Board of Directors

SUMMARY REPORT	Meeting Date:	27 September 2023
	Agenda Item:	25

Report Title:	**Board Assurance Framework 2023/24**	
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:**	Executive Management Team (EMT) People Committee Quality Assurance Committee Finance and Performance Committee
	Date:	7 September 2023 (EMT), 12 September 2023 (People), 13 September 2023 (Quality Assurance) and 14 September 2023 (Finance and Performance)
Key Points recommendations to or previously agreed at:	Changes since last discussed at the board are presented in blue text or strikethrough in the detailed BAF extracts attached as appendices. EMT and the board assurance committees have agreed the changes to the BAF and proposed timetable for receipt in future as outlined.	

Summary of key points in report

The BAF has been updated since last discussed at the Board of Directors in July 2023 by the Director of Corporate Governance working with the Executive Leads. It has been provided to Executive Management Team in advance of discussion at the Board Assurance Committees in September.

Appended are a summary update on movement on the BAF risks and in the Appendices the detailed BAF extracts overseen at board assurance committees.

Attached appendices

Appendix 1 – Summary BAF 2023/24 update September 2023
Appendix 2 – Extract BAF risks overseen at Finance and Performance Committee
Appendix 3 – Extract BAF risks overseen at Quality Assurance Committee
Appendix 4 – Extract BAF risks overseen at People Committee

The Board is asked to agree the reporting cycle for the BAF as outlined below following agreement at board assurance committees:

2023/24 proposed timetable

Quarter 1 (April – June)	EMT – May

	Assurance Committees – June Audit and Risk Committee – June Board of Directors – July
Quarter 2 (July – Sep)	EMT – August Assurance Committees – September Audit and Risk Committee – NA Board of Directors – September
Quarter 3 (October – Dec)	EMT – December Assurance Committees – January Audit and Risk Committee – January Board of Directors – January
Quarter 4 (Jan – March)	EMT – February Assurance Committees – March Audit and Risk Committee – NA Board of Directors – March

Recommendation for the Board/Committee to consider:

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

The Board of Directors is asked to receive for assurance and approval the BAF 2023/24 post discussion at EMT and the assurance committees and to discuss and agree the future reporting cycle.

Please identify which strategic priorities will be impacted by this report:

Recover Services and improve efficiency	*Yes*	***X***	*No*	
Continuous Quality Improvement	*Yes*		*No*	***X***
Transformation – Changing things that will make a difference	*Yes*	***X***	*No*	
Partnerships – working together to make a bigger impact	*Yes*	***X***	*No*	

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

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

Equality, Diversity & Inclusion	*Yes*	***X***	*No*		
Legal	*Yes*	***X***	*No*		
Environmental Sustainability	*Yes*	***X***	*No*		

Appendix 1

Summary BAF

Changes to Finance and Performance Committee BAF risks

As noted previously there is a potential gap in the BAF on overall sustainability issues – Finance and Performance Committee have previously agreed consideration will be given to inclusion of a BAF risk on this alongside reporting on sustainability planned for January 2024.

As noted in July the People Committee asked Finance and Performance Committee to consider if there is a potential question around whether digital capability of staff is sufficiently reflected in digital risks overseen at FPC – this is reflected in the work to develop the roadmap for delivery of the digital strategy in view of delays caused by EPR slippage.

The Executive lead will consider for the next review of the BAF whether the outstanding actions for the DPST internal audit have been sufficiently reflected in the CRR and the BAF (with the exception of those which are low risk).

BAF risk 0021A (current score unchanged – 12)	**Latest update**
Strategic Priority: Transformation: Changing things that will make a difference **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, 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.	• No changes to scoring, risk appetite or level of assurance – Actions, controls/gaps and milestones have been updated. • Since last discussed the EPR revised implementation timescales have been agreed with go live dates of 30 October and 27 November. • The team are reviewing EPR risk scores including feedback following the DPST outcome in relation to the use of the Insights system. • In the next review of the BAF consideration will be given as to whether the DPST outstanding actions are sufficiently reflected in the CRR and BAF (with the exception of those which are low risk). • The assurance rating remains Amber.
BAF risk 0021B (current score unchanged – 12)	**Latest update**
Strategic priority: Transformation: Changing things that will make a difference **DETAILS:** There is a risk that adequate arrangements are not in place to sufficiently mitigate increased cyber security and data protection incidents. This has been compounded by low Information Governance mandatory training levels across the Trust,	This risk is overseen at Audit and Risk Committee and is provided to FPC for information. • No changes proposed to scoring. – Actions, controls/gaps have been updated. Milestones are unchanged • Sources of assurance and actions unlikely to change until Retirement of Insight. • Implementation of RIO delayed but revised plan agreed in August 2023. • The assurance rating remains Amber/Green.

unawareness of Phishing attacks as well as legacy core systems that may not meet current security standards and so remain vulnerable to cyber-attack. An attack may compromise or disable key systems and prevent their operation until we either have confirmation that is safe to do so following the application of software security patches or alternatively the system in its entirety is no longer deemed fit for purpose and removed from active service.	
BAF risk 0022 (current score unchanged - 15)	**Latest update**
Strategic Priority: Transformation: Changing things that will make a difference and Recover Services and Improve Efficiency **DETAILS:** There is a risk that we fail to deliver the break-even position in the medium term caused by factors including non-delivery of the financial plans, lack of 2 – 5 year financial plans including developed CIP programmes and increased cost pressures resulting in a threat to both our financial sustainability and delivery of our statutory financial duties.	• No changes proposed to scoring – Actions, controls/gaps have been updated. Original milestones have been achieved, three additional milestones have been added. • As reported previously a financial impact of 5 was considered by the Executive Lead to be potentially too high but it was noted is currently scored in line with Risk Management Strategy – to be reviewed aligned with the updated Risk Management Framework in due course. • As noted previously sources of assurance and actions are unlikely to change significantly until the retirement of Insight now delayed until Q1 of 2024. • Implementation of RIO new dates confirmed as noted above. Additional milestones added as follows: • Review residual risk score post completion of the revised Risk Management Framework – December 2023 • Review of CIP delivery, financial plan delivery post Q2 • Development of medium term financial planning as part of 2024/25 financial plan development – December 2023 • The assurance rating remains Amber.
BAF risk 0026 (current score unchanged – 16)	**Latest update**
Strategic priority: Transformation: Changing things that will make a difference **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 lack of availability of capital funds resulting in	• Cross reference with BAF risks 0025A and B overseen at QAC. • No changes proposed to scoring – Actions, controls/gaps and milestones have been updated. • As reported previously 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 lack of availability

service quality and safety being compromised by the non-delivery of key strategic projects.	of capital funds resulting in service quality and safety being compromised by the non-delivery of key strategic projects. • There is a need to be clearer about financial risk gap for EPR. The Executive Director of Finance and the Director of Operations and Transformation will be discussing this and agreeing further actions at the end of September. • A thorough review will take place with the Head of PMO on their return to work in September to update the BAF risk for reporting in October which will include identifying any further gaps in control • The assurance rating has changed from Amber/Green to Amber due to some additional slippage to the milestones.
BAF risk 0027 (current score unchanged -12)	**Latest update**
Strategic priority: Transformation: Changing things that will make a difference **DETAILS:** 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	• No changes proposed to scoring - Actions, gaps and milestones updated. One milestone has been achieved since last discussed at Board of Directors. • As previously reported additional BAF risks will be added as system risks and those for the MDLDA Collaborative are developed post discussion at Chair/CEO meetings. • The assurance rating has remained Amber.

<u>Changes to Quality Assurance Committee BAF risks</u>

BAF risk 0024 (current score unchanged – 12)	**Latest update**
Strategic priority: Continuous Quality Improvement **DETAILS:** Risk of failing to meet fundamental standards of care with the regulatory body resulting in avoidable harm and negative impact on service user outcomes and experience staff wellbeing, reputation, future	• No changes proposed to scoring – Actions, gaps and milestones updated. • Controls around fundamental standards and culture and quality visits have been reflected in People BAF risks. • The milestones to achieving the target score have been updated. There is some slippage related to Fixed Ligature anchor point programme. • The 'Back to Good' closure meeting took place

sustainability of particular services *which could result in* regulatory action. This risk could be associated with the failure to detect closed cultures within clinical teams.	in August 2023 with outstanding actions picked up in the new Quality Assurance Report and business as usual assurance reporting through committees. A closure report was expected at the Board in September however this will now be received in November. • The assurance rating remains Amber/Green.
BAF risk 0025a (current score unchanged – 16)	**Latest update**
Strategic priority: Continuous Quality Improvement and Transformation - Changing things that will make a difference **DETAILS:** There is a risk to patient safety caused by failing to effectively deliver essential environmental improvements for the reduction of ligature anchor points / improvements in therapeutic space in inpatient settings	• Cross reference with BAF.0026 overseen at FPC • No changes proposed to scoring - Actions, gaps and milestones updated. • The full Business Case for Maple will now be received at the Board in December following receipt through assurance committees FPC and QAC including design details at QAC in October/November. • Finalisation of the acute ward LAP work will now be completed between June and August 2023. Some updating to milestones is being finalised. • The assurance rating remains red – due to slippage to milestones.
BAF risk 0025b (current score unchanged – 16)	**Latest update**
Strategic priorities: Continuous Quality Improvement and Transformation - Changing things that will make a difference. **DETAILS:** There is a risk of failure to deliver 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 unacceptable service user safety, more restrictive care and a poor staff and service user experience	• Cross reference with BAF 0026 overseen at FPC. • No changes proposed to scores - Actions, gaps and milestones have been updated • There is slippage in timing on several milestones see report for detail. However the Executive lead has a high degree of confidence the new dates will be met. • The assurance rating remains red – due to slippage to milestones.
BAF risk 0029 (current score unchanged – 16)	**Latest update**
Strategic priorities: Recover services and improve efficiency *and Transformation: Changing things that will make a difference* **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	• Cross reference to BAF 0014 overseen at People Committee. • No changes proposed to scores – Actions, gaps and milestones have been updated. • Primary Care Mental Health plan in place, Recovery teams are mobilising plan to be in place by January 2024 and doing joint work with the ICB on transforming the SAANs service particularly in respect of people with suspected ADHD. Action and Gap closed. • Gender service investment to be negotiated by end of Quarter 1 23/24 – no movement as yet around investment and continuing to

	engage. • We are assertively following up with our strategic planners about resolving this very outstanding issue in relation to commissioning specification. A paper on how we are supporting people on waiting lists received at FPC in August and at QAC in September. • As part of workforce planning we are identifying new ways of working by looking at alternative staffing groups for filling vacancies. We can work differently in many of our community services due to the abolition of the care programme approach which means that we can use peer support workers, recovery workers and the VCSE to support service delivery. By the end of the financial year (March 2024) • The assurance rating remains red and is still marked as 'at risk'. A number of gaps and actions have been closed.

