (within documentation audit) August 2025
- Weekly environmental audit within Ulysses to standardise approach – September 2025

Controls

- Each ward has up to date LAP assessments that are available and understood by staff
- Risk assessments in place for patients which take account of ligature risks
- Relational security approaches utilised as even in instances where all LAPs have been removed patients can ligature without a fixed point.

Internal assurance

- LAP risk assessments for all wards in place and in date
- Individual Risk assessment audits

External assurance

- CQC inspection on adult and PICU wards
- Provider Collaborative Annual Quality Review in Forest Lodge reviews LAP assessments and mitigation of risks

Gaps in controls

- Capital Programme unable to address all LAPs across not acute wards in 2025/26

Actions to address gaps in controls

- Capital works prioritisation to address highest risks: **Owner: Director of Strategy**
- Launch of Ulysses audits in August 2025 will include a standardised weekly audit of documentation including quality of risk assessments. **Owner: Executive Director of Nursing, Professions and Quality.**

• Variation in the quality of patient risk assessments across the wards • Standardised audits of individual risk assessments not consistently undertaken across all wards One risk was found to be not mitigated on Forest Lodge despite it being clear in the LAP assessment that the area in question should be locked off from general use (blanket restriction	Regular review of LAP assessment actions as part of environmental audits – August 2025 **Owner: Executive Director of Nursing, Professions and Quality.**
Gaps in assurance • CQC identified a ligature risk on an acute ward not identified on the LAP assessment	**Actions to address gaps in assurance .** • LAP assessment updated and learning taken across all wards - Complete • Environmental audits to be standardised as part of ward weekly audit programme – August 2025

BOARD ASSURANCE FRAMEWORK 2025/26
For receipt in July 2025

BAF RISKS OVERSEEN BY FINANCE AND PERFORMANCE COMMITTEE

~~**BAF0021A**~~ **BAF 0023**

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, performance and digital **Board oversight: Finance and Performance Committee & Audit and Risk Committee** **Last reviewed** – July 2025. **Next review** – September 2025 - **Risk type:** 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: 5462
• Effective use of resources • Deliver outstanding care	• Realise the benefits of implementing RIO safely • Become a digitally enabled organisation, including patient engagement portals and access to shared records.	

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

Summary update

- The implementation of RiO has delivered a modern EPR. The trust now has an opportunity to improve patient care by securely sharing data across organisational boundaries (using federated data platform, shared care record, patient engagement portal)

Milestones in 2025/26 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~~
- Insight decommissioning planned for July 2025

	• RiO Optimisation work will complete by August 2025 • In scope reporting has been delivered by the programme. • RiO upgrade is subject to Trust Board decision on funding. • Benefits case to be presented to Board in Q2 25/26 • Establish Business As usual services to control and govern the RiO and SystmOne electronic patient records by Q2 25/26
Controls 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 • Routine reporting needs Clinical Executive Safety Design Group, Rio/SystmOne Improvement Board to be permanently established with regular reporting lines to Digital Assurance and Approvals group • 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~~ will complete by Dec 2025 • SHSC Digital continue to retire old systems and improve cyber security in line with the guidance provided by the data protection and security toolkit. Making good progress to meeting the standard. Ongoing until legacy system is retired.	
Internal assurance • Governance reporting in place - reporting into Programme Board with oversight by Trust Transformation Board and EMT. Governance arrangements updated and received through the revised EPR implementation plan approved at Board in April 2024. ~~• Additional support is in place should Insight do down.~~ ~~• External independent expertise has been in place to support development of the new plan (from January 2024)~~ • DSPT audit. Internal audit has provided support and assurance around penetration testing.	**External assurance** • Annual Data Security Protection Toolkit (DSPT) internal audit moderate assurance rating received in 2023 and in 2024. • Annual Data Security Protection Toolkit (DSPT) audit significant assurance rating received in 2025 • External independent expertise has been in place to support development of the new plan (from January 2024) • Digital Maturity Assessment gives a view on how the organisation compares to its peersKLAS review of end user experience gives view on how our users experience the application ~~• DSPT submission as part of national reporting~~ • ~~External review - report received on EPR at Board in February 2024 with recommendations on actions required.~~
Gaps in controls	**Actions to address gaps in controls**
1. Put in place assessment and plan for full resourcing and affordability (for IMST).	• Target Operating Model (TOM) to be in place by ~~July~~ Dec 2025 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.

