

# Report to the Meeting of the Oxford Health NHS Foundation Trust

# Board of Directors

BOD 75/2021

(Agenda item: 7)

**30 November 2021**

**Board Assurance Framework (BAF) and Trust Risk Register (TRR) update**

**For: Information/Assurance**

**Executive Summary**

The purpose of this report is to provide the Board with oversight of the Board Assurance Framework (BAF) and the Trust Risk Register (TRR), the progress of risks thereon and any key developments in risk management processes since the last report to a Board meeting in public on 29 September 2021:

* the overall ratings of the extreme (red-rated) risks at both BAF and TRR level are unchanged since the last report (mitigating actions are set out in the report);
* the common and intractable theme which is impacting on the extreme risks across the BAF and TRR is the demand and capacity challenge, which also impacts on the risks related to workforce, recruitment and waiting times; but
* one BAF risk has been proposed for potential closure by their lead Executive: ‘*failure to fully realise the Trust’s Research & Development (R&D) potential may adversely affect its reputation and lead to loss of opportunity’* (BAF 4.1), further to the recruitment of a Director of R&D, and given no immediate impact from Brexit. The Board may wish to approve the closure, or delegate the decision to the Quality Committee for February 2022. If this risk is closed, however, the Trust will have no strategic level risk on the BAF impacting the likelihood of the Trust meeting its objectives under Strategic Objective 4 (to become a leading organisation in healthcare research and education).

The Board is receiving this report to support it in its duties to ensure that the Trust maintains a sound system of internal control to support the achievement of the Trust’s policies, aims and objectives.

**PART 1:** Provides an update on **the BAF** and the strategic risks thereon. The full BAF is presented at **Appendix 1** to this report, if the detail is required. **PART 2:** Provides an update on the operational risks on **the TRR**. The TRR is presented at **Appendix 2** if further detail is required. The Appendices are in the Reading Room of the Board papers.

The table below summarises the BAF and TRR risks rated as extreme (‘red’) with current risk ratings of 15 of more (the detail is in Parts 1-2 and Appendices 1-2):

| **Risk Title** | **Current Risk Rating** | **Target Risk Rating** | **Owner** | **Monitoring Committee** | **Last detailed review by Committee[[1]](#footnote-1)** |
| --- | --- | --- | --- | --- | --- |
| **Extreme (red-rated) BAF risks** |
| 1.6 – Demand and capacity | 16 | 12 | MD Primary & Community Care Services | Quality Committee | 29/09/21 |
| 2.1 – workforce planning  | 16 | 9 | Interim HR Director | People, Leadership & Culture Committee(**PLC**) | To be reviewed by committee[[2]](#footnote-2) |
| 2.2 – recruitment | 16 | 9 | Interim HR Director | PLC | 21/10/21 |
| 3.1 - Failure of the Health and Social Care Place Based, Integrated Care Systems and Provider Collaboratives to work together | 16 | 9 | MD Mental Health & LD | Quality Committee | To be reviewed by committee |
| 3.4 – Delivery of the financial plan and maintaining financial sustainability | 16 | 12 | Director of Finance  | Finance & Investment Committee(**FIC**) | 13/07/21 |
| **Extreme (red-rated) TRR risks** |
| 999 – Demand and capacity in community eating disorder services | 16 | 6 | MD Mental Health & LD | Quality Committee | To be reviewed by committee[[3]](#footnote-3) |
| 1000 – Provision of CAMHS PICU, ED and GAU beds with the Trust’s provider collaborative footprint | 16 | 4 | MD Mental Health & LD | Quality Committee | To be reviewed by committee |
| 1019 – recruitment | 16 | 8 | Chief People Officer | PLC | 21/10/21 |
| 1020 – work related stress | 16 | 9 | Chief People Officer | PLC | 06/05/21  |
| 1068 – waiting times (mental health services) | 15 | 9 | MD Mental Health & LD | Quality Committee | 09/09/21 |
| 1132 - HR Systems | 16 | 6 | Director for Strategy & Partnerships | FIC | 21/09/21 |

**BAF risk proposed for closure – for discussion/decision or delegation to the Quality Committee**

**4.1 - Failure to fully realise the Trust’s Research & Development (R&D) potential may adversely affect its reputation and lead to loss of opportunity**

The Chief Medical Officer has recommended that this risk be closed in light of the recruitment of a Director of R&D, and given there has been no immediate effect from Brexit. The Board may wish to approve this, or delegate the decision to the appropriate monitoring committee for this risk (the Quality Committee which is next due to meet on 10 February 2022). If this risk is closed, however, the Trust will have no strategic level risk on the BAF impacting the likelihood of the Trust meeting its objectives under Strategic Objective 4 (to become a leading organisation in healthcare research and education).