Changes to People Committee BAF risks

BAF risk 0013 (current score unchanged – 12)	**Latest update**
Strategic priorities: Transformation – Changing things that will make a difference. **DETAILS:** Risk the Trust does not have appropriate measures and mechanisms in place to support staff wellbeing resulting in absence continuing to rise, that gaps in health inequalities in the workforce grow and their experience at work is poor with a knock-on impact on service user/patient care.	• No changes to score – Actions, gaps and milestones updated • A number of milestones have been achieved since last report to the Board of Directors: o Menopause accreditation achievement –Achieved August 2023 o Structure for support to manage wellbeing improved and in place due by September 2023 Achieved August 2023 o New Health and Wellbeing guardian in place – from April 23 Board role in place – Achieved • The assurance rating remains Amber/Green.
BAF risk 0014 (current score unchanged – 12)	**Latest update**
Strategic priorities: Transformation – Changing things that will make a difference **DETAILS:** There is a risk of failure to undertake effective workforce planning (train, retain and reform) to support recruiting, attracting and retaining staff to meet current and future needs caused by the absence of a long-term workforce plan that considers training requirements, flexible working and development of new roles.	• Cross ref to risk 0029 overseen at QAC. • No changes to scores – Actions, gaps and milestones updated and a number of milestones have been achieved since last reported to Board of Directors: o Workforce Dashboard implementation from April 2023. (Full roll out by June 23) officially launched on 3 July 2023 – achieved. o Capture improved Diversity data for workforce planning and reporting as appropriate due by August 2023– achieved. • New role development integrated into workforce planning (such as Physician

	Associates and Peer Support workers – looking at skill mix in workforce planning and looking at flex approach/risks and potential other options available) – due by August 2023 will commence in July – achieved. • Deliver recruitment process improvement plan (transactional – better campaigns, experience for new recruits and onboarding) – due by July 2023 in place and being delivered – achieved. • The Executive Director of Nursing, Professions and Quality will advise on timing for any outstanding professions plans to come on the People forward planner. • The assurance rating remains Amber/Green.
BAF risk 0020 (current score unchanged – 12)	**Latest update**
Strategic priorities: Transformation – Changing things that will make a difference **DETAILS:** Risk of failure to move our culture sufficiently to address any closed subcultures, behavioural issues and not reflecting and respecting diversity and inclusion, resulting in poor engagement, ineffective leadership and poor staff experience in turn impacting on quality of service user experience.	• No changes to scores – Actions, gaps and milestones have been updated. • Controls referenced in the BAF risk 0024 received at QAC reflected. This was a recommendation made at the last People Committee meeting around commonality across work underway to address potential closed cultures. • In terms of the milestones there has been a pause of some existing activity as the Chief Executive has engaged external consultants to contribute to the communications structures and our values into behaviour work. Timeline will be adjusted in due course. • The milestone related to EDI around diversity and inclusion – progress as outlined in WRES and WDES – due in July 2023 has been achieved with reporting receive through People Committee and Board • An additional milestone has been added noting the Annual Equality and Human Rights report to be received through EMT, QAC, People committee and Board by November 2023. • The assurance rating remains Amber/Green.

Appendix 2 – Extract BAF risks overseen at Finance and Performance Committee

BOARD ASSURANCE FRAMEWORK 2023/2024 – for receipt at Finance and Performance Committee September 2023 – Risks overseen at Finance and Performance Committee and Audit and Risk Committee

AIM 3: EFFECTIVE USE OF RESOURCES	**STRATEGIC PRIORITY:** Transformation: Changing things that will make a difference
RISK REF: BAF.0021 A **RISK CREATED:** 07/05/2021 *re-worded June – approved at July 2022 Finance and Performance Committee*	**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, 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

Executive lead: Executive Director of Finance **Board sub – committee oversight:** Finance and Performance				**Risk type:** Quality & *Digital (data)*		**Risk appetite: MODERATE** – digital			**Assurance rating – Amber**
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	**4**	**3**	**12**	**Last Review:**	30 August 2023	**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**3**	**3**	**9**	**Next Review:**	September/October		**X**		

Summary update

- Changes since last received at the July Board are in blue text or strikethrough
- The EPR revised implementation timescales have been agreed go live dates 30 October and 27 November.
- Need to consider how we are scoring digital risk in terms of impact on services [and to be clear in the risk management strategy, when updated, on how this is being measured]
- Consideration will be given by the Executive Lead as to whether staff digital capability and training more broadly is sufficiently reflected in BAF or corporate risks at the suggestion of People Committee to FPC. This is reflected in the work to develop the roadmap for delivery of the digital strategy in view of delays caused by EPR slippage.
- Gaps, actions and template updated
- There remain no changes proposed to the residual which remains 4 x 3 = 12 – team reviewing given EPR risk scores – and post Annual DPST – following DPST outcome a continuation of risks in relation to the use of Insights system.
- Risk appetite unchanged.
- The assurance rating on EPR remains Amber.
- Milestone for moving to the target score: Full retirement of Insight has moved from November 2023 to Q1 2024 transitioning to business as usual (phased roll out from October 2023)
- As noted previously sources of assurance and actions are unlikely to change until the full retirement of Insight.

• In the next review consideration will be given as to whether the DSPT outstanding actions are reflected in the CRR and BAF appropriately with the exception of those which are low risk.	
Controls • Governance controls and oversight in place via EPR Programme Board which meets monthly • Board membership of EPR Programme includes 3rd party EPR supplier, 3rd party deployment consultants, CCIO, 3rd party CSO consultancy and Chair of ICS Digital Delivery Board (provides oversight) • Governance controls to move into remit of Digital Assurance group (DAG) • Digital Strategy approved by Trust Board on 4/11/2021 defines a plan for improved technology services and sustainability • Resource plan received at Oct 2022 ARC, as part of update to committee (CDIO) • SHSC Digital continue to retire old systems and improve cyber security in line with the guidance provided by the data protection and security toolkit. Making good progress to meeting the standard. • Assurance reporting through DAG onto ARC.	**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 June 2023 and end in November 2023 • EPR consultancy engaged to take us through implementation phase. CCN option to extend support to end of Nov 2023 as EPR 'beds" in. Unified Tech Fund commits Trust to provide 'blueprints' (good practice for EPR functionality) as part of implementation. • Reporting to DAG and onward reporting to Audit and Risk Committee • Digital Assurance Group – monthly and reports to FPC • Mandate and business case for increased staffing resource in SHSC Digital completed NEW assurance following closure of action agreed in March. • DSPT audit. Internal audit have provided support around penetration testing. **External assurance** • Annual Data Security Protection Toolkit (DSPT) audit moderate assurance rating received. • DSPT submission as part of national reporting
Gaps in controls 1. Implementation of EPR has been delayed; a revised plan is being developed	**Actions to address gaps in controls** • Develop revised plan for approval as EPR programme board; Owners CDIO (Pete Kendall) and SRO Director of Finance (Phill Easthope) (June 23) revised plan under development Board being kept updated. Completed new plan agreed in August 2023
2. Assessment and plan for full resourcing and affordability (for IMST) not currently in place.	• Resources for IMST mandate were initially approved in2022-23 business planning but were halted due to underdeveloped CIPs throughout the Trust. Subsequently, priorities have been reviewed across the organisation and a new digital roadmap will be produced – May 2023 Owner CDIO (Pete Kendall) – work ongoing to be July 2023. This is now expected post implementation new date to be confirmed in Q4
3. Four elements of DSPT still to be achieved, the relevant risks are being tracked.	• Last Windows 2008 server confirmed retired. Will update actions for DSPT for new audit in July. Owner CDIO(Pete Kendall). The next review of the BAF will confirm if there are any outstanding gaps which need to be reflected for example around infrastructure supporting Insight or if this is fully closed.
Gaps in assurance 1. Insight still being used – delays with EPR – consider if reference is needed here in terms of impact on assurance around clinical delivery/safety	**Actions to address gaps in assurance** • Retirement of Insight in Q3 2023(CDIO) - Update: retirement delayed following delay to the implementation to RIO moved from Q1/Q2 to Q3. (CDIO). Retirement of Insight is now likely to take place in Q1 2024. Owner CDIO (Pete Kendall) • Implement DSPT action plan to achieve 'Standards met' - 3 outstanding actions for DSTP will be completed by June 2023. (CDIO). Some outstanding actions relate to

	implementing the new EPR and will be impacted by go live and therefore not be completed by the end of June. DSPT audit for 2023/24 start in July and any outstanding actions will be part of the revised action plan. Implement DPST outstanding actions to be completed by June 2024. • Revised plan and timescale required, impact of EPR delay to be determined. Action - Revised plan July 23. CDIO (Pete Kendall)– Completed August 2023

AIM 3: EFFECTIVE USE OF RESOURCES	**STRATEGIC PRIORITY:** Transformation: Changing things that will make a difference								
RISK REF: BAF.0021 B **RISK CREATED:** 07/05/2021 *re-worded June – approved at July 2022 Finance and Performance Committee for submission to Audit & Risk Committee and Board agreed to split Nov 2022*	**DETAILS:** There is a risk that adequate arrangements are not in place to sufficiently mitigate increased cyber security and data protection incidents. This has been compounded by low Information Governance mandatory training levels across the Trust, unawareness of Phishing attacks as well as legacy core systems that may not meet current security standards and so remain vulnerable to cyber-attack. An attack may compromise or disable key systems and prevent their operation until we either have confirmation that is safe to do so following the application of software security patches or alternatively the system in its entirety is no longer deemed fit for purpose and removed from active service.								
Executive lead: Executive Director of Finance **Board sub – committee oversight:** Finance and Performance/Audit and Risk Committee				**Risk type:** Quality & *Digital (data)*		**Risk appetite: LOW –** cyber			**Assurance rating**
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	**4**	**3**	**12**	**Last Review:**	30 August	**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**4**	**2**	**8**	**Next Review:**	September/ early October 2023		**X**		

Summary update

- Changes since last received at the July Board are in blue text or strikethrough
- No change to scoring at this time and it remains 4 x 3 =12.
- Risk appetite unchanged
- Sources of assurance and actions are unlikely to change until Q3 2022/23 on the retirement of Insight – likely delayed until Q1 2024
- The implementation of Rio has been delayed; a revised plan has been developed and agreed in August 2023.
- Milestones to achieving the target score:
  - DSTP compliance aligned with all DTSP work – June 2024
  - Progress to be expected to be seen from December 2023.
- Assurance rating remains Amber/Green