	Departmental restructure underway
2. Address elements of DSPT still to be achieved, the relevant risks are being tracked.	• Annual Data Security Protection Toolkit (DSPT) audit significant assurance rating received in 2025 • 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.~~ DSPT for 2026 will be updated **Owner CDIO/Exec Director of Finance** January 2025.
3. The need to develop a new Digital Roadmap and Target Operating Model.	• Digital Roadmap– **Owner CDIO/Exec Director of Finance** timing to be confirmed for delivery this will be after the strategy refresh later in the financial year and will be by the end of March ~~2025~~ 2026 This is linked to timescales of the new strategy and will be confirmed in the new financial year.
Gaps in assurance	**Actions to address gaps in assurance**
~~Insight still being used – delays with EPR~~	• Retirement of Insight delayed to Q4 2024/25 Owner CDIO/Director of Finance. Insight will be retired in Q1 2025/26. • Revised plan for Implementation of RIO (EPR) received and approved at Board April 2024. Monthly updates have been received at Board and planning is on track for go live in March 2025. • Insight retired from active use in march 2025. Insight to be decommissioned July 2025, subject to clinical sign off.

BAF 0021~~B~~

There is a risk of a 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 system, and potential clinical risk that will have an impact on staff, people who use or have used services and the wider system.

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	**Executive lead:** Executive director of finance, performance and digital **Board oversight:** Audit and Risk Committee **Last reviewed** – July 2025. **Next review** – September 2025 **Risk type:** 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~~ 5 x 4 = 20 Target 3 x 2 = 6 - Movement ⟺ - Corresponding corporate risks: 5401
• Effective use of resources	• Realise the benefits of implementing RIO safely • Become a digitally enabled organisation, including patient engagement portals and access to shared records.	

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

Summary update	**Milestones in 2025/26 to support reaching target score:**
Improved security using Zscaler tool and Intune. AI risk to be reviewed for inclusion on corporate risk register	• DSPT submission and internal audit (June 25) – Internal audit only found one low risk action • Cyber Security Desktop exercise plan in place (Dec 25) • Pen test took place in April 2025. Action Plan to complete in August 2025 • Information Asset ownership for High priority assets to be socialised and accepted by Mar 26

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.
- Staff are regularly reminded of their responsibilities through training and through incidents that arise
- ICO regularly informed of breeches when appropriate
- Legal advice sought when appropriate
- Annual Penetration test and resulting action plan

Internal Assurance

Governance reporting:

Reports on patching reports are received at Cyber / IG / AI group 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.

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 has re-instated IG, cyber and AI group reporting into ARC.

Monitoring of the Internal Audit action tracker takes place with regular reporting

External assurance

Confirmation provided to NHSD in accordance with prescribed national process.for cyber alerts as they occur

- Self assessment DSPT compliance – key indicator - Annual Data Security Protection Toolkit (DSPT) audit moderate assurance rating received. Internal audit gave assurance on our submission
- Exploring opportunities to share KPIs across SY organisations for further assurance

received at ARC	

BAF 0030 There is a risk that the failure to deliver the Trust Green Plan will have an impact on the local environment, workforce and population and lead to legal and regulatory action and reputational damage.

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	**Executive lead:** Executive Director of Finance **Board oversight:** Finance and Performance Committee **Last reviewed** – July 2025 **Next review** – September 2025
- Effective use of resources	- Realise the benefits of implementing RIO. - Become a digitally enabled organisation, including patient engagement portals and access to shared care records. - Deliver our financial plan of £4.9m deficit including achievement of £8m efficiencies. - Become a more productive in all parts of out Trust, including undertaking a corporate support services review	
		Risk type: Environmental **Risk appetite:** High (open) **Risk rating impact v likelihood** - Current 3 x 4 = 12 no change - Target 2 x 4 = 8 check - Movement ⟺ Corresponding corporate risks: None specifically

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

Summary update	**Milestones in 2025/26 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~~ • Escalation process in place to ensure action plan is completed by August 25 • 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)~~ Oversight of Sustainability under review at ICS as part of wider ICS/NHSE review.
- Green Plan Approved by SHSC Board and refreshed 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. Green Plan and Action Plan to be published on SHSC website by 31st July 25
- 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.
- ~~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. SHSC Sustainability dashboard, including carbon footprint to be shared quarterly via leadership cascade. First dashboard Aug 25.
- 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
- 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)
- 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, Digital and Performance)
- Non-Executive lead identified
- Training on sustainable development and climate change reflected in DaL and SHSC Manager offer.

External assurance

Positive Assurance

- Greener NHS – Quarterly data submission
- Greener NHS Fleet Data submission
- Greener NHS Green Plan Support Tool, Self-Assessment Questionnaire- June 25 new self- assessment questionnaire has been updated to reflect Greener NHS Green Plan Refresh Guidance.
- Climate adaptation framework for NHS organisations in England

