# BOARD ASSURANCE FRAMEWORK JANUARY 2023

**BAF SUMMARY** Contents of this summary table (p.1-2) are hyperlinked to full BAF (at p.3 onwards).

| REF. | LEAD EXEC. DIRECTOR (ED) / MONITORING COMMITTEE | RISK | CURRENT RATING | TARGET | MOVEMENT | REVIEW BY COMMITTEE |
|---|---|---|---|---|---|---|
| **1. Quality - Deliver the best possible care and outcomes** | | | | | | |
| 1.1 | Chief Nurse / Quality Committee | **Triangulating data and learning to drive Quality Improvement** A failure to triangulate different sources of quality data and learning to inform and drive the quality improvement programme could result in patient harm, impaired outcomes, and/or poor patient experience. | 12 | 8 | ↔ | 10/11/22 |
| 1.5 | Exec MD for MH & LD / Quality Committee | **Unavailability of beds/demand and capacity (Mental Health inpatient and LD)** Unavailability of beds (across all mental health inpatient services, including Adult MH & LD, and CAMHS, PICU, ED & GAU) due to: demand outstripping capacity and/or absence of support services in the community to prevent admissions and/or facilitate prompt discharge, could lead to: (i) increase in out of area placements further from home, (ii) inappropriate inpatient placements; (iii) patients being unable to access specialist care required to support recovery; (iv) patients and carers/families having a poor experience; and (v) services falling below reasonable public expectations. | 16 | 8 | ↑ | 10/11/22 |
| 1.6 | Exec MD Primary Care & Community / Quality Committee | **Demand and capacity (Community Oxfordshire)** [*RISK UNDER REVIEW*] Risk that the population's continuously changing need for service exceeds the Trust's capability and capacity to respond in a timely way. Where there are instances of demand outstripping supply, there is a risk that waitlists will grow, quality and safety of care will be compromised, the needs of the service users could be insufficiently met and this will lead to poorer health outcomes and experiences. | 16 | 12 | ↔ | 10/11/22 |
| **2. People - Be a great place to work** | | | | | | |
| 2.1 | Chief People Officer / PLC | **Workforce Planning** Insufficient or ineffective planning for current and future workforce requirements (including number of staff, skill-mix and training) may lead to: impaired ability to deliver the quantity of healthcare services to the required standards of quality; and inability to achieve the business plan and strategic objectives. | 16 | 9 | ↔ | 13/10/22 |
| 2.2 | Chief People Officer / PLC | **Recruitment** A failure to recruit to vacancies could lead to: the quality and quantity of healthcare being impaired; pressure on existing staff and decreased resilience, health & wellbeing and staff morale; over-reliance on agency staffing at high cost/premiums and potential impairment in service quality; and loss of the Trust's reputation as an employer of choice. | 16 | 9 | ↔ | 13/10/22 |
| 2.3 | Chief People Officer / PLC | **Succession planning, organisational development and leadership development** Failure to maintain a coherent and co-ordinated structure and approach to succession planning, organisational development and leadership development may jeopardise: the development of robust clinical and non-clinical leadership to support service delivery and change; the Trust becoming a clinically-led organisation; staff being supported in their career development and to maintain competencies and training attendance; staff retention; and the Trust being a "well-led" organisation under the CQC domain | 12 | 4 | ↔ | 13/10/22 |

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| 2.4 | Chief People Officer<br>PLC | **Culture in line with Trust values**<br>A failure to develop and maintain our culture in line with the Trust values and the NHS people promise which includes: being compassionate and inclusive, recognition and reward, having a voice that counts, health, safety & wellbeing of staff, working flexibly, supporting learning & development, promoting equality, diversity & inclusivity and fostering a team culture. The absence of this could result in; harm to staff; an inability to recruit and retain staff; a workforce which does not reflect Trust and NHS values; and poorer service delivery. | 9 | 4 | ↔ | 13/10/22 |
| 2.5 | Chief People Officer<br>PLC | **Retention of staff**<br>A failure to retain permanent staff could lead to: the quality of healthcare being impaired; pressure on staff and decreased resilience, health & wellbeing and staff morale; over-reliance on agency staffing at high cost/premiums and potential impairment in service quality; and loss of the Trust's reputation as an employer of choice. | 12 | 9 | ↔ | 13/10/22 |

| **3. Sustainability - Make the best use of our resources and protect the environment** | | | | | | |
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| 3.1 | Executive Director of Strategy & Partnerships<br>Quality Committee | **Failure of the Trust to: (i) engage in shared planning and decision-making at system and place level; and (ii) work collaboratively with partners to deliver and transform services at place and system-level**<br>[Formerly - Failure of the Health and Social Care Place Based, Integrated Care Systems and Provider Collaboratives to work together]<br>Failure of the Trust to: (i) engage in shared planning and decision-making at system and place level; and (ii) work collaboratively with partners to deliver and transform services at place and system-level. Such failure would lead to ineffective planning and unsuccessful delivery and transformation of services in the Systems we operate in, and in turn impact both the sustainability and quality of healthcare provision in these Systems and in the Trust. | 12 | 9 | ↔ | 10/11/22 |
| 3.2 | Executive Director of Strategy & Partnerships<br>Quality Committee | **Governance of external partners**<br>[*RISK UNDER REVIEW – see detail in main body*]<br>Failure to manage governance of external partners effectively, could: compromise service delivery and stakeholder engagement; lead to poor oversight of risks, challenges and relative quality amongst partners; and put at risk the Trust's integrity, reputation and accountability to its stakeholders and credibility as a system leader and partner of choice. | 9 | 9 | ↔ | 10/11/22 |
| 3.4 | Chief Finance Officer<br>Finance & Investment | **Delivery of the financial plan and maintaining financial sustainability**<br>Failure to deliver financial plan and maintain financial sustainability, including, but not limited to: through non-delivery of CIP savings; budget overspends; under-funding and constraints of block contracts in the context of increasing levels of activity and demand, could lead to: an inability to deliver core services and health outcomes; financial deficit; intervention by NHS Improvement; and insufficient cash to fund future capital programmes. | 16 | 12 | ↔ | 22/11/22 |
| 3.6 | Director of Corporate Affairs & Co Sec<br>Audit Committee | **Governance and decision-making arrangements**<br>Failure to maintain and/or adhere to effective governance and decision making arrangements, and/or insufficient understanding of the complexities of a decision may lead to: poor oversight at Board level of risks and challenges; (clinical or organisational) strategic objectives not being established or achieved; actual or perceived disenfranchisement of some stakeholders (including members of the Board, Governors and/or Members) from key strategic decisions; or damage to the Trust's integrity, reputation and accountability. | 12 | 4 | ↑ | 23/02/22 |

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|---|---|---|---|---|---|---|
| 3.7 | Executive Director of Strategy & Partnerships<br>Finance & Investment | **Ineffective business planning arrangements**<br>Ineffective business planning arrangements may lead to: the Trust failing to achieve its strategic ambition; problems and issues recurring rather than being resolved; reactive rather than pro-active approaches; decision-making defaulting to short-termism; and inconsistent work prioritisation, further exacerbated by the challenge of limited resources, impacting upon staff frustration and low morale. | 12 | 6 | ↔ | 22/11/22 |
| 3.10 | Executive Director for Digital & Transformation<br>Finance & Investment | **Information Governance & Cyber Security**<br>Failure to protect the information we hold as a result of ineffective information governance and/or cyber security could lead to: personal data and information being processed unlawfully (with resultant legal or regulatory fines or sanctions), cyber-attacks which could compromise the Trust's infrastructure and ability to deliver services and patient care, especially if loss of access to key clinical systems; data loss or theft affecting patients, staff or finances; reputational damage. | 12 | 9 | ↔ | 22/11/22 |
| 3.11 | Executive Director for Digital & Transformation<br>Finance & Investment | **Business solutions in a single data centre**<br>The Trust has an extensive amount of business solutions residing in a single data centre. Failure of that single data centre could result in a number of Trust IT systems becoming unavailable to staff, with the Trust having no direct control over the restoration of services. | 9 | 4 | ↓ | 22/11/22 |
| 3.12 | Director of Corporate Affairs & Co Sec<br>Emergency Planning Group (sub-group to Executive Management Committee) and Audit Committee from 2022 | **Business continuity and emergency planning**<br>Failure to maintain adequate business continuity and emergency planning arrangements in order to sustain core functions and deliver safe and effective services during a wide-spread and sustained emergency or incident, for example a pandemic, could result in harm to patients, pressure on and harm to staff, reputational damage, regulator intervention. | 12 | 9 | ↔ | 23/02/22 |
| 3.13 | Executive Director for Digital & Transformation<br>Finance & Investment | **The Trust's impact on the environment**<br>A failure to take reasonable steps to minimise the Trust's adverse impact on the environment, maintain and deliver a Green Plan, and maintain improvements in sustainability in line with national targets, the NHS Long Term Plan and 'For a Greener NHS' ambitions (30%, 50% and 80% reduction in emissions by 2023, 2025 and 2030 respectively, and net zero carbon by 2040), could lead to: a failure to meet Trust and System objectives, reputational damage, loss of contracts, contribution to increased pollution within the wider community, and loss of cost saving opportunities. | 9 | 3 | ↔ | 22/11/22 |
| 3.14 | Chief Finance Officer and Executive Director for Digital & Transformation<br>Finance & Investment | **Major Capital Projects**<br>Insufficient programme infrastructure (or project management) to resource delivery of major capital projects or to support a necessary control environment and adherence to governance and decision-making arrangements may lead to: poorly planned and ultimately compromised capital projects; inability to proceed with capital projects; failure of capital projects to complete or to deliver against preferred outcomes; and unplanned expenses, delays and wasted resources, effectively amounting to constructive losses. | 16 | 6 | ↔ | 22/11/22 |
| **4. Research & Education - Become a leader in healthcare research and education** | | | | | | |
| 4.1 | Chief Medical Officer<br>Quality Committee | **Failure to realise the Trust's Research and Development (R&D) potential**<br>Failure to fully realise the Trust's academic and Research and Development (R&D) potential may adversely affect its reputation and lead to loss of opportunity. | 6 | 3 | ↔ | 10/11/22 |

# BOARD ASSURANCE FRAMEWORK JANUARY 2023

**Risk rating matrix and scoring guidance appears at Appendix 1**

# Strategic Objective 1: Deliver the best possible care outcomes

## 1.1: Triangulating data and learning to drive Quality Improvement

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| Date added to BAF | 10 February 2022 |
| Monitoring Committee | Quality Committee |
| Executive Lead | Chief Nurse |
| Date of last review | 10/02/22 |
| Risk movement | ↔ |
| Date of next review | November 2022 |

| | Impact | Likelihood | Rating |
|---|---|---|---|
| Gross (Inherent) risk rating | 4 | 5 | 20 |
| **Current risk rating** | **4** | **3** | **12** |
| Target risk rating | 4 | 2 | 8 |
| Target to be achieved by | | | |

**Risk Description:**
A failure to triangulate different sources of quality data and learning to inform and drive the Quality Improvement (QI) programme could result in patient harm, impaired outcomes, and/or poor patient experience.

[Formerly pre-10 February 2022: Failure to (i) meet quality standards for clinical care; (ii) continuously improve care quality and safety; and/or (iii) engage patients and carers in that care, could result in patient harm, impaired outcomes, and poor experience.]

| Key Controls | Assurance | Gaps | Actions |
|---|---|---|---|
| - Use of TOBI (Trust Online Business Intelligence) data from ward to Board level;<br>- Quality & Safety Dashboard;<br>- Integrated Performance Report to Board;<br>- Oxford Healthcare Improvement (**OHI**) Centre;<br>- Quality Improvement (**QI**) Hubs, supported by QI Hub Programme Board and QI & Learning Group;<br>- QI strategy implementation plan as part of wider Trust QI Strategy;<br>- Clinical Audit team transferred to management under the Head of QI (since Q1 FY23);<br>- Weekly Review Meeting triangulating incidents, complaints, deaths/inquests, claims, CAS alerts etc;<br>- Mechanisms for feedback, including 'I Want Great Care' surveys, PALS, complaints and patient stories, and | **Level 1: reassurance**<br>- QI Hubs meet monthly and report into QI & Learning Group to share progress and learning across Hubs;<br>- Monthly Directorate Quality Groups;<br>- Weekly Safety Forums;<br>- Complex Review panels.<br>**Level 2: internal**<br>- Quality & Safety Dashboard regularly reported into Quality Committee;<br>- Integrated Performance Report to Board;<br>- Quality Committee;<br>- Quality & Clinical Governance Sub-Committee;<br>- Weekly Review Meeting (Clinical Standards);<br>- Patient Safety Incident (PSI) updates and review reports at Quality Committee and private Board;<br>- Patient Experience/ Experience & Involvement updates into Quality Committee; | GAP (controls): embedding QI as part of Trust culture still an ongoing process; and appropriate resourcing required to support and maintain the OHI Centre in order to support ambition to embed QI.<br>ACTIONS: To sustain momentum and support continuous and sustainable improvements a review of OHI Centre resource and capacity was undertaken during Q4 FY22 with an options appraisal presented in Q1 FY23 to the Executive to consider support and direction for QI going forwards; options appraisal decision in progress.<br>OWNER(s): Head of QI; and Chief Nurse | QI activity as at Q1 FY23: 165 staff, service users and carers had attended QI training during Q1; and 106 QI projects underway (more detailed QI reporting provided into the Quality Committee in July 2022).<br><br>(1) Embed use of Quality Dashboard to identify areas for improvement and prioritise QI workstreams;<br>(2) continued roll out of QI Hubs and QI Hub Programme Board as vehicles to pick up learning;<br>(3) Engage & train frontline staff in use QI methodology to improve service concerns raised through PSIs. Q1 FY23 saw the launch of OHI Level 1 QI online training module for staff, service users and carers to increase the spread of awareness of QI;<br>(4) External review from peer QI team to benchmark our |

