**Executive Summary**

**Report to the Board of Directors**

**held on 28 January 2025**

| | |
|---|---|
| **Subject** | Board Assurance Framework – January 2025 |
| **Supporting TEG Member** | Sandi Carman, Assistant Chief Executive |
| **Author** | Judith Green, Head of Corporate Governance |
| **Status** | For Discussion |

## PURPOSE OF THE REPORT

This paper presents the updated Board Assurance Framework (BAF) populated from content received from Strategic Risk Owners. The BAF 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

This paper presents an updated BAF with content changes / additions from the September 2024 version noted in **bold**.

Changes to the structure of the BAF have also been made as part of continuous improvement work; specifically incorporation of Risk Appetite and the agreed piloting of risk tolerance scores, as noted below. In addition, re-sequencing of BAF sections has taken place to aid navigation and accessibility and hence improve BAF functionality.

### BAF Ratings Dashboard – Risk and Assurance Profile

The BAF document comprises of a Ratings Dashboard outlining the Strategic Risk and Assurance profile of the Trust. This highlights three Strategic Risks that continue to have Limited Assurance Ratings. Strategic Risk Owners for these risks may wish to provide additional verbal context.

**Board Action - To hold discussion on:**

- **Whether across the agendas of the Board and its Committees there is adequate focus on the following three Strategic Risks:**

| | Aggregated Assurance Rating | Current Risk Score | In / Out Risk Appetite |
|---|---|---|---|
| **Strategic Risk 2: Operational Recovery and Delivery** | LIMITED | 20 | Out of Appetite |
| **Strategic Risk 5: Digital** | LIMITED | 12 | In Appetite |
| **Strategic Risk 7: Research and Innovation** | LIMITED | 12 | In Appetite |

- **Across all Strategic Risks discuss the content of Strategic Risk Owner commentaries to identify any areas for consideration during the Board Committee deep dives.**

### Piloting of Risk Appetite

This BAF update follows agreement by the Board of an updated Risk Appetite Statement. The BAF therefore reflects newly agreed risk tolerance scores and introduces the concept of a Strategic Risk being 'In Appetite' or 'Out of Appetite'.

As part of the piloting the use of risk tolerance scores, the Board is asked to consider whether the agreed Risk Appetite / tolerance score for Digital aligns with levels of current Board scrutiny. The 'In Appetite' rating for Strategic Risk 5 may suggest that Risk Appetite for digital may need further consideration.

**Recommended changes on the BAF**

While no recommendations for changes to ratings / Strategic Risk profile are being made through this update, the commentary for Strategic Risk 6 (Sustainable Healthcare through partnership working) signals that consideration will be prompted at its next deep dive to strengthening focus on risks relating to the Trust's ability to adapt to climate change within the content of this Strategic Risk. In addition the risk score for Strategic Risk 4 (Finance) is likely to change following the publication of the planning guidance and system allocations.

**Cross referencing with the Corporate Risk Register Report**

Review of the Corporate Risk Register Report (CRRR), presented as a separate agenda item, can be used to identify alignment between Operational Risks and Strategic Risks, consideration of which informs judgement on the effectiveness of BAF Controls and potential emerging areas of Strategic Risk.

**Board Action:**

**To consider, during review of the content of the Corporate Risk Register Report, whether there are any themes which should feed into future deep dive discussion.**

## 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 use the prompts noted above to **DISCUSS** levels of assurance in place and current levels of Strategic Risk.

## APPROVAL PROCESS

| Meeting | Date | Approved Y/N |
|---|---|---|
| Risk Management Executive Committee | 16 January 2025 | Y |
| Board of Directors | 28 January 2025 | |

# Board Assurance Framework

## January 2025

**This update of the BAF follows review by Strategic Risk Owners of individual risks entered onto the framework.**

**The BAF is structured around eight Strategic Risks approved by the Board of Directors in September 2023. 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 Score and an assessment against Risk Appetite.**

**Current Strategic Risk profile**

**Across the Trust's current Strategic Risk profile presented in the BAF Dashboard, three Strategic Risks have a 'Limited' Aggregated Assurance Rating. It is recommended that focus is placed on scrutiny and challenge on these risks and, with reference to the planned schedule of deep dive reviews, consideration is given to the oversight arrangements for these Strategic Risks.**

| | Aggregated Assurance Rating | Current Risk Score | In / Out Risk Appetite |
|---|---|---|---|
| Strategic Risk 2: Operational Recovery and Delivery | LIMITED | 20 | Out of Appetite |
| Strategic Risk 5: Digital | LIMITED | 12 | In Appetite |
| Strategic Risk 7: Research and Innovation | LIMITED | 12 | In Appetite |

**While no proposals are being made for a change in rating since presentation of the BAF to the Board of Directors in September 2024, the Commentary for Strategic Risk Four (Finance) signals there is a high likelihood that the rating of this risk will need to change following publication of 2025/26 planning guidance and system allocations.**

| BAF DASHBOARD - January 2025 | Current Aggregated Assurance Rating | Current Risk Score | In / Out Risk Appetite |
|---|---|---|---|
| **Strategic Risk 1: Quality of Care -** Fail to consistently provide compassionate, effective and safe patient centred care that delivers the best clinical outcomes | ADEQUATE | 12 | In Appetite |
| **Strategic Risk 2: Operational Delivery and Recovery** - Fail to deliver operational performance in line with agreed recovery trajectories | LIMITED | 20 | Out of Appetite |
| **Strategic Risk 3: Workforce -** Fail to ensure the Trust can train, recruit and retain the right people to deliver patient centred services and the best clinical outcomes | ADEQUATE | 12 | In Appetite |
| **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 | 15 | Out of Appetite |
| **Strategic Risk 5: Digital -** Fail to deliver the digital capability required to support safe, effective and efficient patient care | LIMITED | 12 | In Appetite # |
| **Strategic Risk 6: Sustainable Healthcare through partnership working** - Fail to deliver sustainable healthcare and be a key partner in our Integrated Care System and the wider healthcare system in England | ADEQUATE | 9 | In Appetite |
| **Strategic Risk 7: Research and Innovation -** Fail to ensure the Trust has the ability to deliver excellent research and innovation | LIMITED | 12 | In Appetite # |
| **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) | ADEQUATE | 8 | In Appetite |

*# Ratings based on implementation of the Risk Appetite agreed by the Board in November 2024 rather than comparison with previously agreed risk target scores.*

**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 / improve the sufficiency of Controls and Assurance provided. |

| Risk Score | Rating |
|---|---|
| 1 – 3 | LOW |
| 4 – 6 | MODERATE |
| 8 – 12 | HIGH |
| 15 – 25 | EXTREME |

| Strategic Aims | |
|---|---|
| Deliver the best clinical outcomes | Spend public money wisely |
| Provide patient centred services | Create a sustainable organisation |
| Employ caring and cared for staff | Deliver excellent research, education and innovation |

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| **Strategic Risk 1: Quality of Care -** Fail to consistently provide compassionate, effective and safe patient centred care that delivers the best clinical outcomes | LINK |
| **Strategic Risk 2: Operational Delivery and Recovery** - Fail to deliver operational performance in line with agreed recovery trajectories | LINK |
| **Strategic Risk 3: Workforce -** Fail to ensure the Trust can train, recruit and retain the right people to deliver patient centred services and the best clinical outcomes | LINK |
| **Strategic Risk 4: Finance -** Fail to manage our finances effectively and deliver value for money to ensure the long-term sustainability of care provision | LINK |
| **Strategic Risk 5: Digital -** Fail to deliver the digital capability required to support safe, effective and efficient patient care | LINK |
| **Strategic Risk 6: Sustainable Healthcare through partnership working** - Fail to deliver sustainable healthcare and be a key partner in our Integrated Care System and the wider healthcare system in England | LINK |
| **Strategic Risk 7: Research and Innovation -** Fail to ensure the Trust has the ability to deliver excellent research and innovation | LINK |
| **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) | LINK |


Content last updated 22 January 2025. Updates to content since the September 2024 BAF noted in **bold**.

# Strategic Risk 1: QUALITY OF CARE

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

| Aggregated Assurance Rating | ADEQUATE |
|---|---|

## Key Causes

| | Key Causes | Assurance Rating |
|---|---|---|
| C1 | Inability to embed effective quality governance arrangements including learning from incidents / patient feedback | Adequate |
| C2 | Lack of cultural competency across our service delivery | Adequate |
| C3 | Fail to maintain an environment which supports safe and effective delivery of modern healthcare | Adequate |

## Key Effects / Consequences (Results in)

- Adverse impact on the health outcomes of patients and public health in the longer term
- Continued regulatory intervention and potential loss of public trust and confidence
- Negative effect on staff wellbeing, motivation and recruitment / retention
- Legal / financial implications
- Unsuitable / unsafe environment impacting patient / staff experience

| Accountabilities / Review History | |
|---|---|
| **Strategic Risk Owner:** | Chief Medical Officer (Operations) |
| **Board oversight forum:** | Quality Committee |
| **Last deep dive review held:** | **18 November 2024** |
| **Date of last update:** | January 2025 |

| Risk Analysis | Jan 2025 | Sept 2024 | May 2024 | Jan 2024 |
|---|---|---|---|---|
| **Current Risk Score:** (C) x (L) | (4) x (3) = **12** | (4) x (3) = **12** | (4) x (4) = **16** | (4) x (4) = **16** |
| **Target Risk Score:** (C) x (L) / Achieved Sept 2024 | (4) x (3) = **12** | (4) x (3) = **12** | (4) x (3) = **12** | (4) x (3) = **12** |
| **Risk Appetite:** | **CAUTIOUS** | - | - | - |
| **In / Out of Appetite:** | **IN APPETITE** | - | - | - |

## Operational risk oversight informed by Risk Appetite

| AVOID | MINIMAL | CAUTIOUS | OPEN | SEEK | *Risk Tolerance 12* |
|---|---|---|---|---|---|

In updating its Risk Appetite Statement in November 2024 the Board of Directors has defined a **CAUTIOUS** Risk Appetite for risks relating to Quality and an agreed risk tolerance score of **12**.

At the 7 January 2025 there were 29 open Operational Risks aligned to this Strategic Risk with a current risk score of 12 or more. Revised reporting arrangements are being introduced to support Board oversight of these Operational Risks.

***Please refer to the Corporate Risk Register Report***

## Strategic Risk Owner Commentary

At the most recent deep dive discussion held on 18 November 2024 the Quality Committee noted the latest scoring / rating for this Strategic Risk and the completion of all actions, and questioned how this risk should be treated going forwarded. The evolving strategic context of this risk is driven by uncertainty around the potential impact on the current regulatory framework following the review into national patient safety organisations by Dr Penny Dash. Following the NHS 10-year plan, due to be published in Spring 2025, there will be a need to maintain oversight of this Strategic Risk via the BAF.

In terms of operational risks aligned to this Strategic Risk, there is a range of themes across the 29 operational risks being managed above the agreed risk tolerance score. Five of these risks relate to the Estate, five relate to neurosciences services; two of these relate to potential delays in treatment and two relate to potential equipment failure. The two equipment risks are within a group of five equipment risks being monitored by the Medical Devices Safety Group. A further two risks relate to the supply / availability of products, both of which have been assigned to relevant oversight fora. There are no themes of concern across risks which currently indicate controls may not be effective.

## Aggregated Action Plan to address gap in control or assurance noted in subsequent tables of Controls and Assurances

| | Action | Lead Exec | Deadline | Progress update |
|---|---|---|---|---|
| **1** | **NEW** – Consider qualitative patient and staff experience reporting at the Board, starting with planned discussions between AuditOne and the lead executive/s.<br><br>*Addresses NEW Assurance Gap - Well-led developmental Phase II Review identified scope for strengthening assurance around use of patient voice* | Chief Nurse | March 2025 | Following a conversation with Audit One, an update on the work on Patient Engagement will be brought to the Board in March 2025 and quarterly thereafter, which will consider the work being undertaken as described in the Quality Strategy against the following headings: Consult, Engage, Co-design/Co-production and inform. |

## Tables of Controls and Assurances

<table>
<tr><th rowspan="2">Key Controls / Mitigations<br><br>**For Cause 1:** Inability to embed effective quality governance arrangements including learning from incidents / patient feedback<br><br>[system in place to help manage the cause / effect]</th><th colspan="3">Assurance / Evidence<br>[where can we gain evidence that the controls we are placing reliance on are working]</th></tr>
<tr><th>First Level<br>[Service delivery and day to day management - how do we know day to day that controls are working?]</th><th>Second Level<br>[Oversight – who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]</th><th>Third Level<br>[Independent challenge – has anyone external come in to check that the controls are working]</th></tr>
<tr><td>• Quality Governance Policy / Framework (Nov 2023) with delivery and oversight structures in place.</td><td>• Directorate Governance Meetings<br>• QUEST Assessments.<br>• Ward Assurance Group monitors compliance with the Fundamental Standards.</td><td>• Quarterly Integrated Quality and Safety Report reviewed by Quality Committee.<br>• Live Quality, Safety and Risk Dashboard.<br>• Outcome of Directorate Reviews reviewed by TEG.<br>• Benchmarking of quality key performance indicators (KPI's) with other organisations / Model System / Public View.<br>• Highlight reports from Care Groups to Quality and Safety Executive Committee (QSEC) and Risk Management Executive Committee (RMEC).<br>• **Self-assessment against CQC quality standards with action plans to address key priorities reviewed by Quality Committee. [16 December 2024]**</td><td>• Dec 22 CQC Report including requires improvement rating for well-led.<br>• External Healthcare Governance Review presented to Board of Directors (Jun 22).<br>• Dec 22 AuditOne Well-led final report (Adequate assurance rating on aggregate).<br>• Letter from NHSE confirms move from Intensive Assurance to Enhanced Assurance.<br>• Internal Audit Reports reported to Audit Committee:<br>– Maternity Standards Review – Advisory report issued Feb 23 noted a high-risk recommendation.<br>– Patient Safety Incident Response Framework (PSIRF) Advisory report issued July 2023.<br>– Learning from Incidents (issued Mar 24) - significant opinion.<br>– Risk Management (focus on RMEC) issued Mar 24 - significant opinion.<br>– Pressure area care revisit – moderate assurance<br>– Medicines management – storage and disposal (Jul 24) – limited assurance.<br>– **Compliance with Quality Governance Framework Oct 24 - significant opinion.**<br>– **NICE guidance process (revisit) Oct 2024 – significant opinion.**<br>• Various External Visits, Accreditation and Inspections.</td></tr>
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| | | | |
|---|---|---|---|
| • Mechanisms in place to support identification and sharing of themes and learning, (e.g. Safety and Risk Forum / Medical Director's Safety Message / Management Board Briefing). | • Weekly Safety Panel.<br>• Structured Judgement Reviews reviewed at Mortality and Morbidity meetings. | • Learning report to TEG, Quality Committee and MBB.<br>• Learning from Deaths Report to Quality Committee and Board of Directors. | • Internal Audit – Serious Incidents and Never Event Actions (May 21) – significant assurance. |
| • Clinical Effectiveness processes including Clinical Audit, NICE guidance compliance. | • Directorate Governance Meetings.<br>• Clinical Audit and Outcomes Group (CAORG). | • Reports on progress with Trust Clinical Audit Programme, and NICE standards to Quality and Safety Executive Committee. | • **NICE guidance process (revisit) Oct 2024 – Significant opinion.**<br>• Internal audit – Clinical Effectiveness [Clinical Audit] – Split Opinion Limited / Significant Assurance (June 23). |
| • Processes in place to seek and receive patient feedback (e.g. surveys and complaints). | • Patient feedback reviewed at Patient Experience Executive Committee. | • Patient feedback reported to TEG, Quality Committee. | • Internal Audit – Patient Experience (Jan 22) – Split opinion.<br>• Complaints (issued Dec 23) – significant opinion.<br>• **Well-led developmental Phase II Review (Oct 2024) – (recommendation around use of patient voice).** |
| • Structures and processes in place for staff to raise or escalate issues. | | • Freedom to Speak Up Guardian Report presented to People Committee. | • Internal Audit – Freedom to Speak Up (July 24) Significant Assurance. |
| **Control Lead**: Chief Medical Officer (Operations) | | | **Assurance Level: ADEQUATE** |
| **Gaps in Controls / Assurances** | | | |
| **NEW Assurance Gap - Well-led developmental Phase II Review identified scope for strengthening assurance around use of patient voice** | | | |