~~• 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** • Boiler replacement at Limbrick and East glade on Capital plan but studies and capital planning not progressed. Limbrick boiler has now broken down (July 25) and is now likely to be replaced with another fossil fuel system rather then a low carbon alternative.	
Gaps in controls	**Actions to address gaps in controls**
• Data quality and availability- access to and effective scrutiny of data to support which KPIs/ metrics can be used to monitor and disclose our performance. (Green Plan Action Plan performance monitoring and embedding sustainability measures into Trust transformational projects)	• Green Plan Action Plan- progress has been stuck ensuring actions within Green Plan are SMART, aligning actions to delivery timescales and establishing milestones. **Ownership- SDG Focus Area Leads to ensure all actions are updated by 31st August 25** • SHSC Sustainability Dashboard go live August 25- **Ownership Sarah Ellison, Sustainability Lead, support by data leads James Clarke and Andy Probert (Estates and Facilities), Andrew Pigott (Transport), Julie Rice (Procurement) Chris Reynolds and Mathew Needham (Digital)** • Embedding sustainability measures- **Ownership Sarah Ellison, Sarah Ellison has been Woking with Zoe Sibeko (PMO) to use the Home First Project as a case study for embedding sustainability measures within the project. Zoe Sibeko to introduce measures at Transformation Board Aug 25.**
• 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.**	• Draft CCRA shared with SDG members and scoping for SHSC approach to deliver a Trust Adaptation Plan in April and June. Next steps to establish a working group to initiate and assign responsibilities for further developing SHSC CCRA (incorporating in SHSC corporate risk register) and developing an adaptation plan. Sarah Ellison has attended SLT (June 25) to raise awareness and seek input from Leadership. **Owner Sarah Ellison, Sustainability Lead. Working Group set up by September 25** • Business Planning green plan objectives include an option for teams to update BCPs based on updated Adverse Weather Policy and in consideration of where exposure/ vulnerability to risk is identified. To support identification of risks/exposure/ vulnerabilities a workplace checklist has been produced to support objective delivery. **Ownership Sarah Ellison, Sustainability lead, Next steps to be carried out August/ September working with Organisational Development Team, Workforce Team and HRBPs to further develop checklist and embed into managers responsibilities**.
• 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. 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 Update **July 25- Sarah Ellison, Sustainability lead is making progress identifying the duties and appropriate job description to introduce a "sustainability office/ Project officer" role to support green plan delivery. In addition, to support delivery of actions under Low Carbon Care which lack leadership a " Green Therapy Network" will be established September 25 to review options for support and action delivery as well as champion examples of green therapy already underway at SHSC**.

• 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 .
Gaps in controls Controls cover people (training and policy), processes(reporting mechanisms) and technology services (products are purchased and deployed in line with good practice from	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 **July 25- Sustainability Lead has been working with Jo Hardwick to review integration of "Make Every Contact Count" (MECC) tool at SHSC which includes potential prompts on ESR to support conversations with patients on climate change hazard e.g. air quality, heatwave resilience and staff training to have informed conversations. Initial conversations had, no expected delivery date determined yet.**
Gaps in assurance System Asset register functionality within Sunrise not yet enabled. Information asset ownership. Senior staff need to be supported to play an active role in asset ownership	•

BAF.0026

There is a risk that we fail to effectively implement the level of improvement and change that is required in order to deliver our strategy and annual operational plan, caused by factors including a failure to embed an improvement culture, to equip our staff, and to manage the delivery of major change in accordance with our ~~take an evidence-led approach to change and improvement supported by staff who are prepared, skilled and trained in delivering the~~ integrated change framework ~~approach~~.

STRATEGIC AIMS - Effective use of resources - Deliver outstanding care - Great Place to Work - Reduce Inequalities	**STRATEGIC PRIORITIES** • Realise the benefits of implementing RIO. • Become a digitally enabled organisation, including patient engagement portals and access to shared care records. • Deliver our financial plan of £4.9m deficit including achievement of £8m efficiencies. • Become a more productive in all parts of out Trust, including undertaking a corporate support services review • Deliver our Quality and Safety Objectives including Culture of Care, risk assessments,	**Executive lead:** Director of Strategy **Board oversight**: Finance and Performance Committee **Last reviewed** – July 2025. **Next review** – September 2025

		care planning, and restrictive practice • Home first – reducing out of area placements, improving productivity and flow. • Implement neighbourhood mental health centre pilot. • Therapeutic environments – refurbish Maple ward. • Develop our culture through the we are our values programme • Develop university trust strategy and partnerships with our universities • Improve the safety of our staff by reducing violence and aggression and sexual safety incidents • Continue our journey to be an anti-racist organisation • Implement our inequalities and population health plan, starting by increasing the recording of personal data • Improve pathways to work and access to housing through local partnerships • Implement PCREF • Deliver our equality objectives • Deliver the SY MHLDA partnership priorities		
				- **Risk type: Strategic** **Risk appetite: High (open)** **Risk rating impact v likelihood** - **Current 4 x 3 = 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 • ~~articulate the key messages, action and movement in risk score here.~~ • ~~Include that the BAF risk scores has been reviewed and updated where appropriate to reflect the impact of action taken to mitigate the risk~~ • The Trust has a standardised method 'Integrated Change Framework' aligned to NHS IMPACT. It has a significant		**Milestones in 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			