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| Trust-wide Experience & Involvement Group;<br>- Experience & Involvement Strategy;<br>- New framework for incidents incl. safety huddles, after action learning reviews and thematic reviews;<br>- central monitoring of progress of Patient Safety Incident (**PSI**), complaints and inquest actions;<br>- Whistleblowing Policy & Freedom to Speak Up Guardian;<br>- Journey to Outstanding internal review self-assessments. | - OHI Centre/QI updates into Quality Committee;<br>- Annual Quality Account.<br>**Level 3: independent**<br>-- CQC Inspections;<br>- Patient/carer feedback, incl. 'I Want Great Care' results;<br>- Quality Account signed off by Local Authorities;<br>- Annual National Community Mental Health Survey results;<br>- Multi-agency review processes e.g. Homicide Reviews, inquests, CDOP;<br>- performance against national NHS Oversight Framework indicators. | | progress and plan for the future;<br>(5) Complete targeted peer reviews following findings of Journey to Outstanding internal review self-assessments;<br>(6) Continue to improve quality of and access to TOBI data so areas for improvement can be identified more easily<br>OWNER: Chief Nurse. |

# Strategic Objective 1: Deliver the best possible care outcomes

## 1.5: Unavailability of beds/demand and capacity (Mental Health inpatient and LD)

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| Date added to BAF | Pre-Jan 2021 |
| Monitoring Committee | Quality Committee |
| Executive Lead | Executive Managing Director for Mental Health & Learning Disabilities |
| Date of last review | 25/10/22 |
| Risk movement | ↑ |
| Date of next review | November 2022 |

| | Impact | Likelihood | Rating |
|---|---|---|---|
| Gross (Inherent) risk rating | 4 | 5 | 20 |
| **Current risk rating** | **4** | **4** | **16** |
| Target risk rating | 4 | 2 | 8 |
| Target to be achieved by | | | |

**Risk Description:**
**Unavailability of beds** (across all mental health inpatient services, including Adult MH & LD, and CAMHS, PICU, ED & GAU) due to: demand outstripping capacity and/or absence of support services in the community to prevent admissions and/or facilitate prompt discharge, could lead to: (i) increase in Out of Area Placements (**OAPs**) further from home, (ii) inappropriate inpatient placements; (iii) patients being unable to access specialist care required to support recovery; (iv) patients and carers/families having a poor experience; and (v) services falling below reasonable public expectations.

| Key Controls | Assurance | Gaps | Actions |
|---|---|---|---|
| - Clinical oversight and review of patients considered to be in an inappropriate bed via Clinical Directors;<br>- proactive management of flow and Out of Area Placements (OAPs);<br>- single point of access for provider collaborative network beds;<br>- robust CPA (Care Programme Approach) planning;<br>- system partner calls to improve discharge;<br>- Roll out of Crisis Resolution, Home Treatment, Early Intervention, Intensive Support and Hospital at Home teams to prevent admission and support earlier discharge;<br>- SOPs/processes in place for any Young Person in seclusion or Long Term Segregation, | **Level 1: reassurance**<br>- Directorate SMT monitoring;<br>- Provider Collaborative Single Point of Access monitoring (weekly);<br>- weekly regional calls for CAMHS<br>**Level 2: internal**<br>- Review of incidents, restraints, seclusions and inappropriate use of s.136 by Heads of Nursing and through Weekly Review Meeting; escalation to OMT and Exec;<br>- OAPs trajectory monitoring internally through Directorate OMT and Executive;<br>- Integrated Performance Report to Board (May 2022) highlighted that Acute | Restricted capacity and instances of long waits for young people requiring CAMHS & Psychiatric Intensive Care Unit (**PICU**) beds. PICU project paused in June 2021, subject to external review December 2021, actions subject to further follow-up January-April 2022 (through Finance & Investment Committee, Audit Committee and Board), likely to miss target of May 2022.<br><br>Restricted capacity leading to long waits for admission to Adult ED units, resulting in patients with very low BMIs being managed in the community or acute hospitals. | Board reviewed PICU project at its meeting in private in May 2022 and received assurance that programme and project governance strengthened. Monthly Programme Board now in place. New target for PICU scheme to complete by 2023.<br><br>Adult Eating Disorder (ED) service to extend and develop Day Hospital and Hospital at Home offerings. In March 2022 there was a surge in referrals to the Thames Valley T4 CAMHS Provider Collaborative (TVPC), particularly for ED services but as at May 2022 this had |

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| including Clinical Director reviews;<br>- Transformation programme to improve flow and reduce length of stay.<br>- Initiation optimisation programmes for Oxfordshire Adult wards. This looks at the process from patient admission to discharge with a view to improving the average length of patient stay which will in turn increase capacity. | OAPs continued to be a challenge and the combined appropriate and inappropriate OAPs for April 2022 were higher than any month in the previous year. Following recent NHSE guidance the Trust has reviewed the use of OAPs and is assured that continuity of care principles adhered to. | | settled. There was a similar increase in other South East areas; the TVPC achieved the biggest reduction in pre-admission demand between March-May. The TVPC established the Hospital at Home ED (H@H ED) pilot with views to reducing the need for T4 admission for ED treatment. As at May 2022, pilot has been successful and the H@H ED is expanding and will recruit further nurses. |
| | **Level 3: independent**<br>NHSE reporting and monitoring of progress against OAPs trajectories.<br><br>South East Integrated Performance Report (06 May 2022):<br>- Trust Adult bed occupancy lowest in the region (averaging 87% compared to region average of 96.1%);<br>- Older Adult bed occupancy amongst highest in the region (averaging 92% compared to region average of 89.3%);<br>- PICU bed occupancy amongst lowest in region (averaging 64% compared to region average 78.1%) | National reduction in Assessment & Treatment Unit (ATU) beds and estate does not enable support for individuals with LD or autism requiring reasonable adjustments or a single person placement.<br><br>Reduced bed capacity as a result of Infection Prevention Control (IPC) guidance; up to 15% less capacity in the Adult and Older Adult Mental Health wards. The interim closure of beds has resulted in additional OAPs which have been mitigated by purchasing block contract beds. | Business plans for revenue and capital has commenced.<br>LD services to continue to provide specialist LD support to mainstream mental health wards to facilitate reasonable adjustments. OWNER: Executive MD for Mental Health & Learning Disabilities<br><br>Work with partners within place and at BOB level to secure a specialist LD/autism beds and local crash pads;<br>OWNER: Executive MD for Mental Health & Learning Disabilities;<br>Target date: March 2022<br><br>In April 2022, changes to IPC guidance have allowed the facilitation of patients who have completed their 14 day period of isolation and are COVID negative to be repatriated to vacant Trust beds, therefore, maximising bed capacity and reducing the need to purchase further inappropriate OAP. |

# Strategic Objective 1: Deliver the best possible care outcomes

## 1.6: Demand and capacity (Community Oxfordshire)

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| Date added to BAF | Pre-Jan 2021 |
| Monitoring Committee | Quality Committee |
| Executive Lead | Executive MD for Primary Care and Community |
| Date of last review | May 2022 |
| Risk movement | ↔ |
| Date of next review | November/December 2022 |

| | Impact | Likelihood | Rating |
|---|---|---|---|
| Gross (Inherent) risk rating | 4 | 5 | 20 |
| **Current risk rating** | **4** | **4** | **16** |
| Target risk rating | 4 | 3 | 12 |
| Target to be achieved by | | | |

**Risk Description:**
Risk that the **population's continuously changing need for service exceeds** the Trust's **capability and capacity** to respond in a timely way. Where there are instances of **demand outstripping supply**, there is a risk that waitlists will grow, quality and safety of care will be compromised, the needs of the service users could be insufficiently met and this will lead to poorer health outcomes and experiences.

This risk materialises from a number of factors that include changes in population characteristics and demographics, staffing and workforce challenges, service accessibility and user demand patterns, staffing and workforce challenges, legal and regulatory requirements, health and care system configuration, commissioning priorities (under commissioning and/or under investment), financial constraints, barriers to innovation and the need to respond to unexpected health emergencies (e.g. pandemic).

| Key Controls | Assurance | Gaps | Actions |
|---|---|---|---|
| - A demand and capacity App has been developed within the Trust's Online Business Intelligence System (TOBI). This helps operational services to visualise patient demand based on previous activity and enables services to forecast their response based on workforce available.<br>- Demand and Capacity Management - the Trust has invested and now deployed a system for the management and rostering of staff. This enables operational managers to plan shift patterns and to identify and resolve gaps in staffing.<br><br>- The Trust is required to report activity to commissioners as part of a regular contract management process. Based on | **Level 1: reassurance**<br>Board Seminar on 20 October 2021 received an update on 'Demand and Capacity – findings from the work so far'<br>**Level 2: internal**<br>- Integrated Performance Report to the Board (standing item) includes reporting on performance against waiting times targets, inpatient admission and length of stay<br>**Level 3: independent** | The Trust is lead provider for 3 Provider Collaboratives: Adult secure services (For Me); CAMHS Inpatient services; and Adult Eating Disorder services. There is a risk that contract management arrangements/information is not sufficient both during the shadow period and after the go-live. Risk of under-reporting patient activity highlighted to the Finance & Investment Committee in January 2022.<br><br>Ongoing development of new Oxfordshire NHS Provider Collaborative for Integrated Care. | The Trust has been developing the Provider Collaboratives from shadow form into live operations. A Provider Collaborative Group has been setup for each service area and regularly meets; regular reporting on the Provider Collaboratives is also provided into the Quality Committee.<br><br>As at end of May 2022, the Trust and Oxford University Hospitals NHS FT (OUH) have signed a Memorandum of Understanding (MoU) to support closer working for Oxfordshire patients and |

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| the output of these meetings, commissioners will use the information gathered to inform priority and investment decisions.<br>- Recovery & Surge Planning: The Trust has set up a specific group to look at a co-ordinated approach to the recovery from COVID-19.<br>- Contract oversight group for Provider Collaboratives | | | communities. The MoU identifies urgent care and end of life care as early priorities for collaboration. MoU reviewed and supported by Trust Board in March 2022 and also approved by OUH Board. MoU is not legally binding and both organisations will continue to operate within current governance frameworks. |
| | | The Trust does not have sufficient information about the demand on services or its capacity to respond | One of the consequences/impact of insufficient capacity to meet demand will be on patient waiting lists. Although progress has been made to visualise waiting lists, the Trust has not set clinical targets across all service lines for waiting lists. The Trust should review each service line and set a target for when patients should be seen by urgency/priority. Performance can then be reported/planned based on the standards agreed. As at May 2022, the Trust was taking part in a southeast region collaboration to benchmark waiting times and share learning on management strategies. |
| | | The Trust has insufficient visibility of the demand for services and capacity to respond. | Further to the action above, the Trust has developed an online training course to accompany the demand and capacity App. This is being rolled out to all Operational Managers and will help them to better manage their services. |
| | | The Workforce Management System has not been rolled out across the Trust. Therefore, there is inconsistency and potential risk of under/overstaffing | The work to complete the rollout of the workforce management system should be completed ASAP. |
| | | In addition to the standard demand and capacity pressures for services, COVID has placed an additional risk that services will become overwhelmed. This is a combined effect of | As at March 2022, the system remained highly challenged from a demand and capacity perspective. Services, especially community hospitals, Urgent Community Response, District Nurses, and Community Therapy staff continued to work hard to |

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| | | patients not presenting during the crisis through fear of contracting COVID and also those that have suffered psychological effects of either responding to (as a staff member) and/or as a patient (AKA long COVID). | support system flow and ensure patients were cared for as close to home as possible. Pressure on primary and community care services across Oxfordshire continued to be impacted due to steady increases in COVID-19 related staff absences.<br>The Community Services Directorate led a successful system day aimed to prevent conveyance to hospital and instead maintain patients safely at home.<br><br>As at May 2022, risks with sustaining the Out-Of-Hours GP Service at peak times due to high demand and ongoing workforce and rota challenges. Additional management support being put in place to respond to identified issues, with support from HR team on rota issues. |
| | | Insufficient funding from commissioner contracts. (including specialised services) | There are a number of services that have already been identified as being under-commissioned. Action has already been taken over the past 18 months via a demand and capacity project to identify areas of under-commissioning within services and reports are being submitted to commissioners. This demand and capacity project work will continue and the output is being used for business planning and risk management. |
| | | As discussed at Audit Committee in May 2022, there are examples of good risk management in many services, but a recent review indicates a more systematic and data driven QI approach would be of benefit. There may also be a need for more protected resource and expertise to enable root cause analysis of capacity gaps and targeted work on monitoring the impacts of waiting times on | Strategic developments over 2022-23 will focus on optimising capacity and efficiency (e.g. Provider Collaborative and Oxfordshire integrated improvement programmes). |

