Sheffield Teaching Hospitals
NHS Foundation Trust

Executive Summary

Report to the Board of Directors

held on 31 January 2023

Subject	Board Assurance Framework – January 2023
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 updated 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

- 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 September 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.
- This January 2023 BAF update follows completion of the first cycle of operation of the BAF and reflects review undertaken by Strategic Risk Owners informed, in part, by discussion held during deep dive reviews of individual Strategic Risks.
- The first cycle of Strategic Risk deep dive reviews is outlined below:

Strategic Risk	Oversight Forum	Date
Strategic Risk 1: Quality	Quality Committee	21 November 2022
Strategic Risk 2: Partnership and Engagement	Board of Directors (Private)	29 November 2022
Strategic Risk 3: Workforce	People Committee	12 December 2022
Strategic Risk 4: Finance	Finance and Performance Committee	14 November 2022
Strategic Risk 5: Infrastructure	Finance and Performance Committee	*Scheduled for 13 February 2023*
Strategic Risk 6: Sustainabilty	Board of Directors (Private)	*Scheduled for 28 February 2023*
Strategic Risk 7: Research, Education and Innovation	Board of Directors (Private)	20 December 2022
Strategic Risk 8: Well-led	Board of Directors (Private)	25 October 2022

- Dates for the next cycle of deep dives have been agreed on Committee / Board workplans to provide a continuous rolling programme of oversight and scrutiny of individual Strategic Risks throughout the year.
- The Summary Dashboard which forms part of the Executive Summary for 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).
- While further review of target risk ratings and associated delivery dates will be informed by planned review of the Trust's Risk Appetite Statement, the Board of Directors satisfy itself that the scope of current action plans and progress being made to address identified gaps in Control and Assurance is sufficient to manage each Strategic Risk. Deep dives provide the forum for more detailed scrutiny to take place on this.
- As part of an agreed approach to develop the BAF iteratively, focus has been placed on developing the Executive Summary as a potential stand-alone segment of the BAF. This has been informed by feedback following a review undertaken by AuditOne as part of the Well-led development review.
- Future development work is also planned in relation to the streamlining and alignment of the content of Control and Assurance tables.
- 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 ratings are appropriate;
- DISCUSS and comment on the adequacy of Controls and Assurances; and
- DISCUSS the sufficiency of actions to address identified gaps in Control and Assurance and AGREE areas for further scrutiny during scheduled deep dive reviews of individual Strategic Risks.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
TEG	25 January 2023	
Board of Directors	31 January 2023	

Board Assurance Framework

Executive Summary

Sheffield Teaching Hospitals NHS Foundation Trust

January 2023

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). This update of the BAF follows completion of the first cycle of operation of the BAF and notes input from discussion held as part of the schedule of deep dive reviews of individual Strategic Risks.

Ongoing Development of the BAF: On review of the September issue of the BAF, the Board of Directors noted planned development in terms of agreeing Target Risk Likelihood Ratings and associated delivery dates. This work will be further informed by planned review of the Trust's Risk Appetite Statement. In assembling this update of the BAF, focus has been placed on ongoing development of the Executive Summary as a potential stand-alone segment of the BAF. Future development work is also planned in relation to the streamlining and alignment of the content of Control and Assurance tables.

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**'.

SR 1: Quality of Care	SR 3: Workforce	SR 7: Research, Education and Innovation	SR 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 Aims


STRATEGIC RISK OWNER COMMENTARY

	**Strategic Risk 1: Quality of Care -** Fail to provide compassionate, effective and safe patient centred care that delivers the best clinical outcomes	Current Risk Likelihood Rating: **LIKELY**	Current Assurance Rating: **LIMITED**

The CQC report (December 2022) showed a significantly improved picture, with no concerns relating to the oversight of healthcare governance. It is therefore suggested that the assurance on Cause 1 [Inability to embed effective quality governance arrangements including learning from incidents / patient feedback] is changed from 'Limited' to 'Adequate' to reflect the improved position, while recognising the work in train to further strengthen this.

Good progress is being made in Maternity services, as reflected in the improved CQC rating to Requires Improvement.

As a result of dissatisfaction with the national pay award the RCN have called their members for strike action to be taken on 18 and 19 January 2023. This will result in a reduction of nursing staff to deliver patient services. During discussion at the People Committee on 12 December 2022, assurance was sought around the impact of Industrial Action and consideration requested in terms of reflecting this on the BAF. This update of the BAF addresses this request by reflecting this within the update of this Strategic Risk in the context of Cause 2 [Insufficient staffing resource] and includes controls and assurance in place.

