Public Board of Directors
Item number: 30
Date: 24 September 2025

Confidential/public paper:	Public
Report Title:	**Board Assurance Framework (BAF) 2025-2026**
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Presented by:	Dawn Pearson, associate director of communications and corporate governance
Vision and values:	The Trust vision is to ensure we **work together for service users**. The BAF helps to assure us that any identified risks are managed, so we can continue to **improve the lives** of the people we serve, through safe and effective services and demonstrate our **commitment to quality**.
Purpose:	The **Board assurance framework (BAF) identifies risks in relation to each of the Trust's strategic objectives** along with the controls in place and assurances available on their operation. The revised BAF risks 2025-2026 have been aligned to the refreshed Trust strategy and were approved by the Board of directors in July 2025 noting further refinement of the risk descriptions would take place for presentation in September 2025.
Executive summary:	The updated risk BAF risks, for 2025-2026 have been reviewed through the relevant committees during September 2025 for presentation to the Board of Directors in September 2025. BAF risk 0021, 0023 will be reported to the Audit and Risk Committee in October 2025. A full summary dashboard of all BAF risks is attached at **appendix 1,** changes are noted in blue text in the extracts attached. Areas of focus for review have been: • Updating risk descriptions for consistency. • Reference to whether assurances are positive or negative. • Updated risk summaries, actions and milestones.

People Committee	**Summary update**:
BAF 0013 There is a risk that staff well-being and absence is negatively impacted	Reducing violence and aggression plan is in place. Violence and aggression reduction strategy and policy in development. Keeping our People Safe campaign implemented and governance structures are being developed.
BAF.0014 There is a risk that our workforce does not reflect the skills required to support our strategic priorities	More testing and development of dashboard needed before full relaunch. Planning, Finance and People have met to agree parameters for workforce and recruitment plans.
BAF 0020 There is a risk that we do not embed an open organisational culture that promotes our values, behaviours and a sense of belonging	Six priority areas of focus related to the Values into Behaviours programme identified and delivery plans with milestones in place.
BAF 0028 There is a risk that we fail to recognise, challenge or respond to tackling all forms of racism and racial inequality	The Workforce Race Equality Standard report actions requested by the Board and the People committee prior to final approval have been completed. The Northwest framework submission is being collated.
Quality Assurance Committee	**Summary update**:
BAF 0024 There is a risk that the organisation fails to meet fundamental standards of care, legal, regulatory, and safety requirements	Least Restrictive practice continues to be a focus with restrictive interventions pre 1000 bed days reducing in July 2025. Work to reduce this further is being undertaken through the delivery of the Least Restrictive Practice Plan.

BAF0025 There is a risk of failure to deliver improvements to environments in the time frame required.	The milestones have been updated to reflect progress in improving access to crisis and mental health services The risk score remains unchanged.
BAF 0029 There is a risk that the quality and safety of patient care is negatively affected, caused by untimely access to crisis support and mental health services, resulting in poor experience of care and potential harm to service users.	The BAF risk description has been updated to reflect the risk to quality, safety and patient care due to delayed access to crisis support and mental health services. The milestones have been updated to reflect progress in improving access to crisis and mental health services
BAF0031 There is a risk that the Trust fails to maximise its contribution to reducing inequalities	The Board self-assessment on health inequalities shows year on year improvement. The milestones have been updated to reflect progress in improving access to crisis and mental health services
BAF0033 There is a risk that unresolved ligature anchor points in patient-accessible areas may lead to incidents of self-harm or suicide	The milestones have been updated.
Finance and Performance Committee	**Summary update**:
BAF0022 There is a risk we fail to deliver the break-even position in the medium term	Current underlying cost pressure of circa £2m and VIP shortfall of c£2.2m pressure mean risk remains the same at this point. Milestones and actions have been updated.
BAF0023 There is a risk of failure to ensure digital systems are in place to meet current and future business needs	There is a revised plan and timescales including additional funding agreed for the optimisation work by the Trust Board. Also monitored at the Audit and Risk Committee.
BAF0026 There is a risk that we fail to effectively implement the level of improvement and change that is required.	Milestones have been updated.
BAF0027 There is a risk that we do not ensure effective and timely stakeholder involvement and partnership working	Milestones have been updated.
BAF 0030 There is a risk that local environment, workforce and population will be impacted	Escalation process completed, significant progress made, summary position will be assessed during September 2025.
BAF 0032 There is a risk that our estates do not adequately enable the delivery of our strategic priorities	Milestones have been updated
Audit and Risk Committee	Summary update
BAF0021 There is a risk of a cyber security breach	Improved security using Zscaler tool and Intune. AI risk to be reviewed for inclusion on corporate risk register

Appendices:

Appendix 1 – summary dashboard

Appendix 2 to 5 - Assurance committee BAF risks

Which strategic objective does the item primarily contribute to:					
Effective Use of Resources	*Yes*	**X**	*No*		
Deliver Outstanding Care	*Yes*	**X**	*No*		
Great Place to Work	*Yes*	**X**	*No*		
Reduce inequalities	*Yes*	**X**	*No*		

What is the contribution to the delivery of standards, legal obligations and/or wider system and partnership working.	
The BAF is the main tool by which the Board overall responsibility for internal control. Owned by the Board, it is a key tool to assure and evidence the delivery of strategic objectives. It is a fundamental component of good governance, providing a tool for the Board to identify risks to the achievement of its strategic objectives and ensure that there is sufficient assurance regarding the effective management of strategic risk.	
Board assurance framework (BAF) and corporate risk(s):	All BAF risks are noted within the report.
Any background papers/items previously considered:	The BAF is reviewed quarterly by each executive director lead prior to EMT and relevant committee prior to Trust Board approval.
Recommendation:	The Board of Directors are asked to: • **Approve** the updated BAF risks 2025-2026.

BOARD ASSURANCE FRAMEWORK DASHBOARD September 2025

Risk Type	Risk	Executive Lead	Lead Committee	Current Risk Rating S X L	Target risk rating S X L	Risk Appetite	Movement (From last quarter)	Assurance Level
Clinical Quality and Safety	**BAF 0024** There is a risk that the organisation fails to meet fundamental standards of care, legal, regulatory, and safety requirements, caused by inadequate systems, processes, or behaviours that do not support a culture of high-quality, safe, and person-centred care, resulting in harm to staff and service users, reputational damage, and regulatory action	Executive Director of Nursing, Quality and Professions	Quality Assurance Committee	**4 x 3 = 12**	**4 x 1 = 4**	**Low (Minimal)**	⟷	
Clinical Quality and Safety	**BAF 0025** There is a risk of failure to deliver improvements to environments in the time frame required, caused by limited availability of capital investment, resulting in an impact on safety, and experience for both service users and staff.	Director of Strategy	Quality Assurance Committee	**4 x 2 = 8**	**3 x 2 = 6**	**Moderate (Cautious)**	↓	
Clinical Quality and Safety	**BAF 0029** There is a risk that the quality and safety of patient care is negatively affected caused by untimely access to crisis support and mental health services, resulting in poor experience of care and potential harm to service users.	Director of Operations	Quality Assurance Committee	**4 x 4 = 16**	**3 x 1 = 3**	**Low (Minimal)**	⟷	
Strategic	**BAF 0031** There is a risk that the Trust fails to maximise its contribution to reducing inequalities caused by a failure to adopt a population health management approach including a focus on prevention leading to poorer outcomes and unfair differences in outcomes.	Director of Strategy	Quality Assurance Committee	**4 x 4 = 16**	**3 x 2 = 6**	**Moderate (Cautious)**	⟷	
Clinical Quality and Safety	**BAF 0033** There is a risk that unresolved ligature anchor points in patient-accessible areas may lead to incidents of self-harm or suicide, caused by delays in capital programme works required to remove or mitigate these risks resulting in serious harm to service users, regulatory breaches, reputational damage, and potential legal consequences.	Executive Director of Nursing, Quality and Professions	Quality Assurance Committee	**5 x 4 = 20**	**3 x 2 = 6**	**Moderate (Cautious)**	**New risk**	
Clinical Quality and Safety	**BAF 0023** There is a risk of failure to ensure digital systems are in place to meet current and future business needs, caused by failure to develop and deliver an up-to-date modern digital strategy and systems and processes to support its delivery, resulting in poorer clinical safety, quality, efficiency and effectiveness.	Executive Director of Finance, Performance and Digital	Audit and Risk Committee Finance and Performance Committee	**4 x 3 = 12**	**3 x 2 = 6**	**Moderate (Cautious)**	⟷	
Clinical Quality and Safety	**BAF 0021** There is a risk of a cyber security breach caused by inadequate arrangements for mitigating increasingly sophisticated cyber security threat and attacks and increased data protection incidents resulting in loss of access to business-critical system, and potential clinical risk that will have an impact on staff, people who use or have used services and the wider system.	Executive director of Finance and Digital	Audit and Risk Committee	**5 x 4 = 20**	**3 x 2 = 6**	**Moderate (Cautious)**	↑	
Financial sustainability	**BAF 0022** There is a risk we fail to deliver the break-even position in the medium term caused by factors including failure to develop and deliver robust financial plans based on delivery of operational, transformation and efficiency plans resulting in a reduction in our financial sustainability and delivery of our statutory duties.	Executive director of Finance and Digital	Finance and Performance Committee	**4 x 4 = 16**	**3 x 1 =3**	**Low (Minimal)**	⟷	

Strategic	**BAF.0026** There is a risk that we fail to effectively implement the level of improvement and change that is required in order to deliver our strategy and annual operational plan, caused by factors including a failure to embed an improvement culture, to equip our staff, and to manage the delivery of major change in accordance with our integrated change framework, resulting in failure to deliver our trust strategy and system expectations.	Director of Strategy	Finance and Performance Committee	**4 x 3 = 12**	**4 x 2 = 8**	**High (open)**	⟷	
Strategic	**BAF 0027** There is a risk that we do not ensure effective and timely stakeholder involvement and partnership working, caused by multiple factors including time pressure, individual skills and preferences, and gaps in systems and processes, resulting in a failure to meet our strategic objectives.	Director of Strategy	Finance and Performance Committee	**4 x 3 = 12**	**4 x 2 = 8**	**High (open)**	⟷	
Environmental	**BAF 0030** There is a risk that local environment, workforce and population will be impacted caused by the failure to deliver the green plan resulting in legal and regulatory action and reputational damage.	Executive director of Finance and Digital	Finance and Performance Committee	**3 x 4 = 12**	**2 x 4 = 8**	**High (open)**	⟷	
Environmental	**BAF 0032** There is a risk that our estates do not adequately enable the delivery of our strategic priorities, which include community models of care and care closer to home, caused by multiple historical factors including an aging estate which was not developed for these future needs, the capital regime in the NHS, and the need to update the trust estates strategy; resulting in limited or delayed implementation of our strategic intentions and the 10 Year Plan.	Director of Strategy	Finance and Performance Committee	**4 x 3 = 12**	**3 x 2 = 6**	**Low to Moderate (Minimal Cautious)**	⟷	
Workforce	**BAF 0013** There is a risk that staff well-being and absence is negatively impacted, caused by a work environment that is not free from violence, aggression, harassment (including sexual harassment) bullying, abuse, racism, resulting in higher levels of absence and incidents against staff and impacting staff experience.	Executive Director of People	People Committee	**4 x 4 = 16**	**4 x 2 = 8**	**High (Open)**	⟷	
Workforce	**BAF.0014** There is a risk that our workforce does not reflect the skills required to support our strategic priorities, caused by lack of effective workforce planning and availability of skills resulting in a negative impact on our ability to retain a flexible modern workforce to provide quality care and services.	Executive Director of People	People Committee	**4 x 3 = 12**	**4 x 2 = 8**	**High (Open)**	⟷	
Workforce	**BAF 0020** There is a risk that we do not embed an open organisational culture that promotes our values, behaviours and a sense of belonging caused by lack of visible action to address feedback from staff resulting in poor staff experience, failure to provide an inclusive environment and negative feedback.	Executive Director of People	People Committee	**4 x 3 = 12**	**3 x 2 = 6**	**Low to Moderate (Minimal Cautious)**	⟷	
Workforce	**BAF 0028** There is a risk that we fail to recognise, challenge or respond to tackling all forms of racism and racial inequality and micro aggression caused by lack of confidence in, and use of systems and pathways for speaking up resulting in racial inequity for people who work in or use trust services	Executive Director of People	People Committee	**4 x 4 = 16**	**2 x 4 = 8**	**High (Open)**	**New risk**	

BOARD ASSURANCE FRAMEWORK 2025/26
For receipt September 2025

BAF RISKS OVERSEEN AT PEOPLE COMMITTEE

<table>
<tr><td colspan="5">BAF 0013 There is a risk that staff well-being and absence is negatively impacted, caused by a work environment that is not free from violence, aggression, harassment (including sexual harassment) bullying, abuse, racism, resulting in higher levels of absence and incidents against staff and impacting staff experience.</td></tr>
<tr><td colspan="2">STRATEGIC AIMS
• Deliver outstanding care
• Create a Great Place to Work
• Reduce inequalities</td><td colspan="2">• STRATEGIC PRIORITIES
• Develop our culture though the ‘we are our values’ programme.
• Improve the safety of our staff by reducing violence and aggression and sexual safety incidents.
• Continue our journey to become an anti-racist organisation.
• Deliver our equality objectives</td><td>Executive lead: Executive Director of People
Board oversight: People Committee
Last reviewed – July 2025. Next review – September 2025
Risk type: Workforce
Risk appetite: High (open)
Risk rating impact v likelihood
- Current 4 X 4 = 16
- Target 4 x 2 = 8
- Movement
Corresponding risks on the Corporate Risk Register: 5385</td></tr>
<tr><td>On track</td><td>Some slippage</td><td>At risk</td><td>Completed</td><td>- Assurance level</td><td>Amber</td></tr>
<tr><td colspan="3"><u>Summary update</u>

