Board Assurance Framework (BAF): May 2022

The key elements of the BAF are:

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

Key to lead committee assurance ratings:

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

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

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

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

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

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

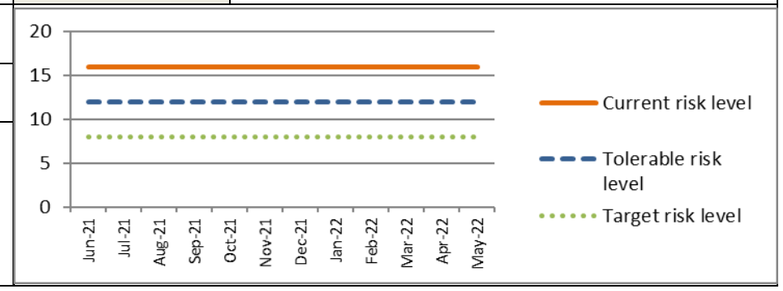
Board committees should review the BAF with particular reference to comparing the tolerable risk level to the current exposure risk rating

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

Reference	Principal risk	Lead committee	Initial date of assessment	Last reviewed	Target risk score C x L	Previous risk score (at previous review/update) C x L	Current risk score C x L
PR1	Significant deterioration in standards of safety and care	Medical Director	01/04/2018	09/05/2022	4 x 2 = 8	4 x 4 = 16	4 x 4 = 16
PR2	Demand that overwhelms capacity	Chief Operating Officer	01/04/2018	09/05/2022	4 x 2 = 8	4 x 4 = 16	4 x 4 = 16
PR3	Critical shortage of workforce capacity and capability	Director of People	01/04/2018	31/05/2022	4 x 2 = 8	4 x 4 = 16	4 x 4 = 16
PR4	Failure to achieve the Trust's financial strategy	Chief Financial Officer	01/04/2018	26/04/2022	4 x 2 = 8	4 x 3 = 16	4 x 3 = 16
PR5	Inability to initiate and implement evidence-based improvement and innovation	Director of Culture & Improvement	17/03/2020	27/05/2022	3 x 2 = 6	3 x 3 = 9	3 x 3 = 9
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	Chief Executive Officer	01/04/2020	25/05/2022	2 x 2 = 4	2 x 3 = 6	2 x 3 = 6
PR7	Major disruptive incident	Director of Corporate Affairs	01/04/2018	30/05/2022	4 x 1 = 4	4 x 2 = 8	~~4 x 2 = 8~~ 4 x 3 = 12
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	Chief Executive Officer	22/11/2021	25/05/2022	3 x 2 = 6	3 x 3 = 9	3 x 3 = 9

Board Assurance Framework (BAF): May 2022

Principal risk (what could prevent us achieving this strategic objective)	**PR 1: Significant deterioration in standards of safety and care** Significant deterioration in standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes							**Strategic objective**	1. To provide outstanding care
Lead Committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Patient harm		
Executive lead	Medical Director	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Minimal		
Initial date of assessment	01/04/2018	**Likelihood**	**4. Somewhat likely**	3. Possible	2. Unlikely				
Last reviewed	09/05/2022	**Risk rating**	**16. Significant**	**12. High**	**8. Medium**				
Last changed	09/05/2022								



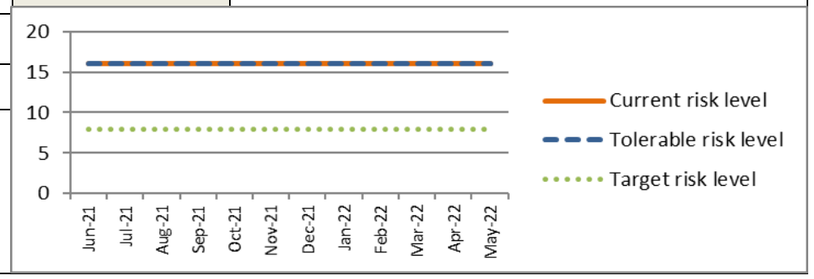
Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction	▪ Clinical service structures, accountability & quality governance arrangements at Trust, division & service levels including: ▪ Monthly meeting of Patient Safety Committee (PSC) with work programme aligned to CQC registration regulations ▪ Nursing and Midwifery and AHP Business meeting ▪ Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems ▪ Clinical audit programme & monitoring arrangements ▪ Clinical staff recruitment, induction, mandatory training, registration & re-validation ▪ Defined safe medical & nurse staffing levels for all wards & departments (Nursing safeguards monitored by Chief Nurse) ▪ Ward assurance/ metrics and accreditation programme ▪ Nursing & Midwifery Strategy ▪ AHP Strategy ▪ Scoping and sign-off process for incidents and Sis ▪ Internal Reviews against External National Reports ▪ Getting it Right First Time (GIRFT) localised deep dives, reports and action plans ▪ CQC Bi-monthly Engagement Meetings ▪ Operational grip on workforce gaps reporting into the Incident Control Team	~~Intranet currently contains some out of date clinical information that may still be accessible~~ Lack of real time data collection Medical, nursing, AHP and maternity staff gaps in key areas across the Trust, which may impact on the quality and standard of care	~~Intranet documents review~~ ~~**SLT Lead:** Head of Communications~~ **Timescale:** ~~March 2022~~ Information, EPMA, EPR and IT Developments in development or progress **SLT Lead:** Medical Director **Progress:** EPMA rollout commenced; EPR business case to Board in June 2022 **Timescale:** ~~March 2022~~June 2022 ~~More specific~~ Continued focus on recruitment and retention in significantly impacted areas, including system wide oversight **SLT Lead:** Executive Director of People **Timescale:** ~~March 2022~~September 2022	**Management:** Learning from deaths Report to QC and Board; Quarterly Strategic Priority Report to Board; Divisional risk reports to Risk Committee bi-annually; Guardian of Safe Working report to Board qrtly Quality and Governance Reporting Pathway; Patient Safety Committee →Quality Committee reports include: - DPR Report to PSC monthly and QC bi-monthly - PSC assurance report to QC bi-monthly - Patient Safety Culture (PSC) programme - EoLC Annual Report to QC - Safeguarding Annual Report to QC - CYPP report to QC quarterly - Medical Education update report to QC - Medicines Optimisation Annual Report to QC Outputs from internal reviews against External National Reports including; - HSIB and HQIP ~~Thromboembolic Maternity Report (Oct 2020)~~National and local Reports - ~~National Audit for Care of end of Life (Sep 2020)~~ - ~~Ockenden Report (Dec 2020)~~ **Risk and compliance:** Quality Dashboard and SOF to PSC Monthly; Quality Account Report Qtrly to PSC and QC; SI & Duty of Candour report to PSC monthly; CQC report to QC bi-monthly; Significant Risk Report to RC monthly **Independent assurance**: CQC ~~Inspection Report 2020~~Engagement meeting reports to Quality Committee bi-monthly Screening Quality Assurance Services assessments and reports of: - Antenatal and New-born screening - Breast Cancer Screening Services - Bowel Cancer Screening Services - Cervical Screening Services External Accreditation/Regulation annual assessments and reports of; - Pathology (UKAS) - Endoscopy Services (JAG) - Medical Equipment and Medical Devices (BSI) - Blood Transfusion Annual Compliance Report (MHRA)	None	Positive No change since April 2020