In terms of a broader narrative update, the Trust has submitted derogations to support delivery of critical patient services in addition to the nationally agreed derogations, strike action would impact on the Trusts ability to provide our full services to our patients. The Chartered Society of Physiotherapists have also balloted members and have a mandate for strike action. They have announced dates on 26 January and 9 February. STH has not yet received notice of strike action and we anticipate this will be 9 February. Other trade unions including the BMA and Hospital Consultants and Specialist Association are currently balloting their members for industrial action.

A parent risk assessment has been completed for the impact of strike action on planning and delivering our services [Datix ID 4975] - this has a current risk score (post controls) of 12 and therefore is not reported on the Corporate Risk Register Report as an Extreme Risk.

Alignment of Extreme Operational Risks on the Corporate Risk Register Report

Total number of Extreme Risks aligned	Number of Extreme Risks overdue for review	Number of Extreme Risks with actions overdue
27	9	9

Extreme Risks newly reported on the Corporate Risk Register Report

- [795] Glaucoma service: Deterioration / loss of vision due to a delay in clinic review and/or surgery
- [4132] Spinal injuries readmission backlogs due to lack of theatre capacity
- [5097] Rationing of in-line monitoring equipment for use in cardiopulmonary bypass circuits
- [5078] Harm to spinal patients due to reduced ability to meet patient access times

	**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	Current Risk Likelihood Rating: **POSSIBLE**	Current Assurance Rating: **ADEQUATE**

Valuable discussion was held at the Board Strategy Session on 20 December 2022 about key partnerships, the purpose of those partnerships and how we organise ourselves for these partnership ambitions. Next steps are to develop this into a more formal partnership plan.

The developmental Well-led review included input from partners and represents a useful source of 360-degree feedback from partners about our approach to partnership working.

Alignment of Extreme Operational Risks on the Corporate Risk Register Report

Total number of Extreme Risks aligned
0

	**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	Current Risk Likelihood Rating: **LIKELY**	Current Assurance Rating: **LIMITED**

At the last deep dive at the People Committee held on 12 December 2022 it was agreed that the ratings for Strategic Risk 3 are appropriate. A discussion was held in regard to the action plan and the Committee confirmed it was satisfied with the progress being made.

The People Committee was updated that an internal audit report on Workforce Planning was issued with a limited audit opinion with summary findings indicating that workforce planning does not align to current or future Trust requirements. Recommendations from this review support Trust proposals to include greater detail on workforce in 2023/24 Business plans and to develop an action plan to address data quality of the workforce dataset.

Consideration following the meeting has addressed the Committee's request to reflect the potential impact of Industrial Action on the BAF by incorporating this within Strategic Risk 1 – Quality of Care. Specifically, describing Controls and Assurances in place in relation to ensuring sufficient staff resource (Cause 2).

Alignment of Extreme Operational Risks on the Corporate Risk Register Report

Total number of Extreme Risks aligned	Number of Extreme Risks overdue for review	Number of Extreme Risks with actions overdue
3	0	0

Extreme Risks newly reported on the Corporate Risk Register Report – N/A

	**Strategic Risk 4: Finance -** Fail to manage our finances effectively and deliver value for money to ensure the long-term sustainability of care provision	Current Risk Likelihood Rating: **POSSIBLE**	Current Assurance Rating: **ADEQUATE**

The Finance & Performance Committee was content with the ratings when the Deep Dive was considered in November 2022.

The Trust's submission on the "Improving NHS financial sustainability- Are you getting the basics right?" was produced in the Autumn of 2022 and has been considered at TEG and the Audit Committee. This was felt to be a valuable source of assurance on financial management systems and processes.

The 2023/24 Financial Planning process is now underway and both the internal and external issues are likely to be challenging to resolve.

Alignment of Extreme Operational Risks on the Corporate Risk Register Report

Total number of Extreme Risks aligned
0

	**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	Current Risk Likelihood Rating: **POSSIBLE**	Current Assurance Rating: **LIMITED**

In relation to capital funding, there has been new starts, minimal modest new schemes and reductions to normal ring-fenced budgets for medical equipment, Infrastructure, etc. Work is taking place on the 2023/24 Capital Plan to try to optimise the position and will be submitted to TEG and the Board of Directors in February/March.

