BOARD ASSURANCE FRAMEWORK FULL VERSION MARCH 2021

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	RATING	TARGET	MOVEMENT	LAST ED REVIEW REVIEW BY COMMITTEE
1. Quality - Deliver the best possible care and outcomes						
1.1	Chief Nurse Quality Committee	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.	12	8	↔	09/02/21
1.3	MD for MH & LD	Failure to deliver transformation, and/or resource and manage change effectively both within the Trust and with system partners could compromise: (i) quality, safety and experience for patients during the transition from current to future service models; (ii) ability to recruit or retain staff, staff morale and wellbeing, and (iii) delivery of the NHS Long Term Plan.	12	8	↔	14/01/21
1.5	MD for MH & LD Quality Committee	Unavailability of beds across mental health inpatient services (including Adult MH, CAMHS, PICU, ED) and LD due to: insufficient bed numbers, 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.	12	4	↔	14/01/21
1.6	MD Primary Care & Community	Risk that a mismatch between the population's continuously changing need for services exceeds the Trust's capability to meet that need (in partnership with system partners), resulting in the quality or safety of care being compromised or the needs of service users being insufficiently met, leading to poorer health and service outcomes and experiences. Such a mismatch may be due to the complex interplay of multiple factors including changes in population characteristics and demographics, wider determinants of health, service accessibility and user demand patterns, staffing and workforce challenges, legal and regulatory requirements, health and care system configuration, commissioning priorities, financial constraints, barriers to innovation and the need to respond to unexpected health emergencies (e.g. pandemic).	16	12	↔	08/02/21
1.7		**Draft new risk – description currently in draft form and not yet agreed** Failure to maintain effective systems to respond to a pandemic could result in: a failure to maintain delivery of core services during a pandemic; disease transmission resulting in staff and patient illness and mortality; unsafe levels of staff absence; a reduction in quality, safety and patient experience.			new	
2. People - Be a great place to work						
2.1	Director of HR 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	16	9		
2.2	Director of HR PLC	Inability to recruit to vacancies or to retain permanent staff may 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 at a potential increased risk of incidents and poorer patient outcomes; and loss of the Trust's reputation as an employer of choice	16	9		
2.3	Director of HR PLC	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 becoming a "well-led" organisation under the CQC domain.	6	4		
2.4	Director of HR PLC	**Placeholder for potential new risk – description currently in draft form and not yet agreed** A failure to develop and maintain our culture in line with Trust values, including: promoting equality, diversity & inclusivity; prioritising the health, safety & wellbeing of staff; and fostering a culture of learning & development, could result in: harm to staff; an inability to recruit and retain staff; a workforce which does not reflect Trust values & community; and poorer service delivery. ***[Proposed risk to be considered c. April 2021 when Key Focus Areas and OKRs under Strategic Objectives have been agreed].***			new	

3. Sustainability - Make the best use of our resources and protect the environment						
3.1	MD for MH & LD	Failure of the Health and Social Care Place Based, Integrated Care Systems and Provider Collaboratives in which we work to act together to deliver integrated care, maintain financial equilibrium and share risk responsibly may impact adversely on the operations of the Trust and compromise service delivery, especially during transition to new models.	16	9		
3.2	Director of Strategy & CIO Quality Committee	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	↔	10/03/21
3.4	Director of Finance Finance & Investment	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	16	↔	16/03/21
3.6	Director of Corporate Affairs & Co Sec Audit Committee	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.	6	4	↔	05/01/21
3.7	Director of Finance Finance & Investment	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.	8	6	↔	16/03/21
3.10	Director of Strategy & CIO Quality Committee	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; data loss or theft affecting patients, staff or finances; reputational damage.	12	9	↔	10/03/21
3.11	Director of Strategy & CIO Finance & Investment	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.	12	4	↔	10/03/21
3.12	Director of Corporate Affairs & Co Sec	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	new	25/01/21
3.13	Director of Finance Finance & Investment	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 (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	new	09/02/21
4. Research & Education - Become a leader in healthcare research and education						
4.1	Medical Director	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	↔	10/12/20
4.2	Chief Nurse	**Placeholder for potential new risk – description currently in draft form and not yet agreed** A failure to maintain an offering of attractive, varied and high quality education opportunities for staff could lead to: difficulty in retaining (or recruiting) staff; failure to realise the potential of and develop our workforce, with resultant negative impact on quality and improvement; failure to meet national public sector targets for apprenticeships; failure to achieve strategic ambitions to be a leader in healthcare education and a great place to work. ***[Proposed risk to be considered c. April 2021 when Key Focus Areas and OKRs under Strategic Objectives have been agreed].***			new	
4.3	Medical Director	**Placeholder for potential new risk** – risk re. research information sharing and opt-out system possibly to be develop. ***[Proposed risk to be considered c. May 2021 when research strategy has been agreed].***				

Risk rating matrix and scoring guidance appears at Appendix 1

Strategic Objective 1: Deliver the best possible care outcomes

1.1: Failure to provide high quality or effective care

Date added to BAF	Pre-Jan 2021
Monitoring Committee	Quality Committee
Executive Lead	Chief Nurse
Date of last review	09/02/21
Risk movement	↔
Date of next review	May 2021

	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:
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
Quality - Quality Sub-Committee; - Quality/safety sub-groups, reporting to quality sub-committee, including (though not limited to): Positive and Safe Group; IPC Committee; Quality Improvement Group; Family & Carers Strategy Group; - Oxford Healthcare Improvement (OHI) Centre; training programmes and QI projects; - Maintenance of competent and capable workforce, through training, operational management, supervision, appraisal and professional development; - Dialogue with regulators to feedback on quality standards; - Processes to pick up issues/variations in quality and for staff to raise concerns e.g. through the Whistleblowing policy & Freedom to Speak Up Guardian;	**Level 1: reassurance** - Monthly Directorate Quality Groups; - Weekly safety forums; - Complex review panels. **Level 2: internal** - Quality Committee (quarterly), with workplans for receipt of reports in relation to quality, safety and patient engagement items; - Mental Health Act / Mental Capacity Act Committee (quarterly); - Quality Sub-Committee (monthly), with workplans for receipt of reports from quality/safety sub-groups (listed in controls); - Trust Quality/Safety Sub-groups, including Friends, Family & Carers Strategy Group; - Mortality Review Group; - Review of serious incidents, complaints, claims, inquests, CAS alerts, safer staffing, and H&S issues at Weekly Review (Clinical Standards) Meeting; - Progress against CQC actions monitored at Quality	GAPS (patient experience): (1) need to more consistently embed co-production and patient and family/carer involvement in care; (2) No systemic and routine implementation of the Triangle of Care across all services. GAP (safety): CQC rating of 'requires improvement' on the question of whether services are Safe at CQC inspection in July-September 2019 (published December 2019) - and unchanged from previous CQC inspections in March 2018 and June 2016 and following comprehensive inspection in September /October 2015. GAP (safety): Safety domain rated 'inadequate' by CQC on LD wards in relation to restrictive practice.	ACTION: reintroduce Trust wide Patient Experience Involvement Group; patient:staff group to oversee implementation of the strategy ensuring co-production with service users at every level. OWNERS: Chief Nurse OVERSIGHT: Quality sub-committee ACTIONS: (1) progress CQC post-inspection improvement plan through the Quality Improvement Group (reporting into the Quality Committee); (2) Clinical Workforce Transformation Programme through 'Improving Quality Reducing Agency' Programme Board. OWNER: Chief Nurse. ACTION: Positive and Safe subcommittee established to reduce restrictive interventions. OWNER: Chief Nurse

