Board of Directors - Public

SUMMARY REPORT	Meeting Date:	28 September 2022
	Agenda Item:	29

Report Title:	**Board Assurance Framework (BAF)**	
Author(s):	Deborah Lawrenson, Director of Corporate Governance	
Accountable Director:	Deborah Lawrenson, Director of Corporate Governance	
Other Meetings presented to or previously agreed at:	**Committee/Group:**	The full BAF for 2022-23 was received at the July Board. The Board discussed Risk appetite for BAF risks at the development session in August for reflecting proposed changes to the Committees in September. The BAF extracts for review were received at Board subcommittees in September.
	Date:	24 August (Board Development session) 13 September 2022 (People Committee) 14 September 2022 (Quality Assurance Committee) 15 September 2022 (Finance and Performance Committee)
Key Points recommendations to or previously agreed at:	The Board Assurance Framework (BAF) risks overseen by the Board sub-committees are presented for discussion.	

Summary of key points in report

The updated detailed BAF risks overseen by the Board subcommittees are attached for reference at **appendix 1**.

Risks have been updated by the Executive leads with updates since the last discussion at committee presented in blue text. This follows discussion at the Board development session in August on risk appetite for the BAF risks and changes were received at the committees in September.

The Risk Oversight Group has been established to provide further opportunity for confirm and challenge around the corporate risk register. It will also have a role in supporting the work to review the Risk Management Strategy in advance of receipt at Audit and Risk Committee in January; and in supporting planning for discussions with regard to risk appetite and interpretation and reflection of this in review of risks below board level.

Below is a summary of the BAF risks overseen by each board sub-committee.

The next review of the BAF risks by Executive leads is planned for early October for presentation to Committees. In this next review some movement is expected on target scores in line with the risk appetite agreed and consideration will be given as to whether any of the assurances can now be moved to controls with a further discussion taking place at the Board development session in October.

As previously reported additional BAF risks will need to be added to reflect system BAF risks when developed.

QUALITY ASSURANCE COMMITTEE OVERSIGHT

BAF.0023

AIM 1: Deliver outstanding care
STRATEGIC PRIORITY: COVID19 – Recovering Effectively

DETAILS: There is a risk of failure to consistently maintain appropriate Infection Prevention Control arrangements to ensure protection of service users and staff *caused by reduction in focus on safe ways of working, staffing issues (through sickness)* ~~which may~~ result*ing* in avoidable spread of infectious diseases.

Summary update
Committee discussed and agreed that

- The updated risk description would be accepted with an amendment to include the additions 'caused by' and 'resulting in' for consistency across all risk descriptions as detailed in blue text.
- The risk type to be "Safety"
- The risk appetite to be MODERATE, as agreed by the Board in August
- The risk target score should therefore be between 9 and 12 and is currently 4 x 2 = 8

An additional control has been added to reflect arrangements in place for managing the latest flu and Covid vaccination programmes – commencing in September 2022

BAF.0024

AIM 1: Deliver outstanding care
STRATEGIC PRIORITY: COVID19 – Recovering Effectively
Exec Lead: Beverley Murphy

DETAILS: There is a risk of failure to anticipate issues with, and achieve, maintain and evidence compliance with fundamental standards of care, caused by capacity and capability issues, cultural challenges, high use of agency and vacancy in some teams, use of out of area placements, lead in time for major estate changes, resulting in avoidable harm or negative impact on service user outcomes and experience, staff wellbeing, reputation, future sustainability of particular services which could result in regulatory action.

Summary update
Committee discussed and agreed that

- The risk type for this risk is Quality.
- The current risk score of 4 x 3 = 12 and the target score of 4 x2 = 8 should remain unchanged.
- The risk appetite should remain LOW, as agreed by the Board in August, and the target risk score is in line with that.

BAF.0025

AIM 1: Deliver outstanding care
STRATEGIC PRIORITY: CQC Continuous Improvement and Transformation - Changing things that will make a difference

Exec Lead: Beverley Murphy

DETAILS: There is a risk of failure to effectively deliver essential environmental improvements including the reduction of ligature anchor points in inpatient settings (the therapeutics environment 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 more restrictive care and a poor staff and service user experience and unacceptable service user safety risks

Summary update
Committee discussed and agreed that

- The current score should remain 4 x 4 = 16. The target score currently is 3 x 2 = 6.
- The risk type should be Quality.
- There should be a separation of the risk into one around Ligature anchor points (LAP) for which the appetite should be LOW and one for Therapeutic environments for which the appetite should be MODERATE.
- Further work will take place to set current and target risk scores for each of these risks.

BAF: 0029

AIM 1: Deliver outstanding care
STRATEGIC PRIORITY: COVID19 – Recovering Effectively
Exec Lead: Beverley Murphy

DETAILS: There is a risk of a delay in people accessing the right community care at the right time caused by issues with models of care, contractual issues and the impact of practice changes during Covid resulting in poor experience of care and potential harm to service users

Summary update
Committee discussed and agreed that

- The previous amalgamation of risk 14 and 19 (People Committee) details mitigation of risk related to causation by staff vacancies in respect of BAF risk 0029.
- The wording of this new risk was agreed.
- The proposed score of 4 x 4 = 16 was agreed. Target score was also agreed as 4 x 2 = 8.
- It was agreed at August Board that further discussion should take place on the risk appetite score for this risk which will take place in October with Executive Leads and at QAC.

FINANCE AND PERFORMANCE COMMITTEE OVERSIGHT

BAF.0021

AIM 3: Effective Use of Resources
STRATEGIC PRIORITY: Transformation: Changing things that will make a difference
Exec Lead: Phillip Easthope

DETAILS: There is a risk of failure to ensure digital systems are in place to meet current and future business needs by failing to effectively address inadequate legacy systems and technology caused by complex historic system issues requiring on-going maintenance, inadequate system monitoring, testing and maintenance, failure to address cyber security weaknesses, delays in procurement and roll out of new systems resulting in negative impact on patient safety and clinical effectiveness due to loss of access to key systems and processes and potential increase in cyber security and data protection incidents

Summary update

- The committee discussed and agreed that the risk should be separated into two – for digital solutions with a risk appetite of MODERATE and for cyber security with a risk appetite of LOW.
- Risk type to be confirmed.
- This will be reviewed by DIGG at its next meeting before a recommendation is made to the Board on proposed changes.

BAF.0022

AIM3: Effective Use of Resources
STRATEGIC PRIORITY: Transformation: Changing things that will make a difference
Exec Lead: Phillip Easthope

DETAILS: There is a risk that we fail to deliver the break-even position agreed for 2022/23 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.

Summary update
Committee discussed and agreed that:

- The risk type will be 'Finance' with a LOW appetite (moving from ZERO) as agreed at the Board in August.
- The current risk score of 5 x 3 = 15 should remain unchanged. It was agreed a revised target score should be set noting the target score should be between 5 and 8 which would sit in the LOW risk appetite category and the score will be confirmed with the Executive Lead.

BAF.0026

AIM 3: Effective Use of Resources
STRATEGIC PRIORITY: Transformation: Changing things that will make a difference
Exec Lead: Pat Keeling

DETAILS: There is a risk of 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 to deliver within the timeframes agreed or availability of capital funds resulting in service quality and safety being compromised by the non-delivery of key strategic projects.

Summary update
Committee discussed and confirmed that:

- The current score of 3 x 3 = 9 should be unchanged.
- The risk appetite should remain LOW as agreed at the Board in August.
- The current target risk score of 3 x 2 is in line with the appetite

BAF: 0027

AIM 3: Effective Use of Resources
STRATEGIC PRIORITY: Transformation: Changing things that will make a difference
Exec Lead: Pat Keeling

DETAILS: There is a risk of failure to engage effectively with system partners as new system arrangements are developed caused by non-participation in partnership forums, capacity issues (focus on Trust), difficulty in meeting increased requirement to provide evidence/data potentially at pace and volume, lack of clarity around governance and decision making arrangements resulting in poorer quality of services, missed opportunities to participate or lead on elements of system change and potential increase in costs

Summary update
Committee discussed and confirmed that:

- The risk appetite should move to MODERATE as agreed by the Board in August

- The current target risk score is in line with the appetite
- The current risk score of 4 x 3 = 12 should remain unchanged
- the focus for this risk type is on 'business'

PEOPLE COMMITTEE OVERSIGHT

BAF.0013

AIM 2: Create a Great Place to Work
STRATEGIC OBJECTIVE: Transformation – Changing things that will make a difference
Exec Lead: Caroline Parry

DETAILS: There is a risk that we fail to identify key cultural and work pressures impacting on staff health and wellbeing and delivery of services, leading to ineffective interventions; caused by failure to engage with staff in a meaningful way around concerns raised in the staff and pulse surveys as well as through engagement with, and demonstration of the values; and failure to implement demonstrable changes resulting in low scores on the staff survey (low morale), high sickness absence levels and negative indicators for quality of care.

Summary update
Committee discussed and confirmed that:

- The risk type for this should be 'workforce'.
- The current risk score should remain
- The current risk score of 4 x 3 = 12 should remain unchanged
- The risk appetite should remain as LOW as agreed by the Board in August.
- The target risk needs to be between 5 and 8 for a risk appetite of LOW – and this will be confirmed by the Executive Lead

There are a small number of actions which are to be finalised in respect of providing updates
In the next review a number of actions will be reviewed for moving into the controls section

BAF.0014

AIM 2: Create a Great Place to Work
STRATEGIC OBJECTIVE: Transformation – Changing things that will make a difference
Exec Lead: Caroline Parry

DETAILS: There is a risk of failure to undertake effective workforce planning to support recruiting, attracting and retaining staff to meet current and future needs caused by ineffective workforce planning, insufficiently attractive flexible working offer, competition, limited availability through international recruitment, reluctance of staff to remain in the NHS post Covid19, any national ICS requirements resulting in a negative impact on delivery of our strategic and operational objectives and provision of high-quality safe care.

Summary update
Committee discussed and confirmed that
- the risk appetite should move to MODERATE from LOW
- Current score to remain 4 x 4 = 16
- Target risk score would need to be between 9 and 12. It is currently 3 x 2 = 6 – Exec lead to review.

