

<b>BAF SUMMARY</b> Contents of this summary table (p.1-2) are <a href="#">hyperlinked</a> to full BAF (at p.3 onwards).						
REF.	LEAD EXEC. DIRECTOR (ED)	RISK	RATING	TARGET	MOVEMENT	LAST ED REVIEW
	MONITORING COMMITTEE					REVIEW BY COMMITTEE
<b>1. Quality - Deliver the best possible care and outcomes</b>						
<a href="#">1.1</a>	Chief Nurse Quality Committee	<b>Clinical quality and safety standards</b>	12	8	↔	09/02/21
<a href="#">1.3</a>	Exec MD for MH & LD Quality Committee	<b>Delivery of transformation and effective management of change</b>	12	8	↔	19/11/21 11/11/21
<a href="#">1.5</a>	Exec MD for MH & LD Quality Committee	<b>Unavailability of beds across mental health inpatient services and LD</b>	12	4	↔	19/11/21
<a href="#">1.6</a>	Exec MD Primary Care & Community Quality Committee	<b>Demand and capacity</b>	16	12	↔	22/11/21 11/11/21
<b>2. People - Be a great place to work</b>						
<a href="#">2.1</a>	Chief People Officer PLC	<b>Workforce Planning</b>	16	9	↔	21/09/21 20/07/21
<a href="#">2.2</a>	Chief People Officer PLC	<b>Recruitment</b>	16	9	↔	21/09/21 21/10/21
<a href="#">2.3</a>	Chief People Officer PLC	<b>Succession planning, organisational development and leadership development</b>	6	4	↔	21/09/21
<a href="#">2.4</a>	Chief People Officer PLC	<b>Developing and maintaining a culture in line with Trust values</b>	9	4	↔	21/09/21 18/02/21
<a href="#">2.5</a>	Chief People Officer PLC	<b>Retention of staff</b>	12	9	↔	21/09/21 20/07/21
<b>3. Sustainability - Make the best use of our resources and protect the environment</b>						
<a href="#">3.1</a>	Exec MD for MH & LD Quality Committee	<b>Failure of the Health and Social Care Place Based, Integrated Care Systems and Provider Collaboratives to work together</b>	16	9	↔	19/11/21 09/09/21
<a href="#">3.2</a>	Director for Strategy & Partnerships	<b>Governance of external partners</b>	9	9	↔	14/05/21

	Quality Committee					
<a href="#">3.4</a>	Director of Finance Finance & Investment	<b>Delivery of the financial plan and maintaining financial sustainability</b>	16	12	↔	03/11/21 13/07/21
<a href="#">3.6</a>	Director of Corporate Affairs & Co Sec Audit Committee	<b>Governance and decision-making arrangements</b>	12	4	↑	22/11/21
<a href="#">3.7</a>	Director of Finance Finance & Investment	<b>Ineffective business planning arrangements and/or inadequate mechanisms to track delivery of plans and programmes</b>	12	6	↑	13/07/21
<a href="#">3.10</a>	Director for Strategy & Partnerships Quality Committee	<b>Protecting the information we hold</b>	12	9	↔	14/05/21
<a href="#">3.11</a>	Director for Strategy & Partnerships Finance & Investment	<b>Business solutions in a single data centre</b>	12	4	↔	13/07/21 13/07/21
<a href="#">3.12</a>	Director of Corporate Affairs & Co Sec	<b>Business continuity and emergency planning</b>	12	9	↔	28/10/21
<a href="#">3.13</a>	Director for Strategy & Partnerships Finance & Investment	<b>The Trust's impact on the environment</b>	9	3	↔	13/07/21 13/07/21
<b>4. Research &amp; Education - Become a leader in healthcare research and education</b>						
<a href="#">4.1</a>	Chief Medical Officer	<b>Failure to realise the Trust's Research and Development (R&amp;D) potential</b>	6	3	↔	12/11/21

Risk rating matrix and scoring guidance appears at [Appendix 1](#)

