Board of Directors Public

SUMMARY REPORT	Meeting Date:	25 May 2022
	Agenda Item:	18

Report Title:	**Board Assurance Framework**	
Author(s):	Amber Wild, Corporate Assurance Manager	
Accountable Director:	Deborah Lawrenson, Director of Corporate Governance	
Other Meetings presented to or previously agreed at:	**Committee/Group:**	People Committee, Quality Assurance Committee, Finance and Performance Committee, Audit and Risk Committee
	Date:	
Key Points:	The Board Assurance Framework is provided for assurance. It was last received at the Board in March 2022. Changes and updates to individual risks are highlighted in bold, italicised text within the register which is attached as an appendix, and a snapshot of the risk register is detailed in the cover report.	

Summary of key points in report

A snapshot of the BAF risks is provided in the report, together with an indication of risk score movement since the previous report.

The full Corporate Risk Register is provided separately and updates that have been added to each risk are shown by bold, italicised text.

All risks highlighted in the summary report have been presented to the appropriate Board subcommittee for discussion and any updates post those discussions reflected.

The full detail of each risk is available in the appendix and progress within each BAF risk has been noted in bold, italicised text.

As the Board is aware a risk review on systems and processes is underway and is due to be received at the Audit and Risk Committee and the Board of Directors in June 2022, after which recommendations will be followed up.

The Board will be receiving and discussing the draft updated BAF for 2022/23 at a Board Development session in June with the updated BAF due to be received at the next public Board meeting in July.

Recommendation for the Board/Committee to consider:

Consider for Action		Approval	X	Assurance	X	Information	

To receive the BAF and consider assurance provided

To note levels of risk reported triangulate with other information considered by Board and its committees
To approve the latest changes to the BAF detailed in the report.

Please identify which strategic priorities will be impacted by this report:				
Covid-19 Recovering effectively	*Yes*	***X***	*No*	
CQC Getting Back to Good- Continuous improvement	*Yes*	***X***	*No*	
Transformation – Changing things that will make a difference	*Yes*	***X***	*No*	
Partnerships – working together to make a bigger impact	*Yes*	***X***	*No*	

Is this report relevant to compliance with any key standards ?					**State specific standard**
Care Quality Commission Fundamental Standards	*Yes*	***X***	*No*		"Systems and processes must be established to ensure compliance with the fundamental standards"
Data Security Protection Toolkit	*Yes*		*No*	***X***	

Have these areas been considered ? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Service User/ Carer Safety and Experience	*Yes*		*No*	***X***	Not directly in relation to this report – specific detail within the BAF for each area
Financial (revenue &capital)	*Yes*		*No*	***X***	
Organisational Development/Workforce	*Yes*		*No*	***X***	
Equality, Diversity & Inclusion	*Yes*		*No*	***X***	
Legal	*Yes*		*No*	***X***	

Section 1: Analysis and supporting detail

BAF Snapshot

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

The BAF is a dynamic document and enables risks to evolve to reflect changing external and internal environments. As such, it is expected that some risks will close over the course of a year once controlled to an acceptable level, or risks may change to reflect emerging issues and priorities.
This has become a feature of BAF reporting since Board considered how it manages risk at successive Board development sessions in February. Risks are now ordered from highest to lowest.

1.2 It should be noted that target risk scores are based within the thresholds of the Risk Appetite Statement agreed by the Board.

1.3

Current Risk Score			Target Risk Score		
Likelihood	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**
BAF.0025: There is a risk that patients could come to harm in our inpatient wards and that inpatient and community environments do not support therapeutic care; **caused by** environments that are not fit for purpose and present unacceptable risks to patient safety; **resulting in** an over reliance on enhanced observations, a restrictive approach to manage safety issues thereby deskilling staff, staff time dedicated to managing environments rather than delivering patient care and giving a very poor patient experience. ⟷					
4	5	20	2	3	6
BAF.0023: There is a risk that we fail to protect service users and staff from the spread of Covid19 infection; **caused** by operational systems and processes staff and patients not adhering to the relevant IPC guidance consistently;**resulting in** preventable spread of infection and risks to health and safety of our staff and the people in our care. ⟷					
5	3	15	4	1	4
BAF.0021: There is a risk that the reliance on legacy systems and technology leads to increasing network or system downtime and cyber security incidents; **caused by** historic system issues requiring complex maintenance, inadequate system monitoring, testing and maintenance, cyber security weaknesses, further development of legacy systems and delays in the procurement and roll out of replacement systems; **resulting in** patient safety and clinical effectiveness being compromised by a loss of access to key clinical and administration systems and data protection incidents. ↓					
4	4	16	1	**2**	**3**
BAF.0014: There is a risk that we fail to attract and retain staff due to competition, reputation issues and the healthcare context, and do not find ways to present a sufficiently attractive, flexible offer of employment; **resulting in** a negative impact on the quality of the workforce and negative indicators for quality of care. ⟷					

4	**4**	**16**	**2**	**3**	**6**
BAF.0013: There is a risk that we fail to identify key cultural and work pressures impacting on staff health and wellbeing, leading to ineffective interventions; **resulting in** low scores on the staff survey (low morale), high sickness absence levels and negative indicators for quality of care.					
4	3	12	2	2	4
BAF.0024: There is a risk that we will be unable to deliver essential improvements in the quality of care in all services within the agreed time frame to comply with the fundamental standards of care; **caused by** leadership changes, short staffing, cultural challenges, the lead in time for significant estates and ISMT actions and the impact of the global pandemic; **resulting in** risk of harm to people in our care and a breach in the Health and Social Care Act					
3	4	12	2	3	6
BAF.0027: There is a risk that engagement with systems partners is ineffective or lacking; caused by weaknesses in partnership relationships or supporting governance arrangements; resulting in a poorer quality of services, missed opportunities and potential costs.					
3	4	12	2	3	6
BAF.0020: There is a risk that we fail to effectively develop and implement a new approach to strengthening leadership and improving the culture of our organization and/or align this with our organisational design; **resulting in** low staff morale, poor service quality and poor staff and service user feedback.					
3	4	12	2	3	6
BAF.0019: There is a risk that our long-term view of workforce planning and/or management of change fails to ensure roles meet future service needs; **resulting in** a disjointed approach and a disengaged workforce (industrial relation issues, increased sickness absence and poor staff retention, poor staff and service user feedback including NHS staff survey results.					
3	4	12	2	3	6
BAF.0022: There is a risk that we fail to deliver a break-even position in 2021/22; **caused by** factors including non-delivery of the financial plan or CIP targets and increased cost pressures; **resulting in** a threat to both our financial sustainability and delivery of our statutory financial duties					
3	3	9	2	2	4
BAF.0026: There is a risk that there is slippage or failure in projects comprising our transformation plans; **caused by** factors including non-delivery of targets by milestones, unanticipated costs arising or lack of sufficient capacity; **resulting in** service quality being compromised by the non-delivery of key strategic projects.					
3	3	9	2	3	6

Summary:

BAF.0021:

- A new control had been added
- Finance and Performance Committee agreed to reduce the risk rating to 3

BAF.0022:

- Action progress updated and risk to be closed for the financial year 2021/22.

BAF.0026:

- This will be raised as a risk to be discussed at May's meeting of the Board within the Therapeutic Environments report and this risk will be updated further following this. Gaps remain with external assurances – this requires further challenge with the risk owners.

BAF.0014:

- deep dive of the risks linked to the strategic aims took place at People Committee. Agreed to include this on the agenda for the Recruitment and Retention group to check the actions and the score. Gaps remain with some internal assurances –this requires further challenge with the risk owners.

BAF.0019:

- Reviewed in May 2022 and action progress updated. There remain some gaps in internal and external assurances.

BAF 0013:

- Reviewed in May 2022 and action progress updated.

BAF.0020:

- No recent review of this risk. There is an upcoming review of overall BAF risks planned for 2022-23 and gaps in internal and external assurances will be challenged.

BAF.0024, BAF 0023 and BAF 0025:

- No recent review. Committee reviewed these risks and agreed to discuss the BAF in detail after the risk review has taken place. All of these risks require a thorough review to ensure gaps in external assurances are in place, and that assurances that have been described are aligned to the corresponding controls.