investment in both in-house and external support for delivery of change; and it has comprehensive governance arrangements for the most complex changes that are critical to achievement of our strategic priorities, including regular board and cttee oversight. Additional focus in 2025/26 on capability building and embedding a culture of continuous improvement, supported by AQUA. • The focus must now be on the effective application of these arrangements, including demonstration of benefits realisation. • Consider reducing 'likelihood' score when major programmes consistently achieve their intended benefits, and staff survey scores on change culture are in upper quartile.	• Trajectory for reduction of OAPs = key success measure for Home First programme • Capability development to support culture of improvement – main delivery method = AQUA forging improvement programme – commenced June 2025 – continues throughout 2025/26 • Utilise staff survey scores on freedom to/ support for change to measure progress with improvement culture **Milestones completed:** • AQUA 'forging improvement programme' launched with Trust Board – June 2025 • EMT review of portfolio and SROs – June 2025 • 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:~~ ~~o Develop Integrated Change 'front door' and 'triage' arrangements - by end of September 2024 Process in place and started January 2025~~ ~~o Develop Integrated change support 'offer' for the 'do and share' category – by October 2024 completed in December through publication of ICF Guide on Jarvis~~ ~~o Test Integrated Change framework with operational colleagues – by end of September 2024 completed in December~~ ~~o 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 Improvement and Change Framework aligned to NHS IMPACT which includes clear Gateways between lifecycle phases~~governance infrastructure aligned to Prince II and Managing Successful Programmes standards.~~
- Reporting through Programme Boards to Improvement and Change Board and onwards to Board sub committees.
- Monthly escalation reporting.
- Health Card and Financial Health Card developed and reviewed monthly at improvement and change ~~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.
- Significant non-recurrent 'Change' budget enables expert additional input as required – e.g. on Home First programme and on capability building
- Improvement and Change Group meets monthly to triage new requests for support and to plan bespoke support packages ranging from training and coaching, to full MDT support and resourcing
- ~~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 Improvement and change ~~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 April 2025~~ Lessons Learned reports following closure of all programmes

Internal assurance	**External assurance**
• Individual programme highlight reports received at Improvement and Change ~~Transformation~~ Portfolio Board. Portfolio report received regularly ~~monthly~~ at ~~Transformation portfolio board~~, EMT and Finance and Performance Committee and Trust Board. ~~These highlighted risks and issues.~~ • Schedule of deep dive reports on specific programmes at EMT • Integrated Change Framework requires gateway reviews at key points in programme lifecycle ~~• 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.~~ • Additional temporary post in PMO to backfill PMO manager focusing on Home First ~~• 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 assurance role ~~representative~~ via St Vincents consulting 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, Home First, We are our Values
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

BAF 0027 There is a risk that we do not ensure effective and timely stakeholder involvement and partnership working, which would have a negative impact on addressing population health and/ or sustainability of the organisation resulting in a failure to meet our strategic objectives.

STRATEGIC AIMS	STRATEGIC PRIORITIES	
• Deliver outstanding care • Effective use of resources • Great Place to WorkReduce inequalities	• Realise the benefits of implementing RIO. • Become a digitally enabled organisation, including patient engagement portals and access to shared care records. • Deliver our financial plan of £4.9m deficit including achievement of £8m efficiencies. • Become a more productive in all parts of out Trust, including undertaking a corporate support services review • Deliver our Quality and Safety Objectives including Culture of Care, risk assessments, care planning, and restrictive practice • Home first – reducing out of area placements, improving productivity and flow. • Implement neighbourhood mental health centre pilot. • Therapeutic environments – refurbish Maple ward. • Develop our culture through the we are our values programme • Develop university trust strategy and partnerships with our universities • Improve the safety of our staff by reducing violence and aggression and sexual safety incidents • Continue our journey to be an anti-racist organisation • Implement our inequalities and population	**Executive lead:** Director of Strategy **Board oversight:** Finance and Performance Committee **Last reviewed** – July 2025. **Next review** – September 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~~ improvement and change programmes

		health plan, starting by increasing the recording of personal data • Improve pathways to work and access to housing through local partnerships • Implement PCREF • Deliver our equality objectives • Deliver the SY MHLDA partnership priorities •			
On track	Some slippages	At risk	Completed	**Assurance level**	**Amber**

Summary update

- ~~articulate the key messages, action and movement in risk score here.~~
- ~~Include that the BAF risk scores has been reviewed and updated where appropriate to reflect the impact of action taken to mitigate the risk~~
- The Trust is an active participant in local and regional partnerships.
- The external environment for health and care system partnership working is entering a period of change, so it is critical that the Trust remains engaged and is clear on its strategy and tactics. Operational and financial delivery is key.
- Internal arrangements to ensure timely coordinated decision making and action, often linked to improvement and change programmes, is an area of focus for 2025. See milestones.
- Consider reducing likelihood score when internal arrangements consistently demonstrate effectiveness, and when outcome of current national system changes are clearer.

