Board Assurance Framework (BAF): May 2023

The key elements of the BAF are:

- A description of each Principal (strategic) Risk, which forms the basis of the Trust's risk framework (with corresponding corporate and operational risks defined at a Trust-wide and service level)
- Risk ratings – current (residual), tolerable and target levels
- Clear identification of primary strategic threats and opportunities that are considered likely to increase or reduce the Principal Risk, within which they are expected to materialise
- A statement of risk appetite for each threat and opportunity, to be defined by the Lead Committee on behalf of the Board (**Averse** = aim to avoid the risk entirely; **Minimal** = insistence on low-risk options; **Cautious** = preference for low-risk options; **Open** = prepared to accept a higher level of residual risk than usual, in pursuit of potential benefits)
- Key elements of the risk treatment strategy identified for each threat and opportunity, each assigned to an executive lead and individually rated by the lead committee for the level of assurance they can take that the strategy will be effective in treating the risk (see below for key)
- Sources of assurance incorporate the three lines of defence: (1) **Management** (those responsible for the area reported on); (2) **Risk and compliance** functions (internal but independent of the area reported on); and (3) **Independent assurance** (Internal audit and other external assurance providers)
- Clearly identified gaps in the primary control framework, with details of planned responses each assigned to a member of the Senior Leadership Team (SLT) with agreed timescales

Key to lead committee assurance ratings:

Green = Positive assurance: the Committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity

- no gaps in assurance or control AND current exposure risk rating = target
  OR
- gaps in control and assurance are being addressed

Amber = Inconclusive assurance: the Committee is not satisfied that there is sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy

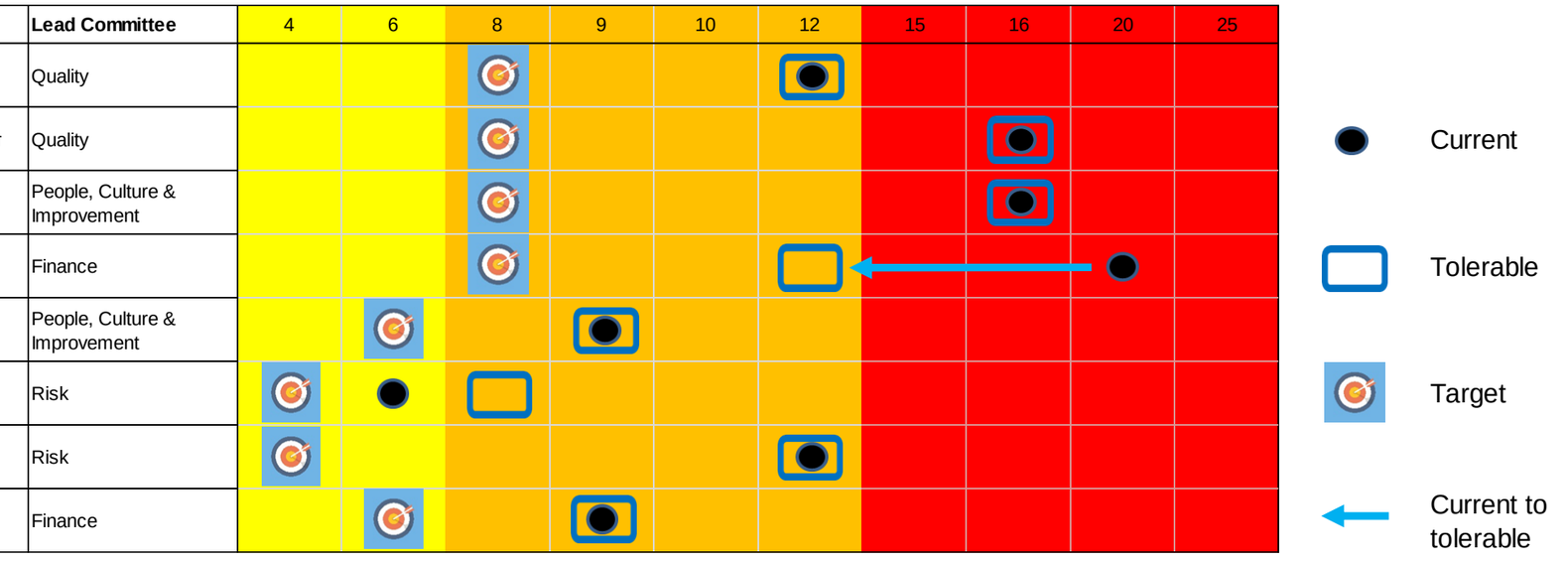
Red = Negative assurance: the Committee is not satisfied that there is sufficient reliable evidence that the current risk treatment strategy is appropriate to the nature and/or scale of the threat or opportunity

This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take, and which can then be provided to the Board in relation to each Principal Risk and also to identify any further action required to improve the management of those risks.

Likelihood score and descriptor					
	Very unlikely 1	**Unlikely 2**	**Possible 3**	**Somewhat likely 4**	**Very likely 5**
Frequency How often might/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally or there are a significant number of near misses / incidents at a lower consequence level	Will probably happen/recur, but it is not necessarily a persisting issue/ circumstances	Will undoubtedly happen/recur, possibly frequently
Probability Will it happen or not?	Less than 1 chance in 1,000 (< 0.1%)	Between 1 chance in 1,000 and 1 in 100 (0.1 - 1%)	Between 1 chance in 100 and 1 in 10 (1- 10%)	Between 1 chance in 10 and 1 in 2 (10 - 50%)	Greater than 1 chance in 2 (>50%)
Board committees should review the BAF with particular reference to comparing the tolerable risk level to the current exposure risk rating					

This BAF includes the following Principal Risks (PRs) to the Trust's strategic priorities and the risk scores:

		Lead Director	Lead Committee
PR1	**Significant deterioration in standards of safety and care**	Medical Director	Quality
PR2	**Demand that overwhelms capacity**	Chief Operating Officer	Quality
PR3	**Critical shortage of workforce capacity and capability**	Director of People	People, Culture & Improvement
PR4	**Failure to achieve the Trust's financial strategy**	Chief Financial Officer	Finance
PR5	**Inability to initiate and implement evidence-based improvement and innovation**	Director of Strategy and Partnerships	People, Culture & Improvement
PR6	**Working more closely with local health and care partners does not fully deliver the required benefits**	Director of Strategy and Partnerships	Risk
PR7	**Major disruptive incident**	Director of Corporate Affairs	Risk
PR8	**Failure to deliver sustainable reductions in the Trust's impact on climate change**	Chief Financial Officer	Finance



Board Assurance Framework (BAF): May 2023

Principal risk (What could prevent us achieving this strategic objective)	**PR 1: Significant deterioration in standards of safety and care** ~~Significant~~ Recognised deterioration in standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes						
Lead committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Patient harm
Lead director	Medical Director	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Minimal
Initial date of assessment	01/04/2018	**Likelihood**	~~4. Somewhat likely~~ 3. Possible	3. Possible	2. Unlikely		
Last reviewed	18/05/2023	**Risk rating**	~~16. Significant~~ 12. High	**12. High**	**8. Medium**		
Last changed	18/05/2023						