BAF.0027:

- Further updates have been completed for presentation to Board in this cycle of reporting. The work undertaken is evidenced within the risk register in bold, italicised text. There remain some gaps in controls and assurance with requires further challenge.

Section 2: Risks

2.1 Failure to properly review the BAF could result in Board, or its committees not being fully sighted on key risks to the delivery of our strategic aims and objectives.

2.2 There are no specific corporate risks around usage of the BAF.

Section 3: Assurance

3.1 The information provided within the BAF is owned by Executive Directors and reviewed/revised by colleagues within their directorates under their leadership.

3.2 For the most effective assurance, information provided within the BAF should be considered alongside other sources of information provided to Board and its committees, including other reports received, discussions held and observations at visits. This triangulation will ensure that the BAF represents the assurance that Board and Committee members believe they have received.

Section 4: Implications

Strategic Aims and Board Assurance Framework

4.1 As this committee reviews the full BAF prior to its consideration by Board, all the

Strategic Aims are relevant.

Equalities, diversity and inclusion

4.2 None directly arising from this report.

Culture and People

4.3 None directly arising from this report.

Integration and system thinking

4.4 None directly arising from this report.

Financial

4.5 None directly arising from this report.

Compliance - Legal/Regulatory

4.6 None directly arising from this report.

Section 5: List of Appendices

1. Board Assurance Framework May 2022

BOARD ASSURANCE FRAMEWORK 2021/2022

Sheffield Health and Social Care NHS Foundation Trust

AIM: 1. DELIVER OUTSTANDING CARE	**Strategic Objective:** COVID: Getting Through Safely.

Risk Ref: BAF.0023 **Date Risk Created:** / /	**Details:** There is a risk that we fail to protect service users and staff from the spread of Covid19 infection; caused by operational systems and processes staff and patients not adhering to the relevant IPC guidance consistently; resulting in preventable spread of infection and risks to health and safety of our staff and the people in our care.

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

Risk Rating:	**Impact**	**Likelihood**	**Score**
Residual Risk (with current controls):	5	3	15
Target Risk (after improved controls):	4	1	4

BAF Risk Review Date:
Last Review: 04/03/2022
Next Review: update pending

CONTROLS & MITIGATION		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**			
Controls	**Gaps in Control**	**Internal Assurance**	**External Assurance**	**Negative Assurance OR Gaps in Assurance**	**Assurance Rating**
Implementation of the operational command structure (Bronze, Silver, Gold) Adherence to national guidance for the prevention and control of infection including the guidance on testing, management and treatment of patients. Implementation of robust cleaning schedules. Assessments for staff, vaccine availability and monitoring if uptake. Covid19 clinical advisory group operational. Working Safely Group in place Robust supply of PPE -updated	Ability to influence the uptake of vaccine in some staff. Limited capacity to fill staffing gaps in the event of a major outbreak	Reporting and decision making through Bronze, Silver, Gold command structure. Procurement cell that monitors PPE on a daily basis to ensure a ready supply and to meet Trust needs. Review following Covid19 wave to reflect on learning Infection Control Lead Nurses will lead activity, in the vent of an outbreak to mitigate and prevent further spread of infection.	Daily Situational Report to NHSE/I covering staff absence, number of beds and number of patients with Covid19. Outbreaks and deaths in Trust reported to NHSE/I. Learning from review reported to NHSE/I.	Review following first wave only Gap in Infection Control staffing as a result of staff absence	AMBER

BOARD ASSURANCE FRAMEWORK 2021/2022

Sheffield Health and Social Care NHS Foundation Trust

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Risk Ref: BAF.0023 Date Risk Created: / /	Details: There is a risk that we fail to protect service users and staff from the spread of Covid19 infection; caused by operational systems and processes staff and patients not adhering to the relevant IPC guidance consistently; resulting in preventable spread of infection and risks to health and safety of our staff and the people in our care.

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	**Gaps in Control**	**Internal Assurance**	**External Assurance**	**Negative Assurance OR Gaps in Assurance**	**Assurance Rating**
daily Agile Working policy in place to enable work from home Reduced physical contact between staff and patiens Implementation of current guidance to support visiting in line with national guidance. Incident control centre operational in line with national guidance Robust reporting and management of any outbreaks. 24hr staff absence report to inform resource decisions Individual Risk Assessments monitored by Human Resources Environmental Risk assessments monitored by Health and Safety Team.					
Covid Risk Register in place					RED

BOARD ASSURANCE FRAMEWORK 2021/2022

Sheffield Health and Social Care NHS Foundation Trust

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Risk Ref: BAF.0023

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Details: There is a risk that we fail to protect service users and staff from the spread of Covid19 infection; caused by operational systems and processes staff and patients not adhering to the relevant IPC guidance consistently; resulting in preventable spread of infection and risks to health and safety of our staff and the people in our care.

ACTION PLAN

Details	Progress	Target Date / Responsibility Of:
Critical areas identified and a resilience plan formulated to ensure that these areas remain with sufficient staff to keep them going. Monitored by the staffing absence reporting via a daily staffing review through Bronze command.	Embedded in command structures. New Infection Prevention Control Lead reviewing all IPC arrangements having joined Silver command week commencing 28 February.	04/04/2022 Neil Robertson
Task and Finish Group in place for vaccination rollout to offer the vaccination and the booster to all staff, as they are available. Currently running until the end of March.	Implemented - 94.7% have had 2 doses and 83.1% of staff have received all three Covid19 vaccines; and now starting to think about 4th Booster. -------- Implemented - [number] and now starting to think of 4th Booster	04/04/2022 Neil Robertson
Task and Finish group for vaccination as a condition of deployment set up in December, as per Government legislation.	Concluded and communicated in line with Government guidance.	04/04/2022 Neil Robertson
Review following Omicron wave to incorporate learning and inform future planning.		31/03/2022 Neil Robertson
Interim Infection Control Prevention Lead recruited.	Started on 21 February 2022.	04/04/2022 Neil Robertson

BOARD ASSURANCE FRAMEWORK 2021/2022

Sheffield Health and Social Care NHS Foundation Trust

AIM: 2. CREATE A GREAT PLACE TO WORK | **Strategic Objective:** CQC: Getting Back To Good

Risk Ref: BAF.0024

Date Risk Created: 28/12/2021

Details: There is a risk that we will be unable to deliver essential improvements in the quality of care in all services within the agreed time frame to comply with the fundamental standards of care;
caused by leadership changes, short staffing, cultural challenges, the lead in time for significant estates and ISMT actions and the impact of the global pandemic;
resulting in risk of harm to people in our care and a breach in the Health and Social Care Act

Executive Lead: Executive Director - Nursing & Professions

Risk Type: Quality

Risk Appetite: Low

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

BAF Risk Review Date:
Last Review: 04/03/2022
Next Review: update pending

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	**Gaps in Control**	**Internal Assurance**	**External Assurance**	**Negative Assurance OR Gaps in Assurance**	**Assurance Rating**
Back to Good improvement actions Active recruitment plan with Clinical Lead for recruitment in post from January 2022 Clinical establishment reviews completed and establishments being revised HCSW regional employment programme Implementation of People plan Service lines and IPQR embedded ensuring oversight Triumvirate leadership oversight with additional nursing leadership to support pace of improvements	Three Back to Good improvement actions are delayed Reliance on temporary workforce to cover vacancies, maternity leave and sickness Number of people applying for posts does not match vacancies Increasing rate of turnover in some teams The outcome of the establishment reviews may require consultation to change working patterns for some Tendable not being utilised consistently Difficulty in keeping pace with recruiting to new posts created by investment Covid19 driven absence Lack of impact of the HCSW employment	Back to Good monthly reports EPR monthly programme Board reports ACM monthly Board reports Transformation Board monthly reports Staffing reports to the People Committee IPQR monthly report Progress report on Clinical Establishment Reviews to People and Finance Committees Leadership recovery plans	August 2020 CQC reinspection Quality Board outcomes CCG Quality Review Group scrutiny External consultant appointed to EPR programme Board NHS benchmarking staff data NHS staff surveys CCG performance oversight 6-monthly NRLS reports CCG oversight of serious incident reports	360 audit plan reporting poor compliance with physical health care standards NHS staff survey 2020-21 CCG delays in SI closures Healthwatch report 2020 CQC inspection report February 2020 Delays in full utilisation of Tendable Delay in ratifying NEWS2 policy Delay in agreeing Physical Health care KPI's	AMBER