There is also still some uncertainty about the Trust's 2023/24 Operational Capital allocation given changes to the construction of System allocations (around historic surpluses) and some funding being tied to System 2022/23 revenue Income and Expenditure performance. This could make the 2023/24 (and thereafter) position worse.

The refresh of the Estates Strategy has progressed with the first draft ready for review during January 2023, consultation with internal and external stakeholders will be commence January 2023. The planned review of Estates governance arrangements is complete; the output of which is a new governance structure which will be rolled out January 2023.

ISO14001 accreditation is on plan for March 2023 and an appointment of an Authorising Engineer (FIRE) is scheduled to complete by February 2023.

During this quarter, a limited assurance internal audit report for Planned Preventative Maintenance was received. This audit opinion reflects the need to strengthen arrangements for the oversight of estates maintenance under an up-to-date plan and within a clear governance framework. Actions have been agreed and should be completed during Quarter 4. The newly implemented Estates governance structure noted above will support delivery of these actions.

Alignment of Extreme Operational Risks on the Corporate Risk Register Report

Total number of Extreme Risks aligned	Number of Extreme Risks overdue for review	Number of Extreme Risks with actions overdue
3	0	1

Extreme Risks newly reported on the Corporate Risk Register Report – N/A

	**Strategic Risk 6: Sustainability -** Fail to identify and maximise sustainable ways to deliver the Trust's strategic aims and objectives	Current Risk Likelihood Rating: **LIKELY**	Current Assurance Rating: **ADEQUATE**

Considerable progress has been made against the planned actions.

In addition, the Trust's Integrated Performance Report will include Sustainability metrics in the forthcoming report. Also, each Directorate has been asked to identify a Sustainability Lead to form a network across the Trust to develop a local action plan that will assist in progressing both local, Trust and external sustainability actions.

Alignment of Extreme Operational Risks on the Corporate Risk Register Report

Total number of Extreme Risks aligned
0

	**Strategic Risk 7: Research, Education and Innovation -** Fail to ensure the Trust has the ability to deliver excellent research, education and innovation	Current Risk Likelihood Rating: LIKELY	Current Assurance Rating: LIMITED

Discussion held as part the Deep Dive Review December 2022 noted that Experimental Cancer Medicine Centre (ECMC) status was not renewed. The Board noted that loss of this status would have a significant impact on the Trust's reputation as a research organisation.

This discussion also confirmed that the Medical Director (Development) will work with counterparts at the University of Sheffield and Sheffield Hallam University to develop a shared cancer research strategy.

In November 2022 TEG and the People Committee were presented with the Trust's self-assessment against quality standards within the Trust's Learning and Development contract with Health Education England (HEE), providing additional second-level assurance around working with external stakeholders (Cause 4).

Alignment of Extreme Operational Risks on the Corporate Risk Register Report

Total number of Extreme Risks aligned
0

	**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)	Current Risk Likelihood Rating: LIKELY	Current Assurance Rating: LIMITED

The publication of the report from the Well-led development review provides external reflection on our governance and leadership arrangements. The output from current work to identify priority themes across recommendations made following this review with those that followed the Healthcare Governance review (June 2022) will be considered by TEG on 26 January 2023 for onward discussion with all Board members. This will shape the Board Development Programme.

Actions identified within the BAF Aggregated Action Plan have been incorporated within the Well-led Improvement Programme being reported to the NHSE Quality Board. Scrutiny of these workstreams therefore provides third-level assurance on the actions / progress.

Alignment of Extreme Operational Risks on the Corporate Risk Register Report

Total number of Extreme Risks aligned
0

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	Adequate ↑
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	Likely
Current	Likely
Target	Possible

Target score to be achieved by March 2024

TREND GRAPH TO BE ADDED FROM NEXT ISSUE
[movement to date is reflected within comparison between previous and current position, noted in grey box to left]

