Board Assurance Framework (BAF): January 2025

The key elements of the BAF are:

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

Key to lead committee assurance ratings:

Green = ~~Positive~~ Significant 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~~ Moderate 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~~ the Committee is not assured that the current risk treatment strategy fully addresses the gaps in assurance or control

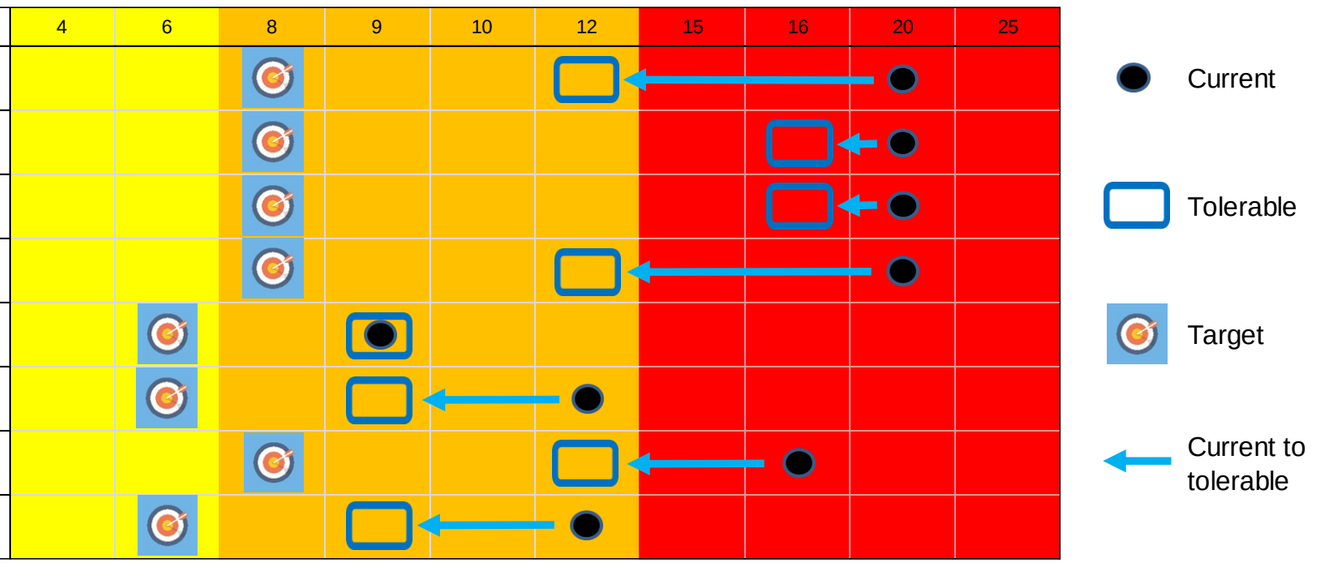
Red = ~~Negative~~ Limited assurance: the Committee is not satisfied that there is sufficient reliable evidence that the current risk treatment strategy is appropriate to the nature and/or scale of the threat or opportunity

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

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

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

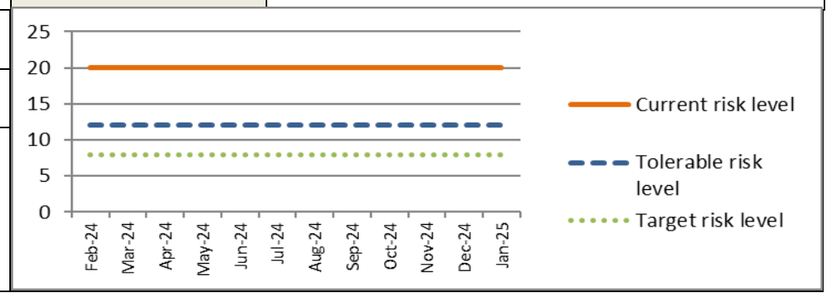
		Lead Director	Lead Committee
PR1	**Significant deterioration in standards of safety and care**	Medical Director Chief Nurse	Quality
PR2	**Demand that overwhelms capacity**	Chief Operating Officer	Quality
PR3	**Critical shortage of workforce capacity and capability**	Director of People	People
PR4	**Insufficient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



Board Assurance Framework (BAF): January 2025

Principal risk (What could prevent us achieving this strategic objective)	**PR 1: Significant deterioration in standards of safety and care** Recognised deterioration in standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes						
Lead committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Patient harm
Lead directors	Medical Director Chief Nurse	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Minimal
Initial date of assessment	01/04/2018	**Likelihood**	**5. Very likely**	3. Possible	2. Unlikely		
Last reviewed	27/01/2025	**Risk rating**	**20. Significant**	**12. High**	**8. Medium**		
Last changed	27/01/2025						

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



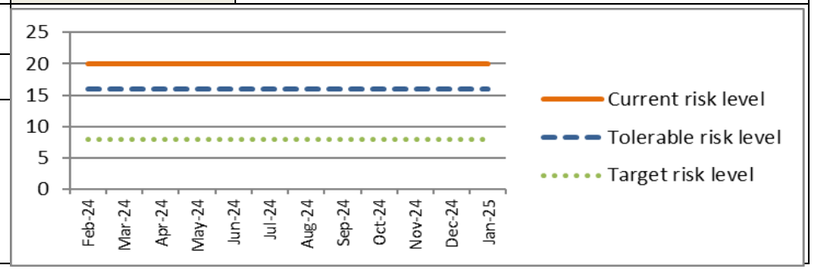
Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Inability to maintain patient safety and quality of care leading to increased incidence of avoidable harm and poor patient experience	▪ Clinical service structures, accountability & quality governance arrangements at Trust, division & service levels including: ▪ Monthly meeting of Patient Safety Committee (PSC) with work programme aligned to CQC registration regulations ▪ Nursing and Midwifery and AHP Business meeting ▪ Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems ▪ Clinical audit programme & monitoring arrangements ▪ Clinical staff recruitment, induction, mandatory training, registration & re-validation ▪ Defined safe medical & nurse staffing levels for all wards & departments (Nursing safeguards monitored by Chief Nurse) ▪ Ward assurance/ metrics and accreditation programme ▪ IPR metric reviewed annually and agreed by Board ▪ Nursing & Midwifery Strategy ▪ AHP Strategy ▪ Patients Safety Incident Response Framework (PSIRF) ▪ Review, oversight and learning from patient safety incidents Internal Reviews against External National Reports ▪ Getting it Right First Time (GIRFT) localised deep dives, reports and action plans ▪ CQC quarterly Engagement Meetings ▪ Operational grip on workforce gaps reporting into the Incident Control Team ▪ People, Culture and Improvement Strategy ▪ Continued focus on recruitment and retention in significantly impacted areas, including system wide oversight ▪ Digital Strategy Group ▪ Enhanced actions to full capacity protocol	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 Inability to re-provide MDT or other outpatients ~~appointments~~ in a timely way, impacting on ~~cancer~~ patient pathway metrics and overall patient care Financial restraints may lead to impacts on ability to maintain patient care and safety, including the ability to recruit temporary staffing Insufficient capacity, particularly beds, to maintain safe standards of care	Review the existing reporting metrics used to monitor patient safety and identify improvements to ensure consistency of the values used across different reports across governance groups, including the development of a quality dashboard **SLT Lead:** Medical Director / Chief Nurse **Progress:** Review completed – developing dashboard **Timescale:** ~~November 2024~~February 2025 Monitoring of fill rates and quality impact **SLT Lead:** Medical Director / Chief Nurse **Timescale:** ~~December 2024~~May 2025 Review of bed capacity and conversion of unconventional bed space **SLT Lead:** Medical Director / Chief Nurse **Timescale:** February 2025	**Management:** Learning from deaths Report to Quality Committee and Board; Quarterly Strategic Priority Report to Board; Divisional risk reports to Risk Committee bi-annually; Guardian of Safe Working report to Board quarterly Quality and Governance Reporting Pathway; Patient Safety Committee → Quality Committee Reports include: - DPR Report to PSC monthly and QC bi-monthly - PSC assurance report to QC bi-monthly - Patient Safety Culture programme - EoLC Annual Report to QC - Safeguarding Annual Report to QC - CYPP report to QC quarterly - Medical Education update report to QC - Medicines Optimisation Annual Report to QC - Sepsis report to Quality Committee and Patient Safety Committee quarterly Outputs from internal reviews against External National Reports including HSIB and HQIP National and local Reports; Digital risks reported to Risk Committee 6-monthly and DSG monthly **Risk and compliance:** Quality Dashboard and IPR to Quality Committee bi-monthly; Quality Account Report qtrly to PSC and QC; SI & Duty of Candour report to PSC monthly; CQC report to QC quarterly; Significant Risk Report to RC monthly; Exception reporting to System Quality Committee bi-monthly **Independent assurance**: CQC Engagement meeting reports to Quality Committee bi-monthly Screening Quality Assurance Services assessments and reports of: - Antenatal and New-born screening - Breast Cancer Screening Services - Bowel Cancer Screening Services - Cervical Screening Services External Accreditation/Regulation annual assessments and reports of: - Pathology (UKAS) - Endoscopy Services (JAG) - Medical Equipment and Medical Devices (BSI) - Blood Transfusion Annual Compliance Report (MHRA)	~~Unmitigated risk associated with the continuation and escalation of industrial action, the lack of progress towards a negotiated solution and the impact across professional groups who inevitably step up to provide cover in service gaps~~ Palpable harm to staff due to work pressures, and the longevity and impact of the ongoing demands Running at OPEL4 for a protracted length of time and full capacity protocol, exceeding full capacity protocol and system-wide critical incidents Full capacity protocol does not fully address bed capacity requirements during winter	~~Positive~~ Moderate ~~No change since April 2020~~Last changed January 2025