BOARD ASSURANCE FRAMEWORK 2021/2022

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caused by leadership changes, short staffing, cultural challenges, the lead in time for significant estates and ISMT actions and the impact of the global pandemic;
resulting in risk of harm to people in our care and a breach in the Health and Social Care Act

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			Assurance Rating
Controls	**Gaps in Control**	**Internal Assurance**	**External Assurance**	**Negative Assurance OR Gaps in Assurance**	
Daily safety huddles in quality team Experts by experience All ward manager posts recruited to Organisational development plan implemented Removal of seclusion room on one ward Reducing restrictive intervention strategy implemented with evidence of impact Safe wards in place Dormitories removed Ward Manager and Matron development plan implemented Safeguarding rapid development plan delivered. Clinical and Social Care strategy implemented Co-production standards launched	programme Additional capacity for nursing will take time to have impact Experts by experience have found making an impact in wards a challenge Leadership development as a part of OD programme will begin March 22 Two wards continue to utilise seclusion until new ward environments are available Phase three plan for reducing ligature anchor points will depend on decant solution and take place over an 18 month period. New EPR not yet implemented Absence of team based monthly workforce metrics Inconsistent workforce and finance data Incident and serious incident actions are open Lack of PALS function	Learning lessons quarterly report Complaints report Staffing report to Peoples Committee Safeguarding Q1 &Q2 reports 2020-21 Safeguarding development plan progress reports to Quality Assurance Committee Policy review by Quality Assurance Committee Quarterly reports to Quality Assurance Committee Safer staffing report to Board Jan 22 Community recovery plans for waits in two teams showing progress	CQC inspection reports -outcome of December acute and PICU inspection reported Jan 22 Section 11 Audit with safeguarding partnerships Engagement with Safeguarding partnerships at Executive level	Increased length of stay in inpatient care Increased breaches in ED December/ January 22 Use of 136 suite rooms to accommodate people awaiting admission Continued dissatisfaction from staff side about delays in community transformation Recovery plans not impacting waiting times in EWS/SPA and Recovery for allocation	

BOARD ASSURANCE FRAMEWORK 2021/2022

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CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	**Gaps in Control**	**Internal Assurance**	**External Assurance**	**Negative Assurance OR Gaps in Assurance**	**Assurance Rating**
Quality and Equality impact assessment process in place Ligature anchor pint removal plan phase 1 and 2 are completed, phase three in planning Daily operational management of safer staffing New EPR implementation partner appointed.	RC vacancies Safe wards not fully embedded Granular team base data not yet embedded Lack of data on the accessible information standard	Supervision rate increasing in some teams Completion of the Safeguarding rapid development plan reported to QAC Medicines management rapid development plan completed and reported to QAC Contract for new EPR signed Experienced EPR implementation partner appointed Improving performance with incident actions reported in the IPQR Culture and quality visits			
Year One back to good actions delivered (exception of 3 items	Acute and Picu services subject to further rapid improvements for reassessment	fundamental standards visits to take place across	CQC reinspection during December 2021	impact of staffing/ covid to deliver on actions.	AMBER

BOARD ASSURANCE FRAMEWORK 2021/2022

Sheffield Health and Social Care NHS Foundation Trust

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Risk Ref: BAF.0024

Date Risk Created: 28/12/2021

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resulting in risk of harm to people in our care and a breach in the Health and Social Care Act

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	**Gaps in Control**	**Internal Assurance**	**External Assurance**	**Negative Assurance OR Gaps in Assurance**	**Assurance Rating**
rolled into year two). CQC reinspection demonstrated improvements across Well Led and Older Peoples services	during December	PICU and Adult wards.			
Contract in place and programme established to implement a new commercially supported EPR		EPR Programme Board chaired by COO. Programme Board reports to Transformation Board	NHS E/I funding required external reporting		GREEN

ACTION PLAN

Details	Progress	Target Date / Responsibility Of:
Back to Good year two programme underway to complete delivery of action plan to maintain improvements and deliver rapid improvements across Acute and PICU	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 development and will be returned back to CQC by 13 March 2022.	31/03/2023 Salli Midgley
ongoing monitoring of Covid impact on improvement actions through command structure and regular review at Board	This remains ongoing. The Command Structure is still in place whilst NHS England deem the pandemic remains a Level 4 national incident, together with the Incident Control Centre that acts as a single point of contact for all incoming guidance to	31/12/2022 Beverley Murphy

BOARD ASSURANCE FRAMEWORK 2021/2022

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resulting in risk of harm to people in our care and a breach in the Health and Social Care Act

Date Risk Created: 28/12/2021

ACTION PLAN

Details	Progress	Target Date / Responsibility Of:
	interpret and cascade as appropriate, reporting in to Silver and Gold groups. The Trust response is updated regularly through reports to Board.	
Ward manager and matron development plan agreed for Q4 20/21 and Q1 21/22 to enhance leadership skills and cultural development	Development programme has been procured, date set and communication to ward managers will take place next week.	30/06/2022 Salli Midgley
Renewed recruitment plan of international recruitment to recruit 20 new staff within 12 months (by March 2023), with first cohort of interviews to begin March 2022	Interviews held on Monday 4 April and conditional offers made to two candidates. Further interviews booked for 5 May 2022. HR recruitment officer has been recruited and they started in post in 4 April. NHSP being used and agreement in place to use an external agency as an additional recruitment support and to provide OCSE training. -------- International recruitment interviews are planned for 4th and 25th March. OCSE training package has been sourced with GTEC. Regular updates with NHSP (once every 2 weeks). Offer letter is being reviewed by HR to give to NHSP by 1 March 2022. Accommodation is being sourced for potential new recruits. Staff and accommodation for job fairs, are all in place. Relocation package offer has been written and approved. Advertisement banners have been secured.	31/03/2023 Joanne Simms

BOARD ASSURANCE FRAMEWORK 2021/2022

Sheffield Health and Social Care NHS Foundation Trust

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caused by leadership changes, short staffing, cultural challenges, the lead in time for significant estates and ISMT actions and the impact of the global pandemic;
resulting in risk of harm to people in our care and a breach in the Health and Social Care Act

Date Risk Created: 28/12/2021

ACTION PLAN

Details	Progress	Target Date / Responsibility Of:
	Training offers for potential recruits are being finalised.	
Renewed recruitment plan of national job fairs with 4 sessions planned on 12 March 2022, 26 March 2022, 19 April 2022 and 23 April 2022.	Two recruitment fairs completed - two leads only for mental health nurses out of the two fairs National Fairs booked for September and October. -------- Travel booked for 12th March fair in Dublin. Further fairs are being booked for September & October.	31/10/2022 Joanne Simms
Ligature Anchor Point Phase 3 work with indicative dates for contractor appointment starting in May 2022, start of work on site by June 2022 and completion of final work expected by November 2022.	The refurbishment works on Burbage continue as planned with an anticipated completion date of 1 June 2022. As part of this programme of works Stanage dormitories have been eradicated, this was completed on 3 December 2021. The LAP eradication programme is well underway; Phase 1 was completed in July/August 2021 (works comprised the improvement to themes such blind spot mirrors, ceiling vents, curtain/blind/rails and light fittings); Phase 2 works are targeted to be completed by 31 March 2022 (works on 'live' wards comprise bedrooms; door, window & furniture followed by non-bedroom areas: doors & windows). Phase 3 works are currently being programmed to commence July 2022 (works will target al remaining LAP works such as ensuites, selective replacement of ceilings etc., and formation of new de-escalation rooms in lieu of seclusion).	30/11/2022 Richard Scott

BOARD ASSURANCE FRAMEWORK 2021/2022

Sheffield Health and Social Care NHS Foundation Trust

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Risk Ref: BAF.0024 **Date Risk Created:** 28/12/2021	**Details:**	There is a risk that we will be unable to deliver essential improvements in the quality of care in all services within the agreed time frame to comply with the fundamental standards of care; caused by leadership changes, short staffing, cultural challenges, the lead in time for significant estates and ISMT actions and the impact of the global pandemic; resulting in risk of harm to people in our care and a breach in the Health and Social Care Act

ACTION PLAN

Details	Progress	Target Date / Responsibility Of:
SHSC leadership development plan is being implemented with the first co-designed programme cohort commencing on 28 February 2022 until 11 July 2022. Programme progress is reported into Transformation Board		31/07/2022 Caroline Parry

BOARD ASSURANCE FRAMEWORK 2021/2022

Sheffield Health and Social Care NHS Foundation Trust

AIM: 2. CREATE A GREAT PLACE TO WORK | **Strategic Objective:** CQC: Getting Back To Good

Risk Ref: BAF.0025

Date Risk Created: 11/05/2021

Details: There is a risk that patients could come to harm in our inpatient wards and that inpatient and community environments do not support therapeutic care;
caused by environments that are not fit for purpose and present unacceptable risks to patient safety; resulting in an over reliance on enhanced observations, a restrictive approach to manage safety issues thereby deskilling staff, staff time dedicated to managing environments rather than delivering patient care and giving a very poor patient experience.