Board Assurance Framework (BAF): May 2022

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
An outbreak of infectious disease (such as pandemic influenza; Coronavirus; norovirus; infections resistant to antibiotics) that forces closure of one or more areas of the hospital	▪ Infection prevention & control (IPC) programme Policies/ Procedures; Staff training; Environmental cleaning audits ▪ PFI arrangements for cleaning services ▪ Root Cause Analysis and Root Cause Analysis Group ▪ Reports from Public Health England received and acted upon ▪ Infection control annual plan developed in line with the Hygiene Code ▪ Influenza and Covid vaccination programmes ▪ Public communications re: norovirus and infectious diseases ▪ Coronavirus identification and management process ▪ Infection Prevention and Control Board Assurance Framework ▪ Outbreak meeting including external representation, CCG, PHE, Regional IPC ▪ CQC IPC Key lines of enquiry engagement sessions	None	N/A	**Management:** Divisional reports to IPC Committee (every 6 weeks); IPC Annual Report to QC and Board; Water Safety Group; IPC BAF report to PSC and QC **Risk and compliance:** IPC Committee report to PSC qtrly; SOF Performance Report to Board monthly; IPC Clinical audits in IPCC report to PSC qtrly **Independent assurance:** Internal audit plan; CQC Rating Good with Outstanding for Care May '20; PLACE Assessment and Scores Estates Governance bi-monthly; Public Health England attendance at IPC Committee; Influenza vaccination cumulative number of staff vaccinated; ICS vaccination governance report monthly; HSE visit (COVID-19 arrangements) Dec ~~'20~~'21 – no concerns highlighted; IPC BAF Peer Review by Medway Trust; HSE External assessment and report; HSIB IPC assessment and report	~~Learning from the impact on activity, patient safety and staffing due to COVID-19 wave 1~~ ~~Constraints of critical care capacity and PPE availability dependent on the size of future waves and restoration activity – Business Case approved in principle – no commencement date yet identified~~ Business case to enhance oxygen capacity/flow has been delivered – BOC commencement date ~~Jan 2022~~April 2022 ~~Unable to provide assurance that infection risk is monitored at the front door and documented in the patient notes~~ Information capture to be moved onto the electronic patient record **SLT Lead:** Chief Nurse **Timescale:** ~~March 2022~~Complete	Inconclusive Last changed April 2020

Board Assurance Framework (BAF): May 2022

Principal risk (what could prevent us achieving this strategic objective)	**PR 2: Demand that overwhelms capacity** Demand for services that overwhelms capacity resulting in a deterioration in the quality, safety and effectiveness of patient care							**Strategic objective**	1. To provide outstanding care
Lead Committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Patient harm		
Executive lead	Chief Operating Officer	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Minimal		
Initial date of assessment	01/04/2018	**Likelihood**	**4. Somewhat likely**	4. Somewhat likely	2. Unlikely				
Last reviewed	09/05/2022	**Risk rating**	**16. Significant**	**16. Significant**	**8. Medium**				
Last changed	09/05/2022								