Board Assurance Framework (BAF): January 2025

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
An outbreak of infectious disease that forces closure of one or more areas of the hospital	▪ Infection prevention & control (IPC) programme Policies/ Procedures; Staff training; Environmental cleaning audits ▪ PFI arrangements for cleaning services ▪ Root Cause Analysis and Root Cause Analysis Group ▪ Reports from Public Health England received and acted upon ▪ Infection control annual plan developed in line with the Hygiene Code ▪ Influenza and Covid vaccination programmes ▪ Reintroduction of enhanced respiratory virus testing during winter ▪ Public communications re: norovirus and infectious diseases ▪ Infectious disease identification and management process ▪ Infection Prevention and Control Board Assurance Framework ▪ Outbreak meeting including external representation, PHE, Regional IPC ▪ CQC IPC Key lines of enquiry engagement sessions	FIT mask testing compliance rate below required rate Influenza vaccination uptake is below target levels	Increase compliance to target rate **Progress:** Fit Testing Data is now included in Divisional Performance Review Packs Compliance increased, but not yet to target rate, and targeting high-risk clinical areas **SLT Lead:** Director of People / Chief Nurse **Timescale:** ~~October 2024~~January 2025 Communications to staff around the importance of vaccinations **SLT Lead:** Medical Director / Chief Nurse **Timescale:** throughout winter 2024/25 Review influenza vaccination programme to understand the reasons for low take-up **SLT Lead:** Director of People **Timescale:** August 2025	**Management:** Divisional reports to IPC Committee (every 6 weeks); IPC Annual Report to QC and Board; Water Safety Group; IPC BAF report to PSC and QC **Risk and compliance:** IPC Committee report to PSC qtrly; Integrated Performance Report to Board monthly; IPC Clinical audits in IPC Committee report to PSC qtrly; Regular IPC updates to ICT; PLACE Assessment and Scores Estates Governance bi-monthly **Independent assurance:** Internal audit plan: UKHSA attendance at IPC Committee; Independent Microbiologist scrutiny via IPC Committee; Influenza vaccination cumulative number of staff vaccinated; ICS vaccination governance report monthly; IPC BAF Peer Review by Medway Trust; HSE External assessment and report; Annual Maternity incentive scheme assessment, which incorporates 10 safety elements, regional monthly heat map and progress towards the Three-Year Delivery Plan		Significant Last changed November 2022

Board Assurance Framework (BAF): January 2025

Principal risk (What could prevent us achieving this strategic objective)	**PR 2: Demand that overwhelms capacity** Demand for services that overwhelms capacity resulting in a deterioration in the quality, safety and effectiveness of patient care							**Strategic objective**	Provide outstanding care in the best place at the right time
Lead committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Patient harm		
Lead director	Chief Operating Officer	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Minimal		
Initial date of assessment	01/04/2018	**Likelihood**	**5. Very likely**	4. Somewhat likely	2. Unlikely				
Last reviewed	27/01/2025	**Risk rating**	**20. Significant**	**16. Significant**	**8. Medium**				
Last changed	27/01/2025								



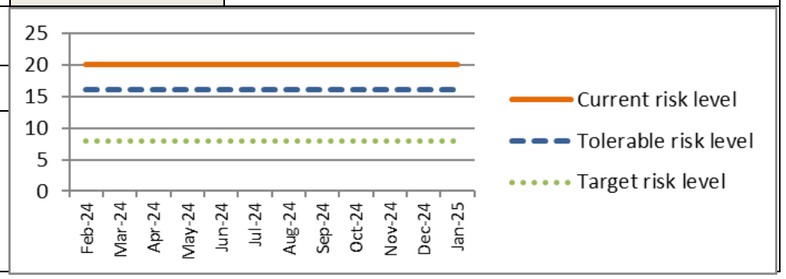
Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Growth in demand for care caused by: • An ageing population and increasing complexity of health needs • Further waves of admissions driven by Covid-19, flu or other infectious diseases • Increased acuity leading to more admissions and longer length of stay	▪ System programme boards with responsibility for oversight and delivery of transformation programmes ▪ UEC Improvement Programme focussing on internal flow, and Getting the Basics Right with internal oversight at the Emergency Care Steering Group ▪ Trust leadership of and attendance at ICS UEC Delivery Board ▪ Emergency admission avoidance schemes across the system under oversight of the Urgent and Emergency Care (UEC) Board and the System Oversight Group ▪ SFH Medical and Surgical Same Day Emergency Care (SDEC) services in place (and expanding in winter 2024/25) to avoid admissions into inpatient facilities ▪ Single streaming process for ED & Primary Care and SDEC direct access – regular meetings with Nottingham Emergency Medical Services (NEMS) ▪ Trust and System escalation policies and processes, including Operational Pressures Escalation Level (OPEL) Framework and Full Capacity Protocol ▪ Inter-professional standards across the Trust to ensure we complete today's work today ▪ SFH annual capacity plan with specific focus on the Winter period via the Winter Planning Group ▪ Referral management systems shared between primary and secondary care ▪ Theatres, Outpatients and Diagnostics Transformation Programmes ▪ Planned Care Steering Group with oversight of performance and improvement activities (including work of the Cancer Steering Group) ▪ System support in place (mutual aid) with regular meetings via the System Elective Hub	Physical staffed capacity/estate is insufficient to cope with surges in demand without undertaking exceptional actions that are part of our full capacity protocol e.g. opening surge capacity, reducing elective operating, bedding patients in alternative areas i.e. day case	Continuation of March 2024 Emergency Department schemes to support non-admitted breach reduction **SLT Lead:** Chief Operating Officer **Timescale:** throughout Q1 and Q2, and continuing into Q3 Trial of frailty SDEC co-located within ~~Discharge Lounge~~Medical Day Case **Progress:** Part of 2024/25 Winter Plan, opened in November 2024 **SLT Lead:** Chief Operating Officer **Timescale:** ~~Commence October 2024~~March 2025 Winter Plan to be agreed and implemented **Progress:** First draft approved by Trust Board in September 2024. Final draft to be approved in October 2024, then immediate implementation **SLT Lead:** Chief Operating Officer **Timescale:** ~~October 2024~~Complete Full Capacity Protocol refreshed, signed off and implemented, including two-over beds on wards **SLT Lead:** Chief Operating Officer **Timescale:** ~~January 2025~~ Complete Undertake an options appraisal to increase bedded capacity **SLT Lead:** Chief Operating Officer **Timescale:** October 2025	**Management:** Performance management reporting arrangements between Divisions, Service Lines, Executive Team on an at least bi-monthly basis, and Board quarterly **Risk and compliance:** Divisional risk reports to Risk Committee bi-annually; Significant Risk Report to RC monthly; Integrated Performance Report including national rankings to Board quarterly **Independent assurance:** Performance Management Framework internal audit report Jun 22; Operational Planning internal audit report Jul 24; System Analytical Intelligence Unit report on changes in Emergency Care Demand to System Urgent & Emergency Care Delivery Board Jan 25	Some transformation schemes overseen by the System programme boards are not currently preventing increases in the number of patients presenting to SFH Continue to work with system partners within ICS forums e.g. ICS UEC Delivery Board and System Flow Meetings **SLT Lead:** Chief Operating Officer **Timescale:** throughout 2025	Moderate Last changed September 2024