Executive Lead: Executive Director - Nursing & Professions

Risk Type: Safety

Risk Appetite: Low

Risk Rating:	Impact	Likelihood	Score
Residual Risk (with current controls):	5	4	20
Target Risk (after improved controls):	3	2	6

BAF Risk Review Date:
Last Review: 18/05/2022
Next Review: 17/06/2022

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	**Gaps in Control**	**Internal Assurance**	**External Assurance**	**Negative Assurance OR Gaps in Assurance**	**Assurance Rating**
Enhanced nursing to manage environmental risks Implementation of new roles (ACP/TNA) Implementation of Least Restrictive Strategy 2021 Revised approach to Clinical Risk Management Investment in preceptorship to develop the skills of newly registered nurses Ligature anchor point assessments in place for all environments Risk heat map implemented for all inpatient wards	High levels of Band 5 vacancies in some wards Use of temporary staffing leading to potential inconsistencies in the application of practice standards Clinical establishment reviews not current Least restrictive Strategy 2021 not yet embedded New Clinical Risk Management policy and training not yet implemented Preceptorship approach not evaluated Variance in staff understanding of ligature anchor point assessment Use of temporary staff Limitations in current approach to clinical	Staffing report to the People Committee reducing Restrictive practice update to the Quality and Assurance committee IPQR monthly report to Quality Assurance Committee Learning Lessons Quarterly reports Health and Safety reports Mandatory Health and Safety training Ligature anchor point progress reported to the	Evidence based approach to Reducing Restrictive practice implementation	February 2020 CQC inspection report	RED

BOARD ASSURANCE FRAMEWORK 2021/2022

Sheffield Health and Social Care NHS Foundation Trust

AIM: 2. CREATE A GREAT PLACE TO WORK | **Strategic Objective:** CQC: Getting Back To Good

Risk Ref: BAF.0025

Date Risk Created: 11/05/2021

Details: There is a risk that patients could come to harm in our inpatient wards and that inpatient and community environments do not support therapeutic care;
caused by environments that are not fit for purpose and present unacceptable risks to patient safety; resulting in an over reliance on enhanced observations, a restrictive approach to manage safety issues thereby deskilling staff, staff time dedicated to managing environments rather than delivering patient care and giving a very poor patient experience.

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	**Gaps in Control**	**Internal Assurance**	**External Assurance**	**Negative Assurance OR Gaps in Assurance**	**Assurance Rating**
Substantive managers for all wards Ward manager development programme Implementation of Matrons and Team Managers with a focused span and clear responsibilities April 2021 Planned environmental improvements to the acute wards Planned environmental improvements to the crisis hub Estate strategy that determines future need for community and ward estates that enables therapeutic and safe care	risk assessment and management Environmental safety work not yet completed variance in management capability and experience Vacancies for responsible clinicians Ward Manager programme to commence in April 2021 Development of nurses into new Matron roles Delays in the delivery of Therapeutic Environment Programme (TEP) Crisis hub building handover not until May 2021	Quality Assurance committee Capital Group reports Operational Structure presentation to the People Committee Therapeutic Environment Programme Board reports Transformation Board reports Health and Safety audits IPQR monthly reports - statutory and mandatory training Board and Executive visits to all wards and teams Crisis Pathway presentation to the Quality Assurance committee March 2021			

BOARD ASSURANCE FRAMEWORK 2021/2022

Sheffield Health and Social Care NHS Foundation Trust

AIM: 2. CREATE A GREAT PLACE TO WORK	Strategic Objective: CQC: Getting Back To Good

Risk Ref: BAF.0025 **Details:** There is a risk that patients could come to harm in our inpatient wards and that inpatient and community environments do not support therapeutic care;
caused by environments that are not fit for purpose and present unacceptable risks to patient safety; resulting in an over reliance on enhanced observations, a restrictive approach to manage safety issues thereby deskilling staff, staff time dedicated to managing environments rather than delivering patient care and giving a very poor patient experience.

Date Risk Created: 11/05/2021

ACTION PLAN

Details	Progress	Target Date / Responsibility Of:
The ward works improvement programme (overseen by the Therapeutic Environments Programme Board) has commenced with the agreed works on Burbage Ward which commenced w/c 12 July 2021. Includes full eradication of LAPs. Consideration is being to how the ward improvements programme can be accelerated either via work on live wards or via acquisition (subject to funding) of a modular decant ward. An interim Project Director has been set on to manage the LAP eradication programme in particular.	Gaps in controls amended as 1) Dovedale 2 ward was reopened for admissions; and 2) the Trust now has a Board approved Estates Strategy ---------- The refurbishment works on Burbage continue as planned with an anticipated completion date of 1 June 2022. As part of this programme of works Stanage dormitories have been eradicated, this was completed on 3 December 2021. The LAP eradication programme is well underway; Phase 1 was completed in July/August 2021 (works comprised the improvement to themes such blind spot mirrors, ceiling vents, curtain/blind/rails and light fittings); Phase 2 works are targeted to be completed by 31 March 2022 (works on 'live' wards comprise bedrooms; door, window & furniture followed by non-bedroom areas: doors & windows). Phase 3 works are currently being programmed to commence July 2022 (works will target al remaining LAP works such as ensuites, selective replacement of ceilings etc., and formation of new de-escalation rooms in lieu of seclusion).	31/07/2022 Richard Scott

BOARD ASSURANCE FRAMEWORK 2021/2022

Sheffield Health and Social Care NHS Foundation Trust

AIM: 3. IMPROVE OUR USE OF RESOURCES | **Strategic Objective:** Transformation: Changing Things That Will Make A Difference

Risk Ref: BAF.0013 **Details:** There is a risk that we fail to identify key cultural and work pressures impacting on staff health and wellbeing, leading to ineffective interventions; resulting in low scores on the staff survey (low morale), high sickness absence levels and negativ indicators for quality of care

Date Risk Created: 07/05/2021

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

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

BAF Risk Review Date:
Last Review: 18/05/2022
Next Review: 17/06/2022

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	**Gaps in Control**	**Internal Assurance**	**External Assurance**	**Negative Assurance OR Gaps in Assurance**	**Assurance Rating**
Staff Health and Wellbeing group monitoring delivery of the People Strategy and reporting to the People Committee ICS HRD Deputy Network ICS staff Health and Wellbeing Group National Wellbeing Guardian Network Flu and Covid19 Campaigns	Identified some engagement groups that are not part of the Health and Wellbeing group Accessibility and membership of Covid19 support offer	Report to the People Committee Report to the Transformation Board	Model Hospital and NHSE/I returns CQC Well-Led 360 staff wellbeing audit	None	GREEN
People Delivery Plan in place Reports to SHWB group NHS People plan and actions for HR and OD	Inpatient area focus	Reports to People Committee	CQC Well-Led Internal Audit (360 assurance) focusing on Wellbeing	recommendations on governance to record completion of action ,milestones (people delivery plan which is being refreshed February 2022)	AMBER

BOARD ASSURANCE FRAMEWORK 2021/2022

Sheffield Health and Social Care NHS Foundation Trust

AIM: 3. IMPROVE OUR USE OF RESOURCES | **Strategic Objective:** Transformation: Changing Things That Will Make A Difference

Risk Ref: BAF.0013 **Details:** There is a risk that we fail to identify key cultural and work pressures impacting on staff health and wellbeing, leading to ineffective interventions; resulting in low scores on the staff survey (low morale), high sickness absence levels and negativ indicators for quality of care