*Return to Strategic Risk front sheet*

| Controls<br>**For Cause 2:** 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). | • Patient Survey results collated and reviewed by Quality Governance Team. | • Complaints and Compliments reported to Patient Experience Executive Committee (PEEC). | • CQC Report 2022.<br>• Dec 22 AuditOne Well-led final report (Vision / Strategy / Ambition Kloe RAG rated RED). |
| • Equality, Diversity and Inclusion (EDI) Strategy and Implementation Plan(s) includes a defined vision for culture, improvement and engagement with a set of objectives underpinned by annual Implementation Plans. | • EDI training plan (e-learning on PALMS and bespoke training continuing to be created and delivered by the EDI Team) available to all.<br>• EDI team interventions / Deep Dives conducted in specific 'hotspot' areas. | • Delivery of all actions within the annual EDI Strategy Implementation Plan(s) reported quarterly to EDI Executive Committee / TEG and final year-end report. | • Dec 22 AuditOne Well-led final report (Culture Kloe RAG rated GREEN). |
| • Workstream in place within Chief Operating Officer's Directorate to deliver Accessible Information Standard (AIS) action plan. | • Delivery of AIS action plan monitored by Chief Operating Officer Directorate. | • Delivery of AIS Action Plan reported to EDI Executive Committee.<br>• Patient Communication Steering Group established which will receive updates and progress actions in relation to the AIS and other patient accessibility issues (linked to new EPR). | • Internal Audit – AIS – limited assurance for compliance with AIS.<br>• Quarterly meeting with Integrated Care Board (ICB) to monitor delivery of AIS action plan. |
| • Health Inequalities Review and Action Planning. | • Directorate level review of EDI Dashboard.<br>• Minutes / Reporting from Health Inequalities Delivery Group, chaired by Trust's Strategy and Partnerships Director and involving the Associate Director of EDI (Deputy Chair). | • EDI Dashboard to be reported to EDI Executive Committee and EDI Data Sub-group. | • Sheffield Race Equality Report published 14 July 2022.<br>• Minutes / reporting from Sheffield Race Equality Partnership (REPS) (supported financially by STH and other anchor organisations across the city). |
| • Review of Language Interpretation and Translation Services at STH **and implementation of actions to address findings including drafting of new Interpretation and Translation Policy.** | • Review completed that identifies key challenges and reported to the EDI Executive Committee on 27th November 2023. | • Action plan monitored through the EDI Executive Committee.<br>• Revised contract for New Interpretation and Translation Services provider being procured through the North of England Commercial Procurement Collaborative (NOECPC). | |
| **Control Lead:** Organisational Development Director | **Assurance Level: ADEQUATE** | | |
| **Gaps in Controls / Assurances** | | | |
| No gaps in Controls or Assurances identified | | | |

Return to Strategic Risk front sheet

| Controls | Assurance / Evidence | | |
|---|---|---|---|
| **For Cause 3:** Fail to maintain an environment which supports safe and effective delivery of modern healthcare | **First Level** | **Second Level** | **Third Level** |
| • Estates Strategy / Estates Delivery plans with governance and oversight arrangements in place. | • Estates Risks managed through routine Estates Directorate Risk/Quality meetings.<br>• Estates Director chairs Estates Management Group through which escalation of capital project issues / delivery risks takes place with reporting from the Estates Director to Finance and Performance Committee. | • Extreme Estates Risks reported to TEG / Board of Directors through the Corporate Risk Register Report. | • Estates Maintenance Governance Internal Audit (February 2024) – significant assurance.<br>• Access surveys – 20% of the sites surveyed on an annual basis by AccessAble. |
| • Trust Planned Preventative Maintenance programme.<br>• Application of Premises Assurance Model (PAM) to support quality and safety compliance and efficiency of Estates.<br>• Essential Maintenance Programme in place. | • Estates Directorate utilise PAM self-assessment to drive improvement.<br>• Estates Directorate collate information for Estates Return Information Collection (ERIC).<br>• On-call engineers - day to day management of Estates.<br>• Budget meetings in place in liaison with finance.<br>• Critical infrastructure reviews every six months (working to condition B estates). | • Premises Assurance Model (PAM) reviewed by Quality Committee.<br>• Capital Investment Team (CIT) Estates Management Report.<br>• Relevant Estates matters discussed and reported through Partnership Forum.<br>• Estates Energy Meeting.<br>• Land and Property Meeting – discuss leases and licences arrangements. | • ERIC return submitted to NHSE Estates and Facilities (checking function) and linked to Model Health System.<br>• Six Facet Survey – NHS Standard – measures utilisation, compliance, function and suitability.<br>• Insurance company site inspections / surveys.<br>• Positive feedback at visit by NHSE colleagues to inspect Reinforced Autoclaved Aerated Concrete (RAAC) regarding maintenance of the RAAC and site generally. |
| • Programme of testing (statutory compliance) – HV/LV including generator black start, legionella, ventilation, and medical gases undertaken by Authorised Persons. | • Authorising Engineers audit / monitor performance against Estates safety / compliance metrics, e.g. (Water, Fire, ventilation, medical gases etc). | • Reports provided to Ventilation Safety Group and Water Safety Group – both report to Infection Prevention and Control (IPC) Executive Committee and Health and Safety Executive Committee.. | • Draft Authorising Engineer (Fire) audit report with identified areas for action / recommendations in respect of Managing Healthcare Fire Safety (HTM 05-01). |
| • Programme in place to monitor compliance with Estates ISO 9001 and ISO 14001 accreditation. | • Regular reviews or improvement discussed at the Estates Compliance and Assurance Group | • Audits undertaken by external assessor | • Estates ISO 9001 accreditation.<br>• **Estates ISO 14001 accreditation.** |
| **Control Lead:** Chief Nurse | | | **Assurance Level: ADEQUATE** |
| **Gaps in Controls / Assurances** | | | |
| No gaps in Controls or Assurances identified | | | |

*Return to Strategic Risk front sheet*

# Strategic Risk 2: OPERATIONAL DELIVERY AND RECOVERY

Fail to deliver activity in line with agreed recovery trajectories

| Aggregated Assurance Rating | LIMITED |
|---|---|

## Key Causes

| | Key Causes | Assurance Rating |
|---|---|---|
| C1 | Insufficient capacity to deliver activity | Adequate |
| C2 | Insufficient directorate leadership capacity – lack of oversight, operational grip and ability to engage teams | Limited |
| C3 | Complexity and uncertainty / competing priorities / lack of clarity of position | Adequate |

## Key Effects / Consequences (Results in)

- Negative patient experience / adverse impact on the health outcomes of patients and public health in the longer term
- Financial implications
- Increased waiting time / underperformance against external targets and national performance standards leads to regulatory action
- Negative effect on staff wellbeing, motivation and recruitment / retention

| Accountabilities / Review History | |
|---|---|
| **Strategic Risk Owner:** | Chief Operating Officer |
| **Board oversight forum:** | Finance and Performance Cttee |
| **Last deep dive review held:** | **11 November 2024** |
| **Date of last update:** | January 2025 |

| Risk Analysis | Jan 2025 | Sept 2024 | May 2024 | Jan 2024 |
|---|---|---|---|---|
| **Current Risk Score:** (C) x (L) | (4) x (5) = 20 | (4) x (5) = 20 | (4) x (5) = 20 | (4) x (5) = 20 |
| **Target Risk Score:** (C) x (L) / Target date Mar 25 | (4) x (3) = 12 | (4) x (3) = 12 | (4) x (3) = 12 | (4) x (3) = 12 |
| **Risk Appetite:** | OPEN | - | - | - |
| **In / Out of Appetite:** | OUT OF APPETITE | - | - | - |

## Operational risk oversight informed by Risk Appetite

| AVOID | MINIMAL | CAUTIOUS | OPEN | SEEK | *Risk Tolerance 15* |
|---|---|---|---|---|---|

In updating its Risk Appetite Statement in November 2024 the Board of Directors has defined an **OPEN** Risk Appetite for risks relating to Operational Delivery and Recovery and an agreed risk tolerance score of **15**.

At the 7 January 2025 there were six Operational Risks aligned to this Strategic Risk with a current risk score of 15 or more. Revised risk reporting arrangements are being introduced to support Board oversight of these Operational Risks.

Three of the risks relate to staffing shortages (Consultant Oncologists and specifically Breast Oncologists, and Sonographers in Maternity Ultrasound). These risks are associated with operational delivery across Weston Park Cancer Services and diagnostic ultrasound, respectively.

Two of the risks relate to cancer waits (potential for harm on Dermatology pathways as a result of the increased demand and reduced capacity across Dermatology and an overarching risk of patient harm for delays in cancer pathways across the organisation).

The final risk related to the risk of A&E crowding as a result of poor organisational flow and increased bed waits.

***Please refer to the Corporate Risk Register Report***

## Strategic Risk Owner Commentary

The Trust continues to increase activity volumes following the COVID pandemic and reduce waiting times as a result of the increased volumes of patients waiting. Focus remains across emergency pathways (A&E and ambulance handover times), Planned care (maximum 65wk wait standard and cancer standards) and Diagnostics (6wk wait). The Trust has returned to Tier 1 of the National Performance Framework across all three of these areas. In 2024, the focus has been on recovery activity and waits whilst preparing for CONNECT EPR and the impact that transition would have on performance.

Internally, Tier 1 meetings have been established to review the longest cancer wait pathways and longest waiting patients. The Cancer Performance Recovery Board has reviewed all cancer pathway but with particular focus on Breast, Urology and Lower GI. National best practice pathways have ensured a multi-directorate approach to reviewing diagnostics, outpatient capacity, MDT pathways and surgery (where appropriate).

In parallel, Tier 1 discussions have also continued with the directorates with the longest waiting patients, particularly Neurology, Gynaecology and General Surgery. Understanding capacity and demand pressures and ensuring all patients have a plan for treatment and identifying non-core capacity (insourcing, outsourcing and mutual aid) as required.

Through the Tier 1 discussions, accompanied by the PMF conversations, specific patient and pathway risks are identified and discussed, triangulating back to directorate risk registers and recovery action plans.

Internal review of the recently published Elective Reform Plan (6 January 2025) is taking place which presents important context for the assessment and ongoing management of this Strategic Risk.

## Aggregated Action Plan to address gap in control or assurance

| | Action | Lead Exec | Deadline | Progress update |
|---|---|---|---|---|
| 1.1 | Delivery Group booster programme to be delivered through Performance management framework arrangements and Delivery Group.<br>*Addresses Control Gap – Requirement to expedite the improvement programmes with highlighted an absence of governance delivery mechanisms.* | Chief Operating Officer | Revised to June 2025<br>(Original Mar 24 then Jun 2024) | Booster Programmes now established in: Urology Cancer, Breast Cancer, Ambulance Handover, Organisational Flow, Cardiotharoacic theatres and Dermatology.<br>Clear reporting route for each Booster Programme established as appropriate: Delivery Group, Performance Management Framework (PMF), Cancer Recovery Board. |
| 2.3 | Introduce new Cancer Recovery Board to improve our CWT performance.<br>*Addresses Control Gap - Need to strengthen oversight across our cancer pathways.* | Chief Strategy Officer | October 2024 | **ACTION CLOSED**<br>Cancer Recovery Board established and progressing well.<br>Operational assurance through Assistant COO and Programme Initiation Document (PID) established.<br>Clarity described on performance discussions at Site and Directorate level. |

## Tables of Controls and Assurances

| **Controls**<br>**For Cause 1: Insufficient capacity to deliver activity**<br>[system in place to help manage the cause / effect] | **Assurance / Evidence**<br>[where can we gain evidence that the controls we are placing reliance on are working] | | |
|---|---|---|---|
| | **First Level**<br>[Service delivery and day to day management - how do we know day to day that controls are working?] | **Second Level**<br>[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**<br>[Independent challenge – has anyone external come in to check that the controls are working] |
| • Patient Care Recovery Plan (PCRP) and establishment of the systems and processes to enable effective recovery through Business as Usual (performance) and transformation. | • Directorate level review of delivery against activity plans.<br>• Cancer Site level performance and pathways meetings / discussions with the Cancer Site lead and wider team.<br>• **Development of 52wk delivery plans and oversight reporting** | • Activity reporting to TEG / Assurance to Finance and Performance Committee (FPC).<br>• Oversight of activity recovery / Recovery Plan.<br>• **Monthly deep dive schedule for Care Groups at PMF and key focus areas at Delivery Group**<br>• Integrated Performance Report (IPR) presented to TEG / Board with benchmarking of operational targets (Model System / Public View benchmarking).<br>• PCRP integrated report to TEG in dashboard format.<br>• Tier 1 reports externally and through Performance and Caseload Oversight Group (PCOG).<br>• Protecting and Expanding Elective Capacity – Board Assurance (based on Care Group Self Assessments) submitted to NHSE and discussed at FPC.<br>• Cancer Executive and **Cancer Recovery Board** oversight. | • Tier 1 meeting outcomes **– return back to NHS England Tier 1 oversight for Elective and Diagnostics /** remain in Tier 1 oversight for Cancer waiting times.<br>• Internal Audit – Outpatients: 2019/20 activity vs 2022/23. (May 2023) – Advisory Report – 2 medium risks identified.<br>• Internal Audit – Waiting list performance management: focus on long waiters. Report issued July 2024 with Significant Assurance opinion. |
| • Directorate level case load management (review of Patient Tracking List - PTL). | • Directorate review of PTL.<br>• Validation of PTL. | • Monitoring through Performance Caseload Overview Group (PCOG) which reports into FPC. | • Tier 1 meeting outcomes (see above). |
| • Maximising offsite / independent sector capacity – insourcing and outsourcing arrangements. | • **Priority Approval process to TEG (minutes).**<br>• **Q4 corporate plan through Operational Executive Group to undertake modelling and 52wk delivery plans**. | • Process in place for TEG approval of insourcing based on directorate delivery of identified improvement metrics. | |

| | | | |
|---|---|---|---|
| • Systems in place to reduce the number of patients who no longer require a hospital bed. | • Monitoring by discharge hub.<br>• Transfer of Care (ToC) Team.<br>• Senior COO team.<br>• **Joint SCC/STH appointment and recovery plan – role out of the Care Transfer Hub Model – managed through Place Discharge Group.** | • Reported in Access Report – TEG and FPC.<br>• Place monitoring through the Urgent and Emergency Care Board - Verbal updates to TEG.<br>• **Discussion held at December Board Strategic Session** | • North East and Yorkshire Benchmarking report – All providers included. |
| • Virtual Ward | • Virtual Ward (VW) Programme Structure – Monthly reporting from VW Project Groups to VW Programme Collaborative Group. | • **Virtual Ward Programme update presented to Delivery Group quarterly** | |
| • Impact of EPR implementation | • Meeting between COO and ODs to review preparedness in line with EPR Programme Board guidelines | • Report to FPC in September 2024. | |
| • Implementation of Board approved Activity Plan. | • Directorate level review of delivery against activity plans. | • Activity reporting to TEG / Assurance to Finance and Performance Committee (FPC).<br>• Booster Programmes and review of capacity at Delivery Group.<br>• Integrated Performance Report (IPR) presented to TEG and Board.<br>• Outcome of Directorate Performance Reviews reported to TEG.<br>• Bi-monthly Public View benchmarking Report to TEG / Finance and Performance Report Committee and circulated to all NEDs.<br>• Tier 1 reports externally and through Performance and Caseload Oversight Group (PCOG).<br>• Protecting and Expanding Elective Capacity – Board Assurance (based on Care Group Self Assessments) submitted to NHSE and discussed at FPC. | • Tier 1 meeting outcomes – see above. |
| **Control Lead:** Chief Operating Officer | **Assurance Level: ADEQUATE** | | |

| **Gaps in Controls / Assurances** |
|---|
| Gap in Control – Requirement to expedite the improvement programmes with highlighted an absence of governance delivery mechanisms. |

*Return to Strategic Risk front sheet*

| Controls | Assurance / Evidence | | |
|---|---|---|---|
| **For Cause 2: Insufficient directorate leadership capacity – lack of oversight, operational grip and ability to engage teams** | **First Level** | **Second Level** | **Third Level** |
| • Implementation of robust Performance Management Framework and rationalisation of performance conversations across different delivery domains. | • Directorate Review meetings. | • Outcome of Directorate Reviews reported to TEG / Board of Directors.<br>• Routine cycle of Care Group deep dives presented to FPC (A&E – Feb 24 / Head and Neck – Mar 24 / Urology - Jun 24 / SYRS – Jul 24 / **SMR – Sept 24 / SCS and Haematology – Nov 24 / IMPEL – Dec 24).** | |
| • Cancer Executive Group and **Cancer Recovery Board** in place to provide oversight of Cancer pathway recovery. | • Monitoring through Performance and Caseload Overview Group (PCOG) / review of long waiters. | • Activity reporting to TEG / Assurance to Finance and Performance Committee (FPC).<br>• Cancer Waiting Times – performance and recovery updates presented to FPC (most recent Oct 2023).<br>• Integrated Performance Report (IPR) presented to TEG and Board.<br>• Tier 1 reports externally and through Performance and Caseload Oversight Group (PCOG). | • Tier 1 meeting outcomes. |
| • Directorate Recovery Plans monitored at Delivery Group. | • Directorate Recovery Plans developed with Finance Managers.<br>• **Tier 1 meetings for directorates with highest risks reported to PCOG.**<br>• **Performance Management Framework (PMF) discussions – Quarterly update to TEG.** | • Meetings between individual directorates and CFO / DCFO.<br>• Formal directorate level Recovery Plans monitored at Delivery Group. | |
| • Patient Care Recovery Plan (PCRP) and establishment of the systems and processes to enable effective recovery. | • Directorate level review of delivery against activity plans. | • Activity reporting to TEG / Assurance to Finance and Performance Committee (FPC).<br>• Activity Delivery Group oversight of activity recovery / Recovery Plan.<br>• Integrated Performance Report (IPR) presented to TEG / Board with benchmarking of operational targets (Model System / Public View benchmarking) | • Tier 1 meeting outcomes.<br>• Internal Audit – Waiting list performance management: focus on long waiters. Report issued July 2024 with Significant Assurance opinion. |

