Sheffield Teaching Hospitals
NHS Foundation Trust

Executive Summary

Report to the Board of Directors

held on 27 September 2022

Subject	Board Assurance Framework – September 2022
Supporting TEG Member	Sandi Carman, Assistant Chief Executive
Author	Judith Green, Corporate Governance Manager
Status	For Discussion

PURPOSE OF THE REPORT

This paper presents the Board Assurance Framework (BAF). It aims to provide the Board of Directors with assurance that the key risks agreed by the Board relating to the delivery of the Trust's Strategic Aims are being managed appropriately.

KEY POINTS

Background

- At its June 2022 meeting the Board of Directors was apprised of actions to deliver Outcome 17 of the CQC Action Plan 'have effective systems to ensure Board oversight of the management of risk'.
- These actions include refreshing the Integrated Risk and Assurance Report (IRAR) to become a Board Assurance Framework (BAF) structured around a refreshed set of Strategic Risks and extending the scope of operational risk reporting to the Board of Directors.
- In consultation with the Board of Directors a set of eight Strategic Risks have been agreed and work undertaken with nominated Strategic Risk Owners to populate the content of the BAF.
- This first full issue of the BAF issued for September 2022 follows discussion of a working draft shared with Board members in July 2022.

Current BAF

- The Board Assurance Framework (BAF) records Executive-led assessments of the key risks to the delivery of the Trust's Strategic Aims and the level of internal control to prevent these risks occurring / mitigating their impact.
- Appendix I presents an updated BAF with changes / additions from the July 2022 issue noted in bold.
- For each Strategic Risk the BAF identifies Controls and Assurances in place. Controls being the systems or processes to mitigate the risk, and Assurances being the evidence available that the controls being relied upon are working.
- The Summary Dashboard on page 2 of the BAF prompts Board debate around:
  - the level of assurance in place that demonstrate the controls being relied upon to manage each Strategic Risk are effective (Current Aggregated Assurance Rating) and where gaps in assurance may exist; and
  - the acceptance of current levels of strategic risk by reviewing ratings for the likelihood of each risk occurring (Current Risk Likelihood Rating).
- A following agenda item presents a Corporate Risk Register Report containing all open and validated operational risks with a score of 15 or more logged on the Risk Register with risks aligned to Strategic Risks entered onto the BAF.

IMPLICATIONS

AIM OF THE STHFT CORPORATE STRATEGY		TICK AS APPROPRIATE
1	Deliver the Best Clinical Outcomes	✓
2	Provide Patient Centred Services	✓
3	Employ Caring and Cared for Staff	✓
4	Spend Public Money Wisely	✓
5	Create a Sustainable Organisation	✓
6	Deliver Excellent Research, Education and Innovation	✓

RECOMMENDATIONS

The Board of Directors is asked to:

- DISCUSS and confirm that the BAF is appropriately focused on the key risk areas that impact on the Trust's ability to meet its Strategic Aims; and
- DISCUSS and comment on the adequacy of Controls and Assurances and AGREE any required additional actions to address gaps.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
TEG	21 September 2022	Y
Board of Directors	27 September 2022	

Board Assurance Framework

Executive Summary

Sheffield Teaching Hospitals
NHS Foundation Trust

September 2022

Background: As part of actions taken to deliver Outcome 17 of the 2022 CQC Action Plan 'have effective systems to ensure Board oversight of the management of risk', work has been undertaken to develop a Board Assurance Framework (BAF) to replace the former Integrated Risk and Assurance Report (IRAR).

Ongoing Development of the BAF: Future iterations of the BAF will focus consideration being placed on agreeing Target Risk Likelihood Ratings and associated delivery dates.

Current Strategic Risk profile: The BAF is structured around a refreshed set of eight Strategic Risks approved by the Board of Directors in June 2022. Each Strategic Risk has:

- An Aggregated Assurance Rating based on the level of assurance that demonstrates the Controls in place are effectively managing the risk and its key causes; and
- A Risk Likelihood Rating based on the probability that the risk will happen / recur.

Across the Trust's current Strategic Risk profile presented by the BAF Summary Dashboard, the following four Strategic Risks have a 'Limited' Aggregated Assurance Rating, **and** a Current Risk Likelihood Rating of 'Likely'.

- Strategic Risk 1: Quality of Care
- Strategic Risk 3: Workforce
- Strategic Risk 7: Research, Education and Innovation
- Strategic Risk 8: Well-led

While reviewing the entirety of the BAF, members of the Board of Directors are directed to these four key areas of Strategic Risk and prompted to review actions in place to address gaps in Control or Assurance, highlighting areas for further scrutiny by Board Committees.

BAF SUMMARY DASHBOARD	Current Aggregated Assurance Rating	Current Risk Likelihood Rating
Strategic Risk 1: Quality of Care - Fail to provide compassionate, effective and safe patient centred care that delivers the best clinical outcomes	LIMITED	LIKELY
Strategic Risk 2: Partnership and Engagement - Fail to take a proactive role and engage effectively with partners to transform services and improve the health of the communities we serve	ADEQUATE	POSSIBLE
Strategic Risk 3: Workforce - Fail to ensure the Trust can recruit and retain the right people to deliver patient centred services and the best clinical outcomes	LIMITED	LIKELY
Strategic Risk 4: Finance - Fail to manage our finances effectively and deliver value for money to ensure the long-term sustainability of care provision	ADEQUATE	POSSIBLE
Strategic Risk 5: Infrastructure - Fail to implement appropriate, cost effective and innovative approaches to digital and estate infrastructure that support our aspirations today and for the future	LIMITED	POSSIBLE
Strategic Risk 6: Sustainability - Fail to identify and maximise sustainable ways to deliver the Trust's strategic aims and objectives	ADEQUATE	LIKELY
Strategic Risk 7: Research, Education and Innovation - Fail to ensure the Trust has the ability to deliver excellent research, education and innovation	LIMITED	LIKELY
Strategic Risk 8: Well-led - Fail to ensure appropriate and effective governance arrangements are in place that support the achievement of our Corporate Strategy (Making a Difference – The Next Chapter)	LIMITED	LIKELY

KEY:

Assurance Rating	Details
Substantial	The scope of Assurances noted on the current BAF demonstrate that the Controls are effectively managing the Risk / Cause.
Adequate	There are a full range of Assurances in place and no material issues have been identified with the effectiveness of Controls. Assurances are reflecting the need to fully embed the Controls.
Limited	Either some of the Assurances noted on the current BAF demonstrate that the Controls in place are not effectively managing the Risk / Cause and action is required to address and / or there are gaps in assurance.
None	No assurance can be taken / is available that the Controls relied upon are working. Action needs to be taken to address to improve Controls and Assurance provided.

Risk Likelihood	Details
Rare	This will probably never happen / recur
Unlikely	Do not expect to happen / recur but is possible
Possible	Might happen / recur occasionally
Likely	Will probably happen / recur, but is not a persistent issue
Almost Certain	Will undoubtedly happen / recur, possibly frequently

Strategic Risk 1: QUALITY OF CARE

Fail to provide compassionate, effective and safe patient centred care that delivers the best clinical outcomes

Aggregated Assurance Rating	LIMITED

Key Causes		Assurance Rating
C1	Inability to embed effective quality governance arrangements including learning from incidents / patient feedback	Limited
C2	Insufficient staffing resource (staffing level, qualifications, and experience)	Limited
C3	Fail to deliver demand within capacity	Limited
C4	Lack of cultural competency across our service delivery	Adequate

Key Effects / Consequences (Results in)

- Adverse impact on the health outcomes of patients and public health in the longer term
- Negative patient experience and potential for patient harm
- Legal / financial implications
- Continued regulatory intervention and potential loss of public trust and confidence
- Negative effect on staff wellbeing, motivation and recruitment / retention
- Underperformance against national quality / performance standards

Risk Likelihood	Rating
Previous Position	n/a
Current	Likely
Target	Tbc

Target score to be achieved by XXX

TREND GRAPH TO BE ADDED

Aggregated Action Plan to address gap in control or assurance

	Action	Lead Exec	Deadline	Progress update
1	Delivery of CQC Action Plan to address findings in respect of healthcare governance arrangements (including delivery of Maternity Services Improvement Programme)	MD (Ops)	**March 2023**	**All actions progressing with regular review at monthly CQC compliance steering group and updates to TEG, Quality Committee and board. Maternity Improvement Board ensuring progress against Maternity Improvement Programme with mitigations for absence of end to end maternity information system in progress.**
2	Development and implementation of Action Plan to address agreed recommendations within Healthcare Governance Review undertaken by external consultancy.	MD (Ops)	**March 2023**	**Action plan agreed at TEG with progress and recommendations underway.**
3	Implementation of workstreams through Workforce Systems Group to support Board level assurance of adequacy of staffing across all staff groups in the Trust.	DHRSD	**March 2023**	**A quarterly report presented to TEG highlights key recruitment challenges and the level of vacancies across the Trust. This report will be used to support the workforce planning process, to identify actions to mitigate workforce shortages and to highlight key areas of challenge e.g. above average turnover and vacancies which have been subject to the recruitment process but remain unfilled.**
4	Delivery of Patient Care Recovery Plan / 'Getting Back on Track'	COO / OID	**February 2024**	**Structure for Patient Care Recovery Plan (PCRP) now described and has been shared with MBB. Core areas of focus are being signed off by individual Pathway leads and will be concluded by the end of September. Discussion with individual services about ways to engage almost complete. Finalisation of "BAU" grip discussions underway. Getting Back on Track programme infrastructure being established – GBOT Board will meet monthly from start of October (see next line).**
5	Agree and embed governance structure for 'Getting Back on Track'.	COO / OID	**September 2023**	**Getting Back on Track (GBOT) programme board being established; and will meet monthly from the start of October. This will include all TEG members, will report to the Board, and will provide oversight of our overall GBOT programme. Patient Care Recovery Plan (PCRP) will report into the GBOT Board.**
6	**Commission, design and deliver Equality Diversity and Inclusion (EDI) Board-level and Governor education, training and development programmes.**	**ODD**	**March 2024**	**Programme scopes have been agreed and we are currently going through Procurement as per our tendering process. The programme will commence in 2022/23 and is an 18 month programme to conclude by end of March 2024**

Commentary *(including changes since last BAF issue / key discussion points notes at most recent Deep Dive review and any relevant entries onto the Corporate Risk Register Report)*

Review / update of Controls and Assurances are noted in bold.