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	Updated CQC report received in December 2022 which identified that 63 of the must and should do requirements were no longer applicable. There were no concerns identified in the new report on healthcare governance arrangements. The review of the Trust structure remains on track to strengthen existing arrangements, and a paper has gone to TEG. Maternity now rated Requires Improvement by CQC; advice from CQC is to consider applying for some of the conditions to be removed – this is being reviewed.
2	Development and implementation of Action Plan to address agreed recommendations within Healthcare Governance Review undertaken by external consultancy.	MD (Ops)	March 2023	An update on progress will be provided to TEG in February 2023. The actions from the GGI review will then be incorporated into the Well-Led action plan review.
3	Implementation of workstreams through ~~**Workforce Systems Group**~~ **Getting Back on Track and the People Strategy Programme Board** to support Board level assurance of adequacy of staffing across all staff groups in the Trust.	DHRSD	March 2023	A governance framework has been established under the Getting Back on Track Programme to provide strategic oversight of workforce recovery workstreams and progress on objectives. Two Operational Groups will focus on non-Medical and the Medical Workforce with the initial priorities being recruitment and improvement of our recruitment timescales and retention of our colleagues. This supplements existing oversight through TEG via Workforce Reports highlighting trends on vacancy levels, turnover and retention and hard to recruit roles; and oversight of workstreams through the People Strategy Programme Board covering attraction, retention and reward as well as employee engagement and wellbeing.
4	Delivery of Patient Care Recovery Plan / 'Getting Back on Track'	COO / OID	February 2024	PCRP Improvement/Spread is well established with OD and clinical leads. Each workstream has project aims and an exception reporting structure. Greenhouse has met and starting to be established. December meeting stood down for operational priorities. PCRP Business as Usual embedded through Weekly Recovery Meetings.

5	Agree and embed governance structure for 'Getting Back on Track'.	DSP	September 2023	Getting Back on Track (GBOT) Board is now established, meeting monthly and chaired by the Chief Executive. Further work needed to get reporting arrangements happening routinely; and also to agree our oversight arrangements for the teaching and research strand of the GBOT programme – this issue will be discussed at the GBOT January meeting
6	Commission, design and deliver Equality Diversity and Inclusion (EDI) Board-level and Governor education, training and development programmes.	**ODD**	March 2024	Procurement of an EDI development programme for the Board and Governors is underway. Deadline for receipt of tenders against the specification was the end of December 2022 and Stage 1 of the evaluation process is currently in progress. Commissioning of a supplier is due to be complete by the end of January / beginning of February 2023.

Accountabilities / Review History

Board Oversight	Last deep dive review held	Strategic Risk Owner	Date of last Update
Quality Committee	**21 November 2022**	Medical Director (Operations)	January 2023

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]
• 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. • Patient feedback reported to TEG, Quality Committee, and Board of Directors.	• **December 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: Directorate Risk Management - July 2021 (split opinion). • Internal Audit: Patient Experience – Jan 2022 (split opinion) • 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 (limited). • AuditOne Well-led review report presented to Board (Dec 2022)
	Assurance Level: ADEQUATE ↑		

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. • **Industrial Action Preparedness and Oversight arrangements including implementation of Command Structure / Incident Control Centre.** • 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 **including launch of Safecare Live (Dec 2022)** • 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. **Control Lead:** Director of HR and Staff Development	• 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. • **Bronze Command Logs / Risk Escalations.** • 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. • **Silver / Gold Command Action / Risk Escalation Logs.** • TEG and People Committee review of workforce modelling tool. [used to guide workforce plans]	• Care hours per patient day (CHPPD) benchmarking data. • **Industrial Action Assurance Reporting to NHSE.**
			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 **Getting Back on Track and the People Strategy Programme Board** to support Board level assurance of adequacy of staffing across all staff groups in the Trust..

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	Possible
Current	Possible
Target	Unlikely

Target score to be achieved by Dec 2023

TREND GRAPH TO BE ADDED FROM NEXT ISSUE
[movement to date is reflected within comparison between previous and current position, noted in grey box to left]

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	Revised to April 2023	Strategy discussion held with Board about key stakeholders – we now need to develop this into a more developed stakeholder engagement plan.
2	Develop 360-degree feedback from partners about our approach to partnership working.	DSP	April 2023	360-degree feedback was sourced during developmental Well-led review which was broadly positive but with an implied desire for more visible ambition.
3	Develop further our inequalities dashboard, including gaining input from public health teams.	COO / OID	April 2023	We have focused on embedding our current inequalities/EDI dashboard so further work required to progress this action.
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	Health inequalities included as a line of enquiry in business plan review meetings. Will continue to embed in other core Trust processes.
5	Seek support from commissioners to review how well we meet needs of our population.	DSP	December 2023	Not yet started.
6	Strengthened patient engagement work through new Quality Strategy.	CN	April 2023	Patient engagement now features as one (of three) headings of our developing Quality Strategy.