<table>
<tr><td></td><td></td><td><ul><li>PCRP integrated report to TEG in dashboard format.</li><li>Tier 1 reports externally and through Performance and Caseload Oversight Group (PCOG).</li><li>Theatre Improvement Deep Dive discussed at May 2024 FPC.</li><li>Theatres Update presented to Delivery Group Nov 24.</li></ul></td><td></td></tr>
<tr><td><ul><li>Review of projects and programmes identified through Use of Resources and Delivery Group presented back at Delivery Group on a monthly basis.</li></ul></td><td></td><td><ul><li>Updates on:<br>– 6-4-2 booking process.<br>– HVLC DSU.<br>– Outpatient recovery.<br>– Medirota.</li></ul>agreed to be monitored through Delivery Group (Delivery Group Minutes)</td><td></td></tr>
<tr><td>Control Lead: Chief Operating Officer</td><td colspan="3" align="right">Assurance Level: LIMITED</td></tr>
<tr><td colspan="4" align="center">Gaps in Controls / Assurances</td></tr>
<tr><td colspan="4">Gap in Control - Need to strengthen oversight across our cancer pathways - GAP NOW ADDRESSED BY ACTION</td></tr>
</table>

*Return to Strategic Risk front sheet*

| Controls<br>**For Cause 3: Complexity and uncertainty / competing priorities / lack of clarity of position** | Assurance / Evidence | | |
|---|---|---|---|
| | **First Level** | **Second Level** | **Third Level** |
| • Delivery Group established with clear set of terms of reference outlining responsibility for directing plans and actions to improve the Trust's elective activity delivery. | | • Formal directorate level Recovery Plans monitored at Delivery Group. | |
| • Agreed Operational Plan following publication of Priorities and operational planning guidance for 2024/5 Planning – **awaiting 2025/26 guidance** | | • 2024/25 Financial Plan (TEG 24 May 2024).<br>• Operational planning submission (TEG 24 May 2024).<br>• Link between Operational Plan and IPR metrics described within IPR. | |
| • Performance and Information Team responsible for co-ordinating / producing accurate and timely information for decision making. | | • Data Quality Steering Group – oversees key data quality issues and develops action plans to improve data quality in areas of concern.<br>• Data Quality Steering Group reports to Audit Committee. | • Internal Audit – Waiting list performance management: focus on long waiters. Report issued July 2024 with Significant Assurance opinion. |
| • Alignment of COO and Chief Strategy Officer around activity, elective and cancer target delivery. | • Combined meeting of PID to focus on elective and cancer delivery. | • PCOG agenda and papers.<br>• Rotating prioritisation of discussions at FPC discussions. | • Tier 1 meeting outcomes – **return back to NHS England Tier 1 oversight for Elective activity and Diagnostics** / remain in Tier 1 oversight for Cancer waiting times. |
| • Mechanisms in place to support engagement and clear communication of priorities. | • Combined meeting of PID to focus on elective and cancer delivery | • Monthly briefing by Executive Team, led by Chief Executive at Management Board Briefing.<br>• Monthly meeting between Trust Executive Group and Clinical Management Board.<br>• Connect EPR Operational Readiness Meeting led by COO to ensure joined up approach of operational asks and requirements. | |
| **Control Lead:** Chief Operating Officer | **Assurance Level: ADEQUATE** | | |

| **Gaps in Controls / Assurances** |
|---|
| No gaps in Controls or Assurances identified |

*Return to Strategic Risk front sheet*

# Strategic Risk 3: WORKFORCE

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

| Aggregated Assurance Rating | ADEQUATE |
|---|---|

| Key Causes | | Assurance Rating |
|---|---|---|
| C1 | Fail to monitor and support the health and wellbeing of our staff | Adequate |
| C2 | Insufficient staffing resource compounded by national shortages across key areas of the workforce / impact of industrial action | Adequate |
| C3 | Ineffective workforce planning fails to deliver a diverse and inclusive workforce with the capacity / capability to meet current and future Trust requirements | Adequate |

**Key Effects / Consequences** (Results in)

- Adverse impact on staff health and wellbeing
- Loss of experience and knowledgeable staff
- Negative effect on patient care
- Unable to deliver Trust strategies and Recovery Plan

| Accountabilities / Review History | |
|---|---|
| **Strategic Risk Owner:** | Chief People Officer |
| **Board oversight forum:** | People Committee |
| **Last deep dive review held:** | **9 December 2024** |
| **Date of last update:** | January 2025 |

| Risk Analysis | Jan 2025 | Sept 2024 | May 2024 | Jan 2024 |
|---|---|---|---|---|
| **Current Risk Score:** (C) x (L) | (4) x (3) = **12** | (4) x (3) = **12** | (4) x (3) = **12** | (4) x (3) = **12** |
| **Target Risk Score:** (C) x (L) / Achieved Nov 2023 | (4) x (3) = **12** | (4) x (3) = **12** | (4) x (3) = **12** | (4) x (3) = **12** |
| **Risk Appetite:** | **OPEN** | - | - | - |
| **In / Out of Appetite:** | **IN APPETITE** | - | - | - |

## Operational risk oversight informed by Risk Appetite

| AVOID | MINIMAL | CAUTIOUS | OPEN | SEEK | *Risk Tolerance 15* |
|---|---|---|---|---|---|

In updating its Risk Appetite Statement in November 2024 the Board of Directors has defined an **OPEN** Risk Appetite for risks relating to Workforce and an agreed risk tolerance score of **15**. At 7 January 2025 there were four open Operational Risks aligned to this Strategic Risk with a current risk score of 15 or more. Revised reporting arrangements are being introduced to support Board oversight of these Operational Risks.

***Please refer to the Corporate Risk Register Report***

## Strategic Risk Owner Commentary

Following review of this risk, assurance ratings for each of the individual key cause statements are deemed to remain as 'Adequate' and there is therefore no recommended change to the overall assurance level, which also remains at 'Adequate'.

There are a number of external factors with the potential to impact this risk, including the Darzi Report / 10 Year Health plan, the consultation open on manager regulation, the Resident doctors pay agreement, the RCN response to the 2024/25 pay award and the wider Trade Union response to national negotiations on the 2025/26 pay award, as well as the planned government changes to employment legislation.

Internal factors with the potential to impact on this risk are the organisational response to operational and winter pressures and the potential impact of these pressures on employee wellbeing, seasonal sickness absence levels and resultant workforce gaps impacting on colleagues, and vacancies in hard to recruit roles.

At 7 January 2025 there were four Operational Risks aligned to this Strategic Risk with a current risk score higher than the risk tolerance score of 15 defined by the Board's Risk Appetite. Controls for these risks are in place at a directorate level and support /oversight is in place for directorate Triumvirates through a combination of the Risk Management Executive Committee, Performance Management Framework meetings, and support from relevant corporate teams.

The most recent deep dive of this Strategic Risk took place at the 9 December 2024 People Committee. After reviewing the documentation and following discussion, the Committee confirmed its assurance that the appropriate controls were in place and were correctly reflected in the assurance rating. All gaps in controls and assurance have an appropriate action plan in place and were progressing as planned.

| Aggregated Action Plan to address gap in control or assurance | | | | |
|---|---|---|---|---|
| | **Action** | **Lead Exec** | **Deadline** | **Progress update** |
| **1.3** | Submission of funding bid to continue Health and Wellbeing Champion lead role.<br>*Addresses Control Gap - Uncertainty in some elements of Health and Wellbeing service provision where funding is provided from external sources on a fixed term basis.* | Chief People Officer | **Revised to April 2025**<br>*(was October 2024)* | Current funding for Staff Engagement and Wellbeing Coordinator extended to June 2025. External charity bid to be considered March / April for longer-term funding (timescale determined by Charity). |
| **2.5** | **NEW - Non-Medical staff appraisals internal audit actions to be incorporated into the Trust's Appraisal Policy**<br>*Addresses Control Gap - key areas for strengthening appraisal arrangements identified by Internal Audit on Non-Medical Appraisals.* | Chief People Officer | February 2025 | Policy due to be presented to the Operational Partnership Forum being held on 8 January 2025. |

## Tables of Controls and Assurance

| Controls<br>**For Cause 1:** Fail to monitor and support the health and wellbeing of our staff<br>[system in place to help manage the cause / effect] | Assurance / Evidence<br>[where can we gain evidence that the controls *we* are placing reliance on are working] | | |
|---|---|---|---|
| | **First Level**<br>[Service delivery and day to day management - how do we know day to day that controls are working?] | **Second Level**<br>[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**<br>[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.<br>• Governance structure in place providing oversight including establishment of Health and Wellbeing Executive. | • Sickness absence data collated by HR department. | • Reporting against Promoting Wellbeing workstream to People Strategy Executive Committee and onward to People Committee.<br>• **Sickness absence performance target review – People Committee Jun 24.**<br>• Workforce Key Performance Indicator (KPI) report presented to People Committee. | • Benchmarking sickness absence data nationally / locally.<br>• Internal Audit: Health and Wellbeing (July 2022) - Significant Assurance. |
| • NED Health and Wellbeing Guardian in place. Increased from 230 to **370** Wellbeing Champions trained and work continuing to increase numbers to cover all Directorates.<br>• Staff Intranet / Sharepoint site with suite of health and wellbeing resources.<br>• Employee assistance programme (Vivup).<br>• Inhouse support from Occupational Health. | • Progress against Promoting Wellbeing objectives / action plan monitored by of workstreams leads.<br>• Statistics on attendance on wellbeing courses / programmes collated by HR department. | • Quarterly data from Vivup presented to Health and Wellbeing Executive Group. | • Integrated Care System (ICS) / Integrated Care Board (ICB) data submission regarding introduction of wellbeing Champions Carers Forum.<br>• Menopause friendly employer accreditation. |
| • Mechanisms in place for Staff feedback inc. Pulse Check.<br>• Staff Experience Action Plans by Directorate developed in response to Staff Survey Results.<br>• Health and Wellbeing offer development in line with People Strategy.<br>• **Stress Management Policy and associated training and risk assessment process.**<br>• Violence Prevention and Reduction Strategy | • Staff Survey collated and reviewed by HR Department.<br>• **Restraint and Reduction Training compliance reviewed by the Mental Health Executive Committee.** | • Trust-level Staff Experience Action Plans by Directorate agreed by TEG. | • 2023 Staff Survey results presented to Board in March 24.<br>• Internal Audit: Staff survey action plans at directorate level (Oct 2023) – Moderate Assurance. |
| **Control Lead**: Chief People Officer | **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. |

*Return to Strategic Risk front sheet*

| Controls | Assurance / Evidence | | |
|---|---|---|---|
| **For Cause 2:** Insufficient staffing resource compounded by national shortages across key areas of the workforce / impact of industrial action | **First Level** | **Second Level** | **Third Level** |
| • People Strategy / Strategic workforce plans. | • Delivery of People Strategy monitored by People Strategy Executive Committee.<br>• Recruitment improvement groups) in place for the medical and general workforce.<br>• HR Recruitment and Improvement Group led by the Director of HR and Staff Development focused on improving time to fill KPI and candidate / manager experience. | • Reporting of People Strategy metrics to People Committee.<br>• People Strategy Deep Dives at People Committee.<br>• **Evaluation of Appraisal Pilot (People Ctte Nov 24)** | • Internal Audits reported to Audit Committee:<br>- People Strategy: Governance (issued Sept 2019) - Split Opinion.<br>- Support for timely recruitment (non-medical and non-bulk recruitment) issued Apr 23 - Split Opinion.<br>- Consultant Job Planning issued Feb 23 - Limited Assurance. All actions implemented and closed by audit.<br>- **Non-medical staff appraisals issued Oct 24 – moderate assurance Opinion**. |
| • Safe Staffing models.<br>– Safer Nursing care tool<br>– A&E Safer Nursing Care tool<br>– Midwifery – Birthrate+<br>– Comm Nursing (early work) | • Safe Staffing models monitored by Chief Nurse. | • People Committee biannual review Nurse/neonatal Staffing levels (latest Nov 24).<br>• Care hours per patient day (CHPPD) benchmarking data.<br>• **Winter preparedness nursing and midwifery safer staffing report to People Ctte (Nov 24)**<br>• **Medical Appraisal and Revalidation Board Report (Oct 24)**<br>• **Guardian of safe working hours annual report (People Ctte Nov 24)**<br>• **Winter Preparedness Nursing and Midwifery Safer Staffing Review (People Ctte Nov 24)**<br>• **Consultant Vacancies and Workforce (People Ctte Nov 24)** | |

| | | | |
|---|---|---|---|
| • E-rostering system in place including launch of Safecare Live in December 2022.<br>• Nursing and Midwifery eRoster Task and Finish Group in place with action plan to address governance issues identified in the internal audit report.<br>• Review of Nursing and Midwifery Roster Policy | • KPI reports issued to Nursing Directors monthly.<br>• Scope of work agreed for task and finish / working group established to oversee actions following the eRostering Internal Audit **and actions identified completed.** | • Central oversight of KPI's by Central Nursing team. Incorporates data on previous current and prospective rosters (inc NHSP spend and staffing costs) and used in check, challenge and coach meetings that are now established).<br>• Trust self-assessment against NHSE standards of attainment for the use of eRostering and e-Job Planning systems – level 1.<br>• Monthly Safe Staffing Report to TEG measures shift fill performance. | • Internal Audit - eRostering (focus on use of the system by nursing staff). April 2023 – Limited Assurance. |
| • Use of NHS Professionals, Locums and Agency to cover staffing gaps.<br>*Note - Additional controls re authorisation of Bank and Agency introduced by the Trust wef 1.9.24* | • NHSP fill rate information reported to central nursing. | • Bank and Agency Usage Report presented to TEG. | • Bank and Agency use and spend monitored with colleagues across SYB.<br>• Bank and Agency use reported to NHSE monthly. |
| • Recruitment Improvement programme to deliver safe and timely recruitment, focused on:<br>– attraction to difficult to fill roles<br>– speed of the recruitment time to fill KPI<br>– international recruitment<br>– addressing risks to speed of Occupational Health Clearance due to system change<br>– increasing complexity of sponsorship and right to work for international candidates.<br><br>• Modernising Medical Recruitment work commenced. Medical Recruitment team to begin recruitment from **3 February 2025**. Plans continue to progress to recruit Lay Members for AAC's. | • KPI monitoring and candidate progress assessed against time to fill KPI for General and Medical HR recruitment.<br>• Regular assessment of hard to recruit posts with staff group recruitment leads.<br>• Monitoring candidate numbers against hard to fill roles.<br>• Development plan for improvement work.<br>• Getting Back on Track Operational Groups (to now be known as recruitment improvement groups) to remain in place for the medical and general workforce.<br>• New HR Right to Work and Sponsorship Management Group established to oversee increase complexity of these issues surrounding. | • KPI, Recruitment Improvement Plan, Workforce Report shared with People Strategy Executive Committee, TEG and People Committee.<br>• **Workforce Plans for Hard to Fill Roles presented to TEG / People Ctte (Dec 24).** | • Internal Audit - Supporting Timely Recruitment (non-medical and non-bulk recruitment). Apr 2023 – Split opinion (timeliness – limited assurance)<br>• Internal Audit - Non-medical bulk and non-bulk recruitment pre-employment checks (Oct 2023) – Significant Assurance. |
| • Industrial Action Preparedness and Oversight Arrangements including implementation of Command Structure / Incident Control Centre.<br>• Risk Assessment and associated action plan in place and reviewed and monitored through HR Risk and Governance Group | • Silver Planners action and risk log / Bronze Command Logs / Risk Escalations.<br>• Data capture and reporting of numbers taking industrial action. | • Silver / Gold Command Action / Risk Escalation Logs.<br>• Industrial Action Assurance Reporting to NHS England / Hot and cold debrief reports. | • National reporting on impact on elective activity.<br>• Benchmarking with impact at other Shelford and regional trusts. |