**PART 3:** Provides some detail as to current risk management processes, and a summary of the committees and meetings which have considered risk registers (or specific risk register risks) since the last report to the Board.

**Governance Route**

The BAF & TRR were last reported to a meeting of the Board on 29 September 2021. Committees and meetings which have since considered a risk registers item are as follows:

|  |  |
| --- | --- |
| 11/09/21 & 11/11/21 | Quality Committee |
| 15/09/21 | Audit Committee |
| 21/09/21 & 24/11/21 | Finance and Investment Committee |

Details of the risk items covered at these meetings is included in Part 3 of the body of this report. Of note, in recent meetings the focus of risk reporting to the committees has moved towards assessing the quality and effectiveness of controls via consideration of available sources of (positive or negative) assurance and our tolerance (i.e. target risk rating) in respect of individual risks.

Individual risk review meetings with Risk Owners are ongoing on a bi-monthly basis. These meetings are supplemented by reviews with operational leads, with the facility to automate TRR risk review requests now being utilised.

**Recommendation**

The Board is invited to:

1. decide whether to approve the closure of BAF risk 4.1 or delegate the decision to the Quality Committee for February 2022 (4.1 is the risk of failure to fully realise the Trust’s Research & Development (R&D) potential which may adversely affect its reputation and lead to loss of opportunity);
2. consider the BAF and TRR (particularly the extreme ‘red’ risks highlighted in this report) and discuss any risk(s) of concern or interest to the Board to seek assurance as to whether the risk is being appropriately managed;
3. reflect on matters arising from other agenda items heard at this meeting (or within the Board’s wider knowledge) and identify any emerging or new risks for consideration for inclusion on the BAF or TRR;
4. note the updates to the registers highlighted in Parts 1 & 2 of this report;
5. note the reviews and discussions undertaken by the Board, committees and other meetings in respect of the management of risk and risk registers, outlined in Part 3; and
6. consider whether it is assured that there is effective management of the key operational and strategic risks and, if not, make recommendations as to how such assurance might be achieved.

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Neil McLaughlin, Trust Solicitor & Risk Manager; and Hannah Smith, Assistant Trust Secretary**

**Lead Executive Director: Kerry Rogers, Director of Corporate Affairs and Company Secretary**

1. *A risk assessment has been undertaken around the legal issues that this report presents and [there are no issues that need to be referred to the Trust Solicitors*
2. ***Strategic Objectives/Priorities*** *– this report relates to or provides assurance and evidence against the following Strategic Objective(s)/Priority(ies) of the Trust:*

*1) Quality - Deliver the best possible care and health outcomes*

*2) People - Be a great place to work*

*3) Sustainability – Make best use of our resources and protect the environment*

*4) Research and Education – Become a leader in healthcare research and education*

**PART 1: Board Assurance Framework (BAF)**

The **BAF sets out the strategic risks** (whilst the TRR sets out the operational risks) **to the Trust achieving its identified long-term Strategic Objectives**. The BAF is a key document for the Board in ensuring principle strategic risks are controlled, that the effectiveness of the key controls has been assured, and that there is sufficient evidence to support the Annual Governance Statement.

The BAF has been kept under review and up to date by way of individual bi-monthly meetings with executive owners and various board, committee and other meetings, as outlined in Part 1 of this report.

The following section highlights **for information** red risks, new risks, closed risks, and risk movement/change in relation to risks on the BAF. Full detail of these risks can be found in the **BAF at Appendix 1**.

**‘Red’ risks on the BAF**

The following BAF risks are rated as extreme risks with a current risk rating of 15 or more:

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| --- | --- | --- | --- | --- | --- |
| **Risk Title** | **Current risk Rating** | **Target Risk Rating** | **Owner** | **Monitoring Committee** | **Last detailed review by Committee** |
| **1.6 – Demand and capacity** | 16 | 12 | MD Primary & Community Care Services | Quality Committee | 11/11/21 |
| Risk that the need for services exceeds the Trust’s capability and capacity to respond, resulting in: increased waits; compromise to quality and safety; and poorer outcomes.

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| Controls: | Potential gaps: |
| 1) Development of Demand & Capacity App – to help operational services to visualise past activity to forecast demand and plan a response | Although progress has been made to visualise waiting lists and demand for services, the Trust has not set clinical targets across all service lines for waiting lists |
| 2) Deployment of a Workforce Management System for the management and rostering of staff. This enables operational managers to plan shift patterns and to identify and resolve gaps in staffing | The Workforce Management System has not been rolled out across the Trust  |
| 3) Reporting of activity to inform priority and investment decisions | Insufficient funding from commissioner contracts in some services |
| 4) Recovery & Surge Planning group to look at a co-ordinated approach to the recovery from COVID-19 |

Actions:* each service line is setting a target timeframes within which patients in each priority group should be seen. Performance can then be reported and workforce and pathways planned based on the standards agreed;
* roll out of training to accompany the Demand & Capacity App to facilitate management of service capacity and waits;
* complete roll out of Workforce Management System;
* complete demand and capacity project work to identify service areas which are under-funded (to support dialogue with commissioners).
 |
| **2.1 – workforce planning**  | 16 | 9 | Interim HR Director | PLC | Not yet reviewed by PLC |
| 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.Risk rating reviewed 21/9/21 with Interim Director of HR – current extreme risk rating unchanged, but to be considered again once workforce planning resource is embedded (see actions).