No change to the risk score is recommended in this update.
Reducing violence and aggression plan is in place.
Violence and aggression reduction strategy and policy in development.
Keeping our People Safe campaign implemented and governance structures are being developed.
Milestones have been reviewed and target dates confirmed.</td><td colspan="3"><u>Milestones in 2025/26 to support reaching target score:</u>

• Health and wellbeing assessment model is in place which informs the scoping and prioritisation of the health and wellbeing work. This will support focus for the new financial year – People Plan 2025/26. March 2026
• The Board have agreed the development of the wellbeing hub and a work plan will be created to support the implementation of this work in the new financial year 2025/2026 with some support identified from Charitable funds. March 2026
• A Violence and aggression reduction plan is in place reported to EMT, People Committee, via WODAG and the health and safety group. Completed
• A fresh review of the Violence and Aggression reduction standards has been commissioned led by a senior clinician reporting to the V&A group to conclude by July 2025 Awaiting outcome
• Survey data regularly reviewed to inform development Further specific survey post NHS staff survey proposed December 2025.
• Violence, aggression and sexual safety dashboard in place (July)</td></tr>
</table>

	• Values into behaviors launched 24th April 2025 **Achieved** • Flu Vaccination targets to be set July 2025 Awaiting update from campaign • Pilot Wellbeing interventions commencing September 2025 • Absence reduction enhanced support plan in place July 2025 completed • SHSC manager reviewed, and new modules all planned modules in place and being delivered (as of May 2025) • Delivery of WDES/WRES action plans July 2025 - July 2026 • Delivery of actions to tackle anti-racism 1 April to 31 March 2026 • Deliver improvements in support for disabled trainees November 2025 • 2025 staff survey results January 2025 • Review progress of recovery actions for compliance with absence policies September 2025. **Milestones completed** • Values delivery group in place from June 2025 • 6 priority areas of focus identified and delivery plans with milestones in place (recruitment, improving lives monthly award, visuals around sites, supervision / PDRs, meetings and leading and managing) • New and Expectant mothers policy developed • Pregnancy risk assessment panel stood up • Reducing Violence and Aggression policy drafted • Legal briefing on health and safety risk assessment for leaders and managers • New process to sign off policy compliance introduced for assurance

Controls

- Governance – ICS HRD Deputy Network, ICS staff Health and Wellbeing Group, National Wellbeing Guardian Network, People Strategy Delivery Plan in place and refreshed in April 2024 and reviewed through tier II groups into People Committee, Regular reporting to committees and to WODAG group, reporting to the ICS (including on HWB)
- NHSEI National Wellbeing lead and ICS Wellbeing Group
- HWB Framework in place
- NHS People Plan and actions for HR and OD
- South Yorkshire People leaders meeting (multi agency) which provides a system view around a range of areas to support people related issues in work.
- The ICS have established a wellbeing roadmap and there are three ICS groups around people, partnerships, prevention and proof [the Trust has nominated a lead to work alongside colleagues to influence the development of this]
- Board level Wellbeing Guardian in place
- Professional nurse advocates in place (nurses) now extended a restorative supervision offer to all staff
- Vaccination planning
- Wellbeing and OD Assurance group (WODAG) overseeing wellbeing support
- OH Contract in place and regular OH contract review meetings in place – quarterly.
- Violence and Aggression Group
- Pregnancy risk assessment panel
- Microsoft form confirming receipt of policy and understanding
- Sexual Safety Charter
- Staff side Recognition agreement in place.
- Wellbeing champion network is established to provide hub and spoke model for sharing feedback, engagement and signposting

• National violence and aggression reduction standards	
Internal assurance noting positive (P) and negative (N) assurances • Menopause accreditation in place from September 2023 (P) • People strategy (approved March 2023 – March 2026) – has a deliverable to support managers to deliver team and individual wellbeing. (P) • Governance reporting to People Committee (P) • Service-led IPQR's monitoring. (P) • Health and Wellbeing self- assessment toolkit. (P) • Health and wellbeing network in place. (P) • Wellbeing and Engagement lead in place. (P) • Wellbeing champions recruited and embedded (P) • Return to work meetings monitored through eRoster. (N) • Wellbeing conversation guidance now embedded in revised Supervision Policy. (P) • Reports to People Committee include progress on milestones. (P) • Sexual safety charter- the associated implementation plan is in place(P) • Occupational health contract with quarterly reviews contract monitoring data/information in place. (P)	**External assurance** noting positive (P) and negative (N) assurances • Model Hospital and NHSE/I returns. (N) • CQC Well-Led. (P) • Internal audit 360 staff wellbeing audit - *Significant assurance.* We participated as a trailblazer to test out the HWB framework trailblazer (NHSEI) community of good practice. National NHS HWB framework diagnostic – this is an assessment tool and was reported into HWB assurance group and fed into the refreshed delivery plan from 2022/23. Findings have informed the plans for 2024-25. (P) • Internal Audit absence management – Significant assurance 2025 (P) • The ICS have established a wellbeing roadmap and there are three elements around people, prevention and partnerships this will support the delivery of our health and Wellbeing priorities in the People plan. (P) • Sexual safety charter –development and oversight provided in partnership with NHS sexual safety and domestic abuse team(P)
Gaps in control 1. Regular reporting on quality of wellbeing conversations	**Actions to address gaps in controls** • Supervision quality survey completed and presented to People Committee
2. Development of the wellbeing hub aligned to the priorities of the NHS wellbeing framework assessment	• The wellbeing plan – hub development to be relaunched in line with charities monies.
Gaps in assurance N/A	**Actions to address gaps in assurance** N/A

BAF.0014 **There is a risk that our workforce does not reflect the skills required to support our strategic priorities, caused by lack of effective workforce planning and availability of skills resulting in a negative impact on our ability to retain a flexible modern workforce to provide quality care and services.**

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	**Executive lead:** Executive Director of People **Board oversight:** People Committee **Last reviewed** – July 2025. **Next review** September 2025 **Risk type:** Workforce **Risk appetite:** High (open) **Risk rating impact v likelihood** - Current 4 x 3 = 12 no change - Target 4 x 2 = 8 - Movement ⟺ Corresponding risks on the Corporate Risk Register: 5321, 5409 -
• Create a Great Place to Work • Effective Use of Resources • Deliver outstanding care • Reduce inequalities	• Develop our culture though the 'we are our values' programme. • Develop university trust strategy and partnerships with our universities. • Improve the safety of our staff by reducing violence and aggression and sexual safety incidents. • Continue our journey to become an anti-racist organisation. • Deliver our financial plan of a £4.9m deficit, including achievement of £8m efficiencies. • Become more productive in all parts of our Trust. • Deliver our quality and safety objectives including culture of care, risk assessments, care planning and restrictive practice.	

On track	Some slippage	At risk	Completed	- **Assurance level**	**Amber**

Summary update

There are no recommended changes to the scoring for this risk
More testing and development of dashboard needed before full relaunch.
Planning, Finance and People have met to agree parameters for workforce and recruitment plans.
Milestones have been reviewed and target dates confirmed.

Milestones in 2025/26 to support reaching target score:

- Workforce plans integrated with Business Plans 25/26 October 2025
- Next Review of flexible working policy is due by April 2027
- Data Warehouse development Dashboard complete. Full Launch planned October 2025
- Training needs analysis (TNA) required for future workforce for People Strategy 26/28 March 2026

Controls

Governance

- Workforce Transformation and Recruitment and Retention Group (WTRG)
- TRAC reports feed into WTRG
- Annual learning needs analysis undertaken to inform Trust training plan priorities for workforce transformation and CPD funding investment *[from BAF risk 0019]*
- Ensuring the apprenticeship level is fully utilised and prioritised for new roles/progression pathways for existing staff and that we meet our public sector apprenticeship targets *[from BAF risk 0019]*
- Workforce data dashboard
- TRAC system in place to manage ALL recruitment. Tracked and reported to People Committee
- Training and further guidance for recruiting managers on TRAC. Rolling programme of training is in place**.**
- All new starters and all establishment change requests have to go through defined approval processes.
- Manager self-service (ESR) in place
- Pre employment and right to work checking

Internal assurance noting positive (P) and negative (N) assurances	**External assurance** noting positive (P) and negative (N) assurances
Governance reporting: • Bi-monthly reporting to People Committee and Board; Project Boards report to workforce assurance group Workforce assurance group apprenticeship levy reported through the Workforce Assurance Group (P) • Workforce Recruitment and Transformation group. (P) • Medical recruitment and engagement group (P) • Retention/ turnover data provided as part of the People Dashboard ~~review~~ at People Committee bi-monthly. (P) • People Delivery plan in place for 25/26. (P) • Internal audit on workforce data quality – received with significant assurance in 2024/25 (P) • Time to hire data cleanse and new national reporting parameters in place (P)	• ICS Recruitment and Retention group attended by Deputy Director of People (P) • Bi-monthly reporting to Quality Board (external group i.e. NHSE/I, CQC, CCG *as was*) (P) • National People Plan reporting to ICS – we are required to provide evidence on meeting priorities so ICS can respond on national level. (P) • Quarterly data benchmarking report (apprenticeship levy data collection) to Health Education England on behalf of ICS [from BAF risk 0019] (P) • National People Plan reports into ICS. (P) • NHSE Performance workforce returns + direct support (P) • NHSE and People workforce return (PWR) reporting which triangulates and checks our data (P) • PWR reporting and NHSEI governance for international recruitment (P) • Internal Audit significant assurance received for Data Quality – July 2024 (P).
Gaps in control 1. Annual learning needs analysis undertaken to inform training plan priorities for investment (completed at high level for external funding only some gaps in process)	**Actions to address gaps in controls** • CPD group established chaired by the Executive Director of Nursing to review training needs. March 2026
Gaps in assurance N/A	**Actions to address gaps in assurance** N/A

BAF 0020 There is a risk that we do not embed an open organisational culture that promotes our values, behaviours and a sense of belonging caused by lack of visible action to address feedback from staff resulting in poor staff experience, failure to provide an inclusive environment and negative feedback.

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	**Executive lead:** Executive Director of People **Board oversight:** People Committee **Last reviewed** –July 2025. **Next review** — September 2025 . **Risk type:** Workforce **Risk appetite:** Low to Moderate (minimal and cautious) **Risk rating impact v likelihood** - Current 4 x 3 = 12 - Target 3 x 2 = 6 - Movement ⟺ Corresponding risks on the Corporate Risk Register: 5385
• Create a great place to work • Reduce inequality	• Develop our culture though the 'we are our values' programme. • Improve the safety of our staff by reducing violence and aggression and sexual safety incidents. • Continue our journey to become an anti-racist organisation. • Deliver our equality objectives	

On track	**Some slippage**	At risk	Completed	**Assurance level**	**Amber**

Summary update	**Milestones in 2025/26 to support reaching target score:**
No recommended change to scoring Six priority areas of focus related to the Values into Behaviours programme identified and delivery plans with milestones in place. Milestones have been reviewed and target dates confirmed.	Recruitment October 25 Improving lives monthly award October 25 Visuals around sites September 25 Supervision / PDRs October 25 Meetings November 25 Leading and managing November 25 Pulse survey July 25 Staff survey launch 1 October – 30 November 25 • Staff survey launch 2025 October 2025. Results received December 2025.

	• Team level summary report out to all senior leaders and team leave February /March 2026.

Controls

- Reporting to People Committee, NHSEI National and regional People Plan
- 2023 -26 People Strategy approved at Board in March 23.
- Board visits programme (15 steps)
- Restorative Just and Learning process
- FTSUG processes
- Refreshed People Delivery Plan
- Leadership development offer in place – Team SHSC – Developing as Leaders programme.
- Fundamental standards of care visits completed across inpatient. Action plans in place. Culture and Quality visit programme in place for community services.
- Transformation Board reports (monthly)
- Workforce and Organisational Assurance group (WODAG) receives regular reports (monthly) on performance against expected outcomes
- Values work to be report to Transformation Portfolio Board from March 2025 – title of 'We are our values'
- Established Co-chairs for the Values Delivery Group and working with OD and PMO to progress the 'We are our values' workstream.

Internal assurance noting positive (P) and negative (N) assurances	**External** noting positive (P) and negative (N) assurances
• Staff engagement steering group reports monthly to Organisational Development Assurance Group which reporting into People Committee bi- monthly (P) • People Pulse survey (N) • Team SHSC: Developing as Leaders (DAL) 5 cohorts (P)	• Quality Improvement Group (ICS) (P) • ICS HR Directors Group (NHS HR Futures report) – long term 10-year strategy to make improvements in HR and OD in the NHS to support delivery of the NHS People Plan (P) • NHS National Survey – amalgamated benchmarking across sector (P) • NHS People Plan provides assurance that SHSC People Strategy was developed taking account of this. (P) • New NHS leadership and management framework published (P)
Gaps in control N/A	**Actions to address gaps in controls** N/A
Gaps in assurance Low engagement scores – confirming with operational lead this is from staff survey and pulse survey data	**Actions to address gaps in assurance** **Owner Head of OD and Deputy Director of People** Staff Survey 2024 organisational response rate (engagement measure) increased by 12% (which is a 20% year on year increase from 2023). Continued increase in participation from ethnically diverse staff within this.