Patient Safety - Clinical Risk Assessment and Management Policy (CP16) and training; - Suicide and Self-Harm Prevention Strategy; - Central Alerting System (CAS) policy and procedure (April 2018); - Patient Safety Team; - Incident investigation and process for learning from incidents (and complaints); - Setting and monitoring of optimal/safe staffing levels; ***Experience and involvement*** - People's Experience & Involvement Strategy 2019-21; - Multiple mechanisms for gathering feedback from patient and carers, including I Want Great Care surveys; - I Care You Care strategy for friends, families and carers; - Complaints and Patient Advice and Liaison Service (PALS) and Directorate Complaint Review Panels; - Friends, Family and Carers Strategy Group; - Care Programme Approach (CPA) involves patients (and carers) in development of care plans; - technological developments to facilitate engaging patients with their electronic plans and records; - Recovery Colleges promoting co-production, co-design and co-delivery of training for staff, patients and carers. ***Clinical Effectiveness*** - Clinical Audit team and overarching monitoring of all audit activity; - Participation in national audit programmes; - Service specific patient outcomes; - Evidence based training and interventions; - NICE compliant services; - External peer reviews with other similar services or	Improvement Group and Quality Sub-Committee; - Clinical Audit Group; - Patient experience and involvement report to Quality Committee (quarterly); - Annual report on patient/carer experience and complaints provided to Quality Committee (most recently July 2020) & Quality Sub-Committee (most recently August 2020); - Quality Reporting with a particular focus on Patient Experience to the Board (most recently September 2020); - Council of Governors operates a Patient Experience sub-group; - Board self-assessment and Well Led governance reviews (most recently March-June 2017); - 'Patient stories' to Board; - SI updates and RCA report review at private Board. **Level 3: independent** - CQC Inspections (incl. CQC monitoring whether care plans have been shared with patients in mental health wards); - Quarterly quality review meetings with CCG; - HSE inspections; - Internal & External audit; - Patient/carer feedback, incl. 'I Want Great Care' results; - 20+ accreditation schemes (including Inpatient Mental Health Services (AIMS)); - Peer review programmes within our networks; - Triangle of Care 'two star' accreditation; - Involvement in developing care plans is monitored as part of CPA metrics and reported to Commissioners; - Quality Account signed off by CCG and published; - Professional Registration systems, and processes for	GAP: UK's exit from the EU and new Trade and Cooperation Agreement may present risks in relation to maintaining supplies of (i) medicines and vaccines; (ii) medical devices and clinical consumables; and (iii) non-clinical consumables, goods and services due to border friction and increased formalities to move products in to the UK from Europe (e.g. customs declarations and paperwork). GAPS (incidents): (1) An increase in SIs has been seen during the Covid-19 pandemic. Themes include: Covid outbreaks, hospital acquired infections, and suspected suicides; (2) Lack of timely completion of SI reports and robust process to follow up actions; (3) Continued similar issues being raised through SI investigations and at Coroners Inquests. GAP: Covid-19 outbreaks/ hospital acquired infections continue to present a direct threat to patient safety from infection, as well as indirect threat to quality and safety due to pressures on staffing levels. GAP (quality improvement): (1) Much of work of OHI Centre paused through Covid-19 pandemic due to redeployment of staff, therefore need to re-establish priorities; (2) Lack of a QI culture embedded across the organisation	ACTION: the Trust will maintain plans and mitigating activities which were put in place in respect of a 'no-deal' Brexit, as set out in the Trust's EU Exit Operational Readiness Plan dated 06/11/20, as approved by the executive Management Team on 19/10/20. OWNERS: Director of Corporate Affairs, Chief Pharmacist (for supply of medicines) and Deputy Director of Finance (for supply of medical devices, clinical consumables, non-clinical consumables, goods and services). ACTIONS: (1) Timely and high-quality SI investigations and thematic reviews across directorates to be continued to maximise learning; (2) Ensure appropriate training and support for those completing SI investigations; (3) Implement revised SOP for follow up actions; (4) Use QI methodology to improve service concerns raised through investigations by engaging frontline staff. OWNER: Chief Nurse. ACTION: Continuation of robust IPC measures; regular review of IPC procedures and practices in line with national guidelines and learning from incidents; IPC BAF. OWNER: Chief Nurse. ACTION: (1) Evaluation and stock take of where we are now; (2) External review from CNTW QI team to benchmark our progress and plan for the future; (3) Development of a clear QI strategy for the Trust. OWNER: Chief Nurse.

national programmes such as Royal College of Psychiatrists AIMS to adult inpatient wards; - Internal peer review process to benchmark across the Trust.	referral and investigation where concerns exist.	increased capacity and capability for QI GAP: Lack of corporate ownership of benchmarking services either externally or internally GAP: Lack of triangulation of all reporting such as complaints; incidents; audit which drives the QI programme and improves service and cared delivery	ACTIONS: (1) To establish a CQC peer review programme led corporately through the clinical governance team; (2) Ensure robust reporting of clinical audit programme and subsequent improvement activity resulting from audit findings – such as Physical health monitoring in patients with SMI. OWNER: Chief Nurse. ACTION: Establish a quality dashboard which brings together all these data in order to prioritise where our efforts need to go to improve using a QI approach and driven by frontline staff. OWNER: Chief Nurse.

Strategic Objective 1: Deliver the best possible care outcomes

1.3: Failure to deliver transformation and manage change effectively

Date added to BAF	Pre-Jan 2021
Monitoring Committee	
Executive Lead	Managing Director for Mental Health & Learning Disabilities
Date of last review	14/01/21
Risk movement	↔
Date of next review	April 2021

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	16
Current risk rating	**4**	**3**	**12**
Target risk rating	4	2	8
Target to be achieved by			

Risk Description:
Failure to deliver transformation, and/or resource and manage change effectively both within the Trust and with system partners could compromise: (i) quality, safety and experience for patients during the transition from current to future service models; (ii) ability to recruit or retain staff, staff morale and wellbeing, and (iii) delivery of the NHS Long Term Plan.

Key Controls	Assurance	Gaps	Actions
- Programme structures at System and Trust level including: Programme Board and workstream groups; - Directorate and service specific workstreams; - Strategic Delivery Group oversight of transformation programmes; - Collaborative working with partner organisations; - Trust CEO is SRO for Mental Health, Autism and Learning Disabilities workstreams for BOB ICS Long Term Plan; - Place-based boards in Bucks, Oxon and BSW. - Trust Provider collaborative Programme Board; - Network oversight groups (system meetings for Provider Collaboratives); - Internal change management processes and joint working with Staff Side representatives; - Warneford redevelopment Board Sub-committee chaired by Trust Chairman.	**Level 1: reassurance** - Directorate workstream meetings; - The impact of transformation and change management on patient experience, safety, workforce and clinical and operational effectiveness will be assessed through the assurances set out in SO 1.1. **Level 2: internal** - Place based boards monthly; - Trust Provider Collaborative Programme Board; - Strategic Delivery Group oversight of transformation programmes. **Level 3: independent** - BOB Board Monthly; - Network oversight groups; - Quarterly SE region deep dives.	GAP: Considerable impact on management and clinical time to input transformation; GAP: inability to recruit to deliver transformation; GAP: Disconnect between National Long Term Plan for MH indicative funding allocations and investment provided by CCGs (e.g. Mental Health Investment Standard, MHIS).	ACTION: Ensure all transformation programmes have a costed overhead and identify project management resource; ACTION: CEO, as chair of BOB Board, and Managing Director for Mental Health & Learning Disabilities to keep board and senior management team informed and involved.