Accountabilities / Review History

Board Oversight	Last deep dive review held	Strategic Risk Owner	Date of last Update
Quality Committee		Medical Director (Operations)	September 2022

Controls and Assurances

Controls	Assurance / Evidence		
For Cause 1: Inability to embed effective quality governance arrangements including learning from incidents / patient feedback [system in place to help manage the cause / effect]	[where can we gain evidence that the controls we are placing reliance on are working]		
	First Level [Service delivery and day to day management - how do we know day to day that controls are working?]	**Second Level** [Oversight – who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]	**Third Level** [Independent challenge – has anyone external come in to check that the controls are working]
• Refreshed Quality Governance Policy / Framework for Delivery. • Processes in place to review and learn from deaths **including Medical Examiner system and Directorate Morbidity and Mortality meetings.** • Patient and Healthcare Governance Department in place to embed Quality Governance across the Trust. • Mechanisms in place to support identification and sharing of themes and learning, (eg Safety and Risk Forum / Medical Director's Safety Message / Management Board Briefing). • **Clinical Effectiveness processes including Clinical Audit, NICE guidance compliance and Getting it Right First Time (GIRFT).** • Quality Governance Structure in place to provide oversight. • Programme of external review / audit of quality governance arrangements. • Development and application of Quest Dashboards. • Processes in place to seek and receive patient feedback via multiple channels (eg surveys and complaints). • **Structures and processes in place for staff to raise or escalate issues.** **Control Lead:** Medical Director (Operations)	• Directorate Governance Meetings review quality metrics. • **Structured Judgement Reviews reviewed at Mortality and Morbidity meetings.** • Directorate Reviews co-ordinated by Director of Strategy and Planning. • Serious incidents reviewed weekly by the Serious Incident (SI) Group with focus placed on overdue reports / actions. • **Quest Assessments reviewed by Nurse Directors.** • Quality, Safety and Risk Dashboards monitored by Directorate Governance Teams. • Patient feedback reviewed at **Patient Experience Committee Clinical audit data and NICE compliance reviewed at the Clinical Effectiveness Committee.**	• Quarterly Integrated Quality and Safety Report reviewed by Quality Committee / Board of Directors. • Quarterly Learning from Deaths Reports to Quality Committee and Board of Directors. • Outcome of Directorate Reviews reviewed by TEG. • Incidents reported and closed reviewed by TEG • **Live Quality, Safety and Risk Dashboard reviewed at Trust-level by Safety and Risk Committee.** • **Trust Clinical Audit Programme reported to TEG through Annual Report.** • **NICE Guidance Compliance reported to TEG through quarterly updates and Annual Report.** • **CQC Insights reviewed by TEG and Quality Committee.** • Patient feedback reported to **TEG, Quality Committee, and Board of Directors.**	• April 2022 CQC Report including requires improvement rating for well-led. • Healthcare Governance Review undertaken by external consultancy presented to Board of Directors (June 2022). • Internal Audit – Risk Management 2021. • **Internal Audit – Patient Experience – Jan 2022.** • Internal Audit – Serious Incidents and Never Event Actions (May 2021). • Benchmarking of quality key performance indicators (KPI's) with other organisations / Model System / Public View. • Getting it Right First Time (GIRFT). • Internal audit – NICE guidance – July 2022
			Assurance Level: LIMITED

Gaps in Controls / Assurances	Actions to address gaps in controls / assurance
Control Gap – Weakness in relation to the Healthcare Governance arrangements.	1. Delivery of CQC Action Plan including Maternity Services Improvement Programme 2. Development and implementation of Action Plan to address agreed recommendations within Healthcare Governance Review undertaken by external consultancy.

Return to Strategic Risk front sheet

Controls **For Cause 2: Insufficient staffing resource (staffing level, qualifications, and experience)**	Assurance / Evidence		
	First Level	**Second Level**	**Third Level**
• People Strategy / Strategic workforce plans. • Mechanisms in place to identify individual training needs (Annual Training Needs Analysis completed). • Use of NHS Professionals to cover staffing gaps. • Business Continuity Plan includes use of bank and building bank resources across all staff groups. • Development of new quarterly workforce reporting to provide an overview of staffing capacity and anticipated shortfalls (Mock Report). • Safe Staffing models. – Safer Nursing care tool – A&E Safer Nursing Care tool – Midwifery – Birthrate+ – Comm Nursing (early work) • Workforce modelling tools in place. • E-rostering system in place. • HR Business Partners in place to support Directorates through monthly performance meetings to discuss staffing / HR matters feeding into quarterly Executive-led performance meetings. • Risk Management Framework in place to support the identification. management and reporting of staffing risks by service managers. • Workforce Information Systems established to develop information systems across all staff groups.	• Delivery of People Strategy monitored by Workforce Redesign, Innovation and Planning (WRIP) Group. • Training Needs Analysis (TNA) One to one with line management and reported to HR. • Safe Staffing models monitored by Chief Nurse. • E-rostering system used at service level. • Service Managers feedback areas of concern to HR Business Partners.	• People Strategy approved by the People Committee(formerly HR and OD Committee) along with reporting of metrics. • Quarterly Workforce report (New) reviewed by TEG. • HROD biannual review Nurse/neonatal Staffing levels. • TEG and People Committee review of workforce modelling tool. [used to guide workforce plans]	• Care hours per patient day (CHPPD) benchmarking data.
Control Lead: Director of HR and Staff Development			**Assurance Level: LIMITED**

Gaps in Controls / Assurances	Actions to address gaps in controls / assurance
Assurance Gap – systems to support Board-level assurance of adequacy of staffing across all staff groups in the Trust.	3. Implementation of workstreams through Workforce Systems Group.

Return to Strategic Risk front sheet

Controls **For Cause 3: Fail to deliver demand within capacity**	**Assurance / Evidence**		
	First Level	**Second Level**	**Third Level**
• Tracking of activity plans through Integrated Performance Report (IPR) and Activity Report. • Clinical prioritisation process in place. • Directorate level caseload management (scrutiny on long-waits / Patient Tracking List - PTL). • Activity Delivery Group in place to oversee activity recovery / Recovery Plan. • Cancer Executive Group in place to provide oversight of Cancer pathway recovery. • Continuation of new ways of working (non-face to face activity / patient initiated follow up). • Operations Improvement Director supports leadership and oversight of the Patient Care Recovery Plan and establishment of the systems and processes to enable effective recovery. • Governance structure in place for 'Getting Back on Track'. **Control Lead:** Chief Operating Officer	• Monitoring through Performance and Caseload Overview Group (PCOG) / review of long waiters. • Directorate Performance Reviews co-ordinated by Director of Strategy and Planning. • Chief Operating Officer's Directorate collate activity and performance reports. • Directorate level review of delivery against activity plans.	• Activity reporting to TEG / Assurance to Finance and Performance Committee (FPC). • Integrated Performance Report (IPR) presented to TEG and Board. • Quarterly caseload management report to TEG and FPC. • Outcome of Directorate Performance Reviews reported to TEG. • All existing Making It Better (MIB) structures that align to Patient Care Recovery Plan will migrate to new GBOT governance arrangements – *in development*. • PCRP integrated report to TEG in dashboard format.	• Public View benchmarking • Benchmarking of performance against operational targets / Model System. • Get It Right First Time.
			Assurance Level: LIMITED

Gaps in Controls / Assurances	**Actions to address gaps in controls / assurance**
Control Gap – Performance exceptions noted with Integrated Performance Report.	4. Directorate level recovery plans, supported and delivered through PMFs, ADG and PCOG
Assurance Gap – Oversight of 'Getting Back on Track' and migration of former MIB structures in process of being defined / agreed.	5. Embed governance structure for 'Getting Back on Track'.

Return to Strategic Risk front sheet

Controls **For Cause 4: Lack of cultural competency across our service delivery**	Assurance / Evidence		
	First Level	**Second Level**	**Third Level**
• Defined Mission, Vision and Values (with Proud behaviours articulated). • Equality, Diversity and Inclusion (EDI) Strategy and Implementation Plan includes a defined vision for culture, improvement and engagement with a set of objectives underpinned by action plans. • EDI Dashboard fed by database of patient demographic information. • Workstream in place within Chief Operating Officer's Directorate to deliver Accessible Information Standard (AIS) action plan. • Health Inequalities Review and Action Planning. **Control Lead:** Organisational Development Director	• Embedding culture through Staff Engagement Leads / Proud Forum. • Patient Survey results collated and reviewed by Patient and Healthcare Governance Team. • Complaints / compliments collated / analysed by Patient Experience Team. • Directorate level review of EDI Dashboard. • Delivery of Accessible Information Standard (AIS) action plan monitored by Chief Operating Officer Directorate.	• Complaints and Compliments reported to Patient Experience Committee (PEC). • EDI Dashboard to be reported to EDI Board. • Delivery of Accessible Information Standards (AIS) Action Plan reported to EDI Board.	• CQC Report 2022. • Internal Audit – Accessible Information Standards (AIS) – limited assurance for compliance with AIS • Quarterly meeting with Integrated Care Board (ICB) to monitor delivery of AIS action plan. • Sheffield Race Equality Report published 14 July 2022.
	Assurance Level: ADEQUATE		

Gaps in Controls / Assurances	Actions to address gaps in controls / assurance
Control Gap – Current best practice for members of the Board of Directors and Governors in understanding and embedding Equality, Diversity and Inclusion (EDI).	6. Commission, design and deliver EDI Board-level and Governor education, training and development programmes

Return to Strategic Risk front sheet

Strategic Risk 2: PARTNERSHIP AND ENGAGEMENT

Fail to take a proactive role and engage effectively with partners to transform services and improve the health of the communities we serve

Aggregated Assurance Rating	**ADEQUATE**

Key Causes		**Assurance Rating**
C1	Fail to engage key stakeholders **with clarity of purpose**	**Adequate**
C2	Fail to deliver future healthcare to align to the needs of the communities we serve (Covid / change in demographics)	**Limited**

Key Effects / Consequences (Results in)