BAF 0028 **There is a risk that we fail to recognise, challenge or respond to tackling all forms of racism and racial inequality and micro aggression caused by lack of confidence in, and use of systems and pathways for speaking up resulting in racial inequity for people who work in or use trust services**

STRATEGIC AIMS.	**STRATEGIC PRIORITIES**	**Executive lead:** Executive Director of People **Board oversight:** People Committee **Last reviewed** – July 2025. **Next review** – September 2025 **Risk type:** Clinical quality and safety **Risk appetite:** High (open) **Risk rating impact v likelihood** - Current 4 X 4 = 16 - Target 2x4 - Movement NEW Corresponding risks on the Corporate Risk Register: 5385
• Deliver outstanding care • Create a Great Place to Work • Reduce inequalities	• **Develop our culture though the 'we are our values' programme.** • **Improve the safety of our staff by reducing violence and aggression and sexual safety incidents.** • **Continue our journey to become an anti-racist organisation.** • **Deliver our quality and safety objectives, including culture of care, risk assessments, care planning and restrictive practice.**	

On track	Some slippage	At risk	Completed	**Assurance level**	**Amber**

Summary update

An update is being provided to the Board in October 2025 on anti-racism action including some case study examples of impact and identified new actions.
The Workforce Race Equality Standard report actions requested by the Board and the People committee prior to final approval have been completed. The Northwest framework submission is being collated, and we are engaged with the Northwest lead for this area.
Milestones have been reviewed and target dates confirmed.

Milestones in 2025/26 to support reaching target score:

- Engage with stakeholders including the Board and Staff Network groups on completing and submitting our bronze level assessment for the Northwest Anti Racism Framework November 2025
- Align action across workforce and service areas to provide a clear plan and framework for reporting progress to Committees and Boards December 2025
- Review the national mandated reporting organisation specific WRES report due in October 2025 to assess how SHSC benchmarks against WRES indicators against other mental health trust and the ICB
- Roll out the new ESR reporting portal target date amended from August 2025 to October 2025

Controls

- Anti Racism anti-Discrimination group (Subgroup of the Inclusion and Equality group)
- Workforce Race Equality Standard Reporting to People Committee and Board.
- Workforce EDI dashboard reporting to the Inclusion and Equality Group
- Partnership and Collaborative working with South Yorkshire Police/ the Crown Prosecution Service and Sheffield City Council Hate Crime Initiatives
- Allyship – Managers Programme
- Microaggressions – Managers Programme
- Racialized Trauma – Training
- Reciprocal Mentoring programme – regional
- Reciprocal mentoring – Trust

<table>
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- Review of Active Bystander
- Ethnically Diverse Staff Network Group including chairs meeting with the Board, policy review groups and Chairs group
- Patient and Carer Race Equality Standard – Action
- Culture of care alignment of action
- Fit To Refer – achieved ahead of target
- Workplace wellbeing proactive support to victims of Racism from service users
- SOP on reporting and responding to hate incidents in place

</td></tr>
<tr><td><u>Internal assurance</u> noting positive (P) and negative (N) assurances

Reduction in WRES metrics on disciplinary rates (N)
Fit To Refer – achieved ahead of time (P)
Inclusion and Equality Group (P)</td><td><u>External assurance</u> noting positive (P) and negative (N) assurances

2024 Mandated reporting WRES report (N)
NHSE National Reporting team (P)
ICB (P)</td></tr>
<tr><td><u>Gaps in control</u>

Governance and outcomes still to be agreed (relates to Keeping our staff safe)</td><td><u>Actions to address gaps in control</u>

Keeping our staff safe governance and confirmation of overall plan</td></tr>
<tr><td><u>Gaps in assurance update</u>

• Lack of progress in ethnically diverse staff moving into posts at 8c and above
• Staff experience of racism from service users – inconsistent support offered
• Staff reluctance to report racism from service users and from other sources</td><td>Actions to address gaps in assurance.

• Deep dive report on lack of progress in ethnically diverse staff moving into posts at 8c and above to be provided to the People Committee with reviewed and updated action plan.
• Staff experience of racism from service users – inconsistent support offered – alignment with Violence and Aggression action
• staff reluctance to report racism from service users and from other sources – implement the ESR portal to allow for anonymous reporting (in response to the in-patient survey completed in 2024)</td></tr>
</table>

BOARD ASSURANCE FRAMEWORK 2025/26
For receipt in September 2025

BAF RISKS OVERSEEN BY QUALITY ASSURANCE COMMITTEE

BAF Risk 0024

There is a risk that the organisation fails to meet fundamental standards of care, legal, regulatory, and safety requirements, caused by inadequate systems, processes, or behaviours that do not support a culture of high-quality, safe, and person-centred care, resulting in harm to staff and service users, reputational damage, and regulatory action.

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	
• Deliver outstanding care. • Reduce inequalities.	• Deliver our quality and safety objectives, including culture of care, risk assessments, care planning and restrictive practice. • Therapeutic environments – refurbish Maple ward	**Executive lead:** Executive Director – Nursing and Professions /Medical Director **Board oversight:** Quality Assurance Committee **Last reviewed** – September 2025. **Next review** – November 2025 **Risk type:** Clinical quality and safety. **Risk appetite:** Low (minimal and cautious) **Risk rating impact v likelihood.** • Current 4 x 3 = 12 • Target 4 x 1 = 4 • Movement • **Corresponding Corporate Risks:** 5026, 5124, 5344, 5429

On track	**Some slippage**	**At risk**	**Completed**	**Assurance level**	**Amber**

Summary Update

BAF risk was reviewed by EMT in June 2025 and risk agreed to remain the same – 12. Significant progress made with the LAP being addressed across in-patient estate with Maple refurbishment due to conclude October 2025.

Home First Programme continues to implement pathway improvements to address out of area placement use. However, the use of out of area placements continues to occur.

RIO was implemented successfully in March 2025, the optimisation and benefits realisation phase has commenced.

Least Restrictive practice continues to be a focus with restrictive interventions pre 1000 bed days reducing in July 2025. Work to reduce this further is being undertaken through the delievry of the Least Restrictve practice Plan

- **Review of Quality Governance –** Full review of Quality Governance by Good Governance Institute – due to conclude September 2025. Revised structure to be presented to EMT and QAC in October 2025, with implementation November 2025.
- **Progression of improvements related to supervision and training –** Supervision overseen through SLT and reported to EMT and People Committee. Significant improvements being seen across services. A review of the supervision policy and the associated supervision tree for both directorates is underway and will be completed by the end of Q2 2025-26.
- The non-medical training oversight group have agreed to the procurement of supervision training from Sheffield Hallam university after a positive evaluation of the programme. Awaiting potential dates from Sheffield Hallam University.
- The Non-Medical Education and Training Group has been established and will ensure that as clinical models/pathways of care are developed the associated training needs are reviewed and funding streams explored (e.g. NHSE CPD funding).
- Regulatory Compliance - A new group to develop the approach to assurance in relation to the CQC assessment framework. This will include a refresh of the Fundamental Standards visits

Focused QI being undertaken to ensure protected characteristics are accurately and consistently recorded. Impact in the pilot teams has been significant, with some teams achieving 100%. Culture of Care (CoC) Programme is established across in-patient wards with ward QI initiatives being presented to the CoC group. Personalised approach to risk assessment being implemented, with the template agreed and being built into RiO. Training underway. PCREF Stakeholder group established to oversee the Trust approach to the Delivery of PCREF Establishment of an Enhanced Support SOP to provide enhanced support to areas experinencing quality concerns.	programme. Q3 2025/26. • The new Ulysses Quality Audit programme was implemented inpatient services in August 2025. This includes a record keeping audit. The results of the audits will be reviewed through governance processes from September 2025. • A back-to-basics programme has commenced across in-patient services, with the aim of improving risk assessment, care planning and physical health monitoring. **Milestones completed.** • **Completion of the Fixed Ligature Anchor Point programme for acute adult in patient services** - the risk to service users will be mitigated through the planned decant of Maple ward to Dovedale 2 following its move to Burbage – this is completed with the Maple move completed 27 June 2024. Cross reference to BAF risks 0025a and 0025b **completed.**

Controls

- Established quality governance mechanisms including fundamental standards of care, culture and quality visits and quality audit programme.
- Monitoring performance and Quality through governance structure which can result in a request for improvement plans monitored through QAC.
- Ongoing recruitment and workforce planning processes including clinical establishment reviews, reviewed via People committee with robust workforce dashboard.
- Service lines and IPQR embedded ensuring a level of oversight.
- Management and leadership structure in place – Ward to Board with increased grip and control around management of establishments.
- Clinical and Social Care strategy implemented and mainstreamed into Quality Governance oversight.
- Robust incident and investigation governance in place in line with PSIRF
- Co-production standards implemented patient experience measures are in place including Care Opinion relaunched July 2025
- Range of leadership offers completed and ongoing across SHSC corporate and clinical teams.
- Quality and Equality impact assessment reporting to QAC.
- Ligature anchors point removal plan phases 1 and 2 are completed, phase 3 in progress. Clinical Environmental Risk Group reviews all LAP assessments and reports to clinical quality and safety group. Exceptions reported to Therapeutic Environment Board.
- Establishment of SLT which consists of leaders from all directorates and receives a quality report.
- Updated Capital Plan received at Board in April 2025 with updates received at subsequent Board meetings.

Internal assurance positive (P), negative (N) • Clinical Quality & Safety Group, SLT and EMT oversight of Enhanced Support (p) • Regular reporting through governance routes includes learning lessons, safeguarding reports, staffing reports, and improvement and change programme reports. (P) • The CQC report that was published on 16 February 2022 demonstrated we had delivered actions against section 29a warning. Significant progress was noticed. New improvement actions are in place. Outstanding actions in respect of Maple ward LAPs will be mitigated when Maple decants to Dovedale 2. (P) • RiO EPR implemented, with an optimisation plan approved by Board in June 2025.	**External assurance** positive (P), negative (N) • CQC Inspection – acute in-patient wards (awaiting feedback) • CQC relationship visits (P) • Provider Collaborative Quality Visits (N) • Section 11 Audit with safeguarding partnerships. (P) • Regularly reviewed by the Clinical Environment review group monthly.(P) • Engagement with safeguarding partnerships at Executive level (P)

(P) • SLT oversight with reporting to EMT (P) • Completion of the Fixed Ligature Anchor Point programme for acute adult in patient services - the risk to service users has been mitigated through the planned decant of Maple ward to Dovedale 2 following its move to Burbage – Maple refurbishment concludes October 2025.	
Gaps in assurance	**Actions to address gaps in assurance:**
1. Tendable was not consistently used and was removed in September 2025. The Ulysses replacement was delayed due to the RIO roll out.	• A Module on Ulyssess has been developed to replace Ulysses was launched August 2025 and is being further rolled out to the Community services across September and October 2025 . **Executive Director of Nursing, Quality and Professions**
2. Regular reporting through governance routes including learning lessons, safeguarding reports, staffing reports, and improvement and change reports.	• Further improvement to governance processes required to strengthen assurance and learning is shared across the organisation. A review of the Quality Governance architecture and will conclude August 2025 with new structure implemented October 2025
3. Completion of the Fixed Ligature Anchor Point programme	• The Therapeutic Environments Programme TEP) is the programme that the Board commissioned to address fixed ligature anchor points in in-patient settings following the CQC inspection. The agreed order of priority is to firstly address working age adult acute wards, then to address older adult wards and forensic wards. Once Maple Ward re-opens later this year the programme to address LAP on working age adult acute wards will be complete. The scoping work for LAP in forensic and older adults is included in the 25/26 capital plan. The older adults scoping work has recently commenced through the TEP and is on track to complete by March 2026. The forensic LAP scoping work has previously been undertaken but has not been taken forward yet due to 1) difficulties in undertaking the work without temporarily decanting services. 2) the need for capital investment. In addition to the forensic LAP work a number of other environmental improvements are planned. The capital plan for 25/26 includes improvements to clinic rooms, doors, and general environmental enhancements within the Forensic setting.
Gaps in controls 2024/25 Phase 3 plan for reducing ligature anchor points will depend on decant solution and take place over an 18-month period see action. **GAP closed.**	**Actions to address gaps in controls.** • Maple ward has been decanted to refurbished Stanage ward Dovedale 2 ward 27 June 2024 **Owner Director of Strategy Action closed** • Full business case for Maple improvements was submitted to Board in April 2024 - **Owner Director of Strategy Action closed**
1. PICU remains mixed gender	• Plans are being worked up to explore options for the management of mixed sex gender on PICU. **Owner Director of Operations** An outline case was presented in November 2025 to the programme board and an updated outline case will be presented to the programme board on 12 March 2025. Completed. • The Sexual Safety working group is in place reporting to QAC 6 monthly, this has been combined with the Violence Reduction Oversight Group.