Strategic Objective 1: Deliver the best possible care outcomes

1.5: Failure to care for patients in an appropriate inpatient setting

Date added to BAF	Pre-Jan 2021
Monitoring Committee	Quality Committee
Executive Lead	Managing Director for Mental Health & Learning Disabilities
Date of last review	14/01/2021
Risk movement	↔
Date of next review	April 2021

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	5	20
Current risk rating	**4**	**3**	**12**
Target risk rating	4	1	4
Target to be achieved by			

Risk Description:
Unavailability of beds (across all mental health inpatient services, including Adult MH, CAMHS, PICU, ED and LD) due to: insufficient bed numbers, 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.

Key Controls	Assurance	Gaps	Actions
- Clinical oversight and review of patients considered to be in an inappropriate bed via Clinical Directors; - proactive management of flow and Out of Area Placements (OAPS); - single point of access or provider collaborative network beds; - robust CPA (Care Programme Approach) planning; - system partner calls to improve discharge; - Roll out of Crisis Resolution, Home Treatment, Early Intervention & Intensive Support teams to prevent admission and support earlier discharge; - SOPs/processes in place for any Young Person in seclusion or Long Term Segregation, including Clinical Director reviews;	**Level 1: reassurance** - Directorate SMT monitoring **Level 2: internal** - Review of incidents, restraints, seclusions and inappropriate use of s.136 beds by Heads of Nursing and through Weekly Review Meeting (Clinical Standards) and escalated to the Exec, as appropriate; - OAPS trajectory monitoring internally through Directorate AMT and Executive. **Level 3: independent** - NHSE/I reporting and monitoring of progress against OAPS trajectories.	GAP: Instances of long waits for young people requiring CAMHS & PICU beds; GAP: Long waits for admission to Adult Eating Disorder units, resulting in patients with very low BMIs being managed in the community or acute hospitals; GAP: Estate does not enable support for individuals with severe LD or autism requiring a single person placement; GAP: Lack of monitoring and reporting of outcomes against benchmarks for	- Planning for PICU build is underway. Capital secured from NHSE, outline design signed off by clinicians and planning application made for PICU on Warneford Site; - Roll out of hospital at home for CAMHS and CAMHS Eating Disorder service; OWNER: MD for Mental Health & Learning Disabilities. - Adult ED service to extend and develop Day Hospital and Hospital at Home offerings; OWNER: MD for Mental Health & Learning Disabilities; - LD services to continue to provide specialist LD support to mainstream mental health wards to facilitate reasonable adjustments; - Work with partners within place and at BOB level to secure a specialist LD/autism bed;

- Transformation programme to improve flow and reduce length of stay.		transformation programmes.	OWNER: MD for Mental Health & Learning Disabilities;

Strategic Objective 1: Deliver the best possible care outcomes

1.6: Demand for services exceeds capacity

Date added to BAF	Pre-Jan 2021
Monitoring Committee	
Executive Lead	MD for Mental Health & Learning Disabilities **and** MD for Primary Care and Community
Date of last review	08/02/21
Risk movement	↔
Date of next review	May 2021

	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 a mismatch between the population's continuously changing need for services exceeds the Trust's capability to meet that need (in partnership with system partners), resulting in the quality or safety of care being compromised or the needs of service users being insufficiently met, leading to poorer health and service outcomes and experiences. Such a mismatch may be due to the complex interplay of multiple factors including changes in population characteristics and demographics, wider determinants of health, service accessibility and user demand patterns, staffing and workforce challenges, legal and regulatory requirements, health and care system configuration, commissioning priorities, financial constraints, barriers to innovation and the need to respond to unexpected health emergencies (e.g. pandemic).

Key Controls	Assurance	Gaps	Actions
- Oversight at Board level; - Increasing health and social-care system recognition of the challenges e.g. 29 January 2019 the Trust hosted a presentation from the NHS Benchmarking Network on Mental Health Analytics and the outcome of the independent review conducted by Trevor Shipman on mental health investment in Oxfordshire (which evidenced historic underinvestment). Stakeholders and partner organisations attended, including from OUH NHS FT, Oxfordshire CCG and the voluntary sector	**Level 1: reassurance** **Level 2: internal** - Oversight by the Board **Level 3: independent**	GAP: insufficient funding from commissioner contracts.	ACTION: Buckinghamshire contracts for FY20 agreed. Oxfordshire contractual discussions ongoing within the context of increasing understanding of what lower than planned additional income from commissioners could mean in terms of potential reduction in Trust activity. Oxfordshire CCG have accepted that, as at the end of FY19, the level of underfunding of Oxfordshire mental health services was £12 million. The Trust's position on this is that although £12 million is short of the level of underfunding established in the Trevor Shipman review, it is still sufficient to underpin the current level of activity delivered and to start the process of service development (but still issue because that amount will fall short of the requirement to implement the range of service provision and capacity to achieve the access

			targets set out in the NHS Long Term Plan). OWNER: Director of Finance
		GAP: insufficient funding from specialist commissioning contracts.	ACTION: contract negotiations ongoing. Due to NHS England Specialist Commissioning engaging late in the contract review process, some contractual matters remain to be resolved particularly in relation to New Care Models. In the meantime, Trust has participated in the interviews for the next phase of New Care Models (due to commence from April 2020) as a preliminary to the development of business cases for more detailed proposals in November 2019.
		GAP: Oxfordshire County Council mental health budget cuts and anticipated reduction in funding by 2022.	ACTION: in recognition of the response to the consultation on original proposals in December 2018/January 2019, the County Council amended its proposal by: removing entirely the originally proposed £1 million reduction in the Council's contribution to the NHS mental health budget; and delaying the proposed £600,000 saving against mental health social workers by a year. However, still issues with the remaining £600,000 proposed saving, even if delayed by a year and especially as spend on children's social care had nearly doubled since 2011, with a significant amount funding children's Out of Area Placements (OAPs). Challenge: if services could provide more mental health and social care support to families then they may be able to improve the environment for children and young people such that fewer children's OAPs would be required.

Strategic Objective 1: Deliver the best possible care outcomes

1.7: Failure to maintain effective systems to respond to a pandemic

Date added to BAF	
Monitoring Committee	
Executive Lead	
Date of last review	**New risk**
Risk movement	n/a
Date of next review	April 2021

	Impact	Likelihood	Rating
Gross (Inherent) risk rating			
Current (residual) risk rating			
Target risk rating			
Target to be achieved by			

Risk Description:
Failure to maintain effective systems to respond to a pandemic could result in: a failure to maintain delivery of core services during a pandemic; disease transmission resulting in staff and patient illness and mortality; unsafe levels of staff absence; a reduction in quality, safety and patient experience.

