Board Assurance Framework (BAF): October 2024

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

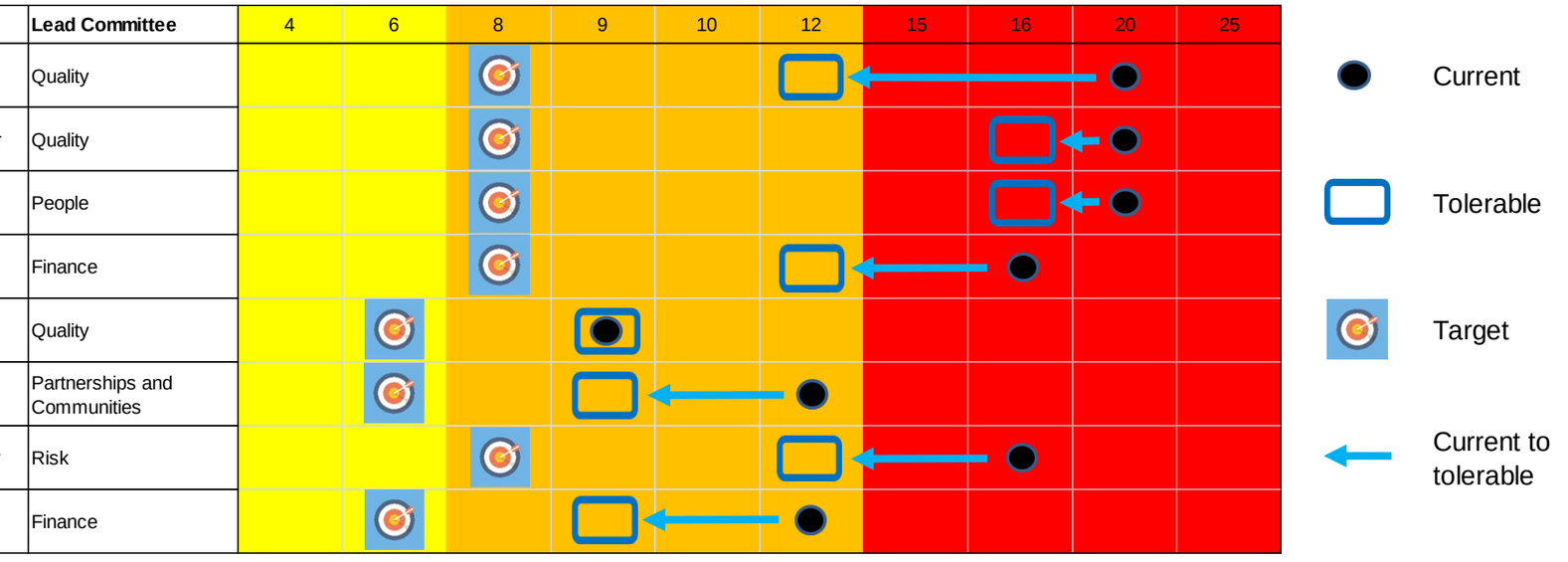
Red = Negative assurance: the Committee is not satisfied that there is sufficient reliable evidence that the current risk treatment strategy is appropriate to the nature and/or scale of the threat or opportunity

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.

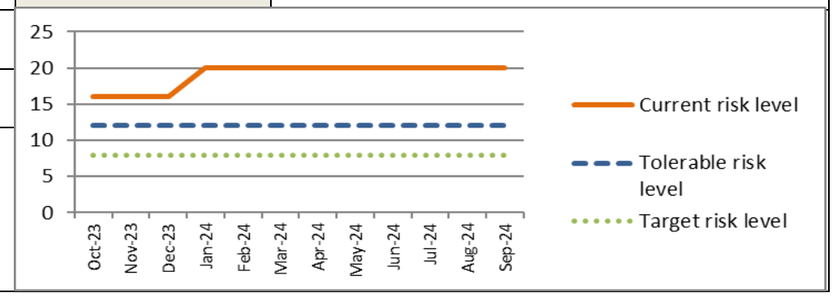
Likelihood score and descriptor					
	Very unlikely 1	**Unlikely 2**	**Possible 3**	**Somewhat likely 4**	**Very likely 5**
Frequency How often might/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally 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 Chief Nurse	Quality
PR2	**Demand that overwhelms capacity**	Chief Operating Officer	Quality
PR3	**Critical shortage of workforce capacity and capability**	Director of People	People
PR4	**Insufficient financial resources available to support the delivery of services**	Chief Financial Officer	Finance
PR5	**Inability to initiate and implement evidence-based improvement and innovation**	Director of Strategy and Partnerships	Quality
PR6	**Working more closely with local health and care partners does not fully deliver the required benefits**	Director of Strategy and Partnerships	Partnerships and Communities
PR7	**Major disruptive incident**	Chief Executive Officer	Risk
PR8	**Failure to deliver sustainable reductions in the Trust's impact on climate change**	Chief Financial Officer	Finance



Board Assurance Framework (BAF): October 2024

Principal risk (What could prevent us achieving this strategic objective)	**PR 1: Significant deterioration in standards of safety and care** 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						**Strategic objective**	Provide outstanding care in the best place at the right time
Lead committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Patient harm	
Lead directors	Medical Director Chief Nurse	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Minimal	
Initial date of assessment	01/04/2018	**Likelihood**	**5. Very likely**	3. Possible	2. Unlikely			
Last reviewed	23/09/2024	**Risk rating**	**20. Significant**	**12. High**	**8. Medium**			
Last changed	23/09/2024							

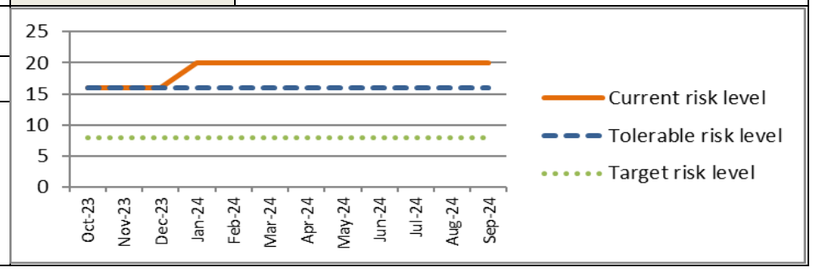
Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required 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 maintain patient safety and quality of care leading to increased incidence of avoidable harm 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 ▪ IPR metric reviewed annually and agreed by Board ▪ Nursing & Midwifery Strategy ▪ AHP Strategy ▪ Patients Safety Incident Response Framework (PSIRF) ▪ Review, oversight and learning from patient safety incidents Internal Reviews against External National Reports ▪ Getting it Right First Time (GIRFT) localised deep dives, reports and action plans ▪ CQC quarterly 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 ▪ Digital Strategy Group	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 ~~Difficulty in maintaining the safety of our existing in-patients during prolonged periods of industrial action~~ Inability to re-provide MDT or appointments in a timely way impacting on cancer pathway metrics and overall patient care Financial restraints may lead to impacts on ability to maintain patient care and safety, including the ability to recruit temporary staffing	Review the existing reporting metrics used to monitor patient safety and identify improvements to ensure consistency of the values used across different reports across governance groups, including the development of a quality dashboard **SLT Lead:** Medical Director / Chief Nurse **Progress:** Review completed – developing dashboard **Timescale:** ~~September~~ November 2024 Monitoring of fill rates and quality impact **SLT Lead:** Medical Director / Chief Nurse **Timescale:** December 2024	**Management:** Learning from deaths Report to Quality Committee and Board; Quarterly Strategic Priority Report to Board; Divisional risk reports to Risk Committee bi-annually; Guardian of Safe Working report to Board quarterly 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 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; Digital risks reported to Risk Committee 6-monthly and DSG monthly **Risk and compliance:** Quality Dashboard and IPR to Quality Committee bi-monthly; Quality Account Report qtrly to PSC and QC; SI & Duty of Candour report to PSC monthly; CQC report to QC quarterly; Significant Risk Report to RC monthly; Exception reporting to System Quality Committee bi-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)	Unmitigated risk associated with the continuation and escalation of industrial action, the lack of progress towards a negotiated solution and the impact across professional groups who inevitably step up to provide cover in service gaps Palpable harm to staff due to work pressures, and the longevity and impact of the ongoing demands Running at OPEL4 for a protracted length of time and full capacity protocol, exceeding full capacity protocol and system-wide critical incidents	Positive No change since April 2020