Further work with Executive Leads on the BAF risks is planned for October. There are a small number of actions for gaps in controls and assurances to be clarified

BAF.0020

AIM 2: Create a Great Place to Work
STRATEGIC OBJECTIVE: Transformation – Changing things that will make a difference
Exec Lead: Caroline Parry

DETAILS: There is a risk of failure to enable a paradigm shift in our culture through delivery of the overarching cultural change programme, caused by a lack of engagement in the wide range of leadership activity and opportunities for development provided, inability to adapt and engage to enable organisational change, resulting in failure to improve the culture of the organisation, ineffective leadership development, application of learning, engagement with our values, emergence of closed subcultures and low staff morale which in turn impacts negatively on service quality and service user feedback.

Summary update
Committee discussed and confirmed that:

- The risk appetite would move to MODERATE from LOW as agreed at the Board in August and the target score would need to change to between 9 and 12 from 3 x 2 = 6
- The current risk score of 4 x 3 = 12 should remain unchanged.
- The risk type ' Workforce' – as the risk descriptor is most appropriate

AIM 4 - **ENSURE SERVICES ARE INCLUSIVE**

STRATEGIC PRIORITY: Transformation: Changing things that will make a difference and Partnership Working (PLACE (equality) addressing deprivation, Provider Alliance (forensic and specialist services) ICS and University (improving outcome measures)

RISK REF: No specific risks identified at this time
Cross References to risks which cover inclusivity and the ones relevant to committees are highlighted below:

- Aim 1 - Deliver Outstanding care BAF risks 0023, 0024, 0025, 0029
- Aim 2 - Create Great Place to Work BAF risks 0013,0014,0020
- Aim 3 - Effective Use of Resources BAF risks 0027

Recommendation for the Board to consider:

Consider for Action		**Approval**	**X**	**Assurance**	**X**	**Information**	

- To receive and discuss the BAF risks for 2022/2023 post discussion at board sub committees.
- To consider assurances provided within the full document and identify if any further work is needed to address any gaps in controls by way of additional actions and timeframes for these, and to consider how the levels of risk reported triangulate with other information considered by Board.

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	*Yes*	***X***	*No*		"Systems and processes must be established to

Fundamental Standards					ensure compliance with the fundamental standards"
Data Security and Protection Governance Toolkit	*Yes*		*No*	***X***	
Any other specific standard	*Yes*		*No*	***X***	
Have these areas been considered ? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Service User and Carer Safety and Experience	*Yes*	***X***	*No*		Specific detail covered within BAF risks
Financial (revenue &capital)	*Yes*		*No*	***X***	
Organisational Development/Workforce	*Yes*	***X***	*No*		
Equality, Diversity & Inclusion	*Yes*	***X***	*No*		
Legal	*Yes*		*No*	***X***	
Sustainability	*Yes*	***X***	*No*		

Board Assurance Framework

Section 1: Analysis and supporting detail

BAF Snapshot

1.1 Risks are ordered from highest to lowest, where the gulf between current risk rating and target risk rating the next denominator where scores are equal.

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

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

1.2 The Risk Appetite was reviewed at the Board in its meeting in August. Below is the snapshot of risks overseen at Quality Assurance Committee. Arrows to show movement since the last discussion.

1.3

Current Risk Score			Target Risk Score require discussion		
Severity	**Likelihood**	**Score**	**Severity**	**Likelihood**	**Score**
BAF.0029 NEW - There is a risk of a delay in people accessing the right community care at the right time caused by issues with models of care, contractual issues and the impact of practice changes during Covid resulting in poor experience of care and potential harm to service users					
4	4	16 ⟺	4	2	8
BAF0014: There is a risk of failure to undertake effective workforce planning to support recruiting, attracting and retaining staff to meet current and future needs caused by ineffective workforce planning, insufficiently attractive flexible working offer, competition, limited availability through international recruitment, reluctance of staff to remain in the NHS post Covid19, any national ICS requirements resulting in a negative impact on delivery of our strategic and operational objectives and provision of high-quality safe care.					
4	4	16 ⟺	3	2	6
BAF.0025 - There is a risk of failure to effectively deliver essential environmental improvements including the reduction of ligature anchor points in inpatient settings (the therapeutics environment 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 more restrictive care and a poor staff and service user experience and unacceptable service user safety risks					
4	4	16 ⟺	3	2	6
BAF0022: there is a risk that we fail to deliver the break-even position agreed for 2022/2023 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.					
5	3	15 ⟺	4	3	12
BAF0020: There is a risk of failure to enable a paradigm shift in our culture through delivery of the overarching cultural change programme, caused by a lack of engagement in the wide range of leadership activity and opportunities for development provided, inability to adapt and engage to enable organisational change, resulting in failure to improve the culture of the organisation, ineffective leadership development, application of learning, engagement with our values, emergence of closed subcultures and low staff morale which in turn impacts negatively on service quality and service user feedback.					
4	3	12 ⟺	3	2	6
BAF0013: There is a risk that we fail to identify key cultural and work pressures impacting on staff health and wellbeing and delivery of services, leading to ineffective interventions; caused by failure to engage with staff in a meaningful way around concerns raised in the staff and pulse surveys as well as through engagement with, and demonstration of the values; and failure to implement demonstrable changes resulting in low scores on the staff survey (low morale), high sickness absence levels and negative indicators for quality of care.					
3	4	12 ⟺	2	2	4
BAF0027: there is a risk of failure to engage effectively with system partners as new system arrangements are developed caused by non-participation in partnership forums, capacity issues (focus on Trust), difficulty in meeting increased requirements to provide evidence/data potentially at pace and volume, lack of clarity around governance and decision-making arrangements resulting in poorer quality of services, missed opportunities to participate or lead on elements of system change and potential increase in costs					
4	3	12 ⟺	4	3	12
BAF. 0024 - There is a risk of failure to anticipate issues with, and achieve, maintain and evidence compliance with fundamental standards of care, caused by capacity and capability issues, cultural challenges, high use of agency and vacancy in some teams, use of out of area placements, lead in time for major estate changes, resulting in avoidable harm or negative impact on service user outcomes and experience, staff wellbeing, reputation, future sustainability of particular services *which could result in* regulatory action.					
4	3	12 ⟺	4	2	8
BAF.0023 There is a risk of failure to consistently maintain appropriate Infection Prevention Control arrangements to ensure protection of service users and staff which may result in avoidable spread of infectious diseases					
4	3	12 ⟺	4	2	8
BAF 0021: there is a risk of failure to ensure digital systems are in place to meet current and future business needs by failing to effectively address inadequate legacy systems and technology caused by complex historic system issues requiring on-going maintenance, inadequate system monitoring, testing and maintenance, failure to address cyber security weaknesses, delays in procurement and roll out of new systems resulting in negative impact on patient safety and clinical effectiveness due to loss of access to key systems and processes and potential increase in cyber security and data protection incidents					
4	3	12 ⟺	1	3	3
BAF0026: there is a risk of 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 to deliver within the timeframes agreed or					

availability of capital funds resulting in service quality and safety being compromised by the non-delivery of key strategic projects					
3	3	9 ⇔	3	2	6

1.4 Board is asked to consider the BAF risks alongside the other sources of information presented.

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 Strategic Aim 1: Deliver Outstanding Care is monitored for risks in the parts of the BAF reviewed by this committee.

Equalities, diversity and inclusion

4.2 Reflected across BAF risks presented

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.

Sustainability

4.7 Reflected in BAF risk 0025

Section 5: List of Appendices

1. BAF risks for 2022-2023.

BOARD ASSURANCE FRAMEWORK 2022/2023 – updated following receipt at the September People Committee

AIM 2: CREATE A GREAT PLACE TO WORK	**STRATEGIC PRIORITY:** Transformation – Changing things that will make a difference
RISK REF: BAF.0013 **RISK CREATED:** 07/05/2021 – *re-worded June 2022 approved at July People Committee for submission to Audit & Risk Committee and Board*	**DETAILS:** There is a risk that we fail to identify key cultural and work pressures impacting on staff health and wellbeing and delivery of services, leading to ineffective interventions; caused by failure to engage with staff in a meaningful way around concerns raised in the staff and pulse surveys as well as through engagement with, and demonstration of the values; and failure to implement demonstrable changes resulting in low scores on the staff survey (low morale), high sickness absence levels and negative indicators for quality of care.

Executive lead: Executive Director of Workforce **Board sub – committee oversight:** People				**Risk type:** Workforce		**Risk appetite:**			**LOW**
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	**3**	**4**	**12**	**Last Review:**	2/09/22 and 5/09/22	**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**2**	**2**	**4**	**Next Review:**	4/10/22	**X**			

Summary update

- *Changes are in blue*
- *Committee agreed added an additional risk type that the risk type for this should be 'workforce'.*
- *Committee agreed the risk appetite should remain as LOW.*
- *The current risk score should remain 3 x 4 = 12*
- *The target risk should be between 5 and 8 for a risk appetite of LOW*
- *There are a small number of actions which are to be finalised in respect of providing updates*

- *In the next review a number of actions will be reviewed for moving into the controls section*
- *For all BAF risks - In the next review consideration will be given as to whether any of the assurances can now be moved to controls*

CONTROLS & MITIGATIONS		ASSURANCES/EVIDENCE (how do we know we are making an impact)		Assurance rating
1 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	***AMBER***
Control • 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 Covid 19 campaigns • Regular reporting to committees • Reporting to the ICS (including on HWB)	**Gaps in control** • Identified some engagement groups that are not represented as part of the Health and Wellbeing Group. • Long Covid 19 support group offer is only available via virtual platforms. Consideration being given to exploring appetite and options for face to face if this is appropriate for the group concerned. To be confirmed. SB – checking with Sue Rutledge if completed **Action** • Embed well being conversations target date 31/8/2022 (Sarah Bawden) **Progress** – Waiting for training to be confirmed and completed. Delayed due to capacity and access to training. Update to be provided on timeframe SB to confirm with Sally Hockey • Revisit membership of HWB to ensure all groups represented **Progress** – Invites to extend the group issued to review membership at next meeting. To be reviewed at HWB	**Internal assurance** • Report to People Committee • ~~Report to Transformation Board~~ [people plan no longer goes to Transformation Board therefore this has been removed] **External assurance** • Model Hospital and NHSE/I returns • CQC Well-Led • Internal audit 360 staff wellbeing audit - *Significant assurance*	**Gaps in assurance** None **Actions** None	