Strategic objective	1. To provide outstanding care in the best place at the right time

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
~~A widespread loss of~~Inability to maintain ~~organisational focus on~~ patient safety and quality of care leading to increased incidence of avoidable harm~~, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction~~ and poor patient experience	▪ Clinical service structures, accountability & quality governance arrangements at Trust, division & service levels including: ▪ Monthly meeting of Patient Safety Committee (PSC) with work programme aligned to CQC registration regulations ▪ Nursing and Midwifery and AHP Business meeting ▪ Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems ▪ Clinical audit programme & monitoring arrangements ▪ Clinical staff recruitment, induction, mandatory training, registration & re-validation ▪ Defined safe medical & nurse staffing levels for all wards & departments (Nursing safeguards monitored by Chief Nurse) ▪ Ward assurance/ metrics and accreditation programme ▪ Nursing & Midwifery Strategy ▪ AHP Strategy ▪ Scoping and sign-off process for incidents and SIs ▪ Internal Reviews against External National Reports ▪ Getting it Right First Time (GIRFT) localised deep dives, reports and action plans ▪ CQC Bi-monthly Engagement Meetings ▪ Operational grip on workforce gaps reporting into the Incident Control Team ▪ People, Culture and Improvement Strategy ▪ Continued focus on recruitment and retention in significantly impacted areas, including system wide oversight	Lack of real time data collection Medical, nursing, AHP and maternity staff gaps in key areas across the Trust, which may impact on the quality and standard of care ePMA project issues identified as part of the maturing rollout ~~Lack of oversight of established clinical governance when meetings are stood down due to operational pressures~~	Review of informatics function and development of informatics strategy ~~**Progress:** Strategic paper developed, awaiting TMT review~~ **SLT Lead:** Chief Digital Information Officer **Timescale:** ~~February 2023~~Complete – business case submitted, currently unsupported Continued focus on recruitment and retention in significantly impacted areas, including system wide oversight **SLT Lead:** Executive Director of People ~~**Progress:** People, Culture and Improvement Strategy launched, and a number of task and finish groups established~~ **Timescale:** ~~March 2023~~Complete – awaiting imminent release of NHS Workforce Plan Oversee the ePMA project board to resolve identified issues with eTTOs, critical medicines and allergy documentation **SLT Lead:** Medical Director **Timescale:** September 2023 Review and describe which committees are essential to maintain quality and patient care and safety when the Trust in a state of sustained heightened clinical activity **SLT Lead:** Director of Patient Safety **Timescale:** ~~May 2023~~Complete	**Management:** Learning from deaths Report to QC and Board; Quarterly Strategic Priority Report to Board; Divisional risk reports to Risk Committee bi-annually; Guardian of Safe Working report to Board qrtly Quality and Governance Reporting Pathway; Patient Safety Committee → Quality Committee Reports include: - DPR Report to PSC monthly and QC bi-monthly - PSC assurance report to QC bi-monthly - Patient Safety Culture (PSC) programme - EoLC Annual Report to QC - Safeguarding Annual Report to QC - CYPP report to QC quarterly - Medical Education update report to QC - Medicines Optimisation Annual Report to QC Outputs from internal reviews against External National Reports including HSIB and HQIP National and local Reports **Risk and compliance:** Quality Dashboard and SOF to PSC Monthly; Quality Account Report Qtrly to PSC and QC; SI & Duty of Candour report to PSC monthly; CQC report to QC bi-monthly; Significant Risk Report to RC monthly **Independent assurance**: CQC Engagement meeting reports to Quality Committee bi-monthly Screening Quality Assurance Services assessments and reports of: - Antenatal and New-born screening - Breast Cancer Screening Services - Bowel Cancer Screening Services - Cervical Screening Services External Accreditation/Regulation annual assessments and reports of; - Pathology (UKAS) - Endoscopy Services (JAG) - Medical Equipment and Medical Devices (BSI) - Blood Transfusion Annual Compliance Report (MHRA)		Positive No change since April 2020

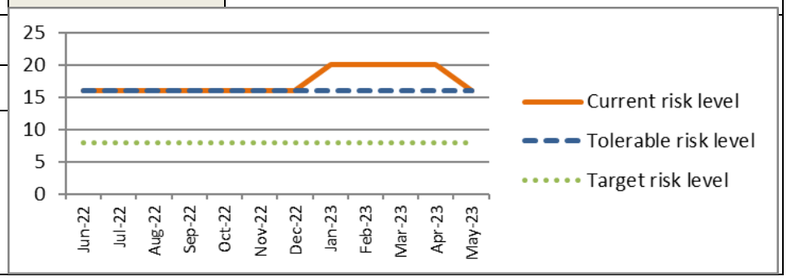
Board Assurance Framework (BAF): May 2023

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
An outbreak of infectious disease ~~(such as pandemic influenza; Coronavirus; norovirus; infections resistant to antibiotics)~~ that forces closure of one or more areas of the hospital	▪ Infection prevention & control (IPC) programme Policies/ Procedures; Staff training; Environmental cleaning audits ▪ PFI arrangements for cleaning services ▪ Root Cause Analysis and Root Cause Analysis Group ▪ Reports from Public Health England received and acted upon ▪ Infection control annual plan developed in line with the Hygiene Code ▪ Influenza and Covid vaccination programmes ▪ Public communications re: norovirus and infectious diseases ▪ Coronavirus identification and management process ▪ Infection Prevention and Control Board Assurance Framework ▪ Outbreak meeting including external representation, ~~CCG,~~ PHE, Regional IPC ▪ CQC IPC Key lines of enquiry engagement sessions ▪ Maintaining mask wearing and screening of patients on admission, and ensuring maintenance of pre-existing IPC requirements			**Management:** Divisional reports to IPC Committee (every 6 weeks); IPC Annual Report to QC and Board; Water Safety Group; IPC BAF report to PSC and QC **Risk and compliance:** IPC Committee report to PSC qtrly; SOF Performance Report to Board monthly; IPC Clinical audits in IPCC report to PSC qtrly; Regular IPC updates to ICT; PLACE Assessment and Scores Estates Governance bi-monthly **Independent assurance:** Internal audit plan:~~; CQC Rating Good with Outstanding for Care May 20;~~ UKHSA attendance at IPC Committee; Independent Microbiologist scrutiny via IPC Committee; Influenza vaccination cumulative number of staff vaccinated; ICS vaccination governance report monthly; ~~HSE visit (COVID-19 arrangements) Dec 21 – no concerns highlighted;~~ IPC BAF Peer Review by Medway Trust; HSE External assessment and report; ~~HSIB IPC assessment and report Nov 20~~CQC Maternity Review Dec 22		Positive Last changed November 2022