Key Controls	Assurance	Gaps	Actions
- Pandemic Plan (v.12 August 2021) (updated multiple times in 2020 to reflect new workstreams, operational changes and learning from Covid-19 pandemic); - Response Manual (Emergency preparedness, resilience and response) (updated Dec 2020) provides emergency response framework, including specific section for pandemic; - Infection Prevention and Control Board Assurance Framework 2020 (V4 Jan 2021) ('IPC BAF'); - IPC Policy (IF1); - Additional business continuity and emergency planning controls as detailed in BAF 3.12; - Annual winter flu vaccinations campaigns; - Immunisation team; - Adherence to PHE IPC guidance; - Investment in and maintenance of IT infrastructure, sytems and	**Level 1: reassurance** - Emergency Planning Resilience and Response (EPRR) Group 3 x per year; - Psychosocial response group (sub-group of Emergency Planning group); - Service Business Continuity Plans signed off by heads of service; - Daily SitReps from teams re PPE stock levels; - Matron's ward rounds include checks for IPC & PPE compliance. **Level 2: internal** - IPC BAF (and updated versions) approved by Quality Sub-Committee, (most recently Jan 2021) and Board (also Jan 2021); - Revised Infection Control and Prevention Policy presented to & ratified by Quality Committee (Sept 2020); - Annual Emergency Planning, Resilience and Response report (most		

equipment to facilitate staff working from home on a mass scale if required; - Systems & equipment to facilitate digital contacts with patients as appropriate; - Systems to maintain safe staffing levels incl. use of Trust Bank and agency, with use of long-lines where possible; - Twice+ weekly Comms briefing to staff & webinars; - Enhanced health and wellbeing offerings for staff. ***Covid-19 specific controls*** - Staff testing (LFT & PCR); - Staff individual risk assessments and bespoke actions plans for those at risk; - PPE: provision of PPE and guidelines for use (role specific), stock monitoring and distribution systems, PPE Champions; - Adaptations to use of the estate; - Covid-19 vaccination programme; - Intranet Covid-19 site; - Additional PPE, IPC, Staff Health & Wellbeing controls detailed in Trust Risk Register risks 990, 991, 995, 997.	recently to Board in Nov 2020); - EPRR Exercises, with learning incorporated into major incident plans, business continuity plans and shared with partners; - Self-assessment against NHSE/I EPRR Core Standards (For 2020 Trust was fully compliant with 50/54 standards, partially compliant with remaining 4); - Weekly Review (Clinical Standards) Meeting receives reports on infection control/ outbreaks (incl. but not limited to Covid-19); - IPC progress reports quarterly to Quality sub-committee, and IPC Annual Report; - Monitoring of staff sickness and safe staffing levels at various levels incl. SMTs, Weekly Review (Clinical Standards), and People Leadership and Culture Committee, - IPC Committee; - Ethics Committee; - L&D maintain data on PPE fit testing and competency assessments; - PPE compliance audits; ***Covid-19 specific*** - Weekly meeting each Friday to look at Covid19 numbers to report to NHSE; - Weekly Covid tactical meeting. **Level 3: external** - Regional IPC Meeting attended by IPC Lead; - NHSE monitoring of infection numbers; - HSE inspection; - CQC.		

Strategic Objective 2: Be a great place to work

2.1: Insufficient or ineffective planning for current and future workforce requirements

Date added to BAF	Pre-Jan 2021
Monitoring Committee	People Leadership and Culture Committee
Executive Lead	Director of HR
Date of last review	
Risk movement	
Date of next review	

	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
- Director of Clinical Workforce Transformation; - Learning and Development training matrices; - Performance & Development Review Policy and supporting processes; - Directorate workforce plans, linked to Business plan/savings plans with regular processes for review; - Senior HR Business Partners are trained in Trust's workforce planning process (developed with input from L&D and Finance); - Flexible Workforce Management System and centralised Bank of staff (Staffing Solutions). Provides detailed management information to drive efficiencies in staffing use and control of temporary staffing spend; - Learning from Staff Movement Forms and Exit Questionnaires/Interviews; - Recruitment and retention initiatives (see BAF 2.2).	**Level 1: reassurance** - Operations SMT (monthly); - HR senior management team performance review (monthly). **Level 2: internal** - HR/Workforce Performance Report to the Board; - People Leadership and Culture Committee (quarterly) oversees 'improving quality, reducing agency' item and receives updates on agency use, operational staffing issues including recruitment and retention, and will monitor progress of workforce transformation projects and workstreams; - Monitoring of KPIs: Appraisal Training Use of agency Vacancy rate. **Level 3: independent**	GAP (controls in relation to local workforce planning activities generally being impacted by national developments): no-deal EU Exit/Brexit and impact of the risks identified in the Trust's EU Exit Operational Readiness Risk Assessment specifically in relation to: (4) shortage of staff members due to EU nationals leaving the UK. Total EU staff members at the Trust = 355.	ACTION: mitigating activities as set out in the risk assessment as presented to the Board meeting in public on 31 January 2019 as appended to the CEO report at paper BOD 02(ii)-(iii)/2019. Actions included participation in pilot programme to enable EU staff members to apply for settled status. OWNERS: specific risk (4) owned by the Director of HR. Presented and discussed at the Board meeting in public on 31 January 2019, including workforce impact. Activity re Settled status and qualifications included in staff communications Q1 FY19. Net/ residual risk scores do not add further to overall BAF current/residual risk rating of 16 (extreme) and if anything indicate low likelihood: impact 4 (high) and likelihood 2 (unlikely) = risk score of 8 (high).

		GAP (controls): despite implementation of Workforce Management System (WFMS), agency spend still high and/or above the ceiling imposed by NHS Improvement. Need to also increase recruitment of Flexible Workers to meet demand and consider whether aim to ultimately reduce demand for temporary staffing or embrace development of more flexible staffing opportunities so can be offered as a career alternative/opportunity.	ACTION: complete implementation and rollout and monitor impact of usage. Develop improved reporting in conjunction with Performance team to drive efficiencies in staffing use. Develop website and use social media to actively advertise and recruit Flexible Workers. OWNER: Director of HR

Strategic Objective 2: Be a great place to work

2.2: Failure to retain and recruit sufficient and appropriately skilled staff

Date added to BAF	Pre-Jan 2021
Monitoring Committee	People Leadership and Culture Committee
Executive Lead	Director of HR
Date of last review	
Risk movement	
Date of next review	

	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 (in a timely manner) or to retain permanent staff 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.