Controls • Digital Assurance Group (DAG) which meets every 2 months monthly. • SHSC CAB use of Sunrise Service management Desk to record time to act following receipt of notifications in accordance with ITIL processes • SHSC Change Advisory Board (CAB) and Emergency CAB meetings reviewing and responding appropriately to NHSD Care Certification notices • Governance controls in place via monthly DAG meetings • Supplier engagement to ensure system patches are notified where vulnerabilities are known. Supplier engagement meetings as part of Service Review Management process, in accordance with ITIL process model Risk only applies if system is hosted locally, strategic shift to cloud hosting for applications • Mandatory IG Training to be monitored and reported across all Trust areas, with staff mandated to ensure compliancy as part of supervision • Revised controls agreed at DIGG to ensure delivery of IG (Data Security awareness) training • Phishing tests in accordance with requirements of DSP Toolkit to be undertaken	**Internal Assurance** • Reporting on patching reports is received at DIGG and reports is to be received as part of the Service Management report received at DAG and reports onward to ARC. • Reporting on System Asset register completeness and functionality to be brought through Digital Strategy Group for review. • Service management reports inclusive of supplier engagement relating to system patching for key suppliers for locally hosted systems • Monthly performance reporting across all Teams • Oversight via reporting to DAG from April 2023 **External assurance** • Confirmation provided to NHSD in accordance with prescribed national process • DSPT compliance – key indicator
Gaps in controls 1. Creation of System Asset Register project, to develop a mechanism to record systems in use and supplier/user details in line with Disaster Recovery Plan	**Actions to address gaps in controls** • System Asset register functionality within Sunrise not yet enabled. Sunrise system development underway through Sunrise Consultancy services – anticipated date for completion in April 2023. We need to identify clinical system owners who will report to the clinical leads (CDIO and CDNO and ensure that each system has a business continuity plan – with the support of the EPRR manager Terry Geraghty. ~~Clinical system owners to be identified and BCP's to be confirmed with by clinical leads.~~ • Asset register functionality within Sunrise to be specified and configured by Service Desk Manager, supported by Graduate Project Manager (April 2024)
2. No current resource to undertake meetings and proactively engage with technology suppliers GAP 2 Closed.	• Graduate recruitment plan in place to establish capacity (June 23) Owner CDIO (Pete Kendall) completed.
3. Management pressure to undertake necessary training where staff are non- compliant with IG training, or have been caught with test phishing processes – propose to remove gap given level of compliance at 95% which will continue to be monitored at DAG.	• Review of options and recommendation to be made by Trust Board following non-compliance for staff Proposals and actions for addressing gaps to be received at DIGG in Jan 2023 - owner CDIO (Pete Kendall) **Progress** Implementation of revised escalation to ensure delivery of IG training which will include a number of reminders and eventual revoke of account - owner CDIO (Pete Kendall) – March 2023. Update: This was awaiting sign off by CCIO due to clinical risk. Now complete – Trust achieved 95% compliance to IG training end of June 2023.
Gaps in assurance 1. System Asset register functionality within Sunrise not yet enabled.	**Actions to address gaps in assurance** • Sunrise system development underway through Sunrise Consultancy services – anticipated date for completion in April 2024 - owner CDIO (Pete Kendall). • Clinical system owners to be identified and BCP's to be confirmed by clinical leads. (April 2024) – BCP's are being confirmed to SHSC EPO (Terry Geraghty) ~~August 2023~~ – still under development. Due date deferred to April 2024.
2. Reports relating to supplier engagement meetings to be brought to DAG from April 2023 as part of Service Management report within regular monthly reporting cycle.	• ~~Projects to engage with suppliers to support aspiration not yet scoped. Specification of requirements to be drafted by service desk manager by March 2023. Meeting with all~~

(CDIO) In the next review we need to understand what is required to close this gap down.	~~key suppliers for locally hosted systems to be in place by July 2023.~~ • Meetings with current key suppliers for locally hosted systems established in part and reported to DAG monthly from within Project and Programme management report from August 24 onwards. List will grow as more suppliers engage. Owner CDIO (Pete Kendal)
3. Agreement to be reached regarding actions to be taken for managing noncompliance by January 2023 at DIGG by CDIO. Proposed to gap given assurance received on level of compliance 95% trained.	• See progress noted in gaps column. An update on progress will be provided by the CDIO for reporting in July. Completed given 95% compliance in IG training. Owner CDIO (Pete Kendal)

AIM3: EFFECTIVE USE OF RESOURCES	**STRATEGIC *PRIORITY*:** Transformation: Changing things that will make a difference and Recover Services and Improve Efficiency								
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 – revised wording approved at Board July 2023*	**DETAILS:** There is a risk that we fail to deliver the break-even position in the medium term caused by factors including non-delivery of the financial plans, lack of 2 – 5 year financial plans including developed CIP programmes 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***			**Assurance rating**
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	**5**	**3**	**15**	**Last Review:**	30 August 2023	**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**4**	**2**	**8**	**Next Review:**	September/early October		**X**		

Summary update

- Changes since last received at the July Board are in blue text or strikethrough
- No changes proposed to scoring at this time remaining as 5 x 3 = 15 - but the risk will be kept under close review noting it is possible if the position worsens that the residual risk score will rise, given there is increasing risk in respect of delivery of the Cost Improvement Plans which are not as progressed as they need to be and therefore progress status has moved to 'some slippage' – Financial impact is considered to be too high but is currently scored in line with Risk Management Strategy – to be reviewed aligned with the updated Risk Management Strategy (query impact of 4 and increased likelihood in terms of status of CIP plans = 16) for discussion at FPC with a 4 x 2 target score.
- Risk description, internal and external assurance, gaps in controls and assurances and actions, and template updated
- Risk appetite unchanged
- Board discussion on statutory /financial risk to break even and variability to sustainability -
- Detailed discussion on CIP has taken place at FPC and Board
- Financial plans approved at May Board.
- Initial milestones to achieving the target score are:
    - Agreeing a revised financial plan with CIP targets in March 2023 – achieved
    - Revised financial plan due for receipt at May 2023 confidential Board – received
    - Scope out and review CIP schemes and identify the opportunity for CIP e.g .overhead benchmarking, organisational structure, capacity and demand – by the end of April 2023 - achieved
    - New milestone – review residual risk score post completion of the revised Risk Management Framework – December 2023
    - New milestone – review of CIP delivery, financial plan delivery post Q2
    - New milestone – development of medium term financial planning as part of 2024/25 financial plan development – December 2023

Controls • Operational plan; financial planning; including CIP planning, processes and delivery monitoring • CIP programme Board established with more sophisticated CIP planning processes	**Internal assurance** • Monthly financial reporting to Team and Programme Board, Assurance report to FPC and Board. • Performance Framework meetings and recovery plans • Key areas identified and plan progressing. FPC being kept abreast of progress and slippage. Updated CIP plan received at FPC and Board in April 2023. • Recurrent CIP plan for 2023/24 **External assurance** • NHSE&I Financial Review *2021/22* and ongoing support as required • Internal audit on CIP received June 2023 - split opinion overall (significant on processes and limited on improvements already in place) it was recognised the gap had already been closed in 2023/24 CIP planning no further action needed.
Gaps in controls 1. Identification of a full recurrent CIP plan over the medium term	**Actions to address gaps in controls** • ~~2022/23 CIP plan including QEIA to be in place by the end of Quarter 3 2022/23. Director of Finance – Completed - We have a recurrent plan for 2023/24~~ • Work in train to develop CIP plan for future years by December 2024 develop a 3 year CIP plan as part of the planning cycle.
Gaps in assurances 1. Full CIP plan 100% recurrently identified. Gap closed for 2023/24. Plan for the medium term to be put in place.	**Actions to address gaps in assurances** • Plan to be developed for future years See update under actions to address gaps in controls.

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 lack of availability of capital funds resulting in service quality and safety being compromised by the non-delivery of key strategic projects.								
Executive lead: Director of Operations and Transformation (interim arrangement until new Director of Strategy is appointed) **Board sub – committee oversight:** Finance and Performance				**Risk type:** Quality		**Risk appetite: LOW**			**Assurance rating**
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	**4**	**4**	**16**	**Last Review:**	31 August 2023	**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**3**	**2**	**6**	**Next Review:**	September/early October 2023		**X**		

Summary update

- Changes since last received at the July Board are in blue text or strikethrough
- Score has remained unchanged at 4 x 4 =16 because of the likelihood of delays and the impact on CIP.
- Risk appetite unchanged
- Gaps updated – closed gaps agreed in July removed
- Risk controls, actions, milestones and template updated
- Milestones to target score:
    - Therapeutic Environments – will impact on OOA and CIP delivery – due to delays in completing the Maple ward improvements this could be impacted up to August 2024. ~~Mid-end of June 2024 Maple should be re-opening at this point and so contracted out of area will cease.~~
    - EPR by end of November 2023
    - Community Facilities – St Georges, Assertive Outreach and Community Forensic team to move by the end of November ~~August~~ 2023 due to structural improvements required to the site which are taking place.
    - The fixed Ligature Anchor points work (other than other acute wards) should be by the end of 2024/25 to include Dovedale 1 and Forest Lodge
    - The fixed Ligature Anchor points work for acute wards will be completed by June 2024
    - HBOS, Stannage and Maple to be completed by November 2023. We are aiming for Maple to be completed by June 2024 however there is a risk of slippage. ~~June 2024~~
    - Fullwood capital received in Q 4 2023/24
    - CMHT delivery January 2024 and LD delivery March 2024 (estimated) ~~– dates being confirmed~~

- There is a need to be clearer about financial risk gap for EPR. Executive Director of Finance and Director of Operations and Transformation to discuss and agree further actions in September 2023.
- A thorough review will take place with Head of PMO in September to update the BAF risk for reporting in October including identifying any further gaps in controls.

Assurance rating – Amber~~/Green~~ due to some additional slippage

Controls	**Internal assurance**

• Effective programme management in place including governance infrastructure aligned to Prince II and Managing Successful Programmes standards
• Reporting through Programme Boards to Transformation Board and onwards to Board sub committees
• Monthly escalation reporting
• Health Card and Financial Health Card developed and reviewed monthly at transformation board and bi- monthly at FPC from March 2023 providing overview of all programmes
• Members of the Executive team as SRO's for all projects and programmes
• Joint board with Primary Care Sheffield for the PCMHT programme
• Monthly review of programme health card by the Transformation Board to support governance
• Use of QEIA's to support change control within projects
• Risks and issues reviewed monthly by programme boards
• Milestone plans in place for each programme and monitored through highlight reports
• Procurement process; Project change control on capital and business case visibility
• Programme Board TORs all reviewed against new standard and revised where necessary
• All programme stakeholder maps have been updated
• Monthly meetings in place with programme managers to review highlight reports, risks and issues
	• 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.
	• Risks and issues are covered in the Transformation Board / Programme Boards and highlight reports. All programmes have plans in place NEW assurance following reporting of closure of gap in March
	• Reporting takes place via PMO. The SRO/Chair of the Back to Good Programme Board is a member of the Transformation Board.
	• Programme and Project Boards are in place for the majority of areas. Activity to standardise the Terms of Reference and agendas. All in place Highlight reports already standardized and stored on SharePoint going back to January 2021.
	• Board, meeting minutes, report to Finance and Performance committee
	• Business case approved to recruit to team to fulfil action. All posts within PMO filled. PMO Analyst to focus on check and challenge activities
	• External resource has been secured to support the completion of the Strategic Outline Case for the Therapeutic Environments programme
	• Suite of templates available. All new projects and programmes use the new templates.
	• All TOR's are on standard template. A review schedule has been developed and PMO will ensure the activity happens
	• Programme Managers have been engaged in roadmap and development work, sharing learning and experiences on specific projects.
	• Benefits realization taking place on Health Roster programme report
	
	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
	  • Health based place of safety bid – monitoring arrangements in place by ICB
	• Primary and Community Mental Health via joint programme board with Primary Care Sheffield.
	• EPR – External representative on Programme Board to advise on procurement.
	• Primary and Community Mental Health Transformation Programme – representation from Primary Care and external organisations.