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| | | patients in certain services. | |

# Strategic Objective 2: Be a great place to work

## 2.1: Workforce planning

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| Date added to BAF | Pre-Jan 2021 |
| Monitoring Committee | People Leadership and Culture Committee |
| Executive Lead | Chief People Officer |
| Date of last review | October 2022 |
| Risk movement | ↔ |
| Date of next review | January 2023 |

| | Impact | Likelihood | Rating |
|---|---|---|---|
| Gross (Inherent) risk rating | 5 | 4 | 20 |
| **Current risk rating** | **4** | **4** | **16** |
| Target risk rating | 3 | 3 | 9 |
| Target to be achieved by | | | |

**Risk Description:**
Insufficient or ineffective planning for current and future workforce requirements (including number of staff, skill-mix and training) may lead to: impaired ability to deliver the quantity of healthcare services to the required standards of quality; and inability to achieve the business plan and strategic objectives

| Controls | Assurance | Gaps | Actions |
|---|---|---|---|
| - E-Rostering Governance Group to progress the movement of the Trust through NHSI/E E-Rostering attainment levels which supports short term management and review of workforce.<br>- Weekly Review Meeting led by Nursing and Clinical Governance reviewing staffing levels and incidents<br>- BOB ICS 'People' workstream has focus on system wide workforce planning capability and capacity | **Level 1: reassurance**<br>- E-Rostering Governance Group<br>- Workforce Performance review (monthly)<br>**Level 2: internal**<br>- People Leadership and Culture Committee Workforce Report;<br>- Safe Staffing reporting via Quality dashboard into Quality Committee;<br>- Weekly Review Meeting led by Nursing and Clinical Governance reviewing staffing levels and incidents.<br>**Level 3: independent** | Lack of Workforce Planning capability and capacity has been identified.<br>. | As at December 2022, Head of Workforce Planning & Efficiencies role (reporting to the Director of Clinical Workforce Transformation and accountable to the Chief Nurse) being recruited to.<br><br>HR priorities defined until the end of FY23/4 which will form the HR People Plan, as agreed at the People, Leadership & Culture Committee on the 7 July 2022. Three cross cutting themes of work to address the most pressing priorities: upskilling line managers to lead teams and increase engagement; a focus on new joiners to support attraction and retention; and strengthening data and systems to free up clinicians' time.<br><br>The Learning & Development and HR teams integrated from 01 April 2022 which will |

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| | | | provide opportunities for developing a more integrated approach to leadership, workforce planning, career development, OD and systems.<br><br>Workforce Planning capability to be added to HR team. A piece of work has been undertaken to map out the workforce requirements for next 5-7 years, this will support future workforce planning decisions. This workforce tool will take into account current committed workforce education programmes such as nurse associate training, top up degrees and advanced clinical practice.<br>Owner: Chief People Officer<br><br>Detailed plans to be put in place once Workforce Planning resource is in place. However, the Improving Quality and Reducing Agency Programme already has several workstreams which aim to improve the quality of services whilst reducing agency spend. One of the workstreams, Retention, will focus on improving retention which will be supported by the new HR Structure with a greater emphasis on organisational development, culture, development and succession planning. Work is also in progress to review the budgeted establishments across inpatient units this is likely to result in an increase in vacancies.<br>Owner: Chief People Officer<br><br>Annual Planning Process started as at September 2022 (with the Executive Director of Strategy & Partnerships) and aiming to integrate Financial Planning, |

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| | | | Workforce Planning and Activity Planning in a single comprehensive approach. Initial reporting into the Board planned for January-March 2023. |

## Strategic Objective 2: Be a great place to work

## 2.2: Recruitment

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| Date added to BAF | Pre-Jan 2021 |
| Monitoring Committee | People Leadership and Culture Committee |
| Executive Lead | Chief People Officer |
| Date of last review | October 2022 |
| Risk movement | ↔ |
| Date of next review | January 2023 |

| | Impact | Likelihood | Rating |
|---|---|---|---|
| Gross (Inherent) risk rating | 4 | 4 | 16 |
| **Current risk rating** | **4** | **4** | **16** |
| Target risk rating | 3 | 3 | 9 |
| Target to be achieved by | | | |

**Risk Description:**
A failure to recruit to vacancies could lead to: the quality and quantity of healthcare being impaired; pressure on existing staff and decreased resilience, health & wellbeing and staff morale; over-reliance on agency staffing at high cost/premiums and potential impairment in service quality; and loss of the Trust's reputation as an employer of choice.

| Controls | Assurance | Gaps | Actions |
|---|---|---|---|
| - Director of Clinical Workforce Transformation to lead quality improvement, aim to reduce agency costs and support recruitment and retention workstreams, as well as develop bids for funding (for e.g. international recruitment);<br>- Improving Quality, Reducing Agency Programme Board;<br>- the development of an overarching recruitment plan for each service to address areas of candidate attraction and retention;<br>- collaboration with other local NHS Trusts to understand the overall employment marketplace and take joint pre-emptive action where possible, including collaboration with | **Level 1: reassurance**<br>- weekly reporting of vacancy levels and fill rates to SMT and the Service Directors;<br>- reporting on inpatient safe staffing levels to SMT and Weekly Review Meeting (Clinical Standards);<br>- integrated activity plan managed daily and reviewed weekly by HR and reviewed by Operations SMT monthly;<br>- Monthly review of recruitment activity by HR SMT.<br>**Level 2: internal**<br>- Improving Quality, Reducing Agency Programme Board<br>- Reports to Extended Executive (monthly);<br>- People Leadership and Culture Committee | Dealing with national and local recruitment challenges, (including: possibility of higher turnover due to health & wellbeing post Covid-19; lack of LD nurse training places in the local area; high costs of living).<br><br>Increase in the number of acting up/secondment roles in order to cover vacancies - leads to chains of staff acting up and additional staffing gaps being created.<br><br>Impact upon HR of increased candidate pipelines due to the number of vacancies at any one time - HR resourcing required in order to take forward change activities and | Additional HR resource to support recruitment. Recruitment Campaign Consultants started in post in January 2022 to focus on proactive recruitment in hotspot areas. A clear process has been agreed following the successful landing of international nurses to reduce reliance on agency workforce. The Recruitment Campaigns Team continue to manage proactive recruitment campaigns for areas of high vacancy and agency spend. Trust-wide campaigns include: Return to Practice for Nurses and Allied Health Professionals; and University/Student recruitment. |

| | | | |
|---|---|---|---|
| OUH on recruiting from Brookes University;<br>- proactive virtual career events at universities, recruitment fairs and for attracting those new to health and care services<br>- Apprenticeship Programme,<br>career development pathway for HCAs, 'grow your own' model. | (quarterly) received workforce report, oversees 'improving quality, reducing agency' item and receives, as standing items, updates on agency use, recruitment & retention and workforce transformation projects, bids and workstreams;<br>- Agency as % total temporary staffing **13.2%** against target of 7.9% as at December 2022, compared to **9.5%** against target <8.5% as at October 2022<br><br>**Level 3: independent** | support the recruitment process. | As at October 2022, the Improving Quality and Reducing Agency Programme has several workstreams which aim to improve the quality of services whilst reducing agency spend:<br>- the recruitment workstream is developing a project around student nurse recruitment;<br>- the agency management workstream has sent out the specifications for the Guaranteed Volume Contract to agencies and the Project Initiation Document for the Agency Master Vendor contract (excluding Medics) has been completed;<br>- the medical staffing workstream is reviewing the use of long line agency medics and recruitment activity; and<br>- the Trust is moving to the NHS Professionals outsourced model for staff bank provision from January 2023.<br><br>OWNER: Chief People Officer |

# Strategic Objective 2: Be a great place to work

## 2.3: Succession planning, organisational development and leadership development

| | |
|---|---|
| Date added to BAF | Pre-Jan 2021 |
| Monitoring Committee | People Leadership and Culture Committee |
| Executive Lead | Chief People Officer |
| Date of last review | 18/11/22 |
| Risk movement | ↔ |
| Date of next review | January 2023 |

| | Impact | Likelihood | Rating |
|---|---|---|---|
| Gross (Inherent) risk rating | 4 | 4 | 16 |
| **Current risk rating** | **3** | **4** | **12** |
| Target risk rating | 2 | 2 | 4 |
| Target to be achieved by | | | |

**Risk Description:**
Failure to maintain a coherent and co-ordinated structure and approach to **succession planning, organisational development and leadership development** may jeopardise: the development of robust clinical and non-clinical leadership to support service delivery and change; the Trust becoming a clinically-led organisation; **staff being supported in their career development and to maintain competencies and training attendance**; staff retention; and the Trust being a "well-led" organisation under the CQC domain

| Key Controls | Assurance | Gaps | Actions |
|---|---|---|---|
| - service model review and modifications of pathways across Operations (cross-reference to 1.2 and the risk against failure to deliver integrated care);<br>- completed restructuring of Operations Directorates to provide for development of clinical leadership and for a social care lead in each directorate;<br>- "planning the future" programme and ongoing Aston Team Working programme;<br>- effective team-based working training in place with L&D;<br>- multi-disciplinary leadership trios within clinical directorates to support and develop clinical leadership;<br>- the Organisational and Leadership Development | **Level 1: reassurance**<br><br>**Level 2: internal**<br>- People, Leadership & Culture Committee;<br>- Use of annual staff survey to measure progress and perception of leadership development;<br>and<br>- staff appraisals;.<br>- OKRs/performance indicators December and October 2022 and looking back into 2022:<br>- PDR compliance **41.4%** in December, improved from **28.9%** in October, from **29%** in August and May, **28%** in April, down from **32%** in March, down from **34%** in February (target >95%).<br>- Clinical supervisions **61%** in December, **46%** in October, down from **48%** in August, **53.6%** in May, **31%** in April, **30%** in March and **34%** in February (target >95%) | GAP (assurance – recording of PDRs, mandatory training and supervision on new Online Training Record (**OTR**)): PDR compliance reduced to 34% as at February 2022, then down to 32% in March, 28% in April and 29% in May 2022. Some low compliance may be an issue of lack of recording, rather than lack of undertaking, on the new OTR; and PDRs also not seen as a priority during COVID-19. Other factors - a review of training matrices, renewable training courses for previous once only courses and the introduction of the new OTR system. The L&D team will continue to monitor the new system and revise the training matrices for the small number of teams that are still outstanding and work with teams and areas where | New PDR process was agreed at the Executive Management Committee in September 2022 and the new PDR form was launched on 01 November 2022 across the Trust. The Trust is now driving to compliance with a clear message that staff who have had a PDR within the last 12 months need to record it, or if one has not yet taken place then it needs to be booked in. This is to drive PDR compliance as the Trust is currently only reporting 25% compliance as at November 2022.<br><br>As at September 2022, work has been completed by the HR System and Reporting team to correct errors in data as well as a full review of mandatory training provision. The true |

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| Strategy Framework (approved by the Board, October 2014) - aims to maximise effectiveness of staff at every level of the Trust by coordinating a range of activities which will promote their ability to deliver high quality services and patient care and by ensuring that structures are in place to enable their effective delivery;<br>- individual professional review and development through development of individual professional leadership strategies e.g. Nursing Strategy (updates provided into the Quality Committee, most recently in July 2020);<br>- Masters' framework offering clinically relevant development opportunities for registered professionals;<br>- Inspire Network (replaced Linking Leaders conferences) event focused on Organisational Development on 10 March 2022 and considered Staff Survey results; and<br>- Trainee Leadership Board - currently being reviewed as part of the wider look into Leadership | - mandatory training performance up to **83.8%** in December, up from **81.6%** in October, down from **84%** in August but heading in the right trajectory from **78%** in May, **73%** in April and **66%** compliance in January 2022 but still below target (target >95%).<br>**Level 3: independent**<br>- CQC reviews - a rating of "good" was achieved in the Well Led domain in 2015 CQC inspection. | compliance is particularly low. **The priority for the next period will be to agree a plan on how mandatory training rates are to be increased**, with an assessment of the barriers in relation to implementation so that these can be removed.<br><br>GAP (controls - application of Strategy Framework): coherent Trust-wide learning from existing leadership development projects. Localised good performance and good practice may not be picked up across the Trust. Although it may not always be necessary or appropriate for all Trust-wide learning in this area to be consistent, as opposed to tailored to meet specific leadership development requirements, it should be more coherent and delivered with more purpose. Unwarranted variation without justification may be a gap rather than variation itself.<br><br>GAP (controls - individual professional review and development): co-ordinated direction of career pathways to steer staff to gain wider experiences. Note also links to Gap at 2.1 above re staff and career development. | compliance picture based on the revised definition of Statutory & Mandatory training will only be known once this work is complete.<br><br>As at November 2022, Organisational Development (OD) Team now embedded into the People/HR team and continues to build relationships across the Trust.<br><br>The Learning & Development (L&D) and HR teams integrated from 01 April 2022 which will provide opportunities for developing a more integrated approach to leadership, workforce planning, career development, OD and systems. Merger also provides for the expertise from the HR Workforce systems teams to be applied to the L&D recording system.<br><br>OD Club has 70+members across the Trust and OD presents on corporate induction as well as ongoing engagement with front lines teams as part of the commitment to ensuring 'everyone having a voice that counts' for the 2022 Staff Survey.<br><br>ACTION: development of individual professional leadership strategies. Nursing Strategy developed and launched in November 2015 (and revised Nursing Strategy being developed in 2022/23). However, risk that may not be sufficient capacity to deliver Nursing |