2. Poor compliance with Supervision in clinical teams	• Supervision rates remain a concern in some areas this continues to be monitored at the People Committee. **Owner Executive Director of People** Supervision recording has moved to manager self-service (ESR) from January 2025. Senior Leadership Team is overseeing compliance improvement and Compliance is expected to reach required levels within Q2.
~~3.~~ Current Length of stay and out of area bed use is above trajectory	• Our Home First Programme and insights from Real World Health have identified the capability and capacity of community and crisis services, the efficiency of hospital care (length of stay), and social care delayed discharge as key drivers. Changes to operational and clinical governance structures and improvements to patient information flow have now been implemented. The Home First Programme launched under a revised structure and terms of reference in February 2025, and The Home First programme is expected to achieve out of area trajectories across Q2. **Owner. Director of Performance and Delivery**
4. Use of 136 suite rooms to accommodate people awaiting admission – still required at the current time	• New HBPOS (136 suite) opened in January 2024. There has been some breaching continuing and this remains under regular review and is reported weekly to EMT and through to the assurance committees. There has been some improvement in breaches since March 24, and this is subject to the revised flow plan for OOA. Monthly monitoring in place. There continues to be some breaching, and this remains under regular review. **Owner Director of Operations.** There was further deterioration in Quarter 3, in relation to breach of use of the 136 beds. It is a priory of the Home First Programme to prevent this. The regional Health Based place of Safety (Third HBPOS at the Longley Site) opened in January 2025, following work by the Provider Collaborative to improve HBPOS capacity. Operational and clinical leadership is provided by our Crisis Service, who work in close partnership with Sheffield City Council and South Yorkshire Police. Cross organisational procedures are now operational which require us to operate a maximum length of stay of 24 hours within a HBPOS, whilst also avoiding out of area hospital care. This forms part of the objectives of the Home First Programme.
5. Establishment of senior leadership team (SLT) which consists of leaders from all directorates.	• The reporting framework and work programme of governance structures will be reviewed by **Director of Operations** and Associate Director of Communications and Operations- January 2025. There are a number of Tier 2 committees that report into Quality Assurance Committee and provide assurances at the present time. An external governance review has been completed, and a final report is expected at the Board of Directors April 2025. OMG has been replaced by the SLT with new terms of reference. **Closed**
6. Patients experience measures are in place, but Friends and Family test (FFT) data is low, and the care opinion subscription no longer in place.	• The FFT has now gone live on Qualtrics, which provides an online way to give feedback. This is accessible via QR code and marketed on Jarvis, SHSC external website, and posters circulated to services. The engagement team will work with services to raise awareness of Qualtrics and encourage services to embed this work and understand the barriers faced. FFT performance will continue to be monitored through LECAG and the IPQR. There is now a feedback improvement plan in place which is starting to demonstrate improvements in feedback

	performance. Safe to share is also in place, which is showing an increase in engagement. The EMT approved the procurement of Care Opinion which will be live by October 2025 and will further support the gathering of FFT data.

BAF 0025 - There is a risk of failure to deliver improvements to environments in the time frame required, caused by limited availability of capital investment, resulting in an impact on safety, and experience for both service users and staff.

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	**Executive lead:** Director of Strategy **Board oversight:** Finance and Performance Committee **Last reviewed** – September 2025. **Next review** – November 2025 **Risk type:** Safety. **Risk appetite:** Moderate (cautious) **Risk rating impact v likelihood.**
• Deliver outstanding care. • Effective use of resources • Reduce inequalities • Great place to work	• Therapeutic environments – refurbish Maple ward. • Home first – reducing out of area placements, improving productivity and flow. • Deliver our quality and safety objectives, including culture of care, risk assessments, care planning and restrictive practice. • Improve the safety of our staff by reducing violence and aggression and sexual safety incidents.	• Current **4 x 2 = 8 (reduced)** • Target 3 x 2 = 6 • Movement • **Assurance rating** –Amber • **Corresponding Corporate risks – 5344**

On track	Some slippage	At risk	Completed	**Assurance level**	

Summary update

- The Therapeutic Environments Programme is the Trust's capital programme designed to respond to safety and quality risks identified by CQC and subsequently by the Trust's own reviews. There is good progress with the second phase of the programme (Maple ward, and small-scale enhancements at DD2) which has been accelerated through bids to secure additional system capital. The final phase of TEP (OPMH and Forensic) is likely to take multiple years to reach delivery due to limited availability of capital. This situation has recently been exacerbated by delays in the sale of Fulwood.
- Key actions being taken in 2025 to address this include) review capital plan prioritization, b) consider additional sources of investment for the options/ design phase to be ready for system capital slippage opportunities, and c) revise Fulwood sales strategy.
- Additionally, it is important that we maintain effective mitigations

Milestones in 2025/26 to support reaching target score:

- TEP final phase scoping (OPMH and Forensic) – subject to capital plan re-prioritisation – December 2025
- Revised plans for sale of Fulwood - September 2025 – ready for re-marketing
- Delivery of phase 1 of programme of investment in fire doors and compartmentation – March 2026. review of effectiveness of operational mitigations of risks at sites that form part of next phase of TEP (Forest Lodge and Grenoside) in view of likely length of time until building work can be completed – Q1 25/26 Forest Lodge multidisciplinary review completed. Older people mental health (OPMH) estates options development underway
- Clarify strategic intent with regard to sites in next phase of TEP - Q1 25/26. Partnership discussions are ongoing to clarify likely commissioning intentions for secure pathway.

Milestones Completed

- Stanage refurbishment – The Stanage ward re-opened in April 2024. Achieved.
- Dovedale 2 moved to Burbage – May 2024 – **completed.**
- Maple Ward decant to Dovedale 2 –27 June 2024 –**completed.**
- Clinical Environmental Risk Group to include detail on any outstanding works – by July 2024 -

and monitoring of risk. Key to this is a) Trust LAP group reviews risks, and b) effective implementation of operational protocols for management of risk at relevant units. • Steps that will trigger a review of current risk ratings are a) completion of Maple and DD2 projects, b) completion of OPMH and Forensic options work, c) securing additional capital, and d) completion of projects in OPMH and Forensic.	**completed.** • Estates strategy – Interim report July 2024 **completed.** • ICS infrastructure strategy – July 2024 **– completed.** • Maple Ward refurbishment commenced in early 2025 – **completed.** • Capital plan for 25/26 revised dynamically in light of progress and income achieved – **completed.** • EMT review of capital plan prioritisation – August 2025 **Complete** • EMT review of Forest Lodge environmental assessment – August 2025 Complete

Control

- Governance was in place to oversee Maple and associated moves.
- Maple full business case received at Board April 2024.
- Quality team have assessed the impact of ligature assessments and tightened controls and processes with mitigations identified and monitored – LAP heat maps in place on all wards.
- Enhanced nursing to manage environmental risks.
- Board and Executive visits.
- PLACE visits programme and Fundamental Standards visits.
- LAP assurance group which is led by the programme manager for therapeutic environments and the clinical risk and patient safety advisor. Governance arrangements will be picked up through the revised approach to managing improvement and change programmes in Q1 of 2024/25.
- LAP work taking place to capture outstanding ligature anchor point work through the Clinical Environmental Risk Group **Owner Exec Dir of Nursing, Professions and Quality** - has undertaken analysis. Addressed through work to close the Maple ward – completed June 2024
- Use of temporary staffing leading to potential inconsistencies in the application of practice standards - GAP Closed (July 2024)
- Clinical Environmental Risk Group confirmed remaining LAP works for wards was completed in June 2024 and the group receives detail on any outstanding works.

Internal assurance positive (P), negative (N)	**External assurance** positive (P), negative (N)
• Forensic internal rapid review – to **EMT July 2025** • Regular reporting (Capital Group; Therapeutic Environment Programme Board; Improvement and Change Board) • IPQR monthly reports – statutory and mandatory training • Board and Executive visits to all wards and teams 'P.' • Recruitment forecast confirmed 'P.' • Completion of Stanage Dovedale 2 and Burbage refurbishments. 'P' • Opening of the new HBPOS in January 2024 'P' • In February and March 2023 Registered Nurse and Healthcare Support Workers were onboarded covering many vacancies across acute wards. Systems are in place for rolling Registered Nurse and Healthcare Support Workers led by the Lead Nurse for recruitment. 'P' • Maple Ward decant to Dovedale June 2024 • Clinical Environmental Risk Group receives details on any outstanding work.	• Evidence based approach to Reducing Restrictive practice implementation (note there is evidence of continuing improvement around use of restricted practice)

• Estates Strategy interim review received at Board September 2024 • ICS Infrastructure Strategy (SHSC has contributed to its development)	
Gaps in control	
1. Use of temporary staffing leading to potential inconsistencies in the application of practice standards **- GAP Closed (July 2024)**	
Gaps in assurance N/A	**Actions to address gaps in assurance.** N/A

BAF 0029 There is a risk that the quality and safety of patient care is negatively affected caused by untimely access to crisis support and mental health services, resulting in poor experience of care and potential harm to service users.

STRATEGIC AIMS	STRATEGIC PRIORITIES	
• Delivering outstanding care • Reduce inequalities	• Deliver our quality and safety objectives including our culture of care, risk assessments, care planning and restrictive practice. • Home First – reducing out of area placements, improving productivity and flow. • Implement neighborhood mental health Centre pilot. • Therapeutic environments – refurbish Maple ward.	**Executive lead: Chief Operating Officer** **Board oversight: Quality Assurance Committee** **Last reviewed** – September 2025 **Next review** November 2025 **Risk type: Safety.** **Risk appetite:** Low (minimal) **Risk rating impact v likelihood.** - Current 4 x 4 = 16 risk - Target 3 x 1 = 3 - Movement - Corresponding Corporate Risks: 5001,4100, 4756, 4747, 5438

On track	Some slippage	**At risk**	Completed	**Assurance level**	**Red**

Summary update • The BAF risk description has been updated to reflect the risk to quality, safety and patint care due to delayed access to crisis support and mental health services. • The milestones have been updated to reflect progress in improving access to crisis and mental health services • The risk score remains unchanged.	**Milestones in 2025/2026 to support reaching target score:** • Agreement of Gender service investment – this remains a challenge in terms of demand and capacity – issues have been escalated to NHSE. August 2025 - Gender and ADHD service now delivering against a trajectory to meet commissioned activity. • Heeley and Gleadless MH Centre to launch in July 2025. This will pilot the ambitions of the NHS 10-year health plan to deliver neighborhood models of care. The pilot will be evaluated from April 2026. • ADHD – We have reviewed the ADHD pathway and remodeled our staffing structure to be nurse-led. We intend to utilise AI technology as part of a pilot to accelerate a reduction in waiting time. As well as this the waiting list is currently being cleansed.

	• PCMHT and CMHT pathway alignment and working on an improved operational delivery – October 2025 • August 2025 – Perinatal Mental Health meeting target trajectory against the birth rate. • We are implementing a plan to implement learning from the Nottingham Homicide independent review and internal learning. This plan was shared with the Trust and SYICB Board in June 2025. We reported progress to NHSE in August 2025. • We are working to reduce Learning Disability Service waiting lists by reviewing intervention and productivity. **Milestones completed.** • CMHT transformation – current lifestyle stage implementation is on track for completion by July 2024. This has been implemented - **completed.** • NHS 111 MH option April 2024 - **completed**
Control • Home First programme • Waiting Well Programme - Waiting list management initiatives in place to support people while they wait and respond to risk and supporting them to 'wait well'. • Duty systems are in place for relevant teams to respond to immediate risks. • We will continue to monitor the improvements in waiting times in our core services and ensure initiatives are in place where there is an increase in waiting times. Monitoring takes place through the directorate and executive IPQR process. • DLT, SLT and EMT governance established from July 2025 • An improved plan in place to have understanding of risks to people waiting for allocation from 1 November 2022. Achieved for our core services and Gender Identify services. • Moving forward ICB place discussions will continue to address waits, re-set service specifications, and explore investment opportunities. • Raising challenges and issues in strategic places, such as, SY NHSE, Autism Learning Disability Board, Place Mental Health Learning Disability Autism and Dementia Board at place. This is a delivery group reporting to the PLACE performance and quality committee and PLACE board. • Continuing to engage with ICB and other partners around unmet commissioning priorities • Guidance from NHSE around requirements for support to 17-year-olds received and being followed.	**Internal assurance** positive (P) negative (N) • Tightened operational governance framework (P) • Regular reporting in place through governance structure including Learning lessons quarterly report; IPQR, Complaints report; Quarterly reports to Quality Assurance Committee; Quarterly reports to Finance and Performance Committee. (P) • Allocation to named worker recovery plan. (N) • Memory Service recovery plan (N) • Culture and quality visits (N) • Contracting updates as required. (N) • Improved oversight of people waiting in CMHT's and Crisis and Urgent recovery teams. Rag rating system provides oversight of people waiting, and where VCSE support is needed this is identified. (P) • Improvement Plan for Gender services in place and being implemented. (N) • NHSE regional deep dive on Gender Services – positive feedback received actions identified and addressed. Implemented changes and have recently been assessed by the Levy Review team and awaiting feedback. (N) **External assurance** positive (P) and negative (N) • Gender services agreements refunding remain pending - Negotiation and escalation through commissioning forums at NHSE. (N) • Adherence to the NHS Long Term Plan and the community team framework. (P) • Relevant adherence to NICE guidance. (P) • Attempting to move close to the 4-week waiting standard for relevant core services

	funding dependent (N)
Gaps in control 1. Where there are large numbers of people waiting for a service, we cannot reach out to every person on a regular basis, so we are reliant on people contacting us if their presentation deteriorates or circumstances change. Each service has a protocol to regularly review people's needs whilst waiting and apply a RAG rating to prioritise contact.	**Actions to address gaps in controls.** • Investment was prioritised in 23/24 in our recovery services and perinatal mental health. • We have reviewed the ADHD pathway and remodeled our staffing structure to be nurse-led. We intend to utilize AI technology as part of a pilot to accelerate a reduction in waiting time. We continue to engage with the Provider Collaborative to consider primary care led models and to re-distribute collective spending via Right to Choose pathways. • There has been no further movement on Gender Services around investment and the Trust is continuing to engage and escalate. However, a recent review by NHSE provided positive feedback on service model and delivery and we have implemented the feedback. We now await the feedback from the Levy Review in early Q4 24/25. Deep dive from NHS England has been completed. Formal report expected latter part of Q4. Once received will review actions. Recruitment of the new workforce plan for GIC has finalized to address single points of failure within operational delivery and support increased throughput.
2. All areas require clear commissioning specification, which require a review and process implemented by Sheffield place, helping us to really understand who a service is for This is still on going and is an action led by Place.	• We are assertively following up with our strategic planners about resolving this very outstanding issue. This is now subject to Executive level escalation through Director of Operations. This is still ongoing and is also being escalated by the Deputy Director of Finance. There are still a significant numbers of service specs outstanding **– completion October 2025.**
Gaps in assurance	**Actions to address gaps in assurance.**
1. Lack of agile technology to maintain a high level of contact with people waiting.	• Part of revised Digital Strategy and road map to be developed in 2025/26 following implementation of RIO and the data warehouse **Owner CDIO** this will be completed following the implementation of RIO during 2025/26

BAF 0031 There is a risk that the Trust fails to maximise its contribution to reducing inequalities caused by a failure to adopt a population health management approach including a focus on prevention leading to poorer outcomes and unfair differences in outcomes.