Accountabilities / Review History

Board Oversight	Last deep dive review held	Strategic Risk Owner	Date of last Update
Board of Directors	**29 November 2022**	Director of Strategy and Planning	January 2023

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). • **Developmental well-led review included focussed discussions with partners (Dec 2022). Broadly positive.**
			Assurance Level: ADEQUATE

Gaps in Controls / Assurances

Control Gap - Stakeholder Engagement Plan required – **to build on Board discussion about partnerships with purpose**

Actions to address gaps in controls / assurance

1. Develop Stakeholder Engagement Plan and subsequent regular report to provide more methodical first and second 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.	• **Half yearly progress on corporate objectives via a report to the Board of Directors (October 2022).**	• 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

Further work on embedding and using data and intelligence about inequalities and the population we serve – for instance, adding more about Core20PLUS5 metrics.

Limited methodical wider understanding of population health

Actions to address gaps in controls / assurance

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).**
5. **Seek support from commissioners to review how well we meet needs of our population.**
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	Likely
Current	Likely
Target	Possible

Target score to be achieved by April 2023

TREND GRAPH TO BE ADDED FROM NEXT ISSUE
[movement to date is reflected within comparison between previous and current position, noted in grey box to left]

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	**Revised to March 2023**	Following rejection of some bids requesting funding for Health and Wellbeing support, and at a subsequent meeting with the Charity, involving the Director of HR & SD, it has been agreed that work will be done to proactively plan the support required in partnership with the Charity to align use of funding to the Trust's Wellbeing strategy. In addition, a further bid for resource has been submitted to the national charity. This work is scheduled to be completed in March 2023.
2	Paper to TEG under construction to outline the risks to short term funding of elements of the Health and Wellbeing Service.	DHRSD	**Revised to April 2023**	The paper needs to account for the outcome of the bids above and has therefore been delayed due to charity position shared above. The deadline has been extended to April 2023.
3	Support provided to Directorates where Staff Experience Plans are outstanding	DHRSD	November 2022	**Action complete**. All plans returned and updated in response to latest CQC visit.
4	Action plan to be agreed with stakeholders to address data quality of workforce core dataset	**DHRSD**	**Revised to April 2023**	HR produce quarterly workforce reports for TEG, and an action plan is underway led by HR and Finance, to identify and better understand discrepancies between databases, as there are differences in calculations of staff in post. A briefing paper has been prepared on the action plan for the Director of HR and Staff Development and with this in mind the owner for the risk has been amended to the Director of HR and Staff Development. More broadly, workforce data issues are on the agenda of the Trust-wide Data Quality Steering Group. HR has joined that group and is looking at data quality for workforce, currently defining the issues, RAG rating and prioritising them. HR are working with colleagues on the associated risk assessments and have been linking in with finance on ESR. The aim is to pull together a defined plan by the end of this financial year.

5	New People Strategy to be refreshed with Trust Workforce Plan included.	ODD	**Revised to March 2023**	The new People Strategy (PS) has been in a consultation phase and was stated and on track to go to the Board of Directors at the end of January 2023. However, with visibility of the latest staff survey results and the Well-led review that the Trust commissioned, it has been agreed to pause the sign off until March 2023 to ensure the themes from these sources are reflected in the new People Strategy. However, as part of the Getting Back on Track programme eight interim objectives have been agreed as the new People Strategy Year One implementation plan, which includes attraction, recruitment, and retention initiatives to support the Trust's workforce plan and requirements.
6	Implement and embed Patient Care Recovery Board to provide oversight of workforce capacity as part of governance arrangements for 'Getting Back on Track'.	COO / **DHRSD/DSP**	**Revised to February 2023**	Getting Back on Track Programme structure being developed and will lead on oversight of the workforce capacity piece. Recruitment enabler Steering group and Operational Board ToR being developed and will confirm reporting arrangements.