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| | | | Strategy in a timely way. Also, talent management dependent upon PDR system roll-out. New appraisal process and training delayed following feedback from Extended Executive. More recently appointment of Associate Director of Clinical Education and Nursing who will review progress against development and delivery of leadership pathways.<br>OWNERS: Executive MD for Mental Health & Learning Disabilities; and Chief Nurse |
| | | GAP (controls): Equality and Diversity. National picture of little progress having been made in the past 20 years to address the issue of discrimination (BAME and other groups including LGBT, people with disabilities and religious groups) in the NHS. | ACTION: work of the Equality & Diversity Lead. NHS Workforce Race Equality Standard reporting. Focus at Board level. Ongoing work with HR to develop routine statistical analysis to identify key areas for actions and follow-up. Development of Quality Improvement Race Equality programme<br>OWNER: Head of OD |

## Strategic Objective 2: Be a great place to work

## 2.4: Developing and maintaining a culture in line with Trust values

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|---|---|
| Date added to BAF | 19/01/21 |
| Monitoring Committee | People Leadership and Culture Committee |
| Executive Lead: | Chief People Officer |
| Date of last review | 18/11/22 |
| Risk movement | ↔ |
| Date of next review | January 2023 |

| | Impact | Likelihood | Rating |
|---|---|---|---|
| Gross (Inherent) risk rating | 4 | 3 | 12 |
| **Current risk rating** | **3** | **3** | **9** |
| Target risk rating | 2 | 2 | 4 |
| Target to be achieved by | | | |

**Risk Description:**
A failure to develop and maintain our culture in line with the Trust values and the NHS people promise which includes: being compassionate and inclusive, recognition and reward, having a voice that counts, **health, safety & wellbeing of staff, working flexibly,** supporting learning & development, promoting equality, diversity & inclusivity and fostering a team culture.

The absence of this could result in; harm to staff; an inability to recruit and retain staff; a workforce which does not reflect Trust and NHS values; and poorer service delivery.

| Key Controls | Assurance | Gaps | Actions |
|---|---|---|---|
| - HR Policies & strategies, inlc. Workplace Stress Prevention & Response, Equal Opportunities, Dignity at Work, Flexible Working, Grievance and Sickness policies;<br>- Freedom to Speak Up Guardian;<br>- Health & Wellbeing Strategy, groups, services and Intranet site& resources;<br>- Employee Assistance Programme;<br>- Occupational Health Service;<br>- Equality, Diversity and Inclusion team, plans, training and groups, Staff Equality Networks;<br>- Health & Safety Policies, and H&S Team;<br>- Zero-Tolerance of Violence and Aggression to Staff Policy;<br>- Training, supervision and Performance and Development Review (PDR) processes;<br>- Communications bulletins & intranet resources and news. | **Level 1: reassurance**<br>- Health and Wellbeing Group;<br>- Stress Steering Group;<br>- Learning Advisory Group (LAG) Group;<br>- Equality & Diversity Steering Group;<br>(all reporting to PLC Committee quarterly);<br>- H&S group SEQOSH accredited<br>**Level 2: internal**<br>- People, Leadership & Culture Committee (quarterly);<br>- Quarterly People Pulse checks (measures of staff engagement)<br>**Level 3: external**<br>- National Staff Survey results;<br>- External endorsement of the Trust's wellbeing work via take-up of Trust's model through BOB ICS. | Until 2022, no team/group focused on this work.<br><br>Need to improve staff experience and respond to issues identified by Staff Survey results in order to improve retention.<br><br>GAP (controls): further to discussion at PLC on 03 February 2022, having an Estate that is fit for purpose for staff returning to work having Worked At Home during the pandemic and providing sufficient flexible working arrangements to prevent reliance on the Estate going forwards.<br>OWNER: Executive Director for Digital & Transformation | This work will be picked up by the new OD function created as part of the HR department restructure. New Head of OD started in post January 2022. In March 2022, the OD Team facilitated organisation-wide action on the areas identified as needing particular attention from the 2021 staff survey feedback: PDRs will be a Quality Improvement project; the Improving Quality Reducing Agency (IQRA) Board is putting measures in place to support teams capacity; and a Flexible Working Project Change Team is in place reporting into the IQRA Retention Workstream. Staff Survey results also reported into the Board in public in May 2022. In June 2022, the OD team commenced a review of workplace culture; the discovery phase of the culture programme was reported into the PLC on 07 July 2022 and the next phase will take place over July-September 2022. This work was paused due to the system outage and will be restarted in the January 2023.<br>Owner: Chief People Officer<br><br>Promotion and embedding of a "wellness culture" including: Team and manager focus on H&W support; wellbeing conversations (July 2021);<br>Embedding Restorative Just Culture model (August 2021);<br>Embedding Civility & respect model (July 2021); |

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| | | | Mental Health First Aid training for managers – (August 2021);<br>Enabling safe spaces and confidential support to all staff.<br>Kindness into Action (part of the Civility & Respect Culture) launched in November 2022.<br>OWNER: Chief People Officer & Head of Health & Wellbeing<br><br>Development of Quality Improvement (QI) Equality Diversity & Inclusion (EDI) programmes around Race Equality (based on feedback from the Workforce Race Equality Standard (WRES)).<br>The key workstreams are<br>1 – Increasing workforce diversity<br>2 – De-biasing the disciplinary process<br>3 – Improving equal opportunities in career development and progression |

# Strategic Objective 2: Be a great place to work

## 2.5: Retention of staff

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|---|---|
| Date added to BAF | May 2021 |
| Monitoring Committee | People Leadership and Culture Committee |
| Executive Lead | Chief People Officer |
| Date of last review | 18/11/22 |
| Risk movement | ↔ |
| Date of next review | January 2023 |

| | Impact | Likelihood | Rating |
|---|---|---|---|
| Gross (Inherent) risk rating | 4 | 4 | 16 |
| **Current risk rating** | **4** | **3** | **12** |
| Target risk rating | 3 | 3 | 9 |
| Target to be achieved by | | | |

**Risk Description:**
A failure to retain permanent staff could lead to: the quality of healthcare being impaired; pressure on staff and decreased resilience, health & wellbeing and staff morale; over-reliance on agency staffing at high cost/premiums and potential impairment in service quality; and loss of the Trust's reputation as an employer of choice.

| Controls | Assurance | Gaps | Actions |
|---|---|---|---|
| - Director of Clinical Workforce Transformation to lead quality improvement, aim to reduce agency costs and support recruitment and retention workstreams;<br>- career development pathway for HCAs;<br>- Learning from Exit Questionnaires/Interviews;<br>- Health & Wellbeing, Equality, Diversity and Inclusivity, and Occupational Health strategies, groups, services and initiatives;<br>- Freedom to Speak Up Guardians;<br>- Training, supervision and Performance and Development Review (PDR) processes; | **Level 1: reassurance**<br>- Quarterly review of leavers exit interview data by HR SMT.<br>**Level 2: internal**<br>- Reports to Extended Executive (monthly);<br>- Reports to People Leadership and Culture Committee (quarterly);<br>- Performance data December and October 2022 and looking back into 2022:<br>- Turnover **16.2%** in December, up from **15.9%** in October, up from **14.9%** in August, **14.5%** in May and **13.3%** in February 2022 (target <10%);<br>- reduction in Vacancies **12.2%** in December and October, down from **13.5%** in August, up from **11.4%** in May and **8.6%** in February 2022 (target <9%); and<br>- Quarterly People Pulse checks (measures of staff engagement)<br>**Level 3: independent** | High vacancy numbers, challenges recruiting to vacancies, and demands of recruitment upon operational management of recruitment can have negative impact on experience of existing staff.<br><br>Need to improve staff experience and respond to issues identified by Staff Survey results to improve retention. | As at October 2022, the turnover rate continues to climb as the cost of living crisis and the below inflation pay offer impacts staff retention (especially in the lower bands and with wages on offer in other sectors).<br><br>As at October 2022, the Improving Quality Reducing Agency (IQRA) work programme will focus on: the Retire and Return Quality Improvement (QI) project to ensure that the Trust continues to retain our most experienced staff; Personal Development Review (PDR) QI project; onboarding QI project; and Career Conversations QI project.<br><br>As at November 2022, PDR processes had been redesigned with a focus on Wellbeing, Flexible working and career development to |

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| | - National Staff Survey results (annual process)<br>- National – BOB ICS recognition for R&R with Enhanced Occupational Health & Wellbeing Pilot Regionally - H&W key group member of R&R planning and new national resource. | Pressure from cost of living increases likely to be a theme for staff over 2022-23. | ensure people have the best experience at work.<br>The Career Conversations QI group is working on setting up the process for staff to have in depth career conversations and 'stay' conversations with people who may be looking to leave for career development or looking for better work life balance<br><br>New Starter Experience QI group is looking to ensure new starters have the best experience in the first 6 months to mitigate the risk posed by people leaving within their first 12 months. A questionnaire has been developed to check in with new starters so improvements can be made quickly to improve new starter experience.<br><br>Staff Survey 2022 engagement plan included the Organisational Development team looking to visit as many teams across the Trust to have direct conversations to drive engagement. As at November 2022, 40 teams had been visited and engagement had been positive.<br><br>Separate Cost of Living risk at an operational level on the Trust Risk Register at TRR 1156. Some action to reward staff with: one off payments; covering cost of Blue Light discount cards; and temporary uplifts in mileage rates and additional annual leave. However, more to do on financial wellbeing into autumn/winter 2022/23 with particular focus on supporting staff with fuel costs, including working with local partners |

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| | | | to support staff given the Trust's wide geographical spread.<br><br>See also linked risk 2.2 for actions relating to recruitment. |

## Strategic Objective 3: Make the best use of our resources and protect the environment

### 3.1: Failure of the Trust to: (i) engage in shared planning and decision-making at system and place level; and (ii) work collaboratively with partners to deliver and transform services at place and system-level

[Formerly - Failure of the Health and Social Care Place Based, Integrated Care Systems and Provider Collaboratives to work together]

| | |
|---|---|
| Date added to BAF | Pre-Jan 2021<br>Refocused and revised in July 2022 |
| Monitoring Committee | Quality Committee |
| Executive Lead | Executive Director of Strategy & Partnerships |
| Date of last review | 30/09/22 |
| Risk movement | ↔ |
| Date of next review | November 2022 |

| | Impact | Likelihood | Rating |
|---|---|---|---|
| Gross (Inherent) risk rating | 5 | 5 | 25 |
| **Current risk rating** | **4** | **3** | **12** |
| Target risk rating | 3 | 3 | 9 |
| Target to be achieved by | | | |

**Risk Description:**
Failure of the Trust to: (i) engage in shared planning and decision-making at system and place level; and (ii) work collaboratively with partners to deliver and transform services at place and system-level. Such failure would lead to ineffective planning and unsuccessful delivery and transformation of services in the Systems we operate in, and in turn impact both the sustainability and quality of healthcare provision in these Systems and in the Trust.