- Missed strategic objectives
- Trust not seen as a partner of choice
- Fail to deliver integrated care systems
- Public trust and confidence damaged
- Services not aligned to community / stakeholder needs

Risk Likelihood	**Rating**
Previous Position	**n/a**
Current	**Possible**
Target	**Tbc**

Target score to be achieved by XXX

TREND GRAPH TO BE ADDED

Aggregated Action Plan to address gap in control or assurance

	Action	Lead Exec	Deadline	Progress update
1	**Develop Stakeholder Engagement Plan and subsequent regular report to provide more methodical first and second level assurance.**	**DSP**	**December 2022**	**Work underway to identify partners and our objectives and purpose for these partnerships.**
2	**Develop 360 degree feedback from partners about our approach to partnership working.**	**DSP**	**April 2023**	**Not yet started – to follow stakeholder engagement plan.**
3	**Develop further our inequalities dashboard, including gaining input from public health teams.**	**COO / OID**	**April 2023**	**Currently embedding first draft – future development for later this year.**
4	**Embed population and health inequalities focus more into our business planning and performance processes – including Directorate reviews and Performance Management Framework.**	**DSP**	**April 2023**	**Will incorporate into narrative for business planning guidance for 2023/24 planning round and for Directorate Review processes.**
5	**Seek support from commissioners to review how well we meet needs of our population.**	**DSP**	**December 2023**	**Not yet underway – should follow more embedding of internal initiatives first.**
6	**Strengthened patient engagement work through new Quality Strategy.**	**CN**	**April 2023**	**A draft of the new Quality Strategy, including strengthened approach to patient engagement on route to TEG and Board by April 2023.**

Commentary *(including changes since last BAF issue / key discussion points notes at most recent Deep Dive review and any relevant entries onto the Corporate Risk Register Report)*

Review / update of Controls and Assurances are noted in bold.

Accountabilities / Review History

Board Oversight	Last deep dive review held	Strategic Risk Owner	Date of last Update
Board of Directors		Director of Strategy and Planning	September 2022

Controls and Assurances

Controls **For Cause 1:** *Fail to engage key stakeholders* ***with clarity of purpose*** [system in place to help manage the cause / effect]	Assurance / Evidence [where can we gain evidence that the controls we are placing reliance on are working]		
	First Level [Service delivery and day to day management - how do we know day to day that controls are working?]	**Second Level** [Oversight – who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]	**Third Level** [Independent challenge – has anyone external come in to check that the controls are working]
• Stakeholder map in place. • Trust Executive participation in key Integrated Care Board (ICB), Acute Federation (AF) and Place partnership governance. • Clinical engagement networks established. • **Regular Chief Executives' meeting with other Sheffield anchor organisations.** • Mechanisms in place for regular informal dialogue with partners. **Control Lead: Director of Strategy and Planning**	• Attendees at system wide meetings. • **Updates at each TEG about meetings and discussions with partners** • **Regular scheduled meetings with local MPs, and other key stakeholders.**	• Individual feedback from attendees at system meetings to TEG **and Board through Chair and Chief Executive's reports.**	• **Healthcare Governance Review undertaken by external consultancy presented to Board of Directors (June 2022).** • **CQC Inspection Report (April 2022).**
	Assurance Level: ADEQUATE		

Gaps in Controls / Assurances	Actions to address gaps in controls / assurance
Control Gap - Stakeholder Engagement Plan required – with an emphasis on 'purpose' for partnership work	1. Develop Stakeholder Engagement Plan and subsequent regular report to provide more methodical first and second level assurance
Assurance Gap - Lack of systematic 360 feedback from partners to address absence of third level assurance	2. Develop 360 degree feedback from partners about our approach to partnership working

Return to Strategic Risk front sheet

Controls	Assurance / Evidence		
For Cause 2: *Fail to deliver future healthcare to align to the needs of the communities we serve (Covid / change in demographics)*	**First Level**	**Second Level**	**Third Level**
• Ongoing engagement with commissioning teams. • Business planning processes understand and respond to changes in needs of patients and communities. • **New dashboard for inequalities in place and reviewed by Equality, Diversity and Inclusion (EDI) Board.** • **Corporate Strategy in place with annual corporate objectives.** • **Quality Strategy in development, including work on patient engagement and involvement.**	• **Equalities Dashboard about to launch - reviewed by Equality, Diversity and Inclusion (EDI) Board and can be added to Performance Management Framework (PMF) packs.** • **Business planning proposals indicate understanding of the communities we serve and how proposals will support.**	• Tbc	• **Emergency Care Improvement Support Team (ECIST) data on health inequalities shared and reviewed by Information Services.**
Control Lead: Director of Strategy and Planning			**Assurance Level: LIMITED**

Gaps in Controls / Assurances	Actions to address gaps in controls / assurance
Further work on embedding and using data and intelligence about inequalities and the population we serve – for instance, adding more about Core20PLUS5 metrics.	3. **Develop further our inequalities dashboard, including gaining input from public health teams .** 4. **Embed population and health inequalities focus more into our business planning and performance processes – including Directorate reviews and Performance Management Framework (PMF).**
Limited methodical wider understanding of population health	5. **Seek support from commissioners to review how well we meet needs of our population.**
Patient engagement approach signalled in Healthcare Governance Review undertaken by external consultancy.	6. **Strengthened patient engagement work through new Quality Strategy.**

Return to Strategic Risk front sheet

Strategic Risk 3: WORKFORCE

Fail to ensure the Trust can recruit and retain the right people to deliver patient centred services and the best clinical outcomes

Aggregated Assurance Rating	**LIMITED**

Key Causes		**Assurance Rating**
C1	Fail to monitor and support the health and wellbeing of our staff	**Adequate**
C2	Failure to ensure a diverse and inclusive workforce	**Adequate**
C3	Workforce planning does not align to current or future Trust requirements (capability, capacity)	**Limited**

Key Effects / Consequences (Results in)

- Staff do not feel cared for / increased pressure and workload on existing staff (capacity)
- Adverse impact on staff health, wellbeing and resilience
- Negative effect on patient care
- Loss of experience and knowledgeable staff
- Unable to deliver Trust strategies and the Patient Care Recovery Plan

Risk Likelihood	**Rating**
Previous Position	**n/a**
Current	**Likely**
Target	**Possible**

Target score to be achieved by XXX

TREND GRAPH TO BE ADDED

Aggregated Action Plan to address gap in control or assurance				
	Action	Lead Exec	Deadline	Progress update
1	Focused work with Sheffield Hospitals Charity to secure funding **for relevant elements** of the Health and Wellbeing Service.	DHRSD	**September 2022**	**Charity Deadline for submission of bids mid-Sept. Work underway on 12 months post to develop and support Wellbeing Champions / extension of CALM room funding / extension of Team Psychologist post funding and extension of Schwartz bid funding.**
2	Paper to TEG under construction to outline the risks to short term funding **of elements** of the Health and Wellbeing Service.	DHRSD	**November 2022**	**Work underway on aspects of the external funding that have enabled an increase in workforce resource within the Health and Wellbeing and Staff Experience team that will not be covered by the Charity Funding bids described above in action 1. Confirmation of bid outcomes is required to progress the paper. This is normally received approximately one month after the deadline for submission of bids.**
3	**Support provided to Directorates where Staff Experience Plans are outstanding**	**DHRSD**	**November 2022**	**This work is ongoing through the Staff Experience and Wellbeing team.**
4	**Action plan to be agreed with stakeholders to address data quality of workforce core dataset**	**ODD**	**November 2022**	**Internal ODD discussion planned for Sept 2022, with subsequent involvement from other corporate functions who manage the datasets needed to create a plan to improve the data quality issue.**
5	New People Strategy to be refreshed with Trust Workforce Plan included.	ODD	**January 2023**	**On track. Cross trust working group formed and has gathered data / views on the key areas for the new People Strategy by August 2022. Draft strategy outline to be agreed in Sept and consulted on during Oct – Nov 2022 including elements relevant to workforce (planning, recruitment, retention, development, and inclusion). Final People Strategy to be drafted for approval at the BoD planned for Jan 2023.**
6	Implement and embed Integrated Recovery Board to provide oversight of workforce capacity as part of governance arrangements for 'Getting Back on Track'.	COO / OID	**October 2022**	**Getting Back on Track programme structure being developed. Patient Care Recovery Plan structure being finalised and will be complete by end of September. Recruitment enabler Steering group and Operational Board ToR being developed and will be complete by end of Oct.**

Commentary *(including changes since last BAF issue / key discussion points notes at most recent Deep Dive review and any relevant entries onto the Corporate Risk Register Report)*

Review / update of Controls and Assurances are noted in bold.

In addition to the risks described work is underway on two further risk assessments for issues impacting upon the workforce as follows:

- Potential Industrial Action: as a result of dissatisfaction with the national pay award the RCN are currently balloting their members for strike action, If strike action is supported this could mean absence in the nursing workforce as a result in November 2022. Other trade unions including Unison and the BMA are also following suit to ballot members views. Whilst the Trust can consider derogations to support delivery of critical patient services strike action would impact on the Trusts ability to provide our full services to our patients.

- Increasing Cost of Living: the national cost of living crisis is already and will continue to have an impact on our employees this could in turn impact on employee wellbeing, attendance, our ability to retain employees and attract candidates to key posts. TEG has reviewed the impact of an potential options to support colleagues with the cost of living crisis but this remains a risk to our workforce.