Accountabilities / Review History

Board Oversight	Last deep dive review held	Strategic Risk Owner	Date of last Update
People Committee	**12 December 2022**	Director of HR and Staff Development	January 2023

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 (July 2022) (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. – **Action Completed**

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 - Oct 22 **(Limited Assurance)** • 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	**Possible**
Current	**Possible**
Target	**Unlikely**

Target score to be achieved by June 2023

TREND GRAPH TO BE ADDED FROM NEXT ISSUE
[movement to date is reflected within comparison between previous and current position, noted in grey box to left]

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	To be progressed after 2023/24 Financial Plan process complete.
2	Update the Scheme of Delegation.	**CFO**	October 2022	**Action complete** Approved by the Board October 2022.
3	Establish the Use of Resources (UoR) Group.	**CFO**	October 2022	**Action complete** Meetings commenced in October 2022.
4	**Develop plans for how to take forward opportunities identified by the UoR Group and engage directorates.**	**CFO**	June 2023	**New Action.**

Accountabilities / Review History

Board Oversight	**Last deep dive review held**	**Strategic Risk Owner**	**Date of last Update**
Finance and Performance Committee	**14 November 2022**	Chief Finance Officer	January 2023

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.	Update Five-year Financial Plan.

Return to Strategic Risk front sheet

Controls **For Cause 3:** *Failure to ensure financial systems and processes are fit for purpose*	Assurance / Evidence		
	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**	

Return to Strategic Risk front sheet

Controls **For Cause 4:** *Failure to deliver the required levels of efficiency savings*	Assurance / Evidence		
	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. • Use of Resources Group established.	• 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. • **Regular reports on Use of Resources (Our) Group progress to Finance and Performance Committee.**	• 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	**Develop plans for how to take forward opportunities identified by the UoR Group and engage Directorates.**

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	Possible
Current	Possible
Target	Unlikely

Target score to be achieved by July 2023

TREND GRAPH TO BE ADDED FROM NEXT ISSUE
[movement to date is reflected within comparison between previous and current position, noted in grey box to left]

Aggregated Action Plan to address gap in control or assurance				
	Action	**Lead Exec**	**Deadline**	**Progress update**
1.1	Production of plan of prioritised capital schemes to inform 2024/25 Capital planning process.	CFO	December 2023	**NEW ACTION**
2.1	Estates Strategy refresh to be undertaken in liaison with Strategy and Planning Directorate.	CN	Revised to March 2023	The first draft of the Estates Strategy has been produced and will be shared with the Strategy and Planning Directorate during January 2023. Wider consultation planned for January and February including Care Groups and Directorates along with external stakeholders across the ICB.
2.2	Head of Information and Governance (Estates) to review operational oversight, quality assurance and associated management and include as part of a Governance Review. **Revised Action**: **to embed** monthly reporting to quality and performance meeting, and routine reporting from the Estates Director to Finance and Performance Committee.	CN	November 2022 **July 2023**	Governance review **complete**, a new Estates Management Board established supported by three sub-groups focussing on: • Health, Safety, Compliance • Finance and Performance • Estates Infrastructure and Capital (EMG) The new governance structure to be rolled out January 2023.
2.3	Gain ISO 14001 Accreditation Status.	CN	March 2023	Work progressing to plan. Additional auditor training provided, and ISO framework procured.
2.4	Appointment of Authorising Engineer (FIRE) and commissioning of External Independent Review	CN	Revised to February 2023	Specification produced and tender documentation prepared. Anticipate Authorising Engineer (FIRE) appointment end of February 2023.
2.5	Monthly reporting to quality and performance meeting, chaired by the Director of Estates	CN	November 2022	**Action Complete -** This action is linked to action 2 above.
3.1	Capture IT Digital enabling requirements within annual business planning process.	MD(Dev) / DSP	November 2022	Included initial cut of 2023/24 plan
3.2	Recruit appropriately qualified deputy role within Cyber Team.	MD(Dev)	March 2023	**Action Complete**

Accountabilities / Review History

Board Oversight	**Last deep dive review held**	**Strategic Risk Owner**	**Date of last Update**
Finance and Performance Committee	*Scheduled for 13 February 2023*	**Chief Nurse**	January 2023

Controls and Assurances

Controls	Assurance / Evidence		
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]	**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
NEW Control Gap – Absence of a prioritised list of schemes for when funding again becomes available (probably 2025/26, possibly a small amount in 2024/25).	**1.1 NEW - Production of plan of prioritised capital schemes to inform 2024/25 Capital planning process.**

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. • **Estates Maintenance Internal Audit – December 2022 (Limited)**
			Assurance Level: LIMITED

Gaps in Controls / Assurances

Control Gap – Estates Strategy refresh required (in line with Estates code)

Control Gap – Operational oversight and management

Control Gap – Working towards ISO 14001

Control / Assurance Gap – Managing Healthcare Fire Safety recommendations. (HTM 05-01)

Assurance Gap – Quality Assurance within Estates internally

Actions to address gaps in controls / assurance

2.1 Estates Strategy refresh to be undertaken in liaison with Strategy and Planning Directorate.

2.2 **Embed** monthly reporting to quality and performance meeting, and routine reporting from the Estates Director to Finance and Performance Committee.