	Assurance group 19/5/22 – Qualtrics survey completed on assurance group effectiveness 31/8 target date to review membership, date changed due number of apologies for August meeting, to include discussion at the next HWB meeting 22/6/22.			
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
2 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
<u>Control</u> • People Delivery Plan in place • Reports to SHWB group • NHS People Plan and actions for HR and OD • People Plan actions have been refreshed for 2022/23 focussed on the Assurance Group with progress reported to People Committee	**<u>Gaps in control</u>** • Inpatient area focus **<u>Action</u>** • OH Health re-specification (engagement with staff and specification development and tender (previously in action 9174) – Target date 31/07/2022 (Sarah Bawden) **<u>Progress</u>** – Assessment of 3 bidders June 2022. Further clarification questions. Decision to be made to aware in July 2022. Engagement with staff in 2020/21 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 end of June 2022. • Update - Tender process completed successful bidder notified, plan for standard contractual 12 week transition from October 2022.	**<u>Internal assurance</u>** • Reports to People Committee **<u>External assurance</u>** • CQC Well-Led • Internal Audit (360 assurance) focussing on wellbeing - Significant assurance	**<u>Gaps in assurance</u>** • Recommendations on governance to record completion of action milestones (people delivery plan which *was* being refreshed February 2022) **<u>Actions</u>** • Assurance groups to report on completion of milestones as part of scheduled update reports to People Committee. Confirmed this is in place.	
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**

3 - Controls	Gaps in control/Actions to address gaps	Internal/External assurance	Negative assurances or Gaps in assurance/ Actions to address gaps	AMBER
Control • HWB Framework in place • NHSEI National Wellbeing lead and ICS Wellbeing Group	**Gaps in control** • Self-assessment has limited clinical operations input **Action** • HWB network to be established proposal to HWB group February 2022 – target date 31/08/2022 (Sarah Bawden) **Progress** - Survey issued, some champions appointed, further work to establish network ongoing as part of a HWB system. Sally Hockey (HR Business Partner) has picked up HWB activity leadership. **Action** • Benchmark against national good practice for reassessment against the criteria and report to HWB Assurance Group **Progress** – Participating in the Trailblazer community of practice and sharing our own good practice. Included updates in HWB Report July 2022. Extended deadline as benchmarking continuing. Reports updating HWB group to each assurance group further report presented to PC July 2022.	**Internal assurance** • Reports to committee **External 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.	**Gaps in assurance** None **Actions** None	

AIM 2: CREATE A GREAT PLACE TO WORK	**STRATEGIC PRIORITY:** Transformation – Changing things that will make a difference
RISK REF: BAF.0014 **RISK CREATED:** 07/05/2021 – *re-worded June 2022 approved at July People committee for submission to Audit & Risk Committee and Board*	**DETAILS:** There is a risk of failure to undertake effective workforce planning to support recruiting, attracting and retaining staff to meet current and future needs caused by ineffective workforce planning, insufficiently attractive flexible working offer, competition, limited availability through international recruitment, reluctance of staff to remain in the NHS post Covid19, any national ICS requirements resulting in a negative impact on delivery of our strategic and operational objectives and provision of high-quality safe care.

Executive lead: Executive Director of People **Board sub – committee oversight:** People				**Risk type:** Workforce		**Risk appetite:**			**MODERATE**
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	**4**	**4**	**16**	**Last Review:**	2/09/22 and 5/09/22	**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**3**	**2**	**6**	**Next Review:**	4/10/22		**X**		

Summary update

- *Changes are in blue*
- *Committee agreed the risk appetite should move to MODERATE from LOW and the target risk score would need to be between 9 and 12 .*
- *Current score to remain 4 x 4 = 16*
- *There are a small number of actions for gaps in controls and assurances to be clarified*
- *For all BAF risks - In the next review consideration will be given as to whether any of the assurances can now be moved to controls*

CONTROLS & MITIGATIONS		ASSURANCES/EVIDENCE (how do we know we are making an impact)		Assurance rating
1 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Control • 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 to oversee delivery plan • People Delivery Plan for 2020/23 signed off at People Committee March 2022 due for re-approval March 2023 • Annual learning needs analysis undertaken to inform Trust training plan priorities for investment *[from BAF risk 0019]* • Developing a career pathway for support workers – business case agreed September 2021. Project Board in place and membership and TOR agreed *[from BAF risk 0019]* • Ensure 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]*	**Gaps in control** • Recruitment group focussed on nursing and HCSW only. • Terms of Reference for Day One Ready require review to ensure they are broad enough • New process for learning needs analysis requires study leave policy to be updated – due July 2022 *[from BAF risk 0019]* • Failure to recruit a suitable candidate for the Project Officer role at the third attempt for the support worker career pathway work – JD/Ps amended. *[from BAF risk 0019]* **Actions** • Implement performance report for workforce planning and transformation group. Progress – regional dashboard in development. SHSC work commenced June. Attain commissioned to develop the dashboard (work commenced April) *[from BAF risk 0019* Demo of dashboard going to Workforce Transformation group September - Sept to Dec 2022 timeframe	**Internal assurance** • Bi-monthly reporting to People Committee and Board • HR team have engaged with services to support completion of Training Needs Analysis templates to identify their needs *[from BAF risk 0019]* • 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]* • Now reporting full use of the levy and no unused funds. Contract position to be double checked with Karen Dickenson **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	**Gaps in assurance** • Dashboard information needs to reflect KPIs • Action log and planner still to be fully implemented for workforce planning and transformation group – aiming to use AAA approach. Will be fully in place from July 2022 [*from BAF risk 0019]* • **Actions** Recruited external consultancy support 'Attain' using improvement monies to support development of a dashboard. Similar work underway at the ICS so the new system will align with work on system level. [*from BAF risk 0019]*	

		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]		
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
2 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Control • Recruitment and Retention Group to support identification of gaps – see new Gap in control will be addressed once merged group in place	**Gaps in control** • Data to support accurate vacancy reporting being addressed with People Directorate and Finance • Workforce Transformation and Recruitment and Retention groups to merge to support new merged BAF risk **Action** • Improve workforce data quality. Create a robust system that monitors vacancy rates. Cleanse data in ESR. Agree simplified codes for recording job roles – target date 30/6/2022 (Sarah Bawden) **Progress –** HCSW and Nursing vacancy data complete. Finance and Workforce leads have developed a plan for data quality improvement. Finance and Workforce developing improvement plan for vacancy rate data. Additional resource employed to ensure	**Internal assurance** • Recruitment and Retention Group reports to People committee quarterly and additionally as requested. • Deep dive took place into retention at People Committee in April 2022 **External assurance** • National People Plan reports into ICS	**Gaps in assurance** • Dashboard information **Actions** • SB to look at actions required around addressing gaps related to dashboard information.	

	accuracy of ESR input. Costs requested from Payroll for direct input of pay effecting changes. • Recruit first cohorts of International nurses (x20) by February 2023 at the latest – target date 28/2/2023 (Sarah Bawden) **Progress –** Recruited nurse recruitment lead. Contracted with NHSP to recruit nurses. Interviews planned for March *2022.* OSCE training packages sourced. Paper to BPG 15.2.2022 and costs approved. Monthly meetings with NHSEI to review progress. Progress has been made with offers to 10 international students.			
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
3 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	***AMBER***
Controls • HCSW and Recruitment Cell weekly meeting with NHSEI (+direct support)	**Gaps** • Not all staff covered at this stage **Action** • SB to identify action to address gap	**Internal assurance** • Recruitment and retention group **External assurance** • NHSEI Performance workforce returns + direct support	**Gaps in assurance** None **Actions** None	
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
4 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Controls	**Gaps**	**Internal assurance**	**Gaps in assurance**	

• TRAC system in place to manage ALL recruitment. Tracked and reported to People Committee	• Users require additional training and support **Action** • Review of transactional processes using established microsystem looking at onboarding and Day One Ready initiative – target date 30/6/200 (Sarah Bawden) **Progress –** Day One Ready Microsystem will now encompass all employee lifecycle activities and renamed Employee Lifecycle microsystem. Transactional process workshop October 2021. Input to People Directorate review to align transactional processes with directorate and provide greater clarity of sight. Continue use of microsystem and focus/timescales to be confirmed Action closed. • Training and further guidance for recruiting managers on TRAC – target date 30/6/200 (Sarah Bawden) Confirmation to be provided if this is closed given rolling programme of training is in place. **Progress –** Training provided by Recruitment Manager. Ongoing and rolling programme of bitesize training and review of training so far being undertaken as part of benefits realisation programme. Costs for training being sought from TRAC.	• Reports to Recruitment and Retention Assurance Group and to each People Committee meeting **External assurance** • NHSEI and People workforce return (PWR) reporting which triangulates and checks our data	ESR data poor quality **Actions** • Interim support engaged 18/7/22 to progress plan of action to address data quality (engaged for 6 months – timeline on data quality to be confirmed)

CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
5 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	***AMBER***
Controls • Nurse Recruitment Group established to review attraction initiatives	**Gaps** • Membership needs to be reviewed **Action**	**Internal assurance** • Reports to Recruitment and Retention Group **External assurance**	**Gaps in assurance** None **Actions**	

	• SB to confirm action	• PWR reporting and NHSEI governance for international recruitment	None

AIM 2: CREATE A GREAT PLACE TO WORK	**STRATEGIC PRIORITY:** Transformation – Changing things that will make a difference
RISK REF: BAF.0020 **RISK CREATED:** 01/04/2021 re-*worded – June - approved at July 2022 People Committee for submission to Audit & Risk Committee and Board*	**DETAILS:** There is a risk of failure to enable a paradigm shift in our culture through delivery of the overarching cultural change programme, caused by a lack of engagement in the wide range of leadership activity and opportunities for development provided, inability to adapt and engage to enable organisational change, resulting in failure to improve the culture of the organisation, ineffective leadership development, application of learning, engagement with our values, emergence of closed subcultures and low staff morale which in turn impacts negatively on service quality and service user feedback.