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| Controls: | Potential Gaps: |
| E-Rostering Governance Group being established to progress the movement of the Trust through NHSI/E E-Rostering attainment levels which supports short term management and review of workforce. | Lack of Workforce Planning capability and capacity has been identified.  |
| Weekly Review Meeting led by Nursing and Clinical Governance reviewing staffing levels and incidents. |  |
|  |  |

Actions:* Workforce Planning capability in HR to be developed - Workforce Planning Consultant role has been advertised, with selection and interview processes to commence following application closure on 23/9/21;
* Detailed plans to be put in place once workforce planning resource is in place;
* Work to more accurately reflect workforce needs within MH inpatient settings via ‘Reducing Agency, Improving Quality’ workstream.
 |
| **2.2 – recruitment** | 16 | 9 | Interim HR Director | PLC | 21/10/21 |
| A failure to recruit to vacancies could lead to: the quality and quantity 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.Risk rating reviewed 21/9/21 with Interim Director of HR – current extreme risk rating unchanged, but to be considered again once actions embedded.

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| Controls: | Potential gaps: |
| - 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);- the development of recruitment plan for each service to address areas of candidate attraction and retention; - collaboration with other local NHS Trusts to understand the overall employment marketplace and take joint pre-emptive action where possible, including collaboration with OUH on recruiting from Brookes University; - proactive virtual career events at universities, recruitment fairs and for attracting those new to health and care services - Apprenticeship Programme; - career development pathway for HCAs;   | * system and national recruitment challenges;
 |

Actions:* Recruitment of dedicated recruitment resource in HR team – selection and interviews of applicants for 2x recruitment campaign manager roles to commence this month;
* Continuation of trust-wide ‘Reducing agency, improving quality’ and recruitment work-streams, including international recruitment;
* Service level recruitment initiatives;
* review of operation model of the transactional recruitment team to improve efficiency;
* Controls and actions to improve retention of existing staff (linked BAF risk 2.5)
 |
| **3.1 - Failure of the Health and Social Care Place Based, Integrated Care Systems and Provider Collaboratives to work together** | 16 | 9 | MD Mental Health & LD | Quality Committee | Not yet reviewed by Quality Committee |
| 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.

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| Controls: | Potential Gaps: |
| BOB MH & LD Oversight Group; | Currently no place-level governance board/group in Oxon; |
| Oxon and Bucks MH, LD & A Delivery Boards, and BSW Thrive Board; | Absence of system-wide data sets and aligned reporting; |
| Joint work / operational processes with CCGs, local authorities and other partners including PCNs; | Financial pressure on CCGs, ICS, County Councils and Social Care impacting adversely on required MH & LD investment. |
| Development of alliances and partnerships with other organisations, including the voluntary sector; |  |
| Exec to Exec discussions with BHFT & OUH & AWP; |  |
| Provider Collaborative Governance arrangements; |  |
| OH participation in key strategic, operational and contracting meetings. |  |

Actions:* Working with place based and local partners to ensure place and system governance;
* Ensuring engagement in funding dialogue with CCGs and ICSs for system clinical and financial planning;
* Work ongoing to understand data and identify reporting inconsistencies.
 |
| **3.4 – Delivery of the financial plan and maintaining financial sustainability** | 16 | 12 | Director of Finance  | FIC | 13/07/21 |
| Risk that we fail to deliver financial plan and maintain financial sustainability, including, but not limited to: through non-delivery of Productivity Improvement Plan/Cost Improvement Plan (PIP/CIP) savings; budget overspends; under-funding and constraints of block contracts in the context of increasing levels of activity and demand.

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| Controls: | Potential Gaps: |
| Annual Financial Plan and Budget produced, and approved by FIC and the Board; | Underfunding of some service contracts (e.g. Oxon Community Services) |
| Standing Financial Instructions; | Uncertainty around NHS financial regime from October 2021 onwards |
| Policies (Budgetary Control, Procure; and Counter Fraud); |  |
| Robust cash management arrangements; |  |
| Active management of Capital Programme; |  |
| Regular reporting on Financial position and impact of wider financial system risks to FIC and Board;Actions: |  |

* Involvement in NHSE/I and ICS planning meetings for latest updates and involvement in any consultation meetings on proposed financial regime;
* close monitoring of internal forecast for 2021-22 with clear assumptions around income; and
* re. Community Directorate underfunding - (a) Community Services Strategy to be completed, followed by (b) costs analysis, and (c) structured discussions about funding gaps with Commissioners.
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**Full BAF Summary**

A summary of all risks currently on the BAF appears on the following pages.