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	**Executive lead:** Director of Strategy **Board oversight:** Quality Assurance Committee **Last reviewed** – September 2025. **Next review** – November 2025 **Risk type:** strategic. **Risk appetite:** Moderate (cautious) **Risk rating impact v likelihood –** Scoring confirmed.
• Reduce inequalities. • Deliver outstanding care. • Effective use of resources •	• Implement our inequalities and population health plan, starting by increasing the recording of personal data. • Improve pathways to work and access to housing through local partnerships. • Implement our Patient and Carer Race Equality Framework.	• Current 4x 4=16 • Target 3 x 2 = 6

		• Deliver out equality objectives. • Implement neighbourhood mental health centre pilot. • Develop university trust strategy and partnerships with our universities. •		• Movement – Corresponding corporate risks: no corresponding Corporate Risks currently.	
On track	Some slippage	At risk	Completed	**Assurance level**	

Summary update

- The Trust has a dedicated lead for reducing inequalities and population health who has been effective in establishing active networks in the Trust and local system and ensuring that the Board is conscious of its responsibilities, with regular consideration of the topic on agendas. A prioritised plan has been agreed and reducing inequalities is prominent in our refreshed strategy. There is progress on the key measure of recording of personal data, but our current level of recording is not acceptable.
- The Board self-assessment on health inequalities shows year on year improvement
- There is a risk that the current means and resourcing of this strategic aim will not achieve the level of change required at the pace that is expected.

Milestones in 2025/26 to support reaching target score:

- Charitable bids for funds to build capacity - outcome of bids known **Sept 2025 TBC**
- HWB development of inequalities fellowship scheme – would grow capacity –TBC

Milestones completed

- Board development session and around MHA QI, health inequalities self-assessment and PCREF – June 2024 – **completed**.
- Following June Board session lead officers for inequalities to create a proposed action plan for inequalities, including the strategic objectives above – by September 2024 – Director of Strategy Completed
- All projects with the 'waiting well QI collaborative' have a health inequalities element by July 2024. All teams are being supported to consider health inequalities throughout their work with their coaches **Head of Quality Improvement – completed.**
- Following June Board session draft self-assessment to be presented back to Board for approval by September 2024 – **Director of Strategy completed**
- Publish alongside the Trust's Annual Report key information on health inequalities and details of how the Trust has responded to it, in accordance with NHS England's statement on information on health inequalities by October 2024 – **Head of Health Inequalities and Director of Strategy/Medical Director. completed**
- Board considered its role in delivering the Fair and Healthy Sheffield Plan and agreed organisation specific actions – December 2024 – **completed.**
- Trust Strategy refresh strengthens focus on tackling inequalities – summary agreed January 2025 - **completed.**
- Operational plan 25/26 includes focus on tackling inequalities. Service Level business plans all include inequalities focused objectives.
- Annual Report 24/25 includes refreshed health inequalities statement – **complete**
- Trust strategy agreed and published in Q2~~4~~ 2025/26 **Complete**
- QI projects with pathfinder services to improve recording of personal data – reporting learning by **September 2025 Complete**

	• Board self-assessment repeated - **September 2025** The Board self-assessment on health inequalities shows year on year improvement •
Controls • Annual Board self assessment • NHSE statement on Inequalities - publication annually • IPQR data showing level of recording of personal characteristics by service • Twice yearly progress reports to Board • Inequalities community of practice established June 2024 • Leadership roles for inequalities established by June 2024 – in place. • All projects with the 'waiting well QI collaborative' have a health inequalities element was in place by July 2024. All teams are being supported to consider health inequalities throughout their work with their coaches.	
Internal assurance positive (P) negative (N) All listed are a balance of positive and negative. • Inequalities reporting to Board – details tbc following June development session • Inequalities measures in IPQR, plus breakdown of key metrics by personal characteristics in IPQR and workforce reports • Board development session and around MHA QI, health inequalities self-assessment and PCREF – June 2024	**External assurance** positive (P) negative (N) All listed are a balance of positive and negative. • Reporting of nationally mandated inequalities measures in October 2024 and beyond in line with NHSE Statement on Inequalities
Gaps in controls N/A –	**Actions to address gaps in controls** N/A
Gaps in assurance • The level of recording of personal characteristics of service users remains low. Increasing the percentage of records with complete demographic information will strengthen the effectiveness of our assurance mechanisms.	**Actions to address gaps in assurance** • Improvement activity to increase the level of recording of personal characteristics – This remains a gap and is owned by Operations- Greg Hackney, Senior head of Service and is reported monthly through the IPQR. A recovery plan related to recording of protected characteristics is in place and reports to the Quality Assurance committee. Further work is required to detail evidence of the impact with data. – April 2025.

NEW BAF 0033

There is a risk that unresolved ligature anchor points in patient-accessible areas may lead to incidents of self-harm or suicide, caused by delays in capital programme works required to remove or mitigate these risks resulting in serious harm to service users, regulatory breaches, reputational damage, and potential legal consequences.

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	**Executive lead: Executive director of nursing, quality and profession** **Board oversight:** Quality Assurance Committee **Last reviewed** – September 2025. **Next review** – November 2025 **Risk type:** clinical quality and safety. **Risk appetite:** Moderate (cautious) **Risk rating impact v likelihood –** Scoring confirmed. • Current 5x 4=20 • Target 3 x 2 = 6 • Movement – Corresponding corporate risks: no corresponding Corporate Risks currently.
• **Deliver outstanding care**	• **Deliver our quality and safety objectives, including culture of care, risk assessments, care planning and restrictive practice.** • **Therapeutic environments – refurbish Maple ward.**	

On track	Some slippage	At risk	Completed	**Assurance level**	

Summary update

- LAP assessments are all up to date and available to staff
- BAF risk was agreed at EMT and Board Development Session in June 2025
- Ligature Anchor Points (LAP) have been addressed across the adult acute units. However, LAPs remain on older people's wards and Forest Lodge, but are well understood and included in the LAP assessments for each ward

Milestones in 2025/26 to support reaching target score:

- Capital works prioritisation to address higher risk LAPs in 2025/26 Q3-Q4
- Personalised approach to risk assessment training to be delivered across all wards – end Q3 2025/26
- Launch of Ulysses audits to include a quality of risk assessment audit (within documentation audit) launched August 2025 with results and actions reported through governance processes in September 2025.
- Weekly environmental audit within Ulysses to standardise approach implemented and will report in September 2025

Controls

- Each ward has up to date LAP assessments that are available and understood by staff
- Risk assessments in place for patients which take account of ligature risks
- Relational security approaches utilised as even in instances where all LAPs have been removed patients can ligature without a fixed point.

Internal assurance positive (P), negative (N) • LAP risk assessments for all wards in place and in date (P) • Individual Risk assessment audits (P/N)	**External assurance** positive (P), negative (N) • CQC inspection on adult and PICU wards – awaiting report • Provider Collaborative Annual Quality Review in Forest Lodge reviews LAP assessments and mitigation of risks (N)
Gaps in controls • Capital Programme unable to address all LAPs across not acute wards in 2025/26 • Variation in the quality of patient risk assessments across the wards • Standardised audits of individual risk assessments not consistently undertaken across all wards • One risk was found to be not mitigated on Forest Lodge despite it being clear in the LAP assessment that the area in question should be locked off from general use (blanket restriction	**Actions to address gaps in controls** • Capital works prioritisation to address highest risks: **Owner: Director of Strategy** • Launch of Ulysses audits in August 2025 will include a standardised weekly audit of documentation including quality of risk assessments, results will report through the Governance structures from September 2025. **Owner: Executive Director of Nursing, Professions and Quality.** • Regular review of LAP assessment actions as part of environmental audits – August 2025 **Owner: Executive Director of Nursing, Professions and Quality.**
Gaps in assurance • CQC identified a ligature risk on an acute ward not identified on the LAP assessment	**Actions to address gaps in assurance.** • LAP assessment updated and learning taken across all wards - Complete • Environmental audits to be standardised as part of ward weekly audit programme, implemented August 2025 and will report through governance structures from September 2025.

BOARD ASSURANCE FRAMEWORK 2025/26
For receipt in September 2025

BAF RISKS OVERSEEN BY FINANCE AND PERFORMANCE COMMITTEE

BAF 0023
There is a risk of failure to ensure digital systems are in place to meet current and future business needs, caused by failure to develop and deliver an up-to-date modern digital strategy and systems and processes to support its delivery, resulting in poorer clinical safety, quality, efficiency and effectiveness.

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	**Executive lead:** Executive director of finance and digital **Board oversight: Finance and Performance Committee & Audit and Risk Committee** **Last reviewed** – September 2025. **Next review** – November 2025 - **Risk type:** Clinical, Quality and Safety **Risk appetite:** Moderate Low to Moderate (minimal and cautious) **Risk rating impact v likelihood** - Current 4 x 3 = 12 - Target 3 x 2 = 6 - Movement Corresponding corporate risks: 5462
• Effective use of resources • Deliver outstanding care	• Realise the benefits of implementing RIO safely • Become a digitally enabled organisation, including patient engagement portals and access to shared records.	

On track	**Some slippages**	At risk	Completed	**Assurance Level**	**Red**

Summary update

- The implementation of RiO has delivered a modern EPR. The trust now has an opportunity to improve patient care by securely sharing data across organisational boundaries (using federated data platform, shared care record, patient engagement portal).
- There is a revised plan and timescales including additional funding agreed for the optimisation work by the Trust Board.

Milestones in 2025/26 to support reaching target score:

- Insight decommissioning planned for September 2025.
- RiO Optimisation work will complete by end of September 2025.
- RiO upgrade will be completed by January 2026.
- In scope reporting has been delivered by the programme.
- Establish Business As usual services to control and govern the RiO and SystmOne electronic patient records by January 2026 (aligned to the closure of the optimisation phase)

Controls

- Governance (EPR programme board structure, EMT oversight, reports to assurance committee FPC and Board, Board oversight, external support sitting on EPR programme board) DAG Governance controls - providing operational oversight through EMT and to assurance committees - ARC/FPC need to embed routine reporting into EMT. NEW GAP
- Routine reporting needs Clinical Executive Safety Design Group, Rio/SystmOne Improvement Board to be permanently established with regular reporting lines to Digital Assurance and Approvals group
- Need to refresh strategy and identify plan for delivery. The Digital Strategy approved by Trust Board on 4/11/2021 defines a plan for improved technology services and sustainability provides control and assurance. Given EPR delay these impacts on the delivery of the strategy and need to develop and continue to refine the digital roadmap and strategy for delivery now in 2025/26.
- New Target Operating Model for Digital agreed and finances in place by Dec 2025
- SHSC Digital continue to retire old systems and improve cyber security in line with the guidance provided by the data protection and security toolkit. Making good progress to meeting the standard. Ongoing until legacy system is retired.
- Insight retired from active use in March 2025.

Internal assurance	**Positive/ negative assurance:**
• Governance reporting in place - reporting into Programme Board with oversight by Trust Transformation Board and EMT. Governance arrangements updated and received through the revised EPR implementation plan approved at Board in April 2024. DSPT audit. Internal audit has provided support and assurance around penetration testing.	Balance of positive and negative assurance.
External assurance	**Positive/ negative assurance:**
• Annual Data Security Protection Toolkit (DSPT) internal audit moderate assurance rating received in 2023 and in 2024. • Annual Data Security Protection Toolkit (DSPT) audit significant assurance rating received in 2025 • External independent expertise has been in place to support development of the new plan (from January 2024) • Digital Maturity Assessment gives a view on how the organisation compares to its peers. KLAS review of end user experience gives view on how our users experience the application.	Positive: Digital Maturity Assessment improved from 1.77 to 2.02. We Improved five out of seven pillars. We made positive improvement and are more aligned to peers, but we need to improve further.

Gaps in controls	**Actions to address gaps in controls**
1. Put in place assessment and plan for full resourcing and affordability (for IMST).	• Target Operating Model (TOM) to be in place by Dec 2025 with the new CDIO as part of development of the revised plan –**Owner CDIO/Exec Director of Finance**. Revised TOM and financial implications are incorporated into draft financial plan and will be agreed as part of planning process. Deadline 31st March 2025 JCF committee in mid-March. Money confirmed within business planning cycle. Likely that corporate VIP will be greater, and more capitalisation of staff will take place. Structure and finance agreed and in place, Organisational change process underway and progressing

	through the structure in stages.
2. Address elements of DSPT still to be achieved, the relevant risks are being tracked.	• Annual Data Security Protection Toolkit (DSPT) audit significant assurance rating received in 2025 • Data Security Standards - DSPT for 2026 will be updated **Owner CDIO/Exec Director of Finance**
3. The need to develop a new Digital Roadmap and Target Operating Model.	• Digital Roadmap– **Owner CDIO/Exec Director of Finance** timing to be confirmed for delivery this will be after the strategy refresh later in the financial year and will be by the end of March 2026 This is linked to timescales of the new strategy and will be confirmed in the new financial year.
Gaps in assurance N/A	**Actions to address gaps in assurance** N/A

BAF 0022 There is a risk we fail to deliver the break-even position in the medium term caused by factors including failure to develop and deliver robust financial plans based on delivery of operational, transformation and efficiency plans resulting in a reduction in our financial sustainability and delivery of our statutory duties.