Board Assurance Framework (BAF): October 2024

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 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 ▪ Infectious disease identification and management process ▪ Infection Prevention and Control Board Assurance Framework ▪ Outbreak meeting including external representation, PHE, Regional IPC ▪ CQC IPC Key lines of enquiry engagement sessions	FIT mask testing compliance rate below required rate	Increase compliance to target rate **Progress:** Fit Testing Data is now included in Divisional Performance Review Packs Compliance increased, but not yet to target rate, and targeting high-risk areas **SLT Lead:** Director of People / Chief Nurse **Timescale:** October 2024 Establish a FIT testing task and finish group **SLT Lead:** IPC Nurse Consultant **Timescale:** ~~August 2024~~Complete	**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; Integrated Performance Report to Board monthly; IPC Clinical audits in IPC Committee report to PSC qtrly; Regular IPC updates to ICT; PLACE Assessment and Scores Estates Governance bi-monthly **Independent assurance:** Internal audit plan: UKHSA attendance at IPC Committee; Independent Microbiologist scrutiny via IPC Committee; Influenza vaccination cumulative number of staff vaccinated; ICS vaccination governance report monthly; IPC BAF Peer Review by Medway Trust; HSE External assessment and report; Annual Maternity incentive scheme assessment, which incorporates 10 safety elements, regional monthly heat map and progress towards the Three-Year Delivery Plan		Positive Last changed November 2022

Board Assurance Framework (BAF): October 2024

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							**Strategic objective**	Provide outstanding care in the best place at the right time
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	2. Unlikely				
Last reviewed	23/09/2024	**Risk rating**	**20. Significant**	**16. Significant**	**8. Medium**				
Last changed	23/09/2024								



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 and increasing complexity of health needs • 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 under oversight of the Urgent and Emergency Care (UEC) Board and the System Oversight Group ▪ SFH Medical and Surgical Same Day Emergency Care (SDEC) services in place (and expanding) to avoid admissions into inpatient facilities ▪ Single streaming process for ED & Primary Care and SDEC direct access – regular meetings with Nottingham Emergency Medical Services (NEMS) ▪ Trust and System escalation policies and processes, including Operational Pressures Escalation Level (OPEL) Framework and Full Capacity Protocol ▪ Trust leadership of and attendance at ICS UEC Delivery Board ▪ Inter-professional standards across the Trust to ensure we complete today's work today ▪ SFH annual capacity plan with specific focus on the Winter period via the Winter Planning Group ▪ Referral management systems shared between primary and secondary care ▪ UEC Improvement Programme focussing on internal flow ▪ Theatres, Outpatients and Diagnostics Transformation Programmes ▪ Planned Care Steering Group ▪ Emergency Care Steering Group	Physical staffed capacity/estate is insufficient to cope with surges in demand without undertaking exceptional actions that are part of our full capacity protocol e.g. opening surge capacity, reducing elective operating, bedding patients in alternative areas i.e. day case	Continuation of March 2024 Emergency Department schemes to support non-admitted breach reduction **SLT Lead:** Chief Operating Officer **Timescale:** throughout Q1 and ~~continuing into~~ Q2, and continuing into Q3 Trial of frailty SDEC co-located with Discharge Lounge **Progress:** ~~Trial commenced 2024~~Part of 2024/25 Winter Plan **SLT Lead:** Chief Operating Officer **Timescale:** ~~End Q2 – then decision to end or make substantive~~Commence October 2024 Provide input and support to the System Analytical Intelligence Unit (SAIU) who are undertaking a system-wide diagnostic to try to identify the drivers to increased urgent care demand **Progress:** ~~First draft of the report (which excludes hospital date)~~ Report completed and has been shared by the SAIU in July 2024 **SLT Lead:** Chief Operating Officer **Timescale:** ~~throughout Q2~~Complete Winter Plan to be agreed and implemented **Progress:** First draft approved by Trust Board in September 2024. Final draft to be approved in October 2024, then immediate implementation **SLT Lead:** Chief Operating Officer **Timescale:** October 2024	**Management:** Performance management reporting arrangements between Divisions, Service Lines, Executive Team on an at least bi-monthly basis, and Board quarterly **Risk and compliance:** Divisional risk reports to Risk Committee bi-annually; Significant Risk Report to RC monthly; Integrated Performance Report including national rankings to Board quarterly **Independent assurance:** Performance Management Framework internal audit report Jun 22; Operational Planning internal audit report Jul 24		~~Positive~~ Inconclusive Last changed ~~December 2020~~ September 2024

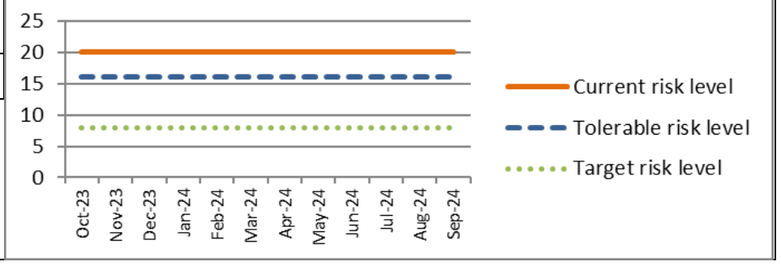
Board Assurance Framework (BAF): October 2024

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**
Constraints in availability of hospital bed capacity caused by elevated 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 in place that undertakes twice-daily reviews of patients awaiting Nottinghamshire packages of care ▪ Full use of our bed base across our 3 sites with further capacity purchased from Ashmere Group Care Homes (at reduced levels in 2024) ▪ Improved use of NerveCentre to facilitate timely patient discharge ▪ Re-introduction of Discharge Co-ordinators across inpatient wards	Lack of consistent achievement of the mid-Notts threshold for MSFT patients of 40	Right-size pathway 2 and pathway 3 bedded capacity required for rehabilitation and re-enablement across the ICS to reduce length of stay and MFFD **SLT Lead:** Chief Operating Officer **Timescale:** October 2024 Roll out a series of one-minute videos that explaining the basic but essential elements of patient flow **SLT Lead:** Chief Operating Officer **Timescale:** December 2024	**Management:** Daily and weekly themed reporting of the number of MFFD patients in hospital beds - reports into the ICS UEC Delivery Board and ICS Demand and Capacity Group monthly **Risk and compliance:** Exception reporting on the number of MFFD into the Trust Board via the Integrated Performance Report quarterly, which is showing positive progress in 2024/25 Q1 and Q2		Inconclusive No change since threat added in January 2022
Failure of Primary Care 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 System Oversight Group meetings across ICS, including Primary Care ▪ ICS Primary Care Strategy Group, with responsibility for overseeing delivery of the Primary Care Access Recovery Plan ▪ Nottingham Emergency Medical Services-run 24/7 primary care service within our Emergency Department			**Management:** Routine mechanism for sharing of ICS and SFH risk registers – particularly with regard to risks for primary care staffing and demand; ICS reports available on the System Analytical Intelligence Unit portal		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 relevant Integrated Care System (ICS) groups/boards~~, and assuming a leading role in Integrated Care Provider development~~ ▪ Horizon scanning with neighbour organisations via meetings between relevant Executive Directors ▪ Mechanism in place to agree peripheral and full diverts of patients via EMAS ▪ Regular meetings in place with EMAS and commissioners to review and discuss appropriate flow of patients to our hospitals			**Management:** A&E attendance demand report (including post code analysis of ambulance conveyance) to Finance Committee Feb 24, and shared with System partners **Independent assurance:** Weekly reports provided by NHSE Regional Team showing performance against key Urgent and Emergency Care metrics; System Analytical Intelligence Unit (SAIU) Drivers of Urgent Care Demand report Sep 24	Lack of control over the flow of patients from the surrounding area, including decisions by EMAS to undertake strategic conveyancing 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 2024 Review volume of patients attending the Trust from peripheral post codes to ensure a consistent approach to ambulance conveyance **Progress:** initial findings have shown an increase of patients from the Hucknall and Alfreton areas **SLT Lead:** Chief Operating Officer **Timescale:** ~~throughout Q2~~Complete	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~~ ▪ Additional antenatal clinics based on overtime/bank ▪ Maternity assurance group (monthly) ▪ Director of Midwifery providing Board-level oversight	Physical capacity/estate will be insufficient should growth trends continue in the coming years		**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): October 2024

