Board Assurance Framework (BAF): May 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.

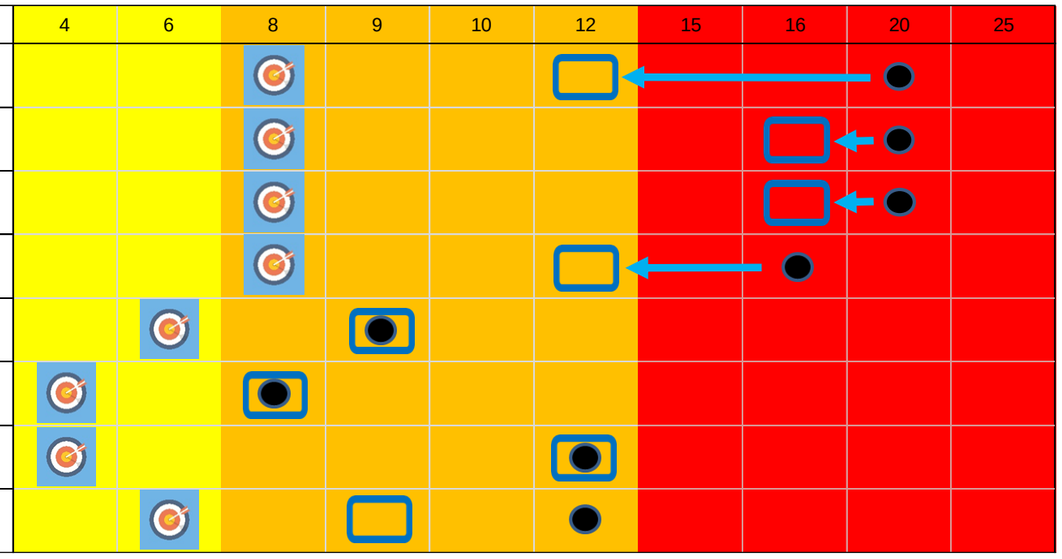
Likelihood score and descriptor

	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%)

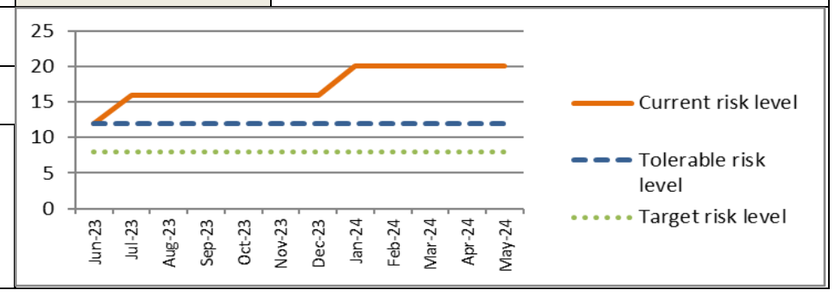
Board committees should review the BAF with particular reference to comparing the tolerable risk level to the current exposure risk rating

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	Quality
PR2	**Demand that overwhelms capacity**	Chief Operating Officer	Quality
PR3	**Critical shortage of workforce capacity and capability**	Director of People	People
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	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): May 2024

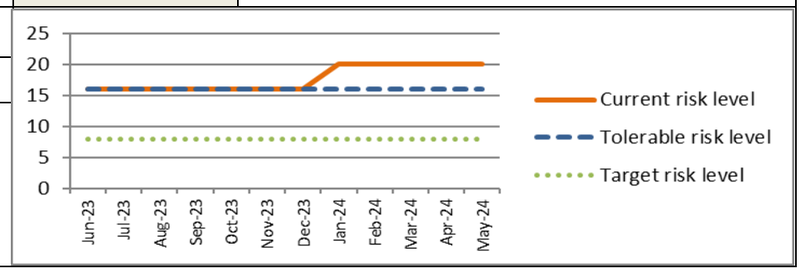
Principal risk (What could prevent us achieving this strategic objective)	**PR 1: Significant deterioration in standards of safety and care** Recognised deterioration in standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical 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	20/05/2024	**Risk rating**	**20. Significant**	**12. High**	**8. Medium**			
Last changed	20/05/2024							