	• Learning disability programme and CMHT project boards have representation from external organisations • 360 Assurance have reviewed all TOR's • External specialist resource is being brought in where appropriate to provide necessary skills, knowledge and capacity - Apira is the implementation partner for the EPR project moved from controls.
Gaps in controls 1. Dependencies register to be redefined and implemented into work and assurance of the Transformation Board.	**Actions to address gaps in controls** • The dependency register is now specified and therefore this action is complete and is reflected in Monday.Com. Owner Head of PMO (Zoe Zibeko) • ~~Will be built using MS Office products. It has been specified in Monday.com to commence implementation from January 2023 – Head of PMO - May update Milestones are in place on Monday.com. with the exception of Leaving Fulwood and Health Roster which are in the closure Phase, and EPR, all other projects and programmes are using Monday.com either fully or are starting to set up structures within there for monitoring delivery.~~ • Further work is required to configure dashboards and reporting for Project boards and Transformation Board (for LD and EPR). Head of PMO (Zoe Zibeko) – ~~end July 2023~~ To update early October 2023 ~~(LD and EPR plans changing)~~
2. ~~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 (Fulwood, Therapeutics environment and community facilities)~~ Control gap wording update - Ensure that a change process is implemented in EPR and establish if this is required for learning disability	• Review of procurement systems and process (PE) reported to FPC – will go through BPG report to FPC and was covered in the report received in April. A more detailed update on review of business process was received ~~will come~~ as part of the Q BPG report to FPC in July – Executive Director of Finance (Phill Easthope) - complete • Transformation board 31 August 2023 – to discuss change controls required for EPR and LD BAF to be updated to reflect this in September Owner Director of Operations and Transformation (Neil Robertson) • Project change control process being implemented to capture changes in scope Programme Manager for Therapeutic Environments (Adele Sabin and Derek Bolton Head of Capital Dev and Improvement) April 2023 - through the Therapeutics Environment Board – finance health card produced and received and using QEIA where there is project slippage e.g impact on Dovedale 1 - Complete • Variations to estates capital projects; business case estimates of cost impact to be provided to programme boards and BPG well in advance of final versions to Jason Rowlands, Chair of BPG April 2023 – Has begun and is being reported to FPC through the transformation (bi-monthly report) in addition any exceptions where this is not on the agenda is reported using standard template end of July 2023 – Owners - Programme Manager for Therapeutic Environments (Adele Sabin) and Head of Capital Dev and Improvement (Derek Boulton) – completed.
3. Control GAP 3 Closed reported to Board in July 2023	
4. Control GAP 4 closed reported to Board in July	

5. 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. This is being reviewed to ensure clear governance flows up from the tier II groups.	• Just finishing health roster programme and a new programme will be put in place in response to the refreshed People Strategy from April 2023. The approach will be dependent upon what is required from the strategy and around refreshed strategic priorities – it will report into the People governance route –– In 2023/24 will focus on the embedding and optimisation of eRoster, including connectivity with other systems, i.e. people plan action for 23/24 is to implement manager self-service by March 2024. On track and should be delivered by the end of the financial year. Head of workforce systems (Stephen Sellars) who is attending a range of forums. An update will be provided in the next review of the BAF on the governance arrangements.
6. Approved revised resource plan following initial go live delay for EPR to June and July 23. Further delay to October/November 2023 – Control GAP 6 updated around a need to be clearer about financial risk gap.	• ~~•~~ Implementation has been delayed; a revised plan has been developed and approved ~~is being developed – a revised data migration go-live plan to be agreed internally and with NHSE~~ • Review phase 2 (post initial go live dates) timing and deliverables with resources plan in May 23. Owner Executive Dir of Finance (Phill Easthope) – go live delayed see updates work in place see actions under EPR related actions 21.A ~~–. Develop revised plan for approval as EPR programme board; CDIO and SRO Director of Finance (June 23) update on progress will be available in July 2023 –~~ Revised plan developed and approved – action closed • Dir of Finance has re-estimated costs for revised go – live point (high level resource plan) which will go in the escalation report to FPC in July 2023. Received at FPC and EMT August 2023. Need to be clearer about financial risk gap. Owners Executive Director of Finance (Phill Easthope) and Director of Operations and Transformation (Neil Robertson) to discuss and agree further actions in September 2023.
Gaps in assurance 1. Replace the SHSC project manager for EPR – Assurance GAP 1 CLOSED.	**Actions to address gaps in assurance** • PMO are providing additional resource and additional support is being sourced – to be completed by September 2023. Head of PMO (Zoe Zibeko) – action 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: Moved to Executive Director of Finance (interim arrangement until new Director of Strategy is appointed) **Board sub – committee oversight:** Finance and Performance				**Risk type:** Business		**Risk appetite: MODERATE**			**Assurance rating**
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	**4**	**3**	**12**	**Last Review:**	31 August 2023	**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**4**	**3**	**12**	**Next Review:**	September/early October 2023	**X**			

Summary update

- Changes since last received at the July Board are in blue text or strikethrough
- Assurance rating Amber.
- Score to remain 4 x 3 = 12
- Discussion will be required on the target score which has remained the same as residual risk score throughout 2022/23. To confirm if this tolerated position.
- Risk appetite unchanged
- Controls, assurances, gaps, actions and template updated
- Risk appetite unchanged
- Milestones to target score:
    - Work on shared priorities and the ICB forward plan received at March 2023 board
    - Mother and baby and associated perinatal service development – by the end of 2023/24
    - Forensic inpatient beds and community forensic team tender – by the end of 2023/24
    - Agreeing South Yorkshire integrated approach to access for Health Based Place of Safety – by the end of 2023/24
    - Eating disorder service co-located with VSCE – by the end of 2023/24
    - Substance misuse service safe transition to new provider – August 2023 achieved
    - Staff bank enhanced with students from Sheffield Universities – by the end of 2023/24

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- The Corporate Governance leads have met to have initial discussion on development of a system BAF – expecting to receive draft BAFs coming through processes across the Summer of 2023. Development of the MHLDA provider collaborative gaps in control and actions to be added in as some proposals are under development following discussion at Chair and CEO meetings in August and planned for the Collaborative Committee in Common in September .

• Sheffield Health and Care Partnership regularly attended by Chair and CEO and other Executives linking into appropriate delivery groups. • SHSC CEO was the CEO lead of the MHLDA Collaborative during 2022/23 and this has now moved to another CEO. SHSC Chair has taken on lead Chair role for the MHLDA Collaborative from July 2023	
Controls • We were fully engaged at PLACE, ICB and Collaborative to participate in the planning of priorities for 2023/24 and worked together with colleagues in PLACE, collaborative and ICB through board workshop and with our senior leaders to support us in ensuring the priorities are reflected in SHSCs annual operating plan – approved by the Board in May 2023 • All core strategies are in place with annual reviews	**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 • The stakeholder engagement map was updated to reflect the latest changes and an update received at board in December 2022. New internal assurance following closure of action. • Active engagement taking place – SROs are engaging as part of new ICS arrangements. New internal assurance following closure of action. • 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 June 2022. • Strategies and associated implementation work plans are in place. • Additional strategies have come through in 2022/23 (e.g. Carers, FTSU) • Board sub-committee review of each strategy prior to approval. • Engagement with the Council of Governors. • Quality Accounts • 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. • 5 year plan and strategic direction received at FPC (Nov 2022) and Board workshop (Dec 2022) approved by Board Jan 2023 **External assurance** • Future review from CQC and NHSE will seek views from system partners. • Link into Outcomes Group in PLACE • New arrangements are now emerging • October 2022 priorities workshop • NHSEE/I and CQC Well-Led monitoring • Significant assurance received from Internal Audit on the transformation programme.
Gaps in controls	**Actions to address gaps in controls**
1.Digital roadmap	• ~~Digital roadmap to be in place by September 2023 – CDIO~~ - Digital roadmap to be worked up within BPG by CDIO supported by Deputy Director of Strategy in place by

	April 2024
1. Still under development for the final strategies not yet approved by the Board (PIDs).	• 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 December 2023. These were delivered for the November workshop – now need to do so for the two new strategies Carers (Exec of Nursing, Professions and Quality) and FTSU (Guardian with Director of Governance) – populating the framework by September 2023 with guidance from Jason Rowlands (Deputy Director of Strategy) by November 2023.
Gaps in assurance **1.** Future CQC and NHSE reviews will not be as frequent. Orientation of enquiry from CQC will be whether partnership working is effective. Not all reports include sufficient consideration of partnership working.	**Actions to address gaps in assurance** • Reflect in planning for CQC visit - timing for visit not yet known therefore the work to prepare is continuing - Executive Team
2. Detailed implementation plans have yet to be finalised for every strategy therefore stakeholder and engagement plans are yet to be fully completed	• 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 owner - Deputy Director of Strategy (Jason Rowlands) **Progress –** implementation plans are being finalised for each of the eight enabling strategies, scheduled for end of November/ early December 2022. Received at the strategy alignment session in November 2022 and implementation plans should be reviewed and updated before each annual review at the board which is planned for and reflected on planners to be finalised by November 2023. • Stakeholder engagement plans are being completed as part of the PID for each strategy – to be completed by end of November/ early December. [JR] In place with exception of the new strategies (Carer and FTSU) by November 2023. Owner - Deputy Director of Strategy (Jason Rowlands)

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, 0025a and 0025b, 0029* • *Aim 2 - Create Great Place to Work BAF risks 0013,0014,0020* • *Aim 3 - Effective Use of Resources BAF risks* ***0026 and 0027***

BOARD ASSURANCE FRAMEWORK 2022/2023 – Risks overseen at Quality Assurance Committee for receipt September 2023

AIM 1: DELIVER OUTSTANDING CARE	**STRATEGIC PRIORITY:** Continuous Quality Improvement							
RISK REF: BAF.0024 **RISK CREATED:** *June 2022* *Risk re-worded June 2022 – approved at July 2022 – revised wording agreed July 2023*	**DETAILS:** Risk of failing to meet fundamental standards of care with the regulatory body resulting in avoidable harm and negative impact on service user outcomes and experience staff wellbeing, reputation, future sustainability of particular services *which could result in* regulatory action. This risk could be associated with the failure to detect closed cultures within clinical teams.							
Executive lead: Executive Director – Nursing and Professions /Medical Director **Board sub – committee oversight:** Quality Assurance				**Risk type:** Quality		**Risk appetite: LOW**		**Assurance rating**
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		***PROGRESS STATUS***		
Residual Risk (with current controls)	**4**	**3**	**12**	**Last Review:**	31 August 2023	***On track***	***Some Slippage***	***At risk***	***Completed***
Target Risk (after improved controls)	**4**	**2**	**8**	**Next Review:**	September/ early October		**X**		

Summary update

- Changes since the BAF was received at the July Board are in blue and strikethrough
- Assurance rating remains Amber/Green
- Cross Ref to FPC BAF risk 0020 received at People Committee
- 'Back to Good' ~~reporting on improvement actions is reflected in a new Quality report from July 2023 onwards~~. Closure meeting took place in August 2023 with outstanding actions picked up in the new Quality Assurance Report and business as usual assurance reporting through committees.
- No proposed change to risk scores and remain 4 x 3 = 12
- Actions have been updated. Controls around fundamental standards and culture and quality visits reflected in People BAF risks.
- The milestones to achieving the target score have been agreed:
    - To achieve the ~~recruitment/~~turnover rate of 10% - timeframe to be confirmed
    - Completion of the Fixed Ligature Anchor Point programme for acute adult services will be between June and August 2024 however exposure to fixed ligature anchor points will be removed from January 2024 due to the decant of service users from Maple Ward (at the point we close that ward for refurbishment)
    - Completion of the Back to Good programme – Last meeting held August 2023 and outstanding. Closure report coming to Board in September 2023.