Milestones in 2025/26 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~~ Strengthen relationships with PCS related to PCMH delivery and interface with CMHT - 2025
-
- Review progress against learning from GGI stakeholder review 20224 – **By September 2025**
- ~~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' a~~nd some form of CRM (Customer Relations Manager) system~~ by March 2025. I~~nitial discussion due September 2024 - December 2024 - this rolled into the stakeholder management project above~~. Agreed to connect into improvement and change board (EMT time-out June 2025). To be established **by September 2025**
- Active participation in Sheffield bid for Neighbourhood NHS pilot programme – submission August 2025. Outcome confirmed **September 2025**
- Review emergent situation with local and regional partnerships as significant changes to NHSE, ICBs etc linked to the Ten-Year Plan are implemented. Ensure the Trust remains an active participant in shaping the next iteration of partnership working.
- Strategy launch and communication – **September 2025**
- University Partnership launch and joint strategies – **2025/26**

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~~ GGI stakeholder review 2024

	~~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~~ 2025 – **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 are fully engaged at Sheffield health care partnership, ICB and SY MHLDA Collaborative, ~~and~~ t~~o 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 ~~partnership~~ priorities are reflected in SHSCs annual operating plan – approved by the Board i~~n May 2023~~

- Sheffield Health and Care Partnership regularly attended by CEO and other Executives leading ~~inking 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. ~~• Systems and Partnerships report at every board meeting~~ • SHSC Chair is lead Chair for the MHLDA Collaborative (effective from July 2023) • Business opportunities, risks (PESTLE AND SWOT) received at Board regularly – last June 2025~~in February 2024 and ongoing updating in place.~~ ~~• Active engagement taking place – SROs are engaging as part of new ICS arrangements.~~ • Engagement with the Council of Governors. ~~• Strategies and associated implementation work plans are in place with reviews reflected in committee/Board planners.~~ ~~• Enabling strategies in place.~~ • Quality Accounts reflects engagement. • Annual Report reflects engagement. ~~• Project Initiation Document (PID) setting out the engagement arrangements including the stakeholder analysis.~~ • ~~Report to Board in June 2022 included detail on stakeholder engagement for each project. Work underway to refresh the approach in 2024/25~~ ~~• 5-year plan and strategic direction received at FPC (Nov 2022), and Board workshop (Dec 2022) approved by Board Jan 2023. Revised priorities agreed in 2023, and Refreshed Strategy discussion planned at Board October 2024.~~ • ~~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)~~	~~• 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.
Gaps in controls	**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	Actions to address 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	• 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~~

BAF 0032 There is a risk that our estates do not adequately enable the delivery of our strategic priorities, which includes community models of care and care closer to home		
STRATEGIC AIMS • Deliver Outstanding Care • Effective use of resources • Reducing inequalities • Create a great place to work	**STRATEGIC PRIORITIES** • Deliver our financial plan of £4.9m deficit including achievement of £8m efficiencies. • Become a more productive in all parts of out Trust, including undertaking a corporate support services review • Deliver our Quality and Safety Objectives including Culture of Care, risk assessments, care planning, and restrictive practice • Home first – reducing out of area placements, improving productivity and flow. • Implement neighbourhood mental health centre pilot. • Therapeutic environments – refurbish Maple ward. • Improve the safety of our staff by reducing violence and aggression and sexual safety incidents • Implement our inequalities and population health plan, starting by increasing the recording of personal data	**Executive lead:** Director of Strategy **Board oversight:** Finance and Performance Committee **Last reviewed** – July 2025. **Next review** – September 2025 **Risk appetite:** Low to Moderate (minimal and cautious) **Risk rating impact v likelihood** - Current 4 x 3 = 12 - Target 3 x 2 = 6 - Movement – - Corresponding corporate Corporate risks: 5344

On track	Some slippage	At risk	Completed	Assurance level	Amber

Summary update

- The Trust requires a significant level of backlog maintenance, which has built up over many years. Recent improvements in processes within Estates And Facilities give greater confidence in assessments of compliance and emerging risks of infrastructure failure, meaning the Trust has a clear understanding of the issues. However, the scale of the challenge and resources available means that our ability to significantly reduce backlog maintenance is limited. In response the Trust has taken a risk based approach, notably by investing in a programme of improvements to fire safety (doors and compartmentation). The Trust also has an ongoing programme of elimination of fixed ligature anchor points, again prioritised based on risk. The TEP programme is progressing well within the limits of the capital expenditure limits of the Trust, and has been accelerated through external funding bids. Nevertheless while we wait for the opportunity to complete the TEP programme in Older Adults and Forensic environments, the risks in those settings require comprehensive operational mitigation strategies which are in place. A Trust LAP group regularly monitors risks and mitigations in all inpatient environments.
- In addition to addressing backlog maintenance requirements within our existing estate, the Trust requires an updated estates strategy to reflect the changing strategy of the organisation – e.g. an integrated neighbourhood NHS, a digitally enabled organisation, and to reflect the realities of post-covid hybrid working practices meaning space utilisation and sale of assets no longer required is a key opportunity.
- To reduce the scoring of this BAF risk will require significant progress with a) the fire safety investment programme, b) the TEP programme, c) space utilisation and divestment, and d) delivery of priority capital schemes associated with the implementation of our strategy (beyond the 'defensive' and safety requirements)
- Our ability to deliver on the above is significantly affected by the external environment, notably policies related to public sector capital and independent sector investment.