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 ▪ 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	Review of informatics function and development of informatics strategy **SLT Lead:** Chief Digital Information Officer **Progress:** ~~business case supported and progressing with recruitment~~ Appointment of Head of Information commenced March 2024 **Timescale:** ~~March 2024~~Complete 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 **SLT Lead:** Chief Digital Information Officer **Timescale:** September 2024	**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 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 (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; Digital risks reported to Risk Committee 6-monthly and DSG monthly **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)	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 ICB PSIRF process awaiting go-live	Positive No change since April 2020

Board Assurance Framework (BAF): May 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 ▪ Coronavirus 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 ▪ Maintaining mask wearing and screening of patients on admission, and ensuring maintenance of pre-existing IPC requirements	~~Increasing numbers of respiratory infections~~ FIT mask testing compliance rate below required rate	Implement the use of face masks in clinical areas **SLT Lead:** Chief Nurse **Timescale:** ~~January 2024~~Complete Reviewed March 2024 and mandatory wearing of facemasks removed Increase compliance to target rate **Progress:** Fit Testing Data is now included in Divisional Performance Review Packs **SLT Lead:** Director of People / Chief Nurse **Timescale:** ~~March~~ October 2024	**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: 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; ~~CQC Maternity Review Dec 22~~ 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): May 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	20/05/2024	**Risk rating**	**20. Significant**	**16. Significant**	**8. Medium**				
Last changed	20/05/2024								

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 ▪ SFH Medical Same Day Emergency Care service (SDEC) in place to avoid admissions into inpatient facilities ▪ Single streaming process for ED & Primary Care and SDEC direct access – regular meetings with NEMS ▪ Trust and System escalation policies and processes, including Operational Pressures Escalation Level (OPEL) Framework, Full Capacity Protocol and Pandemic Surge Plan ▪ 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 ▪ Cancer Services Steering Group ▪ New oversight and additional actions in place to deliver the '4-hour sprint'	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. reducing elective operating, bedding patients in alternative areas i.e. daycase	Utilising the outputs from the process mapping, as a system we are implementing improvements to SFH discharge information and processes including the re-introduction of discharge co-ordinators **SLT Lead:** Chief Operating Officer **Timescale:** ~~March~~ June 2024 **Progress:** Action progressing well, with further developments to be delivered in 2024/25 Q1 Complete the Implementation of expanded long length of stay review meetings with wards to consider pre-medically safe patients as well as MFFD **SLT Lead:** Chief Operating Officer **Timescale:** ~~March 2024~~Complete **Progress:** ~~process commenced in December 2023 and will be fully embedded during Q4~~ Any further developments to long length of stay processes are now business as usual Open a Surgical Same Day Emergency Care facility at KMH to enable ambulatory care instead of admission **Progress:** Trial commenced April 2024 **SLT Lead:** Chief Operating Officer **Timescale:** June 2024 Continuation of March 2024 Emergency Department schemes to support non-admitted breach reduction **SLT Lead:** Chief Operating Officer **Timescale:** throughout Q1 Trial of frailty SDEC co-located with Discharge Lounge **Progress:** Trial commenced 2024 **SLT Lead:** Chief Operating Officer **Timescale:** End Q1 – then decision to end or make substantive	**Management:** Performance management reporting arrangements between Divisions, Service Lines, Executive Team and Board on an at least bi-monthly basis; '4-hour sprint' report to Executive Team weekly **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		Positive Last changed December 2020