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); - the development of an overarching 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; - proactive recruitment initiatives e.g. work with universities, attendance at recruitment fairs; - Apprenticeship Programme; - career development pathway for HCAs; - Recruitment Action Group meetings on improving links with universities;	**Level 1: reassurance** - weekly reporting of vacancy levels and fill rates to SMT and the Service Directors; - reporting on inpatient safe staffing levels to SMT and Weekly Review Meeting (Clinical Standards); - integrated activity plan managed daily and reviewed weekly by HR and reviewed by Operations SMT monthly; - Monthly review of recruitment activity, incl. leavers exit interview data, by HR SMT. **Level 2: internal** - Reports to Extended Executive (monthly); - Workforce performance report as a standing item to the Board; - People Leadership and Culture Committee (quarterly) oversees 'improving quality, reducing agency' item and receives, as standing items, updates on agency use, recruitment & retention and workforce	GAP - cross-reference to gap at 2.1 above (controls) in relation to risk of shortage of staff members due to EU nationals leaving the UK in the event of no-deal EU exit/Brexit; and note mitigation in the business continuity planning which has taken place and presentation to the Board meeting in public on 31 January 2019. GAP (controls - recruitment processes): dealing with national and local recruitment challenges and the impact on pressure on staff numbers, work-related stress, spend with agencies and quality of care provided. Also linked to the Trust's ability to retain staff. Use of agency staff in order to maintain minimum staffing levels to remain safe to deliver patient care also amplifies the complexity of the work to do especially to	

- Learning from Exit Questionnaires/Interviews; - Health & Wellbeing, Equality, Diversity and Inclusivity, and Occupational Health strategies, groups, services and initiatives; - Training, supervision and Performance and Development Review (PDR) processes.	transformation projects, bids and workstreams; - Monitoring of KPIs: Appraisal, Turnover, Vacancy rate. Time to recruit, Use of agency. **Level 3: independent**	carry out improvement work which should be led by substantive staff. GAP (controls - recruitment processes): impact upon operational management of constant advertising and interviewing and time away from the day job. Also impact because of 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. 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. GAP (controls - making the Trust a great place to work): need to improve staff experience and respond to issues identified by Staff Survey results in order to improve retention and take pressure off recruitment. Health & Wellbeing to be addressed.	ACTION: increase recruitment efficiency e.g. through increased notice periods, introduction of a temporary candidate pipeline manager and introduction of in-house recruitment database. OWNER: Director of HR ACTION: respond to Staff Survey results e.g.training for managers to ensure that everyone is getting meaningful appraisals; and development of Fair Treatment at Work Facilitators to provide confidential support to all staff. Health & Wellbeing Action Group empowering health and wellbeing in the workplace and using Champions to create initiatives at a local level. OWNER: Director of HR

Strategic Objective 2: Be a great place to work

2.3: Failure to maintain a coherent and co-ordinated structure and approach to succession planning, organisational development and leadership development

Date added to BAF	Pre-Jan 2021
Monitoring Committee	People Leadership and Culture Committee
Executive Lead	Director of HR
Date of last review	
Risk movement	
Date of next review	

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	16
Current risk rating	**3**	**2**	**6**
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 SO 1.2 and the risk against failure to deliver integrated care); - completed restructuring of Operations Directorates to provide for development of clinical leadership and for a social care lead in each directorate; - "planning the future" programme and ongoing Aston Team Working programme; - effective team-based working training in place with L&D; - multi-disciplinary leadership trios within clinical directorates to support and develop clinical leadership; - the Organisational and Leadership Development Strategy Framework (approved by the Board, October 2014) - aims to	**Level 1: reassurance** **Level 2: internal** - People, Leadership & Culture Committee; - Use of annual staff survey to measure progress and perception of leadership development; and - staff appraisals and ad hoc staff satisfaction surveys. **Level 3: independent** - CQC reviews - a rating of "good" was achieved in the Well Led domain in 2015 CQC inspection.	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. GAP (controls - individual professional review and development): co-ordinated direction of career pathways to steer staff to gain wider	ACTION: Senior Leaders and Team away days. Increased leadership focus through the Executive and Senior Leaders' groups. Leadership Engagement through Linking Leaders Conferences (x4 per year). OWNER: Director of HR ACTION: development of individual professional leadership strategies. Nursing Strategy developed and launched in November

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; - 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); - Linking Leaders conferences aimed at developing strong team networks across the middle tier of management throughout the Trust and supporting the development of a positive organisational culture (running since June 2015 across the Trust's geography and localities with the aim of improving communication and developing networks across the middle tier of management); and - Trainee Leadership Board - most recent cohort presented to the Board (private Seminar session) on 09 September 2020.		experiences. Note also links to Gap at SO 2.1 above re staff and career development. 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.	2015. However, risk that may not be sufficient capacity to deliver Nursing 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. OWNERS: MD for Mental Health & Learning Disabilities; and Chief Nurse 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. OWNER: Equality & Diversity Lead and Associate Director of Strategy & OD

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

3.1: Failure to deliver integrated care

Date added to BAF	Pre-Jan 2021
Monitoring Committee	
Executive Lead	Managing Director for Mental Health & Learning Disabilities
Date of last review	
Risk movement	
Date of next review	

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	5	5	25
Current risk rating	**4**	**4**	**16**
Target risk rating	3	3	9
Target to be achieved by			

Risk Description:
Failure of the Health and Social Care Place Based, Integrated Care Systems and Provider Collaboratives in which we work to act together to deliver integrated care, maintain financial equilibrium and share risk responsibly may impact adversely on the operations of the Trust and compromise service delivery, especially during transition to new models.

Controls	Assurance	Gaps	Actions
Oxfordshire Transformation Board and membership of Healthy Bucks Leaders. Executive Directors and Service/Clinical Directors engage strategically and operationally, working jointly with all CCGs, local authorities and other partners including GP providers to understand strategic issues facing CCGs and provide input and support to delivering integrated services within the context of high levels of change within the health and social care systems. Development of alliances and partnerships with other organisations, including the voluntary sector, to deliver services into the future. Development of Oxfordshire Integrated Locality Teams. Oxfordshire Mental Health Partnership - development of Recovery College completed and outcome measures being monitored monthly through	**Level 1: reassurance** Reporting through OPS SMT, Executive Team and Board. Participation in key strategic, operational and contracting meetings by Service Directors, Clinical Directors and Chief Operating Officer Reporting to/discussions with Oxfordshire CCG and Trust Board. Whole system working across each county to deliver Integrated Care. Improved whole systems working and process with good engagement with Partners demonstrated through the Oxfordshire Transformation Board, Healthy Bucks Leaders and System Resilience groups. Collaborative planning with OUH; delivering on commissioners' strategic intent through initiatives such as moving to 7-day working via the service remodelling; and partnership approaches on Mental	GAP: (assurances - whole system working and collaborative planning for care) - Delayed Transfers of Care (DToCs) remain unresolved; wider system not working effectively to support patients to be sent home. GAP (controls - engagement and joint working): concern around overlaps between OBC processes and the impact of the Better Care Fund (government pooled	ACTION: since September 2017, DToCs highlighted to the Quality Committee and to the Board as a mounting pressure especially for the wider system although the Trust has been able to demonstrate progress in managing those DToCs which were solely in its control. In October 2019, bed days lost to DToCs in Mental Health reduced from 214 in Sept to 207 (equivalent to 7 beds), however, this was still above the rolling 12-month average of 183 (6 beds); Community DToCs increased by 235 days in October 2019 to 1317 bed days lost (equivalent to 43 beds), with a rolling 12-month average of 1304 days per month (42 beds). ACTION: ensuring engagement in national Better Care Fund dialogue at a national and local level. Strategic linking of Outcomes Based Commissioning with