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| **BAF SUMMARY** Contents of this summary table (p.1-2) are hyperlinked to full BAF (at p.3 onwards). |
| **REF.** | **LEAD EXEC. DIRECTOR (ED)**  | **RISK** | **RATING** | **TARGET** | **MOVEMENT** | **LAST ED REVIEW** |
|  | **MONITORING COMMITTEE**  |  |  |  |  | **REVIEW BY COMMITTEE** |
| 1. **Quality - Deliver the best possible care and outcomes**
 |
| [1.1](#BAF_1_1) | Chief Nurse | **Clinical quality and safety standards**  | 12 | 8 | ↔ | 09/02/21 |
|  | Quality Committee |  |  |  |  |  |
| [1.3](#BAF_1_3) | Exec MD for MH & LD | **Delivery of transformation and effective management of change**  | 12 | 8 | ↔ | 19/11/21 |
|  | Quality Committee |  |  |  |  |  |
| [1.5](#BAF_1_5) | Exec MD for MH & LD | **Unavailability of beds across mental health inpatient services and LD**  | 12 | 4 | ↔ | 19/11/21 |
|  | Quality Committee |  |  |  |  |  |
| [1.6](#BAF_1_6) | Exec MD Primary Care & Community | **Demand and capacity**  | 16 | 12 | ↔ | 22/11//21 |
|  | Quality Committee |  |  |  |  | 11/11/21 |
| 1. **People - Be a great place to work**
 |
| [2.1](#BAF_2_1) |  Chief People Officer | **Workforce Planning**  | 16 | 9 | ↔ | 21/09/21 |
|  | PLC |  |  |  |  |  |
| [2.2](#BAF_2_2) | Chief People Officer | **Recruitment** | 16 | 9 | ↔ | 21/09/21 |
|  | PLC |  |  |  |  | 21/10/21 |
| [2.3](#BAF_2_3) | Chief People Officer | **Succession planning, organisational development and leadership development**  | 6 | 4 | ↔ | 21/09/21 |
|  | PLC |  |  |  |  |  |
| [2.4](#BAF_2_4) | Chief People Officer | **Developing and maintaining a culture in line with Trust values**  | 9 | 4 | ↔ | 21/09/21 |
|  | PLC |  |  |  |  | 18/02/21 |
| [2.5](#BAF_2_5) | Chief People Officer | **Retention of staff** | 12 | 9 | ↔ | 21/09/21 |
|  | PLC |  |  |  |  | 20/07/21 |

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| 1. **Sustainability - Make the best use of our resources and protect the environment**
 |
| [3.1](#BAF_3_1) | Exec MD for MH & LD | **Failure of the Health and Social Care Place Based, Integrated Care Systems and Provider Collaboratives to work together**  | 16 | 9 | ↔ | 19/11/21 |
| Quality Committee |  |
| [3.2](#BAF_3_2) | Director for Strategy & Partnerships  | **Governance of external partners**  | 9 | 9 | ↔ | 14/05/21 |
| Quality Committee |  |
| [3.4](#BAF_3_4) | Director of Finance | **Delivery of the financial plan and maintaining financial sustainability** | 16 | 12 | ↔ | 03/11/21 |
| Finance & Investment  | 13/07/21 |
| [3.6](#BAF_3_6) | Director of Corporate Affairs & Co Sec | **Governance and decision-making arrangements**  | 12 | 4 | ↑ | 22/11//21 |
| Audit Committee |  |
| [3.7](#BAF_3_7) | Director of Finance | **Ineffective business planning arrangements and/or inadequate mechanisms to track delivery of plans and programmes**  | 12 | 6 | ↑ | 13/07/21 |
| Finance & Investment |  |
| [3.10](#BAF_3_10) | Director for Strategy & Partnerships | **Protecting the information we hold**  | 12 | 9 | ↔ | 14/05/21 |
| Quality Committee |  |
| [3.11](#BAF_3_11) | Director for Strategy & Partnerships  | **Business solutions in a single data centre** | 12 | 4 | ↔ | 13/07/21 |
| Finance & Investment | 13/07/21 |
| [3.12](#BAF_3_12) | Director of Corporate Affairs & Co Sec | **Business continuity and emergency planning**  | 12 | 9 | ↔ | 28/10/21 |
|  |  |
| [3.13](#BAF_3_13) | Director for Strategy & Partnerships | **The Trust’s impact on the environment** | 9 | 3 | ↔ | 13/07/21 |
| Finance & Investment | 13/07/21 |
| 1. **Research & Education - Become a leader in healthcare research and education**
 |
| [4.1](#BAF_4_1) | Chief Medical Officer | **Failure to realise the Trust's Research and Development (R&D) potential** *[risk to be reviewed following approval of R&D strategy]* | 6 | 3 | ↔ | 12/11/21 |
|  |  |