Board Assurance Framework (BAF): May 2024

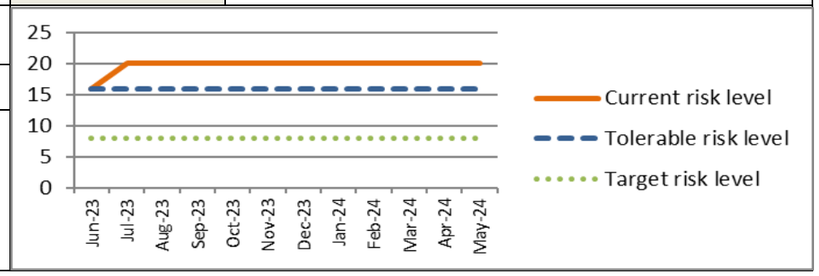
Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required 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 opened at SFH Oct 22
	▪ Use of additional beds
	  ▪ Mansfield Community Hospital (3 wards)
	  ▪ Newark General Hospital (2 wards)
	  ▪ Use of Ashmere Group Care Homes
		Lack of consistent achievement of the mid-Notts threshold for MSFT patients of 40	Delivery of ICS Discharge to Assess Business Case
			SLT Lead: Chief Operating Officer
			Timescale: ~~throughout 23/24~~Complete
			
			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
			
			Virtual ward programme implementation
			SLT Lead: Chief Operating Officer
			Timescale: ~~expanding throughout 23/24~~Complete – scoping under way for 2024/25
			
			Complete the development of and open a new discharge lounge
			SLT Lead: Chief Operating Officer (19 beds and 22 chairs)
			Progress: Trial of 24/7 opening of the discharge lounge commenced 6th May
			Timescale: ~~To open in April 2024~~Complete
				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
						Inconclusive
						
						No change since threat added in January 2022

~~Operational f~~Failure of ~~General Practice~~ 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 Chief Officer calls across ICS, including Primary Care ▪ ICS Primary Care Strategy Group, with responsibility for overseeing delivery of the Primary Care Access Recovery Plan			**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 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 ▪ Mechanism in place to agree peripheral and full diverts of patients via EMAS			**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	Lack of control over the flow of patients from the surrounding area, including decisions by EMAS to undertake strategic conveyancing **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 2024	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	~~Midwifery staffing vacancies~~ ~~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 **Progress:** Review has been carried out and the long-term growth in demand is within expected parameters. National and system funding has been provided to ensure the delivery of a safe and effective service as part of the national Ockenden inquiry. **SLT Lead:** Chief Operating Officer **Timescale:** ~~Q4 23/24~~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 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						**Strategic objective**	Empower and support our people to be the best they can be
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	28/05/2024	**Risk rating**	**20. Significant**	**16. Significant**	**8. Medium**			
Last changed	28/05/2024							

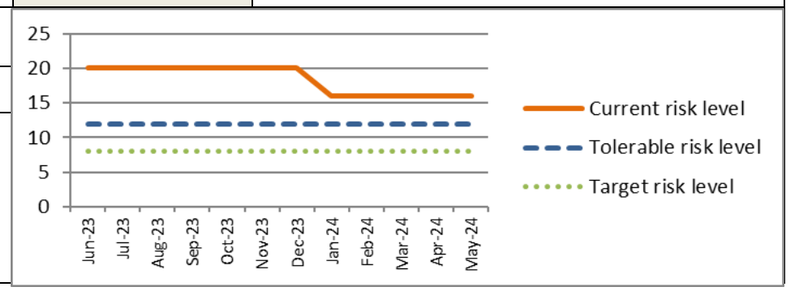


Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required 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 attract and retain staff ~~due to market factors~~, 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, Culture and Improvement Strategy – Year 2 **SLT Lead:** Director of People **Timescale:** ~~March 2024~~Complete 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 **Timescale**: September 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; 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 **Risk and compliance:** Risk Committee significant risk report Monthly; HR & Workforce planning report Risk Committee; ~~SOF~~ 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		Positive Last changed June 2022