| | | | |
|---|---|---|---|
| | • Assessment of impact of likely absence and operational planning of service delivery on strike action days.<br>• Data collection and reporting on elective activity. | • Hot and cold de-brief meetings. | |
| • Quarterly workforce reporting to provide an overview of staffing capacity and anticipated shortfalls. | | • Quarterly Workforce report (New) reviewed by TEG. | • Internal Audit Report following a review of support for timely recruitment (non-medical and non-bulk recruitment) issued with a split Audit opinion (Oct 2023).<br>• Internal Audit Report following review of Consultant Job Planning issued with a Limited Assurance. (Feb 2023). |
| • Education Steering Group overseeing a work programme to address gaps identified through the Self-Assessment Report to NHSE. Annual Learning Needs Analysis used to inform education priorities across all staff groups. | • Update against the work programme reported to Education Steering Group.<br>• Learning Needs Analysis (LNA) processes established. | • KPIs for education and training reported through the Education Steering Group to the People Strategy Executive Committee under the "We are always learning" theme. | • Benchmark data across local, regional and national providers where feasible.<br>• Established a Medical Education Steering Group and work plan reporting to the Education Steering Group to give focus to medical education matters. |
| • Workforce Information Systems Group established to review and implement Medical and Dental Rostering. | • Establishment data collated by MHR.<br>• Rota compliance collated by MHR.<br>• Rota gaps and vacancy data collated by MHR.<br>• Activity management and reporting.<br>• Resident doctor exception reports collated by the Guardian of Safeworking. | • Development of medical workforce report to TEG and People Committee.<br>• Reporting of rota gaps and costs to TEG via financial reports.<br>• **Consultant Vacancies and Workforce (People Ctte Jun 24).**<br>• **Guardian of Safe Working annual report to People Ctte (Nov 24).** | • Benchmarking workforce data nationally / locally.<br>• Future Internal audit.<br>• Benchmarking exception report data nationally / locally. |

| | | | |
|---|---|---|---|
| • Education, Learning and Staff Development agenda / resource in place with associated governance arrangements.<br>• People Strategy<br>• Quality metrics and educational governance dashboard (directorate level) to provide assurance and give early warning of issues.<br>• Mandatory and Job Specific Essential Training (JSET) compliance incorporated into PMF and reported at Management Board Briefing (MBB).<br>• Processes in place to seek and receive feedback from learners (eg surveys and complaints). | • Directorate Reviews co-ordinated by the Director of Strategy and Planning.<br>• Education quality reviewed by Education Steering Group.<br>• Continuing Professional Development (CPD) oversight group.<br>• Student experience review for nursing, midwifery, medical and dental students established in the 2024 work programme. | • KPIs for education and training reported through the Education Steering Group to the People Strategy Executive Committee. Update provided for the "We are always learning" theme as part of the People Strategy.<br>• Dashboard compliance will be included in Directorate Performance Reviews from 2024. For 2023, compliance data by exception will be included.<br>• Progress Reports to People Strategy Executive Committee via the Education Steering Group.<br>• Mandatory and JSET compliance reported at Management Board Briefing (MBB) and Clinical Management Board (CMB).<br>• Self-Assessment against NHSE's Quality Standards to be submitted Nov 24.<br>• **Pause in Mandatory Training (People Ctte Nov 24)** | • Awarded Gold level (highest) for our evidence in meeting the HEE Work Experience Quality Standard Framework.<br>• CQC Compliance achieved for outcome 10.<br>• Quality standard achieved for Nurse Preceptorship Programme.<br>• Positive feedback from the 2023 Senior Leaders Engagement meeting with NHSE |
| **Control Lead:** Chief People Officer | **Assurance Level: ADEQUATE** | | |
| **Gaps in Controls / Assurances** | | | |
| **NEW** Control Gap - key areas for strengthening appraisal arrangements identified by Internal Audit on Non-Medical Appraisals. | | | |

*Return to Strategic Risk front sheet*

| Controls | Assurance / Evidence | | |
|---|---|---|---|
| **For Cause 3:** Ineffective workforce planning fails to deliver a diverse inclusive workforce with the capacity and capability to meet current and future Trust requirements | **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. | • Directorate workforce plans assessed by Workforce Team / challenged as part of the business planning process.<br>• Directorate completion of medical workforce planning proformas in conjunction with Medical Directors' Office.<br>• Quarterly Workforce Report (New) collated by HR. | • Workforce Key Performance Indicators reported to the People Committee.<br>• Nurse / Midwifery Staffing Report presented to TEG and the People Committee.<br>• Quarterly Workforce Report (new) to provide early warning of projected staffing shortages – reported to TEG and the People Committee [Mock Report – July 2022]. | • Internal Audit: Workforce Planning Arrangements - Oct 22 (Limited Assurance). Action now confirmed as closed by 360 Assurance on 14/12/23.<br>• 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. |
| • People Strategy (March 2023) structured around Attract Grow and Retain workforce programmes with revised governance structures in place. | | • Delivery against People Strategy programmes reported to People Strategy Programme Board, TEG and the People Committee. | |
| • Organisational Development Department's (ODD) Workforce programme is part of the Flexible Working stream of the People Strategy. | • All resources and information regarding the Workforce Programme accessible via a dedicated SharePoint site.<br>• Training offer delivered to service leaders continually throughout the year and targeted to the business planning process.<br>• Case studies of planning and redesign projects available via the dedicated Workforce SharePoint site. | • ODD Workforce programme reports to the People Strategy Executive Committee and the People Committee. | |
| • Medical Director's office leading on implementation of Directorate Deep Dive programme on Medical Workforce Planning to identify / quantify workforce shortages and generate action plans within regional / national context. | • Acute Medicine, Oncology, Plastics and Urology identified by Deputy Medical Director lead in November 23 as areas for priority focus for development of targeted action plans over the following three months.<br>• Recommendation that certain approaches should be applied in all areas e.g. exit surveys, senior trainee surveys, retirement planning, awareness and evolution of service delivery model where appropriate. | • Action plans generated from Medical Workforce analysis collection monitored by TEG. GBOT Workforce group to help facilitate actions. | • Internal Audit Report following review of Consultant Job Planning issued with a 'Limited' Audit opinion. |

| | | | |
|---|---|---|---|
| • Workforce Team participate in Operational Planning Improvement Project co-ordinated by Integrated Care System, including acting as pilot organisation to share our approach/best practice. | • STH attendance at Operational Planning Improvement project workshops, outputs shared via the Workforce SharePoint page. | Improvement recommendations made by ICS and progress monitored via regional improvement group. | |
| • Board level commitment to team development and actions following on from the Board Development Session with Professor Michael West | • Michael West session with Board has been held, follow up session for both TEG and BoD and actions set in June and reviewed in October 2023. | | |
| • Executive led workstream in place to support Trust commitment to progressing the Equality, Diversity and Inclusion (EDI) agenda / achieving priority EDI objectives.<br>• **Anti-Racism Working Group established (first meeting held 4 Dec 2024).**<br>• Defined, organised and effective EDI governance structure and arrangements.<br>• Associate Director of EDI and resourced EDI Team supporting effective delivery of EDI Strategy Implementation Plans. | • Minutes of EDI Executive Committee meetings and its subgroups (e.g., EDI Data Sub-group, Staff Networks, etc.)<br>• EDI training sourced from Right Track Learning for Board of Directors and Governors – now complete and evaluation report produced. | • Board-approved EDI Strategy (2021-2025) and associated annual Implementation Plans. New EDI Strategy currently being developed for launch in early 2025.<br>• Progress against EDI Implementation Plan(s) presented to EDI Executive Committee.<br>• EDI Executive Committee minutes / Assurance Report reported to TEG / Quality Committee and People Committee.<br>• Annual EDI Report for 2024 completed and will be published externally following Board of Directors approval in January 2025. | • Internal Audit – Accessible Information Standards (AIS) – significant assurance for EDI governance arrangements. |
| • Staff Networks established for protected characteristics staff groups.<br>• 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.<br>• Trust-wide education, training and awareness programme on wide range of EDI topics.<br>• Participation targets in place for ensuring access to leadership development and training for under-represented groups.<br>• Strategic input into Health Education England (HEE) discussions to promote diverse recruitment to training programmes. | • Diversity monitoring reports of patients and service users by HR and EDI Team.<br>• Directorate level reviews of EDI Dashboard.<br>• Diversity monitoring of workforce (workforce profile, HR processes, access to opportunities (career development / training), etc) by HR and EDI Team and compiled in the Annual EDI Report. | • EDI Dashboard launched in December 2023. Further development of the EDI Dashboard is continuing.<br>• Workforce Race Equality Standard (WRES) / Workforce Disability Equality Standard (WDES) metrics and combined action plan reported to the People Committee and the Board of Directors and available on the Trust's website.<br>• Three Equality Delivery System 2022 (EDS2022 reviews into Blood Cancer Services (including Sickle Cell and Thalassaemia), Sexual Health Services and Diabetes Services (the transition from children's to adult services) completed during 2024 and in process of being peer reviewed. | • 2023 Staff Survey results presented to Board in March 2024.<br>• WRES / WDES reports – metrics and action plans - benchmark well against peers.<br>• Placed in the Top 100 for the Stonewall Workplace Equality Index in 2023 and again in 2024.<br>• Two Equality Delivery System 2022 (EDS2022) service reviews for Maternity Services and Accident and Emergency Services completed and peer reviewed in 2023. Reports now available on the Trust's website. |
| **Control Lead:** Organisational Development Director | | | **Assurance Level: ADEQUATE** |

**Version Control:** January 2025 update

| Gaps in Controls / Assurances |
|---|
| No gaps in Controls or Assurance identified |

*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 compromises strategic financial planning | Adequate |
| C2 | Failure to ensure financial systems and processes are fit for purpose | Substantial |
| C3 | Failure to deliver the required levels of efficiency savings | Limited |
| C4 | Failure to ensure adequate capital funding and manage competing priorities for capital funding | Adequate |

**Key Effects / Consequences** (Results in)

- Lack of financial stability
- Regulatory intervention / restrictions
- Unstable operating environment / service delivery adversely impacted
- Negative patient / staff / stakeholder experience
- Unable to deliver strategic development plans / maximise opportunities

| Accountabilities / Review History | |
|---|---|
| **Strategic Risk Owner:** | Chief Finance Officer |
| **Board oversight forum:** | Finance and Performance Committee |
| **Last deep dive review held:** | **9 December 2024** |
| **Date of last update:** | January 2025 |

| Risk Analysis | Jan 2025 | Sept 2024 | May 2024 | Jan 2024 |
|---|---|---|---|---|
| **Current Risk Score:** (C) x (L) | (5) x (3) = 15 | (5) x (3) = 15 | (5) x (3) = 15 | (5) x (3) = 15 |
| **Target Risk Score:** (C) x (L) / Achieved Nov 2023 | (5) x (2) = 10 | (5) x (2) = 10 | (5) x (2) = 10 | (5) x (2) = 10 |
| **Risk Appetite:** | CAUTIOUS | - | - | - |
| **In / Out of Appetite:** | OUT OF APPETITE | - | - | - |

## Operational risk oversight informed by Risk Appetite

| AVOID | MINIMAL | CAUTIOUS | OPEN | SEEK | *Risk Tolerance 12* |
|---|---|---|---|---|---|

In updating its Risk Appetite Statement in November 2024 the Board of Directors has defined a **CAUTIOUS** Risk Appetite for risks relating to Finance and an agreed risk tolerance score of **12**. The Board has a zero-tolerance approach to fraud.

At 7 January 2025 there were two open Operational Risks aligned to this Strategic Risk with a current risk score of 12 or more. Revised reporting arrangements are being introduced to support Board oversight of these Operational Risks.

***please refer to the Corporate Risk Register Report***

## Strategic Risk Owner Commentary

It is currently difficult to determine the appropriate scoring for this risk, due to the uncertainty within the financial architecture of the NHS, particularly with the delay in release of planning guidance for 2025/26. Therefore the current assessment is based on what is known, rather than some of the verbal briefings received recently about the likely challenges in the coming year. There is a high likelihood that the rating of this risk will need to change following the release of the 2025/26 planning guidance and system allocations.

The Trust is still grappling with the challenge of having a large value of its services on an ‘Aligned incentive Contract’ (Block) basis, as demand is higher than the funding flowing into the organisation, and both the organisation and system need more focus on this area to ensure that demand can be afforded within the funding within the system.

A further risk into the future is the delegation of Specialised Commissioning to ICBs. Due to the Trust’s geography the Trust has material contracts with 3 ICBs and other contracts with several more, and therefore require conversations with each of these, which come with their challenges. Moving Specialised Commissiong budgets to these ICBs as well creates a risk in respect of the amount of funding the Trust is able to secure in respect of growth of demand in its services, and also poses a threat if they look to repatriate services into their own ICBs as part of their own financial sustainability. As a net exporter of services, South Yorkshire ICS in a weaker position in this respect.

The Trust has made good progress this year in the implementation of its financial recovery plan, and there are a number of actions in here that will help deliver strong financial governance in the coming years, contributing to the Trust’s future financial sustainability. However as the Trust continues to have an underlying deficit, it is key this is addressed to ensure its financial sustainability.

| Aggregated Action Plan to address gap in control or assurance | | | | |
|---|---|---|---|---|
| | Action | Lead Exec | Deadline | Progress update |
| **1.1** | Update Five-year Financial Plan.<br><br>*Addresses Control Gap – Five-year financial plan requires updating post Covid-19, reflecting new national funding / contracting arrangements and the establishment of ICBs.* | Chief Finance Officer | **Revised to TBC**<br><br>[Original Oct 2024] | Operational planning guidance was expected in October 2024 but has still not been issued. Therefore it is not considered of best value to develop a five-year plan until this is issued.<br><br>Work has been undertaken on developing the model that will be used to build the five-year plan to ensure it can be progressed quickly once the operational plan for 2025/26 is developed. |
| **3.1** | Develop plans for how to take forward opportunities identified by the Use of Resources Group and engage directorates.<br><br>*Addresses Control Gap – Limited capacity to identify and drive opportunities to deliver efficiency savings.* | CFO | **Revised to TBC**<br><br>~~Dec 24~~<br>~~June 2024~~<br>~~Jan 2024~~<br>(Original Jun 23) | TEG has now agreed on the Booster programme, which will be delivered by Organisational Development, and will be 6-8 programmes of work tackling areas of concern/opportunity at the Trust, which will include Productivity and Efficiency delivery. This will be for clinical programmes of work. Areas of savings more corporate/transactional such as drugs, procurement and estates will continue to be monitored through Use of Resources.<br><br>This was only introduced in October 2024 and therefore further time is required to evaluate its impact, but a plan for taking forward opportunities has been developed and therefore action complete. |

## Tables of Controls and Assurances

| **Controls**<br>**For Cause 1:** Uncertainty around funding / contracting arrangements compromises strategic financial planning<br>[system in place to help manage the cause / effect] | **Assurance / Evidence**<br>[where can we gain evidence that the controls we are placing reliance on are working] | | |
|---|---|---|---|
| | **First Level**<br>[Service delivery and day to day management - how do we know day to day that controls are working?] | **Second Level**<br>[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**<br>[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. | • Chief Finance Officer (CFO) attendance at Integrated Care System (ICS) finance meetings.<br>• CFO attendance at Shelford CFO's Group to understand / influence national architecture and future developments.<br>• CEO and other Directors involved in ICS / NHSE policy agreements and commissioner discussions. | • Regular CFO updates to TEG on development of Financial Plan with discussion on key issues.<br>• Regular financial planning updates taken to Finance and Performance Committee (and Board as required).<br>• Board approval of Financial Plan. | • Submission of financial plan to ICB and NHSE.<br>• External Audit of Annual Accounts and Value for Money Report (including review of financial sustainability, going concern and financial / business planning). |
| • Strategy to maximise all alternative funding streams. | • CFO attendance at ICS finance meetings where ICB funding/allocations are discussed.<br>• Ongoing conversations with NHSE/other ICBs to ensure fair allocation of funding<br>• Commercial Development Group driving other income streams. | • Regular reports to TEG and Board | • Submission of financial plan to ICB and NHSE.<br>• External Audit of Annual Accounts and Value for Money Report (including review of financial sustainability, going concern and financial / business planning). |
| • Financial planning based on validated activity base / predictions for future demand<br>• Robust annual financial plan to underpin the longer-term financial plan, triangulated with workforce and activity. | • Chief Finance Officer leads development of assumptions and financial models. | • Regular CFO updates to TEG on development of Financial Plan with discussion on key issues / Financial plans developed and agreed with TEG prior to submission to Integrated Care Board (ICB). | • Submission of financial plan to ICB and NHSE.<br>• External Audit of Annual Accounts and Value for Money Report (including review of financial sustainability, going concern and financial / business planning). |
| • Robust business planning process to allow prioritisation, and clarity and understanding of cost base enabling support for new funding opportunities/requests. | • Directorate Review meetings co-ordinated by Director of Strategy and Planning.<br>• Processes for review and prioritisation of cost pressures overseen by Chief Finance Officer, working alongside Chief Operating Officer, Chief Strategy Officer and Chief Medical Officer (Operations). | • TEG review of Directorate Business Plans **with outcomes reported to BoD Oct 2024.**<br>• Regular financial planning updates taken to Finance and Performance Committee (and Board as required).<br>• Board approval of Financial Plan. | • Internal Audit – Review of Business Planning (August 2023) – Significant Opinion.<br>• External Audit of Annual Accounts and Value for Money Report (including review of financial sustainability, going concern and financial / business planning). |

| | | | |
|---|---|---|---|
| • Trust five-year Financial Plan and Strategy based on agreed financial assumptions / modelling. | • TEG review of delivery of five-year Financial Plan. | • TEG review of delivery of five-year Financial Plan.<br>• Approval of five-year Financial Plan through Trust-wide governance including Finance and Performance Committee and Board of Directors | • Regulator review and signoff of Trust Financial Plans (as part of system financial plan and process), on which the five-year plan will be based.<br>• Review of HFMA Improving NHS financial sustainability checklist (nationally mandated audit).<br>• Internal Audit – Review of Business Planning (August 2023) – Significant Opinion.<br>• External Audit – Value for Money Assessment (including Financial Sustainability). |
| **Control Lead:** Chief Finance Officer | **Assurance Level: ADEQUATE** | | |

**Gaps in Controls / Assurances**

**Control Gap -** Five-year financial plan requires updating post Covid-19, reflecting new national funding / contracting arrangements and establishment of ICBs.