[Formerly - Failure of the Health and Social Care Place Based, Integrated Care Systems and Provider Collaboratives in which we work to act together to deliver Transformation, the Long-Term Plan, integrated care, maintain financial equilibrium and share risk responsibly may impact adversely on the operations of the Trust and compromise service delivery.]

| Controls | Assurance | Gaps | Actions |
|---|---|---|---|
| - Active participation in shaping emerging BOB and place-levels governance;<br>- Provider Collaboratives arrangement in Mental Health and Community Health;<br>- Joint work / operational processes with local authorities and other partners including PCNs;<br>- Development of alliances and partnerships with other organisations, including the voluntary sector, to deliver services into the future e.g. Oxfordshire Mental Health Partnership; | **Level 1: reassurance**<br>- Reporting through Directorate SMTs and OMT.<br>**Level 2: internal**<br>- Reporting through: Executive Management Committee; and Trust Board.<br>**Level 3: independent**<br>- ICS-level and place-level emerging governance for Mental Health, Learning Disability and Autism (MH, LD&A) and Community | Absence of system-wide data sets and aligned reporting.<br>ICS and Place level governance emerging.<br>Financial pressure on ICSs, County Councils and Social | Work ongoing to understand data and identify reporting inconsistencies, through the work of the Executive Director for Digital & Transformation<br>Working with place based and local partners to ensure place and system governance OWNER: Executive Managing Directors, Executive Director of Strategy & Partnerships and Chief Executive<br>Ensuring engagement in funding dialogue with ICSs |

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| - Exec to Exec engagement with partner organisations;<br>- CEO membership in the Integrated Care Board;<br>- new Executive Director role of Executive Director of Strategy & Partnerships from April 2022. | - Partnership and Alliance arrangements with other organisations, including the voluntary sector;<br>- MH, LD&A Delivery Board;<br>- Provider Collaborative Governance | Care impacting adversely on required MH & LD investment.<br><br>Lack of internal resources to support systematic partnership work beyond executive-level engagement. | for system clinical and financial planning.<br>OWNER: Chief Finance Officer, Executive Director of Strategy & Partnerships and Executive Managing Directors<br><br>As at end of September 2022, first tranche of resourcing focused on strategy approach. Next need to focus on working with Voluntary, Community and Social Enterprise (VCSE) partners to identify resources required to support partnership work and review internally via Executive Management Committee.<br>OWNER: Executive Director of Strategy and Partnerships |

## Strategic Objective 3: Make the best use of our resources and protect the environment

## 3.2: Governance of external partners [*RISK UNDER REVIEW*]

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|---|---|
| Date added to BAF | Pre-Jan 2021 |
| Monitoring Committee | Quality Committee |
| Executive Lead | Executive Director of Strategy & Partnerships |
| Date of last review | 30/09/22 |
| Risk movement | ↔ |
| Date of next review | November 2022 |

| | Impact | Likelihood | Rating |
|---|---|---|---|
| Gross (Inherent) risk rating | 4 | 4 | 16 |
| **Current risk rating** | **3** | **3** | **9** |
| Target risk rating | 3 | 3 | 9 |
| Target to be achieved by | At target level | | |

**Risk Description:**
[*RISK UNDER REVIEW – may need to refocus upon sub-contract management or the contractual aspects of partnerships sitting with Finance, whilst 3.1 focuses on Partnerships*]
Failure to manage governance of external partners effectively, could: compromise service delivery and stakeholder engagement; lead to poor oversight of risks, challenges and relative quality amongst partners; and put at risk the Trust's integrity, reputation and accountability to its stakeholders and credibility as a system leader and partner of choice.

| Controls | Assurance | Gaps | Actions |
|---|---|---|---|
| - Trust maintains a central register of all partnerships;<br>- Central coordination of partnership arrangements by Business Services Team;<br>- Development and use of Trust Partnership Standard;<br>- Partnership Risk Assessments (for existing partners) undertaken in 2019 and risk-assessment process in place for new partnerships;<br>- Section 75 agreements in place for Oxfordshire and Buckinghamshire, with monitoring and collaboration through Section 75 Joint Management Groups (JMGs);<br>- new Executive Director role of Director of Strategy & Partnerships from April 2022. | **Level 1: reassurance**<br>- Partnership Management Group<br>**Level 2: internal**<br>- Future reporting to Quality Committee;<br>- JMG reports to Quality Committee (quarterly).<br>**Level 3: independent**<br>- PWC Audit of partnership working in May 2019. Key recommendations of the audit have been completed;<br>- quality assurance peer-to-peer reviews within Oxford Mental Health Partnership. | GAP (Assurances) – lack of reporting on partnerships activity. Formerly partnerships updates were provided to the Board (in private) (most recently in July 2020) but the Board determined that future reporting should go into the Quality Committee and this has yet to be established with regularity.<br><br>Identified via internal partnerships review (2017) and PWC audit (May 2019): No partnership standard; No single point of ownership for partnerships within the Trust; Lack of distinction between partnership and sub-contracts; No overall register of partnership arrangements within the Trust; No performance monitoring arrangements in | Director of Strategy & Partnerships now in post from April 2022.<br><br>COMPLETED ACTIONS: Partnership standard developed and in use; risk assessment process for partnership working implemented; central coordination of partnership arrangements now sits with Business Services Team.<br><br>ONGOING ACTIONS:<br>(1) Development and use of performance related action logs to monitor progress of |

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| | | place with partners or subcontractors.<br><br>New process for partnership management is not well tested as only one new partnership has been entered into since implementation of new processes. | partnerships; work is ongoing in Business Services to support Operational Services with contract management oversight; (2) Business Services Team currently working with Operational Services to put in place new or varied sub-contracts.<br><br>Continue monitoring of adequacy of partnership governance via Business Services Team and reporting to Quality Committee & the Board. |

## Strategic Objective 3: Make the best use of our resources and protect the environment

## 3.4: Delivery of the financial plan and maintaining financial sustainability

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|---|---|
| Date added to BAF | 11/01/21 |
| Monitoring Committee | Finance and Investment Committee |
| Executive Lead | Chief Finance Officer |
| Date of last review | 17/11/22 |
| Risk movement | ↔ |
| Date of next review | November 2022 |

| | Impact | Likelihood | Rating |
|---|---|---|---|
| Gross (Inherent) risk rating | 5 | 5 | 25 |
| **Current risk rating** | **4** | **4** | **16** |
| Target risk rating | 4 | 3 | 12 |
| Target to be achieved by | [tbc for FY23] | | |

**Risk Description:**
Failure to deliver financial plan and maintain financial sustainability, including, but not limited to: through non-delivery of CIP savings; budget overspends; under-funding and constraints of block contracts in the context of increasing levels of activity and demand, could lead to: an inability to deliver core services and health outcomes; financial deficit; intervention by NHS Improvement; and insufficient cash to fund future capital programmes.

| Controls | Assurance | Gaps | Actions |
|---|---|---|---|
| - Annual Financial Plan and Budget produced, and approved by FIC and the Board;<br>- Standing Financial Instructions;<br>- Budgetary Control Policy (CORP03);<br>- Procurement Policy (CORP04) and Procurement Procedure Manual;<br>- Investment Policy (CORP10);<br>- Treasury Management Policy (CORP09);<br>- Counter Fraud Policy (CORP11);<br>- Robust cash management arrangements;<br>- Active management of Capital Programme;<br>- Regular reporting on Financial position and impact of wider financial system risks to FIC and Board;<br>- Monthly reporting to, and monitoring by, NHSE. | **Level 1: reassurance**<br>-Weekly finance team meeting;<br>- Monthly finance review meetings with directorates;<br>- Capital Programme Sub-Committee (monthly)<br>- daily cash balance reports to DoF, and weekly and monthly cash-flow reports.<br>**Level 2: internal**<br>- Strategic Delivery Group;<br>- Finance and Investment Committee (every 2 months);<br>- Monthly Finance, including CIP, reporting to the Board to provide assurance on progress and recovery actions.<br><br>September 2022 (Month 6):<br>- EBITDA performance £0.2m deficit (£1.3m adverse to plan for the Month but £0.4m favourable to plan for the Year to date)<br>- I&E performance £1.4m deficit (£1.2m adverse to plan for the Month but | Underfunding of Oxon community services contract<br><br>Uncertainty around NHS financial regime from October 2021 onwards | FY23 Budget Setting and Annual Plan update delivered to the FIC on 22 March 2022 and the Board in private on 30 March 2022 (further to FIC review in January 2022 of performance against FY22 Plan and review of capacity to manage aggregate financial risk, including utilisation of reserves and risks and opportunities not included in the current forecast).<br><br>Update on the Long Term Financial Plan to the private Board workshop on 15 December 2021. Included FY22 plan update, FY23 outline plan, 5 year plans and discussion of key deliverables.<br><br>(a) Community Services Strategy to be completed, followed by (b) costs analysis, and (c) structured discussions about funding |

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| | £0.5m favourable to plan for the Year to date)<br>- CIP/PIP **£0.3m** (£0.4m adverse to plan for the Month and £2.3m adverse to plan for the Year to date)<br>- Cash decrease £7.9m (but £6.6m favourable to plan for the Year to date)<br><br>Year to date:<br>- EBITDA performance **£6.6m surplus** (£0.4m favourable to plan)<br>- I&E performance **£0.9m deficit** (£0.5m favourable to plan)<br>- CIP/PIP **£1.6m** (£2.3m adverse to plan)<br>- Cash **£75.2m** (£6.6m favourable to plan) | Agency spend – the Trust is an outlier in terms of agency usage and spend which puts pressure on ability to remain within budget | gaps with Commissioners. Update to the Board meeting in private on 09 June 2021.<br>OWNER: Director of Community & Primary Care Services, and Director of Finance.<br><br>Close attention paid to guidance issued by NHSE, involvement in NHSE and ICS planning meetings for latest updates, involvement in any consultation meetings on proposed financial regime, close monitoring of internal forecast for 2021-22 with clear assumptions around income.<br>OWNER: Chief Finance Officer<br><br>Work to be carried out to review financial controls and assurance around agency use and monitoring.<br>Owner: Chief Finance Officer<br><br>IQRA work programme, led by Matt Edwards, commenced to cover 7 workstreams aimed at addressing underlying drivers of agency use.<br>Owner: Chief Nurse |
| | **Level 3: independent**<br>- Internal Audit review,<br>- External Audit supported financial statements for FY 20/21 and **Going Concern Statement**<br>- Financial Plan submitted to NHSE;<br>- Monthly reporting to, and monitoring by, NHSE. | | |

## Strategic Objective 3: Make the best use of our resources and protect the environment

## 3.6: Governance and decision-making arrangements

| | |
|---|---|
| Date added to BAF | Pre-Jan 2021 |
| Monitoring Committee | Audit Committee |
| Executive Lead | Director of Corporate Affairs & Co Sec |
| Date of last review | January 2022 |
| Risk movement | ↑ |
| Date of next review | November 2022 |

| | Impact | Likelihood | Rating |
|---|---|---|---|
| Gross (Inherent) risk rating | 4 | 4 | 16 |
| **Current risk rating** | **4** | **3** | **12** |
| Target risk rating | 2 | 2 | 4 |
| Target to be achieved by | | | |

**Risk Description:**
Failure to maintain and/or adhere to **effective governance and decision making arrangements**, and/or **insufficient understanding of the complexities of a decision** may lead to: poor oversight at Board level of risks and challenges; (clinical or organisational) strategic objectives not being established or achieved; actual or perceived disenfranchisement of some stakeholders (including members of the Board, Governors and/or Members) from key strategic decisions; or damage to the Trust's integrity, reputation and accountability.

| Controls | Assurance | Gaps | Actions |
|---|---|---|---|
| - Trust Constitution and Standing Orders for the Board and Council (CORP01);<br>- Standing Financial Instructions and Scheme of Delegation;<br>- Integrated Governance Framework (IGF);<br>- Procurement Policy (CORP04) and Procurement Procedure Manual; Investment Policy (CORP10), Treasury Management Policy (CORP09);<br>- Trust Strategic Objectives and setting of key focus areas for achieving objectives (New Strategy approved April 2021);<br>- Maintenance of key Trust registers (e.g. declarations of interest, receipts of gifts);<br>- Processes for capturing meeting minutes to log: consideration of discordant views, discussion of risks, and decisions; | **Level 1: reassurance**<br><br>**Level 2: internal**<br>- Annual Governance Statement;<br>- Strategic Objectives approved by Board, with progress against objectives reported to Board Committees and Board;<br>- Quality Committee, Finance & Investment Committee, People, Leadership & Culture Committee and Audit Committee review risks and key governance issues;<br>- Escalation reports from the Sub Committees to Board Committees and on to Board;<br>- Annual Report and reports for Council of Governors to demonstrate engagement with FT members.<br>**Level 3: independent**<br>- Internal Audit review of governance arrangements;. Internal Audit reviews have included reviews of Quality Strategy & Governance, the | GAP (assurances and review/oversight): Note delays to Psychiatric Intensive Care Unit (**PICU**) project may suggest issues with oversight mechanisms or lack of understanding of complexities of project. Risk that there might be a lack of specialist knowledge and/or expertise amongst decision makers in relation to a significant decision or transaction.<br><br>GAP (controls): systemic tendency towards short-termism and not looking | Appropriate independent expert, internal audit and/or legal advice to be obtained to support decisions relating to significant transactions (e.g. as part of significant capital projects such as PICU build and Warneford redevelopment projects), and decision makers to be fully sighted on such independent advice. Current risk rating increased in November 2021 to overall rating of 12, pending assurance that gaps resolved. Internal Audit (PwC) report on PICU received and reviewed by Audit Committee, December 2021, with follow-up planned for January-February 2022. OWNERS: Director of Corporate Affairs & Co Sec, and Director of Finance.<br><br>Being discussed and explored through Audit Committee workshops on 01 and 08 |

| | | | |
|---|---|---|---|
| - Revised Risk Management Strategy (May 2021);<br>- Board Assurance Framework;<br>- Trust Risk Register and local risk registers at directorate and departmental levels;<br>- Business continuity planning processes and emergency preparedness;<br>- Council of Governors (COG), COG Working Groups;<br>- Membership Involvement Group, Membership Development Strategy, and membership development responsibilities through the Communications function. | IGF, Clinical Audit, Electronic Health Record Programme Governance, the Research Governance Framework, Information Governance, the Board Assurance Framework, Risk and Quality Governance;<br>- Annual External Audit (including review of governance);<br>- Well Led governance review (PwC) completed, presented to the Board meeting in private in June 2017 and reported to Council of Governors in Sept 2017;<br>- Well Led inspection (CQC) March 2018. | ahead/peering around corners to see what could be coming. Not resolving longer term issues around operational performance management or taking a longer view of achievement of Strategy (rather than fire-fighting issues). Potential gap in governance structure and not yet being plugged by improved Integrated Performance Reporting to the Board in 2021/22 – discussion in 2021/22 can still focus on way the data is presented rather than what it says in terms of issues or sub-optimal performance. Lack of Board discussion on long-term operational impact upon services of performance issues or risks may lead to lack of decision around whether or how to continue to run certain services. Risks could cycle and stall on risk registers.<br><br>COG working groups paused for COVID-19 pandemic | February 2022, reviewing Risk Management and Internal Audit planning.<br><br>COG working groups being reinstated. Scheduling started again for 2022, paused during 3rd wave of COVID-19.<br>OWNER: Director of Corporate Affairs & Co Sec.<br>TARGET: March 2022 |

## Strategic Objective 3: Make the best use of our resources and protect the environment

## 3.7: Ineffective business planning

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|---|---|
| Date added to BAF | Pre-Jan 2021<br>Risk description revised July and September 2022 |
| Monitoring Committee | Finance and Investment Committee |
| Executive Lead | Executive Director of Strategy & Partnerships |
| Date of last review | 30/09/2022 |
| Risk movement | ↔ |
| Date of next review | November 2022 |

| | Impact | Likelihood | Rating |
|---|---|---|---|
| Gross (Inherent) risk rating | 4 | 4 | 16 |
| **Current risk rating** | **4** | **3** | **12** |
| Target risk rating | 3 | 2 | 6 |
| Target to be achieved by | 2023 | | |

**Risk Description:**
*Revised risk description, September 2022 (removed reference to performance management, as at July 2022 description had been "Ineffective business planning arrangements and performance management may lead to"):*
Ineffective business planning arrangements may lead to: the Trust failing to achieve its strategic ambition; problems and issues recurring rather than being resolved; reactive rather than pro-active approaches; decision-making defaulting to short-termism; and inconsistent work prioritisation, further exacerbated by the challenge of limited resources, impacting upon staff frustration and low morale.