**New risks on the BAF since 29 September 2021**

None

**Risk change/movement on BAF risks since 29 September 2021**

**3.6 – Governance and decision-making arrangements**

This risk rating has increased from 9 to 12 following a review whereby the impact was increased from 3 to 4 in light of the delays experienced in relation the scheduled anticipated build time for the PICU at the Warneford Hospital site.

**3.7 - Ineffective business planning arrangements and/or inadequate mechanisms to track delivery plans and programmes.**

This risk rating has increased from 8 to 12 following a review whereby the likelihood was increased from 2 to 3. A further gap has been identified and the risk has been updated in detail below. Subject to Board approval.

**Closed risks on BAF since 29 September 2021**

None

**BAF risk proposed for closure – for discussion/decision or delegation to the Quality Committee**

**4.1 - Failure to fully realise the Trust’s Research & Development (R&D) potential may adversely affect its reputation and lead to loss of opportunity**

The Chief Medical Officer has recommended that this risk be closed in light of the recruitment of a Director of R&D, and given there has been no immediate effect from Brexit. The Board may wish to approve this, or delegate the decision to the appropriate monitoring committee for this risk (the Quality Committee which is next due to meet on 10 February 2022). If this risk is closed, however, the Trust will have no strategic level risk on the BAF impacting the likelihood of the Trust meeting its objectives under Strategic Objective 4 (to become a leading organisation in healthcare research and education).

**PART 2: Trust Risk Register (TRR)**

The **TRR** sets out the **key operational risks** to the Trust achieving its identified long-term Strategic Objectives.

Monitoring and management of risks on the TRR is undertaken via the Ulysses system. The Risk Owner of each risk on the TRR is a member of the Executive and has direct access to the TRR through the Ulysses Incident Management portal on the Trust’s Intranet.

The TRR has been kept under review and up to date by way of individual bi-monthly meetings with Executive Owners and various board, committee and other meetings, as outlined in Part 1 of this report. This continuous process of review is evidenced by the development of new risks, closure of risks and any risk movement outlined below.

The following section highlights **for information** red risks, new risks, closed risks, and risk movement/change in relation to risks on the TRR. Further detail relating to these risks can be found in the **Trust Risk Register at Appendix 2**.

**‘Red’ risks on the TRR**

The following TRR risks are rated as extreme risks with current risk ratings of 15 of more:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Risk Title** | **Current risk Rating** | **Target Risk Rating** | **Monitoring Committee** | **Last detailed review by Committee** | **Owner** |
| **999 – Demand and capacity in community eating disorder services** | 16 | 6 | Quality Committee | 11/11/21 | MD Mental Health & LD |
| Insufficient capacity and recruitment challenges, compounded by increasing demand and acuity may result in unsafe waiting times. Patients may not be provided with timely care to prevent deterioration in condition, resulting in harm to patients, poorer outcomes and unsustainable workloads for staff.

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| Controls: | Potential Gaps: |
| Risk based triage and case load reviews for those waiting; | Local and national staff shortages |
| Recent work with external management service on development of existing team to support retention; | MDT vacancies remainMinimal access to support from third sector |
| Active recruitment plan, with recent successes (incl. new Team Leader, consultants, and MDT roles); |  |
|  |  |
| Additional senior management support from Service Director Oxon BSW; |  |
|  |  |
| New operational processes to optimise pathways, learn and manage risk; |  |
|  |  |
| (Temporary) tightening of referral criteria (communicated with primary care) while team development continues;Agency and locum staff to fill vacancies. |  |

Actions:* Work and scoping to agree and develop optimal patient pathways;
* Recruitment support enlisted from Director of Clinical Workforce Transformation and service level recruitment initiatives (including incentives);
* QI project to look at process mapping for the service.
 |
| **1000 – Provision of CAMHS PICU, ED and GAU beds with the Trust’s provider collaborative footprint** | 16 | 4 | Quality Committee | 11/11/21 | MD Mental Health & LD |
| Lack of CAMHS Psychiatric Intensive Care Unit (PICU), General Adolescent Unit (GAU) and specialist Eating Disorder (Tier 3 & 4) beds available nationally and regionally may lead to YP being cared for out of area or in the wrong environment for needs, resulting in poorer outcomes, patient harm, increased cost.