Board Assurance Framework (BAF): May 2023

Principal risk (What could prevent us achieving this strategic objective)	**PR 2: Demand that overwhelms capacity** Demand for services that overwhelms capacity resulting in a deterioration in the quality, safety and effectiveness of patient care						
Lead committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Patient harm
Lead director	Chief Operating Officer	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Minimal
Initial date of assessment	01/04/2018	**Likelihood**	~~5. Very likely~~ 4. Somewhat likely	4. Somewhat likely	2. Unlikely		
Last reviewed	18/05/2023	**Risk rating**	~~20~~16. **Significant**	**16. Significant**	**8. Medium**		
Last changed	18/05/2023						

Strategic objective	1. To provide outstanding care in the best place at the right time



Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Growth in demand for care caused by: • An ageing population • Further waves of admissions driven by Covid-19, Flu or other infectious diseases • Increased acuity leading to more admissions and longer length of stay	▪ Emergency admission avoidance schemes across the system ▪ SFH Same Day Emergency Care service in place to avoid admissions into inpatient facilities ▪ Single streaming process for ED & Primary Care – regular meetings with NEMS ▪ Trust and System escalation policies and processes, including Full Capacity Protocol and Pandemic Surge Plan ▪ ~~COVID-19 Incident planning and governance process~~ ▪ Trust leadership of and attendance at ICS UEC Delivery Board ▪ Inter-professional standards across the Trust to ensure we complete today's work today e.g. turnaround times such as diagnostics are completed within 1 day ▪ SFH annual capacity plan with specific focus on the Winter period ▪ Patient pathways, some of which are joint with NUH ▪ Referral management systems shared between primary and secondary care ▪ Optimising Patient Journey Programme focussing on internal flow ▪ Theatres, Outpatients and Diagnostics Transformation Programmes ▪ Elective Steering Group ~~relaunched~~ to steer the recovery of elective waiting times ▪ Emergency Steering Group ~~relaunched~~ to steer improvement across the emergency pathway ▪ Incident Control Team	Physical staffed capacity/estate is insufficient to cope with surges in demand without undertaking exceptional actions e.g. reducing elective operating, bedding patients in alternative areas i.e. daycase	Bed modelling and review of funded/escalation capacity **SLT Lead:** Chief Operating Officer **Timescale:** ~~January to April 2023~~Complete Work on mitigations to address bed modelling outcomes: - Secure funding for additional ward area (bid submitted in Feb 23 was unsuccessful) - Identify schemes to increase efficiency through length of stay reductions – agreed 4 areas of focus **SLT Lead:** Chief Operating Officer **Timescale:** ~~June 2023~~ Complete Develop delivery plans with system partners for the 4 areas of focus to mitigate demand pressures **SLT Lead:** Chief Operating Officer **Timescale:** July 2023	**Management:** Performance management reporting arrangements between Divisions, Service Lines and Executive Team; Winter Plan considered by Board in Oct 22; Planning documents for 23/24 to identify clear demand and capacity gaps/bridges; Waiting list update to TMT ~~monthly~~ as required; Super Surge Plan considered by Board in Feb 22; Bed model outcomes to Exec Team Feb 23 **Risk and compliance:** Divisional risk reports to Risk Committee bi-annually; Significant Risk Report to RC monthly; Single Oversight Framework Integrated Monthly Performance Report including national rankings to Board; ~~Incident Control Team governance structure considered by TMT in Mar 20; Cancer services report considered by Board in Jun 21~~ **Independent assurance:** ~~NHSI Intensive Support Team reviewed cancer processes in May 20;~~ Performance Management Framework internal audit report Jun 22 ~~with actions under way.~~		Positive Last changed December 2020
Reductions in availability of hospital bed capacity caused by increasing numbers of MFFD (medically fit for discharge) patients remaining in hospital	▪ Engagement in ICB Discharge Operational Steering Group ▪ ICS Discharge to Assess business case being implemented ▪ Multidisciplinary Transfer of Care Hub opened at SFH Oct 22 ▪ Opening of additional beds ▪ ~~(~~Sherwood Care Home ~~May 22~~transferred to MCH Apr 23 ▪ ~~,~~Mansfield Community Hospital Nov 22 ~~– Mar 23)~~ ▪ Use of Ashmere	Lack of consistent achievement of the mid-Notts threshold for MSFT patients of 22	Delivery of ICS Discharge to Assess Business Case **SLT Lead:** Chief Operating Officer **Timescale:** ~~Phased to April 2023~~throughout 23/24 Virtual ward programme implementation **SLT Lead:** Chief Operating Officer **Timescale:** ~~1st phase to April 2023~~expanding throughout 23/24	**Management:** Daily and weekly themed reporting of the number of MFFD patient in hospital beds. Reports into the system CEOs group; ICS UEC Delivery Board and ICS Demand and Capacity Group **Risk and compliance:** Exception reporting on the number of MFFD into the Trust Board via the SOF	Further refinements to MFFD reporting to ensure a single and shared version of the truth within the Trust and between system partners **SLT Lead:** Chief Operating Officer **Timescale:** Continual review and improvement to June 2023	Inconclusive No change since threat added in January 2022

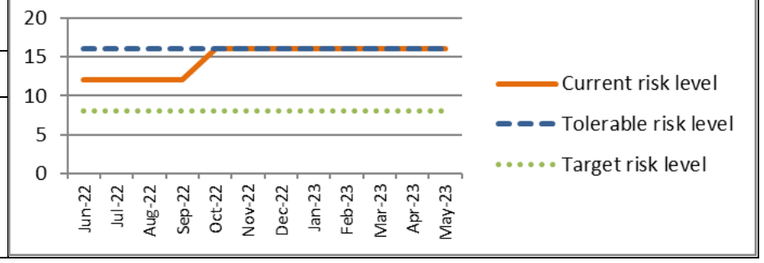
Board Assurance Framework (BAF): May 2023