Potential enablers in order to mitigate the risk:
- develop a strategic plan and an integrated business plan for the organisation;
- realign performance management metrics to these plans; and
- monitor and align the delivery of strategic programmes across the Trust.

*Previous wording:*
Ineffective business planning arrangements and/or inadequate mechanisms to track delivery of plans and programmes, could lead to: the Trust failing to achieve its annual objectives and consequently being unable to meet its strategic objectives; the Trust being in breach of regulatory and statutory obligations.

| Controls | Assurance | Gaps | Actions |
|---|---|---|---|
| - Strategic Framework including 5-Year Strategy 2021-26 and Digital Health and Care Strategy 2021-26;<br><br>- Business Services, Performance Team and Service Change (Programme & Project Management) functions.<br><br>- Annual Planning process jointly led by Finance and Strategy started, as at end of September 2022, and | **Level 1: reassurance**<br>Board Strategy Days – April, July, October/November 2022<br>**Level 2: internal**<br>Integrated Performance Report to the Board in public – on delivery against the strategic objectives, key focus areas and Objective Key Results.<br><br>Integrated Annual Planning Process co-lead by Finance and Strategy and reporting to | Action plan to address challenges in the short, medium and long term. | As at June/July 2022, outline plan being developed by Director of Strategy & Partnerships, with short, medium and long-term actions and expected outputs. Internal delivery architecture will comprise:<br>- high-level Strategy and clear articulation of strategic objectives and their achievement;<br>- medium-term (2-3 years) Strategic Plan to bridge the |

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| involving: Finance team, Strategy team, Workforce planning team, Performance team. | Executive Management Committee<br>**Level 3: independent** | No clear business plans yet set for individual services for current FY. Trust could benefit from medium term (3 year) plan to tie together finance and service improvement/sustainability, workforce planning etc. (particularly in the context of operating within ICS) more clearly and create an implementation for the Trust strategy.<br><br>Operational planning process changed due to impact of being part of the ICS and part of an ICS submission to NHS England. Individual organisations no longer provide individual Operational Plan returns to NHS England.<br>OWNERS: Strategy & System Partnerships Lead; and Director of Finance | gap between daily operations and the Strategy;<br>- in-year Strategic Plan with in-year priorities supported by regularly reported metrics and an integrated operational plan<br><br>Annual Plan process started, as at end of September 2022, to produce integrated plan between workforce, finance and activity for 2023/24 |

## Strategic Objective 3: Make the best use of our resources and protect the environment

## 3.10: Information Governance & Cyber Security

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|---|---|
| Date added to BAF | 12/01/21 |
| Monitoring Committee | Finance & Investment Committee |
| Executive Lead | Executive Director for Digital & Transformation |
| Date of last review | 14/09/2022 |
| Risk movement | ↔ |
| Date of next review | November 2022 |

| | Impact | Likelihood | Rating |
|---|---|---|---|
| Gross (Inherent) risk rating | 5 | 4 | 20 |
| **Current risk rating** | **4** | **3** | **12** |
| Target risk rating | 3 | 3 | 9 |
| Target to be achieved by | | | |

**Risk Description:**

Failure to protect the information we hold as a result of ineffective information governance and/or cyber security could lead to: personal data and information being processed unlawfully (with resultant legal or regulatory fines or sanctions); cyber-attacks which could compromise the Trust's infrastructure and ability to deliver services and patient care, especially if loss of access to key clinical systems; data loss or theft affecting patients, staff or finances; and reputational damage.

| Controls | Assurance | Gaps | Actions |
|---|---|---|---|
| - Information Governance Team;<br>- GDPR Group workshops;<br>- Mandatory IG training for all staff Trust wide, plus ad hoc training with clinical focus on sage info sharing;<br>- Information assets and systems are risked assessed using standard Data Protection Impact Assessment (DPIA) tool;<br>- Appointment of Cyber Security Consultant (2020);<br>- Membership of Oxfordshire Cyber Security Working Group;<br>- 'Third Party Cyber Security Assessment' (checklist & questionnaire) developed, to provide a systems requirement specification and to ensure any new Information Systems being procured adhere to DSPT Cyber Security standards; | **Level 1: reassurance**<br>- Information Management Group (IMG);<br>- Monthly Cyber Security activities review via Oxford Health Cyber Security Working Group.<br>**Level 2: internal**<br>- Finance & Investment Committee receives reports from IMG (most recently July 2022);<br>- Monitoring of IG training attendance;<br>- Incident management and response process (enhanced to meet DSPT requirements) through which data and cyber security incidents are monitored and reviewed;<br>- Programme of independent penetration testing of systems/services (annual from 2020);<br>- NHS Digital Data Security and Protection Toolkit (DSPT) annual self-assessment. | In August 2022, IT failure with patient record systems provided and externally hosted by a third party supplier led to staff being unable to access patient record systems and clinical information, thereby leading to risks to staff and patient harm. Trust internal operational and cyber security not compromised.<br><br>Penetration testing undertaken in May 2020 (with OUH), July 2020 (NHS Digital), and NHSD Data Security Onsite Assessment (CE+ & DSPT) in Nov 2020 identified a few low to medium risk information system and user account weaknesses; | Major incident response set up to manage contingency plans, resolve the technical issue and provide alternative access to clinical information. Patient safety risk and more detailed incident-related risks maintained at Trust Risk Register and Silver Command level. Cyber assessments for alternative solutions fast tracked so as to be implemented without delay.<br><br>Log4Shell Cyber Security vulnerability update provided to Audit Committee on 23 February 2022; assurance provided on the Trust's response.<br><br>ICO Data Protection audit (achieved 'Reasonable' assurance), November 2021, conducted as part of the ICO's routine audit |

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| - AppLocker and restrictions to ensure desktop applications are controlled and centrally approved;<br>- Systems access control and audit managed by way of: programme of penetration testing (annually from 2020); cyber security assessed and tested prior to implementation of new systems; USB device controls; use of external cyber security scoring and scanning tools and services (e.g. NHS Digital's BitSight, VMS Vulnerability Management Service, Nessus Vulnerability Scanning, Microsoft Defender Advanced Threat Protection);<br>- GCHQ-certified Cyber Security Board Briefing delivered by NHS Digital and the IT team to the Board Seminar on 14 February 2019;<br>- Mail filtering system to flag or block suspicious, malicious of unsafe communications, to limit the flow of phishing emails, malware and/or unsafe URLs;<br>- Implementation of Multi-Factor Authentication (MFA) has significantly reduced Office 365 user compromises;<br>- Cyber Security Awareness and Cyber Security SharePoint sites. | - Cyber Security updates to Audit Committee (most recent February 2022);<br>- Data Quality Maturity Index **98.1%** (Dec 2020) (target 95%)<br><br>**Level 3: independent**<br>- Improved NHS Digital's BitSight cyber rating, which exceeds peers in benchmarking and is in top 30% of organisations globally;<br>- VMS Vulnerability Scanning, and NSCN WebCheck Service, with identified vulnerabilities monitored and remediated or mitigated;<br>-NHS Digital penetration test (July 2020) and Data Security Onsite Assessment Non 2020);<br>-Microsoft Defender ATP Threat & Vulnerability Management (TVM) tools and process. The lower our TVM score, the more secure our estate;<br>- Secure messaging accreditation achieved (NHS Digital DCB1596);<br>- ICO investigation of referrals made by data subjects;<br>- ICO Data Protection audit (achieved 'Reasonable' assurance), November 2021, conducted as part of the ICO's routine audit programme and reported into the Audit Committee in December 2021. Purpose to provide independent assurance of compliance with Data Protection legislation. | Trust does not yet have National Cyber Security Centre Cyber Security Essentials Plus certification;<br><br>MFA cannot be applied to all local systems and backup authentication.<br><br>Desktop Third Party Software Patch Management is currently reactive only via ATP and internal resource fails to keep pace with the requirements.<br><br>Training and awareness<br><br>As Cyber Security hardening such as assessments, penetration testing and other enhancements are being developed, the Cyber and Server management resource available to ensure the trust will meet the June 2021 DSPT/CE+ deadline and offer wider support such as awareness training is reduced. Additional Cyber Security and Server Management resource is required to address those needs and maintain and adequate pace. | programme and reported into the Audit Committee in December 2021. Purpose to provide independent assurance of compliance with Data Protection legislation.<br><br>Though Server Team, IAOs and suppliers have addressed the most significant threats, some low vulnerability supplier remediation is still required and forms part of long term programme of work.<br>OWNER: Executive Director for Digital & Transformation<br><br>Focus remains on achieving Cyber Essentials Plus (CE+) certification. Work is ongoing ahead of the mandatory deadline of June 2021 to be CE+ certified.<br>OWNER: Executive Director for Digital & Transformation and Cyber Security Consultant.<br><br>Privileged Access Management (PAM) and conditional access are being developed by the Server Team.<br><br>Software patch management solutions are being investigated by the Desktop & Apps Team.<br><br>Business justification for procurement of awareness training package for staff has been submitted;<br><br>Consider re-delivering further GCHQ-certified Cyber Security Board Briefing during 2021.<br>OWNER: Executive Director for Digital & Transformation and Cyber Security Consultant. |

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| | | | Funding bid for cyber security apprentice has been submitted. |

## Strategic Objective 3: Make the best use of our resources and protect the environment

## 3.11: Business solutions residing in a single data centre

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|---|---|
| Date added to BAF | Pre-Jan 2021 |
| Monitoring Committee | Finance and Investment Committee |
| Executive Lead | Executive Director for Digital & Transformation |
| Date of last review | 20/09/22 |
| Risk movement | ↓ |
| Date of next review | November 2022 |

| | Impact | Likelihood | Rating |
|---|---|---|---|
| Gross (Inherent) risk rating | 4 | 4 | 16 |
| **Current risk rating** | **3** | **3** | **9** |
| Target risk rating | 2 | 2 | 4 |
| Target to be achieved by | Q3 FY23 (delayed from 31 December 2021) | | |

**Risk Description:**
The Trust has an extensive amount of business solutions residing in a single data centre. Failure of that single data centre could result in a number of Trust IT systems becoming unavailable to staff, with the Trust having no direct control over the restoration of services.

| Controls | Assurance | Gaps | Actions |
|---|---|---|---|
| - 'Cloud first' approach where key financial and clinical systems are hosted externally within supplier Public or Private Cloud infrastructures. These systems would not be affected directly by a data centre outage;<br>- Trust hosts a data room within the Whiteleaf Centre where certain systems have resilient hardware;<br>- Clinical business continuity processes in place in the event of a failure over the short term. | **Level 1: reassurance**<br><br>**Level 2: internal**<br>Reporting to the Audit Committee, the Finance & Investment Committee and the Board<br>**Level 3: independent** | | Movement to new data centre (delayed from anticipated completion in December 2021) achieved by September 2022 with new data centre live and disaster recovery resilience in place. The Disaster Recovery plan (in the event of a significant loss of the Trust's data centre) is in the final stages of draft and will be presented to the Trust for adoption once finalised. *This project and its associated risk can then be formally closed*. There is no financial allocation or funding requirement for this project in FY23.<br>Owner: Director of Strategy & Partnerships<br>Target: January 2022 (achieved September 2022)<br><br>New Data Centre was due to be subject to an Internal Audit review as part of FY23 Internal Audit plan but now |