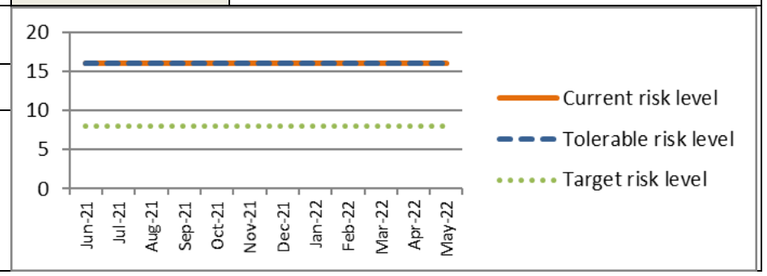


Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gap and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Growth in demand for care caused by: • An ageing population • A further Covid 19 wave of admissions driven by Omicron variant • Increased acuity leading to more admissions and longer length of stay	▪ Emergency admission avoidance schemes across the system ▪ Single streaming process for ED & Primary Care – regular meetings with NEMs ▪ Trust and System escalation process ▪ Cancer Improvement plan ▪ Trust leadership of and attendance at A&E Board ▪ Patient pathway, some of which are joint with NUH ▪ Inter-professional standards across the Trust to ensure turnaround times such as diagnostics are completed within 1 day ▪ Proactive system leadership engagement from SFH into Better Together Alliance Delivery Board ▪ Patient Flow Programme ▪ SFH internal Winter capacity plan & Mid Notts system capacity plan ▪ Referral management systems shared between primary and secondary care ▪ MSK pathways ▪ COVID-19 Incident planning and governance process ▪ Some cancer services maintained during COVID-19 ▪ Risk assessments to prioritise individual patients ▪ Elective Steering Group now meeting monthly to steer the recovery of elective waiting times ▪ Accelerator Programme – SFH has been successful in being part of the national Elective Accelerator programme attracting £2.5m of funding to help speed up the recovery of services ▪ Super Surge Plan	~~Robust delivery of the demand management schemes across the system~~	~~'Super surge' plan developed to cope with growth in Covid-19 admissions caused by Omicron variant against a backdrop of hospitals with already high occupancy, with no national lockdowns~~	**Management:** Performance management reporting arrangements between Divisions, Service Lines and Executive Team; Winter Plan to Board Nov '21; ~~Exec to Exec meetings;~~ Cancer 62 day improvement plan to Board; Planning documents for ~~19/20~~ 22/23 to identify clear demand and capacity gaps/bridges; Identifying and capturing Potential Harm Resultant from COVID-19 Pandemic report to Board Jun '20; COVID-19 Recovery Plan to Board Sep '20; ~~Elective Services Report to Recovery Committee monthly;~~ Elective Steering Group report to Executive Team weekly; Waiting list update to Board quarterly; Super Surge Plan to Board Feb '22 **Risk and compliance:** Divisional risk reports to Risk Committee bi-annually; Significant Risk Report to RC monthly; Single Oversight Framework Integrated Monthly Performance Report including national rankings to Board; Incident Control Team governance structure to TMT Mar '20; Cancer services report to Board Jun '21 **Independent assurance:** NHSI Intensive Support Team review of cancer processes May '20		Positive Last changed December 2020

Board Assurance Framework (BAF): May 2022

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gap and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Reductions in availability hospital bed capacity caused by increasing numbers of MFFD (medically fit for discharge) patients remaining in hospital	▪ Daily and weekly themed reporting of the number of MFFD patients in hospital beds ▪ The provision of a 'Discharge Cell' meeting with system partners to take forward this work ▪ Mitigation Plan to reduce number of MSFT patients in hospital beds	Lack of consistent achievement of the Mid-Notts threshold for MSFT patients of 22 – this is mainly associated with social care packages (Pathway 1) and is related to home care workforce shortages	~~Mitigation plan has been developed and is being implemented across the system to reduce number of MSFT patients in hospital beds (Dec 21).~~ ~~There is national guidance stating that the numbers of MSFT patients in acute beds need to be reduced by 50%~~ Business case for social care expansion **SLT Lead:** TBC **Timescale:** TBC Virtual ward model of care funding plan to beconsidered by Executive Team 27th April **SLT Lead:** Chief Operating Officer **Timescale:** April 2022	**Management:** Reporting into the group reports into the system CEOs group; Trust winter plan presented to Board Nov '21; Mitigation Plan to reduce number of MSFT patients in hospital beds to Board Dec '21 **Risk and compliance:** Exception reporting on the number of MFFD into the Trust Board via the SOF		Inconclusive New threat added January 2022
Operational failure of General Practice to cope with demand resulting in even higher demand for secondary care as the 'provider of last resort'	▪ Visibility on the CCG risk register/BAF entry relating to operational failure of General Practice ▪ Engagement in Integrated Care System (ICS), and assuming a leading role in Integrated Care Provider development ▪ Weekly Executive meeting with the CCGs ▪ Weekly Mid Notts Network Calls			**Management:** Routine mechanism for sharing of CCG and SFH risk registers – particularly with regard to risks for primary care staffing and demand **Independent assurance:** ~~'Drivers of demand' discussed at Board Aug '19~~		Inconclusive No change since April 2020
Drop in operational performance of neighbouring providers that creates a shift in the flow of patients and referrals to SFH	▪ Engagement in Integrated Care System (ICS), and assuming a leading role in Integrated Care Provider development ▪ Horizon scanning with neighbour organisations via meetings between relevant Executive Directors ▪ Weekly management meeting with the Service Director from Notts HC ▪ Bilateral work – Strategic Partnership forum			**Risk and compliance:** Divisional NUH/SFH strategic partnership forum minutes and action log; NUH service support to SFH paper to Executive Team	Lack of control over the flow of patients from the surrounding area	Inconclusive No change since April 2020

Board Assurance Framework (BAF): May 2022

Principal risk (what could prevent us achieving this strategic objective)	**PR 3: Critical shortage of workforce capacity and capability** A shortage of workforce capacity and capability resulting in a deterioration of staff experience, morale and well-being which can have an adverse impact on patient care						**Strategic objective**	3: To maximise the potential of our workforce
Lead Committee	People, Culture & Improvement	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services	
Executive lead	Director of People	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Cautious	
Initial date of assessment	01/04/2018	**Likelihood**	4. Somewhat likely	4. Somewhat likely	2. Unlikely			
Last reviewed	31/05/2022	**Risk rating**	**16. Significant**	**16. Significant**	**8. Medium**			
Last changed	31/05/2022							