Accountabilities / Review History

Board Oversight	Last deep dive review held	Strategic Risk Owner	Date of last Update
People Committee		Director of HR and Staff Development	September 2022

Controls and Assurances

Controls	Assurance / Evidence		
For Cause 1: *Fail to monitor and support the health and wellbeing of our staff* [system in place to help manage the cause / effect]	[where can we gain evidence that the controls *we* are placing reliance on are working]		
	First Level [Service delivery and day to day management - how do we know day to day that controls are working?]	**Second Level** [Oversight – who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]	**Third Level** [Independent challenge – has anyone external come in to check that the controls are working]
• Defined Staff Health and Wellbeing agenda / dedicated People Strategy workstream – Promoting Wellbeing. • Governance structure in place providing oversight including establishment of Health and Wellbeing Executive. • Non-Executive Director Health and Wellbeing Guardian in place. 100 Wellbeing **Champions trained and work underway to increase numbers to cover all Directorates.** • Staff Intranet / Sharepoint site with suite of health and wellbeing resources. • Employee assistance programme (Vivup). • Inhouse support from Occupational Health. • Staff Experience Action Plans by Directorate developed in response to Staff Survey Results. • Mechanisms in place for Staff feedback including Pulse Check. • Patient Care Recovery Plan includes a workforce wellbeing and attraction, recruitment and retention element. **Control Lead:** Director of HR and Staff Development	• Sickness absence data collated by HR department. • Staff Survey collated and reviewed by HR Department. • Statistics on attendance on wellbeing courses / programmes collated by HR department. • Progress against Promoting Wellbeing objectives / action plan monitored by of workstreams leads.	• Workforce Key Performance Indicator (KPI) report presented to People Committee (formerly HR and OD Committee). • Trust-level Staff Experience Action Plans by Directorate agreed by TEG. • Quarterly data from Vivup presented to Health and Wellbeing Executive Group. • Reporting against Promoting Wellbeing workstream to People Strategy Programme Board and onward to People Committee (formerly HR and OD Committee).	• Benchmarking sickness absence data nationally / locally. • Integrated Care System (ICS) / Integrated Care Board (ICB) data submission regarding introduction of wellbeing Champions Carers Forum. • Internal Audit - Health and Wellbeing (Significant Assurance).
			Assurance Level: ADEQUATE

Gaps in Controls / Assurances

Control Gap – Uncertainty **in some elements** of Health and Wellbeing service provision where funding is provided from external sources on a fixed term basis.

Control Gap - Some areas are still to submit Staff Experience Action Plans.

Actions to address gaps in controls / assurance

1. Focused work with Sheffield Hospitals Charity to secure funding for relevant elements of the Health and Wellbeing Service.
2. Paper to TEG under construction to outline the risks to short term funding of Health and Wellbeing Service.
3. Support provided to Directorates where Staff Experience Plans are still outstanding.

Return to Strategic Risk front sheet

Controls	Assurance / Evidence		
For Cause 2: *Fail to ensure a diverse and inclusive workforce*	**First Level**	**Second Level**	**Third Level**
• Executive led workstream in place to support Trust commitment to progressing the Equality, Diversity and Inclusion (EDI) agenda / achieving priority EDI objectives. • Defined EDI Governance structure and arrangements. • Staff Networks established for protected characteristics staff groups. • Mechanisms in place to identify changes across external context / disproportionate impact (horizon scanning), to feed into strategic planning, e.g. through Staff Networks and ICB networks. • EDI Implementation Plan. • Development and implementation of reporting EDI metrics through EDI Dashboard fed by database of patient demographic information. • Trust-wide education, training and awareness programme on wide range of EDI topics. • EDS 2022/23 Peer Review Process. • Participation targets in place for access to leadership development and training by underrepresented groups. • Strategic input into Health Education England (HEE) discussions to promote diverse recruitment to training programmes.	• Head of EDI and resourced team supporting effective delivery of EDI Implementation Plan. • Minutes of EDI Board meetings and its subgroups (Networks) • Diversity monitoring reports of patients and service users by EDI department. • Directorate level review of EDI Dashboard. • Diversity monitoring of workforce (workforce profile, HR processes, access to opportunities (career development / training), etc) by EDI department.	• Board-approved EDI strategy and associated Implementation Plan. • Progress against EDI Implementation Plan presented to EDI Board. • Report from EDI Board reported to TEG / Quality Committee. • Annual EDI Review presented to the Board of Directors (May 22). • Workforce Race Equality Standard (WRED) / Workforce Disability Equality Standard (WDES) action plan reported to the People Committee (formerly HR and OD Committee) and the Board of Directors. • EDI Dashboard to be reported to EDI Board.	• Internal Audit – Accessible Information Standards (AIS) – significant assurance for EDI governance arrangements. • WRES / WDES reports – benchmark well against peers (*note – new data due in September 2022*). • Output from Equality Delivery System (EDS) 2022/23 Peer Review process.
Control Lead: Organisational Development Director			**Assurance Level: ADEQUATE**

Gaps in Controls / Assurances	Actions to address gaps in controls / assurance
Assurance Gap – Integrity of Workforce core dataset due to extraction from multiple systems.	**4. Action plan to be agreed with stakeholders to address the issues data quality of workforce core dataset.**

Return to Strategic Risk front sheet

Controls	Assurance / Evidence		
For Cause 3: *Workforce planning do not align to current or future Trust requirements (capability, capacity)*	**First Level**	**Second Level**	**Third Level**
• Workforce planning process aligned with annual business planning cycle, via Workforce Team reviewing Directorate Business Plans and identifying all known / planned workforce activity within them. • Workforce Redesign, Innovation and Planning (WRIP) Group established under our People Strategy to lead and advise on the workforce agenda. • International Recruitment Programme. • Implementation of Directorate Deep Dive programme on Medical Workforce Planning to identify / quantify workforce shortages, and generate action plans within regional / national context. • Development of new quarterly workforce reporting to provide an overview of staffing capacity and anticipated shortfalls (Mock Report). • Co-ordination by Organisational Development Directorate (ODD) of meetings between professional leads and Health Education England / Integrated Care Board (ICB) to inform external stakeholder workforce planning. Control Lead: Organisational Development Director	• Directorate workforce plans assessed by Workforce Team / challenged as part of the business planning process (Bronze / Silver and Gold Workforce Plans). • Delivery of International Recruitment programme led by Chief Nurse and reported on within monthly Nurse / Midwifery Staffing Report. • Return on investment evaluated by Chief Nurse as part of recruitment programme monitoring. • Directorate completion of medical workforce planning proformas and collation / analysis of co-ordinated by ODD in conjunction with Medical Directors' Office. • Quarterly Workforce Report (New) collated by HR.	• Workforce Key Performance Indicators reported to the People Committee (formerly HR and OD Committee). • WRIP Group reports to People Strategy Board, TEG the People Committee (formerly HR and OD Committee). • Nurse / Midwifery Staffing Report presented to TEG and the People Committee (formerly HR and OD Committee). • Action plans generated from Medical Workforce analysis collection monitored by People Strategy Programme Board and TEG. • Quarterly Workforce Report (new) to provide early warning of projected staffing shortages – reported to TEG and the People Committee (formerly HR and OD Committee) [Mock Report – July 2022].	• NHS Professionals commissioned to deliver International Recruitment Programme. • Internal Audit – Workforce Planning Arrangements – terms of reference agreed. • Annual Workforce Plan submitted to ICB and NHSE (feedback received on draft in advance of final submission) – used to inform training placements offered by Health Education England.
	Assurance Level: LIMITED		

Gaps in Controls / Assurances	Actions to address gaps in controls / assurance
Control Gap – Absence of Trust-wide workforce plan. Assurance Gap – Need to develop arrangements for oversight of workforce capacity in relation to recovery plan. Assurance Gap – Integrity of Workforce core dataset due to extraction from multiple systems.	5. New People Strategy to be refreshed with Trust workforce Plan included. 6. Implement and embed Integrated Recovery Board to provide oversight of workforce capacity as part of governance arrangements for 'Getting Back on Track' See (4) above

Return to Strategic Risk front sheet

Strategic Risk 4: FINANCE

Fail to manage our finances effectively and deliver value for money to ensure the long-term sustainability of care provision

Aggregated Assurance Rating	**ADEQUATE**

Key Causes		**Assurance Rating**
C1	Uncertainty around funding / contracting arrangements	**Substantial**
C2	Lack of strategic financial plan	**Adequate**
C3	Failure to ensure financial systems and processes are fit for purpose	**Substantial**
C4	Failure to deliver the required levels of efficiency savings	**Limited**

Key Effects / Consequences (Results in)

- Lack of financial stability
- Regulatory intervention **/ restrictions**
- Unstable operating environment
- Negative patient / stakeholder experience
- Inability to deliver strategic plans / maximise opportunities

Risk Likelihood	**Rating**
Previous Position	**n/a**
Current	**Possible**
Target	**Unlikely**

Target score to be achieved by XXX

TREND GRAPH TO BE ADDED

Aggregated Action Plan to address gap in control or assurance

	Action	Lead Exec	Deadline	Progress update
1	Update Five-year Financial Plan.	CFO	**June 2023**	**The intention is to build on the 2023/24 Financial Plan reflecting new funding/contracting arrangements and the establishment of ICBs.**
2	**Update the Scheme of Delegation.**	**CFO**	**October 2022**	**Work underway. Aim to submit to the October Board for approval.**
3	**Establish the Use of Resources (UoR) Group.**	**CFO**	**October 2022**	**ToR agreed. Some membership still to be finalised. Recruitment to posts to support UoR Group is underway.**

Commentary *(including changes since last BAF issue / key discussion points notes at most recent Deep Dive review and any relevant entries onto the Corporate Risk Register Report)*

The external environment remains uncertain as we emerge from the Covid pandemic, as revised funding and contracting arrangements are implemented and as Integrated Care Boards (ICBs) are established. It is clear, however, that there will continue to be a requirement to deliver at least 2% efficiency per annum.

Ensuring appropriate internal focus on financial management will also be challenging given the many operational and workforce issues.

Review / update of Controls and Assurances are noted in bold.

Note – movement in Assurance Levels for C1 and C2 since last update (July 2022) is due to review of assessment, rather than material changes in position.