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	**Executive lead:** Executive Director of Finance and digital **Board oversight:** Finance and Performance Committee **Last reviewed** – September 2025. **Next review** November 2025 **Risk type: Finance** **Risk appetite:** Low (minimal) **Risk rating impact v likelihood** - Current 4 x 4 = 16 - Target 3 x 1 = 3 Movement Corresponding corporate risks: 5051
Effective use of resources	• Deliver our financial plan of £4.9m deficit including achievement of £8m efficiencies. • Become more productive in all parts of out Trust, including undertaking a corporate support services review.	

On track	Some slippages	At risk	Completed	**Assurance level**	**Amber**

Summary update

No change in risk score at this point.
Current underlying cost pressure of circa £2m and VIP shortfall of c£2.2m pressure mean risk remains the same at this point however 2025-26 financial plan was approved with breakeven position from 2026-27, need to ensure 2025-26 financial plan is achieved with ability to meet breakeven in 2026-27. Recurrent impacts will be monitored throughout 2025-26

Milestones in 2025/26 to support reaching target score

- Escalation of Directorate VIP development where operational service lines and corporate directorates have gaps to ensure further proposals of £2m are developed into approved plans – September 25.
- Development of additional mitigations as required by EMT, next detailed review for 2025/26 post Month 5 position.
- Engaging national and regional regulatory processes; controls have been strengthened to mitigate financial position, contributing to non-recurrent delivery of VIP. Will continue to review monthly with EMT approving changes.
- Engage with System and Mental Health provider collaborative to contribute to the system financial plan.
- Development of 2025/26 VIP planning and budget setting, initial draft plan building on existing medium-term plan for December FPC (pending work programme review).

Milestones completed

Controls

- Operational plan; financial planning; including VIP planning, processes and delivery monitoring
- Financial plan and value improvement plans for 2025/26 in place.
- Financial plan approved for medium term including breakeven target for 2026/27 and required VIP to 2027/28.
- VIP programme board established with more sophisticated VIP planning processes.
- Strengthened governance arrangements in place, with EMT additional weekly oversight meetings.
- Financial controls assessed and monitored at system level, EMT considers and approves changes periodically.

Internal assurance	**Positive/ negative assurance:**
• Governance reporting in place through - monthly financial reporting to Team and Programme Board, Assurance report to EMT, FPC and Board. • Performance Framework meetings and recovery plans and review processes. • Value Improvement Plan in place for 2025/26 for £6m • Strengthened arrangements in place to develop and challenge VIP plans weekly meetings with Exec leads.	Negative assurance re gaps in 2025/26 VIP delivery and gap to plan.
External assurance	**Positive/ negative assurance:**
• Internal audits 2024/25 significant assurance on Budget setting, performance framework & business planning. • Internal audit on CIP received June 2023 - split opinion overall (significant on processes and limited on improvements already in place) it was recognised the gap had already been closed in 2023/24 CIP planning and no further action was needed • NHSE Financial Review 2021/22 and ongoing support as required. • Ongoing financial controls review with ICB supported by Deloitte	Balance of positive and negative assurance.
Gaps in controls	**Actions to address gaps in controls**
1. Identification of a full recurrent VIP plan over the medium term	• 2025/26. VIP plans continue to be developed and part of financial planning for future years – **owner Executive Director of Finance.** VIP plans continue to be reviewed at SLT, EMT and the newly established VIP programme Board. 3-year VIP plan not yet fully developed. Good plans to be in place by December 2025 and final plans to be in place by April 2026. **Owner Executive Director of Finance** VIP plans continue to be developed.
Gaps in assurances	**Actions to address gaps in assurances**
1. Development of medium-term VIP plan	• Medium term VIP plan will be developed in 2025-26 – already have full year effect of current VIP proposals aligned to national planning timescales – December 2025

BAF.0026
There is a risk that we fail to effectively implement the level of improvement and change that is required in order to deliver our strategy and annual operational plan, caused by factors including a failure to embed an improvement culture, to equip our staff, and to manage the delivery of major change in accordance with our integrated change framework, resulting in failure to deliver our trust strategy and system expectations.

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	**Executive lead:** Director of Strategy **Board oversight**: Finance and Performance Committee **Last reviewed** – September 2025. **Next review** – December 2025
- Effective use of resources - Deliver outstanding care - Great Place to Work - Reduce Inequalities	• Realise the benefits of implementing RIO. • Become a digitally enabled organisation, including patient engagement portals and access to shared care records. • Deliver our financial plan of £4.9m deficit including achievement of £8m efficiencies. • Become a more productive in all parts of out Trust, including undertaking a corporate support services review • Deliver our Quality and Safety Objectives including Culture of Care, risk assessments, care planning, and restrictive practice • Home first – reducing out of area placements, improving productivity and flow. • Implement neighbourhood mental health centre pilot. • Therapeutic environments – refurbish Maple ward. • Develop our culture through the we are our values programme • Develop university trust strategy and partnerships with our universities • Improve the safety of our staff by reducing violence and aggression and sexual safety incidents • Continue our journey to be an anti-racist organisation • Implement our inequalities and population health plan, starting by increasing the recording of personal data • Improve pathways to work and access to housing through local partnerships • Implement PCREF • Deliver our equality objectives • Deliver the SY MHLDA partnership priorities	
		Risk type: Strategic **Risk appetite: High (open)**

				Risk rating impact v likelihood - **Current 4 x 3 = 12** - **Target 4 x 2 = 8** - **Movement** **Corresponding corporate risks: 5051, 5001, 4100, 4756,4757**
On track	**Some slippages**	**At risk**	**Completed**	- **Assurance level** **Amber**

Summary update no change.

- The Trust has a standardised method 'Integrated Change Framework' aligned to NHS IMPACT. It has a significant investment in both in-house and external support for delivery of change; and it has comprehensive governance arrangements for the most complex changes that are critical to achievement of our strategic priorities, including regular board and cttee oversight. Additional focus in 2025/26 on capability building and embedding a culture of continuous improvement, supported by AQUA.
- The focus must now be on the effective application of these arrangements, including demonstration of benefits realisation.
- Consider reducing 'likelihood' score when major programmes consistently achieve their intended benefits, and staff survey scores on change culture are in upper quartile.

Milestones in 2025/26 to support reaching target score:

- Development of appropriate central oversight arrangements for all three levels of the change framework (beyond the most complex major programmes) – Quarter 1 25/26 In Q3 there will be further revision of the Improvement and Change group arrangements based on learning from implementation.
- Implementation of EPR by March 25 and optimisation and benefits realisation throughout 25/26
- Open Maple Ward by Q3 25 26 – key deliverable of TEP
- Trajectory for reduction of OAPs = key success measure for Home First programme – tracked monthly through EMT and Board.
- Capability development to support culture of improvement – main delivery method = AQUA forging improvement programme – commenced June 2025 – continues throughout 2025/26
- Utilise staff survey scores on freedom to/ support for change to measure progress with improvement culture results from staff survey will be available in Q4

Milestones completed:

- AQUA 'forging improvement programme' launched with Trust Board – June 2025
- EMT review of portfolio and SROs – June 2025
- Organisation wide comms and launch of Integrated change framework – by October 2024 Comms launch
  started in December – completed January 2025
  - Further revision of portfolio of complex change in line with 25/26 operational plan and strategy refresh – July 2025

Controls

- Governance - EMT oversight in place. Effective programme management in place including Improvement and Change Framework aligned to NHS IMPACT which includes clear Gateways between lifecycle phases
- Reporting through Programme Boards to Improvement and Change Board and onwards to Board sub committees.
- Monthly escalation reporting.
- Health Card and Financial Health Card developed and reviewed monthly at improvement and change board and bi- monthly at FPC from March 2023 providing overview of all programmes.
- Members of the Executive team as SROs for all programmes.
- Significant non-recurrent 'Change' budget enables expert additional input as required – e.g. on Home First programme and on capability building
- Improvement and Change Group meets monthly to triage new requests for support and to plan bespoke support packages ranging from training and coaching to full MDT support and resourcing
- Use of QEIA's to support change control within projects.

- Risks and issues reviewed monthly by programme boards and escalated to Improvement and change Board and when appropriate.
- Milestone plans in place for each programme and monitored through highlight reports.
- Procurement process; Project change control on capital and business case visibility.
  Business cases and capital expenditure approved in accordance with Trust wide governance processes.
- Programme Board TORs all reviewed against new standard and revised where necessary.
- Lessons Learned reports following closure of all programmes

Internal assurance Positive (P)/ negative (N) assurance:	**External assurance Positive (P)/ negative (N) assurance:**
Combination of positive and some negative assurance - it varies from programme to programme and from month to month. • Individual programme highlight reports received at Improvement and Change Portfolio Board. Portfolio report received regularly at, EMT and Finance and Performance Committee and Trust Board. • Schedule of deep dive reports on specific programmes at EMT • Integrated Change Framework requires gateway reviews at key points in programme lifecycle • Additional temporary post in PMO to backfill PMO manager focusing on Home First • Suite of templates available. All new projects and programmes use the new templates including TORs.	Combination of positive and some negative assurance - it varies from programme to programme and from month to month. • Significant Assurance rating received by 360 Assurance to Audit and Risk Committee in January 2022 for the Transformation Board and PMO. 'P' • Primary and Community Mental Health via joint programme board with Primary Care Sheffield. • EPR – External assurance role via St Vincents consulting on Programme Board to advise on procurement. • 360 Assurance have reviewed all TOR's. • External specialist resource is brought in where required e.g. EPR, Home First, We are our Values
Gaps in controls N/A	**Actions to address gaps in controls** N/A
Gaps in assurance N/A	**Actions to address gaps in assurance** N/A

BAF 0027 There is a risk that we do not ensure effective and timely stakeholder involvement and partnership working, caused by multiple factors including time pressure, individual skills and preferences, and gaps in systems and processes, resulting in a failure to meet our strategic objectives.		
STRATEGIC AIMS • Deliver outstanding care • Effective use of resources • Great Place to Work • Reduce inequalities	**STRATEGIC PRIORITIES** • Realise the benefits of implementing RIO. • Become a digitally enabled organisation, including patient engagement portals and access to shared care records. • Deliver our financial plan of £4.9m deficit including achievement of £8m efficiencies. • Become a more productive in all parts of out Trust, including undertaking a corporate support services review • Deliver our Quality and Safety Objectives including Culture of Care, risk assessments, care planning, and restrictive practice • Home first – reducing out of area placements, improving productivity and flow. • Implement neighbourhood mental health centre pilot. • Therapeutic environments – refurbish Maple ward. • Develop our culture through the we are our values programme • Develop university trust strategy and partnerships with our universities • Improve the safety of our staff by reducing violence and aggression and sexual safety incidents • Continue our journey to be an anti-racist organisation • Implement our inequalities and population health plan, starting by increasing the recording of personal data • Improve pathways to work and access to housing through local partnerships • Implement PCREF • Deliver our equality objectives • Deliver the SY MHLDA partnership priorities	**Executive lead:** Director of Strategy **Board oversight:** Finance and Performance Committee **Last reviewed** – September 2025. **Next review** – November 2025 **Risk type:** Strategic **Risk appetite:** High (open) **Risk rating impact v likelihood** • Current 4 x 3 = 12 • Target 4 x 2 = 8 • Movement Corresponding corporate risks: None specifically though see risks linked to improvement and change programmes

On track	Some slippages	At risk	Completed	**Assurance level**	**Amber**

Summary update no change

- The Trust is an active participant in local and regional partnerships.
- The external environment for health and care system partnership working is entering a period of change, so it is critical that the Trust remains engaged and is clear on its strategy and tactics. Operational and financial delivery is key.
- Internal arrangements to ensure timely coordinated decision making and action, often linked to improvement and change programmes, is an area of focus for 2025. See milestones.
- Consider reducing likelihood score when internal arrangements consistently demonstrate effectiveness, and when outcome of current national system changes are clearer.

Milestones in 2025/26 to support reaching target score:

- Strengthen relationships with PCS related to PCMH delivery and interface with CMHT - 2025
- Review progress against learning from GGI stakeholder review 2024 – **By September 2025.** This has slipped – now December 2025
- Establishment of Trust 'partnerships group' Agreed to connect into improvement and change board (EMT time-out June 2025). To be established **by September 2025.** Concept presented to EMT and I&CB. Mapping of partnership relationships underway
- Active participation in Sheffield bid for Neighbourhood NHS pilot programme – submission August 2025. Outcome confirmed **September 2025**
- Review emergent situation with local and regional partnerships as significant changes to NHSE, ICBs etc linked to the Ten-Year Plan are implemented. Ensure the Trust remains an active participant in shaping the next iteration of partnership working.
- Strategy launch and communication – **September 2025**
- University Partnership launch and joint strategies – **2025/26**

Milestones completed

- GGI stakeholder review 2024
- Desire Code Communications Strategy 2025 – **completed.**
- Establish eating disorder joint committee (in shadow form) for South Yorkshire. Initial meeting in September 2024. February 25 progress being made towards go-live in April 2025 **completed**

Note – as previously reported additional BAF risks will need to be added to reflect system BAF risks when developed and we will in turn have to escalated Risk to those BAFs where appropriate.