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| | | | delayed as transfer not complete in December 2021. |

## Strategic Objective 3: Make the best use of our resources and protect the environment

## 3.12: Business continuity and emergency planning

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|---|---|
| Date added to BAF | 19/01/21 |
| Monitoring Committee | Emergency Planning Group (sub-group to Executive Management Committee) and moving to Audit Committee from 2022 |
| Executive Lead | Director of Corporate Affairs & Co Sec |
| Date of last review | 28/10/2021 |
| Risk movement | ↔ |
| Date of next review | October 2022 |

| | Impact | Likelihood | Rating |
|---|---|---|---|
| Gross (Inherent) risk rating | 5 | 3 | 15 |
| Current (residual) risk rating | 4 | 3 | 12 |
| Target risk rating | 3 | 3 | 9 |
| Target to be achieved by | | | |

**Risk Description:**
Failure to maintain adequate business continuity and emergency planning arrangements in order to sustain core functions and deliver safe and effective services during a wide-spread and sustained emergency or incident, for example a pandemic, could result in harm to patients, pressure on and harm to staff, reputational damage, regulator intervention.

| Key Controls | Assurance | Gaps | Actions |
|---|---|---|---|
| - Accountable Emergency Officer (currently Director of Corporate Affairs & Co Sec), supported by nominated Non-executive lead and a clinical director;<br>- Designated Emergency Planning Lead, supporting the executive in the discharge of their duties;<br>- Emergency Planning Group 3 x per year oversees emergency preparedness work programme with representation from directorates, HR, and estates & facilities.<br>- Psychosocial Response Group (subgroup reporting | **Level 1: reassurance**<br>- Emergency Planning Resilience and Response (EPRR) Group 3 x per year;<br>- Psychosocial response group (sub-group of Emergency Planning group);<br>- Service Business Continuity Plans signed off by heads of service via relevant directorate/corporate committee.<br>**Level 2: internal**<br>- Annual Emergency Planning, Resilience and Response report (most recently to Board in Nov 2021). Aim to bring annual EPRR reporting to the Audit Committee, before final | On 2020 Self-assessment against NHSE/I EPRR Core Standards, Trust was only partially compliant with 4 of 54 standards (fully compliant with other 50). Partial compliance in respect of:<br>- command and control standard (training of on-call staff)<br>- Training and exercising standard (EPRR training for heads on call & strategic and tactical responder training for heads on call)<br>- Response standard (loggists). | Improvement plan for actions against the 4 core standards with which Trust was not compliant was developed and presented to CCG (Oct 2020). Work is ongoing in relation to Action Plan.<br>OWNER: Director of Corporate Affairs & Co Sec, and Emergency Planning Lead<br>**Update** on four areas of partial compliance (July 2021):<br>- Training: OMT agreed in May 2021 that EPRR training should form part of local induction. Next step is to |

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| to Emergency Planning Group);<br>- Trust wide Pandemic Plan first approved 2012, updated annually, and updated multiple times in 2020 to reflect Covid-19 workstreams, operational changes and learning from Covid-19 pandemic;<br>- Response Manual incident response plan - emergency preparedness, resilience and response) (updated July 2021) provides emergency response framework;<br>- On call system;<br>- Directorate/service specific Business Continuity Plans (BCPs) in place for services, in respect of:<br>Reduced staffing levels (for any reason e.g pandemic); evacuation; technology failure; interruption to power supplies (gas & electricity); severe weather; flooding/water leak; water supply disruption; fuel shortage; lockdown; infection control; food supply; pharmacy supply;<br>- Completion and updating of BCPs supported and monitored by Emergency Planning Lead, with register of BCPs held centrally;<br>- BCPs are reviewed annually or following an incident;<br>- Training for directors on call;<br>- Undertaking of exercises (live exercise every three years, tabletop exercise every year and a test of communications cascades every six months (NHS England emergency preparedness framework, 2015)). Lessons incorporated into major incident plans, business continuity plans and shared with partner organisations;<br>- training scenarios on intranet for services to use to | submission to the Board, starting in late 2022;<br>- EPRR Exercises, with learning incorporated into major incident plans, business continuity plans and shared with partners;<br>- Self-assessment against NHSE/I EPRR Core Standards<br><br>**Level 3: independent**<br>- Self-assessment examined and accepted by CCG on behalf of NHSE/I;<br>- Improvement plan for actions against the 4 core standards with which Trust was not compliant was presented to CCG (Oct 2020). | | work with directorates to enable this.<br>- Loggists: Training delivered to PAs and directors on call (who would lead incident response). |

| | | | |
|---|---|---|---|
| exercise business continuity plans;<br>- Engagement with Thames Valley Local Health Resilience partnership, and Membership of Oxon & Bucks Resilience Groups;<br>- Horizon scanning and review of National and Community Risk registers by Emergency Planning Group. | | | |

## Strategic Objective 3: Make the best use of our resources and protect the environment

## 3.13: The Trust's impact on the environment

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|---|---|
| Date added to BAF | 09/02/21 |
| Monitoring Committee | Finance & Investment |
| Executive Lead | Executive Director for Digital & Transformation |
| Date of last review | 17/11/22 |
| Risk movement | ↔ |
| Date of next review | November 2022 |

| | Impact | Likelihood | Rating |
|---|---|---|---|
| Gross (Inherent) risk rating | 3 | 4 | 12 |
| Current (residual) risk rating | 3 | 3 | 9 |
| Target risk rating | 3 | 1 | 3 |
| Target to be achieved by | 2023 | | |

**Risk Description:**
A failure to take reasonable steps to minimise the Trust's adverse impact on the environment, maintain and deliver a Green Plan, and maintain improvements in sustainability in line with statutory duties, national targets, the NHS Long Term Plan and 'For a Greener NHS' ambitions (30%, 50% and 80% reduction in emissions by 2023, 2025 and 2030 respectively, and net zero carbon by 2040), could lead to: a failure to meet Trust and System objectives, reputational damage, loss of contracts, contribution to increased pollution within the wider community, and loss of cost saving opportunities.

[Statutory duties brought in by the Health & Care Act 2022 s.68 require NHS foundation trusts to have regard to relevant guidance published by NHS England and the need to contribute towards compliance with section 1 of the Climate Change Act 2008 (UK net zero emissions target), section 5 of the Environment Act 2021 (environmental targets) and adapt to any current or predicted impacts of climate change identified in the most recent report under section 56 of the Climate Change Act 2008]

| Key Controls | Assurance | Gaps | Actions |
|---|---|---|---|
| - Trust Green Plan/Strategy 2022-25;<br>- Executive Lead for Sustainability (Director of Finance);<br>- Commitment by Board to Zero Carbon Oxford Charter (Jan 2021);<br>- Full time Sustainability Manager post within Estates & Facilities Team;<br>- Sustainability Group; | **Level 1: reassurance**<br>- Monitoring of deliverables by Sustainability Manager via dashboards;<br>- Sustainability sub-groups (which report on to Sustainability Steering Group).<br>**Level 2: internal**<br>- Green Task Force Group to deliver Green Plan chaired by Chief Finance Officer; Green | GAP: Green Delivery Plan – Sustainability Governance Structure. Action: to develop Sustainability Governance structure and sub groups. OWNER: Executive Lead for Sustainability and Sustainability Lead TARGET: Sept 2022 (completed Sept/Nov 2022). | Green Delivery Plan meetings scheduled in key focus areas: buildings; travel; procurement; medicines; sustainable health & green space / biodiversity. Green Task Force Group will meet Quarterly to deliver Green Plan, from November 2022 chaired by Chief Finance Officer. As at November 2022, 2-year Sustainable |

| | | | |
|---|---|---|---|
| - Benchmarking and annual emissions reporting;<br>- Active Travel Plan to transfer vehicle fleet to 100% electric by 2028 (required date by NHSE);<br>- Procurement Policy – sets out sustainability commitments required by suppliers;<br>- Green Energy Supplier for electricity via CCS,<br>- Developments to BREEAM (building sustainability assessments) and Part L (building regs). | Task Force to meet Quarterly.<br>- Sustainability Steering Group meets quarterly;<br>- Annual Travel Survey monitoring against base-line;<br>- Annual C02 emissions against previous year (to measure trend);<br>- Building Energy Surveys to identify areas of improvement;<br>- New ways of working questionnaires gathering information from services.<br>- As at 31 March 2021, reduced carbon emissions by **38% (exceeding NHS target)** against baseline year of 2014-15;<br>- FY 20/21 **reduced business mileage by 60%** when compared to 19/20;<br>- Direct Carbon emissions for FY21 were **4,793 Co2e** (6,522 in FY19/20).<br>**Level 3: external**<br>- BOB ICS Net Zero Program Board<br>- Total Carbon Footprint Plus now reported by NHS England (54,000Tco2) | Energy crisis 2022 has brought into sharp focus reducing the Estates energy demand.<br><br>Sustainability Policy and Plan were outdated and needed a suite of clear and concise action plans with clear delivery targets.<br><br>GAP: current resource may be insufficient to implement Green Plan. Additional resources to be considered (Sustainable Travel Officer /Sustainability Coordinator)<br><br>Lack of visibility/reporting to Board Committees and/or the Board re sustainability & environmental data. Data is captured by Sustainability Manager and Estates Team, but not currently escalated. | travel Trial (EV for Community Nursing Team) supported by National Greener NHS Team .<br><br>As at November 2022, Energy Policy required to meet challenges of Energy crisis; draft complete and ready for Trust sign-off. During September 2022, proposals developed for the installation of energy efficient LED lighting, building insulation and Solar PV. The Trust is also part of ZCOP sprint group with Oxford University to review how to adapt our building estate to climate change risk e.g extreme heat, floods.<br><br>New Trust Green Plan 2022-25 (roadmap to net zero carbon) been developed through Sustainable Development Management Group and recommended by the Executive. Trust Green Plan approved by the Board on 25 May 2022 and presented to the Council of Governors on 15 June 2022. Green Plan reviewed for financial impact with Chief Finance Officer in October 2022. Green Task Force Group will meet Quarterly to deliver Green Plan, from November 2022 chaired by Chief Finance Officer.<br><br>Increased resource as at June/July 2022. 5 Sub groups (Workforce, Assets/Travel, Green Space, Supply Chain, Sustainable Models of Care) reporting into Sustainability Steering Group.<br><br>Sub-groups to develop action plans and establish resource needs to deliver.<br>OWNER: Sustainability Manager & Director of Finance<br>TARGET: Sept 2022 |

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|---|---|---|---|
| | | Progress in last FY may be reversed if news ways of working are not extended/ maintained post- Covid-19. Approach to limit business miles and use of cars to get to work (Note C-19 pandemic has seen a dramatic reduction in business miles). | Securing grants and central funding for sustainability projects;<br>OWNER: Director of Estates and Facilities/Sustainability Manager.<br><br>New ways of working to be extended/maintained;<br>OWNER: Head of Property Services/Service Director. |

## Strategic Objective 3: Make the best use of our resources and protect the environment

## 3.14 Major Capital Projects

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|---|---|
| Date added to BAF | 20/09/22 |
| Monitoring Committee | Finance and Investment Committee |
| Executive Lead | Chief Finance Officer and Executive Director for Digital & Transformation |
| Date of last review | 17/11/22 |
| Risk movement | ↔ |
| Date of next review | November 2022 |

| | Impact | Likelihood | Rating |
|---|---|---|---|
| Gross (Inherent) risk rating | 5 | 4 | 20 |
| **Current risk rating** | **4** | **4** | **16** |
| Target risk rating | 3 | 2 | 6 |
| Target to be achieved by | 2023 | | |

**Risk Description:**
Insufficient programme infrastructure (or project management) to resource delivery of major capital projects or to support a necessary control environment and adherence to governance and decision-making arrangements may lead to: poorly planned and ultimately compromised capital projects; inability to proceed with capital projects; failure of capital projects to complete or to deliver against preferred outcomes; and unplanned expenses, delays and wasted resources, effectively amounting to constructive losses.

| Key Controls | Assurance | Gaps | Actions |
|---|---|---|---|
| - Programme Boards for key capital projects e.g. PICU Programme Board and Warneford Park Programme Board<br>- Standing Financial Instructions and Scheme of Delegation;<br>- Estates Strategy;<br>- Capital Programme Plan;<br>- Estates & Facilities team;<br>- Service Change & Delivery team (projects and | **Level 1: reassurance**<br>- Capital Programme sub-committee<br>- Warneford Park Project Board<br><br>**Level 2: internal**<br>- Finance & Investment Committee (**FIC**) review of Capital Programme Plan and projects and approval of business cases; | GAP (assurances): Psychiatric Intensive Care Unit (**PICU**) project delayed and with budget overspend. PICU project paused in June 2021; subject to external review December 2021; actions subject to further follow-up January-September 2022 (through Finance & Investment Committee, Audit Committee and Board); and missed original target of | Finance & Investment Committee meeting on 20 September 2022 agreed that the Current Risk Rating should be 16 (extreme/red-rated) in light of further delays around the PICU. However, this extreme risk rating may be a short-term position and if there is evidence of improvement then the Current Risk Rating may improve, although the |