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Operational failure of General Practice to cope with demand resulting in even higher demand for secondary care as the 'provider of last resort'	▪ Visibility on the ICS risk register / BAF entry relating to operational failure of General Practice ▪ Weekly Chief Officer calls across ICS, including Primary Care ▪ Mid Notts ICP represented at weekly Incident Control Team meeting			**Management:** Routine mechanism for sharing of ICS and SFH risk registers – particularly with regard to risks for primary care staffing and demand	Lack of visibility in primary care demand and capacity **Action:** Continue to push via ICS UEC Delivery Board and ICS Demand and Capacity Group the importance of system-wide oversight of demand and capacity **SLT Lead:** Chief Operating Officer **Timescale:** Ongoing during 2023	Inconclusive No change since April 2020
Drop in operational performance of neighbouring providers that creates a shift in the flow of patients and referrals to SFH	▪ Engagement in Integrated Care System (ICS), and assuming a leading role in Integrated Care Provider development. ▪ Horizon scanning with neighbour organisations via meetings between relevant Executive Directors			**Risk and compliance:** NUH service support to SFH paper to Executive Team	Lack of control over the flow of patients from the surrounding area **Action:** Continue to work with system partners within ICS forums e.g. ICS UEC Delivery Board and System Flow Meetings **SLT Lead:** Chief Operating Officer **Timescale:** Ongoing during 2023	Positive Last changed November 2022
Growth in demand for care in our maternity services (population growth and increase in out of area referrals)	▪ Over-established midwifery by 10% from 2021/22 ~~▪ Fully restarted home birth services following closure during the pandemic (and partial re-opening in early post-pandemic phase)~~ ▪ Additional antenatal clinics based on overtime/bank ▪ Recruited additional consultants (12 in 2020 to 14 at time of writing) ▪ Maternity assurance group (monthly) ▪ Director of Midwifery providing Board-level oversight	Midwifery staffing vacancies (gap of 5.6% WTE against establishment) No increase in junior medical staffing Nursing gaps in neonatal unit No standalone junior out-of-hours on-call for neonatal (as per critical care review) Physical capacity/estate will be insufficient should growth trends continue in the coming years	Maternity and Neonatal service review document in development **SLT Lead:** Chief Operating Officer **Timescale:** ~~end of March 2023~~Q1 23/24 ANP recruitment under way **SLT Lead:** Chief Operating Officer **Timescale:** ~~Current recruitment round to complete in 22/23 Q4~~ Complete	**Management:** Maternity dashboard that includes all relevant KPIs and quality standards (live and reviewed monthly at performance meetings) **Risk and compliance:** Maternity and gynaecology and divisional performance meetings (monthly)		Positive New threat added January 2023

Board Assurance Framework (BAF): May 2023

Principal risk (What could prevent us achieving this strategic objective)	**PR 3: Critical shortage of workforce capacity and capability** A shortage of workforce capacity and capability resulting in a deterioration of staff experience, morale and well-being which can have an adverse impact on patient care						
Lead committee	People, Culture & Improvement	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services
Lead director	Director of People	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Cautious
Initial date of assessment	01/04/2018	**Likelihood**	4. Somewhat likely	4. Somewhat likely	2. Unlikely		
Last reviewed	22/05/2023	**Risk rating**	**16. Significant**	**16. Significant**	**8. Medium**		
Last changed	22/05/2023						

Strategic objective	~~3: To maximise the potential of our workforce~~ 3. Create an environment for all our colleagues to thrive



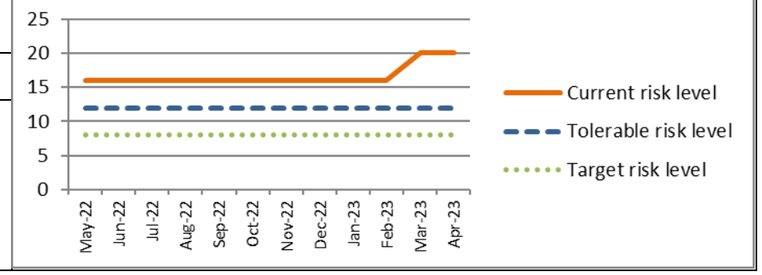
Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Inability to attract and retain staff due to ~~demographic changes (including a significant impact of external factors and/or unforeseen circumstances) and/or unforeseen circumstances) and shifting cultural attitudes to careers, combined with employment market factors (such as reduced availability and increased competition), or mental health issues relating to the working environment~~market factors, resulting in critical workforce gaps in some clinical and non-clinical services	▪ People ~~Culture and Improvement~~ Strategy 2022-2025 ▪ People ~~and Inclusion~~ Cabinet ~~▪ Culture and Improvement Cabinet~~ ~~▪ Medical and Nursing task force~~ ▪ Activity, Workforce and Financial plan ▪ ~~2~~5-year strategic workforce plan supported by associated Tactical People Plans~~Workforce Planning Group and review processes (consultant job planning; workforce modelling; winter capacity plans)~~ ▪ Vacancy management and recruitment systems and processes ▪ TRAC system for recruitment; e-Rostering systems and procedures used to plan staff utilisation ▪ Defined safe medical & nurse staffing levels for all wards and departments / Safe Staffing Standard Operating Procedure ▪ Temporary staffing approval and recruitment processes with defined authorisation levels; Activity Manager to support activity plans and utilisation of Consultant job planning ▪ Education partnerships with formal agreements in place with West Notts College and Nottingham Trent University ▪ Director of People attendance at ICS People and Culture Board ▪ Workforce planning for system work stream ▪ Communications issued regarding HMRC taxation rules on pensions and provision of pensions advice ▪ Pensions restructuring payment introduced ▪ Risk assessments for at-risk staff groups ▪ Refined and expanded Health and Wellbeing support system ~~▪ Operational grip on workforce gaps reporting into the Incident Control Team~~	Workforce gaps across key areas such as Medical, ~~n~~Nursing, AHP and ~~m~~Maternity ~~staff gaps in key areas across the Trust~~, which may impact on the quality and standard of care Lack of consistency across the system with regard to recruitment and retention, creating competition and not maximising opportunities	Deliver the People, Culture and Improvement Strategy – Year 1 **SLT Lead:** Director of People **Timescale:** ~~March 2023~~Complete Deliver the People, Culture and Improvement Strategy – Year 2 **SLT Lead:** Director of People **Timescale:** March 2024 Work with the Chief People Officer to form a provider collaborative forum for recruitment and retention **SLT Lead:** Director of People **Timescale**: June 2023	**Management:** Quarterly Strategic Priority Report to Board; Nursing and Midwifery and AHP six monthly staffing report to PCI Committee; Workforce and OD ICS/ICP update quarterly; Quarterly Assurance reports on People & Inclusion and Culture & Improvement to People Culture and Improvement Committee; Recruitment & Retention report monthly; Strategic Workforce Plan to PCI Committee Jun 22; Employee Relations Quarterly Assurance Report to People, Culture and Improvement Committee; People Plan updates to PCI Committee bi-monthly; Leadership Development Strategy Assurance Report to PCI Committee Jun 22 **Risk and compliance:** Risk Committee significant risk report Monthly; HR & Workforce planning report Risk Committee; SOF – Workforce Indicators to People Cabinet (Monthly) - Quarterly to Board; Bank and agency report (monthly); Guardian of safe working report to Board quarterly **Independent assurance**: Well-led report CQC; NHSI use of resources report; Pre-employment Checks internal audit report Feb 21 – significant assurance; HSJ Award for Acute Trust of the Year 2021; Assurance Report to People, Culture and Improvement Committee quarterly; People Plan to People, Culture and Improvement Committee Apr 21	Staff mental health issues as a result of psychological trauma Train Trauma Risk Management practitioners to provide psychological support following traumatic events **SLT Lead:** Deputy Director of People **Timescale:** August 2023	Positive Last changed June 2022