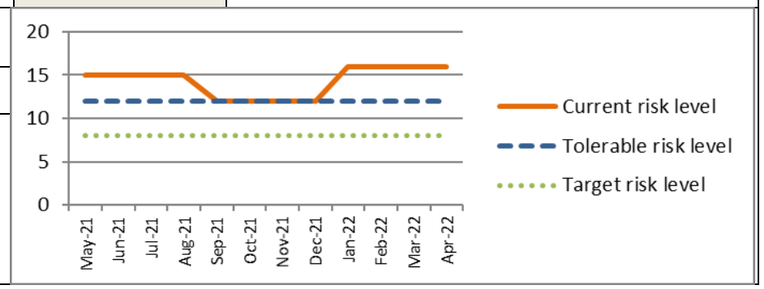
Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19**	**Assurance rating**
Inability to attract and retain staff due to demographic changes (including a significant impact of external factors and/or unforeseen circumstances) and shifting cultural attitudes to careers, combined with employment market factors (such as reduced availability and increased competition), or mental health issues relating to the working environment, resulting in critical workforce gaps in some clinical services	▪ People Culture and Improvement Strategy ▪ People and Inclusion Cabinet ▪ Culture and Improvement Cabinet ▪ Medical and Nursing task force ▪ Activity, Workforce and Financial plan ▪ 2 year workforce plan supported by Workforce Planning Group and review processes (consultant job planning; workforce modelling; winter capacity plans) ▪ Vacancy management and recruitment systems and processes ▪ TRAC system for recruitment; e-Rostering systems and procedures used to plan staff utilisation ▪ Defined safe medical & nurse staffing levels for all wards and departments / Safe Staffing Standard Operating Procedure ▪ Temporary staffing approval and recruitment processes with defined authorisation levels ▪ Education partnerships ▪ Director of People attendance at People and Culture Board ▪ Workforce planning for system work stream ▪ Communications issued regarding HMRC taxation rules on pensions and provision of pensions advice ▪ Pensions restructuring payment introduced ▪ Risk assessments for at-risk staff groups ▪ Refined and expanded Health and Wellbeing support system ▪ Operational grip on workforce gaps reporting into the Incident Control Team ▪ Nursing and Midwifery Workforce Transformation Cabinet ▪ Medical Workforce Transformation Cabinet	~~Lack of Divisional ownership and understanding of their workforce issues~~ Medical, nursing, AHP and maternity staff gaps in key areas across the Trust, which may impact on the quality and standard of care ~~Likely impact of workforce capacity loss due to the pending COVID vaccination legislation across areas of CQC regulated activity~~	Deliver the People, Culture and Improvement Strategy (People and Inclusion) **SLT Lead:** Executive Director of People **Timescale:** ~~March 2022~~Complete Deliver the People, Culture and Improvement Strategy – Year 1 **SLT Lead:** Executive Director of People **Timescale:** March 2023 Continued focus on recruitment and retention in significantly impacted areas, including system wide oversight **SLT Lead:** Executive Director of People **Timescale:** ~~March 2022~~Complete Dedicated focus on improving vaccination uptake through exploring reasons of vaccination hesitancy **SLT Lead:** Executive Director of People **Timescale:** ~~March 2022~~Complete	**Management:** Quarterly Strategic Priority Report to Board; Nursing and Midwifery and AHP six monthly staffing report to PCI Committee; Workforce and OD ICS/ICP update quarterly; Quarterly Assurance reports on People & Inclusion and Culture & Improvement to People Culture and Improvement Committee; Recruitment & Retention report monthly; Strategic Workforce Plan to Board Oct '21; Employee Relations Quarterly Assurance Report to People, Culture and Improvement Committee; People Plan updates to People, Culture and Improvement Committee quarterly **Risk and compliance:** Risk Committee significant risk report Monthly; HR & Workforce planning report Risk Committee; SOF – Workforce Indicators (Monthly); Bank and agency report (monthly); Guardian of safe working report to Board quarterly **Independent assurance**: Well-led report CQC; NHSI use of resources report; Pre-employment Checks internal audit report Feb '21 – significant assurance; HSJ Award for Acute Trust of the Year 2021; Assurance Report to People, Culture and Improvement Committee quarterly; People Plan to People, Culture and Improvement Committee Apr'21	~~Staff becoming infected, leading to increased sickness absence~~ ~~Staff working in unfamiliar roles~~ Staff mental health issues as a result of psychological trauma Potential impact of pending changes to the pensions arrangements and NI rules	Inconclusive Last changed April 2020

Board Assurance Framework (BAF): May 2022

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19**	**Assurance rating**
			Develop and implement mitigations for workforce capacity loss **SLT Lead:** Executive Director of People **Timescale:** ~~March 2022~~Complete			
A significant loss of workforce productivity arising from a short-term reduction in staff availability or a reduction in effort above and beyond contractual requirements amongst a substantial proportion of the workforce and/or loss of experienced colleagues from the service, or caused by other factors such as poor job satisfaction, lack of opportunities for personal development, on-going pay restraint, workforce fatigue or wellbeing issues, or failure to achieve consistent values and behaviours in line with desired culture This could also lead to lack of engagement with patients, resulting in failure to address patient empowerment and self-help and failure to work across the system to empower patients and carers to enable personalised patient centred care	▪ People Culture and Improvement Strategy ▪ People and Inclusion Cabinet ▪ Culture and Improvement Cabinet ▪ Chief Executive's blog / Staff Communication bulletin ▪ Engagement events with Staff Networks (BAME, LGBT, WAND, Time to Change) ▪ Schwartz rounds ▪ Learning from COVID ▪ Staff morale identified as 'profile risk' in Divisional risk registers ▪ Star of the month/ milestone events ▪ Divisional action plans from staff survey ▪ Policies (inc. staff development; appraisal process; sickness and relationships at work policy) ▪ Just and restorative culture ▪ Influenza vaccination programme ▪ COVID-19 vaccination programme ▪ Staff wellbeing drop-in sessions ▪ Staff counselling / Occ Health support ▪ Enhanced equality, diversity and inclusion focus on workforce demographics ▪ Freedom to Speak Up Guardian and champion networks ▪ Emergency Planning, Resilience & Response (EPRR) arrangements for temporary loss of essential staffing (including industrial action and extreme weather event) ▪ Combined violence and aggression campaign across system partners ▪ Anti-racism Strategy	Inequalities in staff inclusivity and wellbeing across protected characteristics groups	Deliver the Equality, Diversity and Inclusivity Strategy **SLT Lead:** Executive Director of People **Timescale:** ~~March 2022~~Complete Deliver the People, Culture and Improvement Strategy (Culture and Improvement) **SLT Lead:** Executive Director of People **Timescale:** ~~March 2022~~Complete Deliver the People, Culture and Improvement Strategy – Year 1 **SLT Lead:** Executive Director of People **Timescale:** March 2023	**Management:** Staff Survey Action Plan to Board May '21; Staff Survey Annual Report to Board Jun '21; Diversity & Inclusion Annual report Jun '21;WRES and WDES report to Board Jun '21; Quarterly Assurance reports on People & Inclusion and Culture & Improvement to People Culture and Improvement Committee; Winter Wellness Campaign report to Board Oct '21; People Plan updates to People, Culture and Improvement Committee quarterly **Risk and compliance:** EPRR Report (bi-annually); Freedom to speak up self-review Board Aug '21; Freedom to Speak Up Guardian report quarterly; Guardian of Safe Working report to Board quarterly; Significant Risk Report to RC monthly; Gender Pay Gap report to Board Apr '21; Assurance Report to People, Culture and Improvement Committee quarterly; People Plan to People, Culture and Improvement Committee Apr'21; Anti-Racism Strategy to Board Mar '22 **Independent assurance:** National Staff Survey Mar '21; SFFT/Pulse surveys (Quarterly); Well-led report CQC; Well-led Review report to Board Apr '22	~~Reduction in available staff due to COVID-19, e.g. staff isolating, shielding of vulnerable staff groups and social distancing; redeployment to the vaccination programme~~ ~~Reduction in effort above and beyond contractual requirements due to COVID-19 service restrictions~~ ~~Reluctance of some staff members to return to work due to COVID-19-associated health concerns~~ ~~Restrictions to deployment of key staff due to reduced availability of Mandatory and Statutory Training, and the consequential expiry of certification~~ ~~Increase in violence and aggression towards staff~~ Potential impact of cost of living issues on staff morale and wellbeing Implement the recommendations from the SWE Expert Group report 'Violence & Aggression and Associated Risks' **SLT Lead:** Chief Nurse **Timescale:** ~~March 2022~~Complete	Inconclusive Last changed May 2020