Milestones in 2025/26 to support reaching target score:

- EMT review of capital plan prioritisation – **August 2025**
- EMT review of Forest Lodge environmental assessment – **August 2025**
- TEP final phase scoping (OPMH and Forensic) – **subject to capital plan re-prioritisation – December 2025**
- Single collocated site for Community LD team – required by **September 2025**
- Sale of St Georges – due to complete soon – **date tbc**
- Revised plans for sale of Fulwood - **September 2025**
- Revised plans for site security and safety at Fulwood – **September 2025**
- Refine options for Eating Disorders inpatient unit collocated with SEDs – **September 2025**
- Sheffield HCP estates group to review collective opportunities to enable neighbourhood health centre roll out (10YP) **– September 2025**
- Strategic outline case for new hospital (including multi-site options) by December 2024 project continuing into Q4 – February 25 no further progress. July 2025 – linked to capital plan re-prioritisation - Delayed
- PLACE audit revisited **October 2025**
- ERIC and PAM results presented to EMT (and Board?) – **October 2025**
- Revised Estates Strategy – due – **November 2025**
- Delivery of phase 1 of programme of investment in fire doors and compartmentation – **March 2026**

Competed milestones:

- Estates strategy annual review was received at FPC in July and is due for receipt at Board in September 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**
- Scope and timeline for next phase of Therapeutic Environments Programme confirmed by November 2024 – slide deck prepared for EMT December 2024 **complete**
- Estates and Facilities Oversight Group established January 25 - **complete**
- PLACE audit results demonstrate improvement year on year – 2024/25 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 - Reporting through EMT, FPC, Business Planning Group, Capital Planning Group.
• Routine Compliance monitoring checks in place with robust tracking in estates department for 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 and Authorised Persons all in place.
• Maintenance programme of work in place
• Capital plan
• 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>

• System of APs in place for all required standards, competence confirmed by AEs.
• Annual PLACE report and associated action plan
• Annual PAM and ERIC returns enabling comparative analysis
• 7 facet survey report
• Annual Health and Safety Report (and quarterly updates)
• Trust LAP group</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
• Independent audit (AE) of fire safety management arrangements - December 2024</td></tr>
<tr><td><u>Gaps in controls</u>
•</td><td><u>Actions to address gaps in controls</u></td></tr>
<tr><td><u>Gaps in assurance</u>
•</td><td><u>Actions to address gaps in assurance</u></td></tr>
</table>

BOARD ASSURANCE FRAMEWORK 2025/26
For receipt July 2025

BAF RISKS OVERSEEN AT PEOPLE COMMITTEE

<table>
<tr><td colspan="5">BAF 0013 Risk that ~~that~~ staff well-being and absence is impacted by the workplace environment, lack of support and failure to provide a workplace ~~environment~~ that is free from violence, aggression, bullying, abuse, racism and promotes sexual safety.</td></tr>
<tr><td colspan="2">STRATEGIC AIMS
• Deliver outstanding care
• Create a Great Place to Work
• Reduce inequalities</td><td colspan="2">• STRATEGIC PRIORITIES
• Develop our culture though the ‘we are our values’ programme.
• Improve the safety of our staff by reducing violence and aggression and sexual safety incidents.
• Continue our journey to become an anti-racist organisation.
• Deliver our equality objectives</td><td>Executive lead: Executive Director of People
Board oversight: People Committee
Last reviewed – July 2025. Next review – September 2025
Risk type: Workforce
Risk appetite: High (open)
Risk rating impact v likelihood
- Current 4 X 4 = 16
- Target 4 x 2 = 8
- Movement
Corresponding risks on the Corporate Risk Register: 5385</td></tr>
<tr><td>On track</td><td>Some slippage</td><td>At risk</td><td>Completed</td><td>- Assurance level Amber</td></tr>
<tr><td colspan="2"><u>Summary update</u>

• We are not recommending any change to the risk score in this update.
• A Reducing Violence and Aggression plan and aligned work on our values is in progress and will reported through the milestone plan.</td><td colspan="3"><u>Milestones in 2025/26 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~~ is in place reported to EMT, People Committee, via WODAG and the health and safety group.
• A fresh review of the Violence and Aggression reduction standards has been commissioned led by a senior clinician reporting to the V&A group to conclude by July 2025
• Survey data regularly reviewed to inform development
• Violence, aggression and sexual safety dashboard in place (July)
• Values into behaviors launched 24th April 2025
• Flu Vaccination targets to be set July 2025
• Pilot Wellbeing interventions commencing</td></tr>
</table>