Board Assurance Framework (BAF): January 2025

Strategic threat (What might cause this to happen)	Primary risk controls (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	Plans to improve control (Are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gaps (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating
Constraints in availability of hospital bed capacity caused by elevated numbers of ~~MFFD~~ MSFT (medically ~~fit for discharge~~safe for transfer) patients remaining in hospital	▪ Engagement in ICB Discharge Operational Steering Group ▪ Multidisciplinary Transfer of Care Hub in place that undertakes twice-daily reviews of patients awaiting Nottinghamshire packages of care ▪ Full use of our bed base across our 3 sites with further capacity purchased from Ashmere Group Care Homes (at reduced levels in 2024) ▪ Improved use of NerveCentre to facilitate timely patient discharge ▪ Re-introduction of Discharge Co-ordinators across inpatient wards	~~Lack of consistent achievement of the mid-Notts threshold for MSFT patients of 40~~	Right-size pathway 2 and pathway 3 bedded capacity required for rehabilitation and re-enablement across the ICS to reduce length of stay and MSFT **Progress:** agreement made with ICS that the current footprint of P2 bedded capacity is right sized to meet demand, with no expectation to reduce length of stay further **SLT Lead:** Chief Operating Officer **Timescale:** ~~October 2024~~Complete Roll out a series of one-minute videos that explaining the basic but essential elements of patient flow **SLT Lead:** Chief Operating Officer **Timescale:** ~~December 2024~~Complete	**Management:** Daily and weekly themed reporting of the number of MSFT patients in hospital beds - reports into the ICS UEC Delivery Board and ICS Demand and Capacity Group monthly **Risk and compliance:** Exception reporting on the number of MSFT into the Trust Board via the Integrated Performance Report quarterly, which is showing positive progress in 2024/25 Q1 and Q2	Challenges in the provision of the ICS-commissioned transport contract to deliver timely patient discharge Supplement the contract with commissioners with locally commissioned additional transport services **SLT Lead:** Chief Operating Officer **Timescale:** June 2025	~~Inconclusive~~ Significant ~~No change since threat added in January 2022~~ Last changed January 2025
Failure of Primary Care to cope with demand resulting in even higher demand for secondary care as the 'provider of last resort'	▪ Visibility on the ICS risk register / BAF entry relating to operational failure of General Practice ▪ Weekly System Oversight Group meetings across ICS~~, including Primary Care~~ ▪ ICS Primary Care Strategy Group, with responsibility for overseeing delivery of the Primary Care Access Recovery Plan ▪ Nottingham Emergency Medical Services-run 24/7 primary care service within our Emergency Department			**Management:** Routine mechanism for sharing of ICS and SFH risk registers – particularly with regard to risks for primary care staffing and demand; ICS reports available on the System Analytical Intelligence Unit portal	Adverse impact due to potential GP collective action Monitor and review the potential impact of GP collective action **SLT Lead:** Chief Operating Officer **Timescale:** Throughout 2025	Moderate 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	▪ System programme boards with responsibility for oversight and delivery of transformation programmes ▪ Engagement in relevant Integrated Care System (ICS) groups/boards ▪ Horizon scanning with neighbour organisations via meetings between relevant Executive Directors ▪ Mechanism in place to agree peripheral and full diverts of patients via EMAS ▪ Regular meetings in place with EMAS and commissioners to review and discuss appropriate flow of patients to our hospitals			**Management:** A&E attendance demand report (including post code analysis of ambulance conveyance) to Finance Committee Feb 24, and shared with System partners **Independent assurance:** Weekly reports provided by NHSE Regional Team showing performance against key Urgent and Emergency Care metrics; System Analytical Intelligence Unit (SAIU) Drivers of Urgent Care Demand report Sep 24; System Analytical Intelligence Unit report on changes in Emergency Care Demand to System Urgent & Emergency Care Delivery Board Jan 25	Lack of control over the flow of patients from the surrounding area, including decisions by EMAS to undertake strategic conveyancing Continue to work with system partners within ICS forums e.g. ICS UEC Delivery Board and System Flow Meetings **SLT Lead:** Chief Operating Officer **Timescale:** ~~Ongoing during 2024~~throughout 2025	~~Positive~~ Moderate Last changed ~~November 2022~~January 2025
~~Growth in demand for care in our maternity services (population growth and increase in out of area referrals)~~	~~▪ Over-established midwifery~~ ~~▪ Additional antenatal clinics based on overtime/bank~~ ~~▪ Maternity assurance group (monthly)~~ ~~▪ Director of Midwifery providing Board-level oversight~~	~~Physical capacity/estate will be insufficient should growth trends continue in the coming years~~		~~**Management:** Maternity dashboard that includes all relevant KPIs and quality standards (live and reviewed monthly at performance meetings)~~ ~~**Risk and compliance:** Maternity and gynaecology and divisional performance meetings (monthly)~~		~~Significant~~ ~~New threat added January 2023~~

Board Assurance Framework (BAF): January 2025

Principal risk (What could prevent us achieving this strategic objective)	**PR 3: Critical shortage of workforce capacity and capability** A shortage of workforce capacity and capability resulting in a deterioration of staff experience, morale and well-being which can have an adverse impact on patient care							**Strategic objective**	Empower and support our people to be the best they can be
Lead committee	People	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services		
Lead director	Director of People	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Cautious		
Initial date of assessment	01/04/2018	**Likelihood**	**5. Very likely**	4. Somewhat likely	2. Unlikely				
Last reviewed	28/01/2025	**Risk rating**	**20. Significant**	**16. Significant**	**8. Medium**				
Last changed	28/01/2025								



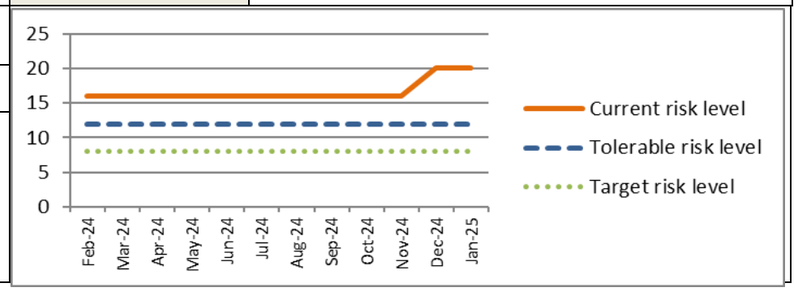
Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Inability to attract and retain staff, resulting in critical workforce gaps in some clinical and non-clinical services	▪ People Strategy 2022-2025 ▪ People Cabinet ▪ Activity, Workforce and Financial plan ▪ 5-year strategic workforce plan supported by associated Tactical People Plans ▪ ICS People and Culture Strategy (2019 to 2029) and Delivery Group ▪ Vacancy management and recruitment systems and processes ▪ TRAC system for recruitment; e-Rostering systems and procedures used to plan staff utilisation ▪ Defined safe medical & nurse staffing levels for all wards and departments / Safe Staffing Standard Operating Procedure ▪ Temporary staffing approval and recruitment processes with defined authorisation levels; Activity Manager to support activity plans and utilisation of consultant job planning ▪ Education partnerships with formal agreements in place with West Notts College and Nottingham Trent University ▪ Director of People attendance at ICS People and Culture Board ▪ Workforce planning for system work stream ▪ Medical Transformation Board ▪ Nursing & Midwifery Transformation Board ▪ ICB Agency Reduction Group ▪ Communications issued regarding HMRC taxation rules on pensions and provision of pensions advice ▪ Pensions restructuring payment introduced ▪ Risk assessments for at-risk staff groups ▪ Refined and expanded Health and Wellbeing support system ▪ Communication of daily SitReps (Situation Reports) for workforce gaps ▪ CDC Workforce Group ▪ CDC Steering Group ▪ People Promises Exemplar Organisation	Workforce gaps across key areas such as Medical, Nursing, AHP and Maternity, which may impact on the quality and standard of care Lack of consistency across the system about recruitment and retention, creating competition and not maximising opportunities Inability to achieve the system workforce efficiency programme target	Deliver the People Strategy – Year 3 priorities and objectives **SLT Lead:** Director of People **Timescale:** March 2025 Work with provider collaborative colleagues to deliver the Vanguard programme in relation to workforce portability / passporting recruitment KPIs **SLT Lead:** Director of People **Progress:** Pilot for resident doctors ~~to~~ commenced in November **Timescale**: ~~November 2024~~March 2025 Deliver the plan to replace premium pay and agency staff with substantive workforce **SLT Lead:** Director of People **Timescale:** March 2025	**Management:** Quarterly Strategic Priority Report to Board; Nursing and Midwifery and AHP six monthly staffing report to People Committee; Workforce and OD ICS/ICP update quarterly; Quarterly Assurance reports on People and Culture to People Committee; Recruitment & Retention report monthly; Strategic People Plan to People Committee May24; Employee Relations Quarterly Assurance Report to People Committee; People Plan updates to People Committee bi-monthly; Leadership Development Strategy Assurance Report to People Committee quarterly; NHSE Planning – Workforce Perspective Report to People Committee May 24 **Risk and compliance:** Risk Committee significant risk report monthly; HR & Workforce planning report Risk Committee; IPR – Workforce Indicators to People Cabinet (monthly) - quarterly to Board; Bank and agency report (monthly); Guardian of safe working report to Board quarterly **Independent assurance**: Well-led report CQC; NHSI use of resources report; Recruitment of agency staff audit report Jun 23; Appraisals internal audit report Jun 24	Impact of the Trust workforce financial efficiency programme with enhanced controls regarding recruitment and a reduction in bank rates of pay (from 11th November 2024) Periodic review of the impact of cost and recruitment restrictions on staff safety and staffing levels **SLT Lead:** Director of People **Timescale:** March 2025 Potential impact of industrial unrest due to the job matching and profile review for Nursing and Midwifery staff Develop a working group to review the profiles and job descriptions **SLT Lead:** Director of People **Timescale:** March 2025 Engage with regional groups to ensure consistency of approach principles **SLT Lead:** Director of People / Chief Nurse **Timescale:** March 2026	Moderate Last changed September 2024