2.3 Gain ISO 14001 Accreditation Status.

2.4 Appointment of Authorised Engineer and commissioning of External Independent Review.

2.5 **Action Completed** - Monthly quality and performance meeting, chaired by the Director of Estates.

Return to Strategic Risk front sheet

Controls **For Cause 3:** *Ineffective delivery plans and strategy for Digital and IM&T*	**Assurance / Evidence**		
	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).	Actio • 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	**Actions to address gaps in controls / assurance**
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.	3.1 Capture IT Digital enabling support requirements within annual business planning process / incorporate within business planning guidance.
Control Gap – Lack of resilience within Cyber team (Expertise dependent on one individual).	3.2 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	Likely
Current	Likely
Target	**Possible**

Target score to be achieved by Summer 2023

TREND GRAPH TO BE ADDED FROM NEXT ISSUE
[movement to date is reflected within comparison between previous and current position, noted in grey box to left]

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	The post has been included in the Directorates plan but will be subject to review as this would present a cost pressure to the Trust. The Head of Sustainability is due to return from maternity leave in March 2023.
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	A draft is in development and will be finalised by the end of January. The approved terms of reference for the Sustainability Delivery Group (previously Committee) include the report being presented quarterly to TEG, which will occur in Q4 2022/23 and then half yearly at Finance and Performance Committee.
3	Communication and engagement plan in order to engage, influence and be embedded sustainability in all aspects of Trust business.	Comms Director	October 2022	A communication and engagement log is reviewed each month by the Sustainability Delivery Group. A bimonthly newsletter covering each of the themes within the Trust's Sustainability Plan will cover over the year.
4	Work with partners – including NHSE and ICB on external review (third level assurance) of our sustainability work.	DSP	Summer 2023	360 Assurance are conducting an internal audit of the Trust's sustainability work in Q4 2022/223. The SY ICB have previously reviewed the Trust's Sustainability Plan and provided comments, which have been incorporated.
5	Sustainability Plan annual refresh to be done to update priorities.	DSP	February 2023	This remains on track and further guidance is awaited from the ICB and Greener NHS Team.
6	Implementation and embedding of revised Sustainability Impact Assessment Tool.	DSP	December 2022	A Sustainability Impact Assessment Tool has been developed. Currently being piloted in order to ensure it can be used to support the Trust's sustainability activities and is both practical and efficient. A final version will progress as a controlled document for implementation across the Trust.
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	This is in development.

Version Control: January 2023 issue

Accountabilities / Review History

Board Oversight	Last deep dive review held	Strategic Risk Owner	Date of last Update
Board of Directors	June 2022 (as part of 2021/22 IRAR) BAF Deep dive scheduled 28 February 2023	Director of Strategy and Planning	January 2023

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**
Control Gap - Sustainability Manager post is fixed term until August 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	Actions to address gaps in controls / assurance
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	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	Likely
Current	Likely
Target	Possible

Target score to be achieved by June 2023

TREND GRAPH TO BE ADDED FROM NEXT ISSUE
[movement to date is reflected within comparison between previous and current position, noted in grey box to left]