Board Assurance Framework (BAF): May 2022

Principal risk (what could prevent us achieving this strategic objective)	**PR 4: Failure to achieve the Trust's financial strategy** Failure to achieve agreed trajectories resulting in regulatory action							**Strategic objective**	5: To achieve better value
Lead Committee	Finance	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Regulatory action		
Executive lead	Chief Financial Officer	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Cautious		
Initial date of assessment	01/04/2018	**Likelihood**	**4. Somewhat likely**	3. Possible	2. Unlikely				
Last reviewed	26/04/2022	**Risk rating**	**16. Significant**	**12. High**	**8. Medium**				
Last changed	26/04/2022								

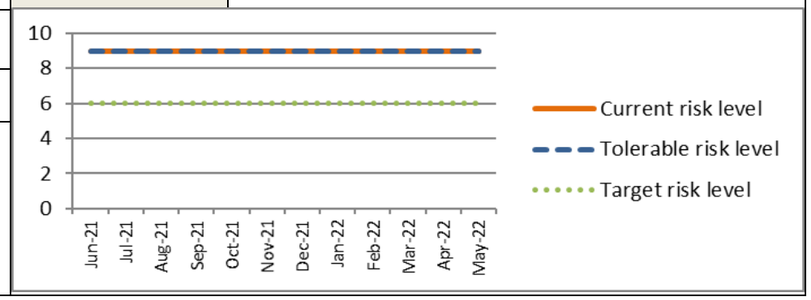


Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control**	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps**	**Assurance rating**
A reduction in funding or change in financial trajectory or unexpected event resulting in an increased Financial Improvement Plan (FIP) requirement to reduce the scale of the financial deficit, without having an adverse impact on quality and safety	▪ 5 year long term financial model ▪ Working capital support through agreed loan arrangements ▪ Annual ~~plan, including control total consideration; reduction of underlying financial deficit and unwinding of the PFI benefit by £0.5m annually~~ financial plan and budgets, based on available resources and stretching financial improvement targets. ▪ ~~Engagement with the Better Together alliance programme~~ ▪ Transformation and Efficiency Cabinet, FIP planning processes and PMO coordination of delivery ▪ Delivery of budget holder training workshops and enhancements to financial reporting ▪ ~~A full 'wash up' of portfolio planning, delivery and engagement conducted; recovery plan in place, Board approved & governance in place~~ ▪ ~~Medical Pay Task Force action plan in place~~ ▪ Close working with ICS partners to identify system-wide planning, transformation and cost reductions ▪ Executive oversight of commitments ▪ COVID-19 related funding application process in place at Trust level ▪ Development of a three-year Transformation and Efficiency Programme covering 2022-25 ▪ ~~2021/22 Planning guidance confirms continuation of 2020/21 funding regime for H1 and H2~~	No long term commitment received for liquidity / cash support ~~Lack of identification of opportunities for recurrent delivery of FIP~~ Financial allocations for 2022/23 not yet confirmed	Full receipt of required cash following delivery of NHSI required future trajectories **SLT Lead:** Chief Financial Officer **Timescale:** ~~end February 2022~~Complete **Progress:** Revenue funding received – awaiting confirmation of allocation of capital cash funding Submission of cash plan for 2022/23 **SLT Lead:** Chief Financial Officer Timescale: April 2022 Full review of ability to improve recurrent delivery of FIP within financial planning for 2022/23 SLT Lead: Director of Culture and Improvement Timescale: ~~March 2022~~Complete Budget setting process for 2022/23 to include enhanced review of recurrent cost base SLT Lead: Chief Financial Officer Timescale: ~~March 2022~~Complete Final 2022/23 Financial Plan submission in April 2022. **SLT Lead:** Chief Financial Officer **Timescale:** April 2022	**Management:** CFO's Financial Reports and ~~FIP~~ Transformation & Efficiency Summary (Monthly); Quarterly Strategic Priority Report to Board; ~~Alliance Progress Report & STP FIP (at each Finance Committee meeting);~~ ICS finance report to Finance Committee (monthly); Capital Oversight Group; Divisonal Perfroamcne Reviews (monthly) ~~Investment governance work programme~~; Divisional risk reports to Risk Committee bi-annually; Transformation & Efficiency Cabinet updates to Executive Team **Risk and compliance:** Risk Committee significant risk report Monthly **Independent assurance**: Inte`rnal Audit of FIP/ QIPP processes Sep '21; EY Financial Recovery Plan; Deloitte audit of COVID-19 expenditure; Internal Audit reports: - Key Financial Systems - Asset Register Jan '22 - Integrity of the General Ledger and Financial Reporting Dec '21 - Financial Reporting Arrangements Nov 21	~~Awaiting 2022/23 NHSI/E planning guidance~~ NHSE/I feedback to be sought on final plan submission	Inconclusive Last changed July 2020
ICS system deficit results in a negative financial impact to the Trust	▪ Full participation in ICS planning ▪ SFH plan consistency with ICS and partner plans ~~plan~~ ▪ ICS DoFs Group ▪ ICS Operational Finance Directors Group ▪ ICS Financial Framework	ICS underlying financial deficit	Full participation in the development of the ICS Financial Strategy and aligned payment mechanisms for 2022/23 **SLT Lead:** Chief Financial Officer **Timescale:** ~~March 2022~~Complete Final aligned SFH and ICS financial plan submission for 2022/23 SLT Lead: Chief Financial Officer Timescale: April 2022	**Risk and compliance:** ICS financial reports to Finance Committee; ICS Board updates to SFH Trust Board	~~Awaiting 2022/23 NHSI/E planning guidance~~ NHSE/I feedback to be sought on final plan submission	Inconclusive Last changed July 2020