Board Assurance Framework (BAF): January 2025

Strategic threat (What might cause this to happen)	Primary risk controls (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	Plans to improve control (Are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gaps (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating
A significant loss of workforce productivity arising from a short-term reduction in staff availability or reduction in morale and engagement	▪ People Strategy 2022-2025 ▪ People Cabinet ▪ Chief Executive's blog / Staff Communication bulletin / Weekly #TeamSFH Brief ▪ Engagement events with Staff Networks (BAME, LGBTQ+, WAND, Carers, Women in Sherwood Wellbeing Champions) ▪ Schwartz rounds ▪ Learning from COVID ▪ Key recognition milestones and events ▪ Annual Staff Excellence / Admin Awards ▪ Divisional action plans from staff survey ▪ Policies (inc. staff development; appraisal process; sickness and relationships at work policy) ▪ Just and Restorative culture ▪ Influenza vaccination programme ▪ COVID-19 vaccination programme ▪ Staff wellbeing drop-in sessions ▪ Staff wellbeing support ▪ Staff counselling / Occ Health support including dedicated Clinical Psychologist for staff ▪ Enhanced equality, diversity and inclusion focus on workforce demographics ▪ Freedom to Speak Up Guardian and champion networks ▪ Emergency Planning, Resilience & Response (EPRR) arrangements for temporary loss of essential staffing (including industrial action and extreme weather event) ▪ Combined violence and aggression campaign across system partners ▪ Anti-racism Strategy ▪ Industrial action group further developing preparedness for the Trust, system and the wider community ▪ Winter Wellness Campaign ▪ Sexual safety working group ▪ Violence Prevention and Reduction Working Group	Inequalities in staff inclusivity and wellbeing across protected characteristics groups Continued staff exposure to violence and aggression by patients and service users Concerns over sexual safety in the workplace	Include actions to address inequalities in staff inclusivity within the new People Strategy **SLT Lead:** Director of People **Timescale:** April 2025 Develop and Implement the Violence Prevention and Reduction action plan **SLT Lead:** Director of People **Timescale:** March 2025 Review with Provider Collaborative Colleagues wellbeing offers and identify areas of duplication and gaps, developing recommendations for delivery at a system level – vanguard programme **SLT Lead:** Director of People **Progress:** ICB have commissioned Arden and Gem (CSU) to produce a report to identify gaps and create an action plan **Timescale**: ~~January 2025~~Complete People Promises work taking forward a plan to address sexual safety in the workplace **SLT Lead:** Director of People **Timescale:** March 2025	**Management:** Staff Survey Action Plan to Board Apr 24; Staff Survey Annual Report to Board Apr 24; Equality and Diversity Annual Report Jul 24; WRES and WDES report to People Committee Jul 24; Quarterly Assurance reports on People Cabinet to People Committee; Wellbeing report to People, Committee Mar 24; People Plan updates to People Committee quarterly; Leadership Report to People Committee Jul 24; Diversity in the Trust – Senior Leadership Roles report to People Committee May 24; Violence and Aggression Improvement Plan to People Committee Mar 24 **Risk and compliance:** EPRR Report (bi-annually); Freedom to speak up self-review Board Jul 24; Freedom to Speak Up Guardian report quarterly; Guardian of Safe Working report to Board quarterly; Significant Risk Report to RC monthly; Gender Pay Gap report to People Committee May 24; NHS Long Term Workforce Plan to People and Culture Committee Sep 23 and Strategic Workforce Plan update to People Committee May 24; Health and Wellbeing Campaign presented to People and Culture Committee Sep 23; Anti-Racism Strategy to Board Mar 22; Mental Health Strategy to PCI Committee Jun 22 **Independent assurance:** National Staff Survey Mar24; SFFT/Pulse surveys (Quarterly); Well-led report CQC; Well-led Review report to Board Apr 22; NHS People Plan – Focus on Equality, Diversity and Inclusion internal audit report Jun 22; Staff Wellbeing internal audit report Jan 24	Potential impact of cost-of-living issues, and the impending job matching and profile review for Nursing and Midwifery staff, on staff morale and wellbeing	Significant Last changed September 2024

Board Assurance Framework (BAF): January 2025

Principal risk (What could prevent us achieving this strategic objective)	**PR 4: Insufficient financial resources available to support the delivery of services** Financial funding allocated to and generated by the Trust does not cover the costs of services provided						**Strategic objective** Sustainable use of resources and estate
Lead committee	Finance	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Regulatory action
Lead director	Chief Financial Officer	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Cautious
Initial date of assessment	01/04/2018	**Likelihood**	~~4. Somewhat likely~~ 5. Very likely	3. Possible	2. Unlikely		
Last reviewed	28/01/2025	**Risk rating**	~~16~~20. **Significant**	**12. High**	**8. Medium**		
Last changed	28/01/2025						



Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Regulatory action due to a failure to deliver NHS England financial targets	▪ 2024/25 Financial Plan agreed with NHSE and ICB, in line with NHSE Revenue Control Limit ▪ Annual budgets based on available resources and stretching financial improvement targets ▪ Scheme of Delegation, Standing Financial Instructions and Executive oversight of commitments ▪ Budgetary Control Procedure Document, delivery of budget holder training workshops and monthly financial reporting ▪ Monthly Provider Finance Return and escalation meetings with NHSE as necessary ▪ Forecast sensitivity analysis and underlying financial position reported to Finance Committee ▪ Divisional Performance Reviews (bi-monthly) ▪ Divisional Finance Committees established in most divisions	Medium/Long Term Financial Strategy was developed pre-pandemic and does not reflect the current financial framework	Financial strategy for 3-5 years to be developed at a Trust and Integrated Care Board level **Progress:** ~~Financial Recovery Plan required to demonstrate financial sustainability by March 2026 in line with NHSE direction. Longer-term financial plan in development as part of strategic priorities, in line with clinical and operational strategies. Update scheduled for Finance Committee in October 2024~~ Finance Strategy presented at January Finance Committee for approval, and to be presented to Board in March **SLT Lead:** Deputy Chief Financial Officer **Timescale:** ~~October 2024~~March 2025	**Management:** Monthly Finance Report to Finance Committee Quarterly; Quarterly Integrated Performance Report to Board; ICS finance report to Finance Committee (monthly); NHSE updates to Finance Committee; Monthly variable pay reports to Trust Management Team; divisional representation at Finance Committee on a cyclical basis; Financial Efficiency reports to Executive Team weekly **Risk and compliance:** **Independent assurance**: NHS England Financial Controls Assessment (Sep 23); External Audit Year-end Report 2023/24 Internal Audit reports: - Improving NHS financial sustainability (Dec 22) - Key Financial Systems – Pay Expenditure (Jul 23) - Financial Governance - Financial Ledger and Reporting (Mar-24) - Budget Setting, Reporting and Monitoring (Jun-24) - Operational Planning (Jun-24) - Financial Improvement Plan – Efficiency & Productivity (Jun-24) - System Financial Controls (Jun-24)	Nottinghamshire system selected for NHSE initiated Investigation and Intervention Process (I&I) **Progress:** ~~Phase 1 (Investigation) report issued and discussed at Finance Committee and Board of Directors.~~ Phase 2 ~~commenced 16th September for a 12 week period~~concluded with close-down report presented to January Finance Committee. SFH evaluation to February Finance Committee. **Lead:** Chief Financial Officer **Timescale:** ~~December 2024~~March 2025	~~Positive~~ Moderate Last changed January ~~2024~~2025
	▪ NHSE Financial controls self-assessment completed and working group set up to undertake improvement actions ▪ Financial Resources Oversight Group (FROG) established and meeting monthly ▪ Vacancy Control panels in place ▪ Updated guidance on Discretionary Spend introduced ▪ Weekly 'Grip & Control Arbitration' panels established ▪ Financial Recovery Cabinet (monthly) and Financial Efficiency Review (weekly) meetings established	Risk adjusted efficiency forecast falls short of the annual target of £38.5m Financial Recovery Plan required to demonstrate a route to a break-even financial position by March 2026	De-risking programme underway on all schemes to increase confidence in delivery of the 2024/25 target. **Progress:** Weekly Financial Efficiency Oversight meetings and monthly Financial Recovery Cabinet established. Weekly reports shared with the Executive Team. As of 10th January, risk-adjusted forecast equates to 98.3% of target. **SLT Lead:** Chief Financial Officer **Timescale:** Ongoing with a target of December 2024 for a risk-adjusted forecast that meets the target Financial Recovery workstreams to be established, plan to be developed and appointments of Associate Director of Financial Recovery and Sustainability to be made **Progress:** ~~Initial workstreams set out and~~ Associate Director of Financial Recovery and Sustainability ~~role~~ recruited ~~(start date October 2024)~~			