Executive lead: Executive Director of People **Board sub – committee oversight:** People				**Risk type:** Quality *& Workforce*		**Risk appetite:**			**MODERATE**
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	**4**	**3**	**12**	**Last Review:**	2/09/22 and 5/09/22	**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**3**	**2**	**6**	**Next Review:**	4/10/22		**X**		

Summary update

- *Changes in blue*
- *Committee agreed the risk appetite should move to MODERATE from LOW and the score would need to change to between 9 and 12*
- *It was agreed the current risk score of 4 x 3 = 12 should remain unchanged.*
- *Committee agreed that the risk type 'Workforce' is most appropriate*
- *For all BAF risks - In the next review consideration will be given as to whether any of the assurances can now be moved to controls*

CONTROLS & MITIGATIONS		ASSURANCES/EVIDENCE (how do we know we are making an impact)		Assurance rating
1 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Control • NHSEI Culture and Leadership framework (CLP) to underpin SHSC Leadership and Culture Development programmes • Reporting to People Committee • Staff Engagement Steering Group established to increase engagement and reporting to People Committee • NHSEI National and regional People Plan	**Gaps in control** • Culture champions *need* to be aligned with NHSEI Culture and Leadership programme • Mechanism needs to be in place to gather and consolidate (triangulate) all staff data and themes. **Action** • Develop a framework for Organisational Development– Target date 30/06/2022 (Caroline Parry) **Progress –** Head of OD commenced 10 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 March 2022. Development of a framework is being progressed by Head of Organisational Development and a Board workshop is currently planned for October final date to be confirmed. Confirmation to be provided on date for completion of the framework (post Board workshop session to reflect feedback) and framework on a page summarising key component. OD assurance group 15.8 to sign off objectives for framework and then People Committee. • Refreshed SHSC values to underpin cultural vision – Target date 31/05/2022 (Sarah Bawden)	**Internal assurance** • Organisational Assurance Group reporting into People Committee bi-monthly • Transformation Board Report monthly **External assurance** • Quality Board bi-monthly report • ICS HR Directors Group (NHS HR Futures report) – this is a long term 10 year strategy to make improvements in HR and OD in the NHS to support delivery of the NHS people plan	**Gaps in assurance** None **Actions** None	

	Progress – Values were approved by the Board In September 2021 and communicated via JARVIS *(intranet)* and discussed at Autumn away days. Staff side session held January 2022. Implementation plan to be developed to embed refreshed values within core People Directorate functions. For example recruitment and PDR. • Refreshed values included in updated PDR documentation for 2022 PDR window. Values included in SHSC developing as leaders, will develop further for cohort 2. • Using 'Big Conversation' methodology to explore what our values mean in practice to our staff, will use this establish a shared set of behaviours to support our values.		

CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
2 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**GREEN**
Control • 2022-23 Refreshed People Delivery Plan (OD Framework)	**Gaps in control** Plan to be presented for final approval at People Committee **Actions** • OD actions refreshed as part of the update of the People Plan for 2022/23, presented to People Committee May 2022.	**Internal assurance** • People Committee received refreshed deliverables in 2022 • People Pulse survey **External assurance** • NHS National Survey – amalgamated benchmarking across sector • NHS People Plan – provides assurance that SHSC People Strategy was developed taking account of the NHS people plan	**Gaps in assurance** None **Actions** None	

CONTROLS & MITIGATIONS		ASSURANCES/EVIDENCE (how do we know we are making an impact)		Assurance rating
3 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Controls • Team SHSC Developing as Leaders (Leadership Development Programme)	**Gaps** • Maximum capacity 30 per cohort. First cohort 28 and roll out will follow • Lack of data to identify eligible leaders **Action** • Co design leadership development programme with Arden and GEM (these are part of a Commissioning Support Unit, delivering leadership development)– Target data 31/08/2022 (Caroline Parry) **Progress –** Co design group will track alongside delivery until July 2022 when group will reform to an internal delivery group. Evaluation of co-design and other information in August to inform future group TOR. The TOR would go to the OD Assurance Group, and People Committee and would close as they would be used for future roll out of the programme. Will engage line managers as we did with the first cohort to identify participants, ensure diversity and achieve target of 30. Improvements in data in progress, will support accurate identification of eligible leaders (also use participants targeted for the monthly leaders calls). • Cohort 1 completed 11.7.22. Arden and GEM contribution concluded 19.7.22 follow on review in September 2022. • Agile Mindset & Behaviours leadership programme – Chief Executive is the senior sponsor. Cohorts 1 & 2 underway with Cohort 3 starting 7.09.22.	**Internal assurance** • Led by and agenda approved by CEO **External assurance** • National staff survey results 2021 – staff engagement scores • External benchmarking report	**Gaps in assurance** • Low engagement scores – confirming with operational lead this is from staff survey and pulse survey data **Actions** • If as above, action planning at service level in progress, staff engagement as a KPI as part of the Performance review meetings with the Exec team with services reporting progress on action plans (based on people promise themes).	

	• Team SHSC: Developing as leaders Cohort 2 - Approval received to recruit to Cohort 2 Developing as Leaders Faculty to be formed - first meeting 16.9.22. Planned 6 Day programme 12 October start until April 2023		

AIM 4: ENSURE SERVICES ARE INCLUSIVE	***STRATEGIC OBJECTIVE:*** *Transformation: Changing things that will make a difference and Partnership Working (PLACE (equality) addressing deprivation, Provider Alliance (forensic and specialist services) ICS and University (improving outcome measures)*
RISK REF: No specific risks identified at this time	***Cross References to risks which cover inclusivity – Those covered at this committee are in bold*** • *Aim 1 - Deliver Outstanding care BAF risks 0023, 0024, 0025, 0029* • *Aim 2 - Create Great Place to Work BAF risks* ***0013,0014,0020*** • *Aim 3 - Effective Use of Resources BAF risks 0027*

BOARD ASSURANCE FRAMEWORK 2022/2023 – extracts for BAF risks overseen at FPC – updated for September 2022 FPC

AIM 3: EFFECTIVE USE OF RESOURCES	**STRATEGIC PRIORITY:** Transformation: Changing things that will make a difference
RISK REF: BAF.0021 **RISK CREATED:** 07/05/2021 *re-worded June – approved at July 2022 Finance and Performance Committee for submission to Audit & Risk Committee and Board*	**DETAILS:** There is a risk of failure to ensure digital systems are in place to meet current and future business needs by failing to effectively address inadequate legacy systems and technology caused by complex historic system issues requiring on-going maintenance, inadequate system monitoring, testing and maintenance, failure to address cyber security weaknesses, delays in procurement and roll out of new systems resulting in negative impact on patient safety and clinical effectiveness due to loss of access to key systems and processes and potential increase in cyber security and data protection incidents

Executive lead: Executive Director of Finance **Board sub – committee oversight:** Finance and Performance				**Risk type:** Quality & *Digital (data)*		**Risk appetite:**			**LOW –** cyber Moderate – digital
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	**4**	**3**	**12**	**Last Review:**	1/09/2022	**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**1**	**3**	**3**	**Next Review:**	4/10/2022	**X**			

Summary update

- *Changes are in blue*
- *Committee agreed that the risks should be considered to be separated out to one for digital solutions with a risk appetite of MODERATE and to one for Cybersecurity with a LOW risk appetite following further discussion at the November DIGG meeting.*
- *For all BAF risks - In the next review consideration will be given as to whether any of the assurances can now be moved to controls*

CONTROLS & MITIGATIONS		ASSURANCES/EVIDENCE (how do we know we are making an impact)		Assurance rating
1 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**GREEN**
Control • Governance controls in place via new EPR Programme Board which meets monthly • Board membership of EPR Programme includes 3rd party EPR supplier, 3rd party deployment consultations, CCIO, CSO and Chair of ICS Digital Delivery Board.	**Gaps in control** None **Actions** None	**Internal assurance** • 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 **External assurance** • 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.	**Gaps in assurance** None **Actions** • Full retirement of Insight in Q1/Q2 2023	
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
2 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**GREEN**
Control • Governance controls in place via Data and Information Governance Group (DIGG) which meets every 2 months	**Gaps in control** None **Actions** None	**Internal assurance** • *Reporting to DIGG and onward* reporting to Audit and Risk Committee **External assurance**	**Gaps in assurance** None **Actions**	

		• Annual Data Security Protection Toolkit (DSPT) audit moderate assurance rating received.	• Implement DSPT action plan to achieve 'Standards met' at June 2023 (Actions Jul, Aug, Sep 22 Jun 23)	
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
3 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Controls • Digital Strategy approved by Trust Board on 4/11/2021 defines a plan and roadmap for improved technology services and sustainability	**Gaps** • Assessment and plan for full resourcing and affordability not currently in place **Actions** Mandate and business case for increased staffing resource in IMST in progress. Target date 30/6/2022 (Andrew Male) **Progress** Decisions through business planning process still pending. Final decisions by BPG still pending.	**Internal assurance** • Digital Strategy Group - meets every 2 months and reports to FPC **External assurance** None	**Gaps in assurance** • Committee oversight **Actions** • Resource plan to be received at Oct 2022 ARC, as part of update to committee.	
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
4 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Controls • IMST 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.	**Gaps** • Four elements of DSPT still to be achieved, the relevant risks are being tracked. **Actions** • The relevant risks are being tracked At DIGG and reported through to ARC. **Progress** • Last Windows 2008 server retired	**Internal assurance** • DSPT audit. Internal audit have provided support around penetration testing. **External assurance** • DSPT submission as part of national reporting	**Gaps in assurance** None **Actions** • Implement DSPT action plan to achieve 'Standards met' at June 23 (Actions Jul, Aug, Sep 22 Jun 23)	

AIM3: EFFECTIVE USE OF RESOURCES	**STRATEGIC *PRIORITY*:** Transformation: Changing things that will make a difference
RISK REF: BAF.0022 **RISK CREATED:** 07/05/2021 – *re-worded – June - approved at July 2022 Finance and Investment Committee for submission to Audit & Risk Committee and Board*	**DETAILS:** There is a risk that we fail to deliver the break-even position agreed for 2022/23 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.