Accountabilities / Review History

Board Oversight	Last deep dive review held	Strategic Risk Owner	Date of last Update
Finance and Performance Committee		Chief Finance Officer	September 2022

Controls and Assurances

Controls **For Cause 1:** *Uncertainty around funding / contracting arrangements* [system in place to help manage the cause / effect]	**Assurance / Evidence** [where can we gain evidence that the controls we are placing reliance on are working]		
	First Level [Service delivery and day to day management - how do we know day to day that controls are working?]	**Second Level** [Oversight – who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]	**Third Level** [Independent challenge – has anyone external come in to check that the controls are working]
• Process / system by which we develop assumptions regarding funding, i.e. tangible description of Commissioner engagement, horizon scanning, Strategy development. • Revised business planning process in place which reflects new funding arrangements. • Strategy to maximise all alternative funding streams. • Financial planning based on validated activity base / predictions for future demand. • Robust business planning process to allow clarity and understanding of cost base enabling support for new funding opportunities/requests. **Control Lead: Chief Finance Officer**	• Chief Finance Officer (CFO) attendance at Integrated Care System (ICS) finance meetings. • CFO attendance at Shelford CFO's Group to understand / influence national architecture and future developments. • Regular financial updates taken by CFO to TEG. • **Regular CFO updates to TEG on development of Financial Plan with discussion on key issues.** • **CEO and other Directors involved in ICS / NHSE policy agreements and commissioner discussions.**	• Financial Reports – monthly financial reports to Finance and Performance Committee and Board of Directors highlighting key issues. • Regular financial planning updates taken to Finance and Performance Committee **(and Board as required)**. • **Board approval of Financial Plan.**	• Internal Audits (as appropriate). • External Audit of Annual Accounts and **Value for Money Report (including review of financial sustainability,** going concern and financial / business planning). • Submission of financial plan to **ICB** and NHSE.
	Assurance Level: SUBSTANTIAL ↑		
Gaps in Controls / Assurances	**Actions to address gaps in controls / assurance**		

Return to Strategic Risk front sheet

Controls **For Cause 2:** *Lack of strategic financial plan*	**Assurance / Evidence**		
	First Level	**Second Level**	**Third Level**
• Trust five-year Financial Plan **and Strategy** based on agreed financial assumptions / modelling. • **Development of a robust annual financial plan to underpin the longer-term financial plan, triangulated with workforce and activity.** **Control Lead: Chief Finance Officer**	• Chief Finance Officer leads development **of assumptions** and financial models. • Financial plans developed and agreed with TEG. • TEG review of Directorate Business Plans. • TEG approval of financial plan prior to submission to Integrated Care System (ICS). • **TEG review of delivery of five-year Financial Plan.**	• Annual Financial Plans approved by Finance and Performance Committee and Board of Directors. • **Approval of five-year Financial Plan through Trust-wide governance including Finance and Performance Committee and Board of Directors.**	• Regulatory review of long-term financial assumptions for the Trust. • Regulator review and signoff of Trust Financial Plans (as part of system financial plan and process). • Internal Audit – Financial sustainability review (nationally mandated audit). • Internal Audit – Review of Business and Financial Planning process. • External Audit – **Value for Money Assessment (including Financial Sustainability**).
	Assurance Level: ADEQUATE ↓		

Gaps in Controls / Assurances	**Actions to address gaps in controls / assurance**
Gap in Control - Five year financial plan requires updating post Covid-19, **reflecting new national funding / contracting arrangements and establishment of ICBs.**	1. Update Five-year Financial Plan.

Return to Strategic Risk front sheet

Controls	Assurance / Evidence		
For Cause 3: *Failure to ensure financial systems and processes are fit for purpose*	**First Level**	**Second Level**	**Third Level**
• Defined set of systems and processes in place for financial transactions reflected in Trust Standing Financial Instructions**, Scheme of Delegation, etc**. • Agreed directorate / department budgets which are monitored monthly via financial systems. • Process for identification and monitoring of efficiency savings. • Directorate Accountant resource in place to support Directorates with financial management. • Establishment control (pay budget). • Procurement Policy including No Purchase Order, No Pay policy. • Financial Governance structure in place to provide oversight. • Programme of external audit review of financial management arrangements within Internal Audit Plan. • Robust process for forecasting / financial modelling. • Performance Management Framework – meetings and escalation processes. • Project Management Office (PMO) resource in place to support delivery of efficiency savings (formerly Making it Better now through Getting Back on Track). • External reporting to NHSE and South Yorkshire Integrated Care Board / System. **Control Lead: Chief Finance Officer**	• Monitoring of budgets and reconciliation of accounts by Finance Team. • Monitoring delivery of efficiency plans by Finance Team. • Triumvirate / Director level review of Key Performance Indicators (KPIs) on budgetary performance and variance including review of delivery of efficiency plans. • Directorate Review meetings co-ordinated by Director of Strategy and Planning. • Project management arrangements monitor delivery of capital plans against agreed budgets and escalate risks.	• Monthly financial reports reviewed by TEG and Finance and Performance Committee. • Integrated Performance Report (IPR) reviewed by Board of Directors. • Outcome of Directorate Reviews reported to TEG. • Capital Investment Committee monitors capital expenditure and delivery of capital programme.	• Annual Internal Audit of selected areas of financial management. • **Internal Audit – Financial sustainability review (nationally mandated audit).** • Annual External Audit of Accounts **and Value for Money report.**
			Assurance Level: SUBSTANTIAL

Gaps in Controls / Assurances	Actions to address gaps in controls / assurance
Gap in Control – The Scheme of Delegation has not been updated / refreshed for some time.	**2. Update the Scheme of Delegation**

Return to Strategic Risk front sheet

Controls	Assurance / Evidence		
For Cause 4: *Failure to deliver the required levels of efficiency savings*	**First Level**	**Second Level**	**Third Level**
• Agreed Efficiency Programme. • Programme Management Office (PMO) resource in place to support delivery of relevant 'Getting Back on Track' workstreams. • **Agreed process for the recording and monitoring of efficiency schemes.** • **Directorate identification of P&E schemes and delivery of schemes monitored.**	• **Review Directorate Efficiency Plans as part of annual Financial / Business Planning process.** • Monitoring delivery of efficiency plans by Finance Team. • Triumvirate / Director level review of delivery of efficiency plans. • Directorate Review meetings co-ordinated by Director of Strategy and Planning.	• Monthly financial reports reviewed by TEG and Finance and Performance Committee. • Integrated Performance Report (IPR) reviewed by Board of Directors. • Outcome of Directorate Reviews reported to TEG.	• Internal Audit of relevant financial management areas **and Efficiency Programme.** • Annual external audit of Accounts **and Value for Money report**.
Control Lead: Chief Finance Officer	**ASSURANCE LEVEL: LIMITED**		

Gaps in Controls / Assurances	Actions to address gaps in controls / assurance
Gap in Control – Limited capacity to identify and drive opportunities to deliver efficiency savings	**3. Establish the Use of Resources Group**

Return to Strategic Risk front sheet

Strategic Risk 5: INFRASTRUCTURE

Fail to implement appropriate, cost effective and innovative approaches to digital and estate infrastructure that support our aspirations today and for the future

Aggregated Assurance Rating	**LIMITED**

Key Causes		**Assurance Rating**
C1	Fail to ensure adequate capital funding and manage competing priorities for capital funding	**Adequate**
C2	Ineffective delivery plans and strategy for Estates	**Limited**
C3	Ineffective delivery plans and strategy for Digital / Information Management and Technology (IM&T)	**Limited**

Key Effects / Consequences (Results in)

- Overspend / project delays
- IT system vulnerabilities [cyber-attack / General Data Protection Regulation (GDPR) - compliance / fraud etc]
- Negative staff and patient experience
- Estate not suitable for modern healthcare
- Service delivery adversely impacted – interdependency / reliance on systems and estates

Risk Likelihood	**Rating**
Previous Position	**n/a**
Current	**Possible**
Target	**Unlikely**

Target score to be achieved by XXX

TREND GRAPH TO BE ADDED

Aggregated Action Plan to address gap in control or assurance

	Action	Lead Exec	Deadline	Progress update
1	Estates Strategy refresh to be undertaken in liaison with Strategy and Planning Directorate.	**CN**	**December 2022**	**Work currently ongoing on refreshing the Estates Strategy.**
2	**Head of Information and Governance (Estates) to review operational oversight, quality assurance and associated management and include as part of a Governance Review.**	**CN**	**November 2022**	**New Head of Information and Governance (Estates) appointed. New governance structure to be implemented by Nov 2022.**
3	Gain ISO 14001 Accreditation Status.	**CN**	**March 2023**	**New Head of Information and Governance (Estates) working on a plan to achieve this accreditation.**
4	Appointment of Authorised Engineer (FIRE) and commissioning of External Independent Review	**CN**	**December 2022**	**Process for the appointment of Authorised Engineer and commissioning of External Independent Review now underway.**
5	**Monthly reporting to quality and performance meeting, chaired by the Director of Estates**	**CN**	**November 2022**	**Report from the Estates Director to Finance and Performance Committee included as part of work plan.**
6	**Capture IT Digital enabling requirements within annual business planning process.**	**MD(Dev) / DSP**	**November 2022**	**To be incorporated within business planning guidance currently under review / development.**
7	**Recruit appropriately qualified deputy role within Cyber Team.**	**MD(Dev)**	**March 2023**	**Recruitment underway.**

Commentary *(including changes since last BAF issue / key discussion points notes at most recent Deep Dive review and any relevant entries onto the Corporate Risk Register Report)*

Review / update of Controls and Assurances are noted in bold.

Estates Director is implementing a new structure with focus on estate compliance and assurance. New Head of Information and Governance (Estates) in post and currently reviewing operational oversight, quality assurance and associated management and include as part of a Governance Review. These actions will drive improvement in current Limited Assurance Rating for Cause C2 (Estates).

Limited Assurance Rating for Cause C3 (Digital and IM&T) reflects current maturity of related governance / assurance arrangements and scope to broaden the focus of third level assurance.