contract meetings and reported monthly to CCG via schedule 4 and OBC measures. Progressing discussions with Oxfordshire's GP Federations to establish opportunities for more formal partnerships and collaborations. PML, OxFed and Oxford Health FT are exploring a united approach to new models of delivery and contracting, to be operational across much of the County . More recently that discussion has also involved colleagues at OUH. Proposals will describe how community services can be integrated with primary care to provide a genuine 'place' based service, addressing population management, prevention and access, and in addition how the relationship with the urgent care pathway and hospital based services will work in the short term and longer term. Ability to deliver integrated care through collaboration and Partnership e.g. Mental Health OBC, Talking Space. Older People's OBC being advanced through Winter Planning.	Health and OP services. Joint working with commissioners on new models of care and extension of contracts and MCP processes. **Level 2: internal** **Level 3: independent**	fund to promote integrated care). GAP (controls - Oxfordshire GP Federation engagement): since October 2016, written outline of proposals and Memorandum of Understanding being developed to describe proposals. GAP (controls - engagement and joint working): financial pressure on County Councils and Social Care impacting adversely on Health.	the Better Care Fund. OWNERS: MD for Mental Health & Learning Disabilities, Director of Finance and Chief Executive ACTION: Development continued with: updates to Board Seminars including in September 2017 and February 2019; attendance by GP Federations at Board workshop in private on 27 June 2019; and review at Board meeting in private in September 2019, OWNER: Service Director - Oxon Community Services; and Chief Executive ACTION: Executive Directors and other directors engage in whole system clinical and financial planning. Engagement with NHS Improvement (Monitor) and introducing them into system-wide discussion with commissioners.

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

3.2: Failure to manage governance of external partners

Date added to BAF	Pre-Jan 2021
Monitoring Committee	Quality Committee
Executive Lead	Director of Strategy and CIO
Date of last review	10/03/21
Risk movement	↔
Date of next review	May 2021

	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:
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; - Central coordination of partnership arrangements by Business Services Team; - Development and use of Trust Partnership Standard; - Partnership Risk Assessments (for existing partners) undertaken in 2019 and risk-assessment process in place for new partnerships; - Section 75 agreements in place for Oxfordshire and Buckinghamshire, with monitoring and collaboration through Section 75 Joint Management Groups (JMGs);	**Level 1: reassurance** - Partnership Management Group **Level 2: internal** - Partnerships updates to the Board (in private) (most recently in July 2020); - Future reporting to Quality Committee; - JMG reports to Quality Committee (quarterly). **Level 3: independent** - PWC Audit of partnership working in May 2019. Key recommendations of the audit have been completed; - quality assurance peer-to-peer reviews within Oxford Mental Health Partnership.	GAPS: 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 place with partners or subcontractors. GAP (Assurance): New process for partnership management is not well tested as only one new partnership has been entered into since implementation of new processes.	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. ONGOING ACTIONS: (1) Development and use of performance related action logs to monitor progress of 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. ACTION: continued 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: Failure to deliver financial plan

Date added to BAF	11/01/21
Monitoring Committee	Finance and Investment Committee
Executive Lead	Director of Finance
Date of last review	16/03/21
Risk movement	↔
Date of next review	May 2021

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	5	5	25
Current risk rating	**4**	**4**	**16**
Target risk rating	4	4	16
Target to be achieved by	At target level		

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; - Standing Financial Instructions; - Budgetary Control Policy (CORP03); - Procurement Policy (CORP04) and Procurement Procedure Manual; - Investment Policy (CORP10); - Treasury Management Policy (CORP09); - Counter Fraud Policy (CORP11); - 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; - Monthly reporting to, and monitoring by, NHSE/I.	**Level 1: reassurance** -Weekly finance team meeting; - Monthly finance review meetings with directorates; - Capital Programme Sub-Committee (monthly) - daily cash balance reports to DoF, and weekly and monthly cash-flow reports. **Level 2: internal** - Strategic Delivery Group; - Finance and Investment Committee (every 2 months); - Monthly Finance, including CIP, reporting to the Board to provide assurance on progress and recovery actions. **Level 3: independent** - Internal Audit review; - External audit; - Financial Plan submitted to NHSE/I; - Monthly reporting to, and monitoring by, NHSE/I.	GAP: There is a short-term risk that COVID interim financial regime may not provide sufficient funding to cover COVID costs, fully fund MHIS and Transformation funding. GAP: Underfunding of Oxon community services contract	ACTION: diligent review and monitoring of COVID national financial regime, calculation of block and top up payments, funding flows in relation to MHIS and Transformation funding, monthly review meetings with NHSE/I and periodic meetings with NHSE/I regional team. OWNER: Director of Finance. ACTION: (a) Community Services Strategy to be completed, followed by (b) costs analysis, and (c) structured discussions about funding gaps with Commissioners. OWNER: Director of Community & Primary Care Services, and Director of Finance. TARGET: currently unclear. Position to be reviewed May 2021

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

3.6: Failure to maintain effective governance (both corporate and clinical) 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	19/01/21
Risk movement	↔
Date of next review	April 2021

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	16
Current risk rating	**3**	**2**	**6**
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); - Council of Governors (COG), COG Working Groups; - Standing Financial Instructions and Scheme of Delegation; - Integrated Governance Framework (IGF); - Procurement Policy (CORP04) and Procurement Procedure Manual; Investment Policy (CORP10), Treasury Management Policy (CORP09); - Trust Strategic Objectives and setting of key focus areas for achieving objectives; - Maintenance of key Trust registers (e.g. declarations of interest, receipts of gifts); - Processes for capturing meeting minutes to log: consideration of discordant	**Level 1: reassurance** **Level 2: internal** - Annual Governance Statement; - Strategic Objectives approved by Board, with progress against objectives reported to Board Committees and Board; - Quality Committee, Finance & Investment Committee, and Audit Committee review risks and key governance issues; - Escalation reports from the Sub Committees to Board Committees and on to Board; - Annual report and reports for Council of Governors to demonstrate engagement with FT members. **Level 3: independent** - Internal Audit review of governance arrangements. Internal Audit reviews have	Risk that there might be a lack of specialist knowledge and/or expertise amongst decision makers in relation to a significant decision or transaction.	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. OWNERS: Director of Corporate Affairs & Co Sec, and Director of Finance.

views, discussion of risks, and decisions; - Risk Management Strategy; - Board Assurance Framework; - Trust Risk Register and local risk registers at directorate and departmental levels; - Business continuity planning processes and emergency preparedness; - Membership Involvement Group, Membership Development Strategy, and membership development responsibilities through the Communications function.	included reviews of Quality Strategy & Governance, the IGF, Clinical Audit, Electronic Health Record Programme Governance, the Research Governance Framework, Information Governance, the Board Assurance Framework, Risk and Quality Governance. Positive Head of Internal Audit opinion and External Audit reliance on same and on relevance of Annual Governance Statement; - 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; - Well Led inspection (CQC) March 2018.		