## Strategic Objective 1: Deliver the best possible care outcomes

### 1.1: Clinical quality and safety standards

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	February 2022

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	5	20
<b>Current risk rating</b>	<b>4</b>	<b>3</b>	<b>12</b>
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
<p><b>Quality</b></p> <ul style="list-style-type: none"> <li>- Quality Sub-Committee;</li> <li>- Quality/safety sub-groups, reporting to quality sub-committee, including (though not limited to): Positive and Safe Group; IPC Committee; Quality Improvement Group; Family &amp; Carers Strategy Group;</li> <li>- Oxford Healthcare Improvement (OHI) Centre; training programmes and QI projects;</li> <li>- Maintenance of competent and capable workforce, through training, operational management, supervision, appraisal and professional development;</li> <li>- Dialogue with regulators to feedback on quality standards;</li> <li>- Processes to pick up issues/variations in quality and for staff to raise concerns e.g. through the Whistleblowing policy &amp; Freedom to Speak Up Guardian;</li> </ul> <p><b>Patient Safety</b></p>	<p><b>Level 1: reassurance</b></p> <ul style="list-style-type: none"> <li>- Monthly Directorate Quality Groups;</li> <li>- Weekly safety forums;</li> <li>- Complex review panels.</li> </ul> <p><b>Level 2: internal</b></p> <ul style="list-style-type: none"> <li>- Quality Committee (quarterly), with workplans for receipt of reports in relation to quality, safety and patient engagement items;</li> <li>- Mental Health Act / Mental Capacity Act Committee (quarterly);</li> <li>- Quality &amp; Clinical Governance Sub-Committee (monthly), with workplans for receipt of reports from quality/safety sub-groups (listed in controls);</li> <li>- Trust Quality/Safety Sub-groups, including Friends, Family &amp; Carers Strategy Group;</li> <li>- Mortality Review Group;</li> <li>- Review of serious incidents, complaints, claims, inquests, CAS alerts, safer staffing, and H&amp;S issues at Weekly Review (Clinical Standards) Meeting;</li> <li>- Progress against CQC actions monitored at Quality</li> </ul>	<p>(1) need to more consistently embed co-production and patient and family/carer involvement in care;</p> <p>(2) No systemic and routine implementation of the Triangle of Care across all services.</p> <p>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.</p> <p>Safety domain rated 'inadequate' by CQC on LD wards in relation to restrictive practice.</p>	<p>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.</p> <p>OWNERS: Chief Nurse OVERSIGHT: Quality sub-committee</p> <p>(1) progress CQC post-inspection improvement plan through the Quality Improvement Group (reporting into the Quality Committee);</p> <p>(2) Clinical Workforce Transformation Programme through 'Improving Quality Reducing Agency' Programme Board.</p> <p>OWNER: Chief Nurse.</p> <p>Positive and Safe subcommittee established to reduce restrictive interventions.</p> <p>OWNER: Chief Nurse</p>

<p>- 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;  <b>Experience and involvement</b>                  - People's Experience &amp; 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.  <b>Clinical Effectiveness</b>                  - 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 national programmes such as</p>	<p>Improvement Group and Quality &amp; Clinical Governance 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) &amp; Quality Sub-Committee (most recently August 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;                  - Integrated performance report to Board (last 9/6/21);                  - Quality Dashboard to Board (last 9/6/21);                  - Annual Complaints report (to Board 6/6/21);                  - OHI reporting to Quality &amp; Clinical Governance Sub-Committee (last 29/06/21)</p> <p><b>Level 3: independent</b></p> <p>- 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 &amp; 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;</p>	<p>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).</p> <p>(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.</p> <p>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.</p> <p>(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 increased capacity and capability for QI</p>	<p>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).</p> <p>(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.</p> <p>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.</p> <p>(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.</p>
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## Strategic Objective 1: Deliver the best possible care outcomes

### 1.3: Delivery of transformation and effective management of change

Date added to BAF	Pre-Jan 2021
Monitoring Committee	Quality Committee
Executive Lead	Managing Director for Mental Health & Learning Disabilities
Date of last review	19/11/21
Risk movement	↔
Date of next review	February 2022