Accountabilities / Review History

Board Oversight	Last deep dive review held	Strategic Risk Owner	Date of last Update
Finance and Performance Committee TBC		**Chief Nurse**	September 2022

Controls and Assurances

Controls **For Cause 1**: *Fail to ensure adequate capital funding and manage competing priorities for capital funding* [system in place to help manage the cause / effect]	Assurance / Evidence [where can we gain evidence that the controls we are placing reliance on are working]		
	First Level [Service delivery and day to day management - how do we know day to day that controls are working?]	**Second Level** [Oversight – who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]	**Third Level** [Independent challenge – has anyone external come in to check that the controls are working]
• Capital is part of the annual Business Planning process. • Directorate Business Plans include identification of capital requirements. • Internal Trust processes for setting Trust revenue and capital investment with defined and agreed budgets. • Annual Business Planning Process to allow for funding to manage Estates / IM&T related operational risks. • Capital Investment Team (CIT) in place. • Capital Plan / cost pressures listing ensures capital investment considers critical infrastructure risks. • Project management / governance arrangements include project risk identification / escalation to ensure existing projects run to time / budget. **Control Lead: Chief Finance Officer**	• Trust representation within system-wide capital allocation processes led by Chief Finance Officer. • Capital planning process led by Chief Finance Officer. • Business planning process led by Director of Strategy and Planning with contributions from TEG members. • Capital plans discussed and agreed at TEG. • Directorate Business Plans drafted by Directorate Triumvirate and reviewed by Executive Lead. • Project delivery monitored by Project / Programme team. • **Delivery of capital investment reviewed and monitored by CIT.** • **CIT minutes submitted to TEG.**	• Capital Programme / Plan approved by Finance and Performance Committee / Board. • Quarterly Update Reports submitted to the Board via TEG. • Strategies (Estates and IM&T) agreed by Board. • Action plans agreed by TEG / Board. • Directorate Business Plans monitored by Directorate Reviews and output reviewed by TEG.	• Internal Audit Work
			Assurance Level: ADEQUATE
Gaps in Controls / Assurances		**Actions to address gaps in controls / assurance**	

Return to Strategic Risk front sheet

Controls	Assurance / Evidence		
For Cause 2: *Ineffective delivery plans / Estates strategy*	**First Level**	**Second Level**	**Third Level**
• Estates Strategy / Estates Delivery plans. • Trust Planned Preventative Maintenance programme. • Application of Premised Assurance Model (PAM) to support quality and safety compliance and efficiency of Estates. • Programme of testing **(statutory compliance)** – HV/LV including generator black start, legionella, **ventilation, and medical gases** undertaken by Authorised Persons. • Programme in place to monitor compliance with Estates ISO 9001 accreditation. • Essential Maintenance Programme in place. **Control Lead:** Chief Nurse	• Estates Director chairs Estates Management Group through which escalation of capital project issues / delivery risks takes place. • Estates Risks managed through routine Estates Directorate Risk/Quality meetings. • Authorising Engineers audit / monitor performance against Estates safety / compliance metrics, e.g. (Water, ventilation, medical gases etc). • Estates Directorate collate information for Estates Return Information Collection (ERIC). • Estates Directorate utilise PAM self-assessment **to drive improvement**. • On-call engineers - day to day management of Estates. • Budget meetings in place in liaison with finance. • Critical infrastructure reviews every six months (working to condition B estates).	• Capital Investment Team (CIT) Estates Management Report. • Premises Assurance Model (PAM) reviewed by Quality Committee. • Reports provided to Ventilation Safety Group and Water Safety Group – both report to Infection Prevention and Control (IPC) Committee. • Relevant Estate matters discussed and reported through Partnership Forum. • Estates Energy Meeting. • Land and Property Meeting – discuss leases and licences arrangements. • Extreme Estates Risks reported to TEG / Board of Directors through the Corporate Risk Register Report (New).	• ERIC return submitted to NHSE Estates and Facilities (checking function) and linked to Model Hospital. • Six Facet Survey – NHS Standard – measures utilisation, compliance, function and suitability. • Access surveys - across site • Insurance company **site inspections** / surveys.
	Assurance Level: LIMITED		

Gaps in Controls / Assurances	Actions to address gaps in controls / assurance
Control Gap – Estates Strategy refresh required (in line with Estates code)	**1.** Estates Strategy refresh to be undertaken in liaison with Strategy and Planning Directorate.
Control Gap – Operational oversight and management	**2. Monthly reporting to quality and performance meeting, chaired by the Director of Estates. Report from the Estates Director to Finance and Performance Committee as part of their work plan.**
Control Gap – Working towards ISO 14001	**3.** Gain ISO 14001 Accreditation Status.
Control / Assurance Gap – Managing Healthcare Fire Safety recommendations. (HTM 05-01)	**4.** Appointment of Authorised Engineer and commissioning of External Independent Review.
Assurance Gap – Quality Assurance within Estates internally	**5. Monthly quality and performance meeting, chaired by the Director of Estates.**

Return to Strategic Risk front sheet

Controls	Assurance / Evidence		
For Cause 3: *Ineffective delivery plans and strategy for Digital and IM&T*	**First Level**	**Second Level**	**Third Level**
• IM&T Strategy includes detailed plan around enabling infrastructure. • Internal Audit Programme in place. • **Contract signed for fully functional Electronic Patient Record (EPR) to be delivered in May 2024 with clear milestones for delivery.** • **Digital Strategy into Action work driving development of Governance arrangements.** • **Digital Planning Group in place (replacement for Technology Planning Group).** • **Informatics has a monthly Risk Governance meeting chaired by Director.** **Control Lead:** Medical Director (Development)	• Digital **and Informatics** Teams manage delivery of programme based on good practice project methodology, **i.e. Prince2 and Managing Successful Programmes (MSP).** • **All IT projects requiring resourcing go through Technology Business Case Assurance Team (TBCAT) / Capital Investment Team (CIT) for approval with highlight / exception reporting following the same route.** • Significant IM&T Risks monitored by Directorate Governance meeting chaired by Medical Director (Development). • **Cyber Security Group meets monthly and feeds into Information Governance Committee and Finance and Performance Committee.**	• Digital Strategy 2022-2025 approved by the Board of Directors. • **Progress on all funded IT/ Digital schemes are monitored by Technology Business Case Assurance Team (TBCAT) / Capital Investment Team (CIT).** • **Informatics** Delivery reports reported to Finance and Performance Committee **on a quarterly basis.** • Extreme IM&T Risks reported to TEG / Board of Directors through the Corporate Risk Register Report (New).	• Internal Audit Programme delivery. • Cyber Security Audits by NHS Digital / **Internal Audit**. • Regular penetration testing and cyber security testing arranged with external expertise. • **All High severity Cyber alerts are acknowledged within 48 hours to NHS Digital (NHSD) and actions and mitigations submitted.** • **Project assurances function within the Electronic Patient Record (EPR) Programme.**
			Assurance Level: LIMITED

Gaps in Controls / Assurances

Control Gap - Projects requiring significant IT Digital enabling coming through routes that don't allow the normal scrutiny around alignment with strategy, allocation of IT resources and cyber requirements.

Control Gap – Lack of resilience within Cyber team (Expertise dependent on one individual).

Actions to address gaps in controls / assurance

6. **Capture IT Digital enabling support requirements within annual business planning process / incorporate within business planning guidance.**

7. **Recruit appropriately qualified deputy role within Cyber Team.**

Return to Strategic Risk front sheet

Strategic Risk 6: SUSTAINABILITY

Fail to identify and maximise sustainable ways to deliver the Trust's strategic aims and objectives

Aggregated Assurance Rating	**ADEQUATE**

Key Causes		Assurance Rating
C1	Competing pressures and priorities deflecting focus and resources	**Adequate**
C2	Limited awareness of potential options for change or new ways of working (ineffective horizon scanning)	**Limited**

Key Effects / Consequences (Results in)

- Trust unable to take advantage of new ways to deliver modern healthcare and technical advancements
- Future funding and delivery of services compromised
- Negative impact on the Trust reputation
- Staff capacity / morale and well-being impacted
- Increased costs / unrealised efficiencies in service delivery changes

Risk Likelihood	**Rating**
Previous Position	**n/a**
Current	**Likely**
Target	**Tbc**

Target score to be achieved by XXX

TREND GRAPH TO BE ADDED

Aggregated Action Plan to address gap in control or assurance

	Action	Lead Exec	Deadline	Progress update
1	**Sustainability manager post to be included in Directorate's 23/24 Business Plan.**	**DSP**	**February 2023**	**To be included in business plan**
2	**Regular sustainability report to be prepared for TEG and for Board, including best practice initiatives being undertaken elsewhere – to strengthen our First and Second level assurance.**	**DSP**	**January 2023**	**Work underway and on track**
3	**Communication and engagement plan in order to engage, influence and be embedded sustainability in all aspects of Trust business.**	**Comms Director**	**October 2022**	**Work underway to develop a comms and engagement approach for work on sustainability for discussion with Sustainability Committee.**
4	**Work with partners – including NHSE and ICB on external review (third level assurance) of our sustainability work.**	**DSP**	**Summer 2023**	**To follow embedding of internal processes.**
5	**Sustainability Plan annual refresh to be done to update priorities.**	**DSP**	**February 2023**	**Not yet started**
6	**Implementation and embedding of revised Sustainability Impact Assessment Tool.**	**DSP**	**December 2022**	**TBC**
7	**Assessment and log of underpinning risks relating to legislative proposals within the Health and Social Care Act and associated guidance relating to sustainability.**	**DSP**	**March 2023**	**TBC**

Commentary *(including changes since last BAF issue / key discussion points notes at most recent Deep Dive review and any relevant entries onto the Corporate Risk Register Report)*

Review / update of Controls and Assurances are noted in bold.

Accountabilities / Review History

Board Oversight	Last deep dive review held	Strategic Risk Owner	Date of last Update
Board of Directors		Director of Strategy and Planning	September 2022

Controls and Assurances

Controls **For Cause 1:** *Competing pressures and priorities deflecting focus and resources* [system in place to help manage the cause / effect]	Assurance / Evidence [where can we gain evidence that the controls we are placing reliance on are working] **First Level** [Service delivery and day to day management - how do we know day to day that controls are working?]	**Second Level** [Oversight – who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]	**Third Level** [Independent challenge – has anyone external come in to check that the controls are working]
• **Head of Sustainability and Sustainability Manager in place providing leadership, capacity and coordination.** • **Sustainability Committee established.** • **Sustainability Plan in place with identified priorities for a three year period.** • **Board performance metrics identified.** **Control Lead: Director of Strategy and Planning**	• **Sustainability Delivery Plan and monthly meetings of the Sustainability Committee.**	• **Board Integrated Performance Report.** • **Sustainability Committee action log.**	• **Integrated Care Board (ICB) review of Sustainability Plan and priorities.** • **Sustainability Plan return submitted to Integrated Care System (ICS).**
	Assurance Level: ADEQUATE		

Gaps in Controls / Assurances	Actions to address gaps in controls / assurance
Sustainability Manager post is fixed term until early 2023.	**1. Sustainability Manager post to be included in Directorate's 23/24 Business Plan.**
Assurance Gap - The relative 'newness' of this strategic focus means we haven't yet settled on an assurance report for TEG and Board.	**2. Regular sustainability report to be prepared for TEG and for Board, including best practice initiatives being undertaken elsewhere – to strengthen our First and Second level assurance**
Control Gap - Need to embed and create a 'pull' and expectation for sustainability work across the Trust.	**3. Communication and engagement plan in order to engage, influence and be embedded sustainability in all aspects of Trust business.**
Assurance Gap - Relatively limited third level assurance at this stage – given this is an emerging area of focus for NHS organisation.	**4. Work with partners – including NHSE and Integrated Care Board (ICB) on external review (third level assurance) of our sustainability work**

Return to Strategic Risk front sheet

Controls	Assurance / Evidence		
For Cause 2: *Limited awareness of potential options for change or new ways of working (ineffective horizon scanning)*	**First Level**	**Second Level**	**Third Level**
• **Member of Shelford Group Sustainability Leads.** • **Head of Sustainability and Sustainability Manager in place providing leadership, capacity and coordination.** **Control Lead: Director of Strategy and Planning**	• **Rely on the expertise and knowledge of staff closely involved in this work.**	• **Deep dive at Board for Integrated Performance Report**	• **Involvement in Shelford Group Sustainability Leads meetings**
			Assurance Level: LIMITED

Gaps in Controls / Assurances

Assurance Gap - Sustainability Plan is our first version of this – further work needed to ensure its relevance and sufficiency.