Board Assurance Framework (BAF): January 2025

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
			Financial Recovery Plan for Q4 (including difficult decisions list) presented to January Finance Committee **SLT Lead:** Chief Financial Officer **Timescale:** March 2025 • ~~September 2024 – Financial Recovery Plan confirmed~~ • ~~September 2024 – Further resourcing requirements confirmed~~ • ~~October 2024 – Associate Director of Financial Recovery and Sustainability appointed~~ Develop a Financial Recovery Plan for 2025/26 **SLT Lead:** Chief Financial Officer **Timescale: March 2025**			
Cash availability leads to delays in paying suppliers and workforce	▪ Daily cash flow forecasts prepared ▪ Cash Management Policy to protect cash balances and establish prioritisation of payments ▪ NHS England process followed to access Revenue Support PDC ▪ Regular liaison with NHSE to support cash applications ▪ Financial Improvement Programme in place to deliver cash-releasing efficiencies ▪ Budgetary control processes and Scheme of Delegation in place to prevent overspends ▪ No Purchase Order, No Pay policy in place ▪ Escalation process to CFO/Deputy CFO for suppliers indicating restrictions on supply ▪ Weekly creditors report reviewed by Deputy CFO ▪	~~2024/25 Revenue Support applications have not been supported in full by NHSE~~	Meeting to be arranged with NHSE representatives to understand the risk and appeals process **Lead:** Deputy Chief Financial Officer **Timescale:** ~~October 2024~~Complete	**Management:** Monthly Finance Report to Finance Committee includes details on cash flow, debtors and creditors **Independent assurance**: NHS England Financial Controls Assessment (Sep 23) Internal Audit reports: - Key Financial Systems – Accounts Payable and Treasury and Cash Management (Mar-24) - Financial Governance – Financial Ledger and Reporting (Mar-24)		~~Positive~~ Limited ~~New threat added July 2024~~Last changed January 2025
ICB system financial performance challenge leads to disinvestment in SFH	▪ 2024/25 Financial Plan agreed with NHSE and ICB, in line with NHSE Revenue Control Limit ▪ ICS Directors of Finance Group established and attended by SFH Chief Financial Officer ▪ ICS Financial Recovery Group meeting weekly ▪ ICS System Opportunities Group meets bi-weekly, with SFH representation ▪ ICS Operational Finance Directors Group established and attended by SFH Deputy Chief Financial Officer ▪ ICB Financial Framework ▪ Close working with ICB partners to identify system-wide planning, transformation and cost reductions	ICB Medium/Long Term Financial Strategy to be developed	Financial strategy for 3-5 years to be developed at a Trust and Integrated Care Board level **Progress:** ~~Sustainability reviews to be completed through Q1/Q2 of 2024/25 to establish a route to sustainability~~Update to be provided in November 2024 with timeline for launch to be confirmed **SLT Lead**: Deputy Chief Financial Officer **Timescale:** ~~November 2024 (dependant on NHSE/I and ICB Guidance)~~March 2025	**Risk and compliance:** ICS financial reports to Finance Committee; ICS Board updates to SFH Trust Board **Independent assurance**: System Financial Controls Internal Audit report (Jun 24)	Impact of ICS partner financial recovery actions on SFH to be assessed Progress: Increasing prevalence of ICB savings that impact on SFH finances – CEO and CFO taking action to understand and mitigate this risk ~~Letter sent from the CFO to ICB confirming the SFH stance on actions that may adversely impact the Trust's financial position – awaiting response~~ **Lead:** Chief Financial Officer **Timescale:** Ongoing as recovery actions are developed	~~Positive~~ Moderate Last changed ~~July 2022~~ January 2025

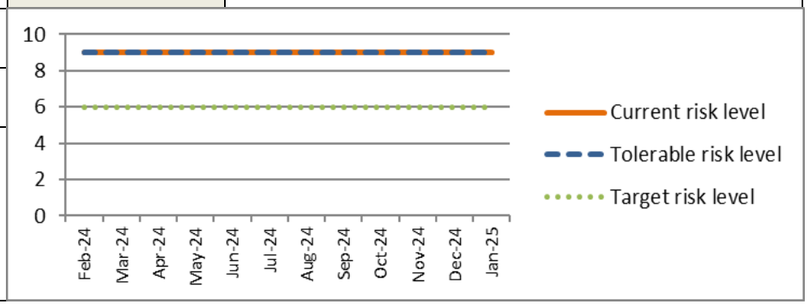
Board Assurance Framework (BAF): January 2025

Strategic threat (What might cause this to happen)	Primary risk controls (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	Plans to improve control (Are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gaps (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating
Insufficient capital resources to fund required infrastructure	▪ Capital Resources Oversight Group (CROG) overseeing capital expenditure plans ▪ Capital Prioritisation process established ▪ ICS Capital Management meetings in place to monitor spend and highlight risks			**Management:** Board approved 2024/25 Capital Expenditure Plan; Capital Resources Oversight Group highlight reports to Trust Management Team; Divisional risk reports to Risk Committee (bi-annually); Monthly Finance Report to Finance Committee includes details on capital expenditure **Risk and compliance:** Monthly Risk Committee significant risks report **Independent assurance**: Capital Internal Audit report Jul 24	Further Internal Audit of capital expenditure process to be undertaken by 360 Assurance to provide independent assurance. **Lead:** Head of Financial Services **Timescale:** ~~December 2024~~March 2025	Significant New threat added July 2024
Reliance on non-recurrent funding and efficiencies threatens long-term sustainability of services	▪ Improvement Faculty established to support the development and delivery of transformation and efficiency schemes ▪ Weekly Financial Efficiency update report to the Executive Team (and Monthly to Trust Management Team), detailing recurrent and non-recurrent savings ▪ Weekly Financial Efficiency Oversight meetings established ▪ Financial Recovery Cabinet in place to support longer-term decision making	Medium/Long Term Financial Strategy was developed pre-pandemic and does not reflect the current financial framework	Financial strategy for 3-5 years to be developed at a Trust and Integrated Care Board level **Progress:** ~~Longer-term financial in development as part of strategic priorities, in line with clinical and operational strategies, annual planning for 2024/25 in progress~~Finance Strategy presented at January Finance Committee for approval, and to be presented to Board in March **SLT Lead:** Chief Financial Officer **Timescale:** ~~September 2024~~March 2025 Planning and budget setting principles to be agreed to enable recurrent delivery of schemes currently deemed non-recurrent **SLT Lead:** Deputy Chief Financial Officer **Timescale:** March 2025	**Management:** Monthly Finance Report to Finance Committee includes details on financial efficiency; Divisional Performance Reviews (bi-monthly); Divisional risk reports to Risk Committee bi-annually; Improvement Cabinet highlight reports to Trust Management Team and Finance Committee **Independent assurance**: Internal Audit reports: - Improving NHS financial sustainability (Dec-22) - Financial Improvement Plan – Efficiency and Productivity (Jun-24)		Significant New threat added July 2024

Board Assurance Framework (BAF): January 2025

Principal risk (What could prevent us achieving this strategic objective)	**PR 5: Inability to initiate and implement evidence-based improvement and innovation** Lack of capacity, capability and agility to optimise strategic and operational opportunities to improve patient care						
Lead committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services
Lead director	Acting Director of Strategy and Partnerships	**Consequence**	**3. Moderate**	3. Moderate	3. Moderate	**Risk appetite**	Cautious
Initial date of assessment	17/03/2020	**Likelihood**	**3. Possible**	3. Possible	2. Unlikely		
Last reviewed	27/01/2025	**Risk rating**	**9. Medium**	**9. Medium**	**6. Low**		
Last changed	27/01/2025						

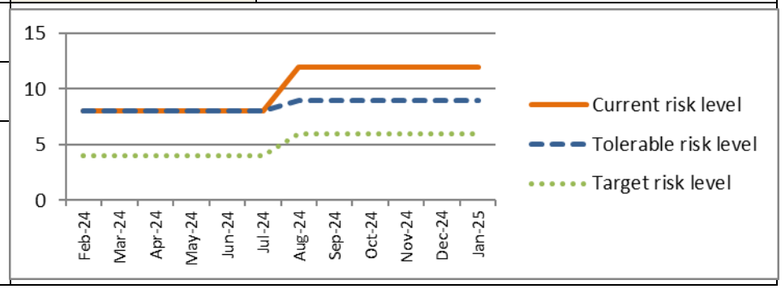
Strategic objective	Continuously learn and improve