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	16
<b>Current risk rating</b>	<b>4</b>	<b>3</b>	<b>12</b>
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
<ul style="list-style-type: none"> <li>- Programme structures at System (BOB), place, and Trust level including: SDG, project Board, and directorate and service specific workstream groups;</li> <li>- Trust CEO is SRO for Mental Health, Autism and Learning Disabilities workstreams for BOB ICS Long Term Plan;</li> <li>- Place-based boards in Bucks, Oxon and BSW.</li> <li>- Trust Provider collaborative Programme Board;</li> <li>- Network oversight groups (system meetings for Provider Collaboratives);</li> <li>- Internal change management processes and joint working with Staff Side representatives;</li> <li>- Warneford redevelopment Board Sub-committee chaired by Trust Chairman;</li> <li>- multi-year and multi-system financial plans and forecasts.</li> </ul>	<b>Level 1: reassurance</b> <ul style="list-style-type: none"> <li>- Directorate workstream meetings;</li> <li>- 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 risk 1.1.</li> </ul>	<ul style="list-style-type: none"> <li>Impact on management and clinical time to lead transformation;</li> <li>Inability to recruit to new clinical services;</li> <li>Disconnect between Long Term Plan for MH indicative funding allocations and investment provided by CCGs (e.g. Mental Health Investment Standard, MHIS), compounded by significant non-recurrent transformation pots (spending review and system transformation);</li> <li>Not recruiting substantive post holder into Managing Director for Mental Health &amp; Learning Disabilities until March 2022.</li> <li>Immature infrastructure at system (BOB) level with increasing demand from</li> </ul>	<ul style="list-style-type: none"> <li>Clarify extent of protected time required to lead transformation;</li> <li>See actions in relation to BAF risk 2.2;</li> <li>Ongoing shared ownership of the gap at each place and at BOB level;</li> <li>CEO, as chair of BOB Board, and Managing Director for Mental Health &amp; Learning Disabilities to keep BOB SLG, Trust board and senior management team informed and involved.</li> <li>Interim post holder in role currently. Consistency is being maintained with ICO and BOB ISC programmes. CEO also maintaining overall ICO role.</li> </ul>
	<b>Level 2: internal</b> <ul style="list-style-type: none"> <li>- Place based boards monthly;</li> <li>- Trust Provider Collaborative Programme Board monthly;</li> <li>- Strategic Delivery Group oversight of transformation programmes monthly.</li> </ul>		
	<b>Level 3: independent</b> <ul style="list-style-type: none"> <li>- BOB Board monthly;</li> <li>- Network oversight groups monthly;</li> <li>- Quarterly SE region deep dives.</li> </ul>		

		region and national team falling on the Trust;	
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## Strategic Objective 1: Deliver the best possible care outcomes

### 1.5: Unavailability of beds across mental health inpatient services and LD

Date added to BAF	Pre-Jan 2021
Monitoring Committee	Quality Committee
Executive Lead	Managing Director for Mental Health & Learning Disabilities
Date of last review	11/19/21
Risk movement	↔
Date of next review	February 2022

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	5	20
<b>Current risk rating</b>	<b>4</b>	<b>3</b>	<b>12</b>
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 & LD, and CAMHS, PICU, ED & GAU) due to: insufficient bed numbers (including Covid-safe admission beds), 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
<ul style="list-style-type: none"> <li>- Clinical oversight and review of patients considered to be in an inappropriate bed via Clinical Directors;</li> <li>- proactive management of flow and Out of Area Placements (OAPS);</li> <li>- single point of access for provider collaborative network beds;</li> <li>- robust CPA (Care Programme Approach) planning;</li> <li>- system partner calls to improve discharge;</li> <li>- Roll out of Crisis Resolution, Home Treatment, Early Intervention, Intensive Support and Hospital at Home teams to prevent admission and support earlier discharge;</li> <li>- SOPs/processes in place for any Young Person in seclusion or Long Term Segregation,</li> </ul>	<b>Level 1: reassurance</b> <ul style="list-style-type: none"> <li>- Directorate SMT monitoring;</li> <li>- Provider Collaborative Single Point of Access monitoring (weekly);</li> <li>- weekly regional calls for CAMHS</li> </ul>	Restricted capacity; Instances of long waits for young people requiring CAMHS & PICU beds;  Restricted capacity leading to long waits for admission to Adult ED units, resulting in patients with very low BMIs being managed in the community or acute hospitals;  National reduction in ATU beds and estate does not enable support for individuals with LD or autism requiring reasonable adjustments or a single person placement;	PICU build is underway. Target date: May 2022;  Adult ED service to extend and develop Day Hospital and Hospital at Home offerings; OWNER: MD for Mental Health & Learning Disabilities; Update: Business plans for revenue and capital has commenced. Target: December 2021 for business case and plans to be approved.  LD services to continue to provide specialist LD support to mainstream mental health wards to facilitate reasonable adjustments; OWNER: MD for Mental Health & Learning Disabilities;
	<b>Level 2: internal</b> <ul style="list-style-type: none"> <li>- Review of incidents, restraints, seclusions and inappropriate use of s.136 by Heads of Nursing and through Weekly Review Meeting; escalation to OMT and Exec;</li> <li>- OAPS trajectory monitoring internally through Directorate OMT and Executive;</li> <li>- Integrated Performance Report to Board (last 28/07/21)</li> </ul>		