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 (R&I) Strategy, with associated delivery plan.	MD (Dev)	Revised to June 2023	Strategy initially developed with internal consultation. An external R&I Strategy workshop held on 9th January 2023 with external stakeholders (Sheffield Hallam University and the University of Sheffield, NHSA, AHSN and other parties including public and patient representation) to inform how we collectively deliver R&I for Sheffield and its wider community over a 3 year term. R&I Strategy to be further developed based on the intelligence received from internal and external sources. The strategy will need to be supported by a delivery plan. This will include clear research priorities and for some programmes, within programme priorities, for example cancer research priorities. These will be developed in partnership with the Universities.
2	**NEW - Medical Director (Development) accessing support from Audit One relating to proposals for a new Research and Innovation oversight group.**	MD (Dev)	April 2023	Planning meeting with AuditOne scheduled for 24 January 2023.
3	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)	Revised to January 2023	Proposal being presented to Medical Director/Director of HR/Chief Nurse on 19th January 2023 to establish education oversight group as discussed at TEG.
4	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)	Revised to June 2023	Review of funding is complete (December 2022). Reconciliation against specific requirements of the Education Contract with HEE to be actioned.
5	Develop metrics to identify good educational practice and areas requiring intervention and support.	DHRSD / MD (Dev)	Revised to April 2023	Project Manager in post from December 2022. Project Manager to develop metrics with directorates and key stakeholders underway.
6	Develop research metrics to evidence directorate research performance.	MD (Dev)	Revised to June 2023	Strategy to detail directorate performance research metrics and trust wide level metrics. These will be informed by the R&I strategy.
7	Engagement programme with directorates to embed good educational governance principles and robust data collection for internal and external (HEE) oversight.	DHRSD / MD (Dev)	Revised to April 2023	As above in 5 and 6.

8	Embed actions for CQC Outcome 10 – Assurance that staff are trained to do their jobs.	DHRSD	December 2022	**Action Closed** - Action plan agreed by TEG in November 2022 to embed processes and ongoing assurance.
9	Ensure all learners on placement receive a positive quality assured experience.	DHRSD	April 2023	As above in 5, 6 and 7.

Accountabilities / Review History

Board Oversight	Last deep dive review held	Strategic Risk Owner	Date of last Update
Board of Directors	**20 December 2022**	Medical Director (Development)	January 2023

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.
Assurance Gap – Research/education governance metrics dashboard.	Develop research metrics to evidence directorate research performance.

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. **Control Lead:** Medical Director (Development)	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.
			Assurance Level: LIMITED
Gaps in Controls / Assurances		**Actions to address gaps in controls / assurance**	

Return to Strategic Risk front sheet

Controls **For Cause 3:** *Infrastructure and resources are insufficient to support delivery of research and education*	Assurance / Evidence		
	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
Assurance Gap - Oversight at Board level of Research and Innovation through consideration of strengthening governance infrastructure.	**NEW - Medical Director (Development) accessing support from AuditOne relating to proposals for a new Research and Innovation oversight group.**

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	• Self-Assessment against HEE's Quality Standards presented to People Committee on 14 November 2022.	• 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	Likely
Current	Likely
Target	Possible

Target score to be achieved by April 2023

TREND GRAPH TO BE ADDED FROM NEXT ISSUE
[movement to date is reflected within comparison between previous and current position, noted in grey box to left]

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	Revised to January 2023	Review was commissioned from AuditOne and has now been completed. The Draft Report was presented in a strategy session to all Board members. A final Report has now been received and shared with the Board of Directors and members of Management Board Briefing. The Report will be received at the public Board of Directors' meeting on 31 January 2023.
2	Monitoring by TEG of progress against agreed trajectory to achieve 85% of Trust policies in date by April 2023.	CEO	April 2023	64.22% of corporate policies (201/313) are now in date, an increase of 8.6% since September 2022. TEG continues to monitor progress on these as well as Clinical Guidelines (33.18%), Patient Information Leaflets (80.26%) and Patient Record Committee Forms (34.28%).
3	Develop structured Board Development Programme for approval by Chair / Board.	ACE	Revised to January 2023	TEG discussion scheduled (26 Jan 2023) for further reflection on prompts for the Board Development Plan within the Well-led report for onward discussion with the full Board.

Accountabilities / Review History

Board Oversight	**Last deep dive review held**	**Strategic Risk Owner**	**Date of last Update**
Board of Directors	**25 October 2022**	Chief Executive	January 2023

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). **AuditOne Well Led Review (BoD 31 January 2023).** • 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 **/ Well-led Improvement Plan on a Page** • GGI Healthcare Governance Review. • **AuditOne Well Led 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 **For Cause 2:** *Ineffective / inconsistent systems and processes to support the management of risks, issues and performance*	**Assurance / Evidence**		
	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. • **AuditOne Well Led Review.** • Internal Audit reports: – Performance Management Framework July 2020 (Significant) – Policy Management Framework 2021 (Limited) – **HR Data Quality Dec 2022 (Significant)**
	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 secretariat. 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. • AuditOne Well Led 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