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	**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**	**5. Very likely**	4. Somewhat likely	2. Unlikely		
Last reviewed	24/09/2024	**Risk rating**	**20. Significant**	**16. Significant**	**8. Medium**		
Last changed	24/09/2024						

Strategic objective	Empower and support our people to be the best they can be



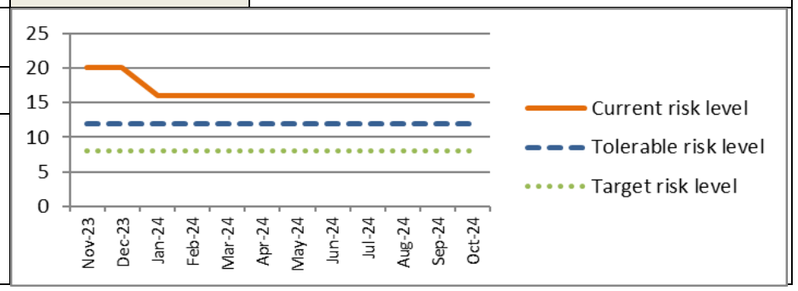
Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required 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, resulting in critical workforce gaps in some clinical and non-clinical services	▪ People Strategy 2022-2025 ▪ People Cabinet ▪ Activity, Workforce and Financial plan ▪ 5-year strategic workforce plan supported by associated Tactical People Plans ▪ ICS People and Culture Strategy (2019 to 2029) and Delivery Group ▪ 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 ▪ Medical Transformation Board ▪ Nursing & Midwifery Transformation Board ▪ ICB Agency Reduction Group ▪ 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 ▪ Communication of daily SitReps (Situation Reports) for workforce gaps ▪ CDC Workforce Group ▪ CDC Steering Group ▪ People Promises Exemplar Organisation	Workforce gaps across key areas such as Medical, Nursing, AHP and Maternity, which may impact on the quality and standard of care Lack of consistency across the system about recruitment and retention, creating competition and not maximising opportunities Inability to achieve the system workforce efficiency programme target	Deliver the People Strategy – Year 3 priorities and objectives **SLT Lead:** Director of People **Timescale:** March 2025 Work with provider collaborative colleagues to deliver the Vanguard programme in relation to workforce portability / passporting recruitment KPIs **SLT Lead:** Director of People **Progress:** Pilot for resident doctors to commence in November **Timescale**: ~~September~~ November 2024 Deliver the plan to replace premium pay and agency staff with substantive workforce **SLT Lead:** Director of People **Timescale:** March 2025	**Management:** Quarterly Strategic Priority Report to Board; Nursing and Midwifery and AHP six monthly staffing report to People Committee; Workforce and OD ICS/ICP update quarterly; Quarterly Assurance reports on People ~~& Inclusion~~ and Culture ~~& Improvement~~ to People Committee; Recruitment & Retention report monthly; Strategic People Plan to People~~, Culture and Improvement~~ Committee May ~~23~~24; Employee Relations Quarterly Assurance Report to People Committee; People Plan updates to People Committee bi-monthly; Leadership Development Strategy ~~Assurance Report to PCI Committee Jul 23;~~ Assurance Report to People Committee quarterly; NHSE Planning – Workforce Perspective Report to People Committee May 24 **Risk and compliance:** Risk Committee significant risk report monthly; HR & Workforce planning report Risk Committee; IPR – 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; Recruitment of agency staff audit report Jun 23; Appraisals internal audit report Jun 24	Impact of the Trust workforce financial efficiency programme with enhanced controls regarding recruitment and a reduction in bank rates of pay Periodic review of the impact of cost and recruitment restrictions on staff safety and staffing levels **SLT Lead:** Director of People **Timescale:** March 2025	~~Positive~~ Inconclusive Last changed ~~June 2022~~ September 2024

Board Assurance Framework (BAF): October 2024

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 significant loss of workforce productivity arising from a short-term reduction in staff availability or reduction in morale and engagement	▪ People Strategy 2022-2025 ▪ People Cabinet ▪ Chief Executive's blog / Staff Communication bulletin / Weekly #TeamSFH Brief ▪ Engagement events with Staff Networks (BAME, LGBTQ+, WAND, Carers, Women in Sherwood Wellbeing Champions) ▪ Schwartz rounds ▪ Learning from COVID ▪ 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 Restorative culture ▪ Influenza vaccination programme ▪ COVID-19 vaccination programme ▪ Staff wellbeing drop-in sessions ▪ 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 ▪ Winter Wellness Campaign ▪ Sexual safety working group ▪ Violence Prevention and Reduction Working Group	Inequalities in staff inclusivity and wellbeing across protected characteristics groups Continued staff exposure to violence and aggression by patients and service users Concerns over sexual safety in the workplace	Develop an action plan from the outcomes of the National 2023 Staff Survey **SLT Lead:** Director of People **Timescale:** ~~September 2024~~Complete Include actions to address inequalities in staff inclusivity within the new People Strategy **SLT Lead:** Director of People **Timescale:** April 2025 Develop and Implement the Violence Prevention and Reduction action plan **SLT Lead:** Director of People **Timescale:** March 2025 Review with Provider Collaborative Colleagues wellbeing offers and identify areas of duplication and gaps, developing recommendations for delivery at a system level – vanguard programme **SLT Lead:** Director of People **Progress:** ICB have commissioned Arden and Gem (CSU) to produce a report to identify gaps and create an action plan **Timescale**: ~~September 2024~~January 2025 Develop and implement a Sexual Safety Policy and process **SLT Lead:** Director of People **Timescale:** ~~December 2024~~Complete People Promises work taking forward a plan to address sexual safety in the workplace **SLT Lead:** Director of People **Timescale:** March 2025	**Management:** Staff Survey Action Plan to Board ~~May 23~~ Apr 24; Staff Survey Annual Report to Board Apr ~~23~~24; Equality and Diversity Annual Report ~~Jun 22~~ Jul 24; WRES and WDES report to ~~Board Oct 23~~ People Committee Jul 24; Quarterly Assurance reports on People Cabinet to People Committee; Wellbeing report to People, ~~Culture and Improvement~~ Committee ~~Dec 22~~ Mar 24; People Plan updates to People Committee quarterly; Leadership Report to People Committee Jul 24; Diversity in the Trust – Senior Leadership Roles report to People Committee May 24; Violence and Aggression Improvement Plan to People Committee Mar 24 **Risk and compliance:** EPRR Report (bi-annually); Freedom to speak up self-review Board ~~Aug 23~~ Jul 24; 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 23~~ People Committee May 24; ~~Assurance Report to People Committee quarterly;~~ NHS Long Term Workforce Plan to People and Culture Committee Sep 23~~;~~ and Strategic Workforce Plan update to People Committee May 24; Health and Wellbeing Campaign presented to People and Culture Committee Sep 23; Anti-Racism Strategy to Board Mar 22; Mental Health Strategy to PCI Committee Jun 22 **Independent assurance:** National Staff Survey Mar ~~23~~24; 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; Staff Wellbeing internal audit report Jan 24	Potential impact of cost-of-living issues on staff morale and wellbeing ~~Industrial action up to and including strike action from all NHS unions, affecting all system partners~~ ~~Potential strike action by junior doctors~~ ~~Industrial action by Medirest staff~~	~~Inconclusive~~ Positive Last changed ~~October 2022~~ September 2024