<p>including Clinical Director reviews;</p> <ul style="list-style-type: none"> <li>- Transformation programme to improve flow and reduce length of stay.</li> <li>- Initiation optimisation programmes for Oxfordshire Adult wards. This looks at the process from patient admission to discharge with a view to improving the average length of patient stay which will in turn increase capacity.</li> </ul>	<p>included the following data (May 2021 data):</p> <ul style="list-style-type: none"> <li>- Inappropriate <b>OAPS Oxon 8, Bucks 0</b></li> <li>- ALOS on Adult/OA MH wards <b>64 (+12.3% FY19/20 ALOS)</b></li> <li>- 84 admissions to adult/OA HM beds (<b>↓ April 2021</b>)</li> </ul> <p><b>Level 3: independent</b></p> <ul style="list-style-type: none"> <li>- NHSE/I reporting and monitoring of progress against OAPS trajectories.</li> </ul>		<p>Work with partners within place and at BOB level to secure a specialist LD/autism beds and local crash pads;</p> <p>OWNER: MD for Mental Health &amp; Learning Disabilities;</p> <p>Target date: March 2022</p> <p>Starting to link with other partners in ICS (i.e. Berkshire) to try and increase the number of out of area placements available.</p> <p>Roll out of Hospital at Home for CAMHS and CAMHS Eating Disorder service;</p> <p>OWNER: MD for Mental Health &amp; Learning Disabilities.</p> <p>Update – roll-out started but not yet at full capacity.</p> <p>Target: December 2021</p>
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## Strategic Objective 1: Deliver the best possible care outcomes

### 1.6: Demand and capacity

Date added to BAF	Pre-Jan 2021				
Monitoring Committee	Quality Committee	Impact	Likelihood	Rating	
Executive Lead	MD for Primary Care and Community	Gross (Inherent) risk rating	4	5	20
Date of last review	22/11/2021	<b>Current risk rating</b>	<b>4</b>	<b>4</b>	<b>16</b>
Risk movement	↔	Target risk rating	4	3	12
Date of next review	February 2022	Target to be achieved by			

#### Risk Description:

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

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

Key Controls	Assurance	Gaps	Actions
<ul style="list-style-type: none"> <li>- A demand and capacity App has been developed within the Trust's Online Business Intelligence System. This helps operational services to visualise patient demand based on previous activity and enables services to forecast their response based on workforce available.</li> <li>- Demand and Capacity Management</li> <li>- The Trust has invested and now deployed a system for the management and rostering of staff. This enables operational managers to plan shift patterns and to identify and resolve gaps in staffing.</li> <li>- The Trust is required to report activity to commissioners as part</li> </ul>	<b>Level 1: reassurance</b>	<p>The Trust does not have sufficient information about the demand on services or its capacity to respond</p> <p>The Trust has insufficient visibility of the demand for services and capacity to respond.</p>	<p>One of the consequences/impact of insufficient capacity to meet demand will be on patient waiting lists. Although progress has been made to visualise waiting lists, the Trust has not set clinical targets across all service lines for waiting lists. The Trust should review each service line and set a target for when patients should be seen by urgency/priority. Performance can then be reported/planned based on the standards agreed.</p> <p>Further to the action above, the Trust has developed an online training course to accompany the demand and capacity App. This is now being rolled out to all Operational Managers and will help them to better manage their services.</p>
	<b>Level 2: internal</b> <ul style="list-style-type: none"> <li>- Focussed waits report to Board (last 9/6/21) showed <b>increased demand, growing waiting list and/or reduced activity</b> across 17 teams (across all directorates);</li> <li>- <b>+9.4% increase and +4% increase in referrals</b> to adult MH services and CAMHS respectively on the 2019/21 monthly average (Apr 2021);</li> <li>- OAPS bed days for adult mental health beds <b>were 5 and 27</b> (Bucks and Oxon respectively) against</li> </ul>		