Controls	**Internal assurance**
• Monitoring of performance and Quality through governance structure which can result	• Back to Good – 9 improvement actions are currently in exception

in request for improvement plans monitored through QAC e.g recovery teams, SAANs. • Back to Good programme dissolved following completion of 10/75 actions. Remaining actions embedded in BAU governance for reporting and monitoring • Ongoing recruitment plans, reviewed via People committee with robust workforce dashboard • Clinical Establishment reviews 2022/23 completed • Service lines and IPQR embedded ensuring oversight • Management and leadership structure in place – Ward to Board • Enabling strategies approved and delivery plans in place • Robust incident and investigation governance in place, PSIRF development and implementation plan for 2023 • Clinical and Social Care strategy implemented • Co-production standards launched • Range of leadership offers completed and ongoing across SHSC corporate and clinical teams • Robust Transformation plans and monitoring for recovery services, LD services and PCMHT with coproduction embedded • Quality and Equality impact assessment reporting to QAC ~~process in place~~ • Ligature anchor point removal plan phase 1 and 2 are completed, phase 3 in progress. Clinical Environmental Risk Group reviews all LAP assessments and reports to clinical quality and safety group. Exceptions to Therapeutic Environment Board. • Daily operational management of safer staffing • New EPR implementation underway and timescale agreed • Fundamental standards of care visits completed across inpatient. Action plans in place. Culture and Quality visit programme in place for community services. • Tendable reporting into appropriate governance groups • Utilising a UEC dashboard to understand the blocks in progress included in IPQR – moved from gaps in assurance to Controls. • CQC reinspection demonstrated improvements across Well Led and Older People's services • Recruitment plan in place • Daily management of staffing	• International Recruitment progressing well with clear plans and trajectories • Tendable being utilised consistently • Regular reports through (Back to Good; EPR monthly programme Board; ACM monthly Board reports; Transformation Board monthly reports; Staffing reports to People Committee) • Learning lessons quarterly report • Safeguarding quarterly reports • Policy review by Quality Assurance Committee • Safer staffing report 6 monthly. • Successful international recruitment with new recruits in post • The CQC report that was published on 16 February 2022 demonstrated we had delivered actions against the section 29a warning. Significant progress was noticed. New improvement actions are in place. Moved from actions. **External assurance** • CQC reinspection – Dec 2021 - 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 • NHSE funding required external reporting
Gaps in controls 1. Phase 3 plan for reducing ligature anchor points will depend on decant solution and take place over an 18 month period see action	**Actions to address gaps in controls** • Maple ward will decant to refurbished Stanage ward – ~~date to be confirmed expected through approvals in June/July. For Business case sign off in July.~~ Expected date is January 2024 Final business case for Maple improvements will be submitted to Board in December 2023 for approval. Owner Director of Operations and Transformation (Neil Robertson).

	• ~~There is a recovery plan in place aligned to the CIP overseen at CIP Board and People Committee.~~
2. New EPR not yet implemented- there is a delay to the programme see separate BAF risk overseen at FPC for actions being taken.	• No additional actions required here.
3. Responsible Clinician vacancies	• This has been led through medical staffing with leadership from Clinical Director Rob Verity. There are 3 locum consultant psychiatrists on 3 inpatient wards fulfilling RC duties. Recruitment as part of the agency reduction programme with enhancements will begin imminently. 1 non multidisciplinary AC/RC is in post on an inpatient ward. A further 2 employees are being supported with AC/RC training in inpatient and SPA which will take 12-18 months to be completed. Approval of a 3rd multidisciplinary AC/RC training position has been successful which will be filled by a member of staff in autism/ LD – time to completion 18-24 months. (Deputy Medical Director (Helen Crimlisk)
4. Two acute wards remain mixed gender- Maple work will move the ward to single gender. GAP 4 Closed. No longer a gap as plan in place see update in actions.	• Final decision to be made on the gender split whilst Maple is refurbished Gender split is subject to the clinical model approval by Board which will go with the Full Business case for Maple following discussion at FPC and QAC as required. Owner Director of Operations and Transformation (Neil Robertson) • Lack of progress with sexual safety work across all acute wards. New lead for sexual safety has been appointed reports into Clinical Quality and Safety and QAAC. Directorate leads are providing support to the newly appointed lead. Plan coming to QAC in September 2023. Owner Director of Operations and Transformation (Neil Robertson)
5. We are restricted on our capital spend each year and we have a large programme of estates improvements which means that they have to be phased over the next two years. ~~Lack of capital to support essential environmental – improvements~~	• Capital programme in place overseen at FPC and has been re-prioritised and is expected to be approved by FPC in September 2023. ~~but cannot meet the needs of SHSC in a timely way.~~
6. Poor compliance with Supervision in clinical teams	• Supervision review underway led by Director of Psychological services. Will complete in October 2023.
7. Flow plan is not impacting at a pace we had hoped – see corresponding action	**Actions to address gaps in assurance** • Additional focus needed on delayed care – September 2022 – Executive Director of Operations and Transformation Neil Robertson Flow plan revised and in place being led by the Clinical Director Rob Verity. Continuously ongoing – reviewing effectiveness in September 2023. • Planning is in place for industrial action which goes through Gold command –Exec Dir of Nursing, Exec Dir of People and Exec Dir of Operations – ongoing no change – ongoing and as required. Addresses gaps 5 and 6. Covid 19 no longer a significant issue. • ~~Piloting a senior matron across all four wards – Agreed at JCF for implementation following successful pilot. – Kelly McKernan, head of Nursing. Consultation now progressing, to completion now expected by end of July 2023~~

8. Use of 136 suite rooms to accommodate people awaiting admission – still required at the current time	• Use of 136 issues will be addressed by November 2023 Executive Director of Operations and Transformation (Neil Robertson)
9. Recovery plans to date are not having sufficient impact ~~on impacting~~ waiting times this is being addressed through the Community Transformation which will be completed in January 2024. ~~in Recovery for allocation addressed through community transformation Sep 23~~	• We have commenced the mobilisation of community transformation which will be fully implemented by January 2024 Head of Service (Greg Hackney)

AIM 1: DELIVER OUTSTANDING CARE	**STRATEGIC PRORITY:** Continuous Quality Improvement and Transformation - Changing things that will make a difference								
RISK REF: BAF.0025A **RISK CREATED:** *11/05/2021 – re-worded June 2022 – divided in March 2023 see 0025B – updated wording agreed July 2023.*	**DETAILS: 0025A** There is a risk to patient safety caused by failing to effectively deliver essential environmental improvements for the reduction of ligature anchor points / improvements in therapeutic space in inpatient settings								
Executive lead: Director of Operations and Transformation **Board sub – committee oversight:** Quality Assurance				**Risk type:** Safety		**Risk appetite: LOW**			**Assurance rating**
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	**4**	**4**	**16**	**Last Review:**	31 August 2023	**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**3**	**2**	**6**	**Next Review:**	September/early October		**x**		

Summary update

- Changes since the BAF was received at the July Board are in blue and strikethrough
- Cross reference with BAF.0026 overseen at FPC
- Risk appetite for LAP confirmed by the Board – LOW
- Actions to address gaps have been updated, template has been updated.
- Descriptor updated.
- It is proposed that there are no changes to the score and it remains 4 x 4 = 16 target score and appetite rating unchanged.
- With regard to Maple Business Case - approval to fund the design phase went through FPC in June. We will go to committees during the summer (the clinical model will be received at QAC in August - all scenarios require decant to Stannage) – the Full Business Case, including design details will go through Committees and Board in September 2023.

The milestones to achieving the target score have been agreed:

- Completion of phase 3 Ligature Anchor Point works - by June 2024 (for adult services – DD1 will be in 2024/25) – expected to be completed between June – August 2024
- New clinical environment risk assessment tool in place with 80% compliance – achieved.
- Robust assurance of monitoring of the assessment tool – monitored through the Clinical environment risk group which meets monthly

Assurance rating – Red

Controls	**Internal assurance**
• Enhanced nursing cover on specific wards to manage environmental risks • Implementation of Least Restrictive Strategy 2021-24 • Investment in preceptorship to develop the skills of newly registered nurses • Ligature anchor point assessments in place for all environments overseen at Clinical Quality and Safety Group • DRAM clinical assessment tool in place • Risk heat map implemented for all inpatient wards • Ward managers for all 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 • 1 Matron for 4 acute wards inplace July 2022. • Executive team visits on site. • Capital investment in 136 provision achieved. • Clinical Environmental Risk Group established Nov 22 reporting through to Clinical Quality and Safety Group • Work to review the DRAM in progress • Record Keeping SOP developed for clinicians.	• Therapeutic Environment Programme 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 • Recruitment forecast confirmed • Refurbishment of Burbage completed November 2022 • Dormitories eradicated on Standage – December 2021 • Requirements from the CQC reports have been met and we are now Requires Improvement. **Negative assurance** • Feb 2020 CQC inspection report • CQC inspection reports - August 2020, May and December 2021 (in respect of the environment)moved from gaps in assurance **External assurance** Evidence based approach to Reducing Restrictive practice implementation CQC reports moving from Inadequate to significant for inpatients.
Gaps in control	**Actions to address gaps in controls**
1. Ongoing vacancies management and use of temporary staffing leading to potential inconsistencies in the application of practice standards.	• Action to address ongoing vacancies involves ongoing recruitment and retention work to ensure regular substantive inpatient staffing with skills and knowledge to mitigate known inpatient environmental risks. Heads of Nursing – ongoing no end date • Work to develop SHSC Bank with standards of training and supervision and cease use of Agency staff . Nin Uppal Graves Executive and the Director of Nursing, Professions and Quality (Salli Midgley) : Valuing Our Bank Improvement Programme. To be complete by December 2023 See BAF Risk 0025 B for detail on work in place around refurbishment • The LAP Assurance Group has been stood back up and is working with the Clinical Environmental Risk Group to tie together LAP work that is either part of the phase 3 programme or is either part of back log maintenance or requires capital works. Areas of work have been identified and plans being put in place over the next three months – to be complete by end of August 2023. Owners Executive Director of Nursing, Quality and Professions (Salli Midgley) and Director of Operations and

	Transformation (Neil Robertson) • Maple business case will be taken for approval by end of Q1 23/24. For DD1 final business case ready for approval by the end of Q3 23/24 –Owner Director of Operations and Transformation (Neil Robertson) - on track to go through FPC committee in July. Approval to fund the design phase went through FPC in June. We will go to committees (the clinical model will be received at QAC in October ~~in August~~) and Board with the Full Business Case – including design details in December ~~September~~ 2023.
Gaps in assurance 1. Addressing negative assurance	**Actions to address gaps in assurance** • Implementation of Back to Good programme and the Therapeutic Environments programme both in progress with Executive leadership from the Medical Director (Mike Hunter) and the Director of Operations and Transformation (Neil Robertson). Significant progress made and regular reports received at committee and board. ~~Gaps are considered to have closed with exception of the 10 outstanding actions from B2G report in May. All others are met.~~ Final Back to Good programme board in August 2023. Closure report due for receipt at Board in September. Outstanding actions monitored at relevant Board Assurance Committees.

AIM 1: DELIVER OUTSTANDING CARE	**STRATEGIC PRORITY:** Continuous Quality Improvement and Transformation - Changing things that will make a difference
RISK REF: BAF.**0025B** **RISK CREATED:** *11/05/2021 – re-worded June 2022 – separated into two risks Feb 2023. See BAF risk 0025A updated wording agreed July 2023.*	**DETAILS:** **0025B -** There is a risk of failure to deliver 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 unacceptable service user safety, more restrictive care and a poor staff and service user experience

Executive lead: Director of Operations and transformation **Board sub – committee oversight:** Quality Assurance	**Risk type:** Safety	**Risk appetite: Moderate**	**Assurance rating**

Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	**4**	**4**	**16**	**Last Review:**		**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**3**	**2**	**6**	**Next Review:**			**x**		

Summary update

- Cross reference with BAF.0026 overseen at FPC
- Changes are in blue and strikethrough
- Actions to address gaps have been updated, template has been updated.
- It is proposed that there are no changes to the score and it remains 4 x 4 = 16 target score and appetite rating unchanged.
- Risk appetite for Therapeutic Environments was agreed as MEDIUM/Moderate by the Board
- Actions have been updated and where closed moved to controls and assurances as appropriate.
- Milestones to achieving the target score are:
    - 136 Build - August 2023 – slippage ~~to September 2023~~ – completion in November 2023.
    - Stanage refurbishment – August 2023 – slippage - completion now expected in October 2023.
    - Maple Ward relocation to Michael Carlisle Centre – ~~October 2023~~ – slippage – now expected January 2024.
    - Maple Completion – ~~March 2024~~ – slippage to between June and August 2024
    - Dovedale 1 feasibility and design – ~~December 2023~~ – slippage to March 2024 for feasibility
    - Dovedale 1 estate work – January 2023 – to be prioritised in the Capital plan for 2024/25 due to CDEL limits
    - Completion – June 2024. – ~~likely October 24~~ for Dovedale 1 – for acute adults between June and August 2024 and Dovedale 1 to be confirmed in 2024/25

Progress

- The refurbishment works on Burbage ward were extended due to unplanned but necessary roof works. Relocation successfully took place in November 2022.
- As part of this programme of works Stanage dormitories have been eradicated, completed on 3 December 2021.
- Phase 3 works 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. Exec Dir of Operations see new assurances on business cases.