Executive lead: Executive Director of Finance **Board sub – committee oversight:** Finance and Performance				**Risk type:** Finance		**Risk appetite:**			***LOW***
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	**5**	**3**	**15**	**Last Review:**	12/07/2022	**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**4**	**3**	**12**	**Next Review:**	11/08/2022	**X**			
Summary update • *Changes are in blue italics* • *Committee agreed that the risk type to be 'Finance' with a LOW appetite (moving from ZERO) and a revised target score set.* • *Committee agreed the current risk score of 5 x 3 = 15 should remain unchanged.* • *Committee agreed that the target score currently is 4 x 3 = 12 which would sit in the MODERATE risk appetite category and should be changed to a Low risk appetite score between 5 and 8* • *For all BAF risks - In the next review consideration will be given as to whether any of the assurances can now be moved to controls*									

CONTROLS & MITIGATIONS	ASSURANCES/EVIDENCE (how do we know we are making an impact)	Assurance rating

1 - Controls	Gaps in control/Actions to address gaps	Internal/External assurance	Negative assurances or Gaps in assurance/ Actions to address gaps	AMBER
Control • Operational plan; financial planning; including CIP planning, processes and delivery monitoring • CIP programme Board established with more sophisticated CIP planning processes	**Gaps in control** • *Identification of a full recurrent CIP plan* • *CIP delivery groups to be fully established (2nd tier reporting to CIP programme Board)* **Actions** 2022/23 CIP plan including QEIA in place by the end of Quarter 3 2021/22. **Progress -** Programme Board established, some CIP scheme identified, Key areas identified and plan progressing.	**Internal assurance** • Monthly financial reporting to Team and Programme Board, Assurance report to FPC and Board. • Performance Framework meetings and recovery plans **External assurance** • NHSE&I Financial Review *2021/22* and ongoing support as required	**Gaps in assurance** • Full CIP plan 100% recurrently identified. **Actions** • Number of schemes identified full plans yet to be provided. Target date for full plans needs to be agreed as Q3 to keep this work on track. • Work taking place to refine capture of recurrent/non-recurrent detail in budget lines.	

AIM 3: EFFECTIVE USE OF RESOURCES	**STRATEGIC *PRIORITY*:** Transformation: Changing things that will make a difference
RISK REF: BAF.0026 **RISK CREATED:** 12/05/2021 re-*worded – June - approved at July 2022 Finance and Performance Committee for submission to Audit & Risk Committee and Board*	**DETAILS:** There is a risk of 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 to deliver within the timeframes agreed or availability of capital funds resulting in service quality and safety being compromised by the non-delivery of key strategic projects.

Executive lead: Director of Strategy **Board sub – committee oversight:** Finance and Performance				**Risk type:** Quality		**Risk appetite:**			**LOW**
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	**3**	**3**	**9**	**Last Review:**	5/09/22	**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**3**	**2**	**6**	**Next Review:**	4/10/22		**X**		

Summary update

- *Changes are blue*
- *Committee agreed that the risk appetite should remain LOW.*
- *It was agreed the current score of 3 x 3 = 9 should be unchanged.*
- *The current target risk score of 3 x 2 is in line with the appetite*
- *For all BAF risks - In the next review consideration will be given as to whether any of the assurances can now be moved to controls*

CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
1 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**

Control	**Gaps in control**	**Internal assurance**	**Gaps in assurance**

• 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 – additional resource (from within the Trust) has been brought into to work on e roster data and increased skills to support that programme. A replacement to an existing role has been brought in (consultancy support) and have increased capacity as working in parallel for a month. With CMHT project we have improved project management support.
	• Portfolio risk and issue register and milestone plan to be embedded within the work and assurance activities of the Transformation Board – we have these in place for all programmes – highlighted risks are received at the Transformation Board.
	• Dependencies register to be redefined and implemented into work and assurance of the 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 – going well in terms of the capital projects so change controls in three of the projects so far (Fullwood, Therapeutics environment and community facilities)
	• Lack of formally assigning colleagues to programmes with acknowledgement of amount of time required to dedicate to the programme –programme manager allocation taking place in PMO and through the PIDs and refreshing PIDs paperwork and TORs as part of the audit which is almost completed.
	Actions
	• Work taking place to look at what is required from a dependency register – by end October 2022
		• Triangulation of information between Back to Good programme and Transformation Portfolio via PMO.
		• Reporting from programmes to relevant committees and Transformation Board to Finance and Performance Committee.
		• Programme Highlight reports.
		
		External assurance
		• 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, as follows:
		  ○ Adult Forensic New Care
		  ○ Models via (tbc)
		• Primary and Committee Mental Health via (tbc)
			Some programmes have external assurance mechanisms as hosted elsewhere (primary and community mental health). There are programme boards overseeing those. Governance appropriate – no further action.
			
			Resource issues. Are improving and being addressed. Additional consultancy support to therapeutic environments programme and additional £2 m capital allocated from National programme. We have an external resource to support drafting of the SOC, have strengthened capacity and capability across our capital and construction projects (including within procurement)
			
			Actions
			• No further action required at this stage

	• Change controls for the remaining projects to be in place by end of November 2022. • Programme manager allocation work as outlined above to be completed by end of September 2022			
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
2 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	***AMBER***
Control • Transformation Board in place to provide read across between programmes (including Back to Good) and operational areas, manage dependencies and provide guidance and support	**Gaps in control** • Dependencies register to be embedded into everyday use. **Actions** • See comment against control above. The actions are with the PMO to put in place by end of October 2022	**Internal assurance** • Reporting takes place via PMO. The SRO/Chair of the Back to Good Programme Board is a member of the Transformation Board. **External assurance** • NHSE/I representation on the Transformation Board and Back to Good Programme Board.	**Gaps in assurance** None **Actions** **None**	
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
3 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	***AMBER***
Controls • Programme/Project Boards in place	**Gaps** • People Plan does not have a Programme Board. It reports to People Committee. It has a project group for E-roster which is the element outstanding – this will report into People Committee and Transformation Board. • For each of the strategies there will be implementation groups feeding into the relevant board sub committees.	**Internal assurance** • Programme and Project Boards are in place *for the majority of areas*. • Activity to standardise the Terms of Reference and agendas. All in place	**Gaps in assurance** None **Actions** None	

	This is being reviewed to ensure clear governance flows up from the tier II groups. **Action** • Implementation reporting to be confirmed by end of November and reflected into Tier I forward planners.	• Highlight reports already standardised. **External assurance** • EPR – External representative on Programme Board to advise on procurement. • Primary and Community Mental Health Transformation Programme – representation from Primary Care and external organisations.		
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
4 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**GREEN**
Controls • Reporting structures in place from Programme Manager to Programme Board, through to Transformation Board and Finance and Performance Committee	**Gaps** None **Action** None	**Internal assurance** • Board, meeting minutes, report to Finance and Performance committee **External assurance** None	**Gaps in assurance** None **Actions** None	
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
5 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**GREEN**
Controls • Standardised highlight reports produced which include milestone plans, financial information and roles and responsibilities	**Gaps** None **Action** None	**Internal assurance** • Highlight reports in place and stored on SharePoint going back to January 2021	**Gaps in assurance** None **Actions** None	

		External assurance None		
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
6 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Controls • Developing maturity of PMO to support, check and challenge of reporting	**Gaps** • Lack of resource within PMO to complete fully. There has been a review and an increase in programme managers supported by our clinical directorates (through provision of 8a resources through a partnering approach). **Action** • Gap addressed no further action.	**Internal assurance** • Business case approved to recruit to team to fulfil action. **External assurance** None	**Gaps in assurance** None **Actions** None	
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
7 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Controls • External specialist resource is being brought in where appropriate to provide necessary skills, knowledge and capacity	**Gaps** • CMHT Programme Manager/Project Lead position – has been recruited to and relates to the update on the gap under control 6. **Action** • None	**Internal assurance** • Job description being reviewed by People Directorate prior to advertising. **External assurance** None	**Gaps in assurance** None **Actions** None	

CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
8 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**

Controls
• Key project documentation templates in place
	Gaps
	• Suite of templates in place but not effectively rolled out across the Transformation Portfolio due to when the programmes were started
	Action
	• The FPC TOR should be revised to include responsibilities for the Committee for: -Receiving reports from Transformation Board - -Delivery and oversight of the transformation programme (although it does reference the Digital Transformation Strategy). Target date 31/05/22 – **Progress** - *FPC TORs updated approved at FPC July 2022 for onward sharing at Board.*
	• 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 control arrangements.
	  • Operational responsibility for programme staff for maintaining and storing documents
	Progress -Document management system is under review – due date 31/5/2022 (Zoe Sibeko) *update to be provided.*
	• Complete the roll-out of common core agenda elements to all programme boards . **Progress -** All completed
		Internal assurance
		• Suite of templates available. All new projects and programmes use the new templates.
		External assurance
		None
			Gaps in assurance
			None
			Actions
			None	

	except EPR, Therapeutic Environments and CMHT (to be updated in June 2022) – these were due by 30/06/2022 and then completed. (Zoe Sibeko)			
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
9 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Controls • Portfolio Risk and issue register and milestone in place	**Gaps** • 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 ad Performance Committee. Activity to take place to bring this up to date. They are received at each of the meetings and are on Ullyses and updates are provided in the monthly highlight reports in a section on top risks. Risks are also flagged on the summary page of the Transformation report to FPC and Board as a golden thread. **Action** • None	**Internal assurance** • *To be identified* **External assurance** None	**Gaps in assurance** None **Actions** None	
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
10 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Controls • Community of Practice in place to share knowledge and experiences between the Transformation Programme/Project Managers	**Gaps** • Attendance at meetings. **Action** • Programme Board TORs are to be reviewed against the new standard and revised where necessary to include all required elements, including:	**Internal assurance** • Evidence of monthly meetings **External assurance** • None	**Gaps in assurance** None **Actions** None	