Board Assurance Framework (BAF): October 2024

Principal risk (What could prevent us achieving this strategic objective)	**PR 4: Insufficient financial resources available to support the delivery of services** Financial funding allocated to and generated by the Trust does not cover the costs of services provided					**Strategic objective**	Sustainable use of resources and estate
Lead committee	Finance	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Regulatory action
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**	3. Possible	2. Unlikely		
Last reviewed	29/10/2024	**Risk rating**	**16. Significant**	**12. High**	**8. Medium**		
Last changed	29/10/2024						



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**
Regulatory action due to a failure to deliver NHS England financial targets	▪ 2024/25 Financial Plan agreed with NHSE and ICB, in line with NHSE Revenue Control Limit ▪ Annual budgets based on available resources and stretching financial improvement targets ▪ Scheme of Delegation, Standing Financial Instructions and Executive oversight of commitments ▪ Budgetary Control Procedure Document, delivery of budget holder training workshops and monthly financial reporting ▪ Monthly Provider Finance Return and escalation meetings with NHSE as necessary ▪ Forecast sensitivity analysis and underlying financial position reported to Finance Committee ▪ Divisional Performance Reviews (bi-monthly) ▪ Divisional Finance Committees established in most divisions ▪ NHSE Financial controls self-assessment completed and working group set up to undertake improvement actions ▪ Financial Resources Oversight Group (FROG) established and meeting monthly. ▪ Vacancy Control panels in place ▪ Updated guidance on Discretionary Spend introduced ▪ Weekly 'Grip & Control Arbitration' panels established ▪ Financial Recovery Cabinet (monthly) and Financial Efficiency Review (weekly) meetings established	Medium/Long Term Financial Strategy was developed pre-pandemic and does not reflect the current financial framework ~~Shortfall in schemes identified to deliver the £38.5m efficiency target included in the 2024/25 Financial Plan~~ Risk adjusted efficiency forecast falls short of the annual target of £38.5m	Financial strategy for 3-5 years to be developed at a Trust and Integrated Care Board level **Progress:** Financial Recovery Plan required to demonstrate financial sustainability by March 2026 in line with NHSE direction. Longer-term financial plan in development as part of strategic priorities, in line with clinical and operational strategies. Update scheduled for Finance Committee in October 2024 **SLT Lead:** Chief Financial Officer **Timescale:** ~~September~~October 2024 Rapidly identify and implement efficiency schemes to meet the 2024/25 Financial Plan **Progress:** ~~Weekly Financial Efficiency Oversight meetings established and 'Plan B' list in development. Grant Thornton 6-weeks diagnostics exercise near completion~~ Overall plan now exceeds the 2024/25 target **SLT Lead:** Chief Financial Officer **Timescale:** ~~August 2024~~Complete De-risking programme underway on all schemes to increase confidence in delivery of the 2024/25 target. **Progress:** Weekly Financial Efficiency Oversight meetings and monthly Financial Recovery Cabinet established. Weekly reports shared with the Executive Team. **SLT Lead:** Chief Financial Officer **Timescale:** Ongoing with a target of December 2024 for a risk-adjusted forecast that meets the target	**Management:** Monthly Finance Report to Finance Committee Quarterly; Quarterly Integrated Performance Report to Board; ICS finance report to Finance Committee (monthly); NHSE updates to Finance Committee; Monthly variable pay reports to Trust Management Team; divisional representation at Finance Committee on a cyclical basis **Risk and compliance:** **Independent assurance**: NHS England Financial Controls Assessment (Sep 23); External Audit Year-end Report 2023/24 Internal Audit reports: - Improving NHS financial sustainability (Dec 22) - Key Financial Systems – Pay Expenditure (Jul 23) - Financial Governance - Financial Ledger and Reporting (Mar-24) - Budget Setting, Reporting and Monitoring (Jun-24) - Operational Planning (Jun-24) - Financial Improvement Plan – Efficiency & Productivity (Jun-24) - System Financial Controls (Jun-24)	Nottinghamshire system selected for NHSE initiated Investigation and Intervention Process (I&I) **Progress:** Phase 1 (Investigation) report issued and discussed at Finance Committee and Board of Directors. Phase 2 commenced 16th September for a 12 week period **Lead:** Chief Financial Officer **Timescale:** December 2024	Positive Last changed January 2024

Board Assurance Framework (BAF): October 2024

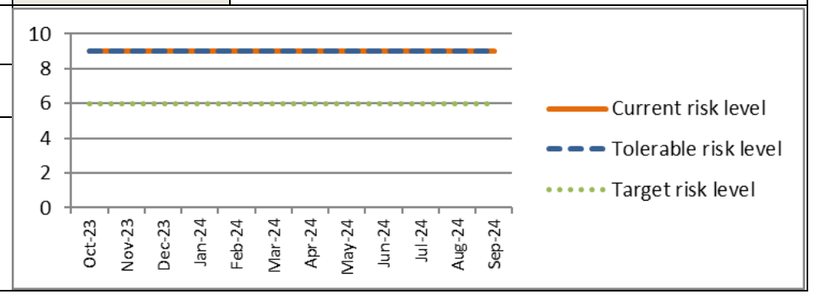
Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required 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**
		Financial Recovery Plan required to demonstrate a route to a break-even financial position by March 2026	Financial Recovery workstreams to be established, plan to be developed and appointments of ~~Financial Turnaround Director and~~ Associate Director of Financial Recovery and Sustainability to be made **Progress:** Initial workstreams set out and Associate Director of Financial Recovery and Sustainability role recruited (start date October 2024) **SLT Lead:** Chief Financial Officer **Timescale:** • July 2024 – Workstreams established (Complete) • ~~August 2024 – Turnaround Director appointed~~ • September 2024 – Financial Recovery Plan confirmed • September 2024 – Further resourcing requirements confirmed • October 2024 – Associate Director of Financial Recovery and Sustainability appointed			
Cash availability leads to delays in paying suppliers and workforce	▪ Daily cash flow forecasts prepared ▪ Cash Management Policy to protect cash balances and establish prioritisation of payments ▪ NHS England process followed to access Revenue Support PDC ▪ Financial Improvement Programme in place to deliver cash-releasing efficiencies ▪ Budgetary control processes and Scheme of Delegation in place to prevent overspends ▪ No Purchase Order, No Pay policy in place		2024/25 Revenue Support applications have not been supported in full by NHSE Meeting to be arranged with NHSE representatives to understand the risk and appeals process **Lead:** Deputy Chief Financial Officer. **Timescale:** October 2024	**Management:** Monthly Finance Report to Finance Committee includes details on cash flow, debtors and creditors **Independent assurance**: NHS England Financial Controls Assessment (Sep 23) Internal Audit reports: - Key Financial Systems – Accounts Payable and Treasury and Cash Management (Mar-24) - Financial Governance – Financial Ledger and Reporting (Mar-24)		**Positive** New threat added July 2024
ICB system financial performance challenge leads to disinvestment in SFH	▪ 2024/25 Financial Plan agreed with NHSE and ICB, in line with NHSE Revenue Control Limit ▪ ICS Directors of Finance Group established and attended by SFH Chief Financial Officer ▪ ICS Financial Recovery Group meeting weekly ▪ ICS System Opportunities Group meets bi-weekly, with SFH representation ▪ ICS Operational Finance Directors Group established and attended by SFH Deputy Chief Financial Officer ▪ ICB Financial Framework ▪ Close working with ICB partners to identify system-wide planning, transformation and cost reductions	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 **Progress:** Sustainability reviews to be completed through Q1/Q2 of 2024/25 to establish a route to sustainability **SLT Lead**: Deputy Chief Financial Officer **Timescale:** ~~September~~ November 2024 (dependant on NHSE/I and ICB Guidance)	**Risk and compliance:** ICS financial reports to Finance Committee; ICS Board updates to SFH Trust Board **Independent assurance**: System Financial Controls Internal Audit report (Jun-24)	Impact of ICS partner financial recovery actions on SFH to be assessed **Progress:** Increasing prevalence of ICB savings that impact on SFH finances – CEO and CFO taking action to understand and mitigate this risk Letter sent from the CFO to ICB confirming the SFH stance on actions that may adversely impact the Trust's financial position – awaiting response **Lead:** Chief Financial Officer **Timescale:** ~~September 2024~~ Ongoing as recovery actions are developed	Positive Last changed July 2022
Insufficient capital resources to fund required infrastructure	▪ Capital Resources Oversight Group (CROG) overseeing capital expenditure plans ▪ Capital Prioritisation process established ▪ ICS Capital Management meetings in place to monitor spend and highlight risks			**Management:** Board approved 2024/25 Capital Expenditure Plan; Capital Resources Oversight Group highlight reports to Trust Management Team; Divisional risk reports to Risk Committee (bi-annually); Monthly Finance	Further Internal Audit of capital expenditure process to be undertaken by 360 Assurance to provide independent assurance. **Lead:** Head of Financial Services **Timescale:** December 2024	**Positive** New threat added July 2024