Board Assurance Framework (BAF): May 2023

Strategic threat (What might cause this to happen)	Primary risk controls (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	Plans to improve control (Are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gaps (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating
	▪ Communication of daily SitReps (Situation Reports) for workforce gaps ▪ ~~Nursing and Midwifery Workforce Transformation Cabinet~~ ▪ ~~Medical Workforce Transformation Cabinet~~ ▪ ~~Strategic People Plan~~ ▪ ~~Partnership agreement with Vision West Notts College~~					
A significant loss of workforce productivity arising from a short-term reduction in staff availability or reduction in morale and engagement, which could lead to a detremental impact on patients and service users ~~a reduction in effort above and beyond contractual requirements amongst a substantial proportion of the workforce and/or loss of experienced colleagues from the service, or caused by other factors such as poor job satisfaction, lack of opportunities for personal development, on-going pay restraint, workforce fatigue or wellbeing issues, or failure to achieve consistent values and behaviours in line with desired culture~~ ~~This could also lead to lack of engagement with patients, resulting in failure to address patient empowerment and self-help and failure to work across the system to empower patients and carers to enable personalised patient centred care~~	▪ People ~~Culture and Improvement~~ Strategy 2022-2025 ▪ People ~~and Inclusion~~ Cabinet ▪ ~~Culture and Improvement Cabinet~~ ▪ Chief Executive's blog / Staff Communication bulletin / Weekly #TeamSFH Brief ▪ Engagement events with Staff Networks (BAME, LGBTQ+, WAND, Carers, Women in Sherwood ~~Time to Change~~Welbeing Champions) ▪ Schwartz rounds ▪ Learning from COVID ▪ ~~Staff morale identified as 'profile risk' in Divisional risk registers~~ ▪ ~~Star of the month/ milestone events~~Key recognition milestones and events ▪ Annual Staff Excellence / Admin Awards ▪ Divisional action plans from staff survey ▪ Policies (inc. staff development; appraisal process; sickness and relationships at work policy) ▪ Just and ~~r~~Restorative culture ▪ Influenza vaccination programme ▪ COVID-19 vaccination programme ▪ Staff wellbeing drop-in sessions ▪ ~~Winter wellbeing approach for 2022/23~~ ▪ Staff wellbeing support ▪ Staff counselling / Occ Health support including dedicated Clinical Psychologist for staff ▪ Enhanced equality, diversity and inclusion focus on workforce demographics ▪ Freedom to Speak Up Guardian and champion networks ▪ Emergency Planning, Resilience & Response (EPRR) arrangements for temporary loss of essential staffing (including industrial action and extreme weather event) ▪ Combined violence and aggression campaign across system partners ▪ Anti-racism Strategy ▪ Industrial action group further developing preparedness for the Trust, system and the wider community	Inequalities in staff inclusivity and wellbeing across protected characteristics groups Continued staff exposure to violence and aggression by patients and service users	Deliver the People, Culture and Improvement Strategy – Year 1 **SLT Lead:** Director of People **Timescale:** ~~March 2023~~Complete Develop and embed staff network groups to address inequalities in staff inclusivity **SLT Lead**: Director of People **Timescale**: June 2023 Violence and Aggression Working Group to establish an action plan in related to the V&A agenda **SLT Lead:** Director of People **Timescale:** Oct 2023	**Management:** Staff Survey Action Plan to Board May 2~~1~~3; Staff Survey Annual Report to Board ~~Jun 21~~ Apr 23; Equality and Diversity Annual Report Jun 22; WRES and WDES report to Board ~~Jun 21~~ Sep 22; Quarterly Assurance reports on People Cabinet ~~& Inclusion and Culture & Improvement~~ to People Culture and Improvement Committee; ~~Winter Wellness Campaign report to Board Oct 21~~ Wellbeing report to People, Culture and Improvement Committee Dec 22; People Plan updates to People, Culture and Improvement Committee quarterly **Risk and compliance:** EPRR Report (bi-annually); Freedom to speak up self-review Board Aug ~~21~~22; Freedom to Speak Up Guardian report quarterly; Guardian of Safe Working report to Board quarterly; Significant Risk Report to RC monthly; Gender Pay Gap report to Board Apr ~~21~~23; Assurance Report to People, Culture and Improvement Committee quarterly; People Plan to People, Culture and Improvement Committee Apr ~~21~~22; Anti-Racism Strategy to Board Mar 22; Mental Health Strategy to PCI Committee Jun 22 **Independent assurance:** National Staff Survey Mar ~~21~~23; SFFT/Pulse surveys (Quarterly); Well-led report CQC; Well-led Review report to Board Apr 22; NHS People Plan – Focus on Equality, Diversity and Inclusion internal audit report Jun 22	Potential impact of cost-of-living issues on staff morale and wellbeing ~~Expected increase in staff sickness and isolation levels due to COVID-19 and influenza~~ Potential industrial action up to and including strike action from all NHS unions, affecting all system partners Develop operational plans for any junior doctor strikes **SLT Lead:** Director of People Timescale: ~~February 2023~~Complete Capture learning from the doctors' strike to implement in ongoing plans for potential future strikes **SLT Lead**: Director of People **Timescale**: ~~April 2023~~ Complete	Inconclusive Last changed October 2022

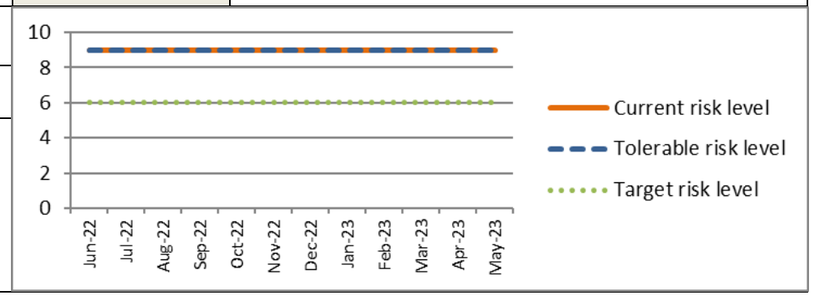
Board Assurance Framework (BAF): May 2023

Principal risk (What could prevent us achieving this strategic objective)	**PR 4: Failure to achieve the Trust's financial strategy** Failure to achieve agreed trajectories resulting in regulatory action							**Strategic objective**
Lead committee	Finance	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Regulatory action	~~5: To achieve better value~~ 5. Sustainable use of resources and estate
Lead director	Chief Financial Officer	**Consequence**	4. High	4. High	4. High	**Risk appetite**	Cautious	
Initial date of assessment	01/04/2018	**Likelihood**	~~4. Somewhat likely~~ 5. Very likely	3. Possible	2. Unlikely			
Last reviewed	25/04/2023	**Risk rating**	~~16~~20. Significant	**12. High**	**8. Medium**			
Last changed	25/04/2023							



Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
A reduction in funding or change in financial trajectory or unexpected event resulting in an increased Financial Improvement Plan (FIP) requirement to reduce the scale of the financial deficit, without having an adverse impact on quality and safety	▪ 5 year long term financial model ▪ Working capital support through agreed loan arrangements ▪ Annual financial plan and budgets, based on available resources and stretching financial improvement targets. ▪ Transformation and Efficiency Cabinet, FIP planning processes and PMO coordination of delivery ▪ Delivery of budget holder training workshops and enhancements to financial reporting ▪ Close working with ICB partners to identify system-wide planning, transformation and cost reductions ▪ Executive oversight of commitments ▪ COVID-19 related funding application process in place at Trust level ▪ Development of a three-year Transformation and Efficiency Programme covering 2022-25 ▪ Forecast sensitivity analysis and underlying financial position reported to Finance Committee ▪ Capital Oversight Group	Medium/Long Term Financial Strategy was developed pre-pandemic and does not reflect the current financial framework Revenue business case process may not adequately represent the longer-term priorities and potential consequences of future years	Financial strategy for 3-5 years to be developed at a Trust and Integrated Care Board level **Progress:** 2023/24 financial plan in development Longer-term financial strategy to be finalised during 2023/24 as part of strategic priorities, in line with clinical and operational strategies **SLT Lead:** Chief Financial Officer **Timescale:** ~~January 2023~~March 2024 Review and implement enhanced business case process for 2023/24 planning and in-year prioritisation **Progress:** Business case process for 2023/24 planning completed – process for in-year prioritisation post-planning to be confirmed **SLT Lead:** Chief Financial Officer **Timescale:** ~~January 2023~~June 2023	**Management:** CFO's Financial Reports and Transformation & Efficiency Summary (Monthly); Quarterly Strategic Priority Report to Board; ICS finance report to Finance Committee (monthly); Capital Oversight Group; Divisional Performance Reviews (monthly); Divisional risk reports to Risk Committee bi-annually; Transformation & Efficiency Cabinet updates to Executive Team **Risk and compliance:** Risk Committee significant risk report Monthly **Independent assurance**: Deloitte audit of COVID-19 expenditure; External Audit Year-end Report 2021/22 Internal Audit reports: - Key Financial Systems - Asset Register Jan 22 - ~~Integrity of the General Ledger and Financial Reporting Dec 21~~ - ~~Financial Reporting Arrangements Nov 21~~ - Improving NHS financial sustainability Dec 22	~~Off trajectory to achieve year-end financial plan, including FIP target~~ Complete the steps of the forecast change protocol and agree a revised forecast with ICB partners and NHS England **SLT Lead:** Chief Financial Officer **Progress:** We have been instructed by NHSE not to change the forecast for month 9 **Timescale:** ~~February 2023~~Complete	Positive Last changed July 2022
ICB system deficit results in a negative financial impact to the Trust	▪ Full participation in ICB planning ▪ SFH plan consistency with ICB and partner plans ▪ ICB DoFs Group ▪ ICB Operational Finance Directors Group ▪ ICB Financial Framework	ICB Medium/Long Term Financial Strategy to be developed	Financial strategy for 3-5 years to be developed at a Trust and Integrated Care Board level **SLT Lead**: Chief Financial Officer **Timescale:** ~~TBC~~ March 2024 (dependant on NHSE/I and ICB Guidance)	**Risk and compliance:** ICS financial reports to Finance Committee; ICS Board updates to SFH Trust Board		Positive Last changed July 2022

Board Assurance Framework (BAF): May 2023

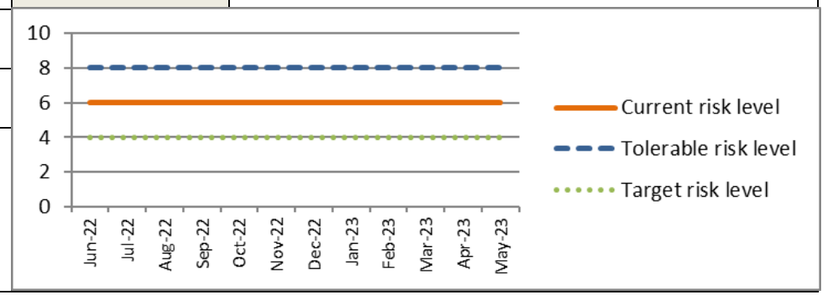
Principal risk (What could prevent us achieving this strategic objective)	**PR 5: Inability to initiate and implement evidence-based improvement and innovation** Lack of support, capability and agility to optimise strategic and operational opportunities to improve patient care							**Strategic objective**	4: To continuously learn and improve
Lead committee	People, Culture & Improvement	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	~~Reputation~~ Services		
Lead director	Director of Strategy and Partnerships	**Consequence**	**3. Moderate**	3. Moderate	3. Moderate	**Risk appetite**	Cautious		
Initial date of assessment	17/03/2020	**Likelihood**	**3. Possible**	3. Possible	2. Unlikely				
Last reviewed	22/05/2023	**Risk rating**	**9. Medium**	**9. Medium**	**6. Low**				
Last changed	22/05/2023								

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Lack of understanding and agility resulting in reduced efficiency and effectiveness around how we provide care for patients	▪ Digital Strategy ▪ People, Culture & Improvement Strategy ▪ Quality Strategy ▪ People, Culture & Improvement Committee ▪ Leadership development programmes ▪ Talent management map ▪ Programme Management Office ▪ Culture & Improvement Cabinet ▪ Transformation Cabinet ▪ Ideas generator platform	The improvement function needs to be defined and organisationally embedded following the restructure	Development of an ideas platform within the remit of the Improvement Faculty **SLT Lead:** Director of Strategy and Partnerships **Timescale:** June 2023	**Management:** Monthly Transformation and Efficiency report to FC; Clinical Audit & Improvement report to Advancing Quality Group quarterly; Culture & Improvement Assurance Report to PC&IC bi-monthly **Risk and compliance:** SOF Culture and Improvement indicators; SFH Trust Priorities to Board quarterly **Independent assurance:** Internal Audit of FIP/ QIPP processes Sep 21; 360 assessment in relation to Clinical Effectiveness - report May 2022	Lack of capacity for colleagues to engage with improvement Consider ways to provide the capacity to progress improvement activity **SLT Lead:** Director of Strategy and Partnerships **Timescale:** June 2023 **Progress:** the transformation programme has now been designed and integrated with strategic priorities and FIP to reduce the number of things we ask the organisation to focus on and to make connections across multiple layers of our business. This will assist in a reduction of meetings and programme reviews. Thereby releasing headspace Improvement Faculty launched 4th May	Inconclusive Last changed October 2022

Board Assurance Framework (BAF): May 2023

Principal risk (What could prevent us achieving this strategic objective)	**PR 6: Working more closely with local health and care partners does not fully deliver the required benefits** Influencing the wider determinants of health and improving our collective financial position requires close partnership working. ~~This may be difficult because of differences in governance, objectives and appetite for and ability to change~~						
Lead committee	Risk	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services
Lead director	Director of Strategy and Partnerships	**Consequence**	**2. Low**	2. Low	2. Low	**Risk appetite**	Cautious
Initial date of assessment	01/04/2020	**Likelihood**	**3. Possible**	4. Somewhat likely	2. Unlikely		
Last reviewed	09/05/2023	**Risk rating**	**6. Low**	**8. Medium**	**4. Low**		
Last changed	09/05/2023						

Strategic objective	~~2: To promote and support health and wellbeing~~ 6. Work collaboratively with partners in the community