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| Controls: | Potential Gaps: |
| Clinical oversight (via provider collaborate clinical director and case managers) of YP considered to be in an inappropriate bed and involve of carers in care planning  |  |
| Provider collaboratives now live with a single point of access for CAMHS beds and proactive management of beds needs and allocation;  |  |
| SE regional sit rep calls at least weekly to manage demand and flow; |  |
| Trust is providing QI resource to independent sector providers to facilitate opening of beds. |  |
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| Build of new PICU at Warneford site has commenced. |  |
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Actions:* Scoping exercise with system partners to develop joint acute CAHMS ED bed provision;
* Continuing QI support to independent sector to facilitate opening of additional beds;
* PICU build.
 |
| **1019 – recruitment** | 16 | 8 | PLC | 21/10/21 | Chief People Officer |
| 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 | Potential Gaps |
| - 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); | 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). |
| - Improving Quality, Reducing Agency Programme Board; |  |
| - the development of an overarching recruitment plan for each service to address areas of candidate attraction and retention;  | 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.  |
| - collaboration with other local NHS Trusts to understand the overall employment marketplace and take joint pre-emptive action where possible, including collaboration with OUH on recruiting from Brookes University;  | 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 support the recruitment process.  |
| - proactive virtual career events at universities, recruitment fairs and for attracting those new to health and care services  |  |
| - Apprenticeship Programme, career development pathway for HCAs, ‘grow your own’ model.  |  |
| Actions: * Additional HR resource to support recruitment:
* Increase recruitment efficiency, including via review of operation model of transactional recruitment ream.
 |
| **1020 – work related stress** | 16 | 9 | PLC | 06/05/21  | Chief People Officer |
| Multiple pressures on staff may cause stress resulting in harm to staff; increased sickness absence and/or poor staff engagement; reduction in quality of care delivered; poorer patient outcomes and experience; loss of staff and difficulty in recruiting.

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| Controls: | Potential Gaps: |
| Work of Health & Wellbeing team (incl. e.g Wellbeing Champions); | Work ongoing to embed restorative just culture and compassionate leadership models.  |
| H&W Strategy (incl. Restorative Just Culture work) |  |
| Stress Steering Group and H&W action groups; |  |
| Staff support services e.g. EAP, Occupational Health, You Matter hub |  |
| Pastoral support team  |  |
| Intranet resources |  |
|  |  |
| Training e.g. Mental Health First Aid, REACT and TRiM |  |
| Engagement with Staff SideActions: |  |

* Development of ‘one front door’ app for staff support offering;
* Review of H&W Strategy to align with Trust and national people strategy;
* System (BOB) wide 'proactive & preventative' project which OH is leading;
* Embedding of Restorative Just Culture model;
* Full roll out of TRiM training.
 |
| **1068 – waiting times (mental health services)** | 15 | 9 | Quality Committee | 11/11/21 | MD Mental Health & LD |
| Demand for mental health services exceeds capacity, resulting in long wait times for assessment and/or treatment across a number of services. This may result in patient harm (patients suffer deterioration and poorer outcomes due to delay in commencing treatment).

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| Controls: | Potential Gaps: |
| 1)Directorate tracking of service line pressures through SMTs, with associated action plans for top 5 clinical risk areas. |  |
| 2) Prioritisation of emergency and urgent referrals, business continuity escalation for routine waits, supported by clinical triage and risk reviews for patients waiting. |  |
| 3) Transformation Programme Demand and Capacity projects across a number of services and patient age groups in Oxon BSW and Bucks. |  |
| 4) Directorate Harm Minimisation Groups. |  |
| 5) Development of TOBI Demand & Capacity App – to help operational services to visualise activity to forecast demand and plan a response | Although significant progress has been made to visualise waiting lists and demand for services, the Trust has not set clinical targets across all service lines for waiting lists |
| 6) Deployment of a Workforce Management System for the management and rostering of staff. This enables operational managers to plan shift patterns and to identify and resolve gaps in staffing | The Workforce Management System has not been rolled out across the whole Trust.  |
| 7) Reporting of activity and joint work with commissioners to inform priority and investment decisions. | Insufficient funding from commissioner contracts in some services.Local and national recruitment challenges.Covid-19 continues to put pressure on services (e.g. affecting staffing levels and limiting face to face assessments and therapeutic interventions). |
| 8) Trust-wide recruitment activity.  |
| 9) Recovery & Surge Planning Group to look at a co-ordinated approach to the recovery from COVID-19. |

Actions:* Waiting list deep dives by MD for Mental Health & LD with Director of Strategy & CIO in relation to the top 5 clinical risk services through August/September 2021, to be presented to September Board Meeting.
* Continued development of TOBI Waits and Demand & Capacity Apps to support services in understanding and managing demand.
* Recruitment activity.
 |
| **1132 - HR Systems** | 16 | 6 | FIC | 21/09/21 | Director for Strategy & Partnerships |
| The Trust uses several systems to capture information about its employees. These systems are not joined up, data is often updated manually, not in real time, and there is no visibility of requests or automated process to verify changing data. This presents challenges and risks relating to system access, data quality and adherence to GDPR.