Board Assurance Framework (BAF): October 2024

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**
				Report to Finance Committee includes details on capital expenditure **Risk and compliance:** Monthly Risk Committee significant risks report **Independent assurance**: Capital Internal Audit report Jul 24		
Reliance on non-recurrent funding and efficiencies threatens long-term sustainability of services	▪ Improvement Faculty established to support the development and delivery of transformation and efficiency schemes ▪ Weekly Financial Efficiency update report to the Executive Team (and Monthly to Trust Management Team), detailing recurrent and non-recurrent savings ▪ Weekly Financial Efficiency Oversight meetings established ▪ ~~Improvement~~ Financial Recovery Cabinet in place to support longer-term decision making	Medium/Long Term Financial Strategy was developed pre-pandemic and does not reflect the current financial framework	Financial strategy for 3-5 years to be developed at a Trust and Integrated Care Board level **Progress:** Longer-term financial in development as part of strategic priorities, in line with clinical and operational strategies, annual planning for 2024/25 in progress **SLT Lead:** Chief Financial Officer **Timescale:** ~~July~~ September 2024 Planning and budget setting principles to be agreed to enable recurrent delivery of schemes currently deemed non-recurrent **SLT Lead:** Deputy Chief Financial Officer **Timescale:** March 2025	**Management:** Monthly Finance Report to Finance Committee includes details on financial efficiency; Divisional Performance Reviews (bi-monthly); Divisional risk reports to Risk Committee bi-annually; Improvement Cabinet highlight reports to Trust Management Team and Finance Committee **Independent assurance**: Internal Audit reports: - Improving NHS financial sustainability (Dec-22) - Financial Improvement Plan – Efficiency and Productivity (Jun-24)		**Positive** New threat added July 2024

Board Assurance Framework (BAF): October 2024

Principal risk (What could prevent us achieving this strategic objective)	**PR 5: Inability to initiate and implement evidence-based improvement and innovation** Lack of capacity, capability and agility to optimise strategic and operational opportunities to improve patient care							**Strategic objective** / Continuously learn and improve
Lead committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	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	23/09/2024	**Risk rating**	**9. Medium**	**9. Medium**	**6. Low**			
Last changed	23/09/2024							

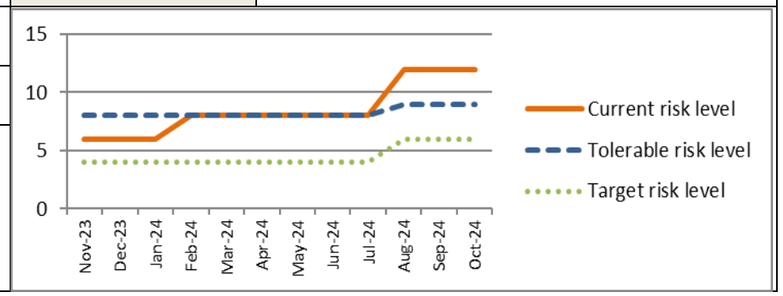


Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required 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 embedded improvement culture across the Trust resulting in suboptimal efficiency and effectiveness around how we provide care for patients	▪ Digital Strategy ▪ People Strategy ▪ People Committee ▪ Quality Strategy ▪ Quality Committee ▪ Leadership development programmes ▪ Talent management map ▪ Strategy & Partnerships Cabinet ▪ Ideas generator platform ▪ Improvement Faculty ▪ Financial Recovery Programme ▪ ~~Improvement~~ Financial Recovery Cabinet	Continuous Quality Improvement Strategy not yet approved	Continue communications to promote further engagement while the Continuous Improvement Strategy is being developed **Progress:** attendance at various meetings, with others planned **SLT Lead:** Director of Strategy and Partnerships **Timescale:** ~~July 2024~~Complete Develop a process for clinical input for public and colleague engagement in improvement and transformation activities **Progress:** Process under development with the support of key stakeholders Recruited to key roles to support the process and plans in place to complete the documented process. To be reviewed to encompass the pending recommendations in the Darzi report **SLT Lead:** Director of Strategy and Partnerships **Timescale:** ~~August 2024~~February 2025 Develop and roll out a Continuous Improvement Strategy **Progress:** ~~Strategy developed for approval by the Strategy and Partnerships Cabinet in July, then immediate roll-out~~Paused until the new Improvement Director is in post **SLT Lead:** Director of Strategy and Partnerships **Timescale:** ~~August 2024~~April 2025	**Management:** Monthly Transformation and Efficiency report to FC; Improvement report to Quality Committee bi-monthly; NHS Impact Self-Assessment **Risk and compliance:** Strategic Priorities report to Board quarterly **Independent assurance:** 360 assessment in relation to Clinical Effectiveness - report May '22		Inconclusive Last changed October 2022

Board Assurance Framework (BAF): October 2024

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~~ Working more closely with health, care and educational partners, does not deliver the Trust's Improving Lives strategic objectives** ~~Influencing the wider determinants of health and improving our collective financial position requires close partnership working~~						
Lead committee	Partnerships and Communities	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services
Lead director	Acting Director of Strategy and Partnerships	**Consequence**	~~2. Low~~ **3. Moderate**	~~2. Low~~ 3. Moderate	~~2. Low~~ 3. Moderate	**Risk appetite**	Cautious
Initial date of assessment	01/04/2020	**Likelihood**	4. Somewhat likely	~~4. Somewhat likely~~ 3. Possible	2. Unlikely		
Last reviewed	22/10/2024	**Risk rating**	~~8. Medium~~ **12. High**	~~8~~9. Medium	~~4~~6. Low		
Last changed	22/10/2024						