Date Risk Created: 07/05/2021

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	**Gaps in Control**	**Internal Assurance**	**External Assurance**	**Negative Assurance OR Gaps in Assurance**	**Assurance Rating**
HWB Framework in place NHSEI National Wellbeing Lead and ICS Wellbeing group National NHS HWB framework diagnostic	Self-assessment has limited clinical operations input	Reports to People Committee	Health and Wellbeing trailblazer (NHSE/I)	Need to establish regular reassessment	AMBER

ACTION PLAN

Details	Progress	Target Date / Responsibility Of:
HWB network to be established. proposal to HWB group February 2022	***Sally Hockey has picked up HWB activity leadership supported by David Palfreyman*** -------- Proposals discussed at HWB group. action plan in development, feedback given and second proposal and plan in prep	31/05/2022 Sarah Bawden
Embed Wellbeing Conversations	***delayed due to capacity and access to training*** -------- Booked 4 training (train the trainer) places (date TBC SH) expect to roll out training for managers once complete. roll out plan will be developed and will support toolkit already shared with all staff through JARVIS.	30/06/2022 Sarah Bawden

BOARD ASSURANCE FRAMEWORK 2021/2022

Sheffield Health and Social Care NHS Foundation Trust

AIM: 3. IMPROVE OUR USE OF RESOURCES	**Strategic Objective:** Transformation: Changing Things That Will Make A Difference

Risk Ref: BAF.0013 **Date Risk Created:** 07/05/2021	**Details:**	There is a risk that we fail to identify key cultural and work pressures impacting on staff health and wellbeing, leading to ineffective interventions; resulting in low scores on the staff survey (low morale), high sickness absence levels and negativ indicators for quality of care

ACTION PLAN

Details	Progress	Target Date / Responsibility Of:
OH Health respecification (engagement with staff and specification development) and tender (previously in action 9174)	***Engagement with staff in 20/21 received feedback for new service requirements. Sub group of the HWB group revised specification (SQOHS) and engaged with procurement to tender (Find my Tender). Delays in submission of the tender due to staffing shortages in procurement. Nicola Woodhead to extend current contract to endJune 2022***	30/06/2022 Sarah Bawden
Revisit membership of HWB to ensure all groups represented	***to be reviewed at HWB assurance group 19/5/22*** -------- Action for HWB group 28/2 to confirm membership and invite additional groups / confirm escalation arrangements with groups	31/05/2022 Sarah Bawden
Benchmark against national good practice for reassessment against th ecriteria and report to HWB Assurance Group	***Reports updating HWB group to each assurance group next report to PC July*** -------- Taking part in the trailblazer programme	30/06/2022 Sarah Bawden

BOARD ASSURANCE FRAMEWORK 2021/2022

Sheffield Health and Social Care NHS Foundation Trust

AIM: 3. IMPROVE OUR USE OF RESOURCES | **Strategic Objective:** Transformation: Changing Things That Will Make A Difference

Risk Ref: BAF.0014 **Details:** There is a risk that we fail to attract and retain staff due to competition, reputation issues and the healthcare context, and do not find ways to present a sufficiently attractive, flexible offer of employment; resulting in a negative impact on the quality of the workforce and negative indicators for quality of care

Date Risk Created: 07/05/2021

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

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

BAF Risk Review Date:
Last Review: 18/05/2022
Next Review: 17/06/2022

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	**Gaps in Control**	**Internal Assurance**	**External Assurance**	**Negative Assurance OR Gaps in Assurance**	**Assurance Rating**
WPG monitoring delivery and reporting to People Committee GAP Recruitment group (Nursing) Weekly reporting on vacancies for HCSW to meet funding specification. TRAC reports feed into R&R group and People Committee reporting on progress Recruitment and Retention Group to oversee delivery plan Review of Delivery plan for 20/23 to be signed off at People Committee March 2022	GAP Recruitment group focused on Nursing and HCSW only. Terms of Reference for Day One Ready require review to ensure they are broad enough		ICS Recruitment and Retention group		AMBER
Recruitment and retention Assurance Group to support identification of gaps	Data to support accurate vacancy reporting being addressed with People Directorate and Finance.	Recruitment and Retention Group reports to People Committee quarterly and			GREEN

BOARD ASSURANCE FRAMEWORK 2021/2022

Sheffield Health and Social Care NHS Foundation Trust

AIM: 3. IMPROVE OUR USE OF RESOURCES | **Strategic Objective:** Transformation: Changing Things That Will Make A Difference

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Date Risk Created: 07/05/2021

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	**Gaps in Control**	**Internal Assurance**	**External Assurance**	**Negative Assurance OR Gaps in Assurance**	**Assurance Rating**
		additionally as requested			
HCSW and Recruitment Cell weekly meeting with NHSEI (+ Direct support)	Not all staff groups covered at this stage	Recruitment and Retention group	NHSEI Performance Workforce Returns + Direct support		GREEN
TRAC system in place to manage ALL recruitment	users require additional training and support	Reports to Recruitment and Retention Assurance Group and People Committee	NHSEI and PWR reporting which triangulates and checks our data	ESR data quality poor	AMBER
Nurse Recruitment group established to review attraction initiatives	Membership needs to be reviewed	Report to Recruitment and retention Group	PWR reporting and NHSEI governance for International Recruitment		GREEN

ACTION PLAN

Details	Progress	Target Date / Responsibility Of:
Improve workforce data quality Create a robust system that monitors vacancy rates . Cleanse data in ESR Agree simplified codes for recording job roles	***HCSW and Nursing vacancy data complete. Finance and Workforce leads havedeveloped a plan for data quality improvement*** ---------- Finance and Workforce developing improvement plan for vacancy rate data. Additional resource employed to ensure accuracy of ESR input Costs requested from Payroll for direct input of pay effecting changes	30/06/2022 Sarah Bawden

BOARD ASSURANCE FRAMEWORK 2021/2022

Sheffield Health and Social Care NHS Foundation Trust

AIM: 3. IMPROVE OUR USE OF RESOURCES | **Strategic Objective:** Transformation: Changing Things That Will Make A Difference

Risk Ref: BAF.0014 **Details:** There is a risk that we fail to attract and retain staff due to competition, reputation issues and the healthcare context, and do not find ways to present a sufficiently attractive, flexible offer of employment; resulting in a negative impact on the quality of the workforce and negative indicators for quality of care

Date Risk Created: 07/05/2021

ACTION PLAN

Details	Progress	Target Date / Responsibility Of:
Review of transactional processes using established microsystem looking at onboarding and Day One Ready initiative	***Day one Ready Microsystem will now encompass all employee lifecycle activities anrenamed Employee Lifecycle microsystem*** -------- Transactional process workshop october 2021. Input to People directorate review to align transactional processes with directorate and provide greater line of sight	d30/06/2022 Sarah Bawden
Training and further guidance for recruiting managers on TRAC	***Training provided by Recruitment Manager. Ongoing and rolling programme of bitesize training and review of training so far being undertaken as part of benefitsrealisation programme*** -------- Costs for training being sought from TRAC	30/06/2022 Sarah Bawden
Recruit first cohorts of International Nurses (x20) by February 2023 at the latest.	Recruited nurse recruitment lead Contracted with NHSP to recruit nurses Interviews planned for March OSCE training packages sources Paper to BPG 15.2 and costs approved Monthly meetings with NHSEI to review progress	28/02/2023 Sarah Bawden

BOARD ASSURANCE FRAMEWORK 2021/2022

Sheffield Health and Social Care NHS Foundation Trust

AIM: 3. IMPROVE OUR USE OF RESOURCES | **Strategic Objective:** Transformation: Changing Things That Will Make A Difference

Risk Ref: BAF.0019 **Details:** There is a risk that our long-term view of workforce planning and/or management of change fails to ensure roles meet future service needs; resulting in a disjointed approach and a disengaged workforce (industrial relation issues, increased sickness absence and poor staff retention, poor staff and service user feedback including NHS staff survey results