Work is needed to review whether the actions we have identified are sufficiently ambitious for the scale of the challenge

Actions to address gaps in controls / assurance

5. Sustainability Plan annual refresh to be undertaken to review and update priorities.

6. Implementation and embedding of revised Sustainability Impact Assessment Tool.

Deep dive on sustainability should describe best practice initiatives being undertaken elsewhere – to strengthen our First and Second level assurance.

See Action (4) above.

7. Assessment and log of underpinning risks relating to legislative proposals within the Health and Social Care Act and associated guidance relating to sustainability

Return to Strategic Risk front sheet

Strategic Risk 7: RESEARCH, EDUCATION AND INNOVATION

Fail to ensure the Trust has the ability to deliver excellent research, education and innovation

Aggregated Assurance Rating	**LIMITED**

Key Causes		**Assurance Rating**
C1	Fail to ensure relevant strategies and delivery plans are clearly defined and effective	**Limited**
C2	Service pressures displace research and education activity	**Limited**
C3	Infrastructure and resources are insufficient to support delivery of research and education	**Limited**
C4	Fail to align priorities with higher and further education providers and Health Education England (external stakeholders)	**None**

Key Effects / Consequences (Results in)

- Fail to deliver modern integrated care / missed opportunities to improve patient care and operational efficiencies
- Adverse impact on reputation as a teaching hospital
- Service delivery not aligned to future community / stakeholder needs
- Inadequately trained staff / future workforce compromised
- Reduced research funding

Risk Likelihood	**Rating**
Previous Position	**n/a**
Current	**Likely**
Target	**Tbc**

Target score to be achieved by XXX

TREND GRAPH TO BE ADDED

Aggregated Action Plan to address gap in control or assurance

	Action	Lead Exec	Deadline	Progress update
1	Develop and agree with the Board of Directors a refresh of the Trust's Research and Innovation Strategy, with associated delivery plan.	MD (Dev)	November 2022	Drafted Trust Research & Innovation Strategy is under final review by Medical Director (Development) and Assistant Chief Executive.
2	Director of Education, Learning and Staff Development to review operational oversight, quality assurance and associated management and include as part of an Educational Governance review.	DHRSD / MD (Dev)	December 2022	Medical Education Time Out held in July 2022 to engage with senior medical educators. Production of an action plan and outputs from the session.
3	Review of education funding through the Education Contract with Health Education England (HEE) with Finance colleagues to inform educational governance, quality assurance and management of resources.	DHRSD / MD (Dev)	December 2022	Transparent funding flows articulated by the Deputy Chief Finance Office and Finance Manager – Contracts.
4	Develop metrics to identify good educational practice and areas requiring intervention and support.	DHRSD / MD (Dev)	December 2022	Job banding requested for a Project Manager to lead on engagement and development of metrics with directorate leads.
5	Engagement programme with directorates to embed good educational governance principles and robust data collection for internal and external (HEE) oversight.	DHRSD / MD (Dev)	December 2022	Within the role of the Project Manager leading on engagement and development of metrics with directorate leads.
6	Embed actions for CQC Outcome 10 – Assurance that staff are trained to do their jobs.	DHRSD	December 2022	Initial set of actions completed. Mandatory and JSET performance at 90% or above. Revised action plan agreed.
7	Ensure all learners on placement receive a positive quality assured experience.	DHRSD	March 2023	Job banding requested for a Project Manager to lead on engagement and development of metrics with directorate leads.

Commentary *(including changes since last BAF issue / key discussion points notes at most recent Deep Dive review and any relevant entries onto the Corporate Risk Register Report)*

Review / update of Controls and Assurances are noted in bold.

Accountabilities / Review History

Board Oversight	Last deep dive review held	Strategic Risk Owner	Date of last Update
Board of Directors		Medical Director (Development)	September 2022

Controls and Assurances

Controls	Assurance / Evidence		
	[where can we gain evidence that the controls we are placing reliance on are working]		
For Cause 1: *Fail to ensure relevant strategies and delivery plans are clearly defined and effective* [system in place to help manage the cause / effect]	**First Level** [Service delivery and day to day management - how do we know day to day that controls are working?]	**Second Level** [Oversight – who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]	**Third Level** [Independent challenge – has anyone external come in to check that the controls are working]
Education: • **People Strategy.** • **Processes in place to review educational governance arrangements at Directorate level.** • **Development of a Directorate level Education Dashboard with metrics in place to support identification of good practice, sharing of themes and areas where improvement is required.** • **Processes in place to seek and receive feedback from learners (eg, surveys and complaints).** Research and Innovation: • Research and Innovation Strategy refresh. • Clinical Research and Innovation Office (CRIO) in place to support delivery of Trust research strategy. • Research and Innovation plans developed by every Clinical Directorate. • Academic Directorate Accreditation Scheme in place. • Directorate Reviews cover research and innovation activity. **Control Lead:** Medical Director (Development)	Education: • **Directorate Reviews co-ordinated by the Director of Strategy and Planning**. • **Education Dashboard reviewed by the Education Leadership Team**. • **Learner feedback reviewed at Education Leadership meetings**. Research and Innovation: • National Institute for Health Research (NIHR) reports reviewed by Clinical Research and Innovation Office (CRIO). • Reporting arrangements for funders reviewed by CRIO • Directorate Reviews co-ordinated by the Director of Strategy and Planning. • Academic Directorate Accreditation Scheme measures reviewed by TEG.	Education: • **Dashboard compliance monitored at Performance Management Reviews.** • **Progress Reports to People Strategy Programme Board.** Research and Innovation: • Research and Innovation Integrated Performance Report metrics reviewed by the Board of Directors. • Research and Innovation presentation delivered by the Medical Director (Development) to the Board of Directors three times a year. • Reports received by STH Research and Innovation Executives. • Outputs from Directorate Reviews reviewed by TEG.	Education: • **Compliance reviewed through Health Education England (HEE) quality assurance mechanisms (Monitoring the Learning Environment [MLE] visits).** Research and Innovation: • NIHR performance and activity reports.
			Assurance Level: LIMITED

Gaps in Controls / Assurances	Actions to address gaps in controls / assurance
Control Gap – Refresh of Research and Innovation Strategy required and development of associated delivery plan.	Develop and agree with the Board of Directors a refresh of the Trust's Research and Innovation Strategy, with associated delivery plan. See Aggregated Action Plan

Return to Strategic Risk front sheet

Controls	Assurance / Evidence		
For Cause 2: *Service pressures displace research and education activity*	**First Level**	**Second Level**	**Third Level**
Education: • **Hybrid models of education delivery so colleagues can access training flexibly.** • **Quality metrics and educational governance dashboard to provide assurance and give early warning of issues.** • **Mandatory and Job Specific Essential Training (JSET) compliance incorporated into PMF and reported at Management Board Briefing (MBB).** Research and Innovation: • **Clinical Research & Innovation Office (CRIO) dedicated to support research and innovation activity.** • **Workforce planning by CRIO based on research portfolio, current and in set-up.** • **Mandatory and Job Specific Essential Training (JSET) compliance incorporated into PMF and reported at MBB.** • **National Institute for Health Research (NIHR) Clinical Research Network (CRN) and NIHR RCF funding allocated to CRIO to support delivery of research.**	Education: • **Directorate engagement process.** • **Directorate reviews.** • **Dashboard monitored by the Education leadership team.** • **Learner feedback reviewed at Education leadership meetings.** Research and Innovation: • **CRIO Senior Management Team meetings.** • **Dashboard monitored by the CRIO leadership team.** • **Directorate engagement process.**	Education: • **Dashboard compliance at Performance Management Reviews.** • **Progress reports to People Strategy Programme Board.** • **Mandatory and JSET compliance reported at Management Board Briefing (MBB) and Clinical Management Board (CMB).** Research and Innovation: • **STH Research & Innovation Leads Committee meeting.** • **STH Research and Innovation Executive meetings.**	Education: • **CQC Compliance** • **Compliance reviewed through Health Education England (HEE) quality assurance mechanism (Monitoring the Learning Environment [MLE] visits).** Research and Innovation • **NIHR CRN Partner meetings with CRIO, NIHR performance and activity reports.**
Control Lead: Medical Director (Development)			**Assurance Level: LIMITED**

Gaps in Controls / Assurances	Actions to address gaps in controls / assurance
	See Aggregated Action Plan