Board Assurance Framework (BAF): May 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~~, which could lead to a detrimental impact on patients and service users~~	▪ 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	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	Implement the actions from the Equality, Diversity and Inclusivity improvement plan **SLT Lead**: Deputy Director of People **Timescale**: ~~March 2024~~Complete Develop an action plan from the outcomes of the National 2023 Staff Survey **SLT Lead:** Director of People **Timescale:** September 2024 Implement the actions from the Violence and Aggression Working Group action plan **SLT Lead:** Director of People **Timescale:** ~~March 2024~~Complete 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 **Timescale**: September 2024 Develop and implement a Sexual Safety Policy and process **SLT Lead:** Director of People **Timescale:** December 2024	**Management:** Staff Survey Action Plan to Board May 23; Staff Survey Annual Report to Board Apr 23; Equality and Diversity Annual Report Jun 22; WRES and WDES report to Board Oct 23; Quarterly Assurance reports on People Cabinet to People Committee; Wellbeing report to People, Culture and Improvement Committee Dec 22; People Plan updates to People Committee quarterly **Risk and compliance:** EPRR Report (bi-annually); Freedom to speak up self-review Board Aug 23; 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; Assurance Report to People Committee quarterly; NHS Long Term Workforce Plan to People and Culture Committee Sep 23; 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; 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 Industrial action up to and including strike action from all NHS unions, affecting all system partners Co-ordinated strike action by consultants, SAS doctors and junior doctors – on strike days Christmas Day cover only Industrial action by Medirest staff	Inconclusive Last changed October 2022

Board Assurance Framework (BAF): May 2024

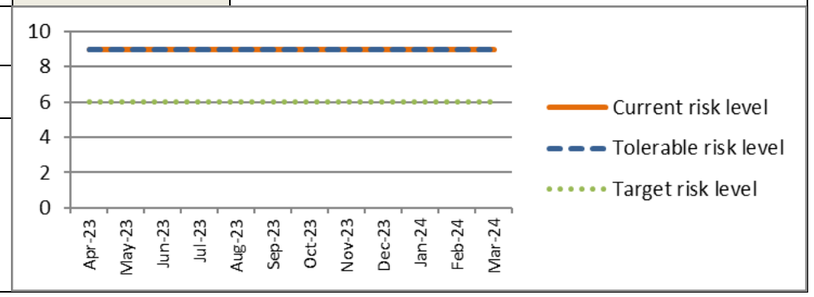
Principal risk (What could prevent us achieving this strategic objective)	**PR 4: ~~Failure to achieve the Trust's financial strategy~~Insufficient financial resources available to support the delivery of services** ~~Failure to achieve agreed trajectories resulting in regulatory action~~ Financial funding 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	23/05/2024	**Risk rating**	**16. Significant**	**12. High**	**8. Medium**			
Last changed	23/05/2024							