Date Risk Created: 01/04/2021

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

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

BAF Risk Review Date:
Last Review: 04/05/2022
Next Review: 03/06/2022

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	**Gaps in Control**	**Internal Assurance**	**External Assurance**	**Negative Assurance OR Gaps in Assurance**	**Assurance Rating**
Workforce planning and transformation group monitoring delivery and reporting to People Committee	Workforce plan still in progress			Committee governance has been under review and although now agreed templates, action log and planner still to be fully implemented	AMBER
Annual Learning Needs Analysis undertaken to inform Trust Training Plan priorities for investment (dependent on agreement for centralised training budget to align with delivery needs and strategic aims - Centralised training budget agreed at BPG 6 April 2021 Workforce Planning Group	New process needs study leave policy update to reflect changes - due July 2022	***workforce assurance group***		***Implementation of trainingbudget not possible and will not address unmet training needs - new process for 22/23 to measure impact and risks***	AMBER

BOARD ASSURANCE FRAMEWORK 2021/2022

Sheffield Health and Social Care NHS Foundation Trust

AIM: 3. IMPROVE OUR USE OF RESOURCES | **Strategic Objective:** Transformation: Changing Things That Will Make A Difference

Risk Ref: BAF.0019 **Details:** There is a risk that our long-term view of workforce planning and/or management of change fails to ensure roles meet future service needs; resulting in a disjointed approach and a disengaged workforce (industrial relation issues, increased sickness absence and poor staff retention, poor staff and service user feedback including NHS staff survey results

Date Risk Created: 01/04/2021

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	**Gaps in Control**	**Internal Assurance**	**External Assurance**	**Negative Assurance OR Gaps in Assurance**	**Assurance Rating**
Regular monitoring by People Committee of development of new roles to align roles with future organisational service need.	Not in place yet				AMBER
Developing a career pathway for support workers - business case agreed September 21. Project board in place and membership and TOR agreed	***project officer - failure to recruit a suitablecandidate - 3rd attempt at advertising - JD/Ps amended***	***Project board reporting to workforce assurance group***			AMBER
Ensure the apprenticeship levy is fully utilised and prioritised for new roles/progression pathways for existing staff and that we meet our public sector apprenticeship targets	***contracts with training providers for new apprenticeships delayed due to capacity inprocurement team.*** ***some levy remains unutilised***	***Workforce assurance group***	***ICS benchmarking data***		AMBER

ACTION PLAN

Details	Progress	Target Date / Responsibility Of:
Implement performance report for workforce planning and transformation group	***regional dashboard in development . SHSC dashboard scope to be agreed - May-andwork to commence in June.***	31/05/2022 Karen Dickinson

BOARD ASSURANCE FRAMEWORK 2021/2022

Sheffield Health and Social Care NHS Foundation Trust

AIM: 3. IMPROVE OUR USE OF RESOURCES	**Strategic Objective:** Transformation: Changing Things That Will Make A Difference

Risk Ref: BAF.0019	**Details:**	There is a risk that our long-term view of workforce planning and/or management of change fails to ensure roles meet future service needs; resulting in a disjointed approach and a disengaged workforce (industrial relation issues, increased sickness absence and poor staff retention, poor staff and service user feedback including NHS staff survey results
Date Risk Created: 01/04/2021		

ACTION PLAN

Details	Progress	Target Date / Responsibility Of:
	-------- ***Attain commissioned to develop dashboard and work commenced April 2022***	

BOARD ASSURANCE FRAMEWORK 2021/2022

Sheffield Health and Social Care NHS Foundation Trust

AIM: 3. IMPROVE OUR USE OF RESOURCES | **Strategic Objective:** Transformation: Changing Things That Will Make A Difference

Risk Ref: BAF.0020 **Details:** There is a risk that we fail to effectively develop and implement a new approach to strengthening leadership and improving the culture of our organization and/or align this with our organisational design resulting in low staff morale, poor service quality and poor staff and service user feedback

Date Risk Created: 01/04/2021

Executive Lead: Director Of Human Resources
Risk Type: Quality
Risk Appetite: Low

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

BAF Risk Review Date:
Last Review: 25/02/2022
Next Review: Update pending

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	**Gaps in Control**	**Internal Assurance**	**External Assurance**	**Negative Assurance OR Gaps in Assurance**	**Assurance Rating**
NHSi Culture and Leadership framework (CLP) to underpin the SHSC Leadership and Culture development programmes Reporting to People Committee Staff Survey Steering Group established to increase engagement and reporting to People Committee NHSi framework National and Regional People Plan	Culture champions to be aligned with NHSi Culture and Leadership programme Mechanism needs to be in place to gather and consolidate (triangulate) all staff data and themes			Pace in decision making Sufficient and right level of resource to deliver	AMBER
22/23 Refreshed People delivery plan (Organisation Development Framework)	plan to be presented for final approval by Board in March 2022	People Committee to receive refreshed deliverables in March 2022 People Pulse staff survey	NHS National Staff survey - amalgamated benchmarking across sector NHS People Plan		AMBER

BOARD ASSURANCE FRAMEWORK 2021/2022

Sheffield Health and Social Care NHS Foundation Trust

AIM: 3. IMPROVE OUR USE OF RESOURCES | **Strategic Objective:** Transformation: Changing Things That Will Make A Difference

Risk Ref: BAF.0020 **Details:** There is a risk that we fail to effectively develop and implement a new approach to strengthening leadership and improving the culture of our organization and/or align this with our organisational design resulting in low staff morale, poor service quality and poor staff and service user feedback

Date Risk Created: 01/04/2021

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	**Gaps in Control**	**Internal Assurance**	**External Assurance**	**Negative Assurance OR Gaps in Assurance**	**Assurance Rating**
Team SHSC: Developing as Leaders (Leadership Development Programme)	Maximum capacity 30 per cohort. First cohort 28 and roll out will follow Lack of data to support identification of eligible leaders	Transformation Portfolio Board oversees progress and reports monthly to the Finance and Performance Committee	Arden & GEM (Arden and Greater East Midlands Commissioning support unit) external provider	Roll out project plan	GREEN
SHSC Leadership Meeting (Monthly MS Teams Leaders call) for all Leaders and Aspiring Leaders	self identified participation. Lack of data to identify eligible leaders	Led by and Agenda approved by CEO	National Staff Survey results 2020 - Staff engagement scores	not aware of external benchmarking Low engagement scores and low completion rates	GREEN

ACTION PLAN

Details	Progress	Target Date / Responsibility Of:

BOARD ASSURANCE FRAMEWORK 2021/2022

Sheffield Health and Social Care NHS Foundation Trust

AIM: 3. IMPROVE OUR USE OF RESOURCES	Strategic Objective: Transformation: Changing Things That Will Make A Difference		
Develop a framework for Organisation Development	Head of OD commenced 10th January 2022. Recruitment to OD and Leadership team has commenced Refreshed delivery plan proposes key elements of OD Framework : Leadership development, management Development, Team Development, Talent Development , Refreshed Values rollout, Just and Learning Culture and staff engagement. People Committee 8th March 2022 -------- Appointed Head of Organisation Development and Leadership commences 10/1/22.	31/03/2022	Caroline Parry

BOARD ASSURANCE FRAMEWORK 2021/2022

Sheffield Health and Social Care NHS Foundation Trust

AIM: 3. IMPROVE OUR USE OF RESOURCES	**Strategic Objective:** Transformation: Changing Things That Will Make A Difference

Risk Ref: BAF.0020 **Date Risk Created:** 01/04/2021	**Details:**	There is a risk that we fail to effectively develop and implement a new approach to strengthening leadership and improving the culture of our organization and/or align this with our organisational design resulting in low staff morale, poor service quality and poor staff and service user feedback

ACTION PLAN

Details	Progress	Target Date / Responsibility Of:
Co design leadership development programme with Arden and GEM	Co-Design group will track alongside Cohort delivery until July 2022 when group wi l reform to an internal delivery group. Evaluation of Co-design and other informatior in August to inform future group TOR Co Design work continuing to January 2022	31/08/2022 Caroline Parry
Refreshed SHSC values to underpin cultural vision	Values were approved by Board in September 2021 and communicated via JARVIS and discussed at Autumn away days. Staff side session held in January 2022. Implementation plan to be developed to embed refreshed values within core People Directorate functions. For example recruitment and PDR	31/05/2022 Sarah Bawden

BOARD ASSURANCE FRAMEWORK 2021/2022

Sheffield Health and Social Care NHS Foundation Trust

AIM: 3. IMPROVE OUR USE OF RESOURCES | **Strategic Objective:** Transformation: Changing Things That Will Make A Difference