Return to Strategic Risk front sheet

Controls	Assurance / Evidence		
For Cause 3: *Infrastructure and resources are insufficient to support delivery of research and education*	**First Level**	**Second Level**	**Third Level**
Education: • **Review of education funding by the Director of Education, Learning and Staff Development, the Deputy Chief Finance Officer and Finance Manager – Contracts.** • **Review of funding utilisation within the educational governance metrics.** • **Continuing Professional Development (CPD) oversight group.** • **Reconciliation of the funding from Health Education England (HEE) to the Trust and individual learner level**. Research and Innovation: • **Continuous review of capacity and capability to support research delivery undertaken by Support Services and Research Infrastructures.** • **Workforce planning by Support Services and Research Infrastructures based on research portfolio, current and in set-up.** • **Resource needs of Support Services and Research Infrastructures identified for each research trial, costed and invoiced against actual activity to trial Sponsor.** • **NIHR CRN and NIHR Research Capability Funding (RCF) allocated to Support Services and Research Infrastructures to deliver research trials.** **Control Lead: Medical Director (Dev)**	Research and Innovation: • **Support Service and Research Infrastructure Senior Management Team meetings.** • **Capacity and Capability issues raised by Directorates, Support Services and Research Infrastructures to CRIO which is escalated to the Medical Director (Development).** • **Research activity recorded in electronic management systems, reviewed, and validated by Sponsors as part of invoicing by Research Finance Team.**	Research and Innovation: • **Activity based funding model and allocation reviewed by STH Research Executive.**	Research and Innovation: • **NIHR CRN Partner Organisation financial returns and meetings with CRIO.**
			Assurance Level: LIMITED
Gaps in Controls / Assurances	**Actions to address gaps in controls / assurance**		
	See Aggregated Action Plan		

Return to Strategic Risk front sheet

Controls **For Cause 4:** *Fail to align priorities with higher and further education and Health Education England (external stakeholders)*	**Assurance / Evidence**		
	First Level	**Second Level**	**Third Level**
` • **Actively contribute to System-wide Education meetings.** • **Health Education England Monitoring of the Learning Environment (MLE) meetings.** • **Senior Leaders meetings between the Trust and the Dean.** • **Medical Workforce review undertaken by the Medical Directors.** **Control Lead:** tbc	• tbc	• tbc	• tbc
	Assurance Level: NONE		
Gaps in Controls / Assurances	**Actions to address gaps in controls / assurance**		

Return to Strategic Risk front sheet

Strategic Risk 8: WELL LED

Fail to ensure appropriate and effective governance arrangements are in place that support the achievement of our Corporate Strategy (Making a Difference – The Next Chapter)

Aggregated Assurance Rating	**LIMITED**

Key Causes		Assurance Rating
C1	Senior leaders fail to effectively articulate or implement mission, vision and strategy	Adequate
C2	Ineffective / inconsistent systems and processes to support the management of risks, issues and performance	Limited
C3	Ineffective Board oversight, challenge and action	Limited

Key Effects / Consequences (Results in)

- Decisions based on inaccurate / outdated information
- Trust and confidence in Trust leadership questioned / Regulatory intervention
- Long term vision and mission undeliverable
- Leadership turnover
- Staff and Patient experience / satisfaction impacted

Risk Likelihood	Rating
Previous Position	n/a
Current	Likely
Target	Possible

Target score to be achieved by XXX

TREND GRAPH TO BE ADDED

Aggregated Action Plan to address gap in control or assurance				
	Action	**Lead Exec**	**Deadline**	**Progress update**
1	Commission independent review against NHSI Well-led framework to be undertaken in September 2022 **and present final report for discussion with the Board of Directors**.	CEO	**November 2022**	**Review commissioned and underway with delivery timetable agreed.**
2	Monitoring by TEG of progress against agreed trajectory to achieve 85% of Trust policies in date by April 2023.	CEO	April 2023	**Reporting of Trust Controlled Dashboard embedded within TEG forward plan with reports by Executive Sponsor circulated. Current position is 57%.**
3	Develop structured Board Development Programme for approval by Chair / Board.	ACE	**December 2022**	**Development of programme will consider agreed recommendations following external Well-led development review currently being undertaken by AuditOne.**

Commentary *(including changes since last BAF issue / key discussion points notes at most recent Deep Dive review and any relevant entries onto the Corporate Risk Register Report)*

Review / update of Controls and Assurances are noted in bold.

Accountabilities / Review History

Board Oversight	Last deep dive review held	Strategic Risk Owner	Date of last Update
Board of Directors		Chief Executive	September 2022

Controls and Assurances

Controls	Assurance / Evidence		
For Cause 1: *Senior management fail to effectively articulate or implement mission, vision and strategy* [system in place to help manage the cause / effect]	**First Level** [Service delivery and day to day management - how do we know day to day that controls are working?]	**Second Level** [Oversight – who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]	**Third Level** [Independent challenge – has anyone external come in to check that the controls are working]
• Refreshed Corporate Strategy: Making a Difference – the Next Chapter. • Reconfirmed statements for Trust Mission, Vision and Values. • Mechanisms in place to support communication of vision, mission and Trust Strategic Aims / Strategic Priorities. • Strategy and Planning Directorate in place to co-ordinate development and monitoring of Corporate Strategy / Aims. • Trust's annual Corporate Objectives aligned to Trust Strategy to underpin delivery. • Directorate Business Plans linked to delivery of Strategic Aims. • Alignment of reports to the Board of Directors and its Committees to Strategic Aims confirmed through Executive Summary. **Control Lead: Chief Executive**	• Directorate Reviews co-ordinated by Director of Strategy and Planning. • Performance against Corporate Aims co-ordinated by Director of Strategy and Planning. • Staff Survey Results collated by HR Department. • **Monthly briefing by Executive Team, led by Chief Executive at Management Board Briefing.** • **Monthly meeting between Trust Executive Group and Clinical Management Board.**	• Board approved Corporate Strategy underpinned by agreed annual Corporate Aims monitored mid-year / end of year by Board. • Monitoring of key performance metrics by Board through Integrated Performance Report (IPR) and Quarterly Integrated Quality and Safety Report. • Staff Survey results presented to Board. • Good Governance Institute (GGI) Healthcare Governance Review presented to Board (June 2022). • **Annual Review of every Directorate with respect to past performance and assurance of future plans by Trust Executive Group with outcome determining level of performance management framework.**	• CQC Well-led review. • GGI Healthcare Governance Review.
			Assurance Level: ADEQUATE

Gaps in Controls / Assurances	Actions to address gaps in controls / assurance
Assurance Gap: Well-led developmental review not undertaken within recommended timescales.	1. Commission independent review against NHSI Well-led framework to be undertaken in September 2022 **and present final report for discussion with the Board of Directors.**

Return to Strategic Risk front sheet

Controls	Assurance / Evidence		
For Cause 2: *Ineffective / inconsistent systems and processes to support the management of risks, issues and performance*	**First Level**	**Second Level**	**Third Level**
• Integrated Governance arrangements – Quality Governance Policy and Framework and associated policies. Patient and Healthcare Governance Team in place – development and application of Quest dashboards. – Performance Management Framework - dedicated Information Team and Integrated Performance Reports (IPR). – Corporate Governance Framework – Financial Governance Arrangements - resourcing in place (systems, skills and capacity) to deliver effective reporting of financial position from Directorate to Board. – People and Organisational Development Plans • Board and Committee workplans / reporting schedules. • Annual cycle of self-assessment to inform Provider Licence Declaration. • Internal Audit programme of external review / audit of implementation of Trust policies and procedures. • Trust wide approach to standardisation. **Control Lead: Chief Executive**	• Individual Executive Director portfolios. • Chief Executive's Office co-ordinating Board Effectiveness Review. • Integrated Performance Report collated by Information Team. • **Performance Management Framework level assigned to every Directorate at least annually to determine level of support and review.**	• Board Assurance Framework considered by Board Committees and Board. • Audit Committee reviews Annual Governance Statement. Board Effectiveness Review discussed by Board. • Committee Annual Reports reviewed by Audit Committee / Board. • Audit Committee reviews Annual Governance Statement. • Data Quality Steering Group – oversees key data quality issues and develops action plans to improve data quality in areas of concern. • Data Quality Steering Group reports to Audit Committee.	• IQIPs (Improving Quality in Physiological Services accreditation. • Other external accreditation. • CQC Well-led review. • Good Governance Institute (GGI) Healthcare Governance Review. • Internal Audit reports: – Performance Management Framework July 2020 (Significant) – Policy Management Framework 2021 (Limited)
			Assurance Level: LIMITED

Gaps in Controls / Assurances	Actions to address gaps in controls / assurance
Assurance Gap: Well-led developmental review not undertaken within recommended timescales.	See above
Control Gap: Percentage of Trust policies not in date	2. Delivery against agreed trajectory for in date policies - achieve 85% by April 2023

Return to Strategic Risk front sheet

Controls **For Cause 3:** *Ineffective Board oversight, challenge and action*	**Assurance / Evidence**		
	First Level	**Second Level**	**Third Level**
• Board Governance Arrangements including Committee Structure / agreed workplans. • Board Nomination and Remuneration Committee in place with responsibility for effective Board Succession Planning • Annual programme of Board Effectiveness Review. • Foundation Trust (FT) Model (established Council of Governors). • Board Assurance Framework (BAF) with assurances rated. • Oversight by regulators and external accreditation bodies. • Refreshed Management Arrangements. • Directorate Review process sitting within Performance Management Framework. • Quality Governance Structure in place setting out Directorate Governance Arrangements. . **Control Lead: Chief Executive**	• Quarterly review / update of Management Arrangements co-ordinated by Chief Executive's Office. • Assessment of BAF assurance ratings co-ordinated by Chief Executive's Office. • Annual Governance Statement drafted by Chief Executive's Office with input from TEG members. • Quarterly review / update of Management Arrangements co-ordinated by Chief Executive's Office. • Board Skills and Diversity Matrix maintained by Chief Executive's Office. • Board Responsibilities matrix updated by Chief Executive's Office. • Committee secretariate. management of Board Committee and Board action logs.	• Audit Committee reviews Annual Governance Statement. • Code of Governance declarations approved by Audit Committee. • Board effectiveness survey results reviewed by Board of Directors with identified gaps addressed by Board Development action plan.	• CQC Well-led review. • Good Governance Institute (GGI) Healthcare Governance Review. • Internal Audit reports.
			Assurance Level: LIMITED

Gaps in Controls / Assurances	**Actions to address gaps in controls / assurance**
Assurance Gap: Well-led developmental review not undertaken within recommended timescales.	See above
Control Gap: Lack of a formal structured Board Development Plan.	3. Develop structured Board Development Programme for approval by Chair / Board.

Return to Strategic Risk front sheet