	○ 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 **Progress -** All completed except EPR, Therapeutic Environments and CMHT (to be updated in June 2022) – completed		

AIM 3: EFFECTIVE USE OF RESOURCES	**STRATEGIC PRIORITY:** Transformation: Changing things that will make a difference
RISK REF: 0027 **RISK CREATED:** 19/11/2021 – re-worded – June - approved at July 2022 Finance and Performance Committee for submission to Audit & Risk Committee and Board	**DETAILS:** There is a risk of failure to engage effectively with system partners as new system arrangements are developed caused by non-participation in partnership forums, capacity issues (focus on Trust), difficulty in meeting increased requirement to provide evidence/data potentially at pace and volume, lack of clarity around governance and decision making arrangements resulting in poorer quality of services, missed opportunities to participate or lead on elements of system change and potential increase in costs

Executive lead: Director of Strategy **Board sub – committee oversight:** Finance and Performance				**Risk type:** Business		**Risk appetite:**			**MODERATE**
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	**4**	**3**	**12**	**Last Review:**	2/09/2022	**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**4**	**3**	**12**	**Next Review:**		**X**			

Summary update

- Changes in blue
- *Committee agreed to move the risk appetite to MODERATE*
- *The current target risk score is in line with the appetite*
- *It was agreed the current risk score of 4 x 3 = 12 should remain unchanged.*
- *Committee agreed that the risk type assigned to this risk is 'business'.*
- *For all BAF risks - In the next review consideration will be given as to whether any of the assurances can now be moved to controls*
- 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 & MITIGATIONS		ASSURANCES/EVIDENCE (how do we know we are making an impact)		Assurance rating
1 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Control • 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 Chair and CEO engagement meetings, Executive Directors. As part of the strategic priorities there is partnership working with Sheffield PLACE, Provider Alliance, SYICS and the University	**Gaps in control** • Some gaps remain in our engagement of Trust Board members for external forums related to housing, education and employment services. We have been engaging with the Sheffield Health and Care Partnership group. PK is linked into Housing. HRD meetings link in on some of these issues • Need to determine if there are further system-wide partnership forums (ICS, PLACE and Collaborative) that the Trust should be equally engaging with to support delivery of plans. • System governance infrastructure is also going through a period of transition. **Actions** • Continue to proactively engage – as part of new place arrangements which are developing as part of the whole ICS change	**Internal assurance** • CEO and Chair's briefing and report to Board provides an overview of system and system governance arrangements. • 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 **External assurance** • Future review from CQC and NHSE/I will seek views from system partners. • Link into Outcomes group in PLACE. • New arrangements are now emerging - Priorities workshop taking place on 12 September.	**Gaps in assurance** 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. **Actions** • Reflect in planning for CQC visit ongoing.	

CONTROLS & MITIGATIONS		ASSURANCES/EVIDENCE (how do we know we are making an impact)		Assurance rating
2 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/**	**AMBER**

			Actions to address gaps	
Control • Programme in place to review and update core strategies by June 2022. • Each strategy will develop and 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.	**Gaps in control** None **Actions** None	**Internal assurance** • Agreed timeline for development and delivery of the strategies was regularly reported to Board up to March 2022 and triangulated with the Board forward plan. Completion is due in June 2022. Is this finished? • Strategies and associated implementation work plans are in place. **External assurance** • NHSEE/I and CQC Well-Led monitoring	**Gaps in assurance** None **Actions** None	
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
3 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Controls • Stakeholder analysis matrix and engagement plan will form part of each strategy implementation plan.	**Gaps** • Still under development for the final strategies not yet approved by the Board. **Actions** • PIDs are being developed for each of the strategies – some are in place and others to be finalised following gap analysis – to be completed in October 2023.	**Internal assurance** • Board sub-committee review of each strategy prior to approval. • Engagement with the Council of Governors. • Quality Accounts **External assurance** • CQC and NHSE/I Well-Led monitoring.	**Gaps in assurance** • Detailed implementation plans have yet to be finalised for every strategy therefore stakeholder and engagement plans are yet to be fully completed **Action** • Standardised implementation plans for Trust strategies and	

			operational plan to actively consider and identify how partnership working will support delivery of the objective – due date 30/06/2022 (Jason Rowlands) • **Progress –** Update – September 2022 – detailed implementation plans are in place – those outstanding are - finance and procurement which are due for approval in October 2023). • Stakeholder engagement plans are being completed as part of the PID for each strategy – to be completed in October.
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**	**Assurance rating**
4 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps** **AMBER**
Controls • Transformation Board oversees delivery of strategic transformation priorities and reviews effectiveness and outcomes from system engagement and impact on programmes. • Monthly highlight reports from each strategic transformation programme.	**Gaps** • Identifying the explicit interaction with the ACP/HCP and the new ICS governance strategy **Action** • Transformation Board to consider the most effective way to progress a strategic appraisal of ongoing partner relationships **Progress** – Strategic appraisal of ongoing partnerships is underway and will be brought back to Board as part of the strategic direction refresh – original due date 30/6/2022 (Jason Rowlands) this will link in with the 5 year plan and strategic direction and context of the 5yr plan will go to the FPC in November and the Board in December	**Internal assurance** • Project Initiation Document (PID) setting out the engagement arrangements including the stakeholder analysis. • *Report to Board in June 2022 included detail on stakeholder engagement by project.* **External assurance** • Significant assurance received from Internal Audit of transformation programme.	**Gaps in assurance** None **Actions** None

	(workshop) and then Board for approval in January 2023		

AIM 4: ENSURE SERVICES ARE INCLUSIVE	***STRATEGIC PRIORITY:*** *Transformation: Changing things that will make a difference and Partnership Working (PLACE (equality) addressing deprivation, Provider Alliance (forensic and specialist services) ICS and University (improving outcome measures)*
RISK REF: No specific risks identified at this time	***Cross References to risks which cover inclusivity*** • *Aim 1 - Deliver Outstanding care BAF risks 0023, 0024, 0025, 0029* • *Aim 2 - Create Great Place to Work BAF risks 0013,0014,0020* • ***Aim 3 - Effective Use of Resources BAF risks 0027 (overseen at FPC)***

BOARD ASSURANCE FRAMEWORK 2022/2023 – BAF risks overseen at Quality Assurance Committee following receipt in September 2022

AIM 1: DELIVER OUTSTANDING CARE	**STRATEGIC PRIORITY: COVID19 –** Recovering Effectively
RISK REF: BAF.0023 **RISK CREATED:** *Risk re-worded June 2022 – approved at July 2022 Quality Assurance Committee for submission to Audit & Risk Committee and Board*	**DETAILS:** There is a risk of failure to consistently maintain appropriate Infection Prevention Control arrangements to ensure protection of service users and staff which may result in avoidable spread of infectious diseases.

Executive lead: Executive Director – Nursing and Professions **Board sub – committee oversight:** Quality Assurance				**Risk type:** Safety		**Risk appetite:**			**MODERATE**
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	**4**	**3**	**12**	**Last Review:**	02/09/22	**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**4**	**2**	**8**	**Next Review:**	04/10/22	**X**			

Summary update

- *Changes are in blue.*
- *Committee agreed for the wording to be changed to broaden it around infection control and pandemics (with Covid being one element) and that it should include 'caused by" and 'resulting in' to keep it consistent with other risk descriptions.*
- *Committee agreed that the risk appetite is MODERATE*
- *Committee agreed that the risk target score should therefore be between 9 and 12 and is currently 4 x 2 = 8*
- *For all BAF risks - In the next review consideration will be given as to whether any of the assurances can now be moved to controls*

CONTROLS & MITIGATIONS		ASSURANCES/EVIDENCE (how do we know we are making an impact)		Assurance rating
1 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
<u>Controls</u> • 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 of uptake • Covid19 clinical advisory group operational • Working Safely Group in place • Robust supply of PPE updated daily • Agile working place to enable work from home • Reduced physical contact between staff and patients • 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	**<u>Gaps</u>** • Variable adherence to fundamental standards of hand hygiene • *Some service* Users refusal to wear PPE (masks) • When in outbreak not all Service Users agree to isolate • In-patient estate does not facilitate adequate ventilation • *Ina*bility to influence the uptake of vaccine in some staff • Limited capacity to fill staffing gaps in the event of major outbreak • *Lack of available estate on a clinical site to use as a vaccination hub for the 2022/23 booster roll out* • Lack of confidence in available staff data in respect of Covid vaccination going forward. • Complacency caused by an ongoing global pandemic • Vaccine hesitancy • Lack of consistent staffing with right IPC training **<u>Actions</u>** • Critical areas identified, and 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, *education and advice freely available for service users* – Target date 30/06/2022	**<u>Internal assurance</u>** • Reporting and decision making through Bronze, Silver and 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 event of an outbreak to mitigate and prevent further spread of infection • *Reporting on recovery from Covid to Board of directors* - new • *Vaccination performance reporting*- new • *IPC mandatory training- new* • *On site presence of senior and executive leaders* **<u>External assurance</u>** • Daily situation 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	**<u>Gaps in assurance</u>** • Review following first wave only • Limited number of staff reporting LFTs results as required • Gap in Infection Control staffing as a result of staff absence **<u>Actions</u>** • *Continued communication and support for staff to report LFTs* • *Support from the Director of Nursing for the IPC nurse*	

• Individual risk assessments monitored by HR • Environmental Risk assessments monitored by H & S team • *Ability to move to enhanced cleaning when in outbreak or risk of infection incrases – newly added* • *Fully recruited IPC team – newly added* • *IPC practices and approach to Covid is embedded – newly* added • Latest Flu and Covid vaccination programme – commencing September 2022	(Neil Robertson) **Progress -** Embedded in command structures. New Infection Prevention Control Lead has reviewed all IPC arrangements having joined Silver command week commencing 28 February. Currently considering impact of moving from Critical Incident Level 4 to Level 3. Action will be dormant until such time it needs to be utilised. • Task and Finish Group in place for vaccination rollout to offer the vaccination and the booster to all staff, as they are available. Target date 30/06/2022 (Neil Robertson). *Vaccination hub solutions being considered.* **Progress -** task and finish group delivered. Implemented – 94.7% have had 2 doses and 83.1% all three Covid 19 vaccines. Focussing now on 4th vaccine booster. • Update – national guidance being followed and uptake of vaccines being monitored; additional controls in place with the autumn 2022 vaccination programme.		