*Return to Strategic Risk front sheet*

| Controls<br>**For Cause 2:** 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.<br>• Financial Governance structure in place to provide oversight. | • Consideration by TEG via annual Finance Report.<br>• 2023/24 Financial Recovery Plan approved by TEG and overseen by Delivery Group. | • Audit Committee reviews Annual Governance Statement<br>• **Financial Recovery Plan Update (BoD Nov 24)** | • Internal Audit (IA) Reports:<br>– Financial ledger and reporting (Jul 2024) – Significant Assurance.<br>– Procurement (Mar 2022) – Significant Assurance.<br>– Key financial systems: Stock inventory management system (Oct 2023) – Limited Opinion.<br>– Business Case approval (Sept 2023) – Significant Assurance.<br>– Accounts Payable (STH Controls) (Jul 24) – Significant Assurance. Addendum (Jan 25)<br>– Accounts Receivable (Oct 24) – Significant Assurance.<br>• Review of HFMA Improving NHS financial sustainability checklist (nationally mandated audit). |
| • Robust process for forecasting / financial modelling.<br>• Process for identification and monitoring of efficiency savings.<br>• Use of Resources Group (UoR) in place to support delivery of efficiency savings (formerly Making it Better Programme). | • Monitoring delivery of efficiency plans by Finance Team.<br>• Triumvirate / Director level review of Key Performance Indicators (KPIs) on budgetary performance and variance including review of delivery of efficiency plans.<br>• Monthly Finance Reports to TEG. | • Monthly Finance Reports to Finance and Performance Committee.<br>• Quarterly UoR Group Update Reports to Finance and Performance Committee. | • Review of HFMA Improving NHS financial sustainability checklist (nationally mandated audit).<br>• Annual External Audit of Accounts and Value for Money report.<br>• **Efficiency programme internal audit report issued Oct 2024 – limited assurance** |
| • Agreed directorate / department budgets which are monitored monthly via financial systems.<br>• Establishment control (pay budget).<br>• Finance Manager resource in place to support Directorates with financial management.<br>• Performance Management Framework – meetings and escalation processes. | • Monitoring of budgets and reconciliation of accounts by Finance Team.<br>• Triumvirate / Director level review of Key Performance Indicators (KPIs) on budgetary performance and variance including review of delivery of efficiency plans.<br>• Directorate Review meetings. | • Outcome of Directorate Reviews reported to TEG and **Board (Nov 24).**<br>• Monthly financial reports reviewed by TEG and Finance and Performance Committee.<br>• Integrated Performance Report (IPR) reviewed by Board of Directors. | • Annual External Audit of Accounts and Value for Money report.<br>• Internal Audit (IA) Report on Budget setting, reporting and monitoring (Jan 2024) – Significant Opinion<br>• **Efficiency programme internal audit report issued Oct 2024 – limited assurance** |
| • Programme of external audit review of financial management arrangements w/i Internal Audit Plan.<br>• External reporting to NHSE and South Yorkshire Integrated Care Board / System. | • Issues highlighted to TEG as required. | | • Head of Internal Audit Opinion<br>• Annual External Audit of Accounts and Value for Money report.<br>• **Service Line Reporting (FPC Sept 24)**<br>• **National Costs Collection / Reference Costs (FPC Nov 24)** |

| | | | |
|---|---|---|---|
| | | | • **Pay expenditure: central testing (issued Jan 25) – Moderate assurance**<br>• **Pay expenditure (issued Jan 25) – Significant assurance** |
| **Control Lead:** Chief Finance Officer | **ASSURANCE LEVEL: SUBSTANTIAL** | | |

**Gaps in Controls / Assurances**

No Gaps in Controls or Assurance identified

*Return to Strategic Risk front sheet*

| **Controls**<br><br>**For Cause 3:** Failure to deliver the required levels of efficiency savings | **Assurance / Evidence** | | |
|---|---|---|---|
| | **First Level** | **Second Level** | **Third Level** |
| • Agreed Efficiency Programme and process for recording and monitoring of efficiency schemes.<br>• Directorate identification of P&E schemes and delivery of schemes monitored.<br>• Performance Management Framework – meetings and escalation processes.<br>• P&E Policy approved and in place. | • Review Directorate Efficiency Plans as part of annual Financial / Business Planning process.<br>• Monitoring delivery of efficiency plans by Finance Team.<br>• Triumvirate / Director level review of Key Performance Indicators (KPIs) on budgetary performance and variance including review of delivery of efficiency plans. | • Monthly financial reports reviewed by TEG and Finance and Performance Committee.<br>• Integrated Performance Report (IPR) reviewed by Board of Directors.<br>• Outcome of Directorate Reviews reported to TEG / **BoD (Nov 24).** | • **Efficiency programme internal audit report issued Oct 2024 – limited assurance**<br>• Review of HFMA Improving NHS financial sustainability checklist (nationally mandated audit).<br>• Annual external audit of Accounts and Value for Money report. |
| • Use of Resources Group in place to drive productivity and efficiency alongside general consideration of how well the Trust uses its resources. | • Oversight of individual Use of Resources Workstreams by nominated SRO.<br>• Development of PROUD improvement, to promote improvement mindset at the Trust, which includes improvements in spending public money wisely.<br>• Development of the Booster programme within PROUD improvement to include a focus on productivity and efficiency. | • Regular reports on Use of Resources (UoR) Group progress to Finance and Performance Committee.<br>• Paper to TEG (6 Sept 2023) summarising progress made by the Use of Resources Group in quantifying targets for delivery of opportunities within 2023/24. | • Review of HFMA Improving NHS financial sustainability checklist (nationally mandated audit).<br>• Annual external audit of Accounts and Value for Money report.<br>• **Efficiency programme internal audit report issued Oct 2024 – limited assurance** |
| **Control Lead:** Chief Finance Officer | **ASSURANCE LEVEL: LIMITED** | | |

**Gaps in Controls / Assurances**

**Control Gap** – Limited capacity to identify and drive opportunities to deliver efficiency savings

*Return to Strategic Risk front sheet*

<table>
<tr><th rowspan="2">Controls<br><br>**For Cause 4**: Fail to ensure adequate capital funding and manage competing priorities for capital funding</th><th colspan="3">Assurance / Evidence</th></tr>
<tr><th>First Level</th><th>Second Level</th><th>Third Level</th></tr>
<tr><td>• Capital is part of the annual Business Planning process / Directorate Business Plans include identification of capital requirements.<br>• Capital Plan / cost pressures listing ensures capital investment considers critical infrastructure risks.<br>• Annual Business Planning Process to allow for funding to manage Estates / IM&T / Equipment related operational risks.</td><td>• Business planning process led by Director of Strategy and Planning with contributions from TEG members.<br>• Directorate Business Plans drafted by Directorate Triumvirate and reviewed by Executive Lead.</td><td>• Capital plans discussed and agreed at TEG.<br>• Directorate Business Plans monitored by Directorate Reviews and output reviewed by TEG / **reported to BoD (Nov 24).**<br>• Strategies (Estates and IM&T) agreed by Board.</td><td>• Internal Audit - Capital Planning (July 2022) – Significant Opinion<br>• Internal Audit – Review of Business Planning (August 2023) – Significant Opinion</td></tr>
<tr><td>• Trust representation within system-wide capital allocation processes led by Chief Finance Officer.</td><td>• Issues highlighted to TEG as required.</td><td>• Issues noted in Quarterly Update Reports submitted to the Board via TEG.</td><td></td></tr>
<tr><td>• Internal Trust processes for setting Trust revenue and capital investment with defined and agreed budgets.<br>• Capital Investment Team (CIT) in place to determine priorities (within delegated limits) and manage the Capital Programme and planning processes.</td><td>• CIT minutes submitted to TEG and MBB.</td><td>• Capital plans discussed and agreed at TEG.<br>• Quarterly Update Reports submitted to the Board via TEG.<br>• Capital Programme / Plan approved by Board.<br>• **Update on Five Yr Capital Plan and Programme presented to BoD (Nov 24).**</td><td>• Internal and External Audit oversight as appropriate.<br>• Internal Audit Report on Business Case approval (Sept 2023) – Significant Assurance</td></tr>
<tr><td>• Project management / governance arrangements include project risk identification / escalation to ensure existing projects run to time / budget.<br>• Specific Groups to manage key areas, i.e. Estates Capital Management Group, Technology Planning Group (TPG) / TBCAT (Technology), Medical Devices Management Group and Major Medical Equipment Group.</td><td>• Project management reporting to individual project / programme boards.<br>• Project management arrangements monitor delivery of capital plans against agreed budgets and escalate risks.<br>• Regular reports to CIT.</td><td>• Capital Investment Committee monitors delivery of capital programme / CIT minutes submitted to TEG.</td><td>• Internal Audit - Capital Planning (July 2022) – Significant Opinion</td></tr>
<tr><td>**Control Lead:** Chief Finance Officer</td><td colspan="3">**Assurance Level: ADEQUATE**</td></tr>
<tr><td colspan="2">**Gaps in Controls / Assurances**</td><td colspan="2">**Actions to address gaps in controls / assurance**</td></tr>
<tr><td colspan="2"></td><td colspan="2"></td></tr>
</table>

Return to Strategic Risk front sheet

# Strategic Risk 5: DIGITAL

Fail to deliver the digital capability required to support safe, effective and efficient patient care

| Aggregated Assurance Rating | LIMITED |
|---|---|

## Key Causes

| | Key Causes | Assurance Rating |
|---|---|---|
| C1 | Ineffective delivery plans for Electronic Patient Records | Limited |
| C2 | Failure to maintain effective cyber security | Adequate |
| C3 | Ineffective maintenance and modernisation of the information technology infrastructure | Adequate |

## Key Effects / Consequences (Results in)

- Operational problems causing detriment to patient care and impacting on patient safety
- Failure to deliver seamless cross-region clinical work
- Catastrophic loss of access to key clinical systems / delivery of services and patient care compromised
- Poor staff experience

| Accountabilities / Review History | |
|---|---|
| **Strategic Risk Owner:** | Chief Medical Officer (Development) |
| **Board oversight forum:** | Digital Committee |
| **Last deep dive review held:** | 15 July 2024 |
| **Date of last update:** | January 2025 |

| Risk Analysis | Jan 2025 | Sept 2024 | May 2024 | Jan 2024 |
|---|---|---|---|---|
| **Current Risk Score:** (C) x (L) | (4) x (3) = **12** | (4) x (3) = **12** | (4) x (3) = **12** | (4) x (3) = **12** |
| **Target Risk Score:** (C) x (L) / Target date Apr 25 | (4) x (2) = **8** | (4) x (2) = **8** | (4) x (2) = **8** | (4) x (2) = **8** |
| **Risk Appetite:** | SEEK | - | - | - |
| **In / Out of Appetite:** | IN APPETITE | - | - | - |

## Operational risk oversight informed by Risk Appetite

| AVOID | MINIMAL | CAUTIOUS | OPEN | SEEK | *Risk Tolerance 20* |
|---|---|---|---|---|---|

In updating its Risk Appetite Statement in November 2024 the Board of Directors has defined a **SEEK** Risk Appetite for risks relating to Digital and an agreed risk tolerance score of 20. However, as part of the risk appetite statement, there is zero tolerance for increasing our exposure to breaches in cyber security.

There are currently no open Operational Risks aligned to this Strategic Risk with a current risk score of 20 or more, however there is a risk relating to cyber security. This is currently scored at 15, with a target risk of 12. Revised reporting arrangements are being introduced to the new Digital, Data and Technology Executive Committee which will support Board oversight of these Operational Risks.

***Please refer to the Corporate Risk Register Report***

## Strategic Risk Owner Commentary

1. The Digital, Data and Technology (DDaT) Executive Committee will meet for the first time on 8 January 2024. The DDaT Executive Committee will oversee delivery against the STH DDaT Strategy, as well as reviewing and proposing an updated strategy.
2. As we approached the 14 October 2024, the intended go-live date for the Connect EPR, a decision was taken by the Board of Directors that we should give ourselves more time to ensure that the risks associated with introducing the Connect EPR were fully mitigated.
3. A replan proposal with a revised go-live date of 14 July 2024 was discussed at an Extraordinary Meeting of TEG on Friday 20 December 2024 and a revised proposal will be presented to STH BoD at an Extraordinary Meeting on Friday 17 January 2024.
4. Specific attention is being given to the organisational changes that are required to ensure a safe go-live and delivery of the full range of benefits described in the Full Business Case.
5. External review commissioned by the ICS, carried out by ANS, but final report still not agreed pending meeting with ANS Director.
6. A Cyber Security review will be commissioned directly by the Trust.
7. Limited assurance IT BC audit. Recent 360 audit highlighted gaps in IT Business Continuity procedures, which are being address with EPRR and actions are on target to be completed as per management response to the Audit.