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** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Lack of embedded improvement culture across the Trust resulting in suboptimal efficiency and effectiveness around how we provide care for patients	▪ Digital Strategy – overview of strategic digital improvement ▪ People Strategy – overview of strategic people development ~~▪ People Committee~~ ▪ Quality Strategy – overview of strategic quality development ▪ Quality Committee - Executive Director oversight on all aspects of quality ▪ Leadership development programmes - opportunity for Trust leaders to gain improvement skills ▪ Talent management map ▪ Strategy & Partnerships Cabinet – Executive Director oversight on all aspects of Improvement activity ▪ Ideas generator platform - easy-to-access mechanism to seek improvement support and advice ▪ Improvement Faculty - Single point of contact for all colleagues seeking improvement support ~~▪ Financial Recovery Programme~~ ▪ Financial Recovery Cabinet - Provides Executive Director oversight on all aspects of financial improvement activity ▪ Trust Board 'Improvement Showcase' - Increased awareness of improvement activity and sharing of good practice ▪ Quality, Service Improvement and Redesign Networks - informal forums to share knowledge, skills and experience	Continuous Quality Improvement Strategy not yet approved	Develop a process for clinical input for public and colleague engagement in improvement and transformation activities **Progress:** Process under development with the support of key stakeholders Recruited to key roles to support the process and plans in place to complete the documented process. To be reviewed to encompass the pending recommendations in the Darzi report **SLT Lead:** Acting Director of Strategy and Partnerships **Timescale:** February 2025 Develop and roll out a Continuous Improvement Strategy **Progress:** Paused until the new Improvement Director is in post **SLT Lead:** Acting Director of Strategy and Partnerships **Timescale:** April 2025	**Management:** Monthly Transformation and Efficiency report to FC; Improvement report to Quality Committee bi-monthly; NHS Impact Self-Assessment **Risk and compliance:** Strategic Priorities report to Board quarterly **Independent assurance:** 360 assessment in relation to Clinical Effectiveness - report May '22; Financial Improvement Plan - Efficiency and Productivity internal audit Jul 24		Moderate Last changed October 2022

Board Assurance Framework (BAF): January 2025

Principal risk (What could prevent us achieving this strategic objective)	**PR 6: Working more closely with health, care and educational partners, does not deliver the Trust's Improving Lives strategic objectives**							**Strategic objective**	Work collaboratively with partners in the community
Lead committee	Partnerships and Communities	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services		
Lead director	Acting Director of Strategy and Partnerships	**Consequence**	**3. Moderate**	3. Moderate	3. Moderate	**Risk appetite**	Cautious		
Initial date of assessment	01/04/2020	**Likelihood**	**4. Somewhat likely**	3. Possible	2. Unlikely				
Last reviewed	21/01/2025	**Risk rating**	**12. High**	**9. Medium**	**6. Low**				
Last changed	21/01/2025								



Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Competing priorities within SFH could result in a lack of commitment or contribution of resources to those partnerships that could contribute to the delivery of the Trust's priorities	▪ Trust's five-year strategy, Improving Lives, outlines strategic deliverables to focus Trust resources ▪ Alignment of Trust's Strategy with the ICS Joint Forward Plan ▪ Clinical Services Strategy established guiding principles and priorities ▪ Partnership Strategy and delivery plan with oversight on delivery by Strategy and Partnership Cabinet ▪ People Strategy identifies key people partnership priorities and priority partners ▪ Partnerships and Communities Committee oversight ▪ Partnership canvas tool structuring the planning and execution of partnerships ▪ Partnership database and annual evaluation ▪ Nottingham and Nottinghamshire Integrated Care System (ICS) priority aim of integration by default and continued engagement with Nottingham and Nottinghamshire Integrated Care Partnership (ICP) and the ICS planning and governance arrangements ▪ Quarterly ICS performance review with NHSE ▪ Joint Forward Plan, supporting workstreams and delivery group supporting partnership working ▪ Full alignment of organisational priorities with system planning ▪ ICS Finance Directors Group, ICS Planning Group and ICS System Oversight Group act as assurance and escalation route ▪ SFH Chief Executive is a member of the ICB as a partner member representing hospital and urgent & emergency care services ▪ Nottingham(shire) Provider Collaborative at Scale (NNPC) annual plan and programme resource. Oversight through the NNPC Distributed Executive Group and governance structure ▪ East Midlands Acute Providers (EMAP) Network annual plan and programme resource. Oversight of delivery and risks through the Chief Executive Forum and Executive Group ▪ Primary secondary care interface annual plan and oversight through the Interface Group with representatives from SFH and general practice ▪ Mid-Nottinghamshire Place-Based Partnership (MNPBP) annual place plan setting priorities and agreed actions	Workforce capacity to progress key partnership workstreams in provider collaboratives and place partnerships to progress clinical service strategy priorities on fragile services, workforce and health inequalities	Investigate opportunities to expand workforce capacity within the systems financial constraints **SLT Lead:** Director Strategy and Partnerships **Timescale:** ~~December 2024~~Complete Reflect constrained resources in plans and strategies for Years 2 to 5 **SLT Lead:** Director Strategy and Partnerships **Timescale:** ~~December 2024~~Complete Engage with the provider collaboratives strategic reviews to determine priorities **SLT Lead:** Director Strategy and Partnerships **Timescale:** February 2025	**Management:** ~~2023/24 strategy reporting (the "dials") to Board quarterly~~ Strategy and Partnership Cabinet chair's report to PCC ~~bi—monthly~~ Provider collaborative effectiveness updates to PCC ~~every four months~~ Partnership Delivery Plan updates to Strategy and Partnership Cabinet ~~monthly~~ Supporting strategy reporting to relevant sub committees ~~quarterly~~ 6-monthly MNPBP highlight reports to ~~Strategy and Partnership Cabinet and~~ Health Inequalities Steering Group quarterly Monthly HISG chair's report to Strategy and Partnership Cabinet ~~monthly~~ **Risk and compliance:** Significant Risks Report to Risk Committee monthly **Independent assurance**: 360 Assurance review of SFH readiness to play a full part in the ICS – Significant Assurance		Significant Threat updated August 2024

Board Assurance Framework (BAF): January 2025

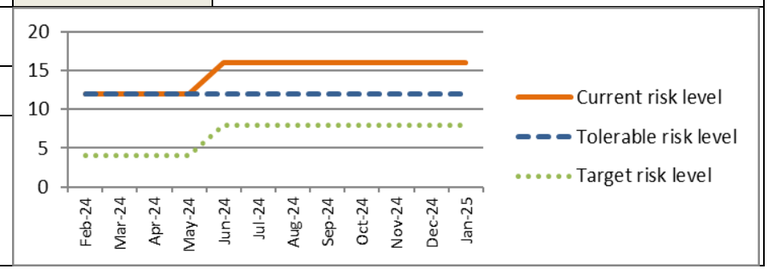
Strategic threat (What might cause this to happen)	Primary risk controls (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	Plans to improve control (Are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gaps (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating
	▪ Established PBP leadership arrangements in place of which SFH is a committed member including Mid-Nottinghamshire PBP Executive providing oversight and leadership ▪ Membership of and engagement with the three Place Boards in Ashfield, Mansfield and Newark and Sherwood agree plans, oversee delivery and agree shared resources					
Competing priorities within our partners could result in a lack of commitment or contribution of resources to those partnerships that could contribute to the delivery of the Trust's priorities	▪ Trust's five-year strategy, Improving Lives, outlines strategic deliverables to focus Trust resources ▪ Partnerships and Communities Committee oversight ▪ Partnership canvas tool structuring the planning and execution of partnerships ▪ Nottingham and Nottinghamshire Integrated Care System (ICS) priority aim of integration by default and continued engagement with Nottingham and Nottinghamshire Integrated Care Partnership (ICP) and the ICS planning and governance arrangements ▪ Quarterly ICS performance review with NHSE ▪ Joint Forward Plan, supporting workstreams and delivery group supporting partnership working ▪ Full alignment of organisational priorities with system planning ▪ ICS Finance Directors Group, ICS Planning Group and ICS System Oversight Group act as assurance and escalation route ▪ SFH Chief Executive is a member of the ICB as a partner member representing hospital and urgent & emergency care services ▪ Nottingham(shire) Provider Collaborative at Scale (NNPC) annual plan and programme resource. Oversight through the NNPC Distributed Executive Group and governance structure ▪ East Midlands Acute Providers (EMAP) Network annual plan and programme resource. Oversight of delivery and risks through the Chief Executive Forum and Executive Group ▪ Primary secondary care interface annual plan and oversight through the Interface Group with representatives from SFH and general practice ▪ Mid-Nottinghamshire Place-Based Partnership (MNPBP) annual place plan setting priorities, aligning resources and agreeing actions ▪ Established PBP leadership arrangements in place of which SFH is a committed member including Mid-Nottinghamshire PBP Executive providing oversight and leadership ▪ Membership of and engagement with the three Place Boards in Ashfield, Mansfield and Newark and Sherwood agree plans, oversee delivery and agree shared resources ▪ Formal partnership arrangements with Vision West Notts College and Universities of Nottingham	Workforce capacity to progress key partnership workstreams in provider collaboratives and place partnerships to progress clinical service strategy priorities on fragile services, workforce and health inequalities	Investigate opportunities to expand workforce capacity within the systems financial constraints **SLT Lead:** Director Strategy and Partnerships **Timescale:** ~~December 2024~~Complete Reflect constrained resources in plans and strategies for Years 2 to 5 **SLT Lead:** Director Strategy and Partnerships **Timescale:** ~~December 2024~~Complete Engage with the provider collaboratives strategic reviews to determine priorities **SLT Lead:** Director Strategy and Partnerships **Timescale:** February 2025	**Management:** Partnership Delivery Plan updates to Strategy and Partnership Cabinet MNPBP highlight reports to ~~Strategy and Partnership Cabinet and~~ Health Inequalities Steering Group as appropriate HISG chair's report to Strategy and Partnership Cabinet Monthly highlight reports from Notts Provider Collaborative to SFH executive lead East Midlands Acute Providers monthly update reports to EMAP Executive Group **Risk and compliance:** Significant Risks Report to Risk Committee monthly **Independent assurance**: 360 Assurance review of SFH readiness to play a full part in the ICS – Significant Assurance		Significant Threat updated August 2024