<p>of a regular contract management process. Based on the output of these meetings, commissioners will use the information gathered to inform priority and investment decisions.</p> <ul style="list-style-type: none"> <li>- Recovery &amp; Surge Planning: The Trust has set up a specific group to look at a co-ordinated approach to the recovery from COVID.</li> <li>- Contract oversight group for Provider Collaboratives</li> </ul>	<p>NHS targets of 0 (Apr 2021);</p> <ul style="list-style-type: none"> <li>- % waiting six weeks or less from referral to entering a course of talking treatment under IAPT was <b>98.5%</b> against NHS target of 75% (March 2021);</li> <li>- % waiting 18 weeks or less from referral to entering a course of talking treatment under IAPT was <b>99.8%</b> against NHS target of 95% (March 2021);</li> <li>- A&amp;E maximum waiting time <b>95.7%</b> against NHS target of 95% (June 2021);</li> <li>- People with a first episode of psychosis begin treatment within two weeks of referral was <b>87.3%</b> against NHS target of 56% (June 2021).</li> </ul>	<p>The Workforce Management System has not been rolled out across the Trust. Therefore, there is inconsistency and potential risk of under/overstaffing</p> <p>In addition to the standard demand and capacity pressures for services, COVID has placed an additional risk that services will become overwhelmed. This is a combined effect of patients not presenting during the crisis through fear of contracting COVID and also those that have suffered psychological effects of either responding to (as a staff member) and/or as a patient (AKA long COVID).</p>	<p>The work to complete the rollout of the workforce management system should be completed ASAP.</p> <p>Work to understand any potential surge has been carried out at both a local and in part, at a regional level. Whilst surge planning was based on assumptions (10%/20%/30%) this was done to simulate the effects on waiting lists/pressures on services. This work is almost complete and will at the very least, provide the Trust with an indicative view on what could happen.</p>
	<p><b>Level 3: independent</b></p>	<p>The Trust is currently in shadow form with a number of provider collaboratives and is acting as the lead provider. There is a risk that contract management arrangements/information is not sufficient both during the shadow period and after the go-live</p> <p>Insufficient funding from commissioner contracts. (including specialised services)</p>	<p>The Trust is currently developing the provider collaboratives from shadow form into live operations. A provider collaborative group has been setup for each service area and regularly meets. Any risks identified to demand/capacity will be picked up and addressed through this route.</p> <p>There are a number of services that have already been identified as being under-commissioned. Action has already been taken over the past 18 months via a demand and capacity project to identify areas of under-commissioning within services and reports are being submitted to commissioners. This demand and capacity project work will continue and the output is being used for business planning and risk management.</p>

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

### 2.1: Workforce planning

Date added to BAF	Pre-Jan 2021
Monitoring Committee	People Leadership and Culture Committee
Executive Lead	Chief People Officer
Date of last review	21/09/21
Risk movement	↔
Date of next review	November 2021

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	5	4	20
<b>Current risk rating</b>	<b>4</b>	<b>4</b>	<b>16</b>
Target risk rating	3	3	9
Target to be achieved by	April 2022		

#### 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
<ul style="list-style-type: none"> <li>- 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.</li> <li>- Weekly Review Meeting led by Nursing and Clinical Governance reviewing staffing levels and incidents</li> <li>- BOB ICS 'People' workstream has focus on system wide workforce planning capability and capacity</li> </ul>	<b>Level 1: reassurance</b>	Lack of Workforce Planning capability and capacity has been identified.	Proposal to add Workforce Planning capability to HR team. Owner: Interim Director of HR/Chief People Officer, target date: November 2021 <i>Update Sept 2021: Workforce Planning Consultant role has been advertised, with selection and interview processes to commence from application closure on 23/9/21</i>  Detailed plans to be put in place once Workforce Planning resource is in place Owner: Interim Director of HR/Chief People Officer Target date: January 2022  Work to more accurately reflect workforce needs within MH inpatient settings via 'Reducing Agency, Improving Quality' workstream
	<ul style="list-style-type: none"> <li>- E-Rostering Governance Group</li> <li>- Workforce Performance review (monthly)</li> </ul>		
	<b>Level 2: internal</b>		
	<ul style="list-style-type: none"> <li>- People Leadership and Culture Committee Workforce Report;</li> <li>- Safe Staffing Board Report;</li> <li>- Weekly Review Meeting led by Nursing and Clinical Governance reviewing staffing levels and incidents.</li> </ul>		
	<b>Level 3: independent</b>		