Risk Ref: BAF.0021

Date Risk Created: 07/05/2021

Details: There is a risk that the reliance on legacy systems and technology leads to increasing network or system downtime and cyber security incidents;
caused by historic system issues requiring complex maintenance, inadequate system monitoring, testing and maintenance, cyber security weaknesses, further development of legacy systems and delays in the procurement and roll out of replacement systems;
resulting in patient safety and clinical effectiveness being compromised by a loss of access to key clinical and administration systems and data protection incidents

Executive Lead: Executive Director Of Finance

Risk Type: Quality

Risk Appetite: Low

Risk Rating:	**Impact**	**Likelihood**	**Score**
Residual Risk (with current controls):	4	4	16
Target Risk (after improved controls):	***2***	***1***	***3***

BAF Risk Review Date:
Last Review: 02/05/2022
Next Review: 01/06/2022

CONTROLS & MITIGATION		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**			
Controls	**Gaps in Control**	**Internal Assurance**	**External Assurance**	**Negative Assurance OR Gaps in Assurance**	**Assurance Rating**
Governance controls in place via new EPR Programme Board which meets monthly	None - comprehensive programme governance structure for implementation being put in place.	Reporting into Programme Board with oversight by Trust Transformation Board EPR system has been procured with contracts signed in January 2022. trust wide go live will be via a number of phases and is due to commence in April 2023.	New EPR consultancy engaged to take us through implementation phase. Unified Tech Fund commits Trust to provide 'blueprints' (good practice for EPR functionality) as part of implementation.	None	GREEN
Governance controls in place via Data and Information Governance Group (DIGG) which meets every 2 months		Reporting to Audit and Risk Committee	Annual Data Security Protection Toolkit (DSPT) audit moderate assurance rating received.	Improvement plan in place for DSPT audit	GREEN

BOARD ASSURANCE FRAMEWORK 2021/2022

Sheffield Health and Social Care NHS Foundation Trust

AIM: 3. IMPROVE OUR USE OF RESOURCES | **Strategic Objective:** Transformation: Changing Things That Will Make A Difference

Risk Ref: BAF.0021

Date Risk Created: 07/05/2021

Details: There is a risk that the reliance on legacy systems and technology leads to increasing network or system downtime and cyber security incidents;
caused by historic system issues requiring complex maintenance, inadequate system monitoring, testing and maintenance, cyber security weaknesses, further development of legacy systems and delays in the procurement and roll out of replacement systems;
resulting in patient safety and clinical effectiveness being compromised by a loss of access to key clinical and administration systems and data protection incidents

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	**Gaps in Control**	**Internal Assurance**	**External Assurance**	**Negative Assurance OR Gaps in Assurance**	**Assurance Rating**
Digital Strategy approved by Trust Board on 24/11/2021 defines a plan and roadmap for improved technology services and sustainability	Assessment and plan for full resourcing and affordability not currently in place	Digital Strategy Group - meets every 2 months and reports to FPC	None	None at this time	AMBER
Board membership of EPR Programme includes 3rd party EPR supplier, 3rd party deployment consultations, CCIO, CSO and Chair of ICS Digital Delivery Board.	Focus to date has been on EPR Programme, but other digital change is also covered under this risk. Actions listed provide route to expand the controls and further actions to make the required progress	Highlight reports at Transformation Board	None	None at this time	AMBER
IMST continue to retire old systems and improve cyber security in line with the guidance provided by the data protection and security toolkitmaking good progress to meeting the standard.	***Four elements of DSPT still to be achieved,the relevant risks are being tracked.***	***DSPT audit. Internal audit have provided support around penetration testing.***	***DSPT submission as part ofnational reporting***		AMBER

BOARD ASSURANCE FRAMEWORK 2021/2022

Sheffield Health and Social Care NHS Foundation Trust

AIM: 3. IMPROVE OUR USE OF RESOURCES	**Strategic Objective:** Transformation: Changing Things That Will Make A Difference

Risk Ref: BAF.0021

Date Risk Created: 07/05/2021

Details: There is a risk that the reliance on legacy systems and technology leads to increasing network or system downtime and cyber security incidents;
caused by historic system issues requiring complex maintenance, inadequate system monitoring, testing and maintenance, cyber security weaknesses, further development of legacy systems and delays in the procurement and roll out of replacement systems;
resulting in patient safety and clinical effectiveness being compromised by a loss of access to key clinical and administration systems and data protection incidents

ACTION PLAN

Details	Progress	Target Date / Responsibility Of:
Mandate and business case for increased staffing resource in IMST in progress	***Final decisions by BPG still pending. Action target date updated.*** -------- Mandate submitted awaiting decisions from Business Planning Group	31/05/2022 Andrew Male

BOARD ASSURANCE FRAMEWORK 2021/2022

Sheffield Health and Social Care NHS Foundation Trust

AIM: 3. IMPROVE OUR USE OF RESOURCES | **Strategic Objective:** Transformation: Changing Things That Will Make A Difference

Risk Ref: BAF.0022 **Details:** There is a risk that we fail to deliver a break-even position in 2021/22; caused by factors including non-delivery of the financial plan or CIP targets and increased cost pressures; resulting in a threat to both our financial sustainability and delivery of our statutory financial duties

Date Risk Created: 07/05/2021

Executive Lead: Executive Director Of Finance
Risk Type: Statutory
Risk Appetite: Zero

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

BAF Risk Review Date:
Last Review: 17/05/2022
Next Review: 16/06/2022

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	**Gaps in Control**	**Internal Assurance**	**External Assurance**	**Negative Assurance OR Gaps in Assurance**	**Assurance Rating**
Operational plan; financial planning, including CIP planning, processes and delivery monitoring Performance Framework	Sophisticated CIP planning process and identification of a full CIP plan	Monthly financial reporting to Team to Board Performance Framework meetings and recovery plans	NHS E&I Financial Review	Full CIP plan 100% recurrently identified Robust CIP processes	AMBER

ACTION PLAN

Details	Progress	Target Date / Responsibility Of:
2022/23 CIP plan including QEIA in place by end of Quarter 3 21/22	***Detailed discussions have taken place at FPC and Board on CIPS and this will conti u and be reflected in the updated BAF 2022/23. This risk will be closed for the financi l year 2021/2022 as the organisation achieve better than breakeven by year end.*** -------- Action delayed while Trust identifies 22-23 CIP requirements.	26/05/2022 Matt White

BOARD ASSURANCE FRAMEWORK 2021/2022

Sheffield Health and Social Care NHS Foundation Trust

AIM: 3. IMPROVE OUR USE OF RESOURCES | **Strategic Objective:** Transformation: Changing Things That Will Make A Difference

Risk Ref: BAF.0026 **Details:** There is a risk that there is slippage or failure in projects comprising our transformation plans; caused by factors including non-delivery of targets by milestones, unanticipated costs arising or lack of sufficient capacity; resulting in service quality being compromised by the non-delivery of key strategic projects

Date Risk Created: 12/05/2021

Executive Lead: Director Of Special Projects (Strategy)
Risk Type: Quality
Risk Appetite: Low

Risk Rating:	Impact	Likelihood	Score
Residual Risk (with current controls):	3	3	9
Target Risk (after improved controls):	3	2	6

BAF Risk Review Date:
Last Review: 18/05/2022
Next Review: 17/06/2022

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	**Gaps in Control**	**Internal Assurance**	**External Assurance**	**Negative Assurance OR Gaps in Assurance**	**Assurance Rating**
Members of the Executive Team as SRO's for all projects and programmes	To ensure skilled and experienced Project / Programme Managers in role for People Plan and CMHT project Portfolio risk and issue register and milestone plan to be embedded within the work and assurance activities of the Transformation Board Dependencies register to be redefined and implemented into work and assurance of Transformation Board Change control process to be implemented across all programmes to ensure changes to scope, quality and plans are visible and agreed at the appropriate level of authority Lack of formally assigning colleagues to programmes with acknowledgment of amount of time required to dedicate to the	Triangulation of information between Back to Good programme and Transformation Portfolio via PMO Reporting from programmes to relevant committee's and Transformation Board to Finance and Performance Committee Programme highlight reports	***Significant Assurance ratingreceived by 360 Assuranceto Audit and Risk committeein January 2022 for the Transformation Board and PMO*** ***Some programmes haveexternal assurance mechanisms, as followsAdult Forensic New CareModels via (tbc)*** ***Primary and CommunityMental Health via (tbc)***	Some programmes have external assurance mechanisms Resource issues	AMBER