Strategic objective	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 PBP Executive~~ ~~• Mid-Nottinghamshire PBP annual work plan~~ ~~• Nottingham and Nottinghamshire Integrated Care System Board~~ ~~• Continued engagement with PBP 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 PBP plans through the joint forward plan~~ ~~• Full alignment of organisational priorities with system planning~~ ~~• Independent chair for PBP~~ ~~• Approved implementation plan for establishing system risk arrangements~~ ~~• ICS Provider Collaborative~~ ~~• ICS System Oversight Group~~ ~~• SFH Chief Executive is a member of the ICB as a partner member representing hospital and urgent & emergency care services~~ ~~• New Place-based Partnership (PBP) leadership arrangements in place~~ ~~• New PBP executive providing oversight and leadership~~ ~~• Distributed Executive Group~~ ~~• East Midlands Acute Providers (EMAP) Network - attendance at both the Chief Executive Forum and Executive Group~~ ~~• Partnerships and Communities Committee~~	~~Lack of control over staffing, and therefore service provision, by other system providers of services at SFH~~ ~~PBP priorities and work plan not agreed for 2024/25~~	~~Review service level agreements in contract management processes~~ ~~**SLT Lead:** Director of Strategy and Partnerships~~ ~~**Timescale:** July 2024~~ ~~PBP priorities and work plan to be agreed for 2024/25~~ ~~**Progress:** priorities agreed, work plan to be finalised~~ ~~**SLT Lead:** Director of Strategy and Partnerships~~ ~~**Timescale:** June 2024~~	~~**Management:** Strategic Partnerships Update to Board; Finance Committee report to Board; Nottingham and Nottinghamshire ICS Leadership Board Summary Briefing to Board; Planning Update to Board; East Midlands Acute Provider Collaborative report to Board Sep 23~~ ~~**Risk and compliance:** Significant Risks Report to Risk Committee monthly~~ ~~**Independent assurance**: 360 Assurance review of SFH readiness to play a full part in the ICS – Significant Assurance~~		~~Inconclusive~~ ~~Last changed February 2024~~
~~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~~ ~~• 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~~ ~~• Partnerships and Communities Committee~~ ~~• Trust Strategy – Improving Lives~~			~~**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): October 2024

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
	~~Clinical Services strategy~~ ~~Health Inequalities Working Group~~					
Competing priorities within SFH could result in a lack of commitment or contribution of resources to those partnerships that could contribute to the delivery of the Trust's priorities	▪ Trust's five-year strategy, Improving Lives, outlines strategic deliverables to focus Trust resources ▪ Alignment of Trust's Strategy with the ICS Joint Forward Plan ▪ Clinical Services Strategy established guiding principles and priorities ▪ Partnership Strategy and delivery plan with oversight on delivery by Strategy and Partnership Cabinet ▪ People Strategy identifies key people partnership priorities and priority partners ▪ Partnerships and Communities Committee oversight ▪ Partnership canvas tool structuring the planning and execution of partnerships ▪ Partnership database and annual evaluation ▪ Nottingham and Nottinghamshire Integrated Care System (ICS) priority aim of integration by default and continued engagement with Nottingham and Nottinghamshire Integrated Care Partnership (ICP) and the ICS planning and governance arrangements ▪ Quarterly ICS performance review with NHSE ▪ Joint Forward Plan, supporting workstreams and delivery group supporting partnership working ▪ Full alignment of organisational priorities with system planning ▪ ICS Finance Directors Group, ICS Planning Group and ICS System Oversight Group act as assurance and escalation route ▪ SFH Chief Executive is a member of the ICB as a partner member representing hospital and urgent & emergency care services ▪ Nottingham(shire) Provider Collaborative at Scale (NNPC) annual plan and programme resource. Oversight through the NNPC Distributed Executive Group and governance structure ▪ East Midlands Acute Providers (EMAP) Network annual plan and programme resource. Oversight of delivery and risks through the Chief Executive Forum and Executive Group ▪ Primary secondary care interface annual plan and oversight through the Interface Group with representatives from SFH and general practice ▪ Mid-Nottinghamshire Place-Based Partnership (PBP) annual place plan setting priorities and agreed actions ▪ Established PBP leadership arrangements in place of which SFH is a committed member including Mid-Nottinghamshire PBP Executive providing oversight and leadership ▪ Membership of and engagement with the three Place Boards in Ashfield, Mansfield and Newark and Sherwood agree plans, oversee delivery and agree shared resources	Workforce capacity to progress key partnership workstreams in provider collaboratives and place partnerships to progress clinical service strategy priorities on fragile services, workforce and health inequalities	Investigate opportunities to expand workforce capacity within the systems financial constraints **SLT Lead:** Director Strategy and Partnerships **Timescale:** December 2024 Reflect constrained resources in plans and strategies for Years 2 to 5. **SLT Lead:** Director Strategy and Partnerships **Timescale:** December 2024	**Management:** 2023/24 strategy reporting (the "dials") to Board quarterly Strategy and Partnership Cabinet chair's report to PCC bi—monthly Provider collaborative effectiveness updates to PCC every four months Partnership Delivery Plan updates to Strategy and Partnership Cabinet monthly Supporting strategy reporting to relevant sub committees quarterly MNPBP highlight reports to Strategy and Partnership Cabinet and HISG quarterly HISG chair's report to Strategy and Partnership Cabinet monthly **Risk and compliance:** Significant Risks Report to Risk Committee monthly **Independent assurance**: 360 Assurance review of SFH readiness to play a full part in the ICS – Significant Assurance		Positive Threat updated August 2024
Competing priorities within our partners could result in a lack of commitment or contribution of resources to those partnerships that could contribute to the delivery of the Trust's priorities	▪ Trust's five-year strategy, Improving Lives, outlines strategic deliverables to focus Trust resources ▪ Partnerships and Communities Committee oversight ▪ Partnership canvas tool structuring the planning and execution of partnerships ▪ Nottingham and Nottinghamshire Integrated Care System (ICS) priority aim of integration by default and continued engagement with Nottingham and	Workforce capacity to progress key partnership workstreams in provider collaboratives and place partnerships to progress clinical service strategy priorities on fragile services,	Investigate opportunities to expand workforce capacity within the systems financial constraints. **SLT Lead:** Director Strategy and Partnerships **Timescale:** December 2024	**Management:** Partnership Delivery Plan updates to Strategy and Partnership Cabinet MNPBP highlight reports to Strategy and Partnership Cabinet and HISG as appropriate HISG chair's report to Strategy and Partnership Cabinet		Positive Threat updated August 2024

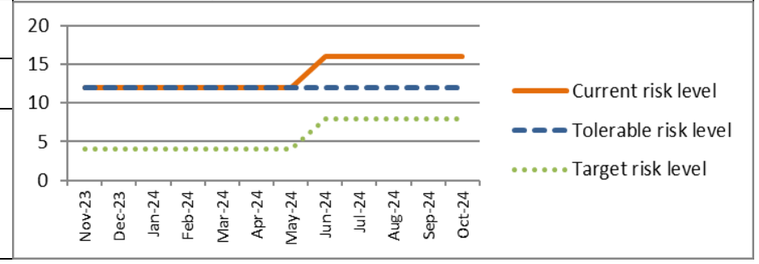
Board Assurance Framework (BAF): October 2024