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

### 2.2: Recruitment

Date added to BAF	Pre-Jan 2021
Monitoring Committee	People Leadership and Culture Committee
Executive Lead	Chief People Officer
Date of last review	21/09/21
Risk movement	↔
Date of next review	November 2021

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	16
<b>Current risk rating</b>	<b>4</b>	<b>4</b>	<b>16</b>
Target risk rating	3	3	9
Target to be achieved by			

#### Risk Description:

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

Controls	Assurance	Gaps	Actions
<ul style="list-style-type: none"> <li>- 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);</li> <li>- Improving Quality, Reducing Agency Programme Board;</li> <li>- the development of an overarching recruitment plan for each service to address areas of candidate attraction and retention;</li> <li>- 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;</li> <li>- proactive virtual career events at universities, recruitment fairs and for attracting those new to health and care services</li> <li>- Apprenticeship Programme,</li> </ul>	<b>Level 1: reassurance</b> <ul style="list-style-type: none"> <li>- weekly reporting of vacancy levels and fill rates to SMT and the Service Directors;</li> <li>- reporting on inpatient safe staffing levels to SMT and Weekly Review Meeting (Clinical Standards);</li> <li>- integrated activity plan managed daily and reviewed weekly by HR and reviewed by Operations SMT monthly;</li> <li>- Monthly review of recruitment activity by HR SMT.</li> </ul>	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).  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.	Additional HR resource to support recruitment. Target: November 2021 <i>Update Sept 2021: Recruitment of 2x Recruitment Campaign Managers as dedicated resource to lead recruitment work is underway. Roles have been advertised; selection and interview process to be commenced this month.</i>  Increase recruitment efficiency, including via review of operation model of the transactional recruitment team. OWNER: Interim Director of HR/Chief People Officer
	<b>Level 2: internal</b> <ul style="list-style-type: none"> <li>- Improving Quality, Reducing Agency Programme Board</li> <li>- Reports to Extended Executive (monthly);</li> <li>- Workforce performance report as a standing item to the Board;</li> <li>- People Leadership and Culture Committee (quarterly) received workforce report, oversees 'improving quality, reducing agency' item and receives, as standing items, updates on agency use, recruitment &amp;</li> </ul>	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.	

<p>career development pathway for HCAs, 'grow your own' model.</p>	<p>retention and workforce transformation projects, bids and workstreams;            May 2021 Workforce data, as reported to PLC July 2021:            - 358 FTE recruitment activity in progress (an increase on April 2021)            - number of adverts:            Not filled <b>105</b>            Partially filled <b>16</b>            Successfully filled <b>48</b>            - Agency spend <b>10.2%</b> of total pay (NHSI target &lt;18.2%)            - Agency spend decreased by <b>19%</b> in May 2021            - number of apprentices <b>5.16%</b> (national target 2.3%)            - Vacancies <b>11.5%</b> (target &lt;9%) (May 2021)            - Bank spend <b>8.7%</b> of total pay (NHSI target &gt;9.7%)            - Agency as % total temporary staffing <b>54.1%</b></p>		
	<p><b>Level 3: independent</b></p>		

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

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

Date added to BAF	Pre-Jan 2021
Monitoring Committee	People Leadership and Culture Committee
Executive Lead	Chief People Officer
Date of last review	21/09/21
Risk movement	↔
Date of next review	November 2021