Controls & Mitigations		**Internal/External assurance**		**Assurance rating**
2 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**GREEN**
• Covid risk register in place • *Command structure*	**Gaps in control** None **Actions** None	**Internal assurance** • Coronavirus weekly Sit Rep dashboard reported in Silver and Gold group meetings • Risk score is reviewed with every change in guidance and legislation • Shared with Audit and Risk Committee and Board **External assurance**	**Gaps in assurance** None **Actions** None	

		• Weekly sit rep is reported externally to ICS and Local Authority. • Risk score is reviewed with every change in guidance and legislation	

AIM 1: DELIVER OUTSTANDING CARE	**STRATEGIC PRIORITY: COVID19 –** Recovering Effectively
RISK REF: BAF.0024 **RISK CREATED:** *June 2022 Risk re-worded June 2022 – approved at July 2022 Quality Assurance Committee for submission to Audit & Risk Committee and Board*	**DETAILS:** There is a risk of failure to anticipate issues with, and achieve, maintain and evidence compliance with fundamental standards of care, caused by capacity and capability issues, cultural challenges, high use of agency and vacancy in some teams, use of out of area placements, lead in time for major estate changes, resulting in avoidable harm or negative impact on service user outcomes and experience, staff wellbeing, reputation, future sustainability of particular services *which could result in* regulatory action.

Executive lead: Executive Director – Nursing and Professions **Board sub – committee oversight:** Quality Assurance				**Risk type:** Quality		**Risk appetite:**			**LOW**
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		***PROGRESS STATUS***			
Residual Risk (with current controls)	**4**	**3**	**12**	**Last Review:**	**02/09/22**	***On track***	***Some Slippage***	***At risk***	***Completed***
Target Risk (after improved controls)	**4**	**2**	**8**	**Next Review:**	**04/10/22**		**X**		

Summary update

- *Changes are in blue*
  - *Committee agreed that the risk type for this risk is Quality*
  - *Committee agreed the current risk score of 4 x 3 = 12 and the target score of 4 x2 = 8 should remain unchanged.*
  - *Committee agreed the risk appetite should remain LOW and the target risk score is in line with that.*

- *For all BAF risks - In the next review consideration will be given as to whether any of the assurances can now be moved to controls*

CONTROLS & MITIGATIONS		ASSURANCES/EVIDENCE (how do we know we are making an impact)		Assurance rating
1 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Control • 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 • *Clinical Directorate* leadership oversight with additional nursing leadership to support pace of improvements • Daily safety huddles in quality team • Experts by experience • OD 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	**Gaps in control** • Three Back to Good improvement actions are delayed • Reliance on temporary workforce to cover vacancies, maternity leave and sickness • Lead in time for international recruitment • Number of people applying for posts does not match vacancies • Increasing rate of turnover in some teams • *Not all ward manager posts are filled by substantive appointments* • The outcome of the establishment reviews may require consultation to change working patterns for some • *Lack of reliable workforce data by team* • Tendable not being utilised consistently • Difficulty in keeping pace with recruiting to new posts created by investment • Covid19 driven absence *and exhaustion and low morale following a long running pandemic creating some burnout* • Lack of impact of the HCSW employment programme. • Additional capacity for nursing will take time to have impact • Experts by experience have found making an impact in wards a challenge • Two wards continue to utilise seclusion until new ward environments are available • Phase 3 plan for reducing ligature anchor points will depend on decant solution and take place over an 18 month period • New EPR not yet implemented • Inconsistent workforce and finance data	**Internal assurance** • Back to Good monthly reports • EPR monthly programme Board reports • ACM monthly Board reports • Transformation Board monthly reports • Staffing reports to People Committee • IPQR monthly report • Progress report on Clinical Establishment Reviews to People and Finance Committees • Leadership Recovery plans • Learning lessons quarterly report • Complaints report • Staffing report to People Committee • Safeguarding Q1 & 2 reports 2020-21 • Safeguarding development plan progress reports to Quality Assurance Committee • Policy review by Quality Assurance Committee • Quarterly reports to Quality Assurance Committee	**Gaps in assurance** • Use of 136 suite rooms to accommodate people awaiting admission • *Delays* in community transformation • Recovery plans not impacting waiting times in EWS/SPA and Recovery for allocation • *Flow plan is not impacting at a pace we had hoped* • *Turnover remains high* • *Outcome of Culture and Quality visit to recovery team July 2022* **Actions** • *Flow plan revised and being led by the Clinical Director* • *Community transformation programme* • *Acute and community leadership team have developed an immediate improvement plan for the recovery teams performance. July 22 with a revisit to the service in September 2022 – to look at impact*	

• Safeguarding rapid development plan delivered • Clinical and Social Care strategy implemented • Co-production standards launched • Quality and Equality impact assessment process in place • Ligature anchor point removal plan phase 1 and 2 are completed, phase 3 in planning • Daily operational management of safer staffing • New EPR implementation partner appointed	• Incident and serious incident actions are open • *Responsible Clinician* vacancies • Safe wards not fully embedded • Two acute wards remain mixed gender • Granular team base data not yet embedded • Lack of data on the accessible information standards • *Lack of capital to support essential environmental improvements* **Actions** • Ligature Anchor Point Phase 3 work with indicate 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 – Target date 30/11/2022 (Adele Sabin) **Progress –** The programme has been delayed by 8 weeks due to essential roof works at the Michael Carlisle Centre. Burbage ward will be complete by 5 August 2022. Work on Stanage ward will begin September 2022 completed March 2023. Maple ward works estimated start date April 2023 however, beginning the Maple works is dependent on the relocation on the health-based place of safety suites based within the Longley Centre. Phase 1 and 2 works are now complete on Acute wards. This includes replacement doors, windows and bedroom furniture. Phase 3 works are currently preparing to be tendered in July 2022. The refurbishment works on Burbage continue as planned with an anticipated completion date of *September 22*. As part of this programme of works Standage 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 as blind spot mirrors, ceiling vents, curtain/blind/rails and light fittings); Phase 3 works are currently being programmed to commence *September 2022* (works will target all remaining LAP works such as en-suites, selective replacement of ceilings etc., and	• Safer staffing report to Board January 2022 • Community recovery plans for waits in two teams showing progress • Supervision rate increasing in some teams • Completion of the Safeguarding rapid development plan reported to QAC • Medicines management rapid dev 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 **External assurance** • Outcome of December 2021 acute and PICU inspection by CQC – reported Jan 2022 • Section 11 Audit with safeguarding partnerships • Engagement with safeguarding partnerships at Executive level	• *Utilising a UEC dashboard to understand the blocks in progress – started from July 2022.* • *Additional focus needed on delayed care – September 2022*

	formation of new de-escalation rooms in lieu of seclusion). *Four bids submitted for additional capital.* • Ongoing monitoring of Covid impact on improvement actions through command structure and regular review at Board – Target date 31/12/2022 (Beverley Murphy) **Progress –** 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 interpret and cascade as appropriate, reporting into Silver and Gold groups. The Trust response is updated regularly through reports to the Board. • 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 – Target date 31/03/2023 (Joanne Simms) **Progress –** Practice development manager funding requested to support new recruits. Preceptorship training programme being developed for international nurse recruits. Working towards using international RGN nurse recruitments to fulfil the 20 quota and for placement in SHSC nursing homes. From the 5 May interviews, two candidates recruited. NHSP invited to SHSC to attend an international Mental Health recruitment falls in May 2022 – 6 candidates recruiting bringing the total to 12 with a potential start date in December 2022. Computer based test and English exams need to be undertaken within 6 months of accepting the post and prior to recruitment being finalised. • Ward manager and matron development plan agreed for Q4 20/21 and Q1 21/22 to enhance leadership skills and cultural development – Target date 30/06/2022 (Salli Midgley) **Progress –** Development programme has been procured and *implemented May* 2022.		

	• 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 – Target date 31/10/2022 (Joanne Simms) **Progress** – *four* recruitment fairs completed , *very few people appointed. Planning for the year ahead underway.* Looking to RGN recruitment for support in Nursing Homes. • 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. Target date 31/07/22 (Caroline Parry) **Progress** – *Commenced as planned this may now move to control* • *Commitment to develop team based workforce metrics has been given, this action requires a detailed timeline for delivery – Executive Director of People to provide timeline*		

CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
2 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**AMBER**
Control • Year One Back to Good actions delivered (exception of 3 items rolled into year two) • CQC reinspection demonstrated improvements across Well Led and Older People's services	**Gaps in control** • Acute and PICU services subject to further rapid improvements for reassessment during December. *This has happened and therefore may move to assurance.* • Leadership vacancies at Michael Carlisle Centre **Actions** • Back to Good year two programme underway to complete delivery of action plan to maintain improvements and deliver rapid improvements across Acute and PICU – Target date 31/03/2023 (Salli Midgley) **Progress** – CQC report that was published on 16 February 2022 demonstrated we had delivered actions against the section 29a warning. Significant progress was	**Internal assurance** • Fundamental standards visits to take place across PICU and Adult wards • IPQR data **External assurance** • CQC reinspection – Dec 2021	**Gaps in assurance** • Impact of staffing/covid to deliver on actions **Actions** • *Recruitment plan in place, daily management of staffing resource* • *Impact of recruitment plan being reviewed w/c 5 September 2022 by Executive lead.*	

	noticed. New improvement actions are in development *returned to* CQC by March 2022. *Good progress being made, reported into Back to Good.*			
CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
3 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**GREEN**
<u>Controls</u> • Contract in place and programme established to implement a new commercially supported EPR	**<u>Gaps</u>** None **Actions** – none	**<u>Internal assurance</u>** • EPR Programme Board chaired by COO • Programme Board reports to Transformation Board **<u>External assurance</u>** • NHSE/I funding required external reporting	**<u>Gaps in assurance</u>** None **<u>Actions</u>** None	