|  |  |
| --- | --- |
| Controls:  | Potential Gaps: |
| Individual system audits | There is no 'single view' or 'one stop shop' platform where employees and managers can find information, make changes, or ask for employee related support.  |
| Data checks between ESR and e-rostering system | All relevant systems are not automatically updated when changes are made to one system. |
| Data in some systems not updated until formal change form is received to ensure accuracy |  |
|  |  |

Actions: A 9-stage roadmap and business case has been developed to improve the data quality and integration of employee information used across HR and other functions.  Funding for stages 1 and 2 is agreed, procurement is complete and the project has commenced. It is due to go live in November. Stages 3 – 9 have been considered by Exec and agreed in principal, and funding will be considered by the Capital Funding Group. |

**New risks on TRR since 29 September 2021**

**1144 – Montreal Cognitive Assessment Tool (MoCA)** – if staff continue using the MoCA tool without being officially trained and certified, which requires appropriate licensing, there is increased risk of administration, scoring and interpretation errors, leading to misdiagnosis of patients and liability issues.

**Risk change/movement on TRR since 29 September 2021**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Direction of change** | **Former rating**  | **Current rating** | **Target rating** | **Risk**  |
| **Down** | **12** | **8** | **8** | **1014 – GDPRs. The main risk is the level of financial fines imposed by the ICO.**  |
| **Down** | **12** | **8** | **8** | **1011 – Access to roofs. No longer an Estates-led risk.** |

**Closed risks since 29 September 2021**

None.

**PART 3: Risk Management and risk reviews**

**TRR and BAF Risk Management**

Risks on the TRR and BAF are reviewed and kept up to date via a programme of bi-monthly risk meetings with executive members of the Board at which their BAF and TRR risks are discussed, as well as any new risks for adding to the registers. These meetings are supplemented by reviews with operational leads, with the facility to automate TRR risk review requests now being utilised.

A member of the risk team routinely attends Board committee meetings, as well as the Quality & Clinical Governance Sub-Committee and Weekly Review meetings. The risk team gathers intelligence as to emerging risks via those meetings, and committees are routinely invited to consider whether any issues arising in a meeting warrant consideration for inclusion as a new risk on a risk register.

The risk team also seeks to gather intelligence from other sources, for instance audit reports, to identify gaps in the Trust’s risk register profile. The most recent internal audit progress report has, for example, identified risks around health, safety and security, and the risk team will now explore whether these issues are fully captured in risk registers.

**Risk Escalation Process**

There are four levels of risk register below the BAF: Team, Service, Directorate, Trust (and then ultimately the BAF for strategic level risks). A risk may be entered at any level. A risk does not have to start at Team level. Each risk is subject to escalation and de-escalation.

Risk escalation should be considered as part of the routine review of each risk by the owner of each risk register. Criteria for escalation are that if any risk:

1. is beyond the risk owner’s ability or control to mitigate, control or remove; or
2. affects more than their area of responsibility; or
3. constitutes a significant and material risk to the Trust, then
it must be escalated to the next tier of management/risk register owner.

**Risk escalation route**



Directorate and service level risk and risk registers are managed by those directorate and services’ respective governance processes. The two mental health and the community directorates have governance leads into whose portfolios risk registers fall. Those directorate risk registers are managed via the central Ulysses risk management system (like the TRR) thus providing a single and central view of key risks at directorate as well as Trust wide level, though day to day management of directorate risk registers sits with the directorates. There are good channels of communication between the directorates and central risk team regarding risk registers, including escalation/de-escalation of risks between directorate and Trust risk registers.

Directorate and service level risks are reported and escalated via various means (service dependent), including directorate performance meetings, and committee subgroups. For instance, the Quality & Clinical Governance Sub-Committee receives directorate highlight reports for clinical directorates at each monthly meeting, which include a risks and mitigations update.

**Risk discussions at meetings**

The BAF and TRR are routinely presented to committees of the Board. The respective committees’ work in respect of risk registers in the period since the Board last received a risk registers report is outlined below.

The tables included in the Executive Summary, and repeated in Parts 1 & 2, summarise the extreme rated (‘red’) risks, and confirm the monitoring committee to which each risk is assigned and the date of last detailed review of that risk by its committee.

In recent meetings the focus of risk reporting to the committees has moved towards assessing the quality and effectiveness of controls via detailed consideration of available sources of (positive or negative) assurance and our tolerance (i.e. target risk rating) in respect of individual risks.