Board Assurance Framework (BAF): May 2022

Principal risk (what could prevent us achieving this strategic objective)	**PR 5: Inability to initiate and implement evidence-based improvement and innovation** Lack of support, capability and agility to optimise strategic and operational opportunities to improve patient care						
Lead Committee	People, Culture & Improvement	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Reputation
Executive lead	Director of Culture & Improvement	**Consequence**	**3. Moderate**	3. Moderate	3. Moderate	**Risk appetite**	Cautious
Initial date of assessment	17/03/2020	**Likelihood**	**3. Possible**	3. Possible	2. Unlikely		
Last reviewed	27/05/2022	**Risk rating**	**9. Medium**	**9. Medium**	**6. Low**		
Last changed	27/05/2022						

Strategic objective	4: To continuously learn and improve

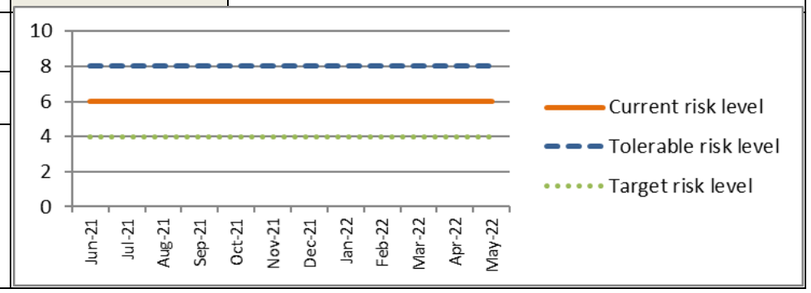


Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19**	**Assurance rating**
Lack of understanding and agility resulting in reduced efficiency and effectiveness around how we provide care for patients	▪ Digital Strategy ▪ People, Culture & Improvement Strategy ▪ Quality Strategy ▪ People, Culture & Improvement Committee ▪ Leadership development programmes ▪ Talent management map ▪ Programme Management Office ▪ Culture & Improvement Cabinet ▪ Transformation Cabinet ▪ Ideas generator platform	The full scope of potential issues is not currently known – therefore further investigation is under way	Establishment of an Innovation Hub **SLT Lead:** Director of Culture and Improvement **Timescale:** ~~March 2022~~May 2022 **Progress:** Pursuing a joint venture with Notts Healthcare and NUH Recruit a Chief Digital Information Officer **SLT Lead:** Medical Director **Timescale:** ~~January 2022~~Complete Recommendations implemented following the review of the EPMA programme of work **SLT Lead:** Medical Director **Timescale:** ~~January 2022~~Complete	**Management:** Monthly Transformation and Efficiency report to FC; Clinical Audit & Improvement report to ~~PSC~~ Advancing Quality Group quarterly; Culture & Improvement Assurance Report to PC&IC bi-monthly **Risk and compliance:** SOF Culture and Improvement indicators; SFH Trust Priorities ~~breakthrough objectives~~ to Board quarterly **Independent assurance:** ~~none currently in place~~ Internal Audit of FIP/ QIPP processes Sep '21; 360 assessment in relation to Clinical Effectiveness. Report May 2022	Delays in training, planned improvement and innovation programmes due to COVID-19 Lack of independent assurance, evidence and insight Progress: Independent review and recommendations by EMAHSN relating to the SFH Vision for Continuous Improvement. Complete.	Positive No change since April 2020

Board Assurance Framework (BAF): May 2022

Principal risk (what could prevent us achieving this strategic objective)	**PR 6: Working more closely with local health and care partners does not fully deliver the required benefits** Influencing the wider determinants of health and improving our collective financial position requires close partnership working. This may be difficult because of differences in governance, objectives and appetite for and ability to change						
Lead Committee	Risk	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services
Executive lead	Chief Executive Officer	**Consequence**	**2. Low**	2. Low	2. Low	**Risk appetite**	Cautious
Initial date of assessment	01/04/2020	**Likelihood**	**3. Possible**	4. Somewhat likely	2. Unlikely		
Last reviewed	25/05/2022	**Risk rating**	**6. Low**	**8. Medium**	**4. Low**		
Last changed	10/05/2022						

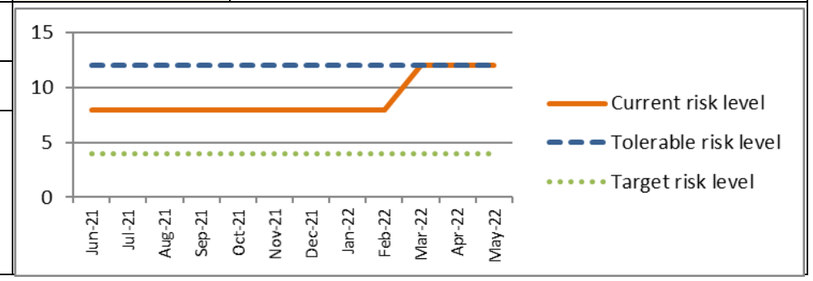
Strategic objective	2: To promote and support health and wellbeing



Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19**	**Assurance rating**
Conflicting priorities, financial pressures (system financial plan misalignment) and/or ineffective governance resulting in a breakdown of relationships amongst ICS and ICP partners and an inability to influence further integration of services across acute, mental, primary and social care	• Mid-Nottinghamshire Integrated Care Partnership Board • Mid-Nottinghamshire ICP Executive formed May 2020 • Mid-Nottinghamshire ICP breakthrough objectives signed off July 2020 • Nottingham and Nottinghamshire Integrated Care System Board • Continued engagement with ICP and ICS planning and governance arrangements • Quarterly ICS performance review with NHSI • Joint development of plans at ICS level • Finance Directors Group • ICS Planning Group • Alignment of Trust, ICS and ICP plans • Statutory submission of Trust plans as a component of the ICS plan for the system • Independent chair for ICP • ICS Transition and Risk Committee • Approved implementation plan for establishing system risk arrangements • ICS Provider Collaborative development • ICS System Oversight Group • Engagement with the establishment of the formal ICB and place-based partnership	Continued misalignment in organisational priorities Suboptimal system oversight and arrangements for discharge of complex patients	Delivery of the agreed system priorities and plans **SLT Lead:** Chief Executive Officer **Timescale:** March 2022 Consideration by ICS Chief Executives Group of sustainable architecture for to enable effective and timely discharge of MFFD patients. Provider collaborative considering taking ownership **SLT Lead:** Chief Executive Officer **Timescale:** TBC	**Management:** ~~Alliance Development Summary to Board;~~ Strategic Partnerships Update to Board; mid-Nottinghamshire ICP delivery report to FC (as meeting schedule); Finance Committee report to Board; Nottingham and Nottinghamshire ICS Leadership Board Summary Briefing to Board; Planning Update to Board **Risk and compliance:** Significant Risk Report to RC monthly **Independent assurance**: 360 Assurance review of SFH readiness to play a full part in the ICS – Significant Assurance	~~Delay in delivering the benefits of system working due to the impact of COVID-19~~	Positive Last changed May 2022
Clinical service strategies and/or commissioning intentions that do not sufficiently anticipate evolving healthcare needs of the local population and/or reduce health inequalities	▪ Continued engagement with commissioners and ICS developments in clinical service strategies focused on prevention ▪ Partnership working at a more local level, including active participation in the mid-Nottinghamshire ICP ▪ ICS Clinical Services Strategy now complete ▪ ICS Health and Equality Strategy	The needs of the population and the statutory obligations of each individual organisation will not be met until the ICS Clinical Services Strategy is implemented	Implement the ICS Clinical Services Strategy **SLT Lead:** Medical Director **Timescale:** TBC	**Management:** Mid-Notts ICP Objectives Update to Board**;** Strategic Partnerships Update to Board; mid-Nottinghamshire ICP delivery report to FC (as meeting schedule); Finance Committee report to Board; Planning Update to Board **Independent assurance**: none currently in place	~~Delay in delivering the benefits of system working due to the impact of COVID-19~~	~~Positive~~ Inconclusive Last changed ~~May 2021~~ May 2022

Board Assurance Framework (BAF): May 2022

Principal risk (what could prevent us achieving this strategic objective)	**PR 7: Major disruptive incident** A major incident resulting in temporary hospital closure or a prolonged disruption to the continuity of core services across the Trust, which also impacts significantly on the local health service community						**Strategic objective** 1: To provide outstanding care
Lead Committee	Risk	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services
Executive lead	Director of Corporate Affairs	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Cautious
Initial date of assessment	01/04/2018	**Likelihood**	~~2. Unlikely~~3. Possible	3. Possible	1. Very unlikely		
Last reviewed	30/05/2022	**Risk rating**	~~8. Medium~~ 12. High	**12. High**	**4. Low**		
Last changed	10/05/2022						



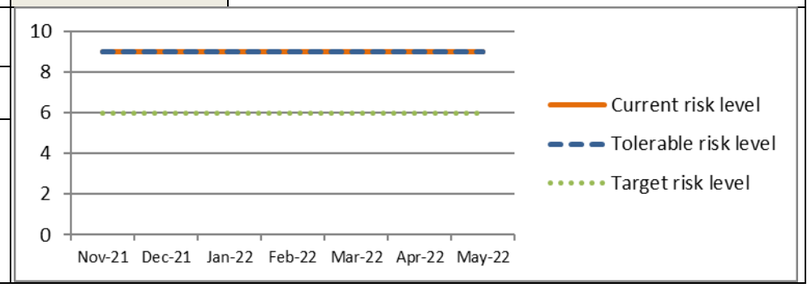
Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19**	**Assurance rating**
Shut down of the IT network due to a large-scale cyber-attack or system failure that severely limits the availability of essential information for a prolonged period	▪ Information Governance Assurance Framework (IGAF) & NHIS Cyber Security Strategy ▪ Cyber Security Programme Board & Cyber Security Project Group and work plan ▪ Cyber news – circulated to all NHIS partners ▪ High Severity Alerts issued by NHS Digital ▪ Network accounts checked after 50 days of inactivity – disabled after 80 days if not used ▪ Major incident plan in place ▪ Periodic phishing exercises carried out by 360 Assurance ▪ Spam and malware email notifications circulated ▪ Periodic cyber-attack exercises carried out by NHIS and the Trust's EPRR lead	~~Misalignment with NCSC Cyber Security Metrics:~~ ~~- High Severity Alerts completion and reporting not within required timeframe~~ ~~- Unsupported systems~~ ~~- Low degree of alignment with NCSC backup guidance~~ ~~Password criteria do not meet IT Healthcheck standards~~		**Management:** Data Protection and Security Toolkit submission to Board Apr '21- 100% compliance; Hygiene Report to Cyber Security Board monthly; NHIS report to Risk Committee quarterly; IG Bi-annual report to Risk Committee; ~~Cyber Security and COVID-19 Report to Board May '20~~; Cyber Security report to Risk Committee – increased levels of attack due to Ukraine **Risk and compliance:** **Independent assurance**: ~~360 Assurance Cyber Security Governance Report Jan '19 – Significant Assurance;~~ ISO 27001 Information Security Management Certification; TIAN / 360 Assurance Cyber Security Survey - The impact of Covid-19 on the NHS Dec '20; CCG Cyber Security Report Mar '21- Significant Assurance; 360 Assurance NHIS Governance and Interface audit – limited assurance; 360 Assurance Data Security and Protection Toolkit audit May '21 – substantial assurance; ~~Cyber Essentials achieved Sep '21~~; IT Healthcheck – 2 of 9 elements failed (negative assurance); Cyber Essentials Plus accreditation Jan '22	Implement the actions from the NHIS Governance and Interface internal audit report **SLT Lead:** Medical Director **Timescale:** ~~March 2022~~Complete	Positive No change since April 2020
A critical infrastructure failure caused by an interruption to the supply of one or more utilities (electricity, gas, water), an uncontrolled fire, flood or other climate change impact, security incident or failure of the built environment that renders a significant proportion of the estate inaccessible or unserviceable, disrupting services for a prolonged period	▪ Premises Assurance Model Action Plan ▪ Estates Strategy 2015-2025 ▪ PFI Contract and Estates Governance arrangements with PFI Partners ▪ Fire Safety Strategy ▪ NHS Supply Chain resilience planning ▪ Emergency Preparedness, Resilience & Response (EPRR) arrangements at regional, Trust, division and service levels ▪ Operational strategies & plans for specific types of major incident (e.g. industrial action; fuel shortage; pandemic disease; power failure; severe winter weather; evacuation; CBRNe) ▪ Gold, Silver, Bronze command structure for major incidents ▪ Business Continuity, Emergency Planning & security policies ▪ Resilience Assurance Committee (RAC) oversight of EPRR ▪ Independent Authorising Engineer (Water) ▪ Major incident plan in place			**Management:** Central Nottinghamshire Hospitals plc monthly performance report; Fire Safety Annual Report; Water Safety Update Report to Risk Committee Jul '20; Patient Safety Concerns report to QC March '21; Hard and soft FM assurance reports **Risk and compliance:** Monthly Significant Risk Report to Risk Committee **Independent assurance:** Premises Assurance Model to RC Dec '18; ~~EPRR Report;~~ EPRR Core standards compliance rating (Oct ~~'19~~'21) – Substantial Assurance; Water Safety report (WSP) to Joint Liaison Committee Oct '19; WSP report – hard FM independent audit; MEMD ISO 9001:2015 Recertification Mar '21; British Standards Institute MEMD Assessment Report Feb '22	360 Assurance internal audit of contract management **SLT Lead:** Associate Director of Estates & Facilities **Timescale:** ~~January 2022~~April 2022 **Progress:** Terms of Reference agreed	Positive No change since April 2020