**Aggregated Action Plan to address gap in control or assurance**

| | Action | Lead Exec | Deadline | Progress update |
|---|---|---|---|---|
| **1.1** | Develop and embed oversight / governance arrangements for delivery of the Digital, Data and Technology (DDaT) Strategy including establishment of an Executive Committee and delivery of a DDaT update summary to the new Digital Committee.<br><br>*Addresses potential Control and Assurance Gap: DDAT Executive Committee to meet quarterly / provide DDAT update summary to Digital Committee.* | Chief Medical Officer (Dev) | Revised to February 2025<br><br>(original 31 May 2024) | DDaT Exec Committee to meet on 8 January 2025. The Committee will begin work to review progress against the strategy taking into account the deferred Connect EPR go-live. |
| **1.2** | Operationalise TEG sponsorship to move forward with resourcing and review.<br><br>*Addresses potential Control and Assurance Gap: TBC* | Chief Medical Officer (Dev) | Date tbc | |
| **2.1** | Recommendations regarding need for additional external assurance on cyber security arrangements to be presented to Digital Committee following discussion on potential for ICS-wide external review through the ICS Delivery Board.<br><br>*Addresses gap in assurance: Scope for additional independent audit of cyber security risk discussion at Digital Committee held 2 October 2023.* | Chief Medical Officer (Dev) | **Revised to X 2025**<br><br>(Original Sept 2024) | ICS commissioned review by ANS is not yet complete and a first draft inaccurate. Meeting planned to ensure report is accurate. |

## Tables of Controls and Assurances

| Controls<br>**For Cause 1:** Ineffective delivery plans for Electronic Patient Records<br>[system in place to help manage the cause / effect] | Assurance / Evidence<br>[where can we gain evidence that the controls we are placing reliance on are working] | | |
|---|---|---|---|
| | **First Level**<br>[Service delivery and day to day management - how do we know day to day that controls are working?] | **Second Level**<br>[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**<br>[Independent challenge – has anyone external come in to check that the controls are working] |
| • Digital, Data and Technology Strategy in place. | | • **Reporting into newly established (Jan 25) Digital, Data and Technology Executive Committee which provides assurance to Digital Committee.** | |
| • Connect Programme Board with significant Trust Board representation oversees the Connect Programme including STH EPR (STH Connect2024) and SYB Laboratory Information Management System (SYB LIMS). | • Digital and Informatics Teams manage delivery of programme based on good practice project methodology, i.e. Prince2 and Managing Successful Programmes (MSP).<br>• Digital and Informatics team working to a 'countdown plan' that encompasses the critical path. | • Connect Programme Steering Groups provide day-today oversight of the STH Connect2024 and SYB LIMS phases of the Programme.<br>• **Connect EPR replan proposal establishes a Programme Delivery Leadership Group as a replacement for the Connect EPR Steering Group.**<br>• Digital Committee established as a formal Committee of the Board overseeing Connect Programme (STH Connect2024 and SYB LIMS) through Programme Summary Report and receipt **of Connect Programme Board Minutes.**<br>• SYB Pathology Network Board receive updates on the progress of the SYB LIMS phase. | • Independent Advisors – Cloud21 supporting the delivery of the Connect Programme.<br>• A Programme Assurance Review of the first phase of the Connect Programme that will deliver the Connect completed by Cloud21, with action plan developed in response.<br>• Digital System Support. Frontline Digital Programme Stage 4.5 Assurance Review. Interim report received and final Stage 4.5 report due 16 September<br>• Internal Audit Advisory Report (Mar 24) EPR Staff Engagement. To assess the existing and planned arrangements for staff engagement since agreement of the Full Business Case. One medium risk action agreed.<br>• **NHSE engagement / oversight via Director of Digital Systems Support fortnightly catch-ups / agreed revised Stage 4.5 Assurance approach.** |

| | | | |
|---|---|---|---|
| Contract management arrangements in place [contract signed for fully functional Electronic Patient Record (EPR) with clear milestones for delivery; Change Control Notice signed to establish similar for SYB LIMS with phased delivery in 2025/26].<br>• **Oracle Health proposal to support replan has been provided as a formal quotation that will be included in the fully costed replan proposal to STH BoD. If approved, this will be incorporated into the contract via a further CCN.**<br>• **Contractual arrangements with third parties to support the replan will also be put in place.**<br>• **Specialist legal advice available to support specific issues with all suppliers as required.** | • Business as usual contract management with procurement and IT contract manager leading. | • Response to escalation reported to Digital Committee within programme update report (most recent 2 Oct 2023). Any commercial aspects requiring escalation will continue to be reported to Digital Committee as appropriate. | • Previously scrutinised and signed off by NHSE. NHSE continue to monitor (Frontline Digitisation team**).** |
| • Identification of key risk areas based on lessons learned review exercise.<br>• **Optimisation of NHSE Frontline Digitisation support (access to library of support material as well as direct support offer via regular meetings).** | • Day-to-day communication with other Oracle Health EPR trusts and lessons shared within the leadership team.<br>• Cloud21 provide insights and guidance based on experience elsewhere. | • Action plan in response to programme assurance review which includes lessons learned and incorporated into risks identified and the resulting action plan.<br>• **Connect EPR replan proposal incorporating all lessons learnt so far / application to LIMS phase of programme as appropriate.** | • Part of NHSE Frontline Digitisation team assurance. |
| **Control Lead:** Chief Medical Officer (Development) | | | **Assurance Level: LIMITED** |

**Gaps in Controls / Assurances**

Potential gap in **Control and Assurance** – DDAT Executive Committee to meet quarterly / provide DDAT update summary to Digital Committee.

*Return to Strategic Risk front sheet*

**Version Control:** January 2025 update

| Controls<br>**For Cause 2:** Failure to maintain effective cyber security | Assurance / Evidence | | |
|---|---|---|---|
| | **First Level** | **Second Level** | **Third Level** |
| • Delivery of key Information Governance / cyber workstreams by resourced Informatics Directorate, including Backup Security and Network Infrastructure.<br>• Subscription to the NCSC Active Cyber Defence program for services such as Early Warning Service, threat-notification service, Web Check, websites monitoring, Protective DNS (PDNS) designed to stop malware distribution and protect users from unsafe sites and Vulnerability Management Service (VMS), provided by NHS England, to scan / report on external infrastructure. | • Cyber Security Group meets monthly and feeds into Information to DDAT Executive Committee quarterly. Reviews Cyber Risk Rating on Datix<br>• Monthly ICS meetings held with cyber leads from each SYB Trust and NHSE regional cyber lead in attendance to share information/ guidance, feedback to NHSE, pickup issues raised by NHSE | • Quarterly Cyber Security update including progress on remediation of vulnerabilities, risks and incidents / alerts during the last three months presented to Digital Committee (most recent Oct 2023).<br>• IG Group reporting into Quality Committee / TEG.<br>• DDAT Executive Committee reporting into Digital Committee.<br>• Annual Trust Board Update. | • Cyber Security Audits by NHS Digital / Internal Audit including Data Security and Protection Toolkit (DPST) published in Jun 24 (Substantial Assurance / High Confidence)<br>• **Latest DSPT (Submission June 2025) includes alignment with Cyber Assessment Framework and hence has more of a cyber focus with a number of the CAF standards required to be met, with NHSE requiring IA audit of key standards.**<br>• Regular penetration testing and cyber security testing arranged with external expertise.<br>• NHSE Vulnerability Management Service monthly reporting. |
| • Top three cyber risks identified and risk assessed and reviewed regularly. | • Top three risks discussed at the IT Security Group for approval by Cyber Security Group. | • Focus on IT / Informatics Risk Management through focus on MD Directorate's risks as part of cycle of deep dives at Risk Management Executive Committee.<br>• Extreme Risks reported through Corporate Risk Register Report. | • Reviewed as part of DPST Audit. |
| • Delivery of programme of Trust-wide Cyber Training. | • Directorate mandatory training reports. | • Mandatory Training reporting to TEG and Management Board. | • Data Security and Protection Toolkit (DPST) published in Jun 24. |
| • Policy framework in place for the reporting and management of breaches in information security, including Incident Management Policy, Procedure for the management of Data Security and Protection Incidents and Major Incident Plan. | • Incident reporting / management within directorates | • Information Governance reporting to Quality Committee<br>• Annual Governance Statement – data loss / confidentiality breaches reported within Annual Governance Statement. | • Reporting to Health and Social Care Information Centre, Department of Health and Information Commissioner's Office. |
| **Control Lead:** Medical Director (Development) | **Assurance Level: ADEQUATE** | | |
| **Gaps in Controls / Assurances** | | | |
| **Gap in Assurance** – Scope for additional independent audit of cyber security risk discussion at Digital Committee held 2 October 2023. | | | |

Return to Strategic Risk front sheet

| Controls<br>**For Cause 3:** Ineffective maintenance and modernisation of the information technology infrastructure | Assurance / Evidence | | |
|---|---|---|---|
| | **First Level** | **Second Level** | **Third Level** |
| • Digital, Data and Technology Strategy includes detailed plan around enabling infrastructure. | • TBCAT annually reviews technology schemes for inclusion in Technology Ring-Fenced Plan including requirement for alignment to/ support of Digital Strategy. This will be reviewed by DDAT Executive Committee and supported for approval by CIT. | • Digital Strategy 2022-2025 approved by the Board of Directors.<br>• Progress on all funded IT/ Digital schemes are monitored by Technology Business Case Assurance Team (TBCAT) / Capital Investment Team (CIT).<br>• Informatics Delivery reports to DDAT Committee on a quarterly basis.<br>• Digital, Data and Technology Strategy into Action Progress reported to Digital Committee (most recent Nov 23). | • Internal Audit Programme delivery.<br>• NHSE What Good Looks Like (WGLL) framework assessments. |
| • DDAT Executive Committee in place (replacement for Technology Planning Group). | • DDAT Executive Committee, reviews annual investment priorities for Technology Ring-Fenced plan, CIT makes final approval. | • 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. | |
| • Informatics has a monthly Risk Governance meeting chaired by Director. | • Significant DDAT Risks monitored by Directorate Governance meeting chaired by Medical Director (Development).<br>• Informatics Risk Group meets monthly to discuss and update all Informatics risks all due for review. Chaired by Informatics Director. | • Focus on IT / Informatics Risk Management through focus on MD Directorate's risks as part of cycle of deep dives at Risk Management Executive Committee.<br>• Extreme Risks reported through Corporate Risk Register Report. | • Audit of Risk management processes within Informatics. |
| • Digital Committee is established as a formal subcommittee of the Board overseeing all digital projects including key infrastructure developments. | • Digital Committee has met several times, has an established meeting pattern and associated workplan. | • Board approved Terms of Reference for Digital Committee.<br>• Meeting Assurance Report submitted to the Board of Directors held in public. | |
| **Control Lead:** Medical Director (Development) | **Assurance Level: ADEQUATE** | | |
| **Gaps in Controls / Assurances** | | | |
| No gaps in Control or Assurance identified | | | |

Return to Strategic Risk front sheet

# Strategic Risk 6: SUSTAINABLE HEALTHCARE THROUGH PARTNERSHIP WORKING

Fail to deliver sustainable healthcare, to be an effective partner in our Integrated Care System and the wider healthcare system in England

| Aggregated Assurance Rating | ADEQUATE |
|---|---|

## Key Causes

| | | Assurance Rating |
|---|---|---|
| C1 | Inability to effectively influence / manage the impact of conflicting priorities amongst system partners, system financial plan misalignment and/or ineffective governance | Adequate |
| C2 | The Trust's strategies and plans don't anticipate evolving healthcare needs of the local population and/or deliver reductions in health inequalities | Limited |
| C3 | Failure to deliver actions set out in our Sustainability Plan, to embed sustainability and to engage key stakeholders in the process | Adequate |

## Key Effects / Consequences (Results in)

- Poor stakeholder relationships / Trust not seen as a partner of choice
- Limited impact on reducing health inequalities and population health
- Increased costs / unrealised efficiencies in service delivery changes
- Unable to reduce the Trust's impact of climate change on our services and communities

| Accountabilities / Review History | |
|---|---|
| **Strategic Risk Owner:** | Chief Strategy Officer |
| **Board oversight forum:** | Board of Directors |
| **Last deep dive review held:** | **29 October 2024** |
| **Date of last update:** | For January 2025 |

| Risk Analysis | Jan 2025 | Sept 2024 | May 2024 | Jan 2024 |
|---|---|---|---|---|
| **Current Risk Score:** (C) x (L) | (3) x (3) = **9** | (3) x (3) = **9** | (3) x (3) = **9** | (3) x (3) = **9** |
| **Target Risk Score:** (C) x (L) / Target date Mar 25 | (3) x (2) = **6** | (3) x (2) = **6** | (3) x (2) = **6** | (3) x (2) = **6** |
| **Risk Appetite:** | **OPEN** | - | - | - |
| **In / Out of Appetite:** | **IN APPETITE** | - | - | - |

## Operational risk oversight informed by Risk Appetite

| AVOID | MINIMAL | CAUTIOUS | OPEN | SEEK | *Risk Tolerance 15* |
|---|---|---|---|---|---|

In updating its Risk Appetite Statement in November 2024 the Board of Directors has defined an **OPEN** Risk Appetite for risks relating to Sustainable Healthcare and Working in Partnership and an agreed risk tolerance score of 15.

At 7 January 2025 there were two operational Risks aligned to this Strategic Risk with a current risk score of 15 or more. Revised risk reporting arrangements are being introduced to support Board oversight of these Operational Risks.

***Please refer to the Corporate Risk Register Report***

## Strategic Risk Owner Commentary

In recent months, there have been significant developments in the national policy context, with the publication of the independent review into the performance of the NHS by Lord Darzi (published September 2024), the Reforming Elective Care plan (published January 2024), and anticipated changes being trailed for the upcoming 2025/26 Planning Guidance and the Spring Spending Review. We continue to work closely with our system partners to anticipate, understand and respond to these developments. We have confirmed executive to executive governance arrangements for the 2025/26 planning process with system partners, in order to ensure we have appropriate oversight of what is likely to be a challenging timeline for developing an operational and financial plan, as well as difficult decisions to be made to reach a system financial plan.

The development of a refreshed Sustainability Plan continues to progress, including through collaboration with the ICB and other partners in our local system. We continue to wait for national planning guidance and expectations to inform this Plan. We are exploring research funding opportunities with local university partners to support in the delivery of this Plan.

We anticipate that a key focus of the next Sustainability Plan will be how we prepare and adapt to changing environmental conditions caused by climate change, in particular more frequent periods of high temperatures and increased risk of flooding. We have seen this year that periods of sustained high temperatures create risks for maintaining normal operational service, such as challenges or inability to operate within very high temperatures and risks to safely storing temperature-controlled drugs. This has led to capital requests for air conditioning and cooling interventions. We intend to increase oversight through the Sustainability Delivery Group of the operational risks raised related to adaptation and environmental change. In light of these risks, we recommend adding a new cause statement to the BAF under this strategic risk of 'Inability to maintain service provision due to failure to adapt to changing environmental conditions caused by climate change'.

## Aggregated Action Plan to address <u>gap</u> in control or assurance

| Action | | Lead Exec | Deadline | Progress update |
|---|---|---|---|---|
| 1.2 | Develop 360-degree feedback from partners about our approach to partnership working.<br>*Addresses gap in Assurance - Assurance from partners about how well we are working in partnership* | Chief Strategy Officer | Revised to **Mar 2025**<br>~~June 2024~~<br>~~April 2024~~<br>(Original April 2023) | The development of the 360-feedback process is in development, in line with the deadline for this action. |
| 2.2 | Develop a workplan in response to the national planning guidance in relation to health inequalities including the Core20PLUS5 framework.<br>*Addresses gap in Control - Limited methodical wider understanding of population health.* | Chief Strategy Officer | Revised to **Mar 2025**<br>~~Dec 2024~~<br>~~Oct 2024~~<br>~~January 2024~~<br>(Original Dec 2023) | A terms of reference for the Health Inequalities Delivery Group to oversee this work have been agreed. Timeline has been revised to March 2025, which will enable responsiveness to the latest national planning guidance, expected to be published in January 2025. |
| 2.3 | Ensure population health needs inform the clinical blueprint in development.<br>*Addresses gap in Control - Further work on embedding and using data and intelligence about inequalities and the population we serve.* | Chief Strategy Officer | March 2025 | We are working with the public health team at Sheffield City Council. They are providing regular advice on the development of the clinical blueprint, including with plans to engage in the development workshops for the clinical blueprint. They are also producing an up-to-date analysis of multi-morbidity and population health for Sheffield to help inform this work.<br>We are also using national data on population health, including the technical analysis developed as part of the Independent Investigation of the NHS in England, to inform the development of the clinical blueprint through discussion with clinical and operational leads. |
| 3.7 | Sustainability Plan to be refreshed for 2025, when current plan concludes, and to incorporate lessons from first Plan in the refreshed Plan to accelerate progress towards sustainability ambitions.<br>*Addresses gap in Control: Sustainability Plan is our first version of this – further work needed to ensure its relevancy and sufficiency.* | Chief Strategy Officer | **Oct** 2025 | The Sustainability Plan is in development and is updated on as a regular agenda item at the Sustainability Delivery Group to ensure there is a breadth of insight and expertise informing the strategy development. A recent Board strategy session shared a high-level update on direction of travel and sought the input of Board Directors at an early stage in the development of the refreshed plan. Engagement with the ICS level Sustainability Plan development continues, led by the Head of Sustainability. NHS England guidance on sustainability plan is still awaited, and will be used to inform further development when available. |

| | | | | |
|---|---|---|---|---|
| 3.8 | Work with partners on sustainability plan development and delivery to help bolster available resource and expertise.<br>*Addresses gap in Control: Limited resource in place to undertake activity to drive forward.* | Chief Strategy Officer | March 2025 | The University of Sheffield has been invited to collaborate in the Plan development through the Sustainability Delivery Group, and areas of opportunity for collaboration have been shared with the University for consideration. We are proposing to host at least one masters student from The University of Sheffield to support with projects related to the development and delivery of our sustainability plan.<br>The financial challenges facing the university sector nationally as well as locally pose some risks to the capacity of university partners to support this work. |

## Tables of Controls and Assurances

<table>
<tr><td rowspan="2">Controls<br>For Cause 1: Inability to effectively influence / manage the impact of conflicting priorities amongst system partners, system financial plan misalignment and/or ineffective governance<br>[system in place to help manage the cause / effect]</td><td colspan="3">Assurance / Evidence<br>[where can we gain evidence that the controls we are placing reliance on are working]</td></tr>
<tr><td>First Level<br>[Service delivery and day to day management - how do we know day to day that controls are working?]</td><td>Second Level<br>[Oversight – who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]</td><td>Third Level<br>[Independent challenge – has anyone external come in to check that the controls are working]</td></tr>
<tr><td>• Stakeholder map in place.<br>• Trust Executive participation in key Integrated Care Board (ICB), Acute Federation (AF) and Place partnership governance.<br>• Clinical engagement networks established.<br>• Regular Chief Executives' meeting with other Sheffield anchor organisations.<br>• Mechanisms in place for regular informal dialogue with partners.</td><td>• Attendees at system wide meetings.<br>• Updates at each TEG about meetings and discussions with partners.<br>• Regular scheduled meetings with local MPs, and other key stakeholders.</td><td>• Individual feedback from attendees at system meetings to TEG and Board through Chair and Chief Executive's reports.</td><td>• Healthcare Governance Review undertaken by external consultancy presented to Board of Directors (June 2022).<br>• CQC Inspection Report (April 2022).<br>• Developmental well-led review included focussed discussions with partners (Dec 2022). Broadly positive RAG rating for Engagement KLOE - Amber</td></tr>
<tr><td>Control Lead: Chief Strategy Officer</td><td colspan="3">Assurance Level: ADEQUATE</td></tr>
<tr><td colspan="4">Actions to address gaps in controls / assurance</td></tr>
<tr><td colspan="4">Gap in Assurance – Assurance from partners about how well we are working in partnership</td></tr>
</table>

*Return to Strategic Risk front sheet*

| **Controls**<br>**For Cause 2:** *The Trust's strategies and plans don't anticipate evolving healthcare needs of the local population and/or deliver reductions in health inequalities* | **Assurance / Evidence** | | |
|---|---|---|---|
| | **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. | • Business planning proposals indicate understanding of the communities we serve and how proposals will support. | | |
| • New dashboard for inequalities in place and reviewed by Equality, Diversity and Inclusion (EDI) Board. | • Equalities Dashboard reviewed by Equality, Diversity and Inclusion (EDI) Board and added to Performance Management Framework (PMF) packs. | | • Emergency Care Improvement Support Team (ECIST) data on health inequalities shared and reviewed by Information Services. |
| • Corporate Strategy in place with annual corporate objectives. | | • Half yearly progress on corporate objectives via reports to the Board of Directors | |
| • Quality Strategy in development, including work on patient engagement and involvement.<br>• Supporting strategies in place. | | | |
| **Control Lead:** Chief Strategy Officer | **Assurance Level: LIMITED** | | |

**Gaps in Controls / Assurances**

Gaps in Control:

- Limited methodical wider understanding of population health.
- Further work on embedding and using data and intelligence about inequalities and the population we serve.