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
	Nottinghamshire Integrated Care Partnership (ICP) and the ICS planning and governance arrangements ▪ Quarterly ICS performance review with NHSE ▪ Joint Forward Plan, supporting workstreams and delivery group supporting partnership working ▪ Full alignment of organisational priorities with system planning ▪ ICS Finance Directors Group, ICS Planning Group and ICS System Oversight Group act as assurance and escalation route ▪ SFH Chief Executive is a member of the ICB as a partner member representing hospital and urgent & emergency care services ▪ Nottingham(shire) Provider Collaborative at Scale (NNPC) annual plan and programme resource. Oversight through the NNPC Distributed Executive Group and governance structure. ▪ East Midlands Acute Providers (EMAP) Network annual plan and programme resource. Oversight of delivery and risks through the Chief Executive Forum and Executive Group ▪ Primary secondary care interface annual plan and oversight through the Interface Group with representatives from SFH and general practice ▪ Mid-Nottinghamshire Place-Based Partnership (PBP) annual place plan setting priorities, aligning resources and agreeing actions ▪ Established PBP leadership arrangements in place of which SFH is a committed member including Mid-Nottinghamshire PBP Executive providing oversight and leadership ▪ Membership of and engagement with the three Place Boards in Ashfield, Mansfield and Newark and Sherwood agree plans, oversee delivery and agree shared resources ▪ Formal partnership arrangements with Vision West Notts College and Universities of Nottingham	workforce and health inequalities	Reflect constrained resources in plans and strategies for Years 2 to 5. **SLT Lead:** Director Strategy and Partnerships **Timescale:** December 2024	Monthly highlight reports from Notts Prov Collab to SFH executive lead EMAP monthly update reports to EMAP Executive Group **Risk and compliance:** Significant Risks Report to Risk Committee monthly **Independent assurance**: 360 Assurance review of SFH readiness to play a full part in the ICS – Significant Assurance		
Limited SFH partnership engagement capacity could result in a missed opportunity to bring in a wider patient and citizen voice to shape future healthcare services	▪ 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 PBP (MNPBP) and the district level Place Boards. ▪ ICS Clinical Services Strategy and Quality Strategy set priority re coproduction and personalised care ▪ ICS Health and Equality Strategy ▪ Nottingham and Nottinghamshire Joint Forward Plan, supporting workstreams and delivery group supporting partnership working ▪ ICS Clinical Services workstreams are well established across elective and urgent care and SFH is represented and involved appropriately ▪ SAIU dashboards and themed reports to focus on key priority areas for inputs and provide assurance of outputs and outcomes ▪ Clinical Directors and PCN Directors clinical partnership working ▪ Partnerships and Communities Committee (PCC) oversees delivery and receives assurance ▪ Partnership canvas tool structuring the planning and execution of partnerships ▪ SFH Health Inequalities Steering Group (HISG) linked to Mid Notts Health Inequalities Oversight Group to build relationships, share population health information and agree priorities and ICS Health Inequalities Steering Group, which facilitates sharing of patient/citizen voice and provides oversight of delivery	Workforce capacity to progress key partnership workstreams in provider collaboratives and place partnerships to progress clinical service strategy priorities on fragile services, workforce and health inequalities	Investigate opportunities to expand workforce capacity within the systems financial constraints. **SLT Lead:** Director Strategy and Partnerships **Timescale:** December 2024 Reflect constrained resources in plans and strategies for Years 2 to 5. **SLT Lead:** Director Strategy and Partnerships **Timescale:** December 2024	**Management:** Strategy and Partnership Cabinet chair's report to PCC Partnership Delivery Plan updates to Strategy and Partnership Cabinet Supporting strategy reporting to relevant sub committees MNPBP highlight reports to Strategy and Partnership Cabinet and HISG as appropriate HISG chair's report to Strategy and Partnership Cabinet **Independent assurance**: None currently in place		Positive Threat updated August 2024

Board Assurance Framework (BAF): October 2024

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	Chief Executive Officer	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Cautious
Initial date of assessment	01/04/2018	**Likelihood**	**4. Somewhat likely**	3. Possible	2. Unlikely		
Last reviewed	08/10/2024	**Risk rating**	**16. Significant**	**12. High**	**8. Medium**		
Last changed	08/10/2024						

Strategic objective	Provide outstanding care in the best place at the right time

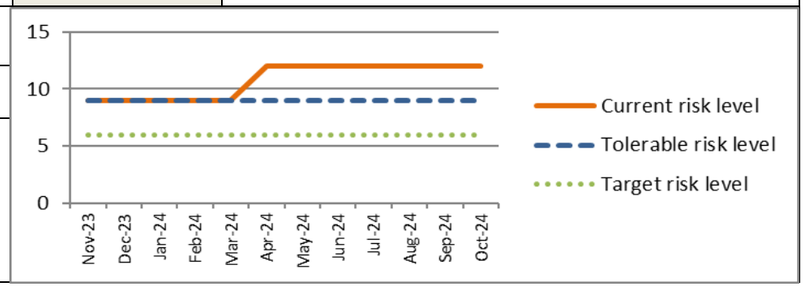


Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required 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 ▪ National Cyber Security Centre updates to Cyber Delivery Group ▪ High Severity Alerts issued by NHS Digital ▪ Network accounts checked after 50 days of inactivity – disabled after 80 days if not used ▪ Devices that have failed to take the most recent security patch checked after 21 days of inactivity – disabled after 28 days ▪ Major incident response 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			**Management:** Data Security and Protection Toolkit submission to Board Jul 23- compliant on all 113 elements; DSPT updates to Information Governance Committee bi-monthly and Risk Committee 6-monthly; Hygiene Report to Cyber Security Board bi-monthly; Cyber Security Assurance Highlight Report to Cyber Security Board bi-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 Mar 22; NHIS Cyber Strategy approved at DSG May 24 **Risk and compliance:** Significant Risks Report to Risk Committee monthly **Independent assurance**: ISO 27001 Information Security Management Certification (NHIS) Mar24; 360 Assurance Data Security and Protection Toolkit audit Jun 23 – moderate assurance; Cyber Essentials Plus accreditation (NHIS) Dec 23	Not fully assured that all business continuity processes are robust and fully tested in the event of prolonged system downtime Review and test IT and business continuity processes **SLT Lead:** Chief Digital Information Officer **Timescale:** December 2024 Insufficient Board oversight of the risk and impact of cyber security Cyber threat to be fully addressed at a Board Workshop **SLT Lead:** Chief Executive Officer **Timescale:** October 2024	Inconclusive Last changed March 2024
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 ▪ Estates Strategy 2015-2025 ▪ PFI Contract and Estates Governance arrangements with PFI Partners ▪ Fire Safety Policy ▪ Health Technical Memorandum governance structure ▪ 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) and other HTM Specialties ▪ Major incident response plan in place	Gaps in controls and processes identified in the 2022 Fire Safety Management audit	Finalise and issue the Trust Fire Safety Strategy documents **SLT Lead:** Chief Financial Officer **Timescale:** ~~June~~ December 2024 Complete the actions within the Fire Audit action plan **SLT Lead:** Associate Director of Estates & Facilities **Timescale:** ~~August~~ September ~~2024~~ Complete	**Management:** Central Nottinghamshire Hospitals plc monthly performance report; Fire Safety Annual Report; Fire Safety reports to Risk committee quarterly **Risk and compliance:** Significant Risks Report to Risk Committee monthly **Independent assurance:** Premises Assurance Model to Executive Team Oct 22; EPRR Core standards compliance rating (Oct22) – Substantial Assurance; MEMD ISO 9001:2015 Recertification (3-year) Mar 21; British Standards Institute MEMD Assessment Report Feb 22; External cladding report to Executive Team Jan 24; ARUP Fire Surveys included in Annual Fire Safety report to Risk Committee Apr 24; ARUP Milestone 2 (Fire) Reports issued in draft July 2024 for review	Inconclusive evidence of buildings cladding and structures compliance with fire regulations Determine the remedial work required to ensure that the cladding is compliant with fire regulations **Progress:** It has now been agreed by Project Co. that the existing cladding will be replaced in full, programme currently being updated to take into account the new Building Safety Act. **SLT Lead**: Associate Director of Estates & Facilities **Timescale:** ~~September~~ October 2024 Trust actions required from the ARUP Milestone 2 (Fire) Report	Inconclusive Last changed March 2024