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

3.7: Ineffective business planning

Date added to BAF	Pre-Jan 2021
Monitoring Committee	Finance and Investment Committee
Executive Lead	Director of Finance
Date of last review	16/03/21
Risk movement	↔
Date of next review	May 2021

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	16
Current risk rating	**4**	**2**	**8**
Target risk rating	3	2	6
Target to be achieved by			

Risk Description:
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; - The planning requirements of NHS Improvement, including Quality Account, are integrated within the Trust's business planning requirements; - Annual Strategic & Operational Plans approved by the Board and submitted to NHS Improvement; - The annual planning process begins in the autumn and is "bottom-up" including consultation with internal and external stakeholders, working with Directorates, aligning priorities with the strategy and developing a Trust-wide Business Plan and Priorities; - Business Services, Performance Team and Service Change (Programme & Project Management) functions.	**Level 1: reassurance** **Level 2: internal** - Business planning is a key component of Extended Executive meetings with particular focus on progress review and plan themes development; - Strategic Delivery Group; - Formal progress reports on the Operational/ Business Plan presented to the Executive and the Board; - The Council of Governors (CoG) is involved in the development of business planning and the CoG formally review and approve the Annual Business Plan. **Level 3: independent** - Annual Strategic Plan submitted to NHS I.	GAP: Business Planning process and objectives not sufficiently aligned with individual PDR processes. GAP: Key Performance Indicators (KPIs) not effectively aligned with strategic objectives and Business plans.	ACTION: working with L&D and HR to align processes. OWNER: Business Services Team and Director of Finance ACTION: working with Performance teams and directorates to agree KPIs and method for reporting. KPIs continue to be developed in conjunction with PLICS, activity-based budgets and productivity management. PDRs in the process of review and will include alignment of personal objectives with those of the Trust. OWNER: Director of Strategy/CIO and Director of Finance

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

3.10: Protecting the information we hold

Date added to BAF	12/01/21
Monitoring Committee	Quality Committee
Executive Lead	Director of Strategy and CIO
Date of last review	10/03/21
Risk movement	↔
Date of next review	May 2021

	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	April 2022		

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; data loss or theft affecting patients, staff or finances; reputational damage.

Controls	Assurance	Gaps	Actions
- Information Governance Team; - GDPR Group workshops; - Mandatory IG training for all staff Trust wide, plus ad hoc training with clinical focus on sage info sharing; - Information assets and systems are risked assessed using standard Data Protection Impact Assessment (DPIA) tool; - Appointment of Cyber Security Consultant (2020); - Membership of Oxfordshire Cyber Security Working Group; - '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; - AppLocker and restrictions to ensure desktop	**Level 1: reassurance** - Information Management Group (IMG); - Monthly Cyber Security activities review via Oxford Health Cyber Security Working Group **Level 2: internal** - Quality Committee receives reports from IMG (most recently Nov 2020); - Monitoring of IG training attendance; - Cyber Security reporting quarterly into Audit Committee and the Board (most recently to the Audit Committee in Sept 2020); - Incident management and response process (enhanced to meet DSPT requirements) through which data and cyber security incidents are monitored and reviewed; - Programme of independent penetration testing of systems/services (annual from 2020);	GAP: 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; GAP: Trust does not yet have National Cyber Security Centre Cyber Security Essentials Plus certification; GAP: MFA cannot be applied to all local systems and backup authentication.	ACTION: 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. OWNER: Director of Strategy and Chief Information Officer ACTION: Focus remains on achieving Cyber Essentials Plus (CE+) certification. Work is ongoing ahead of the mandatory deadline of June 2021 to be CE+ certified. OWNER: Director of Strategy and Chief Information Officer & Cyber Security Consultant. ACTION: Privileged Access Management (PAM) and conditional access are being developed by the Server Team.

applications are controlled and centrally approved; - 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); - GCHQ-certified Cyber Security Board Briefing delivered by NHS Digital and the IT team to the Board Seminar on 14 February 2019; - Mail filtering system to flag or block suspicious, malicious of unsafe communications, to limit the flow of phishing emails, malware and/or unsafe URLs; - Implementation of Multi-Factor Authentication (MFA) has significantly reduced Office 365 user compromises.	- NHS Digital Data Security and Protection Toolkit (DSPT) annual self-assessment. **Level 3: independent** - NHS Digital's BitSight cyber rating, VMS Vulnerability Scanning, and NSCN WebCheck Service, with identified vulnerabilities monitored and remediated or mitigated; -NHS Digital penetration test (July 2020) and Data Security Onsite Assessment Non 2020); -Microsoft Defender ATP Threat & Vulnerability Management (TVM) tools and process. The lower our TVM score, the more secure our estate; - ICO investigation of referrals made by data subjects.	GAP: Desktop Third Party Software Patch Management is currently reactive only via ATP and internal resource fails to keep pace with the requirements. GAP: 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 is reduced. Additional Cyber Security and Server Management resource is required to address those needs and maintain and adequate pace.	ACTION: Software patch management solutions are being investigated by the Desktop & Apps Team. ACTION: Deliver further GCHQ-certified Cyber Security Board Briefing during 2021. OWNER: Director of Strategy and Chief Information Officer & Cyber Security Consultant.

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

3.11: Risk of extensive amount of business solutions residing in a single data centre

Date added to BAF	Pre-Jan 2021
Monitoring Committee	Finance and Investment Committee
Executive Lead	Director of Strategy and CIO
Date of last review	10/02/21
Risk movement	↔
Date of next review	May 2021

	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	31 August 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; - Trust hosts a data room within the Whiteleaf Centre where certain systems have resilient hardware; - Clinical business continuity processes in place in the event of a failure over the short term.	**Level 1: reassurance** **Level 2: internal** Reporting to the Audit Committee, the Finance & Investment Committee and the Board **Level 3: independent**		- IM&T Department has been in detailed discussions with other Data Centres in order to create a fully-costed proposal for migrating all Trust-hosted systems to a commercial data centre, including geographical resilience for those systems which require it on the basis of true business-criticality; - Finance & Investment Committee in September 2020 approved the business case to relocate the Data Centre to a professionally managed alternative data centre.

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

3.12: Failure to maintain adequate business continuity and emergency planning arrangements

Date added to BAF	19/01/21
Monitoring Committee	Emergency Planning Group (sub-group to Executive Management Committee)
Executive Lead	Director of Corporate Affairs & Co Sec
Date of last review	**New risk**
Risk movement	
Date of next review	April 2021

	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; - Designated Emergency Planning Lead, supporting the executive in the discharge of their duties; - Emergency Planning Group 3 x per year oversees emergency preparedness work programme with representation from directorates, HR, and estates & facilities; - Psychosocial Response Group (subgroup reporting to Emergency Planning Group); - Trust wide Pandemic Plan first approved 2012, updated annually, and updated multiple times in 2020 to reflect Covid-19 workstreams, operational	**Level 1: reassurance** - Emergency Planning Resilience and Response (EPRR) Group 3 x per year; - Psychosocial response group (sub-group of Emergency Planning group); - Service Business Continuity Plans signed off by heads of service. **Level 2: internal** - Annual Emergency Planning, Resilience and Response report (most recently to Board in Nov 2020); - EPRR Exercises, with learning incorporated into major incident plans, business continuity plans and shared with partners; - Self-assessment against NHSE/I EPRR Core Standards (For 2020 Trust was fully compliant with 50/54 standards, partially compliant with remaining 4).	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).	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. OWNER: Director of Corporate Affairs & Co Sec, and Emergency Planning Lead

changes and learning from Covid-19 pandemic; - Response Manual (Emergency preparedness, resilience and response) (updated Dec 2020) provides emergency response framework; - Director on call system; - Directorate/service specific Business Continuity Plans (BCPs) in place for every service, in respect of: 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; - Completion and updating of BCPs supported and monitored by Emergency Planning Lead, with register of BCPs held centrally; - BCPs are reviewed annually or following an incident; - Training for directors on call; - 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; - Engagement with Thames Valley Local Health Resilience partnership, and Membership of Oxon & Bucks Resilience Groups; - Horizon scanning and review of National and Community Risk registers by Emergency Planning Group.	**Level 3: independent** - Self-assessment examined and accepted by CCG on behalf of NHSE/I; - Improvement plan for actions against the 4 core standards with which Trust was not compliant was presented to CCG (Oct 2020).		