AIM 1: DELIVER OUTSTANDING CARE	STRATEGIC PRORITY: CQC Continuous Improvement and Transformation - Changing things that will make a difference
RISK REF: BAF.0025 **RISK CREATED:** *11/05/2021 – re-worded June 2022 – approved at Quality Assurance Committee for submission to Audit Committee and Board*	**DETAILS:** There is a risk of failure to effectively deliver essential environmental improvements including the reduction of ligature anchor points in inpatient settings (the therapeutics environment 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 more restrictive care and a poor staff and service user experience and unacceptable service user safety risks

Executive lead: Executive Director – Nursing and Professions **Board sub – committee oversight:** Quality Assurance				**Risk type:** Safety		**Risk appetite:**			LOW – MEDIUM
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	**4**	**4**	**16**	**Last Review:**	**02/09/22**	**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**3**	**2**	**6**	**Next Review:**	**04/10/22**		**x**		

Summary update

- *Cross reference with BAF.0026*
- *At the August Board session it was agreed the current score should be 4 x 4 = 16.*
- *Committee agreed that the risk type 'safety' in July 'environmental' has now been removed.*
- *Committee agreed that there should be a separation of the risk into one around Ligature anchor points (LAP) for which the appetite should be LOW and Therapeutic environments for which the appetite should be MODERATE.*
- *Committee agreed that the current and target risk score should be reviewed following the separation of these risks.*

- *For all BAF risks - In the next review consideration will be given as to whether any of the assurances can now be moved to controls*

CONTROLS & MITIGATIONS		ASSURANCES/EVIDENCE (how do we know we are making an impact)		Assurance rating
1 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/**	**RED**

			Actions to address gaps
Control • Enhanced nursing to manage environmental risks • 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 • *Ward managers* for all wards • *Ward manager and Matron* development programme • Implementation of Matrons and Team managers with a focussed span and clear responsibilities April 2021 • Planned environmental improvements to the acute wards • Estate strategy that determines future need for community and ward estates that enables therapeutic and safe care • IPQR used to identify emerging risks • *On site presence of senior and executive leadership* • *Board visits*	**Gaps in control** • High levels of Band 5 vacancies in some wards *with a lack of workforce data to rapidly identify staffing risks* • Use of temporary staffing leading to potential inconsistencies in the application of practice standards • Clinical *establishments not being worked to and a revised skill mix that has not yet been implemented* • Least restrictive Strategy not yet embedded • New Clinical Risk Management Policy and training not yet implemented • Variance in staff understanding of ligature anchor point assessment • Use of temporary staff • Limitations in current approach to clinical risk assessments and management • Environmental safety at work not yet completed • Variance in management capability and experience • Vacancies for responsible clinicians • Delays in the delivery of Therapeutic Environment Programme (TEP) • Vacancies in *substantive* nurse leadership at Michael Carlisle Centre *Lack of outcomes from expressions of interest to the new hospitals bid and the bid for additional capital for the 136 reprovision* • *Lack of de-escalation space on Endcliffe ward* • *Stanage Ward team lack of confidence to work without seclusion* **Actions** • The ward works improvement programme (overseen by the Therapeutic Environments Programme Board) commenced w/c July 2021. Consideration was taken on how to accelerate the ward improvement programme. The method chosen was to work on live wards for the programme which covered Stanage, Maple and Dovedale 1 wards. **Progress** – The refurbishment works on Burbage ward have been extended due to unplanned roof works which are necessary. Completion date is now September 2022. As part of this programme of works Stanage dormitories have been eradicated, completed on 3 December 2021. The Ligature Anchor point eradication programme phase 1 is complete; phase 2 is completed	**Internal assurance** • Capital Group reports • Operational Structure presentation to 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 Quality Assurance Committee March 2021 **External assurance** • Evidence based approach to Reducing Restrictive practice implementation	**Gaps in assurance** • Feb 2020 CQC inspection report • *CQC inspection reports - August 2020, May and December 2021 (in respect of the environment)* **Actions** • *Implementation of Back to Good programme and the Therapeutic Environments programme*

	on acute wards. Phase 3 works on Stanage ward *have two items outstanding which will be completed when the ward is decanted. This is* are currently programmed to commence *now in October* 2022. This work will be undertaken on a closed ward and will target items such as en-suites, ceilings and a new de-escalation room. Gaps in controls amended as 1) Dovedale 2 war was reopened for admissions, and 2) the Trust now has a Board approved Estates Strategy.		

AIM 1: DELIVER OUTSTANDING CARE	***STRATEGIC PRIORITY: COVID19 –*** *Recovering Effectively*
RISK REF: *BAF.0029* ***RISK CREATED: new risk*** *descriptor approved at Quality Assurance Committee for submission to Audit & Risk Committee and Board*	***DETAILS:*** *There is a risk of a delay in people accessing the right community care at the right time caused by ~~staff vacancies,~~ issues with models of care, contractual issues and the impact of practice changes during Covid resulting in poor experience of care and potential harm to service users*
Summary update • *Cross reference BAF.0014* • *Committee agreed the wording to this new risk and noted that draft controls, gaps, assurances, and actions have been identified.* • *Committee confirmed agreement for the proposed scoring* • *Committee noted the previous amalgamation of risk 14 and 19 covers this risk off in terms of causation by staff vacancies and mitigates this element of the risk.*	

Executive lead: Executive Director – Nursing and Professions **Board sub – committee oversight:** Quality Assurance				**Risk type:** Safety		**Risk appetite:**			**LOW**
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	4	4	16	**Last Review:**	05/09/22	**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	4	2	8	**Next Review:**	04/10/22			**X**	
Summary update • New risk - Discussion required on risk description and potential scoring									

CONTROLS & MITIGATIONS		**ASSURANCES/EVIDENCE (how do we know we are making an impact)**		**Assurance rating**
1 - Controls	**Gaps in control/Actions to address gaps**	**Internal/External assurance**	**Negative assurances or Gaps in assurance/ Actions to address gaps**	**RED**
Control	Gaps in control	Internal assurance	Gaps in assurance	

• Waiting list management initiatives in place to support people while they wait and respond to risk. • Information shared with service users about their waits and what to do if their situation worsens. • Use of the Voluntary Community and Social Enterprise sector to support people who are waiting. • Duty systems for relevant teams respond to immediate risks. • Transformation programmes in place to resolve waiting in key services – recovery teams and the single point of access and emotional wellbeing service and Learning Disability. • General manager and service manager development session utilise to promote new practice and share learning. • A protocol in place for the management of waiting lists. • All staff forums held with the recovery team to find solutions in managing people waiting. • Moving forward ICB place discussions to address waits, re-set service specifications, and explore investment opportunities. • Raising challenges and issues in strategic places,	• Where there are large numbers of people waiting for a service, we can not reach out to every person on a regular basis, so are reliant on people contacting us if their presentation deteriorates or circumstances change. • Key areas where people are waiting require service transformation (SPA/EWS Recovery and SANNS), so we need to deliver this to resolve the issues, which is taking time. • People waiting for the gender service are required to be seen by a specialist doctor, which are not available due to sickness and recruitment challenges. • Where areas need investment, clear commissioning intentions are required by the ICB to move waits forward. • 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. **Actions** • Identify technological solutions that are available to support regular contact with people waiting for a service, encouraging people get help and where to get it if their circumstances change. This will be progressed by the 31st October 2022. • Finalise recovery team transformation plan in October 2022 and deliver mobilisation plan as agreed. • Identify and deliver early adoption initiatives between primary care mental health and the SPA/EWS to reduce waiting time whilst we prepare the system transformation by 30th November 2022. • Continue to work with strategic planners about commissioning intentions that address key wait areas and ensure service specification are finalised for each service by 30th September 2022. • Work with NHSE about the support needed for the Gender Service by 30th September 2022.	• Back to Good monthly reports • EPR monthly programme Board reports • Transformation Board monthly reports • IPQR monthly report • Leadership Recovery plans • Learning lessons quarterly report • Complaints report • Quarterly reports to Quality Assurance Committee • Quarterly reports to Finance and Performance Committee. • Community recovery plans for relevant services. • Culture and quality visits • Contracting updates as required. **External assurance** • Negotiation and escalation through commissioning forums at place, ICB and NHSE. • Adherence to the NHS Long Term Plan and the community team framework. • Relevant adherence to NICE guidance. • Adherence to the 4-week waiting standard for relevant core services.	• August QAC Waiting Times Paper (also to be sent to FPC) • Recovery plans not delivering downward trajectory in waits. • Not finalised the primary care, recovery teams and SANS transformation plans • Staff vacancies and turnover remains high in some areas. • Lack of agile technology to maintain a high level of contact with people waiting. • Long terms sickness in Gender Service. **Actions** • Clear strategic plan on moving forward the issues raised in the waiting times paper to move forward priorities by 31st October 2022. • Identify services where a realistic trajectory can be achieved to reduce waits by 30th September 2022. • Utilise transformation portfolio board to monitor and scrutinise delivery of key transformation by 30th September 2022. • Identify contract vehicles that enables us to mobilise VCSE resources to support initiatives and where appropriate workforce gaps by 31st October 2022.

such as, SY NHSE, Autism Learning Disability Board, Place Mental Health Learning Disability Autism and Dementia Board at place. • IPQR framework used to monitor waits of services and review mitigation processes in place. • Undertaking waiting list reviews for key services to ensure people are in the right place for care.			• Work with IMT to identify technology that can reach people waiting to support them more effectively while waiting by 31st October 2022. • Develop and implement an improvement plan for Gender services by 30th September 2022.

AIM 4: ENSURE SERVICES ARE INCLUSIVE	***STRATEGIC OBJECTIVE:*** *Transformation: Changing things that will make a difference and Partnership Working (PLACE (equality) addressing deprivation, Provider Alliance (forensic and specialist services) ICS and University (improving outcome measures)*
RISK REF: No specific risks identified at this time	***Cross References to risks which cover inclusivity*** • *Aim 1 - Deliver Outstanding care BAF risks* ***0023, 0024, 0025, 0029*** • *Aim 2 - Create Great Place to Work BAF risks 0013,0014,0020* • *Aim 3 - Effective Use of Resources BAF risks 0027*