Controls

- We are fully engaged at Sheffield health care partnership, ICB and SY MHLDA Collaborative, the priorities are reflected in SHSCs annual operating plan – approved by the Board
- Sheffield Health and Care Partnership regularly attended by CEO and other Executives leading appropriate delivery groups.
- All core Trust strategies are in place with annual reviews process.
- Regular meetings with Sheffield LA, Sheffield Health and Care Partnership, ICS and Provider Alliance (moved from assurance)
- All reports to Committees and Board are prompted to consider the partnership implications arising from the report (moved from assurance)

Internal assurance Positive P)/ negative (N) assurance:

All these sources cover both N and P assurance

- CEO and Chair's briefing and reports to Board provides an overview of system and system governance arrangements.
- Systems and Partnerships report at every board meeting
- SHSC Chair is lead Chair for the MHLDA Collaborative (effective from July 2023)
- Business opportunities, risks (PESTLE AND SWOT) received at Board regularly – last June 2025
- Engagement with the Council of Governors.
- Quality Accounts reflects engagement.
- Annual Report reflects engagement.

External assurance Positive P)/ negative (N) assurance:

- Externally supported (GGI) stakeholder review outcome received at Board in April 2024. 'P'

Gaps in controls

N/A

Actions to address gaps in controls

N/A

Gaps in assurance

1. Revised CQC approach and revised performance management roles for NHSE (less ICB) require monitoring to understand implications for SHSC. Once clearer this needs to be reflected in our assurance

Actions to address gaps in assurance

- Monitor and evaluate the implications of changing approach of CQC **Owner Director of Nursing.**

<table>
<tr><td colspan="6">BAF 0030 There is a risk that local environment, workforce and population will be impacted caused by the failure to deliver the green plan resulting in legal and regulatory action and reputational damage.</td></tr>
<tr><td colspan="2">STRATEGIC AIMS
- Effective use of resources</td><td colspan="2">STRATEGIC PRIORITIES

- Realise the benefits of implementing RIO.
- Become a digitally enabled organisation, including patient engagement portals and access to shared care records.
- Deliver our financial plan of £4.9m deficit including achievement of £8m efficiencies.
- Become a more productive in all parts of out Trust, including undertaking a corporate support services review</td><td colspan="2">Executive lead: Executive Director of Finance
Board oversight: Finance and Performance Committee
Last reviewed – September 2025 Next review – November 2025</td></tr>
<tr><td colspan="2"></td><td colspan="2"></td><td colspan="2">Risk type: Environmental
Risk appetite: High (open)
Risk rating impact v likelihood
- Current 3 x 4 = 12
- Target 2 x 4 = 8
- Movement ⟺
Corresponding corporate risks: None specifically</td></tr>
<tr><td>On track</td><td>Some slippages</td><td>At risk</td><td>Completed</td><td>Assurance level</td><td>Amber</td></tr>
</table>

Summary update	**Milestones in 2025/26 to support reaching target score:**
• Escalation process completed, significant progress made summary position will be assessed prior to Sustainable Development Group on 17th September	• Escalation process in place to ensure action plan is completed by August 25 Escalation process including Executive led meetings completed in August 2025. • Monitoring delivery of the action plan – quarterly at FPC. Additional periodic reporting is planned through EMT.

Controls

- Governance - Sustainable Development Group, delegated Board oversite via the FPC linked to partnership and collaboration in place through Place and system.
- Oversight of Sustainability under review at ICS as part of wider ICS/NHSE review.
- Green Plan Approved by SHSC Board and refreshed annually. Our Green plan has been refreshed and final word content has been approved by Board January 25. Green Plan and Action Plan to be published on SHSC website by 31st July 25.
- Climate change and the need for continuous sustainable quality embedded with Quality strategy, strategic priorities and annual objectives.
- Supporting EPPR Policies and minimum annual review of BCPs
- Engagement with wider NHS Sustainability Program (GNHS), for best practice, guidance and support.
- Green Plan Service Objectives 25/26- each Service/Team must pick 1 minimum of 3 Green Plan pick list objectives.
- Sustainable Development included in SHSC QEIA (Limited feedback on effectiveness) In addition Sustainability Lead is a member of the QEIA Panel.
- Carbon footprint performance and projection reporting using Defra emission factors 25/26. SHSC Sustainability dashboard, including carbon footprint to be shared quarterly via leadership cascade. First dashboard Aug 25.
- Capital and business planning processes aligned to green plan strategy and wider Greener NHS net zero goals
- Improved governance for the integration of sustainable development and Climate change risk into SHSC governance structures and performance reviews
- Estates and Facilities Sustainability Steering Group has been established and first meeting held December 2024.
- Sustainability is embedded within the SHSC Improvement and Change Framework for consideration within change projects and as a signpost for support ensuring change projects align to Green Plan.
- Sustainability has been embedded into our Quality Improvement Approach. (included in Full Day QI training and a question on how projects align to the principles of sustainable healthcare included in QI project form)
- Supply Chain and Procurement- Sustainability considerations are included in Purchasing Officer Non-Pay script, minimum 10% weighting on Net Zero and Social Value in every tender and work is progressing to embed sustainability and our net zero goals in the SHSC Invitation to Tender template documents

Internal assurance	**Positive/ negative assurance:**
Governance reporting: • Annual Reports on Strategy delivery to the Board • Executive Lead identified for Net zero (Green Plan) in place (Director of Finance, Digital and Performance) • Non-Executive lead identified • Training on sustainable development and climate change reflected in DaL and SHSC Manager offer.	**Executive management team and FPC oversight of action plan development and progress.**

External assurance -positive	**External assurance – negative**
• Greener NHS – Quarterly data submission • Greener NHS Fleet Data submission • Greener NHS Green Plan Support Tool, Self-Assessment Questionnaire- June 25 new self- assessment questionnaire has been updated to reflect Greener NHS Green Plan Refresh Guidance. • Climate adaptation framework for NHS organisations in England	• Boiler replacement at Limbrick and East glade on Capital plan but studies and capital planning not progressed. Limbrick boiler has now broken down (July 25) and is now likely to be replaced with another fossil fuel system rather then a low carbon alternative

• Greener NHS Green Plan Support Tool Assessment Questions included in the refreshed Green Plan Action Plan.	
Gaps in controls	**Actions to address gaps in controls**
• Data quality and availability- access to and effective scrutiny of data to support which KPIs/ metrics can be used to monitor and disclose our performance. (Green Plan Action Plan performance monitoring and embedding sustainability measures into Trust transformational projects)	• Green Plan Action Plan- progress has been stuck ensuring actions within Green Plan are SMART, aligning actions to delivery timescales and establishing milestones. **Ownership- SDG Focus Area Leads to ensure all actions are updated by 31st August 25** • SHSC Sustainability Dashboard go live August 25- **Ownership Sarah Ellison, Sustainability Lead, support by data leads James Clarke and Andy Probert (Estates and Facilities), Andrew Pigott (Transport), Julie Rice (Procurement) Chris Reynolds and Mathew Needham (Digital)** • Embedding sustainability measures- **Ownership Sarah Ellison, Sarah Ellison has been Woking with Zoe Sibeko (PMO) to use the Home First Project as a case study for embedding sustainability measures within the project. Zoe Sibeko to introduce measures at Transformation Board Aug 25.**
• No Climate Change Risk Assessment (CCRA) in place to address gaps in BCPs and support delivery of SHSC Adaptation Plan. **GAP reported as closed to FPC however it has been re-opened by the sustainability lead as work is continuing.**	• Draft CCRA shared with SDG members and scoping for SHSC approach to deliver a Trust Adaptation Plan in April and June. Next steps to establish a working group to initiate and assign responsibilities for further developing SHSC CCRA (incorporating in SHSC corporate risk register) and developing an adaptation plan. Sarah Ellison has attended SLT (June 25) to raise awareness and seek input from Leadership. **Owner Sarah Ellison, Sustainability Lead. Working Group set up by September 25** • Business Planning green plan objectives include an option for teams to update BCPs based on updated Adverse Weather Policy and in consideration of where exposure/ vulnerability to risk is identified. To support identification of risks/exposure/ vulnerabilities a workplace checklist has been produced to support objective delivery. **Ownership Sarah Ellison, Sustainability lead,** • Next steps to be carried out August/ September working with Organisational Development Team, Workforce Team and HRBPs to further develop checklist and embed into managers responsibilities.
• Current Capacity of Sustainable Development Lead (and wider Green Plan Focus Area leads) could be insufficient to deliver green plan aims and meet statutory targets at pace required.	• Sustainability Lead to scope what additional roles could support delivery of the Green Plan in the longer Term. Owner Sustainability Lead This action has been delayed due to work refreshing green plan. Now Green plan refresh is complete and in conjunction to review of refreshed Green Plan against new Greener NHS Green Plan Refresh Statutory Guidance (published 4th Feb 25) work can continue to review priorities, capacity to deliver and additional resource required - April 2025 Update **July 25- Sarah Ellison, Sustainability lead is making progress identifying the duties and appropriate job description to introduce a "sustainability office/ Project officer" role to support green plan delivery. In addition, to support delivery of actions under Low Carbon Care which lack leadership a " Green Therapy Network" will be established September 25 to review options for support and action delivery as well as champion examples of green therapy already underway at SHSC**.

• Gaps in representation from Service Users or those with Lived experience in Sustainable Development Group.	• Work is ongoing to make links with Service User Engagement team to review what engagement with Sustainable Development Group could involve including the intent to make clearer and more meaningful links with service users to support co-production . A limited amount of engagement has taken place in the form of engagement with the Peer support network leads and Engagement and Experience team. Next steps, in conjunction of development of updated Green Plan Action Plan development is for each staff network group, including those with lived experience to review the green plan action plan and the equality impact considerations to offer feedback and input into our approach for action plan delivery. Sustainability Lead is working with Dasal Abayaratne to development opportunities to engage with our service users on this subject in the form of a climate cafes/ focus groups **July 25- Sustainability Lead has been working with Jo Hardwick to review integration of "Make Every Contact Count" (MECC) tool at SHSC which includes potential prompts on ESR to support conversations with patients on climate change hazard e.g. air quality, heatwave resilience and staff training to have informed conversations. Initial conversations had, no expected delivery date determined yet.**
Gaps in controls Controls cover people (training and policy), processes(reporting mechanisms) and technology services (products are purchased and deployed in line with good practice from	
Gaps in assurance System Asset register functionality within Sunrise not yet enabled. Information asset ownership. Senior staff need to be supported to play an active role in asset ownership	•

<table>
<tr><td colspan="5">BAF 0032 There is a risk that our estates do not adequately enable the delivery of our strategic priorities, which include community models of care and care closer to home, caused by multiple historical factors including an aging estate which was not developed for these future needs, the capital regime in the NHS, and the need to update the trust estates strategy; resulting in limited or delayed implementation of our strategic intentions and the 10 Year Plan.</td></tr>
<tr><td colspan="2">STRATEGIC AIMS
Deliver Outstanding Care
Effective use of resources
Reducing inequalities
Create a great place to work</td><td colspan="2">STRATEGIC PRIORITIES
Deliver our financial plan of £4.9m deficit including achievement of £8m efficiencies.
Become a more productive in all parts of out Trust, including undertaking a corporate support services review
Deliver our Quality and Safety Objectives including Culture of Care, risk assessments, care planning, and restrictive practice
Home first – reducing out of area placements, improving productivity and flow.
Implement neighbourhood mental health centre pilot.
Therapeutic environments – refurbish Maple ward.
Improve the safety of our staff by reducing violence and aggression and sexual safety incidents
Implement our inequalities and population health plan, starting by increasing the recording of personal data</td><td>Executive lead: Director of Strategy
Board oversight: Finance and Performance Committee
Last reviewed – September 2025. Next review – November 2025
Risk type: Quality and Safety, and Strategy
Risk appetite: Low to Moderate (minimal and cautious)
Risk rating impact v likelihood
Current 4 x 3 = 12
Target 3 x 2 = 6
Movement –
Corresponding corporate
Corporate risks: 5344</td></tr>
<tr><td>On track</td><td>Some slippage</td><td>At risk</td><td>Completed</td><td>Assurance level</td><td>Amber</td></tr>
</table>