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

3.13: Failure to take reasonable steps to minimise the Trust's adverse impact on the environment

Date added to BAF	09/02/21
Monitoring Committee	TBC
Executive Lead	Director of Finance
Date of last review	New Risk
Risk movement	N/A
Date of next review	May 2021

	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	2040		

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 national targets, the NHS Long Term Plan and 'For a Greener NHS' ambitions (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.

Key Controls	Assurance	Gaps	Actions
- Environmental Sustainability Policy (CORP26); - Sustainability Development Management Plan 2014; - Executive Lead for Sustainability (Director of Finance); - Commitment by Board to Zero Carbon Oxford Charter (Jan 2021); - Full time Sustainability Manager post within Estates & Facilities Team; - Sustainability Group; - Benchmarking and annual emissions reporting; - Active Travel Plan to transfer fleet to electric by 2028 (required date by NHSE); - Procurement Policy – sets out sustainability commitments required by suppliers; - Green Energy Supplier for electricity via CCS, - Developments to BREEAM (building sustainability	**Level 1: reassurance** - Monitoring of deliverables by Sustainability Manager via dashboards; - Sustainability Group (quarterly); **Level 2: internal** - Annual Travel Survey monitoring against base line; - Annual C02 emissions against previous year (to measure trend); - Building Energy Surveys to identify areas of improvement; - New ways of working questionnaires gathering information from services. **Level 3: external** - Estates Return Information Collection (ERIC) data reports and benchmarking; - Annual SDATT submission (NHSE).	Sustainability Policy and Plan are outdated; 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;	New Green Strategy, Policy & Plan to be prepared and ratified by Board; OWNER: Sustainability Manager & Director of Finance; TARGET: Sept 2021 UPDATE: considerable work has already been undertaken by Sustainability Manager in developing revised Strategy, Policy and Plan. Completion is pending release of NHSE/I's new Green Plan and guidance, to ensure Trust Policy aligns with National ambitions. Plan to be presented at Extended Exec in March 2021. The Board and/or appropriate Board Committee to receive reports on progress against targets for sustainability & environmental deliverables (with Annual Report to Board and Commissioner as a minimum, in line with Standard Contract SC18).

assessments) and Part L (building regs).		Current resource likely to be insufficient to implement Green Plan. Approach to limit business miles and use of cars to get to work (**Note** C-19 pandemic has seen a dramatic increase in business miles).	Assuming Green Plan is approved, consideration to be given to additional resource to implement travel plan, band 6 post. OWNER: Director of Finance; TARGET: June 2021. Funding to deliver required capital works; OWNER: Director of Finance and Director of Estates and Facilities; TARGET: June 2021 Securing grants and central funding for sustainability projects; OWNER: Director of Estates and Facilities/Sustainability Manager. New ways of working to be extended/maintained; OWNER: Head of Property Services/Service Director.

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

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

Date added to BAF	Pre-Jan 2021
Monitoring Committee	
Executive Lead	Medical Director
Date of last review	10/12/20
Risk movement	↔
Date of next review	March 2021

	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
- Research Management Group (RMG); - BRC Steering Committee (BRC-SC), reports into RMG; - ARC Management Board, reporting into the Quality Committee and the RMG; - The R&D Director sits on the OUH Joint R&D committee; - Representation and collaboration via these groups help to ensure that OHFT maximises the opportunities to fully realise its academic and research potential.	**Level 1: reassurance** **Level 2: internal** - R&D reports to Board (twice a year); - RMG reports to Quality Sub-Committee (Quarterly). **Level 3: independent** - The BRC, CRF, ARC and MIC report annually to the National Institute for Health Research (NIHR); - R&D is audited by the Thames Valley & South Midlands Clinical Research Network (TV&SM- CRN) annually; - 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.	GAP: the delivery of clinical trials could be impacted by the UK having left the EU.	ACTIONS: the Trust will maintain plans and mitigating activities which were put in place in respect of a 'no-deal' Brexit, as set out in the Trust's EU Exit Operational Readiness Plan dated 06/11/20. Changes in regulations will be actioned as they appear. OWNERS: Director of Corporate Affairs, Head of Research & Development.

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 No time off work	Minor injury or illness requiring minor intervention Increase in length of hospital stay by 1–3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4–15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Incident resulting serious injury or permanent disability/incapacity Requiring time off for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident resulting in fatality Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/ Complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major safety implications if findings are not acted upon	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints / independent review Low performance rating Critical report Major patient safety implications	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry 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 Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective / service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory / key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff 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. Reduced performance rating if unresolved.	Single breach in statutory duty Challenging external recommendations / improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices	Multiple breaches in statutory duty Prosecution

APPENDIX 1 TO BAF: RISK SCORING GUIDANCE

				Low performance rating Critical report	Complete systems change required Zero performance rating Severely critical report
Adverse publicity / reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence 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) Total loss of public confidence
Business objectives / projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage of a week	5–10 per cent over project budget Schedule slippage of two to four weeks	10–25 per cent over project budget Schedule slippage of more than a month Key objectives not met	>25 per cent over project budget Schedule slippage of more than six months Key objectives not met
Finance including claims	Negligible loss	Claim of <£10,000 Loss of 0.1-0.25% of budget	Claim of between £10,000 and £100,000 Failure to meet CIPs or CQUINs targets of between £10,000 and £50,000 Loss of 0.25-0.5% of budget	Claim of between £100,000 and £1million Purchasers fail to pay promptly Uncertain delivery of key objective / Loss of 0.5-1.0% of budget	Loss of major contract / payment by results Claim of >£1million Non-delivery of key objective/loss of >1% of budget
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss / interruption of >8 hours Minor impact on environment	Loss / interruption of >1 day Moderate impact on environment	Loss / interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment
Additional examples	Incorrect medication dispensed but not taken Incident resulting in bruise/graze Delay in routine transport for patient.	Wrong drug or dosage administered with no adverse effects Physical attack such as pushing, shoving or pinching causing minor injury Self harm resulting in minor injury Grade 1 pressure ulcer Laceration, sprain, anxiety requiring occupational health counselling (no time off work)	Wrong drug or dosage administered with potential adverse effects Physical attack causing moderate injury Self-harm requiring medical attention Grade 2/3 pressure ulcer Healthcare acquired infection (HCAI)	Wrong drug or dosage administered with adverse effects Physical attack resulting in serious injury Grade 4 pressure sore Long term HCAI Loss of a limb Post-traumatic stress disorder	Unexpected death Suicide of patient know to the service in the last 12 months Homicide committed by mental health patient Incident leading to paralysis Rape/serious sexual assault Incident leading to long term mental health problem