• Forecast of new starters in place improving vacancy gap for registered nurses to 6% by February 2022. Exec Dir of Nursing – update provided and moved to assurance. • As noted above we have slippage identified – there is high level of confidence in the revised dates.	
Control • Quality team have assessed the impact of ligature assessments and tightened controls and processes • Ligature anchor point assessments in place for all environments • Risk heat map implemented for all inpatient wards • Enhanced nursing to manage environmental risks • Planned environmental improvements to the acute wards • Estate strategy that determines future need for community and ward estates that enables therapeutic and safe care • Board visits • Capital investment in 136 provision achieved • Clinical Environmental Risk Group established Nov 2022	**Internal assurance** • Regular reporting (Capital Group; Therapeutic Environment Programme Board; Transformation Board) • Operational Structure presentation to People Committee • Crisis Pathway presentation to Quality Assurance Committee March 2021 • Health and Safety audits • IPQR monthly reports – statutory and mandatory training • Board and Executive visits to all wards and teams • Recruitment forecast confirmed • Board have approved business case for refurbishment of Stanage with works now underway. • We have had a business case approved for Health Based Place of Safety which is an enabling works to support the relocation of Maple in the autumn of 2023 to the newly refurbished Stanage ward. Plan to relocate Stanage to a ward without seclusion now agreed. Have moved to new Burbage ward – moved from actions • LAP assurance group which is led by the programme manager for therapeutic environments and the clinical risk and patient safety advisor. • In February and March 2023 Registered Nurse and Healthcare Support Workers were onboarded covering many vacancies across acute wards. Systems are in place for rolling Registered Nurse and Healthcare Support Workers led by the Lead Nurse for recruitment. **External assurance** • Evidence based approach to Reducing Restrictive practice implementation
Gaps in control 2. Use of temporary staffing leading to potential inconsistencies in the application of practice standards	**Actions to address gaps in control** • 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 programme. The method chosen was to work on live wards for the programme which covered Stanage, Maple and Dovedale 1 wards. wards for phase 2 works only as wards need to be unoccupied during phase 3 works. Owner Director of Operations and Transformation (Neil Robertson)
3. Delays in the delivery of Therapeutic Environment Programme (TEP)	• Ligature Anchor Points - Work taking place to capture outstanding ligature anchor point work through the Clinical Environmental Risk Group Exec Dir of Nursing, Professions and Quality -has undertaken analysis – The LAP Assurance Group has been stood back up to tie together LAP work that is either part of the phase 3 programme or is either part of back log maintenance or requires capital works. Areas of work have been identified and plans being put in place over the next three

	months – to be complete by end of August. Owners Executive Director of Nursing, Professions and Quality (Salli Midgley) and Director of Operations and Transformation (Neil Robertson) – • ~~We are now working on the business case on Maple to start works later in 2023/24.~~ • Maple business case Full Business case going through governance route for approval at Board in December 2023 following receipt of the clinical model at QAC in October. Owner Director of Operations and Transformation (Neil Robertson)~~will be taken for approval by end of Q1 23/24. For DD1 final business case ready for approval by the end of Q3 23/24 - on track and going through committees in June and for final approval of OBC in July 2023. Approval to fund the design phase went through FPC in June. We will go to committees (the clinical model will be received at QAC in August) and Board with the Full Business Case – including design details in September 2023.~~
4. No outcomes from expressions of interest to the new hospitals bid (The bid for additional capital for the 136 reprovision has been approved and work started beginning of January 23). GAP 4 closed.	
5. Lack of de-escalation space on Endcliffe ward. This is subject to a business case process and will be factored into the 23/24 capital plan. GAP 5 closed.	• This gap has been closed. The work has been completed.
6. Provision of 136 suite not yet completed.	• However business case approved and works underway due for completion in September 2023. Director of Operations and Transformation (Neil Robertson)
7. Dovedale 1 now subject to a new feasibility plan that is exploring other estate options, which will be delivered on in 12-18months. We are managing the risk during this process with increased CCTV coverage and refresh of managed risks	• Dovedale 1 requires extensive work and we are scoping the best environment to improve quality on the ward– we have identified a possible new location for Dovedale 1 and improvements will require a full business case and wide engagement. Due to the CDEL limits on capital we will prioritise this for 2024/25 Capital Plan. We are exploring opportunities to begin the design phase in 2023/24. Owner Director of Operations and Transformation (Neil Robertson)
Gaps in assurance 1. To address negative assurance • Feb 2020 CQC inspection report • CQC inspection reports - August 2020, May and December 2021 (in respect of the environment) moved from gaps in assurance	**Actions to address gaps in assurance** • Implementation of Back to Good programme and the Therapeutic Environments programme – completed August 2023 – closure report due for receipt at the September 2023 Board. Owner Medical Director (Mike Hunter) ~~both in progress with Executive leadership from the Medical Director and Executive Director of Operations. Monthly monitoring in place.~~

AIM 1: DELIVER OUTSTANDING CARE	***STRATEGIC PRIORITY:*** Recover services and improve efficiency *and Transformation: Changing things that will make a difference*
RISK REF: *BAF.0029* ***RISK CREATED:*** *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, 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

- Changes are in blue and strikethrough
- Updates made to controls, assurances gaps and actions.
- It is proposed that there are no changes to the score and it remains 4 x 4 = 16 target score and appetite rating unchanged.
- Cross reference BAF.0014
- A number of gaps and actions have been closed. This is still marked as 'at risk' due to continuing working on reducing on the waits.

Milestones to achieving target score:

- Investments to support waiting list reduction will be agreed as part of the ICB planning round in Quarter 1 23/24 – Received further investment in relation to peri natal and recovery team waits. Milestone partially met. Funding confirmation awaited for SAANs and Memory services. PC MH plan in place, Recovery teams are mobilizing plan to be in place by January 2024 and doing joint work with the ICB on transforming the SAANs service particularly in respect of people with suspected ADHD. Action and Gap closed.
- Gender service investment to be negotiated by end of Quarter 1 23/24 – no movement as yet around investment and continuing to engage.
- Phase one of community recovery team transformation to begin August 23 and phase 2 in Q4 23/24
- Phase 3 of primary care community mental health, which forms part of reconfiguration of SPA and EWS is expected to be deliver in October 23 – slippage December 2023

Update

- We are assertively following up with our strategic planners about resolving this very outstanding issue in relation to commissioning specification. A paper on how we are supporting people on waiting lists received at FPC in August and due at QAC in September.
- As part of workforce planning we are identifying new ways of working by looking at alternative staffing groups for filling vacancies. We can work differently in many of our community services due to the abolition of the care programme approach which means that we can use peer support workers, recovery workers and the VCSE to support service delivery. By the end of the financial year (March 2024)

Executive lead: Executive Director – Executive Director of Operations and Transformation	**Risk type:** Safety	**Risk appetite: LOW**	**Assurance rating**

Board sub – committee oversight: Quality Assurance									
Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	**4**	**4**	**16**	**Last Review:**		**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**4**	**2**	**8**	**Next Review:**				**X**	

Control

- EWS and SPA service being transformed with Primary Care Sheffield.
- 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 in place for relevant teams to 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 utilised to promote new practice and share learning.
- An improved plan in place to have understanding of risks to people waiting for allocation from 1 November 2022.
- 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, such as, SY NHSE, Autism Learning Disability Board, Place Mental Health Learning Disability Autism and Dementia Board at place. This is a delivery group reporting to the PLACE performance and quality committee and PLACE board
- 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.
- Identification and delivery of early adoption initiatives between primary care mental health and the SPA/EWS to reduce waiting time whilst we prepare the system transformation is ongoing as part of phase 3 PCMH development plan which is overseen by the PCMH Transformation board. Moved from action to control.

Internal assurance

- Regular reporting through (Back to Good; EPR monthly programme Board; Transformation Board)
- Regular reports (Learning lessons quarterly report; Complaints report; Quarterly reports to Quality Assurance Committee; Quarterly reports to Finance and Performance Committee)
- Exec Dir of Nursing, Quality and Professions reviewed people waiting in recovery ~~in~~ team for assurance around how that was being managed. Through a move to control and to assurance – in the last 12 months SPA/EWS have reduced waits by 50% - and have now moved from action to assurance
- IPQR monthly report
- Leadership Recovery plans
- Community recovery plans for relevant services.
- Culture and quality visits
- Contracting updates as required.
- Improved oversight of people waiting in recovery teams and EWSand SPA. Rag rating system provides oversight of people waiting, and where VCSE support is needed this is identified.
- Improvement Plan for Gender services in place and being implemented.

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.

Gaps in control	Actions to address gaps in controls
1. Where there are large numbers of people waiting for a service, we cannot reach out to every person on a regular basis, so are reliant on people contacting us if their presentation deteriorates or circumstances change. Each service has a protocol to regularly review peoples needs whilst waiting and apply a RAG rating to prioritise contact.	• 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. Ongoing and we have a meeting with commissioners on 6 Feb to discuss focusing of investment in those areas with longest waits – Investment being submitted as part of the ICB planning round, which asserts investment to eradicate waiting list as Priority – Investment has been prioritised in 23/24 in our recovery services and perinatal mental health. Owners Executive Director of Operations and Transformation Neil Robertson and Executive Director of Finance Phillip Easthope. Action expected to be ongoing into the next financial year (2023/24) • Work with NHSE about the support needed for the Gender Service. We continue to work with NHSE and more planning guidance is expected from NHSE in the coming months. SHSC are presented a deep dive of the service to the NHSE national team in March 23 and we will be exploring additional funding for the service – Owner Clinical Director Dr Jonathan Mitchell No further movement on Gender Services around investment and continuing to engage. • A NHSE regional deep dive was undertaken (on the Gender Service) and positive feedback was received about the system put in place to manage waits. Actions were identified by NHSE, which we have put in place. • ~~We continue to work with NHSE to seek their approval for care pathway changes, which will impact on the patients journey and waits in the future.~~ • We are working with NHSE about their requirement for us see 17 year-olds as part of the changes to children's clinic nationally. This needs a governance review. There is no new investment being provided by NHSE at this time. This again may continue into the next financial year (2023/24). Guidance received from NHSE and protocol being put in place and expected to be completed by end of September 2023. ~~Still awaiting guidance from NHSE which will influence next steps and timeframe.~~
2. 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. Issue re sickness has been resolved. GAP 2 Closed	
3. Where areas need investment, clear commissioning intentions are required by the ICB to move waits forward This is ongoing and not just about SPA EWS. The recovery team have received investment to fund posts at risk and new post identified as part of the new model. GAP 3 Closed.	