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 reduction in funding or change in financial trajectory or unexpected event resulting in a requirement to reduce the scale of the financial deficit, without having an adverse impact on ~~quality and safety~~patient care	▪ Working capital support through agreed PDC arrangements ▪ Annual financial plan and budgets, based on available resources and stretching financial improvement targets. ▪ Improvement Faculty established to support the development and delivery of transformation and efficiency schemes ▪ Budgetary Control Procedure Document, delivery of budget holder training workshops and monthly financial reporting ▪ Close working with ICB partners to identify system-wide planning, transformation and cost reductions ▪ Scheme of Delegation, Standing Financial Instructions and Executive oversight of commitments ▪ Development of a three-year Transformation and Efficiency Programme covering 2022-25 ▪ Forecast sensitivity analysis and underlying financial position reported to Finance Committee ▪ Capital Resources Oversight Group (CROG) overseeing capital expenditure plans ▪ Divisional Performance Reviews (monthly) ▪ Divisional Finance Committees established in most divisions ▪ Financial Recovery Cabinet (monthly) and Financial Recovery Plan workstreams established ▪ Financial controls self-assessment completed and working group set up to undertake improvement actions ▪ Vacancy Control panels established ▪ Financial re-forecast undertaken in line with NHSE process ▪ Financial Resources 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 recovery opportunities require the completion of Quality Impact Assessments (QIAs)~~	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:** ~~March~~ July 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.~~ ~~Limited resources mean that business cases are currently paused, however in-year cases are managed through the Financial Recovery Cabinet and Trust Management Team on an exceptional basis. All paused cases are managed through the risk management framework~~ ~~A further review of the business case process will be undertaken as part of the 2024/25 Planning round~~ Risks & Opportunities review undertaken as part of 2024/25 planning **SLT Lead:** Chief Financial Officer **Timescale:** ~~March 2024~~Complete QIA process to be undertaken on financial recovery opportunities. Progress: QIAs ~~in progress~~complete SLT Lead: Chief Nurse Timescale: ~~January 2024~~Complete	**Management:** CFO's Financial Reports and Transformation & Efficiency Summary (Monthly); Quarterly Strategic Priority Report to Board; ICS finance report to Finance Committee (monthly); Capital Resources Oversight Group quadrant reports to Execs; Divisional Performance Reviews and Divisional Finance Reviews (monthly); Divisional risk reports to Risk Committee bi-annually; Monthly Agency reports to Trust Management Team; Financial Recovery Cabinet quadrant reports to Finance Committee (Monthly) **Risk and compliance:** Risk Committee significant risk report monthly **Independent assurance**: NHS England Financial Controls Assessment (Sep 23); External Audit Year-end Report 2022/23 Internal Audit reports: - Key Financial Systems - Asset Register Jan 22 - Improving NHS financial sustainability Dec 22 - Key Financial Systems – Pay Expenditure Jul 23 - Key Financial Systems – Accounts Payable and Treasury and Cash Management Mar 24 - Financial Ledger and Reporting Mar 24	~~2023/24 run-rate forecast falls short of the break-even financial plan, and NHSE expectations~~ Action: Finance re-forecast completed in-line with NHSE process demonstrating an improvement to the financial run-rate. SLT Lead: Chief Financial Officer Timescale: ~~March 2024~~Complete	~~Inconclusive~~ Positive Last changed ~~December 2023~~ January 2024

Board Assurance Framework (BAF): May 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**
~~ICB system deficit results in a negative financial impact to the Trust~~ICB system financial performance challenge leads to restrictions in SFH funding	▪ 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 Agency Reduction Group (Chaired by SFH CFO) ▪ NHSE Re-forecasting Process ▪ ICB Financial Recovery Group	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**: Chief Financial Officer **Timescale:** ~~March~~ September 2024 (dependant on NHSE/I and ICB Guidance)	**Risk and compliance:** ICS financial reports to Finance Committee; ICS Board updates to SFH Trust Board	~~2023/24 forecast falls short of the break-even financial plan, and NHSE expectations~~ **Action:** ICB engagement with NHSE on opportunities to further improve financial position **SLT Lead:** Chief Financial Officer **Timescale:** ~~March 2024~~Complete	Positive Last changed July 2022

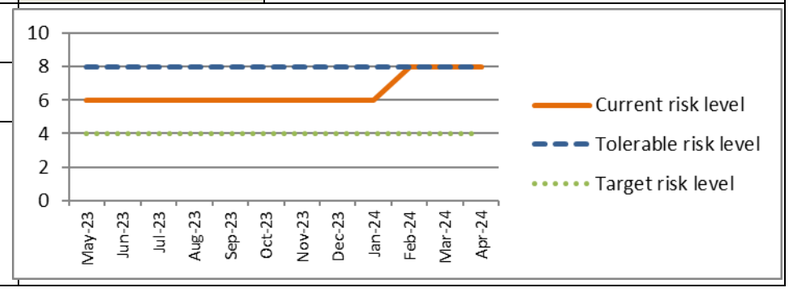
Board Assurance Framework (BAF): May 2024

Principal risk (What could prevent us achieving this strategic objective)	**PR 5: Inability to initiate and implement evidence-based improvement and innovation** Lack of ~~support~~ 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	25/03/2024	**Risk rating**	**9. Medium**	**9. Medium**	**6. Low**			
Last changed	25/03/2024							