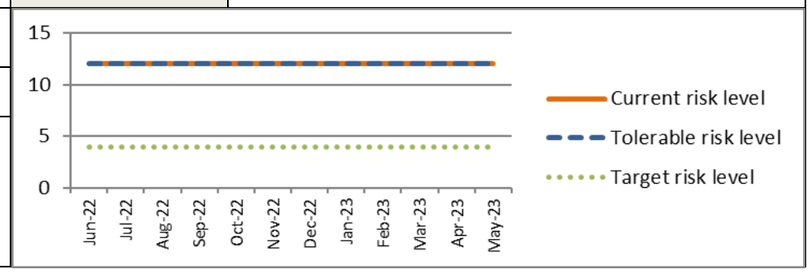


Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Conflicting priorities, financial pressures (system financial plan misalignment) and/or ineffective governance resulting in a breakdown of relationships amongst ICS and ICP partners and an inability to influence further integration of services across acute, mental, primary and social care	• Mid-Nottinghamshire Integrated Care Partnership • Mid-Nottinghamshire ICP Executive formed May 2020 • Mid-Nottinghamshire ICP ~~breakthrough objectives signed off July 2020~~annual work plan • Nottingham and Nottinghamshire Integrated Care System Board • Continued engagement with ICP and ICS planning and governance arrangements • Quarterly ICS performance review with NHSE • Joint development of plans at ICS level • Finance Directors Group • ICS Planning Group • Alignment of Trust, ICS and ICP plans through the joint forward plan • Full alignment of organisational priorities with system planning ~~for 2022/23~~ • Independent chair for ICP • Approved implementation plan for establishing system risk arrangements • ICS Provider Collaborative ~~development~~ • ICS System Oversight Group • ~~Engagement with the establishment of the formal ICB and place-based partnership~~ • SFH Chief Executive is a member of the ICB as a partner member representing hospital and urgent & emergency care services (both formally established on 1st July 2022) • Mid Notts Place Executive • Mid Notts Place-based Partnership			**Management:** Strategic Partnerships Update to Board; mid-Nottinghamshire ICP delivery report to FC (as meeting schedule); Finance Committee report to Board; Nottingham and Nottinghamshire ICS Leadership Board Summary Briefing to Board; Planning Update to Board **Risk and compliance:** Significant Risk Report to RC monthly **Independent assurance**: 360 Assurance review of SFH readiness to play a full part in the ICS – Significant Assurance		Positive Last changed May 2022
Clinical service strategies and/or commissioning intentions that do not sufficiently anticipate evolving healthcare needs of the local population and/or reduce health inequalities, which limits our ability to care for patients in the right place, at the right time	▪ Continued engagement with commissioners and ICS developments in clinical service strategies focused on prevention ▪ Partnership working at a more local level, including active participation in the mid-Nottinghamshire ICP ▪ ICS Clinical Services Strategy now complete ▪ ICS Health and Equality Strategy ▪ ICS Clinical Services workstreams are well established across elective and urgent care and SFH is represented and involved appropriately ▪ Clinical Directors and PCN Directors clinical partnership working	The needs of the population ~~and the statutory obligations of each individual organisation~~ will not be ~~met~~fully understood or aligned to our clinical services until the ICS Clinical Services Strategy is implemented	Refreshed ICS Clinical Services Strategy led by the ICB Medical Director **SLT Lead:** Medical Director **Timescale:** September 2023	**Management:** Mid-Notts ICP Objectives Update to Board**;** Strategic Partnerships Update to Board; mid-Nottinghamshire ICP delivery report to FC (as meeting schedule); Finance Committee report to Board; Planning Update to Board **Independent assurance**: none currently in place		Positive Last changed October 2022

Board Assurance Framework (BAF): May 2023

Principal risk (What could prevent us achieving this strategic objective)	**PR 7: Major disruptive incident** A major incident resulting in temporary hospital closure or a prolonged disruption to the continuity of core services across the Trust, which also impacts significantly on the local health service community						
Lead committee	Risk	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services
Lead director	Director of Corporate Affairs	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Cautious
Initial date of assessment	01/04/2018	**Likelihood**	**3. Possible**	3. Possible	1. Very unlikely		
Last reviewed	09/05/2023	**Risk rating**	**12. High**	**12. High**	**4. Low**		
Last changed	09/05/2023						

Strategic objective	1: To provide outstanding care in the best place at the right time