*Return to Strategic Risk front sheet*

| Controls<br>**For Cause 3:** *Failure to deliver actions set out in our Sustainability Plan, to embed sustainability and to engage key stakeholders in the process* | Assurance / Evidence<br>First Level | <br>Second Level | <br>Third Level |
|---|---|---|---|
| • Head of Sustainability in place providing leadership, capacity and coordination.<br>• Sustainability Delivery Group established to provide oversight of delivery of plans<br>• Sustainability Plan in place with identified refreshed priorities for a three-year period.<br>• Board performance metrics identified.<br>• Initial baseline carbon analysis completed.<br>• SusQI included in Trust's improvement methodology | • Sustainability Delivery Plan and monthly meetings of the Sustainability Delivery Group.<br>• Rolling programme of review of carbon accounting by Head of Sustainability. | • Board Integrated Performance Report.<br>• Sustainability Report to Risk Management Committee<br>• Sustainability Delivery Group action log.<br>• Terms of reference for the Sustainability Delivery Group.<br>• Monthly review of Communication and Engagement Log by the Sustainability Delivery Group. | • Integrated Care Board (ICB) review of Sustainability Plan and priorities.<br>• Sustainability Plan return submitted to Integrated Care System (ICS)<br>• Internal Audit Report on Sustainability Plans issued Mar 23 and presented to Audit Committee – Significant Opinion. |
| **Control Lead**: Chief Strategy Officer | | | **Assurance Level: ADEQUATE** |

**Gaps in Controls / Assurances**

Gaps in Control

- Limited resource in place to undertake activity to drive forward.
- Sustainability Plan is our first version of this – further work needed to ensure its relevance and sufficiency

*Return to Strategic Risk front sheet*

# Strategic Risk 7: RESEARCH AND INNOVATION

Fail to ensure the Trust has the ability to deliver excellent research 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 innovation | Limited |

**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

| Accountabilities / Review History | |
|---|---|
| **Strategic Risk Owner:** | Chief People Officer |
| **Board oversight forum:** | People Committee |
| **Last deep dive review held:** | **9 December 2024** |
| **Date of last update:** | January 2025 |

| Risk Analysis | Jan 2025 | Sept 2024 | May 2024 | Jan 2024 |
|---|---|---|---|---|
| **Current Risk Score:** (C) x (L) | (4) x (3) = **12** | (4) x (3) = **12** | (4) x (3) = **12** | (4) x (3) = **12** |
| **Target Risk Score:** (C) x (L) / **Target date now July 25** | (4) x (3) = **9** | (4) x (3) = **9** | (4) x (3) = **9** | (4) x (3) = **9** |
| **Risk Appetite:** | **SEEK** | - | - | - |
| **In / Out of Appetite:** | **IN APPETITE** | - | - | - |

## Operational risk oversight informed by Risk Appetite

| AVOID | MINIMAL | CAUTIOUS | OPEN | SEEK | *Risk Tolerance 20* |
|---|---|---|---|---|---|

In updating its Risk Appetite Statement in November 2024 the Board of Directors has defined a **SEEK** Risk Appetite for risks relating to Research and Innovation and an agreed risk tolerance score of 20.

There are currently no Operational Risks aligned to this Strategic Risk with a current risk score of 20 or more. Revised reporting arrangements are being introduced to support Board oversight of any Operational Risks with a score at or above the Board's agreed risk tolerance.

## Strategic Risk Owner Commentary

Despite good progress implementing the action plan and improvements in governance and control as summarised significant improvement in research performance is unlikely to become evident until later in the year. Difficulty expanding pharmacy research capacity remains a major barrier.

**Research and Innovation Strategy:** To support the delivery of the Trust Research and Innovation (R&I) Strategy, a comprehensive implementation plan has been developed and approved by TEG, Research Executive, Innovation Executive and Research and Innovation Committee in October 24 with an action log designed to ensure actions are monitored was approved December 24.

**360 Assurance Report: Directorate Research – Planning and Performance:** The independent audit committee provided limited assurance and highlighted areas for improvement in the framework of governance, risk management and control and some inconsistent application of controls puts the achievement of the organisation's objectives at risk. The review identified 5 medium level risks and made 5 recommendations aimed at strengthening the Trust arrangements for R&I planning and oversight/ management of its performance:

- **Governance:** Governance arrangements should be strengthened both for the Research Executive leads Committee and within directorates to support clearer oversight and accountability for directorate research.
- **Control:** Annual planning should be based on research actions plans linked to performance metrics.

Four individuals (Wendy Baird, Dipak Patel, Simon Heller and Julie Patchett) are responsible for delivering the eight agreed actions to address the five findings. The findings and actions agreed align with the existing research and implementation plan; delivery against these actions will be monitored by the Research and Innovation Committee using the implementation plan action log.

**Pharmacy:** Two rounds (Aug and Nov 24) of the new clinical trials prioritisation process approved at TEG in April 2024 have been completed. The process has encouraged Directorates to prioritise high quality, strategically relevant research. The review of the full pipeline of clinical trials has facilitated the removal of

projects from the backlog that did not meet the criteria set out in the prioritisation process. Despite additional investment from the Trust, Pharmacy has not been able to increase capacity due to lack of suitable applicants for vacant positions therefore it is proposed that the six month pilot of the prioritisation continues.

**CCTC:** A report outlining a recovery plan was submitted to TEG 6 Nov 24. Support to CCTC reduce the financial deficit is ongoing, with additional input from HR. Work is to determine workforce demand capacity, will be completed by end January 25 and will inform the future staffing structure to include recommendations for CCTC staff currently holding a University of Sheffield contract.

**To note:** From October 2024 the NIHR Clinical Research Network (CRN) was renamed the NIHR Research Delivery Network (RDN) and the NIHR CRN YH has been renamed the NIHR Regional Research Delivery Network (RRDN) which has been updated throughout the document.

**Aggregated Action Plan to address gap in control or assurance**

| | Action | Lead Exec | Deadline | Progress update |
|---|---|---|---|---|
| 1.1(b) | Develop and agree with the Board of Directors a Research and Innovation Strategy implementation plan.<br><br>*Addresses Control Gap - Research and Innovation Strategy implementation plan required.* | Chief Medical Officer (Dev) | December 2024 | ACTION COMPLETE<br>The R&I Implementation Plan was submitted and approved at the October 2024 R&I Committee. |
| 1.2 | Develop and agree organisational research and innovation KPIs and associated metrics.<br><br>*Addresses Assurance Gap – Need for Research and innovation key performance indicators.* | Chief Medical Officer (Dev) | Revised to Nov 24<br>(Original May 24) | ACTION COMPLETE<br>A set of key metrics and KPIs to monitor performance against the R&I Implementation plan were approved at the 16 December 2024 R&I Committee. The KPIs and metrics are aligned with the actions of the 360 Assurance Directorate Governance – Planning and Performance. |
| 1.3 | **NEW** - Strengthen governance arrangements for the Research & Innovation Leads Committee. Also, within directorates to support clearer oversight and accountability for directorate research.<br><br>*Addresses Control Gap - Need to strengthen directorate accountability for research.* | Chief Medical Officer (Dev) | December 2025 | 360 Assurance Report (18 Nov 2024) has been shared with the Research Executive Committee and R&I Committee on 10 and 16 Dec 2024 respectively. Required actions will be taken forward and are aligned with the Implementation plan. |

| | | | | |
|---|---|---|---|---|
| 1.4 | **NEW** - Include Research and Innovation in Directorate Annual Business Planning<br><br>*Addresses Control Gap - Need to strengthen directorate accountability for research.* | Chief Medical Officer (Dev) | March 25 | Feedback has been provided to Phase I of Directorate Business Planning. Directorates will be supported to develop proportional and relevant targets aligned to R&I activity in Phase II of Business Planning. Directorates have been encouraged to include R&I Leads in developing the R&I section of their Business Plans. |
| 3.1 | Report on performance of CRF, BRC, CCTC and CRIO to STH Research Executive Committee and of the HRC to STH Innovation Executive Committee.<br><br>*Addresses Control Gap – Need to Strengthen operational oversight of all Trust infrastructures and facilities (CRF, BRC, HRC, CCTC and CRIO) in place to support delivery of research and innovation.* | Chief Medical Officer (Dev) | December 24 | ACTION COMPLETE<br>A form has been developed to facilitate reporting on performance of the CRF, BRC, CCTC and CRIO to STH Research Executive Committee and of the HRC to STH Innovation Executive Committee. Reports were received for the first time 9 (Innovation Executive) and 10 (Research Executive) December 2024] |
| 3.2 | Revised action (Aug 24) – formal external review not required.<br><br>*Addresses Control Gap - Need to strengthen directorate accountability for research.* | Chief Medical Officer (Dev) | Revised to October 2024 ~~May 2024~~ (Original Mar 24) | ACTION COMPLETE<br>This action has been superseded by the creation of the extensive R&I Implementation Plan. |

## Tables of Controls and Assurances -

| Controls<br>**For Cause 1:** *Fail to ensure relevant strategies and delivery plans are clearly defined and effective*<br>[system in place to help manage the cause / effect] | Assurance / Evidence<br>[where can we gain evidence that the controls, we are placing reliance on are working] | | |
|---|---|---|---|
| | **First Level**<br>[Service delivery and day to day management - how do we know day to day that controls are working?] | **Second Level**<br>[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**<br>[Independent challenge – has anyone external come in to check that the controls are working] |
| • Research and Innovation Strategy refresh completed with implementation plan **completed and monitoring arrangements in place through the Research and Innovation Executive Committees.**<br>• Clinical Research and Innovation Office (CRIO) in place to support delivery of Trust research strategy.<br>• NIHR Infrastructure (BRC, CRF, HRC) strategies and annual plans.<br>. | • National Institute for Health Research (NIHR) reports reviewed by CRIO.<br>• Reporting arrangements for funders reviewed by CRIO. | • Research and Innovation Integrated Performance Report metrics reviewed by the Board of Directors.<br>• Research and Innovation Committee established. Receives 'Research Performance metrics' that have been significantly developed.<br>• Reports received by STH Research Executive Committee and Innovation Executive Committee **(including progress in delivery of R&I Innovation Plan using agreed KPIs).**<br>• Reports received by the STH Innovation Executive Committee from the NIHR HRC Strategy Board.<br>• Reports received by the Innovation Executive Committee from the NIHR HRC Network Executive Committee (This is a national NIHR committee of the 15 NIHR HRCs in England). | • NIHR **RDN** research performance and activity reporting<br>• NIHR BRC annual performance reporting to NIHR<br>• NIHR CRF annual performance reporting to NIHR<br>• NIHR HRC annual performance reporting to NIHR<br>• NIHR HRC Network Independent Advisory Board<br>• Dec 22 AuditOne Well-led final report (Learning and Innovation Kloe RAG rated AMBER).<br>• NIHR Annual Funding Review |
| • Research and Innovation plans developed by every Clinical Directorate.<br>• Academic Directorate Accreditation Scheme in place.<br>• Directorate Reviews cover research and innovation activity. | • Directorate Reviews co-ordinated by Chief Strategy Officer. | • Outputs from Directorate Reviews reviewed by TEG.<br>• Internal audit by 360 Assurance has commenced on Directorate research – planning and performance | |
| **Control Lead:** Chief Medical Officer (Development) | **Assurance Level: LIMITED** | | |

**Gaps in Controls / Assurances**

Control Gap – Research and Innovation Strategy implementation plan required. GAP RECOMMENDED FOR CLOSURE THROUGH COMPLETION OF ACTION

Assurance Gap – Research and innovation key performance indicators GAP RECOMMENDED FOR CLOSURE THROUGH COMPLETION OF ACTION

**NEW** Control Gap – Need to strengthen directorate accountability for research.

*Return to Strategic Risk front sheet*

| Controls | Assurance / Evidence | | |
|---|---|---|---|
| **For Cause 2:** *Service pressures displace research and innovation activity* | **First Level** | **Second Level** | **Third Level** |
| • Clinical Research & Innovation Office (CRIO) dedicated to support research and innovation activity.<br>• Workforce planning by CRIO based on research portfolio, current and in set-up. | • CRIO Senior Management Team meetings. | • STH Research Executive Committee and STH Innovation Executive Committee. | |
| • National Institute for Health Research (NIHR) ~~Clinical~~ **Regional Research Delivery** Network (**RRDN**) and NIHR RCF funding allocated to CRIO to support delivery of research. | • Dashboard monitored by the CRIO leadership team.<br>• Directorate engagement process.<br>• Directorate Research and Innovation Leads Meeting | • STH Research and Innovation Leads Committee meeting.<br>• STH Research Executive Committee and STH Innovation Executive Committee. | • NIHR **RRDN** Partner meetings with CRIO<br>• NIHR performance and activity reports.<br>• NIHR **RRDN** **f**unding allocation. |
| **Control Lead:** Chief Medical Officer (Development) | | | **Assurance Level: LIMITED** |

**Gaps in Controls / Assurances**

Control Gap – Improve operational oversight of Directorate research and innovation performance. GAP RECOMMENDED FOR CLOSURE THROUGH COMPLETION OF ACTION

Assurance Gap – Research and innovation key performance indicators. GAP RECOMMENDED FOR CLOSURE THROUGH COMPLETION OF ACTION