	• Absence reduction enhanced support plan in place July 2025 • SHSC manager reviewed and new modules • Delivery of WDES/WRES action plans • Delivery of actions to tackle anti-racsim • Deliver improvements in support for disabled trainees • 2025 staff survey results **Milestones completed** • Values delivery group in place from June 2025 • ~~Completion of review of Occupational Health Contract – Annual contract meeting against SLAs held with STH in May 2024. **Achieved**~~ • 6 priority areas of focus identified and delivery plans with milestones in place (recruitment, improving lives monthly award, visuals around sites, supervision / PDRs, meetings and leading and managing) • New and Expectant mothers policy developed • Pregnancy risk assessment panel stood up • Reducing Violence and Aggression policy drafted • Legal briefing on health and safety risk assessment for leaders and managers • New process to sign off policy compliance introduced for assurance • ~~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
- N~~ew~~ 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
- Pregnancy risk assessment panel
- Microsoft form confirming receipt of policy and understanding
- Sexual Safety Charter
- Staff side Recognition ~~refreshe~~d 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

Internal assurance

- Menopause accreditation in place from September 2023
- People strategy (approved March 2023 – March 2026) – 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.

External assurance

- Model Hospital and NHSE/I returns.
- CQC Well-Led.
- Internal audit 360 staff wellbeing audit - *Significant assurance*. We participated as a trailblazer to test out the HWB framework trailblazer (NHSEI) community of good practice. National NHS HWB framework diagnostic – this is an assessment tool and was reported into HWB assurance group and fed into the refreshed delivery plan from 2022/23. Findings have informed the plans for 2024-25.
- Internal Audit absence management – Significant assurance 2025
- The ICS have established a wellbeing roadmap and there are three elements around people, prevention and partnerships this will support the delivery of our health and Wellbeing priorities in the People plan.
- Sexual safety charter –development and oversight provided in partnership with NHS sexual safety and domestic abuse team

Gaps in control	**Actions to address gaps in controls**
~~1. Lack of systems to check quality well-being conversations are happening (although guidance has been issued)~~ 2. Regular reporting on quality of wellbeing conversations	• ~~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.~~ • Supervision quality survey completed and presented to People Committee
~~3. 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**~~
~~4. 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.**~~
5. Development of the wellbeing hub aligned to the priorities of the NHS wellbeing framework assessment	• The wellbeing plan – hub development to be relaunched in line with charities monies.
Gaps in assurance	**Actions to address gaps in assurance**

BAF.0014 There is an increasing risk of ensuring a flexible modern workforce that reflects the workforce market, community we serve to ensure skill mix and retention as well as alignment with strategic priorities and finances.

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STRATEGIC AIMS	**STRATEGIC PRIORITIES**	**Executive lead:** Executive Director of People **Board oversight:** People Committee **Last reviewed** – July 2025. **Next review** September 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 • Deliver outstanding care • Reduce inequalities	• Develop our culture though the 'we are our values' programme. • Develop university trust strategy and partnerships with our universities. • Improve the safety of our staff by reducing violence and aggression and sexual safety incidents. • Continue our journey to become an anti-racist organisation. • Deliver our financial plan of a £4.9m deficit, including achievement of £8m efficiencies. • Become more productive in all parts of our Trust. • Deliver our quality and safety objectives including culture of care, risk assessments, care planning and restrictive practice.	

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

Summary update

There are no recommended changes to the scoring for this risk

Milestones in 2025/26 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).~~
- Workforce plans integrated with Business Plans 25/26

- ~~Review of local reward and benefits offer – March 2024. Included in the 24/25 priority with a target date for Q1. Update expected end 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 Dashboard complete. Full Launch planned XXXXXX

Controls

Governance

- ~~From April 2023 the~~ Workforce Transformation and Recruitment and Retention Group ~~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 WRTG ~~R & R group to oversee People delivery plan – recruitment reporting through the workforce dashboard goes to People Committee~~
- People Plan 2025/26
- 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
- Pre employment and right to work checking

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).~~
- Workforce Recruitment and Transformation group.
- 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/ turnover data provided as part of the People Dashboard ~~review~~ at People Committee bi-monthly.
- People Delivery plan in place for 25/26.
- ~~Improved data and systems to support accurate vacancy in place following work by People and Finance directorates.~~

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.

~~ESR has been updated with funded establishments. This gives workforce the ability to accurately report on vacancies (funded establishment – Staff in post) and means vacancy data can be updated on a daily basis~~. • Internal audit on workforce data quality – received with significant assurance in 2024/25 • Time to hire data cleanse and new national reporting parameters in place	
Gaps in control 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** • **CPD group established chaired by the Executive Director of Nursing to review training needs.** ~~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 ~~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.~~**

BAF 0020 Risk of failure to the organisation of embedding an open culture, and a sense of belonging driven by Trust values and behaviours which result in a lack of inclusion, poor staff experience and negative feedback.