4. All areas require clear commissioning specification, which require a review and process implemented by Sheffield place, helping us to really understand who a service is for This is still on going and is an action led by Place.	• We are assertively following up with our strategic planners about resolving this very outstanding issue. Owner – Senior Head of Services (Greg Hackney)
Gaps in assurance	**Actions to address gaps in assurance**
1. Recovery plans not delivering downward trajectory in waits.	• A paper on how we are supporting people on waiting lists received at FPC in August and due at QAC in September – Owner Senior Head of Services (Greg Hackney) • Clear strategic plan on moving forward the issues raised in the waiting times paper to move forward priorities by 31st October 2022 – ~~still awaiting gender planning guidance from NHSE - we are making own changes to pathway subject to NHSE approval~~ – Guidance received protocol will be completed by end of September 2023. owner Executive Director of Operations and Transformation, Neil Robertson • Recovery team plan finalized and are beginning to mobilise. Primary mental health plan will be signed off by Board in July 23 – owner Executive Director of Operations and Transformation, Neil Robertson – Closed.
2. Not finalised the primary care, recovery teams and SAANS transformation plans – Assurance GAP 2 Closed.	• Reduction in waiting times from 24 months to 12 months for people needing an autism assessment. In formal consultation with the recovery teams on making changes as part of the transformation programme. Consultation for recovery teams ended 31 May 2023 and mobilising for September 2023 – owner Director of Operations and Transformation (Neil Robertson) – PC MH plan in place, Recovery teams are mobilizing plan to be in place by January 2024 and doing joint work with the ICB on transforming the SAANs service particularly in respect of people with suspected ADHD. Action closed. • With EWS/SPA we have seen reduction in last 12 months in waiting times by 50% achieved through efficiency and process change. Continue to sustain with a further reduction. Waits will be eradicated as part of the primary care mental health transformation, which should be mobilised by December 2024 – owner Director of Operations and Transformation (Neil Robertson) – see above action closed. • Next steps are to design a crisis and urgent response team in line with PCMH transformation programme – will take 12 months to implement. This will be implemented by December 23 subject to formal consultation – this will be implemented by January 2024 owners Medical Director (Mike Hunter) and Executive Director of Nursing, Professions and Quality (Salli Midgley) and Director of Operations and Transformation (Neil Robertson)
3. Staff vacancies and turnover remains high in some areas.	• As part of workforce planning we are identifying new ways of working by looking at alternative staffing groups for filling vacancies. We can work differently in many of our community services due to the abolition of the care programme approach which

	means that we can use peer support workers, recovery workers and the VCSE to support service delivery. By the end of the financial year (March 2024) – Owner Senior Head of Services (Greg Hackney) • Community nursing recruitment will become a focus of our lead nurse for recruitment by end of February 2024. Owner Executive Director of Nursing, Professions and Quality (Salli Midgley)
4. Lack of agile technology to maintain a high level of contact with people waiting.	• This will be reflected through the digital roadmap work – due to be in place by April 2024. Owner CDIO (Pete Kendall)
5. Number and nature of complaints from recovery service users	• Identify services where a realistic trajectory can be achieved to reduce waits by 30th September 2022. See above. This ongoing and capacity resource is being brought in to look demand and capacity modelling expected to be completed by end of Q4 2023/24– owner Director of Operations and Transformation (Neil Robertson) • Identify contract vehicles that enables us to mobilise VCSE resources to support initiatives and where appropriate workforce gaps by 31st October 2022. Not yet progressed - beginning to work with key stakeholders on strategic approach to working with VCSE to support care delivery –We are waiting for the lead provider of the VCSE alliance to be awarded, which will be completed in the next 3 months – i.e. by September 2023 – owner Director of Operations and Transformation (Neil Robertson) – see update on gap in assurance 3.

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, 0025a and 0025b, 0029*** • *Aim 2 - Create Great Place to Work BAF risks 0013,0014,0020* • *Aim 3 - Effective Use of Resources BAF risks 0027*

Appendix 4 – Extract BAF risks overseen at People Committee

BOARD ASSURANCE FRAMEWORK 2023/2024 – for receipt at People Committee in September 2023

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. The Board approved new wording in July 2023	**DETAILS:** Risk the Trust does not have appropriate measures and mechanisms in place to support staff wellbeing resulting in absence continuing to rise, that gaps in health inequalities in the workforce grow and their experience at work is poor with a knock-on impact on service user/patient care.

Executive lead: Executive Director of Workforce **Board sub – committee oversight:** People	**Risk type:** Workforce	**Risk appetite: LOW**	**Assurance rating**

Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	**3**	**4**	**12**	**Last Review:**	31 August 2023	**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**3**	**2**	**6**	**Next Review:**	October	**X**			

Summary update

- Changes since last received at the July Board are in blue text or strikethrough)
- The current risk score remains 3 x 4 = 12
- Risk descriptor updated, gaps, actions and assurances updated and template refreshed.
- Milestones to support reaching target score:
  - Staff side Recognition agreement – September - December 2023
  - Establish core requirements for all management/leadership roles – December 2023
  - Absence reduction plan implementation – ~~Commencing April 2023 – plan to be fully delivered by March 2024~~ Review of progress Sept 23. Focused period ends March 24
  - Menopause accreditation achievement – ~~by the end of March 2024~~ Achieved August 2023
  - Dedicated Wellbeing champion roles in place – June 2023 – 6 in post, planned increase in numbers by December 2023
  - Structure for support to manage wellbeing improved and in place September 2023 Achieved August 2023
  - New Health and Wellbeing guardian in place – from April 23 Board role in place – Achieved
  - Complete diagnostic self-assessment of the health and well-being self-assessment (7 key areas) – underway and due to complete by the end of September/October 2023

Controls	**Internal assurance**
• People Strategy Delivery Plan in place April 2023 • NHS People Plan and actions for HR and OD • HWB Framework in place • NHSEI National Wellbeing lead and ICS Wellbeing Group • Staff Health and Wellbeing group in place with expanded membership having been reviewed. Group monitors delivery of the People strategy reporting to People	• Report to People Committee • Service-led IPQR's monitoring • Health and Wellbeing self- assessment toolkit • People strategy (approved March 2023) – has a deliverable to support managers to deliver team and individual wellbeing. • Wellbeing and Engagement lead in place

Committee. • ICS HRD Deputy Network • ICS staff Health and Wellbeing Group • National Wellbeing Guardian Network • Vaccination planning • Regular reporting to committees and to SHWB group • Reporting to the ICS (including on HWB) • ~~Long Covid support available virtually (by demand from participants) at SHSC and via the ICS (demand has decreased locally and at ICS)~~ supporting staff with complex long-term conditions. - special interest group (ICS) • Well being lead appointed (Rebecca Malone – Charlotte Turnbull (Head of OD) • Professional nurse advocates in place supporting restorative supervision and wellbeing for nursing staff • Trailblazer community of practice framework is in place • New OH provider in place from Jan 23	• Band 7 OD Practitioner – Staff Engagement & Wellbeing post appointed to and commenced in post 01.08.23 • Return to work meetings now monitored through eRoster • Wellbeing conversation guidance now embedded in revised Supervision Policy. • Reports to People Committee include progress on milestones. • HWB NED lead • Diagnostic undertaken against national wellbeing framework (informed People strategy review and delivery plan) – updates received at People Committee **External assurance** • Model Hospital and NHSE/I returns • CQC Well-Led Internal audit 360 staff wellbeing audit - *Significant assurance*We participated as a trailblazer to test out the HWB framework trailblazer (NHSEI) community of good practice. National NHS HWB framework diagnostic – this is an assessment tool and was reported into HWB assurance group and fed into the refreshed delivery plan from 2022/23.
Gaps in control 1. Lack of ~~capacity~~ systems to check quality well-being conversations are happening (although guidance has been issued)	**Actions to address gaps in controls** • ~~Appoint wellbeing lead (June 23) – Charlotte Turnbull (Head of OD) - role offered expected to be in post by August 2023~~ • Wellbeing focus group to establish factors impacting on wellbeing and tailor support where it is needed September 2023 (when new OD post in place) – Head of OD (Charlotte Turnbull) • Wellbeing champions and the networks being established ~~(Deputy Director of People Sarah Bawden Sept 2023)~~ (this will now be undertaken by the HWB lead) • Review of supervisions and Supervision training now included Wellbeing conversations
2. Review of new Occupational Health Contract	• OH new contract in place QEIA completed for review. Evaluation of OH contract July 2023 – Evaluation commencing August 2023. Deputy Director of People (Sarah Bawden)
3. Wellbeing Self-assessment has limited clinical operations input	**Action** • Wellbeing assessment will be repeated for 2023-24 Deputy Director of People Sarah Bawden – September 2023 onwards by the Health and Well Being lead who has now been appointed. ~~(when new post in place)~~ • HWB network to be established proposal to HWB group February 2022 – target date 31/08/2022 (Sarah Bawden) Relaunch / support to network when OD appointed – September 23 – Sarah Bawden Deputy Director of People – being taken forward by Health and Wellbeing lead in October 2023. ~~**Progress**~~ • ~~Survey issued, some champions appointed, further work to establish network ongoing as part of a HWB system. In progress of reviewing leadership support to staff wellbeing. This has been delayed due to due to long-term absence. 2nd advertisement of B7 wellbeing leader B7 reporting to OD – March 23 3rd Advertisement and additional resource to make post full time. Now in the interview process, expected to conclude before August 2023.~~

	~~Charlotte Turnbull Head of OD~~
Gaps in assurance • Diagnostic framework has gone to assurance group but unable to complete.	**Actions to address gaps in assurance** • Two further sessions in June to review framework evidence being compiled by assurance group to inform assessment to be presented to People Committee in November 2023 (note for planner) Owner Deputy Director of People (Sarah Bawden)

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 Proposed re-wording July 2023.*	**DETAILS: Revised wording for approval** - There is a risk of failure to undertake effective workforce planning (train, retain and reform) to support recruiting, attracting and retaining staff to meet current and future needs caused by the absence of a long-term workforce plan that considers training requirements, flexible working and development of new roles.

Executive lead: Executive Director of People Board sub – committee oversight: People	Risk type: Workforce	Risk appetite: MODERATE	Assurance rating

Risk Rating:	Impact	Likelihood	Score	BAF Risk Review Date:		PROGRESS STATUS			
Residual Risk (with current controls)	4	3	12	Last Review:	31 August 2023	On track	Some Slippage	At risk	Completed
Target Risk (after improved controls)	3	3	9	Next Review:	October 2023	X			

Summary update

- Changes since last received at the July Board are in blue text or strikethrough
- Recommended to remain moderate risk appetite as we need to be open to innovation
- Current score proposed to remain at 4x3 = 12 due to progress made particularly around workforce data and reporting, links with ICS, improvements with KPI's supported by a strengthened workforce team
- Risk descriptor updated, gaps, actions and assurances updated and template refreshed.
- We are currently expected to reach target score by the end of the financial year
- One of the corporate risks impacting on this strategic risk around the apprenticeship levy is being reviewed to reflect a new business appropriate focus – the risk has been updated on the CRR where it remains with an updated rating and areas of action identified to mitigate the risk.
- Milestones to support reaching the target score:
    - Workforce Dashboard implementation from April 2023. (Full roll out by June 23) officially launched on 3 July 2023 – achieved
    - Capture improved Diversity data for workforce planning and reporting as appropriate August 2023– achieved
    - Service-led 3-year workforce plan in place – draft by September ~~August~~ 2023 – this is going to take longer to finalise draft expected currently by December 2023
    - New role development integrated into workforce planning (such as Physician Associates and Peer Support workers – looking at skill mix in workforce planning and looking at flex approach/risks and potential other options available) – August 2023 will commence in July – achieved
    - SHSC recruitment plan (derived from the three-year workforce plan – how we do it) – October 2023
    - Deliver recruitment process improvement plan (transactional – better campaigns, experience for new recruits and onboarding) – July 2023 in place and being delivered - – achieved
    - Review of local review and benefits offer – December 2023
    - Review retirement and flexible working policies – by September 2023.
    - Executive Director of Nursing, Professions and Quality, to advise on timing for any outstanding for the professions plans to come on the forward plan.