**NEW** Control Gap – Need to strengthen directorate accountability for research.

*Return to Strategic Risk front sheet*

| Controls | Assurance / Evidence | | |
|---|---|---|---|
| **For Cause 3:** *Infrastructure and resources insufficient to support delivery of research and innovation* | First Level | Second Level | Third Level |
| • Review of capacity and capability to support research delivery undertaken by Support Services and Research Infrastructures.<br>• Workforce planning by some Support Services and Research Infrastructures based on research portfolio, current and in set-up. | • Support Service and Research Infrastructure Senior Management Team meetings.<br>• Capacity and Capability issues raised by Directorates, Support Services and Research Infrastructures to CRIO which is escalated to the Chief Medical Officer (Development).<br>• New Research Trials prioritisation process approved at TEG in April 2024 and has commenced (Aug 24)<br>• Expansion of pharmacy research team agreed at TEG in April 2024 - Recruitment is underway (Aug 24). | • TEG to receive regular updates on the progress on expansion of pharmacy research.<br>• Reporting to STH Research Executive Committee and STH Innovation Executive Committee **including that of performance of CRF, BRC, CCTC, CRIO and HRC**. | • Dec 22 AuditOne Well-led final report (Learning and Innovation Kloe RAG rated AMBER). |
| • Resource needs of Support Services and Research Infrastructures identified for each research trial, costed and invoiced against actual activity to trial Sponsor. | • Research activity recorded in electronic management systems, reviewed, and validated by Sponsors as part of invoicing by Research Finance Team. | | |
| • NIHR **RRDN** allocated to Support Services and Research Infrastructures to deliver research trials. | | • Activity based funding model and allocation reviewed by STH Research Executive. | • NIHR **RRDN** Partner Organisation financial returns and meetings with CRIO. |
| • NIHR Research Capability Funding (RCF) allocated to Support Services and Research Infrastructures to deliver research trials. | • CRIO Senior Management Team to include STH Research Finance. | • Reporting to STH Research Executive Committee. | • NIHR **RRDN** Partner Organisation financial returns and meetings with CRIO.<br>• NIHR Annual Funding Review |
| • NIHR funding allocated to the NIHR Clinical Research Facility (CRF). | • NIHR CRF Senior Management Team. | • Reporting to STH Research Executive Committee. | • NIHR CRF Annual Report<br>• NIHR Annual Funding Review |
| • NIHR funding allocated to the NIHR Biomedical Research Centre (BRC). | • NIHR BRC Executive. | • Reporting to STH Research Executive Committee. | • NIHR BRC Annual Report<br>• NIHR Annual Funding Review |
| • NIHR funding allocated to the NIHR HealthTech Research Centre (HRC). | • NIHR HRC Strategy Board. | • Reporting to STH Innovation Executive Committee. | • NIHR HRC Annual Report<br>• NIHR HRC Network Annual Report |

| | | | |
|---|---|---|---|
| • NIHR funding allocated to the NIHR HealthTech Research Centre (HRC) Network. | • NIHR HRC Executive Committee (National committee of all 15 HRCs). | • Reporting to STH Innovation Executive Committee. | • NIHR HRC Strategy Board |
| • Review and recommend financial arrangements for Sheffield Cancer Clinical Trials Centre (CCTC). | • CCTC Business Executive.<br>• CCTC Working Group Terms of Reference | • Reporting to STH Research Executive Committee. | |
| **Control Lead:** Chief Medical Officer (Development) | | | **Assurance Level: LIMITED** |

**Gaps in Controls / Assurances**

Control Gap – Need to strengthen operational oversight of all Trust infrastructures and facilities (CRF, BRC, HRC, CCTC and CRIO) in place to support delivery of research and innovation. GAP RECOMMENDED FOR CLOSURE THROUGH COMPLETION OF ACTION

Assurance Gap - Key performance indicators to monitor performance of CRIO. GAP RECOMMENDED FOR CLOSURE THROUGH COMPLETION OF ACTION

*Return to Strategic Risk front sheet*

Version Control: January 2025 update

# 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 | ADEQUATE |
|---|---|

| 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 | Adequate |
| C3 | Ineffective Board oversight, challenge and action | Adequate |

**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

| Accountabilities / Review History | |
|---|---|
| **Strategic Risk Owner:** | Chief Executive |
| **Board oversight forum:** | Board of Directors |
| **Last deep dive review held:** | 23 July 2024 |
| **Date of last update:** | January 2025 |

| Risk Analysis | Jan 2025 | Sept 2024 | May 2024 | Jan 2024 |
|---|---|---|---|---|
| **Current Risk Score:** (C) x (L) | (4) x (2) = 8 | (4) x (2) = 8 | (4) x (2) = 8 | (4) x (2) = 8 |
| **Target Risk Score:** (C) x (L) / Achieved Jan 2024 | (4) x (2) = 8 | (4) x (2) = 8 | (4) x (2) = 8 | (4) x (2) = 8 |
| **Risk Appetite:** | CAUTIOUS | - | - | - |
| **In / Out of Appetite:** | IN APPETITE | - | - | - |

## Operational risk oversight informed by Risk Appetite

| AVOID | MINIMAL | CAUTIOUS | OPEN | SEEK | *Risk Tolerance 12* |
|---|---|---|---|---|---|

In updating its Risk Appetite Statement in November 2024 the Board of Directors has defined a **CAUTIOUS** Risk Appetite for risks relating to Well-led and an agreed risk tolerance score of 12.

At 7 January 2025 two open Operational Risks aligned to this Strategic Risk with a current risk score of 12 or more, both of these relate to arrangement for managing controlled documents. Revised reporting arrangements are being introduced to support Board oversight of these Operational Risks.

***Please refer to the Corporate Risk Register Report***

## Strategic Risk Owner Commentary

The external strategic context for this risk is dynamic and it is anticipated that the NHS 10-year plan will introduce changes around accountability, governance and regulation. There will be a need to ensure that our own leadership and governance arrangements respond effectively to these changes and we deliver necessary assurance on this.

Internally, robust governance and risk control arrangements supports the Trust's response to the current significantly challenging operational position. These are also key to providing the necessary evidence and assurance that the Trust is compliant with all enforcement undertakings following receipt of correspondence from NHSE regional team in December 2024. As noted to Board members, the NHSE response to the Trust's request for a compliance certificate is being evaluated to determine the necessary assurances to address the undertakings. This BAF section will be maintained and updated in line with this evaluation.

**Version Control:** January 2025 update

| Aggregated Action Plan to address gap in control or assurance | | | | |
|---|---|---|---|---|
| | **Action** | **Lead Exec** | **Deadline** | **Progress update** |
| **1** | Revised action agreed July 2024 – Eliminate all longest overdue policies by April 2025 and achieve 90% of Trust policies in date by this date.<br><br>*Addresses Control Gap - Percentage of Trust policies not in date.* | CEO | **Date for revised action April 2025** | Based on data at 6 January, 82.3% (251 / 305) of policies were in date (increase from 78.3% reported in September 2024 BAF update). This is a continued upward trajectory.<br><br>The Audit Committee is now providing additional oversight of policy compliance with standing reporting established from its July 2024 meeting. The Committee has requested focus also be placed on timeliness of review for policies approaching their review date. Using data extracted 6 January 2025, 12 policies that had review dates in the last three months became additional overdue policies. Eight policies were reviewed and ratified in line with review dates. |

**Version Control:** January 2025 update

## Tables of Controls and Assurances

| **Controls**<br>**For Cause 1:** *Senior management fail to effectively articulate or implement mission, vision and strategy* | **Assurance / Evidence**<br>[where can we gain evidence that the controls we are placing reliance on are working] | | |
|---|---|---|---|
| [system in place to help manage the cause / effect] | **First Level**<br>[Service delivery and day to day management - how do we know day to day that controls are working?] | **Second Level**<br>[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**<br>[Independent challenge – has anyone external come in to check that the controls are working] |
| • Refreshed Corporate Strategy: Making a Difference – the Next Chapter.<br>• Reconfirmed statements for Trust Mission, Vision and Values.<br>• Mechanisms in place to support communication of vision, mission and Trust Strategic Aims / Strategic Priorities.<br>• Alignment of reports to the Board of Directors and its Committees to Strategic Aims confirmed through Executive Summary. | • Monthly briefing by Executive Team, led by Chief Executive at Management Board Briefing.<br>• Monthly meeting between Trust Executive Group and Clinical Management Board.<br>• Monthly All Staff meetings led by Chief Executive and quarterly All Consultant meetings also led by Chief Executive. | • Board approved Corporate Strategy underpinned by agreed annual Corporate Aims monitored mid-year / end of year by Board.<br>• Annual Operational Plan setting out aims and ambitions for the 2024/25 approved by Board of Directors in June 2024.<br>• Monitoring of key performance metrics by Board through Integrated Performance Report (IPR) and Quarterly Integrated Quality and Safety Report. | • 2023 Staff Survey results presented to Board in March 24.<br>• CQC Well-led review / Well-led Improvement Plan on a Page.<br>• External Healthcare Governance Review.<br>• Dec 22 Report from AuditOne Well-led review presented to January Board – Aggregate Assurance Rating = Adequate / Leadership KLoE RAG rating - Green. |
| • Strategy and Planning Directorate in place to co-ordinate development and monitoring of Corporate Strategy / Aims.<br>• Trust's annual Corporate Objectives aligned to Trust Strategy to underpin delivery.<br>• Directorate Business Plans linked to delivery of Strategic Aims. | • Directorate Reviews co-ordinated by Chief Strategy Officer.<br>• Performance against Corporate Aims co-ordinated by Chief Strategy Officer. | • 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. | • Business Planning Internal Audit Report – Aug 2023 – Significant Assurance |
| **Control Lead:** Chief Executive | | | **Assurance Level: ADEQUATE** |

| **Gaps in Controls / Assurances** |
|---|
| No gaps in Control or Assurance identified. |

Return to Strategic Risk front sheet

**Version Control:** January 2025 update

| Controls<br><br>**For Cause 2:** *Ineffective / inconsistent systems and processes to support the management of risks, issues and performance* | Assurance / Evidence<br><br>First Level | <br><br>Second Level | <br><br>Third Level |
|---|---|---|---|
| • Integrated Governance arrangements<br>– Quality Governance Policy and Framework and associated policies. Patient and Healthcare Governance Team in place – development and application of Quest dashboards.<br>– Performance Management Framework - dedicated Information Team and Integrated Performance Reports (IPR).<br>– Corporate Governance Framework including Framework for Risk Management.<br>– Financial Governance Arrangements - resourcing in place (systems, skills and capacity) to deliver effective reporting of financial position from Directorate to Board.<br>– People and Organisational Development Plans.<br>• Internal Audit programme of external review / audit of implementation of Trust policies and procedures. | • Individual Executive Director portfolios.<br>• Directorate Governance Meetings.<br>• Performance Management Framework level assigned to every Directorate at least annually to determine level of support and review.<br>• Controlled Documents (Policies) reported by Executive Sponsor. | • Board Assurance Framework considered by Board Committees and Board.<br>• **BAF Effectiveness Review presented to Audit Ctte (Oct 24).**<br>• Audit Committee reviews Annual Governance Statement.<br>• **Self-Assessment against HFMA Audit Committee Handbook (Audit Ctte Oct 2024).**<br>• Board Effectiveness Review discussed by Board.<br>• Self-assessment to inform Provider Licence Declaration.<br>• Draft Enforcement Undertakings Assurances presented to Board August 2024 to support application to NHSE for a compliance certificate.<br>• Outcome of Directorate Performance Reviews reported to TEG.<br>• Corporate Risk Register and Extreme Risk trajectory report discussed by Risk Management Executive Committee.<br>• Bi-monthly Controlled Documents Dashboard with in-date policy compliance discussed by TEG.<br>• Reporting of Corporate Policy compliance to the Audit Committee commenced July 2024. | • External visits, accreditation and inspections.<br>• CQC Well-led review.<br>• CQC confirmation of closure of IR(ME)R Improvement Notice based on satisfaction with Trust action plan following inspection to Neuro-radiology on 31 Jan 2024.<br>• CQC confirmation of satisfaction with Trust action plan following IR(ME)R inspection visit to WPH on 2 July 2024.<br>• Dec 22 AuditOne Well Led Review -RAG rating for Performance and Risk Kloe – Amber / Green.<br>• Enforcement Undertakings November 2022 – **NHSE response to Trust submission of request for certificate of compliance (Dec 2024).**<br>• Board to Board letter from NHSE confirms move from need for Intensive Assurance and Improvement Segment to Enhanced Assurance and Improvement Segment.<br>• Trust exit from Maternity Safety Support Programme (MSSP) agreed at National Quality Performance Committee in August 2024.<br>• **Tier 1 and performance tiering system in relation to elective and diagnostic performance (return to Tier 1)**, and for cancer.<br>• 2023/24 Head of Internal Audit Opinion Report – BAF (Significant) / Individual assignments (Moderate) / Follow up of actions (Significant).<br>• **Internal Audit review of BAF draft report (Jan 25) – (Significant)** |

| | | | |
|---|---|---|---|
| | | | • 2023/24 External Audit ISA 260 no identified weaknesses.<br>• External Auditors' 2023/24 Annual Report inc. Value for Money report issued with no significant issues identified (including closure of previous year's recommendation re risk management arrangements – risks overdue local review).<br>• Internal Audit reports reported to Audit Committee inc: Performance Management Framework July 2020 (Significant) / Policy Management Framework 2021 (Limited) / HR Data Quality Dec 2022 (Significant) / Directorate Risk Management Mar 2023 (Significant) / Risk Management Mar 2024 (Significant) / Waiting list performance management: focus on long waiters July 2024 (Significant). |
| • Board and Committee workplans / reporting schedules. | • Chief Executive's Office co-ordinating Board Effectiveness Review. | • Board Assurance Framework considered by Board Committees and Board.<br>• Audit Committee reviews Annual Governance Statement. Board Effectiveness Review discussed by Board.<br>• Committee Annual Reports reviewed by Audit Committee / Board.<br>• Audit Committee reviews Annual Governance Statement.<br>• Self-assessment to inform Provider Licence Declaration.<br>• Board Effectiveness Review reported to Board (Nov 23). | • CQC Well-led review.<br>• External Healthcare Governance Review.<br>• Dec 22 AuditOne Well Led Review - RAG rating for Performance and Risk Kloe – Amber / Green.<br>• **Well-Led Development Follow-up Review Outcomes (BoD October 2024).** |
| • Trust wide approach to standardisation. | | • Data Quality Steering Group – oversees key data quality issues and develops action plans to improve data quality in areas of concern.<br>• Data Quality Steering Group reports to Audit Committee. | • HR Data Quality Internal Audit Report - Dec 2022 (Significant). |

**Version Control:** January 2025 update

| **Control Lead:** Chief Executive | **Assurance Level: ADEQUATE** |
| --- | --- |
| **Gaps in Controls / Assurances** | |
| Control Gap - Percentage of Trust policies not in date | |

*Return to Strategic Risk front sheet*

| **Controls**<br>**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.<br>• Annual programme of Board Effectiveness Review. | • Board Responsibilities matrix updated by Chief Executive's Office.<br>• Committee secretariat management of Board Committee and Board action logs. | • Audit Committee review of Annual Governance Statement.<br>• Code of Governance declarations approved by Audit Committee.<br>• Board Effectiveness Review reported to Board (Nov 23).<br>• Developmental Well-led Action Plan Update and Impact Report presented to May 2024 Board. | • CQC Well-led review.<br>• External Healthcare Governance Review.<br>• Dec 22 AuditOne Well Led Review -RAG rating for Leadership Kloe – Green.<br>• **Well-Led Development Follow-up Review Outcomes (BoD October 2024).** |
| • Board Nomination and Remuneration Committee in place with responsibility for effective Board Succession Planning. | • Board Skills and Diversity Matrix maintained by Chief Executive's Office. | • Consideration of outcome of Board Skills Audit by Board Nom Rem Ctte to inform succession planning.<br>• Board Skills, Knowledge and Experience Audit completed and reported to TEG (Dec 23). | • Dec 22 AuditOne Well Led Review -RAG rating for Leadership Kloe – Green. |
| • Well established leadership / organisational structure. | • Quarterly review / update of Management Arrangements co-ordinated by Chief Executive's Office. | • Vacancy reporting to People Committee. | • Findings from Internal Audit reports presented routinely to Audit Ctte. |
| • Foundation Trust (FT) Model (established Council of Governors). | • Council of Governors Forum discuss ongoing development of CoG. | • Council of Governors Effectiveness Review presented to Council of Governors (Dec 23). | • Dec 22 Audit One Well Led Review.<br>• Internal Audit Supporting the statutory duties of the Council of Governors (Jan 24) - Significant Assurance. |
| **Control Lead:** Chief Executive | **Assurance Level: ADEQUATE** | | |
| **Gaps in Controls / Assurances** | | | |
| No gaps in Control or Assurance identified. | | | |

*Return to Strategic Risk front sheet*

## STRATEGIC RISK DEEP DIVE SCHEDULE

Dates for the most recent and for the next cycle of Strategic Risk Deep Dives can be confirmed as:

| Strategic Risk | Oversight Forum | Date of last Deep Dive | Next planned Deep Dive |
|---|---|---|---|
| Strategic Risk 1: Quality | Quality Committee | 18 November 2024 | 16 June 2025 |
| Strategic Risk 2: Operational delivery and recovery | Finance and Performance Committee | 11 November 2024 | 14 April 2025 |
| Strategic Risk 3: Workforce | People Committee | 9 December 2024 | 9 June 2025 |
| Strategic Risk 4: Finance | Finance and Performance Committee | 9 December 2024 | 9 June 2025 |
| Strategic Risk 5: Digital | Digital Committee | 15 July 2024 | 10 February 2025 |
| Strategic Risk 6: Sustainable healthcare through partnership working | Board of Directors (Private) | 29 October 2024 | 25 March 2025 |
| Strategic Risk 7: Research and Innovation | Research and Innovation Committee | 9 December 2024 | 17 February 2025 |
| Strategic Risk 8: Well-led | Board of Directors (Private) | 23 July 2024 | 24 February 2025 |