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 ~~understanding~~ embedded improvement culture across the Trust ~~and agility~~ resulting in ~~reduced~~ suboptimal efficiency and effectiveness around how we provide care for patients	▪ Digital Strategy ▪ People~~, Culture & Improvement~~ Strategy ▪ People~~, Culture & Improvement~~ Committee ▪ Quality Strategy ▪ Quality Committee ▪ Leadership development programmes ▪ Talent management map ▪ ~~Programme Management Office~~ ▪ ~~Culture & Improvement Cabinet~~ ▪ Strategy & Partnerships Cabinet ▪ ~~Transformation Cabinet~~ ▪ Ideas generator platform ▪ Improvement Faculty ▪ Financial Recovery Programme	~~The improvement function needs to be organisationally embedded following the restructure~~ Continuous Quality Improvement Strategy not yet approved ~~Lack of capacity for colleagues to engage with improvement~~ ~~Lack of organisational clear direction in terms of continuous improvement across the Trust~~	Continue communications to promote further engagement while the Continuous Improvement Strategy is being developed **SLT Lead:** Director of Strategy and Partnerships **Timescale:** ~~March~~ May 2024 Develop a process for clinical input for public and colleague engagement in improvement and transformation activities **SLT Lead:** Director of Strategy and Partnerships **Timescale:** ~~March~~ May 2024 Promote the training an ongoing support available to all colleagues via the Improvement Faculty **SLT Lead:** Director of Strategy and Partnerships **Timescale:** ~~September 2023~~Complete Develop and roll out a Continuous Improvement Strategy **SLT Lead:** Director of Strategy and Partnerships **Timescale:** ~~March~~ May 2024	**Management:** Monthly Transformation and Efficiency report to FC; ~~Clinical Audit &~~ Improvement report to ~~Advancing Quality Group~~Quality Committee ~~quarterly~~bi-monthly; ~~Culture & Improvement Assurance Report to PC&IC bi-monthly~~; NHS Impact Self-Assessment **Risk and compliance:** ~~SFH Trust~~ 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): May 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** Influencing the wider determinants of health and improving our collective financial position requires close partnership working							**Strategic objective**	Work collaboratively with partners in the community
Lead committee	Partnerships and Communities	**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	4. Somewhat likely	2. Unlikely				
Last reviewed	11/04/2024	**Risk rating**	~~6. Low~~ 8. Medium	**8. Medium**	**4. Low**				
Last changed	11/04/2024								



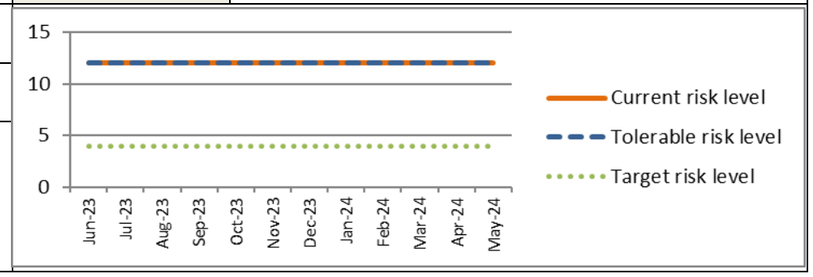
Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required 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**
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~~ PBP Executive ~~formed May 2020~~ • Mid-Nottinghamshire ~~ICP~~ PBP annual work plan • Nottingham and Nottinghamshire Integrated Care System Board • Continued engagement with ~~ICP~~ 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 ~~ICP~~ PBP plans through the joint forward plan • Full alignment of organisational priorities with system planning • Independent chair for ~~ICP~~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 • ~~PBP priorities and work plan agreed for 2023/24~~ • 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; mid-~~Nottinghamshire ICP delivery report to Finance Committee (as meeting schedule)~~; 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		~~Positive~~ Inconclusive Last changed ~~May 2022~~ February 2024