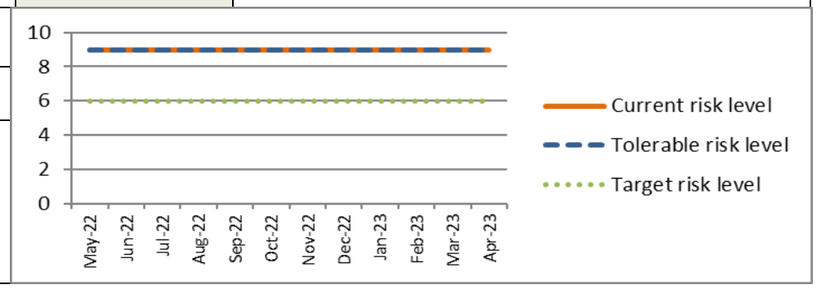


Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Shut down of the IT network due to a large-scale cyber-attack or system failure that severely limits the availability of essential information for a prolonged period	▪ Information Governance Assurance Framework (IGAF) & NHIS Cyber Security Strategy ▪ Cyber Security Programme Board & Cyber Security Project Group and work plan ▪ Cyber news – circulated to all NHIS partners ▪ High Severity Alerts issued by NHS Digital ▪ Network accounts checked after 50 days of inactivity – disabled after 80 days if not used ▪ Major incident plan in place ▪ Periodic phishing exercises carried out by 360 Assurance ▪ Spam and malware email notifications circulated ▪ Periodic cyber-attack exercises carried out by NHIS and the Trust's EPRR lead	Systems connected to the network are not all supported by the respective software suppliers, so are not receiving the latest security updates	A report on unsupported systems to be presented to the Risk Committee **SLT Lead:** Director of NHIS **Timescale:** ~~February 2023~~ Complete A report on the data protection implications from unsupported systems to be presented to the Risk Committee **SLT Lead:** Data Protection Officer **Timescale:** ~~March 2023~~ Complete Ensure all systems have support in place, or the cyber risk is assessed and appropriately mitigated **SLT Lead:** Chief Digital Information Officer **Timescale:** May 2023	**Management:** Data Security and Protection Toolkit submission to Board Jul 22- compliant on 108/109 elements; Hygiene Report to Cyber Security Board monthly; Cyber Security Assurance Highlight Report to Cyber Security Board monthly; NHIS report to Risk Committee quarterly; IG Bi-annual report to Risk Committee; Cyber Security report to Risk Committee – increased levels of attack due to the war in Ukraine **Risk and compliance:** **Independent assurance**: ISO 27001 Information Security Management Certification; TIAN / 360 Assurance Cyber Security Survey - The impact of Covid-19 on the NHS Dec 20; CCG Cyber Security Report Mar 21- Significant Assurance; 360 Assurance NHIS Governance and Interface audit – limited assurance; 360 Assurance Data Security and Protection Toolkit audit Jul 22 –moderate assurance; IT Healthcheck – 2 of 9 elements failed (negative assurance); Cyber Essentials Plus accreditation Jan 22		~~Positive~~ Inconclusive ~~No change since April 2020~~ Last changed February 2023
A critical infrastructure failure caused by an interruption to the supply of one or more utilities (electricity, gas, water), an uncontrolled fire, flood or other climate change impact, security incident or failure of the built environment that renders a significant proportion of the estate inaccessible or unserviceable, disrupting services for a prolonged period	▪ Premises Assurance Model Action Plan ▪ Estates Strategy 2015-2025 ▪ PFI Contract and Estates Governance arrangements with PFI Partners ▪ Fire Safety Strategy ▪ NHS Supply Chain resilience planning ▪ Emergency Preparedness, Resilience & Response (EPRR) arrangements at regional, Trust, division and service levels ▪ Operational strategies & plans for specific types of major incident (e.g. industrial action; fuel shortage; pandemic disease; power failure; severe winter weather; evacuation; CBRNe) ▪ Gold, Silver, Bronze command structure for major incidents ▪ Business Continuity, Emergency Planning & security policies ▪ Resilience Assurance Committee (RAC) oversight of EPRR ▪ Independent Authorising Engineer (Water) ▪ Major incident plan in place			**Management:** Central Nottinghamshire Hospitals plc monthly performance report; Fire Safety Annual Report; Water Safety Update Report to Risk Committee Jul 20; Patient Safety Concerns report to QC March 21; Hard and soft FM assurance reports **Risk and compliance:** Monthly Significant Risks Report to Risk Committee **Independent assurance:** Premises Assurance Model to Executive Team Oct 22; EPRR Core standards compliance rating (Oct~~21~~22) – Substantial Assurance; Water Safety report (WSP) to Joint Liaison Committee Oct 19; WSP report – hard FM independent audit; MEMD ISO 9001:2015 Recertification Mar 21; British Standards Institute MEMD Assessment Report Feb 22	~~Potential insufficient capacity within the Estates department to deliver major capital projects~~ Review of capacity and planned projects **SLT Lead:** Associate Director of Estates and Facilities **Timescale:** ~~March 2023~~ Complete	Positive ~~No change since April 2020~~ Last changed March 2023

Board Assurance Framework (BAF): May 2023

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
~~A critical supply chain failure that severely restricts the availability of essential goods, medicines or services for a prolonged period~~	~~▪ NHS Supply Chain resilience planning Business Continuity Management System & Core standards~~ ~~▪ CAS alert system – Disruption in supply alerts~~ ~~▪ Major incident plan in place~~ ~~▪ PPE Strategy~~ ~~▪ COVID-19 Pandemic Surge Plan~~ ~~▪ Procurement Influenza Pandemic Business Continuity Plan~~ ▪ ~~Interim provision for transmission of personal data to the United Kingdom clause within the EU Exit agreement~~			~~**Management:** Procurement Annual Report to Audit & Assurance Committee; Oxygen Supply Assurance report to Incident Control Team Apr 20; COVID-19 Governance Assurance Report to Board May 20~~ ~~**Risk and compliance:**~~ ~~**Independent assurance**: 2021/22 Counter Fraud Annual Report; 360 Assurance Procurement Review Apr 21 – Significant Assurance; 360 Assurance internal audit of contract management – limited assurance~~		Positive No change since April 2020
Severe restriction of service provision due to a significant operational incident or other external factor	▪ Emergency Preparedness, Resilience & Response (EPRR) arrangements at regional, Trust, division and service levels ▪ Operational strategies & plans for specific types of major incident (e.g. industrial action; fuel shortage; pandemic disease; power failure; severe winter weather; evacuation; CBRNe) ▪ Gold, Silver, Bronze command structure for major incidents ▪ Business Continuity, Emergency Planning & security policies ▪ Resilience Assurance Committee (RAC) oversight of EPRR ▪ Major incident plan in place ▪ Industrial Action Group			**Management:** Industrial Action debrief report to Executive Team Mar 23 **Independent assurance:** EPRR Core standards compliance rating (Oct22) – Substantial Assurance		Positive New threat added May 2023

Board Assurance Framework (BAF): May 2023

Principal risk (What could prevent us achieving this strategic objective)	**PR 8: Failure to deliver sustainable reductions in the Trust's impact on climate change** The vision to further embed sustainability into the organisation's strategies, policies and reporting processes by engaging stakeholders and assigning responsibility for delivering the actions within our Green Plan may not be achieved or achievable						**Strategic objective**	~~2: To promote and support health and wellbeing~~ 2: Improve health and wellbeing within our communities
Lead committee	Finance	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Reputation / regulatory action	
Lead director	Chief Financial Officer	**Consequence**	**3. Moderate**	3. Moderate	3. Moderate	**Risk appetite**	Cautious	
Initial date of assessment	22/11/2021	**Likelihood**	**3. Possible**	3. Possible	2. Unlikely			
Last reviewed	25/04/2023	**Risk rating**	**9. Medium**	**9. Medium**	**6. Low**			
Last changed	28/03/2023							

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Failure to take all the actions required to embed sustainability and reduce the impact of climate change on our community	▪ Estates & Facilities Department oversee the plan and education on climate change impacts ▪ Green Plan 2021-2026 ▪ Climate Action Project Group ▪ Sustainability Development Strategy Group ▪ Engagement and awareness campaigns (internal/external stakeholders) ▪ Estates Strategy ▪ Digital Strategy ▪ Capital Planning sustainability impact assessments ▪ Environmental Sustainability Impact Assessments built into the Project Implementation Documentation process ▪ Engagement with the wider NHS sustainability sector for best practice, guidance and support ▪ Process in place for gathering and reporting statistical data ▪ Adoption of NHS Net Zero building standard 2023 for all works from October 2023 ▪ Awareness to, and applications for, funding sources both internally and externally such as the Public Sector Decarbonisation Scheme and grants from Salix Ltd	Education of Board and staff at all levels Dedicated capacity to implement ideas for change	Training of the Board, decision makers and all staff at an appropriate level to increase awareness and understanding of sustainable healthcare **Progress:** Training package developed with Notts Healthcare Trust – awaiting ratification and training dates **Lead:** Associate Director of Estates and Facilities **Timescale:** ~~December 2022~~July 2023 Proposal to ICB partners for collaborative approach and resource **Progress:** At the ICB Estates Group in March 2023 a common approach to system wide sustainability reporting and resourcing was suggested and will be reflected in revised ToR **Lead:** Chief Financial Officer **Timescale:** ~~December 2022~~June 2023	**Management:** Sustainability update report to TMT Oct 22; Green updates provided routinely to Finance Committee **Risk and compliance:** Green Plan to Board Apr 21; Sustainability Report included in the Trust Annual Report **Independent assurance:** ERIC returns and benchmarking feedback		Positive Last changed November 2022