July 2023 referral from People Committee to Finance and Performance committee around whether digital capability of our staff is sufficiently reflected in Digital risk or increased risk of loss of roles. To note - digital will be in the People Plan activities for year 2.

Controls	**Internal assurance**
• WPG monitoring delivery and reporting to People Committee • Recruitment and Retention Group for all professions in place • Regular reporting on vacancies for HCSW tomeet funding specification • TRAC reports feed into R & R group to oversee People delivery plan – recruitment reporting through the workforce dashboard goes to People Committee • People Plan in place • Annual learning needs analysis undertaken to inform Trust training plan priorities for workforce transformation and CPD funding investment *[from BAF risk 0019]* • 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]* • *Education and Training group governing apprentceship levy* • Recruitment optimisation workstream reporting into the agency reduction project • Study Leave Policy • Workforce Recruitment and Retention Group to support identification of gaps – see new Gap in control will be addressed once merged group in place • Workforce data dashboard • External ICS retention group • Health care support worker regional NHSE group • Project officer in post for the support worker career pathway work • From April 2023 the Workforce Transformation and Recruitment and Retention groups merged to one group now called Workforce Recruitment and Transformation group to support new merged BAF risk. • Recruitment delivery group for all professions put in place from March 2023 • Recruitment delivery group in place for all staff • TRAC system in place to manage ALL recruitment. Tracked and reported to People Committee • Training and further guidance for recruiting managers on TRAC. Rolling programme of training is in place. • Employee Lifecycle microsystem in place - encompasses all employee lifecycle activities • Nurse Recruitment Group established to review attraction initiatives reporting into Workforce Transformation Group	• 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]* • ~~levy changes continuously~~ • 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 • Recruitment and retention group (and reports received at People Committee) **External assurance** • ICS Recruitment and Retention group attended by Deputy Director of People • Bi-monthly reporting to Quality Board (external group i.e. NHSE/I, CQC, CCG *as was*) • National People Plan reporting to ICS – we are required to provide evidence on meeting priorities so ICS can respond on national level. • ICS partnership working on workforce dashboard [from BAF risk 0019] Quarterly data benchmarking report (apprenticeship levy data collection) to Health Education England on behalf of ICS [from BAF risk 0019] • National People Plan reports into ICS • A set of subgroups has been established reporting to the newly formed Workforce Recruitment and Transformation group. A new medical recruitment and engagement group (a subgroup of the assurance group) has been in place since December 2022 • People Delivery plan final version presented to People Committee in May 2024. • Improved data and systems to support accurate vacancy in place following work by People and Finance directorates. ESR has been updated with funded establishments. This gives workforce the ability to accurately report on vacancies (funded establishment – Staff in post) and means vacancy data can be updated on a daily basis. • Progress with international recruitment 15 International nurses arriving this year (2023/24). Further funding submitted for a further 6 nurses NHSEI Performance workforce returns + direct support • NHSEI and People workforce return (PWR) reporting which triangulates and checks our data • PWR reporting and NHSEI governance for international recruitment
Gaps in control	**Actions to address gaps in controls**
1. Annual learning needs analysis undertaken to inform training plan priorities for investment (completed at high level for external funding only some gaps in process)	• The plan for supporting usage is being reviewed over the next 3-6 months from April 2023. Rollout expected to be completed by 31 October 2023 – Stephen Sellars Interim Workforce Systems Lead.

2. ~~Requests for apprenticeships have fallen and we are at risk of losing some of the levy.~~ The level and numbers of apprenticeships are changing with fewer large cohorts of clinical apprenticeships such as CAPS- this impacts on levy spend and could lead to the levy not being fully utilised.	• A workforce planning event with service leads to look at apprenticeship opportunities is taking place in early July with a further session planned for September 2023. Head of Workforce Development and Training (Karen Dickinson). ~~Education Training and Development.~~ Developing opportunities in partnership to maximise use of apprenticeship levy by 31 March 2024. Owner Head of Workforce Development and Training (Karen Dickinson). ~~Education Training and Development~~
3. Control GAP 3 closed at July 2023 Board.	
4. Users (of TRAC) require additional training and support	• Training provided by Recruitment Manager. No end date currently as 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. Owner Deputy Director of People (Sarah Bawden)
Gaps in assurance 1. Dashboard information needs to reflect KPIs. GAP 1 Closed	**Actions to address gaps in assurance** • 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] Update:* project work complete and Dashboard designed and complete- next phase to roll out and embed – Owner Executive Director of People (Caroline Parry) and Deputy Director of People (Sarah Bawden) May 2023 – roll out underway and completed. Demonstration planned to take place at EMT in the autumn. Action closed.
2. 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 2023 [*from BAF risk 0019]*	• AAA reports are being received and action log in place. The groups are working to the people plan which has specific actions and dates. Planners still to be developed by January 2024. Sarah Bawden Deputy Director of People.
3. Dashboard information	• Deputy Director of People to look at actions required around addressing gaps related to dashboard information. Workforce review process is ongoing good progress being made. Some data validation underway and completed by June 2023 cleanse has taken place and will remain ongoing. Owner Interim Workforce Systems Lead (Steven Sellars)
4. ESR data poor quality	• Interim support engaged 18/7/22 to progress plan of action to address data quality (engaged for 6 months) Latest Update: Data quality within the ESR system has been updated by carrying out a series of workforce data reviews. This was a pack that was sent out to all services to complete and return. In cases where no return was received the gaps were filled in with current data held by finance. The next steps are for each area to confirm we hold the correct information. This will be done before 30 June 2023 – Linked to the above action. Cleanse has taken place and will remain ongoing. Confirmation to be requested of the owner that this is now completed from the perspective of users. Owner Interim Workforce Systems Lead (Steven Sellars)

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 – Rewording agreed July 2023.*	**DETAILS:** Risk of failure to move our culture sufficiently to address any closed subcultures, behavioral issues and not reflecting and respecting diversity and inclusion, resulting in poor engagement, ineffective leadership and poor staff experience in turn impacting on quality of service user experience.

Executive lead: Executive Director of People **Board sub – committee oversight:** People	**Risk type:** Quality *& Workforce*	**Risk appetite: MODERATE**	**Assurance rating**

Risk Rating:	**Impact**	**Likelihood**	**Score**	**BAF Risk Review Date:**		**PROGRESS STATUS**			
Residual Risk (with current controls)	**4**	**3**	**12**	**Last Review:**	31 August 2023	**On track**	**Some Slippage**	**At risk**	**Completed**
Target Risk (after improved controls)	**3**	**3**	**9**	**Next Review:**	October		**X**		

Summary update

- Changes since last received at the July Board are in blue text or strikethrough
- The Head of Leadership and OD has reviewed and edited the detail under this risk to reflect current practice.
- Current risk score remains 4 x 3 = 12
- Risk descriptor updated, gaps, actions and assurances updated. Controls referenced in the BAF risk 0024 received at QAC reflected.
- Milestones to support reaching target score:
    - Values into behaviours consultation and launch of outcomes – April to December 2023. Pause on activity August 2023 as Chief exec has engaged external consultants to contribute to the communications structures and this work. Timeline will be adjusted in due course.
    - Expectations of SHSC Managers and Leaders – consultation on expectations of managers and leaders will be part of our values into behaviours consultation. Outcomes will define our leadership and management development offers – April to December 2023. As above.
    - SHSC Manager Development offer – new offer defined and launched - February 2024.
    - EDI milestones around diversity and inclusion – progress as outlined in WRES and WDES – July 2023 People Committee and Board – achieved
    - Annual Equality and Human Rights report to be received through EMT, QAC, People committee and Board by November 2023.

The Committee asked that in the next review cross referencing be made to the closed culture work taking place as part of the work overseen at Quality Assurance Committee covered under BAF risk 0024. This has been addressed.

Controls	**Internal assurance**
• Reporting to People Committee • Staff Engagement Steering Group established to increase engagement and reporting to People Committee • NHSEI National and regional People Plan • 2023 -26 People Strategy approved at Board in March 23. • OD framework in place and detailed within People strategy delivery plan	• Staff engagement steering group reports monthly to Organisational Development Assurance Group which reporting into People Committee bi- monthly • People Plan 23 -24 received at May People committee (contains all OD activity) • People Committee received refreshed deliverables in 2022 • People Pulse survey • OD actions were refreshed as part of the People Plan update for 2022-23 NEW assurance following closure of action in March

• Fundamental standards of care visits completed across inpatient. Action plans in place. Culture and Quality visit programme in place for community services. • Board visits programme (15 steps) • Restorative Just and learning process and FTSUG processes • Transformation Board reports (monthly) • 2022-23 Refreshed People Delivery Plan (OD Framework) • Leadership development offer in place - Team SHSC: Developing as Leaders (in-house Leadership Development Programme) cohorts 1, 2 and 3 completed. • Agile Mindsets & Behaviours leadership programme (contracted programme)	• Team SHSC: developing as Leaders Cohort 3 recruited to with line manager and Exec support. 30 participants. Will run June 2023 to December 2023. Day 1 held 12.6.23 and Day 2 19.07.23 . Positive evaluation received from both days. • Agile Mindset & Behaviours leadership programme –3 Cohorts completed ~~20 week programme 31.01.23. Now~~ now 30 leaders trained in Agile Mindset & Behaviours methodology and tools. Cohort 4 underway ~~recruited to~~, 11 participants working through the 20 week programme. Two learning events have been held to embed knowledge. ~~. and programme started start 16.05.23. Learning event for Cohorts 1,2 & 3 held 05.06.23 - processes well embedded.~~ • People Pulse July results showed an increase in Mood in all 9 Engagement scores **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 • 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 control 1. Mechanism needs to be in place to gather and consolidate (triangulate) all staff data and themes.	**Actions to address gaps in controls** • Framework on a page is being developed – July 2023. Head of OD (Charlotte Turnbull) – Action closed July 2023 • Exploratory meeting with Quality, Service Improvement, Business Performance, IT held to see how different data areas could work together more effectively to support our managers/leaders took place on 08.08.23 – confirmation taking place with the lead to ascertain if anything further is required before this gap/and associated action is closed down. For the next review of the BAF risk (October) Owner Head of OD (Charlotte Turnbull)
Gaps in assurance 2 Low engagement scores – confirming with operational lead this is from staff survey and pulse survey data	**Actions to address gaps in assurance** • Action planning at service level in progress, staff engagement included as part of the triannual Performance review meetings with the Exec team with services reporting progress on action plans (based on people promise themes). ~~Action closed as~~ templates have gone out. Confirmation required that the templates are being fully utilized before the gap can be closed down for the next review of the BAF risk (October) will be tested through performance review process. Owner Deputy Director of People (Sarah Bawden)

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 - ective Use of Resources BAF risks 0027*