Board Assurance Framework (BAF): January 2025

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Limited SFH partnership engagement capacity could result in a missed opportunity to bring in a wider patient and citizen voice to shape future healthcare services	▪ Continued engagement with commissioners and ICS developments in clinical service strategies focused on prevention ▪ Partnership working at a more local level, including active participation in the Mid-Nottinghamshire PBP (MNPBP) and the district level Place Boards. ▪ ICS Clinical Services Strategy and Quality Strategy set priority re coproduction and personalised care ▪ ICS Health and Equality Strategy ▪ Nottingham and Nottinghamshire Joint Forward Plan, supporting workstreams and delivery group supporting partnership working ▪ ICS Clinical Services workstreams are well established across elective and urgent care and SFH is represented and involved appropriately ▪ SAIU dashboards and themed reports to focus on key priority areas for inputs and provide assurance of outputs and outcomes ▪ Clinical Directors and PCN Directors clinical partnership working ▪ Partnerships and Communities Committee (PCC) oversees delivery and receives assurance ▪ Partnership canvas tool structuring the planning and execution of partnerships ▪ SFH Health Inequalities Steering Group (HISG) linked to Mid Notts Health Inequalities Oversight Group to build relationships, share population health information and agree priorities and ICS Health Inequalities Steering Group, which facilitates sharing of patient/citizen voice and provides oversight of delivery	Workforce capacity to progress key partnership workstreams in provider collaboratives and place partnerships to progress clinical service strategy priorities on fragile services, workforce and health inequalities	Investigate opportunities to expand workforce capacity within the systems financial constraints **SLT Lead:** Director Strategy and Partnerships **Timescale:** ~~December 2024~~Complete Reflect constrained resources in plans and strategies for Years 2 to 5. **SLT Lead:** Director Strategy and Partnerships **Timescale:** ~~December 2024~~Complete Engage with the provider collaboratives strategic reviews to determine priorities **SLT Lead:** Director Strategy and Partnerships **Timescale:** February 2025	**Management:** Strategy and Partnership Cabinet chair's report to PCC Partnership Delivery Plan updates to Strategy and Partnership Cabinet Supporting strategy reporting to relevant sub committees MNPBP highlight reports to ~~Strategy and Partnership Cabinet and~~ HISG as appropriate HISG chair's report to Strategy and Partnership Cabinet **Independent assurance**: None currently in place		Significant Threat updated August 2024

Board Assurance Framework (BAF): January 2025

Principal risk (What could prevent us achieving this strategic objective)	**PR 7: Major disruptive incident** A major incident resulting in temporary hospital closure or a prolonged disruption to the continuity of core services across the Trust, which also impacts significantly on the local health service community							**Strategic objective**	Provide outstanding care in the best place at the right time
Lead committee	Risk	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services		
Lead director	Chief Executive Officer	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Cautious		
Initial date of assessment	01/04/2018	**Likelihood**	**4. Somewhat likely**	3. Possible	2. Unlikely				
Last reviewed	14/01/2025	**Risk rating**	**16. Significant**	**12. High**	**8. Medium**				
Last changed	14/01/2025								

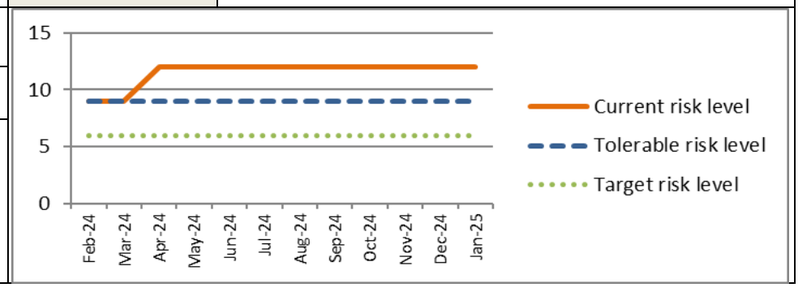


Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Shut down of the IT network due to a large-scale cyber-attack or system failure that severely limits the availability of essential information for a prolonged period	▪ Information Governance Assurance Framework (IGAF) & NHIS Cyber Security Strategy ▪ Cyber Security Programme Board & Cyber Security Project Group and work plan ▪ National Cyber Security Centre updates to Cyber Delivery Group ▪ High Severity Alerts issued by NHS Digital ▪ Network accounts checked after 50 days of inactivity – disabled after 80 days if not used ▪ Devices that have failed to take the most recent security patch checked after 21 days of inactivity – disabled after 28 days ▪ Major incident response plan in place ▪ Periodic phishing exercises carried out by 360 Assurance ▪ Spam and malware email notifications circulated ▪ Periodic cyber-attack exercises carried out by NHIS and the Trust's EPRR lead			**Management:** Data Security and Protection Toolkit submission to Board Jul 23- compliant on all 113 elements; DSPT updates to Information Governance Committee bi-monthly and Risk Committee 6-monthly; Hygiene Report to Cyber Security Board bi-monthly; Cyber Security Assurance Highlight Report to Cyber Security Board bi-monthly; NHIS report to Risk Committee quarterly; IG Bi-annual report to Risk Committee; Cyber Security report to Risk Committee – increased levels of attack due to the war in Ukraine Mar 22; NHIS Cyber Strategy approved at DSG May 24 **Risk and compliance:** Significant Risks Report to Risk Committee monthly **Independent assurance**: ISO 27001 Information Security Management Certification (NHIS) Mar24; 360 Assurance Data Security and Protection Toolkit audit Jun 23 – moderate assurance; Cyber Essentials Plus accreditation (NHIS) Dec 23	NHS-targeted cyber-attacks continue to be increased and there are inherent risks which are almost impossible to mitigate ~~Not fully assured that all business continuity processes are robust and fully tested in the event of prolonged system downtime~~ Review and test IT and business continuity processes **SLT Lead:** Chief Digital Information Officer **Timescale:** ~~December 2024~~Complete ~~Insufficient Board oversight of the risk and impact of cyber security~~ Cyber threat to be fully addressed at a Board Workshop **SLT Lead:** Chief Executive Officer **Timescale:** ~~October 2024~~Complete	~~Moderate~~ Limited Last changed ~~March 2024~~January 2025
A critical infrastructure failure caused by an interruption to the supply of one or more utilities (electricity, gas, water), an uncontrolled fire, flood or other climate change impact, security incident or failure of the built environment that renders a significant proportion of the estate inaccessible or unserviceable, disrupting services for a prolonged period	▪ Premises Assurance Model ▪ Estates Strategy 2015-2025 ▪ PFI Contract and Estates Governance arrangements with PFI Partners ▪ Fire Safety Policy ▪ Health Technical Memorandum governance structure ▪ NHS Supply Chain resilience planning ▪ Emergency Preparedness, Resilience & Response (EPRR) arrangements at regional, Trust, division and service levels ▪ Operational strategies & plans for specific types of major incident (e.g. industrial action; fuel shortage; pandemic disease; power failure; severe winter weather; evacuation; CBRNe) ▪ Gold, Silver, Bronze command structure for major incidents ▪ Business Continuity, Emergency Planning & security policies ▪ Resilience Assurance Committee (RAC) oversight of EPRR	~~Gaps in controls and processes identified in the 2022 Fire Safety Management audit~~	Finalise and issue the Trust Fire Safety Strategy documents **Progress:** Gaps in controls addressed – documents to be considered by the Operational Fire Safety Group in February **SLT Lead:** Chief Financial Officer **Timescale:** ~~December 2024~~February 2025	**Management:** Central Nottinghamshire Hospitals plc monthly performance report; Fire Safety Annual Report; Fire Safety reports to Risk Committee quarterly **Risk and compliance:** Significant Risks Report to Risk Committee monthly **Independent assurance:** Premises Assurance Model to Executive Team Oct 22; EPRR Core standards compliance rating (Oct22) – Substantial Assurance; MEMD ISO 9001:2015 Recertification (3-year) Mar 21; British Standards Institute MEMD Assessment Report Feb 22; External cladding report to Executive Team Jan 24; ARUP Fire Surveys included in Annual Fire Safety report to Risk Committee Apr 24; ARUP Milestone 2 (Fire) Reports issued in draft July 2024 for review	Inconclusive evidence of buildings cladding and structures compliance with fire regulations Determine the remedial work required to ensure that the cladding is compliant with fire regulations **Progress:** It has now been agreed by Project Co. that the existing cladding will be replaced in full, programme currently being updated to take into account the new Building Safety Act. Program is on track due for completion June 2025. **SLT Lead**: Associate Director of Estates & Facilities	Moderate Last changed March 2024