Board Assurance Framework (BAF): May 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 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 ▪ Clinical Services strategy ▪ Health Inequalities Working Group			**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 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							**Strategic objective**	Provide outstanding care in the best place at the right time
Lead committee	Risk	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services		
Lead director	~~Director of Corporate Affairs~~Chief Executive Officer	**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	14/05/2024	**Risk rating**	**12. High**	**12. High**	**4. Low**				
Last changed	14/05/2024								

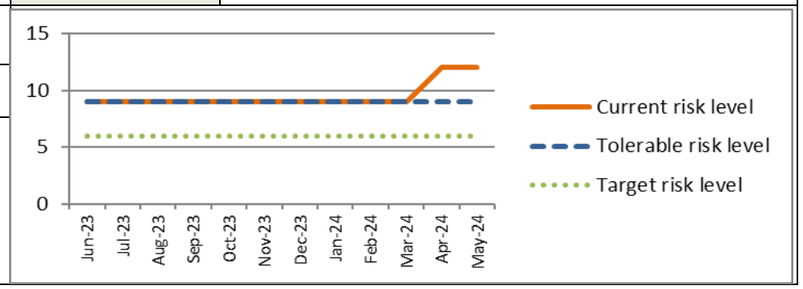


Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required 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**
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~~ ▪ 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 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 **Risk and compliance:** Significant Risks Report to Risk Committee monthly **Independent assurance**: ISO 27001 Information Security Management Certification (NHIS) Mar ~~23~~24; 360 Assurance Data Security and Protection Toolkit audit Jun 23–moderate assurance; Cyber Essentials Plus accreditation (NHIS) Dec 2~~2~~3	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	~~Positive~~ Inconclusive Last changed ~~December 2023~~ 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 ~~Action Plan~~ ▪ Estates Strategy 2015-2025 ▪ PFI Contract and Estates Governance arrangements with PFI Partners ▪ Fire Safety ~~Strategy~~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) ▪ Major incident 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 2024 Complete the actions within the Fire Audit action plan **SLT Lead:** Associate Director of Estates & Facilities **Timescale:** August 2024	**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	Inconclusive evidence of buildings cladding and structures compliance with fire regulations Pursue the outcomes of buildings cladding and structures survey **SLT Lead:** Associate Director of Estates & Facilities **Timescale:** March 2024 - complete Determine the remedial work required to ensure that the cladding is compliant with fire regulations **SLT Lead**: Associate Director of Estates & Facilities **Timescale:** March 2024	~~Positive~~ Inconclusive Last changed March ~~2023~~2024

Board Assurance Framework (BAF): May 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**
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 ▪ Annual Core Standards Process (NHSE & ICB), with follow up report to Board ▪ Annual CBRN Audit (EMAS) ▪ Three yearly annual 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			**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 ~~(Oct 22)~~ 2023 – ~~Substantial Assurance~~ 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): May 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**	~~3. Possible~~ 4. Somewhat likely	3. Possible	2. Unlikely				
Last reviewed	23/05/2024	**Risk rating**	~~9. Medium~~ 12. High	**9. Medium**	**6. Low**				
Last changed	23/05/2024								

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:** ~~April~~July 2024 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:** ~~April~~ June 2024 Review of Green Plan Quarterly Energy and Sustainability Report to SDOG **Progress:** Data and information now readily available and now needs to show how we utilise this to inform our decisions on capital etc, **Lead:** Sustainability Officer **Timescale:** July 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	**Management:** 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	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 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 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

			Progress: Review of all aspects of the Green Plan have been undertaken and this is currently being reviewed by the EFM team. **Lead:** Associate Director of Estates and Facilities **Timescale:** July 2024 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 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. **Lead:** Sustainability Officer **Timescale:** July 2024 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. **Lead:** Sustainability Officer **Timescale:** August 2024		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 Decarbonisation Plan: Submission to Phase 5 Public Sector Low Carbon Skills Fund to produce our decarbonisation plan **Progress:** Bid Submitted May 2024 **Lead:** Sustainability officer **Timescale:** TBC following the outcome of the bid submission	