Board Assurance Framework (BAF): October 2024

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**
					Progress: An overarching risk assessment is to be produced for each site highlighting the common themes/issues that have come out of the draft report and to be discussed with all areas. ~~Awaiting~~ ARUP fee proposal received – CNH approaching other companies for costs Execs to be briefed on the ARUP findings ~~in August 2024~~ on 4th September. **SLT Lead**: Associate Director of Estates & Facilities **Timescale:** ~~August 2024~~ October 2024	
Severe restriction of service provision due to a significant operational incident or other external factor	▪ Emergency Preparedness, Resilience & Response (EPRR) arrangements at regional, ICS, 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 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 response plan in place ▪ Industrial Action Group ▪ Annual Core Standards Process (NHSE & ICB), with follow up report to Board ▪ Annual CBRN Audit (EMAS) ▪ Three-yearly internal audit of EPRR arrangements with report to Board ▪ Incident Response and command and control training to all tactical and strategic leads across the organisation carried out annually ▪ Testing and exercising of service level plans carried out annually ▪ Health Risk Management Group for EPRR	The current Business Continuity Management System (BCMS) does not meet the requirements of the Core Standards	Roll out an updated BCMS to align with the national standards and include associated training **SLT Lead**: Chief Operating Officer **Timescale:** ~~June 2024~~Complete Embed the updated BCMS within all divisions **SLT Lead**: Chief Operating Officer **Timescale:** December 2024	**Management:** Industrial Action debrief report to Executive Team Mar 23, and following each subsequent period of industrial action; Monthly Quadrant Report into Risk Committee **Independent assurance:** EPRR Core standards compliance rating 2023 – Partial Compliance; CBRN Audit carried out in March 2024 by EMAS	Improve compliance rating with Core Standards from "Partial" to "Substantial" **SLT Lead**: Chief Operating Officer **Timescale:** October 2024	Positive New threat added May 2023

Board Assurance Framework (BAF): October 2024

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**	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**	**4. Somewhat likely**	3. Possible	2. Unlikely				
Last reviewed	29/10/2024	**Risk rating**	**12. High**	**9. Medium**	**6. Low**				
Last changed	29/10/2024								

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 (may be due to capacity and/or capability)	▪ Estates & Facilities Department oversee the plan and education on climate change impacts ▪ Green Plan 2021-2026 ▪ Climate Action Project Group ▪ Sustainability Development Operational Group (SDOG) and Sustainability Development Strategy Group (SDSG) ▪ 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 ▪ Annual Travel Survey ▪ Display energy certificates ▪ Building Research Establishment Environmental Assessment Methodology ▪ Net Zero Strategy ▪ Regular updates through Comms on the screen savers (included lighting, bees, waste etc.)	Education of ~~Board and~~ staff at all levels Dedicated capacity to implement ideas for change Insufficient capital resource available to realise Trust ambition Support from our PFI partners in developing 'green' solutions	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:** ~~July 2024~~Complete Proposal to ICB partners for collaborative approach and resource **Progress:** The ICS Infrastructure Strategy (January 2024) makes explicit reference to a system wide solution to consistent sustainability reporting and need for resource across the system to realise the ICS and provider ambitions. **Lead:** Chief Financial Officer **Timescale:** ~~August 2024~~Complete Additional resource **Progress**: Junior Energy Manager Apprentice and Sustainability Apprentice are being worked up for advertisement in Autumn 2024 **Lead**: Hard FM Manager **Timescale:** October 2024 Review of Green Plan Quarterly Energy and Sustainability Report to SDOG **Progress:** Data and information now readily available and now need to show how we utilise this to inform our decisions on capital etc, **Lead:** Sustainability Officer **Timescale:** ~~July 2024~~Complete	**Management:** Green updates provided routinely to Finance Committee via SDSG **Risk and compliance:** Green Plan to Board Apr 21; Sustainability Report included in the Trust Annual Report **Independent assurance:** ERIC returns and benchmarking feedback	Car Parking Strategy: To be developed for the long-term solution to KMH, MCH and NH **Lead:** Associate Director of Estates and Facilities **Timescale:** ~~September~~ December 2024 Travel Plan: To be developed for the long-term solution to KMH, MCH and NH **Lead:** Associate Director of Estates and Facilities **Timescale:** ~~September~~December 2024 Display Energy Certificates Review all certificates and what actions need to be taken to improve the Energy Efficiency of the buildings. **Lead:** Sustainability officer **Timescale:** September 2024 Energy / Sustainability Business Cases: Ensure business case schemes are all worked up and ready to be issued if further funding becomes available through various government routes **Lead:** Sustainability officer **Timescale:** November 2024 Review of Performance on Sustainability Matters: - Yearly Energy and Sustainability Report to Trust Board (July 2024) - TMT Session on progress on the Green Plan (June 2024) - Annual Travel Survey 2024 - Regular review of how our staff travel to work	Inconclusive Last changed December 2023

Board Assurance Framework (BAF): October 2024

			Quarterly Review of all outstanding actions within the Green Plan and when they are planned to be completed (including year up to 2026) to SDOG **Progress:** ~~Review of all aspects of the Green Plan have been undertaken and this is currently being reviewed by the EFM team.~~ Green Plan – review planned for March 2025 & E&F strategy should take into account what is still outstanding, ready for refreshed SFH Green Plan in 2026 **Lead:** Associate Director of Estates and Facilities **Timescale:** ~~July 2024~~Complete Capital Bid Reviews: Further detail to be implemented into the process to show actual savings that are applied to capital schemes and how this impacts the overall trust financial position. **Progress:** Development of key metrics that would be included as part of the business case template for completion. **Lead:** Chief Financial Officer **Timescale:** ~~July 2024~~Complete CROG Scheme Bids: Ensure there are sufficient schemes developed and feasibilities undertaken to ensure the validity of the bids that are to be taken forward to Business Case Level **Progress:** ~~Solar Panels, Geothermal, Electric Vehicle Charging Points all currently being reviewed.~~ Several CROG applications rejected due to lack of funds. Considering external EV & Solar 'rental' schemes but progress has been impeded by IFRS16 considerations. Attended Geothermal meetings but awaiting advice via Heat Decarbonisation Plan on the best system for SFH **Lead:** Sustainability Officer **Timescale:** ~~July 2024~~March 2025 PFI Partners: Engage with our PFI provider and relevant parties to develop a combined energy reduction plan associated with the financial close out of the deed, retained estate upgrades, lifecycle developments and how all these aspects will support SFH in its energy/sustainability targets. **Progress:** ~~Awaiting completion of the settlement, key principles on sustainability, carbon and energy reduction to be set out when the works are undertaken.~~ Awaiting PFI settlement & changes in Skanska personnel **Lead:** Sustainability Officer **Timescale:** ~~August~~ October2024		and how this can be improved with alternative methods (additional bus stops on site was completed 23/24) **Lead:** Associate Director of Estates and Facilities **Timescale:** ~~July 2024~~Complete Decarbonisation Plan: Submission to Phase 5 Public Sector Low Carbon Skills Fund to produce our decarbonisation plan **Progress:** ~~Bid Submitted May 2024~~ LCSF5 bid rejected **Lead:** Sustainability officer **Timescale:** ~~TBC following the outcome of the bid submission~~Complete ICS identified SFH had very poor LED lighting as a percentage nationally **Progress:** Skanska have now commenced LED lighting upgrades. To be monitored via E&F Monthly KPI Dashboard **Lead:** Sustainability officer **Timescale**: To Be Agreed with Skanska	