Board Assurance Framework (BAF): May 2022

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19**	**Assurance rating**
A critical supply chain failure that severely restricts the availability of essential goods, medicines or services for a prolonged period	▪ NHS Supply Chain resilience planning Business Continuity Management System & Core standards ▪ CAS alert system – Disruption in supply alerts ▪ Major incident plan in place ▪ PPE Strategy ~~▪ PPE Winter Forecast 2020/21~~ ~~▪ EU Exit Preparation Meetings~~ ▪ COVID-19 Pandemic Surge Plan ▪ Procurement Influenza Pandemic Business Continuity Plan ▪ Interim provision for transmission of personal data to the United Kingdom clause within the EU Exit agreement	None		**Management:** Procurement Annual Report to Audit & Assurance Committee; Oxygen Supply Assurance report to Incident Control Team Apr '20; COVID-19 Governance Assurance Report to Board May '20 **Risk and compliance:** **Independent assurance**: ~~Internal Audit Business Continuity and Emergency Planning Sep '18 – Significant Assurance; 2019/20~~2020/21 Counter Fraud, Bribery and Corruption Annual Report; ~~EU Exit Risk System Overview – Nottingham and Nottinghamshire System Dec '20;~~ 360 Assurance Procurement Review Apr '21 – Significant Assurance		Positive No change since April 2020

Board Assurance Framework (BAF): May 2022

Principal risk (what could prevent us achieving this strategic objective)	**PR 8: Failure to deliver sustainable reductions in the Trust's impact on climate change** The vision to further embed sustainability into the organisation's strategies, policies and reporting processes by engaging stakeholders and assigning responsibility for delivering the actions within our Green Plan may not be achieved or achievable						**Strategic objective**	2: To promote and support health and wellbeing
Lead Committee	Risk	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Reputation / regulatory action	
Executive lead	Chief Executive Officer	**Consequence**	**3. Moderate**	3. Moderate	3. Moderate	**Risk appetite**	Cautious	
Initial date of assessment	22/11/2021	**Likelihood**	**3. Possible**	3. Possible	2. Unlikely			
Last reviewed	25/05/2022	**Risk rating**	**9. Medium**	**9. Medium**	**6. Low**			
Last changed	08/03/2022							



Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19**	**Assurance rating**
Failure to take all the actions required to embed sustainability and reduce the impact of climate change on our community	▪ Estates & Facilities Department oversee the plan and education on climate change impacts ▪ Green Plan 2021-2026 ▪ Climate Action Project Group ▪ Engagement and awareness campaigns (internal/external stakeholders) ▪ Estates Strategy ▪ Digital Strategy ▪ Capital Planning sustainability impact assessments ▪ Environmental Sustainability Impact Assessments built into the Project Implementation Documentation process ▪ Engagement with the wider NHS sustainability sector for best practice, guidance and support	Lack of data to accurately measure and monitor improvements Education of Board and staff at all levels Lack of Environmental Impact Assessments	Develop and embed processes for gathering and reporting statistical data **Lead:** Associate Director of Estates and Facilities **Timescale:** June 2022 Training of the Board, decision makers and all staff at an appropriate level to increase awareness and understanding of sustainable healthcare **Lead:** Associate Director of Estates and Facilities **Timescale:** June 2022 Capital Oversight Group to develop a mechanism to ensure that environmental impact assessments are embedded in decision making processes and key documents (e.g. business cases, investment cases, board papers, capital bids, new and existing policies) **Lead:** Chief Financial Officer **Timescale:** ~~January 2022~~March 2022 **Progress:** Environmental Impact tool approved by TMT	**Management:** **Risk and compliance:** Green Plan to Board Apr '21 Sustainability Report included in the Trust Annual Report **Independent assurance:** ERIC returns and benchmarking feedback	Reporting to Transformation and Efficiency Cabinet not yet defined Agree reporting structure **Lead:** Associate Director of Estates and Facilities **Timescale:** ~~March 2022~~July 2025	Inconclusive New risk added November 2021