*Quality Committee*

At a meeting on **11 November 2021**, that committee was provided with sight of the full BAF and TRR, as well as a covering report highlighting extreme (red) risks, new risks, closed risks, and risk changes/movement during the reporting period for risks for which it is the monitoring committee. Reasons were provided for any risk rating changes and closures.

The committee was invited to consider, and was provided with additional detail in respect of the red risks on the TRR, namely:

* **999 – demand and capacity in eating disorder services**
* **1000 – provision of CAMHS PICU, ED ad GAU beds within the Trust’s provider collaborative footprint; and**
* **1068 – waiting times in mental health services,**

*Audit Committee*

The Audit Committee received a BAF & TRR report on **15 September 2021**. That committee was provided with copies of the full BAF and TRR, as well as a covering report highlighting extreme (red) risks, new risks, closed risks, and risk changes/movement for risks across both the TRR and BAF since the last risk report to that committee in May 2021. It was also provided with detail as to the work of the Board, Board committees and other groups in monitoring the BAF and TRR since May 2021.

That committee noted that it was assured by evidence as to the increased visibility of risk and risk registers across the Trust, and apparent improvements in the depth and quality of discussions regarding risks at the various Board committees. The Committee suggested some possible additions to future reporting, including some exception reporting (e.g. risks with mitigating actions which were failing to progress as hoped) and further detail as to the actions effected / decisions made by or as a result of other Board committees in relation to the risks they consider.

*Finance & Investment Committee*

The Finance & Investment Committee received a BAF & TRR report on **21 September 2021 and 24 November 2021**. That committee was provided with sight of extracts of the BAF and TRR, as well as a covering report highlighting extreme (red) risks, new risks, closed risks, and risk changes/movement for risk for which it is the monitoring committee.

That committee was invited to review and discuss TRR extreme/red risk 1132 – HR systems (as well as high risk 1014 – GDPRs). The Committee assured itself, based on the risk report and information from other sources (such as discussions at other committees and the Information Management Group escalation report), that these risks were appropriately rated and managed. The Committee also took an overview of the full profile of risks assigned to it and agreed that those risk remained reflected current areas of concern, current ratings were appropriate, and there were no emerging risks within the knowledge of the Committee to be added to the BAF or TRR.

*Other meetings/sub-groups*

Specific risks have been reviewed in sub-committees and groups, including:

TRR 997 – IPC risk – reviewed in the *Infection Prevention and Control (IPC) Committee* on 29/07/21.

**Risk management training**

Although the team is not currently resourced to provide a dedicated risk management training package, all employees have access to a copy of the Risk Management Strategy and Policy and undertake statutory and mandatory training, as may be required for various staff groups, in: health and safety; incident reporting and risk assessment processes; fire and manual handling; and the management of information governance risks. Line managers are responsible for ensuring that staff training is up to date.

More locally, the Senior Nurse Clinical Lead (CAMHS Community Services) has delivered risk management training to CAMHS and ED managers as an adjunct to his ongoing monitoring of the individual team risk registers in the service (which are reviewed monthly). This began with CAMHS and ED and has been extended (on occasion) to other pathways and directorates to provide staff with opportunities to work through risk-based scenarios and practice with risk registers. 95 staff members have attended this training as of 18 November 2021.

 **RECOMMENDATIONS**

The Board is invited to:

1. decide whether to approve the closure of BAF risk 4.1 or delegate the decision to the Quality Committee for February 2022 (4.1 is the risk of failure to fully realise the Trust’s Research & Development (R&D) potential which may adversely affect its reputation and lead to loss of opportunity);
2. consider the BAF and TRR (particularly the extreme ‘red’ risks highlighted in this report) and discuss any risk(s) of concern or interest to the Board to seek assurance as to whether the risk is being appropriately managed;
3. reflect on matters arising from other agenda items heard at this meeting (or within the Board’s wider knowledge) and identify any emerging or new risks for consideration for inclusion on the BAF or TRR;
4. note the updates to the registers highlighted in Parts 1 & 2 of this report;
5. note the reviews and discussions undertaken by the Board, committees and other meetings in respect of the management of risk and risk registers, outlined in Part 3; and
6. consider whether it is assured that there is effective management of the key operational and strategic risks and, if not, make recommendations as to how such assurance might be achieved.
1. Further detail of reviews included at Part 3 of this report. [↑](#footnote-ref-1)
2. No discussion (yet) of this risk (BAF 2.1) as part of a specific risk registers agenda item, though PLC has considered in detail other agenda items addressing workforce planning and associated actions. [↑](#footnote-ref-2)
3. No discussion (yet) of TRR risk 999 as part of a specific risk registers agenda item, though Quality Committee (including via highlight reports from Quality & Clinical Governance Sub-Committee) has considered other agenda items addressing risks, mitigations and mitigating actions associated with challenges in ED services. [↑](#footnote-ref-3)