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Controls	**Gaps in Control**	**Internal Assurance**	**External Assurance**	**Negative Assurance OR Gaps in Assurance**	**Assurance Rating**
	programme				
Transformation Board in place to provide read across between programmes (including Back to Good Board) and operational areas, manage dependencies and provide guidance and support	Dependencies register to be embedded into every day use	Reporting takes place via PMO. The SRO / Chair of the Back to Good Programme Board is a member of the Transformation Board	NHSE/I representation on the Transformation Board and Back to Good Programme Board		GREEN
Programme / Project Boards in place	People Plan does not have a Programme Board. It reports to People Committee	Programme and Project Boards are in place. Activity to standardise the Terms of Reference and agendas. Highlight reports already standardised	EPR - External representative on Programme Board to advise on procurement Primary and Community Mental Health Transformation Programme - Representation from Primary Care and external organisations		GREEN
Reporting structures in place from Programme Manager to Programme Board, through to Transformation Board and Finance	None	Evidence stored on SharePoint of highlight reports to Transformation Board, meeting minutes,			GREEN

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Controls	**Gaps in Control**	**Internal Assurance**	**External Assurance**	**Negative Assurance OR Gaps in Assurance**	**Assurance Rating**
and Performance Committee		report to Finance and Performance Committee			
Standardised highlight reports produced which include milestone plans, financial information and roles and responsibilities	None	Highlight reports in place and stored on SharePoint going back to January 2021			GREEN
Developing maturity of PMO to support check and challenge of reporting	Lack of resource within PMO to complete fully	Business case approved to recruit to team to fulfil action			AMBER
External specialist resource is being brought in where appropriate to provide necessary skills, knowledge and capacity	CMHT Programme Manager / Project Lead position.	Job description being reviewed by People Directorate prior to advertising			AMBER
Key project documentation templates in place	Suite of templates in place but not effectively rolled out across the Transformation Portfolio due to when the programmes were started.	Suite of templates available. All new projects and programmes use new templates			AMBER
Portfolio risk and issue register and milestone plan in place	Risk and issue register for portfolio is not kept up to date. The individual risks are recorded and managed and highlighted to the Transformation Board and Finance and				AMBER

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Controls	**Gaps in Control**	**Internal Assurance**	**External Assurance**	**Negative Assurance OR Gaps in Assurance**	**Assurance Rating**
	Performance Committee. Activity to take place to bring this up to date				
Community of Practice in place to share knowledge and experiences between the Transformation Programme / Project Managers	Attendance at meetings	Evidence of monthly meetings			AMBER

ACTION PLAN

Details	Progress	Target Date / Responsibility Of:
The FPC ToR should be revised include responsibilities of the committee for: - Receiving reports from Transformation Board - Delivery and oversight of the transformation programme (although it does reference the Digital Transformation Strategy).	***TOR's updated for Transformation Board to be approved at end of May 2022.***	31/05/2022 Susan Rudd
Improve project / programme document management including: - expectations for maintenance and storage of project and programme documentation that is considered core (both operationally and strategically). This should include which documents should be stored where, version	***Document management system is under review.***	31/05/2022 Zoe Sibeko

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Date Risk Created: 12/05/2021		

ACTION PLAN

Details	**Progress**	**Target Date / Responsibility Of:**
control arrangements. - operational responsibility for programme staff for maintaining and storing documents.		
Programme Board ToRs are to be reviewed against the new standard and revised where necessary to include all required elements, including: - Date of ToR review and approval, and due date for review - Updated lines of reporting, including to Transformation Board - Updated membership list - Membership attendance requirements - Quoracy requirements.	***All completed except EPR, Therapeutic Environments and CMHT (to be updated inJune 2022).***	30/06/2022 Zoe Sibeko
Complete the roll-out of common core agenda elements to all programme boards.	***All completed except EPR, Therapeutic Environments and CMHT (to be updated inJune 2022).***	30/06/2022 Zoe Sibeko

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AIM: 3. IMPROVE OUR USE OF RESOURCES | **Strategic Objective:** Transformation: Changing Things That Will Make A Difference

Risk Ref: BAF.0027 **Details:** There is a risk that engagement with systems partners is ineffective or lacking; caused by weaknesses in partnership relationships or supporting governance arrangements; resulting in a poorer quality of services, missed opportunities and potential costs

Date Risk Created: 19/11/2021

Executive Lead: Director Of Special Projects (Strategy)
Risk Type: Business
Risk Appetite: Low

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

BAF Risk Review Date:
Last Review: 18/05/2022
Next Review: 17/06/2022

CONTROLS & MITIGATION		ASSURANCES/EVIDENCE (how do we know we are making an impact)			
Controls	**Gaps in Control**	**Internal Assurance**	**External Assurance**	**Negative Assurance OR Gaps in Assurance**	**Assurance Rating**
Trust Board members engaged with and part of system-wide governance, delivery and partnership boards at system and place level. We have mapped out the external meetings already attended by Executive Directors. As part of the strategic priorities, there is partnership working with Sheffield PLACE, Provider Alliance, SYICS and the University.	Some gaps remain in our engagement of Trust Board members for external forums related to housing, education and employment services. Need to determine if there are further system-wide partnership forums that the Trust should be equally engaging with to support delivery of plans. System governance infrastructure is also going through a period of transition.	CEO and Chair's briefing and report to Board provides an overview of system and system governance developments. All reports to Committees and Board are prompted to consider the partnership implications arising from the report. ***Regular meetings with Sheffield LA, PLACE, ICS and Provider Alliance***	Future review from CQC and NHSE/I will seek views from system partners Link into Outcomes group in PLACE	Future CQC and NHSE/I reviews will not be as frequent. Orientation of enquiry from CQC will be whether partnership working is effective. Not all reports include sufficient consideration of partnership working.	AMBER
Programme in place to review and update core strategies by June 2022. Each strategy will develop and		***Agreed timeline for development and delivery ofthe strategies was regularlyreported to Board***	***NHSE/I and CQC Well-Ledmonitoring.***		AMBER

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			up to			

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agree a programme of work to implement each strategy. There will be an agreed reporting cycle to report progress to each of the responsible committees and Board.		***March 2022, and triangulated with the Boardforward plan. Completion isdue in June 2022. Strategies and associated implementation work plans are in place.***			
Stakeholder analysis matrix and engagement plan will form part of each strategy implementation plan.	Still under development for the final strategies not yet approved by the Board.	***Board sub-committee review of each strategy priorto approval. Engagement with Council ofGovernors. Quality Accounts***	***CQC and NHSE/I Well-Ledmonitoring.***	Detailed implementation plans have yet to be finalised for every strategy therefore stakeholder analyses and engagement plans are yet to be fully completed.	AMBER

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Transformation Board oversees delivery of strategic transformation priorities and reviews effectiveness and outcomes from system engagement and impact on programmes Monthly highlight reports form each strategic transformation	Identifying the explicit interaction with the ACP/HCP and the new ICS governance and strategy.		***Project Initiation Document(PID) setting out the engagement arrangements including the stakeholder analysis.***	Significant assurance received from Internal Audit of transformation programme.		AMBER

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programme.					

ACTION PLAN

Details	Progress	Target Date / Responsibility Of:
Standardised implementation plans for Trust strategies and operational plan to actively consider and identify how partnership working will support delivery of the objective.	***Standardised operational plans and implementation plans for Trust strategies ar being reviewed in relationship to partnership working using the stakeholder analysitemplate.***	30/06/2022 Jason Rowlands
Implementation workplans for each strategy to be finalised and reported to the responsible committee by Quarter one.	***This action is underway and will also be reflected in the annual plan Quarter 1progress report.***	30/06/2022 Jason Rowlands
Transformation Board to consider the most effective way to progress a strategic appraisal of ongoing partner relationships.	***Strategic appraisal of ongoing partnerships is underway and will be brought back tBoard as part of the strategic direction refresh.***	30/06/2022 Jason Rowlands