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| programme support for transformational projects and service change internally and with external partners); | -FIC monitors work of the Capital Programme sub-committee;<br>- FIC receives updates on/minutes of the Warneford Park Project Board for the Warneford redevelopment project<br>**Level 3: independent**<br>Internal Audit report on PICU project (December 2021) - highlighted actions to strengthen the PICU project | May 2022. Revised target of completion by 2023 unlikely to be met. New target of completion after March 2023. May remain a Gap pending evidence that lessons learned been embedded.<br><br>GAP (assurances): Warneford redevelopment project still in negotiation and development phase. | strategic risk may still remain for monitoring.<br><br>Internal Audit PICU project review report reviewed by Audit Committee, December 2021 and actions undertaken January-September 2022. Board reviewed PICU project at its meeting in private in May 2022 and received assurance that programme and project governance strengthened. Monthly Programme Board now in place. New target for PICU scheme to complete within 2023.<br>OWNERS: Executive Director for Digital & Transformation<br><br>Regular updates into the FIC and the Board meeting in private on the progress of the Warneford redevelopment. Board kept updated on negotiations, Memorandum of Understanding and legal agreements, for example recently at its meeting in private in June 2022 which confirmed creation of a Warneford Park Programme Board (chaired by a Non-Executive Director). Further updates to Board in private in July and September 2022. Appropriate independent expert and/or legal advice to be obtained to support decisions relating to significant transactions (e.g. as part of significant capital projects such as PICU build and Warneford redevelopment projects), and decision makers to be fully sighted on such independent advice.<br>OWNERS: Director of Corporate Affairs & Co Sec, Executive Director for Digital & Transformation, and Chief Finance Officer. |

# Strategic Objective 4: Become a leading organisation in healthcare research and education

## 4.1: Failure to realise the Trust's Research and Development (R&D) potential

| | |
|---|---|
| Date added to BAF | Pre-Jan 2021 |
| Monitoring Committee | Quality Committee |
| Executive Lead | Chief Medical Officer |
| Date of last review | 22/02/22 |
| Risk movement | ↔ |
| Date of next review | November 2022 |

| | Impact | Likelihood | Rating |
|---|---|---|---|
| Gross (Inherent) risk rating | 3 | 3 | 9 |
| **Current risk rating** | **3** | **2** | **6** |
| Target risk rating | 3 | 1 | 3 |
| Target to be achieved by | | | |

**Risk Description:**
Failure to fully realise the Trust's academic and Research and Development (R&D) potential may adversely affect its reputation and lead to loss of opportunity.

| Controls | Assurance | Gaps | Actions |
|---|---|---|---|
| - Director of R&D;<br>- NIHR Infrastructure Managers Group (formerly the Research Management Group (RMG)) which provides an opportunity for managers of the NIHR awards and the R&D Director to meet regularly;<br>- Clinical Research Facility (CRF) and Biomedical Research Centre (BRC)<br>- BRC Steering Committee (BRC-SC);<br>- Oxford Applied Research Collaboration Oxford and Thames Valley (OxTV) (ARC);<br>- ARC Management Board;<br>- The R&D Director sits on the OUH Joint R&D committee. In December 2021 the Oxford Joint Research Office (JRO) was expanded with the Trust and Oxford Brookes University formally joining with the University of Oxford and OUH; | **Level 1: reassurance**<br><br>**Level 2: internal**<br>- Research updates and R&D reporting into the Quality Committee;<br>- R&D reports to Board (at least twice a year, most recently in March 2022 and next due in July 2022);<br>- progress reporting on the Toronto – Oxford Psychiatry Collaboration also provided to the Board (most recently in the Reading Room for the Board meeting in public in January 2022)<br><br>**Level 3: independent**<br>- The BRC, CRF, ARC and MIC report annually to the National Institute for Health Research (NIHR);<br>- R&D is audited by the Thames Valley & South Midlands Clinical Research Network (TV&SM- CRN) annually; | GAP (Controls): R&D Strategy in development.<br><br>GAP (Controls): Outcome of the Clinical Research Facility (CRF) bid is expected in early 2022.<br><br>GAP (Controls): Outcome of the Biomedical Research Centre (BRC) bid (otherwise the current BRC award will finish at the end of November 2022). BRC renewal will be key in | R&D Strategy and future goals discussed at the Inspire Network event on 09 June 2022 (themed on 'R&D: Today's Research, Tomorrow's Care'). The Inspire Network event covered how research was embedded in services and how staff could get involved. A future goal was for the R&D Strategy to support clinical strategy in the Trust and to increase the amount of translational research.<br><br>In February 2022 the NIHR confirmed that the CRF application had been successful and just over £4m had been awarded.<br><br>Interviews for the Trust's BRC application took place in April 2022. NIHR will announce outcome and any funding awards in May 2022. |

| | | | |
|---|---|---|---|
| - representation and collaboration via these groups help to ensure that OHFT maximises the opportunities to fully realise its academic and research potential;<br>- Toronto – Oxford Psychiatry Collaboration under a Memorandum of Understanding between the Trust, University of Oxford, the University of Toronto and the Centre for Addiction and Mental Health in Toronto | - In December 2018 R&D was subject to a two audits by the Department for Health and Social Care where no areas of concern where raised. | developing and embedding a culture of research across the Trust. It will also be an attractive feature in recruitment and may lead to the appointment of more clinical academics.<br><br>GAP (Controls): Warneford redevelopment – to progress. Complicated capital project and is being carefully monitored by the Finance & Investment Committee and with regular updates to the Board in private session. | Recent reporting on the Warneford into the Extraordinary Board (private session) in March 2022 and to the Board in private in May and June 2022. Also reporting into the FIC in January and July 2022. |

## APPENDIX 1 TO BAF: RISK SCORING GUIDANCE

**Table 1a: Risk Matrix**

| | | Likelihood | | | | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 |
| | | Rare | Unlikely | Possible | Likely | Almost certain |
| Impact/severity | 5 Catastrophic | 5 | 10 | 15 | 20 | 25 |
| | 4 Major | 4 | 8 | 12 | 16 | 20 |
| | 3 Moderate | 3 | 6 | 9 | 12 | 15 |
| | 2 Minor | 2 | 4 | 6 | 8 | 10 |
| | 1 Negligible | 1 | 2 | 3 | 4 | 5 |

**Table 1b: Likelihood scores (broad descriptors of frequency and probability)**

| **Likelihood score** | **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|
| **Descriptor** | **Rare** | **Unlikely** | **Possible** | **Likely** | **Almost certain** |
| **Frequency** How often might/does it occur | This will probably never happen/recur | Do not expect it to happen/recur but it is possible | Might happen or recur occasionally | Will probably happen/recur, but it is not a persisting issue | Will undoubtedly happen/recur, possibly frequently |
| **Probability** Will it happen or not? | <0.1% | 0.1-1% | 1-10% | 10-50% | >50% |

## APPENDIX 1 TO BAF: RISK SCORING GUIDANCE

**Table 1c - Assessment of the impact/severity of the consequence of an identified risk: domains, consequence scores and examples**

| | Consequence score (severity) and examples | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| Domains | Negligible | Minor | Moderate | Major | Catastrophic |
| Impact on the safety of patients, staff or public (physical/psychological harm) | Minimal injury requiring no/minimal intervention or treatment<br><br>No time off work | Minor injury or illness requiring minor intervention<br><br>Increase in length of hospital stay by 1–3 days | Moderate injury requiring professional intervention<br><br>Requiring time off work for 4-14 days<br><br>Increase in length of hospital stay by 4–15 days<br><br>RIDDOR/agency reportable incident<br><br>An event which impacts on a small number of patients | Incident resulting serious injury or permanent disability/incapacity<br><br>Requiring time off for >14 days<br><br>Increase in length of hospital stay by >15 days<br><br>Mismanagement of patient care with long-term effects | Incident resulting in fatality<br><br>Multiple permanent injuries or irreversible health effects<br><br>An event which impacts on a large number of patients |
| Quality/ Complaints/audit | Peripheral element of treatment or service suboptimal<br><br>Informal complaint/inquiry | Overall treatment or service suboptimal<br><br>Formal complaint (stage 1)<br><br>Local resolution<br><br>Single failure to meet internal standards<br><br>Minor implications for patient safety if unresolved<br><br>Reduced performance rating if unresolved | Treatment or service has significantly reduced effectiveness<br><br>Formal complaint (stage 2)<br><br>Local resolution (with potential to go to independent review)<br><br>Repeated failure to meet internal standards<br><br>Major safety implications if findings are not acted upon | Non-compliance with national standards with significant risk to patients if unresolved<br><br>Multiple complaints / independent review<br><br>Low performance rating<br><br>Critical report<br><br>Major patient safety implications | Totally unacceptable level or quality of treatment/service<br><br>Gross failure of patient safety if findings not acted on<br><br>Inquest/ombudsman inquiry<br><br>Gross failure to meet national standards |
| Human resources / organisational development / staffing / competence | Short-term low staffing level that temporarily reduces service quality (< 1 day) | Low staffing level that reduces the service quality | Late delivery of key objective / service due to lack of staff<br><br>Unsafe staffing level or competence (>1 day) | Uncertain delivery of key objective / service due to lack of staff<br><br>Unsafe staffing level or | Non-delivery of key objective/service due to lack of staff<br><br>Ongoing unsafe staffing levels or competence |

## APPENDIX 1 TO BAF: RISK SCORING GUIDANCE

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|---|---|---|---|---|---|
| | | | Low staff morale<br><br>Poor staff attendance for mandatory/key training | competence (>5 days)<br><br>Loss of key staff<br><br>Very low staff morale<br><br>No staff attending mandatory / key training | Loss of several key staff<br><br>No staff attending mandatory training / key training on an ongoing basis |
| **Statutory duty / inspections** | No or minimal impact or breach of guidance / statutory duty | Informal recommendation from regulator.<br><br>Reduced performance rating if unresolved. | Single breach in statutory duty<br><br>Challenging external recommendations / improvement notice | Enforcement action<br><br>Multiple breaches in statutory duty<br><br>Improvement notices<br><br>Low performance rating<br><br>Critical report | Multiple breaches in statutory duty<br><br>Prosecution<br><br>Complete systems change required<br>Zero performance rating<br><br>Severely critical report |
| **Adverse publicity / reputation** | Rumours<br><br>Potential for public concern | Local media coverage – short-term reduction in public confidence<br><br>Elements of public expectation not being met | Local media coverage– long-term reduction in public confidence | National media coverage with <3 days service well below reasonable public expectation | National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House)<br><br>Total loss of public confidence |
| **Business objectives / projects** | Insignificant cost increase/ schedule slippage | <5 per cent over project budget<br><br>Schedule slippage of a week | 5–10 per cent over project budget<br><br>Schedule slippage of two to four weeks | 10–25 per cent over project budget<br><br>Schedule slippage of more than a month<br><br>Key objectives not met | >25 per cent over project budget<br><br>Schedule slippage of more than six months<br><br>Key objectives not met |
| **Finance including claims** | Negligible loss | Claim of <£10,000<br><br>Loss of 0.1-0.25% of budget | Claim of between £10,000 and £100,000<br><br>Failure to meet CIPs or CQUINs targets of between £10,000 and £50,000<br><br>Loss of 0.25-0.5% of budget | Claim of between £100,000 and £1million<br><br>Purchasers fail to pay promptly<br><br>Uncertain delivery of key objective / Loss of 0.5-1.0% of budget | Loss of major contract / payment by results<br><br>Claim of >£1million<br><br>Non-delivery of key objective/loss of >1% of budget |

# APPENDIX 1 TO BAF: RISK SCORING GUIDANCE

| | | | | | |
|---|---|---|---|---|---|
| **Service/business interruption Environmental impact** | Loss/interruption of >1 hour<br><br>Minimal or no impact on the environment | Loss / interruption of >8 hours<br><br>Minor impact on environment | Loss / interruption of >1 day<br><br>Moderate impact on environment | Loss / interruption of >1 week<br><br>Major impact on environment | Permanent loss of service or facility<br><br>Catastrophic impact on environment |
| **Additional examples** | Incorrect medication dispensed but not taken<br><br>Incident resulting in bruise/graze<br><br>Delay in routine transport for patient. | Wrong drug or dosage administered with no adverse effects<br><br>Physical attack such as pushing, shoving or pinching causing minor injury<br><br>Self harm resulting in minor injury<br><br>Grade 1 pressure ulcer<br><br>Laceration, sprain, anxiety requiring occupational health counselling (no time off work) | Wrong drug or dosage administered with potential adverse effects<br><br>Physical attack causing moderate injury<br><br>Self-harm requiring medical attention<br><br>Grade 2/3 pressure ulcer<br><br>Healthcare acquired infection (HCAI) | Wrong drug or dosage administered with adverse effects<br><br>Physical attack resulting in serious injury<br><br>Grade 4 pressure sore<br><br>Long term HCAI<br><br>Loss of a limb<br><br>Post-traumatic stress disorder | Unexpected death<br><br>Suicide of patient know to the service in the last 12 months<br><br>Homicide committed by mental health patient<br><br>Incident leading to paralysis<br><br>Rape/serious sexual assault<br><br>Incident leading to long term mental health problem |