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	**Executive lead:** Executive Director of People **Board oversight:** People Committee **Last reviewed** –July 2025. **Next review** — September 2025 . **Risk type:**Workforce **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 • Reduce inequality	• Develop our culture though the 'we are our values' programme. • Improve the safety of our staff by reducing violence and aggression and sexual safety incidents. • Continue our journey to become an anti-racist organisation. • Deliver our equality objectives	

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

Summary update

- No recommended change to target scoring

Milestones in 2025/26 to support reaching target score:

6 priority areas of focus identified and delivery plans with milestones in place
Recruitment October 25
Improving lives monthly award October 25
Visuals around sites September 25
Supervision / PDRs October 25
Meetings November 25
Leading and managing November 25
Pulse survey July 25
Staff survey launch 1 October – 30 November 25

- ~~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.~~ • Staff survey launch ~~2024 –~~ 2025 October 2025. Results received December 2025 • ~~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.~~ • ~~Developing As Leaders (DAL) Alumni event planned for the Autumn 2024 – date tbc Completed. Held on 09.10.24~~ •

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	**External**
• Staff engagement steering group reports monthly to	• Quality Improvement Group (ICS)

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) 5 cohorts ~~• People Pulse July 2024 results showed an increase in Mood in all 9 Engagement scores. People Pulse surveys quarterly – frequency to be reviewed.~~	• 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~~ published
Gaps in control Review of processes and impact and alignment with safeguarding FTSU	**Actions to address gaps in controls**
~~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. Action CLOSED~~
Gaps in assurance	**Actions to address gaps in assurance**
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~~.

BAF 0028 A risk that we fail to recognise, challenge or respond to tackling all forms of racism and racial inequality and micro-aggression which would mean the Trust is not truly inclusive resulting in racial inequity for people who work in or use Trust services.		
STRATEGIC AIMS. • Deliver outstanding care	**STRATEGIC PRIORITIES** • **Develop our culture though the 'we are our values' programme.**	**Executive lead:** Executive Director of People **Board oversight:** People Committee **Last reviewed** – July 2025. **Next review** – September 2025

• Create a Great Place to Work • Reduce inequalities		• **Improve the safety of our staff by reducing violence and aggression and sexual safety incidents.** • **Continue our journey to become an anti-racist organisation.** • **Deliver our quality and safety objectives, including culture of care, risk assessments, care planning and restrictive practice.**		**Risk type:** Clinical quality and safety **Risk appetite:** High (open) **Risk rating impact v likelihood** - Current 4 X 4 = 16 - Target 2x4 - Movement NEW Corresponding risks on the Corporate Risk Register: 5385	
On track	Some slippage	At risk	Completed	**Assurance level**	**Amber**

Summary update

- This is a new BAF risk.

Milestones in 2025/26 to support reaching target score:

- Engage with stakeholders including the Board and Staff Network groups on completing and submitting our bronze level assessment for the Northwest Anti Racism Framework
- Align action across workforce and service areas to provide a clear plan and framework for reporting progress to Committees and Boards
- Review the national mandated reporting organisation specific WRES report due in October 2025 to assess how SHSC benchmarks against WRES indicators against other mental health trust and the ICB
- Roll out the new ESR reporting portal

Controls

- Anti Racism anti-Discrimination group (Subgroup of the Inclusion and Equality group)
- Workforce Race Equality Standard Reporting to People Committee and Board.
- Workforce EDI dashboard reporting to the Inclusion and Equality Group
- Partnership and Collaborative working with South Yorkshire Police/ the Crown Prosecution Service and Sheffield City Council Hate Crime Initiatives
- Allyship – Managers Programme
- Microaggressions – Managers Programme
- Racialized Trauma – Training
- Reciprocal Mentoring programme – regional
- Reciprocal mentoring – Trust
- Review of Active Bystander
- Ethnically Diverse Staff Network Group including chairs meeting with the Board, policy review groups and Chairs group
- Patient and Carer Race Equality Standard – Action
- Culture of care alignment of action
- Fit To Refer – achieved ahead of target
- Workplace wellbeing proactive support to victims of Racism from service users
- SOP on reporting and responding to hate incidents in place

Internal assurance	**External assurance**
Reduction in WRES metrics on disciplinary rates Fit To Refer – achieved ahead of time Inclusion and Equality Group	2024 Mandated reporting WRES report NHSE National Reporting team ICB
Gaps in control **Governance and outcomes still to be agreed (relates to Keeping our staff safe)**	**Actions to address gaps in control** Keeping our staff safe governance and confirmation of overall plan
Gaps in assurance update • Lack of progress in ethnically diverse staff moving into posts at 8c and above • Staff experience of racism from service users – inconsistent support offered • Staff reluctance to report racism from service users and from other sources	**Actions to address gaps in assurance.** • Deep dive report on lack of progress in ethnically diverse staff moving into posts at 8c and above to be provided to the People Committee with reviewed and updated action plan. • Staff experience of racism from service users – inconsistent support offered – alignment with Violence and Aggression action • staff reluctance to report racism from service users and from other sources – implement the ESR portal to allow for anonymous reporting (in response to the in-patient survey completed in 2024)