Summary update	**Milestones in 2025/26 to support reaching target score:**
• The Trust requires a significant level of backlog maintenance, which has built up over many years. Recent improvements in processes within Estates And Facilities give greater confidence in assessments of compliance and emerging risks of infrastructure failure, meaning the Trust has a clear understanding of the issues. However, the scale of the challenge and resources available means that our ability to significantly reduce backlog maintenance is limited. In response the Trust has taken a risk based approach, notably by investing in a programme of improvements to fire safety (doors and compartmentation). The Trust also has an ongoing programme of elimination of fixed ligature anchor points, again prioritised based on risk. The TEP programme is progressing well within the limits of the capital expenditure limits of the Trust, and has been accelerated through external funding bids. Nevertheless while we wait for the opportunity to complete the TEP programme in Older Adults and Forensic environments, the risks in those settings require comprehensive operational mitigation strategies which are in place. A Trust LAP group regularly monitors risks and mitigations in all inpatient environments. • In addition to addressing backlog maintenance requirements within our existing estate, the Trust requires an updated estates strategy to reflect the changing strategy of the organisation – e.g. an integrated neighbourhood NHS, a digitally enabled organisation, and to reflect the realities of post-covid hybrid working practices meaning space utilisation and sale of assets no longer required is a key opportunity. • To reduce the scoring of this BAF risk will require significant progress with a) the fire safety investment programme, b) the TEP programme, c) space utilisation and divestment, and d) delivery of priority capital schemes associated with the implementation of our strategy (beyond the 'defensive' and safety requirements) • Our ability to deliver on the above is significantly affected by the external environment, notably policies related to public sector capital and independent sector investment.	• TEP final phase scoping (OPMH and Forensic) – **subject to capital plan re-prioritisation – December 2025** • Single collocated site for Community LD team – required by **September 2025.** Solution identified. Staff engagement underway prior to move. • Revised plans for sale of Fulwood - **September 2025** ready for remarketing • Refine options for Eating Disorders inpatient unit collocated with SEDs – options developed to be discussed with Joint Committee **September 2025** • Sheffield HCP estates group to review collective opportunities to enable neighbourhood health centre roll out (10YP) **–** data updated and collated in readiness **September 2025** • Strategic outline case for new hospital (including multi-site options) by December 2024 project continuing into Q4 – February 25 no further progress. July 2025 – linked to capital plan re-prioritisation - Delayed • PLACE audit revisited **October 2025** • ERIC and PAM results presented to EMT (and Board?) – **October 2025** • Revised Estates Strategy – due – ~~November 2025~~ January 2026 • Delivery of phase 1 of programme of investment in fire doors and compartmentation – **March 2026** Competed milestones: • Estates strategy annual review was received at FPC in July and is due for receipt at Board in September 2024 - **complete** • Opportunities from improved space utilisation quantified by November 2024 – initial tranche of opportunities identified at Wardsend Rd, Distington House and Netherthorpe House**.** Initial tranche **complete** • Scope and timeline for next phase of Therapeutic Environments Programme confirmed by November 2024 – slide deck prepared for EMT December 2024 **complete** • Estates and Facilities Oversight Group established January 25 - **complete** • PLACE audit results demonstrate improvement year on year – 2024/25 Q4 **complete** • Independent audit of fire doors and fire compartmentation delivered, programme of work to address agreed by Board December 24, and included in capital plan for 25/26 and beyond. • EMT review of capital plan prioritisation – **August 2025** • EMT review of Forest Lodge environmental assessment – **August 2025** • Sale of St Georges – completed September 2025 • Revised plans for site security and safety at Fulwood – **September 2025 –** security arrangements revised and in place

<table>
<tr><td colspan="2"><u>Controls</u>

• Governance - Reporting through EMT, FPC, Business Planning Group, Capital Planning Group.
• Routine Compliance monitoring checks in place with robust tracking in estates department for water safety, fire safety, lifts, electrical and gas
• PLACE (patient-led assessment of the care environment) audit – provide benchmarking information and support identifying areas for action.
• ERIC (estates returns information collection) returns – provide benchmarking information.
• PAM (premises assurance model) returns – provide benchmarking information
• Authorised Engineers (AE) and Authorised Persons (AP's) all in place.
• Maintenance programme of work in place
• Capital plan
• Estates and Facilities Oversight Group established January 25
• Independent audit of fire doors and fire compartmentation delivered</td></tr>
<tr><td><u>Internal assurance</u> Positive (P)/ negative (N) assurance

Where otherwise indicated, both positive and negative assurance.
• System of APs in place for all required standards, competence confirmed by AEs. 'Positive'
• Annual PLACE report and associated action plan
• Annual PAM and ERIC returns enabling comparative analysis
• 7 facet survey report
• Annual Health and Safety Report (and quarterly updates)
• Trust LAP (ligature anchor point) group</td><td><u>External assurance</u> Positive(P)/ negative (N) assurance:

Where otherwise indicated, both positive and negative assurance.
• Authorised Engineers Annual Audit including of the competencies required of internal teams
• ERIC returns and benchmarking
• Annual Premises Assurance Model (PAM)
• Sircle independent review of fire doors and compartmentation at all in-patient locations
• Independent audit (AE) of fire safety management arrangements - December 2024</td></tr>
<tr><td><u>Gaps in controls</u>
N/A</td><td><u>Actions to address gaps in controls</u>
N/A</td></tr>
<tr><td><u>Gaps in assurance</u>
N/A</td><td><u>Actions to address gaps in assurance</u>
N/A</td></tr>
</table>

BOARD ASSURANCE FRAMEWORK 2025/26
For receipt in September 2025

BAF RISKS OVERSEEN BY AUDIT AND RISK COMMITTEE

<table>
<tr><td colspan="6">BAF 0021
There is a risk of a cyber security breach caused by inadequate arrangements for mitigating increasingly sophisticated cyber security threat and attacks and increased data protection incidents resulting in loss of access to business-critical system, and potential clinical risk that will have an impact on staff, people who use or have used services and the wider system.</td></tr>
<tr><td colspan="2">STRATEGIC AIMS
• Effective use of resources</td><td colspan="2">STRATEGIC PRIORITIES
• Realise the benefits of implementing RIO safely
• Become a digitally enabled organisation, including patient engagement portals and access to shared records.</td><td colspan="2">Executive lead: Executive director of finance, performance and digital
Board oversight: Audit and Risk Committee
Last reviewed – July 2025. Next review – October 2025
Risk type: Clinical Quality and Safety, Business and reputation
Risk appetite: Low to Medium (minimal and cautious)
Risk rating impact v likelihood
- Current 5 x 4 = 20
Target 3 x 2 = 6
- Movement ⟺
- Corresponding corporate risks: 5401</td></tr>
<tr><td>On track</td><td>Some slippages</td><td>At risk</td><td>Completed</td><td>Assurance level</td><td>Amber</td></tr>
<tr><td colspan="3"><u>Summary update</u>
Improved security using Zscaler tool and Intune.
AI risk to be reviewed for inclusion on corporate risk register</td><td colspan="3">Milestones in 2025/26 to support reaching target score:
• DSPT submission and internal audit (June 25) – Internal audit only found one low risk action
• Cyber Security Desktop exercise plan in place (Dec 25)
• Pen test took place in April 2025. Action Plan to complete in August 2025 Information Asset ownership for High priority assets to be socialised and accepted by Mar 26</td></tr>
<tr><td colspan="6"><u>Controls</u>
• Governance controls in place via bi-monthly Information Governance, Cyber Security & Artificial Intelligence Group meetings and reporting via EMT and into the Audit and Risk Committee.
• SHSC CAB use of Sunrise Service management Desk to record time to act following receipt of notifications in accordance with ITIL processes (i.e. necessary standards)
• SHSC Change Advisory Board (CAB) and Emergency CAB meetings reviewing and responding appropriately to NHSD Care Certification notices.
• Supplier engagement to ensure system patches are notified where vulnerabilities are known. Supplier engagement meetings as part of Service Review Management process,</td></tr>
</table>

in accordance with ITIL process model Risk only applies if system is hosted locally, strategic shift to cloud hosting for application.

- Mandatory IG Training to be monitored and reported across all Trust areas, with staff mandated to ensure compliancy as part of supervision. Monitored through DAG and through reporting on mandatory training compliance to committees.
- Phishing tests in accordance with requirements of DSP Toolkit is being undertaken annually.
- New DSPT aligned to the annual audit programme received.
- Staff are regularly reminded of their responsibilities through training and through incidents that arise
- ICO regularly informed of breeches when appropriate
- Legal advice sought when appropriate
- Annual Penetration test and resulting action plan

Internal Assurance Balance of positive and negative assurance.	**External assurance** Balance of positive and negative assurance.
Governance reporting: Reports on patching reports are received at Cyber / IG / AI group reflected in the Service Management report received at DAG which reports onward to ARC and EMT (which is additional reporting in 2024/25). Service management reports include supplier engagement relating to system patching for key suppliers for locally hosted systems. Monthly performance reporting across all Teams for mandatory IG training. DSPT compliance aligned with DPST work confirmed June 2024. The new DSPT is aligned to the annual audit programme and monitoring of internal audit actions takes place through the tracker received at ARC. Internal governance has re-instated IG, cyber and AI group reporting into ARC. Monitoring of the Internal Audit action tracker takes place with regular reporting received at ARC.	Confirmation provided to NHSD in accordance with prescribed national process for cyber alerts as they occur Self-assessment DSPT compliance – key indicator - Annual Data Security Protection Toolkit (DSPT) audit moderate assurance rating received. Internal audit gave assurance on our submission Exploring opportunities to share KPIs across SY organisations for further assurance
Gaps in controls Controls cover people (training and policy), processes(reporting mechanisms) and technology services (products are purchased and deployed in line with good practice	**Actions to address gaps in controls** N/A
Gaps in assurance System Asset register functionality within Sunrise not yet enabled. Information asset ownership. Senior staff need to be supported to play an active role in asset ownership	**Actions to address gaps in assurance** Information Asset Owner work replacement of legacy hardware to support going live with Rio. Timeline for completion July 2025. Creation of SOPs continue to support Digital staff and managers to manage assets effectively.

BAF 0023
There is a risk of failure to ensure digital systems are in place to meet current and future business needs, caused by failure to develop and deliver an up-to-date modern digital strategy and systems and processes to support its delivery, resulting in poorer clinical safety, quality, efficiency and effectiveness.

STRATEGIC AIMS	**STRATEGIC PRIORITIES**	**Executive lead:** Executive director of finance, performance and digital **Board oversight: Finance and Performance Committee & Audit and Risk Committee** **Last reviewed** – September 2025. **Next review** – November 2025 - **Risk type:** Clinical, Quality and Safety **Risk appetite:** Moderate Low to Moderate (minimal and cautious) **Risk rating impact v likelihood** - Current 4 x 3 = 12 - Target 3 x 2 = 6 - Movement Corresponding corporate risks: 5462
• Effective use of resources • Deliver outstanding care	• Realise the benefits of implementing RIO safely • Become a digitally enabled organisation, including patient engagement portals and access to shared records.	

On track	**Some slippages**	At risk	Completed	**Assurance Level**	**Red**

Summary update

- The implementation of RiO has delivered a modern EPR. The trust now has an opportunity to improve patient care by securely sharing data across organisational boundaries (using federated data platform, shared care record, patient engagement portal).
- There is a revised plan and timescales including additional funding agreed for the optimisation work by the Trust Board.

Milestones in 2025/26 to support reaching target score:

- Insight decommissioning planned for September 2025.
- RiO Optimisation work will complete by end of September 2025.
- RiO upgrade will be completed by January 2026.
- In scope reporting has been delivered by the programme.
- Establish Business As usual services to control and govern the RiO and SystmOne electronic patient records by January 2026 (aligned to the closure of the optimisation phase)

Controls

- Governance (EPR programme board structure, EMT oversight, reports to assurance committee FPC and Board, Board oversight, external support sitting on EPR programme board) DAG Governance controls - providing operational oversight through EMT and to assurance committees - ARC/FPC need to embed routine reporting into EMT. NEW GAP
- Routine reporting needs Clinical Executive Safety Design Group, Rio/SystmOne Improvement Board to be permanently established with regular reporting lines to Digital Assurance and Approvals group
- Need to refresh strategy and identify plan for delivery. The Digital Strategy approved by Trust Board on 4/11/2021 defines a plan for improved technology services and sustainability provides control and assurance. Given EPR delay these impacts on the delivery of the strategy and need to develop and continue to refine the digital roadmap and strategy for delivery now in 2025/26.
- New Target Operating Model for Digital agreed and finances in place by Dec 2025
- SHSC Digital continue to retire old systems and improve cyber security in line with the guidance provided by the data protection and security toolkit. Making good progress to meeting the standard. Ongoing until legacy system is retired.
- Insight retired from active use in March 2025.

Internal assurance	**Positive/ negative assurance:**
• Governance reporting in place - reporting into Programme Board with oversight by Trust Transformation Board and EMT. Governance arrangements updated and received through the revised EPR implementation plan approved at Board in April 2024. DSPT audit. Internal audit has provided support and assurance around penetration testing.	Balance of positive and negative assurance.
External assurance • Annual Data Security Protection Toolkit (DSPT) internal audit moderate assurance rating received in 2023 and in 2024. • Annual Data Security Protection Toolkit (DSPT) audit significant assurance rating received in 2025 • External independent expertise has been in place to support development of the new plan (from January 2024) • Digital Maturity Assessment gives a view on how the organisation compares to its peers. KLAS review of end user experience gives view on how our users experience the application.	**Positive/ negative assurance:** Positive: Digital Maturity Assessment improved from 1.77 to 2.02. We Improved five out of seven pillars. We made positive improvement and are more aligned to peers, but we need to improve further.

Gaps in controls	**Actions to address gaps in controls**
1. Put in place assessment and plan for full resourcing and affordability (for IMST).	• Target Operating Model (TOM) to be in place by Dec 2025 with the new CDIO as part of development of the revised plan –**Owner CDIO/Exec Director of Finance**. Revised TOM and financial implications are incorporated into draft financial plan and will be agreed as part of planning process. Deadline 31st March 2025 JCF committee in mid-March. Money confirmed within business planning cycle. Likely that corporate VIP will be greater, and more capitalisation of staff will take place. Structure and finance agreed and in place, Organisational change process underway and progressing through the structure in stages
2. Address elements of DSPT still to be achieved, the relevant risks are being tracked.	• Annual Data Security Protection Toolkit (DSPT) audit significant assurance rating received in 2025 • Data Security Standards - DSPT for 2026 will be updated **Owner CDIO/Exec Director of Finance**
3. The need to develop a new Digital Roadmap and Target Operating Model.	• Digital Roadmap– **Owner CDIO/Exec Director of Finance** timing to be confirmed for delivery this will be after the strategy refresh later in the financial year and will be by the end of March 2026 This is linked to timescales of the new strategy and will be confirmed in the new financial year.
Gaps in assurance N/A	**Actions to address gaps in assurance** N/A