Board Assurance Framework (BAF): January 2025

Strategic threat (What might cause this to happen)	Primary risk controls (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	Plans to improve control (Are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gaps (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating
	▪ Independent Authorising Engineer (Water) and other HTM Specialties ▪ Major incident response plan in place				**Timescale:** ~~October 2024~~June 2025 Trust actions required from the ARUP Milestone 2 (Fire) Report **Progress:** An overarching risk assessment ~~is to be~~ produced for each site highlighting the common themes/issues that have come out of the draft report and to be discussed with all areas. ~~ARUP fee proposal received – CNH approaching other companies for costs~~ Execs ~~to be~~ briefed on the ARUP findings on 4th September. Awaiting final version from CNH following Trust comments. **SLT Lead**: Associate Director of Estates & Facilities **Timescale:** ~~October 2024~~February 2025	
Severe restriction of service provision due to a significant operational incident or other external factor	▪ Emergency Preparedness, Resilience & Response (EPRR) arrangements at regional, ICS, Trust, division and service levels ▪ Operational strategies & plans for specific types of major incident (e.g. industrial action; fuel shortage; pandemic disease; power failure; severe weather; evacuation; CBRNe) ▪ Gold, Silver, Bronze command structure for major incidents ▪ Business Continuity, Emergency Planning & security policies, including new Business Continuity Management system ▪ Resilience Assurance Committee (RAC) oversight of EPRR ▪ Major incident response plan in place ▪ Industrial Action Group ▪ Annual Core Standards Process (NHSE & ICB), with follow up report to Board ▪ Annual CBRN Audit (EMAS) ▪ Three-yearly internal audit of EPRR arrangements with report to Board ▪ Incident Response and command and control training to all tactical and strategic leads across the organisation carried out annually ▪ Testing and exercising of service level plans carried out annually ▪ Health Risk Management Group for EPRR	~~The current Business Continuity Management System (BCMS) does not meet the requirements of the Core Standards~~	Embed the updated BCMS within all divisions **SLT Lead**: Chief Operating Officer **Timescale:** ~~December 2024~~Complete	**Management:** Industrial Action debrief report to Executive Team Mar 23, and following each subsequent period of industrial action; Monthly Quadrant Report into Risk Committee **Independent assurance:** EPRR Core standards compliance rating ~~2023~~2024 – ~~Partial~~Substantial Compliance; EPRR Business Continuity internal audit report Nov 24 – Significant assurance; CBRN Audit carried out in March 2024 by EMAS	Improve compliance rating with Core Standards from “Partial” to “Substantial” **SLT Lead**: Chief Operating Officer **Timescale:** ~~October 2024~~Complete	Significant New threat added May 2023

Board Assurance Framework (BAF): January 2025

Principal risk (What could prevent us achieving this strategic objective)	**PR 8: Failure to deliver sustainable reductions in the Trust's impact on climate change** The vision to further embed sustainability into the organisation's strategies, policies and reporting processes by engaging stakeholders and assigning responsibility for delivering the actions within our Green Plan may not be achieved or achievable							**Strategic objective**	Improve health and wellbeing within our communities
Lead committee	Finance	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Reputation / regulatory action		
Lead director	Chief Financial Officer	**Consequence**	**3. Moderate**	3. Moderate	3. Moderate	**Risk appetite**	Cautious		
Initial date of assessment	22/11/2021	**Likelihood**	**4. Somewhat likely**	3. Possible	2. Unlikely				
Last reviewed	28/01/2025	**Risk rating**	**12. High**	**9. Medium**	**6. Low**				
Last changed	28/01/2025								

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Failure to take all the actions required to embed sustainability and reduce the impact of climate change on our community (may be due to capacity and/or capability)	▪ Estates & Facilities Department oversee the plan and education on climate change impacts ▪ Green Plan 2021-2026 ▪ Climate Action Project Group ▪ Sustainability Development Operational Group (SDOG) and Sustainability Development Strategy Group (SDSG) ▪ Engagement and awareness campaigns (internal/external stakeholders) ▪ Estates Strategy ▪ Digital Strategy ▪ Capital Planning sustainability impact assessments ▪ Environmental Sustainability Impact Assessments built into the Project Implementation Documentation process ▪ Engagement with the wider NHS sustainability sector for best practice, guidance and support ▪ Process in place for gathering and reporting statistical data ▪ Adoption of NHS Net Zero building standard 2023 for all works from October 2023 ▪ Awareness to, and applications for, funding sources both internally and externally such as the Public Sector Decarbonisation Scheme and grants from Salix Ltd ▪ Annual Travel Survey ▪ Display energy certificates ▪ Building Research Establishment Environmental Assessment Methodology ▪ Net Zero Strategy ▪ Regular updates through Comms on the screen savers (included lighting, bees, waste etc.)	~~Dedicated capacity to implement ideas for change~~ Insufficient capital resource available to realise Trust ambition Support from our PFI partners in developing 'green' solutions	Additional resource **Progress**: Junior Energy Manager Apprentice and Sustainability Apprentice are being worked up for advertisement in Autumn 2024 **Lead**: Hard FM Manager **Timescale:** ~~October2024~~Complete CROG Scheme Bids: Ensure there are sufficient schemes developed and feasibilities undertaken to ensure the validity of the bids that are to be taken forward to Business Case Level **Progress:** Several CROG applications rejected due to lack of funds. Considering external EV & Solar 'rental' schemes but progress has been impeded by IFRS16 considerations. Attended Geothermal meetings but awaiting advice via Heat Decarbonisation Plan on the best system for SFH **Lead:** Sustainability Officer **Timescale:** ~~March 2025~~Complete PFI Partners: Engage with our PFI provider and relevant parties to develop a combined energy reduction plan associated with the financial close out of the deed, retained estate upgrades, lifecycle developments and how all these aspects will support SFH in its energy/sustainability targets. **Progress:** Awaiting PFI settlement & changes in Skanska personnel **Lead:** Sustainability Officer **Timescale:** ~~October2024~~January 2025	**Management:** Green updates provided routinely to Finance Committee via SDSG **Risk and compliance:** Green Plan to Board Apr 21; Sustainability Report included in the Trust Annual Report **Independent assurance:** ERIC returns and benchmarking feedback	Car Parking Strategy: To be developed for the long-term solution to KMH, MCH and NH **Lead:** Associate Director of Estates and Facilities **Timescale:** ~~December 2024~~April 2025 Travel Plan: To be developed for the long-term solution to KMH, MCH and NH **Lead:** Associate Director of Estates and Facilities **Timescale:** ~~December 2024~~April 2025 Display Energy Certificates Review all certificates and what actions need to be taken to improve the Energy Efficiency of the buildings. **Lead:** Sustainability officer **Timescale:** ~~September 2024~~Complete Energy / Sustainability Business Cases: Ensure business case schemes are all worked up and ready to be issued if further funding becomes available through various government routes **Lead:** Sustainability officer **Timescale:** ~~November 2024~~Complete ICS identified SFH had very poor LED lighting as a percentage nationally **Progress:** Skanska have now commenced LED lighting upgrades. To be monitored via E&F Monthly KPI Dashboard **Lead:** Sustainability officer **Timescale**: ~~To Be Agreed with Skanska~~Complete	Moderate Last changed December 2023