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	16
<b>Current risk rating</b>	<b>3</b>	<b>2</b>	<b>6</b>
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
<ul style="list-style-type: none"> <li>- service model review and modifications of pathways across Operations (cross-reference to 1.2 and the risk against failure to deliver integrated care);</li> <li>- completed restructuring of Operations Directorates to provide for development of clinical leadership and for a social care lead in each directorate;</li> <li>- "planning the future" programme and ongoing Aston Team Working programme;</li> <li>- effective team-based working training in place with L&amp;D;</li> <li>- multi-disciplinary leadership trios within clinical directorates to support and develop clinical leadership;</li> <li>- the Organisational and Leadership Development Strategy Framework (approved by the Board, October 2014) - aims to maximise effectiveness of</li> </ul>	<b>Level 1: reassurance</b>	<p>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.</p> <p>GAP (controls - individual professional review and development): co-ordinated direction of career pathways to steer staff to gain wider experiences. Note also links</p>	<p>HR OD function to be created as part of ongoing HR department restructure. Target Date: Jan 2022 <i>Update Sept 2021: Dedicated OD Lead role is approved and going out to advert for recruitment imminently</i></p> <p>ACTION: development of individual professional leadership strategies. Nursing Strategy developed and launched in November 2015. However, risk that</p>
	<b>Level 2: internal</b>		
	<ul style="list-style-type: none"> <li>- People, Leadership &amp; Culture Committee;</li> <li>- Use of annual staff survey to measure progress and perception of leadership development; and</li> <li>- staff appraisals;.</li> <li>- OKRs May 2021: PDR compliance <b>72%</b> (target &gt;90%). Supervisions <b>53%</b> (target &gt;85%)</li> </ul>		
	<b>Level 3: independent</b>		
	<ul style="list-style-type: none"> <li>- CQC reviews - a rating of "good" was achieved in the Well Led domain in 2015 CQC inspection.</li> </ul>		

<p>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;</p> <ul style="list-style-type: none"> <li>- 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);</li> <li>- Masters' framework offering clinically relevant development opportunities for registered professionals;</li> <li>- 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</li> <li>- Trainee Leadership Board - most recent cohort presented to the Board (private Seminar session) on 09 September 2020.</li> </ul>		<p>to Gap at 2.1 above re staff and career development.</p> <p>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.</p>	<p>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.</p> <p>OWNERS: MD for Mental Health &amp; Learning Disabilities; and Chief Nurse</p> <p>ACTION: work of the Equality &amp; 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.</p> <p>OWNER: Equality &amp; Diversity Lead and Associate Director of Strategy &amp; OD</p>
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## Strategic Objective 2: Be a great place to work

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

Date added to BAF	19/01/21
Monitoring Committee	People Leadership and Culture Committee
Executive Lead:	Chief People Officer
Date of last review	21/09/21
Risk movement	↔
Date of next review	November 2021

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	3	12
<b>Current risk rating</b>	<b>3</b>	<b>3</b>	<b>9</b>
Target risk rating	2	2	4
Target to be achieved by	April 2022		

#### Risk Description:

A failure to develop and maintain our culture in line with the Trust values and the NHS people promise which includes: being compassionate and inclusive, recognition and reward, having a voice that counts, health, safety & wellbeing of staff, working flexibly, supporting learning & development, promoting equality, diversity & inclusivity and fostering a team culture. The absence of which could result in; harm to staff; an inability to recruit and retain staff; a workforce which does not reflect Trust and NHS values; and poorer service delivery.

Key Controls	Assurance	Gaps	Actions
<ul style="list-style-type: none"> <li>- HR Policies &amp; strategies, inc. Workplace Stress Prevention &amp; Response, Equal Opportunities, Dignity at Work, Flexible Working, Grievance and Sickness policies;</li> <li>- Freedom to Speak Up Guardian;</li> <li>- Health &amp; Wellbeing Strategy, groups, services and Intranet site&amp; resources;</li> <li>- Employee Assistance Programme;</li> <li>- Occupational Health Service;</li> <li>- Equality, Diversity and Inclusion team, plans, training and groups, Staff Equality Networks;</li> <li>- Health &amp; Safety Policies, and H&amp;S Team;</li> <li>- Zero-Tolerance of Violence and Aggression to Staff Policy;</li> <li>- Training, supervision and Performance and Development Review (PDR) processes;</li> </ul>	<b>Level 1: reassurance</b> <ul style="list-style-type: none"> <li>- Health and Wellbeing Group;</li> <li>- Stress Steering Group;</li> <li>- Learning Advisory Group (LAG) Group;</li> <li>- Equality &amp; Diversity Steering Group;</li> <li>(all reporting to PLC Committee quarterly);</li> <li>- H&amp;S group SEQOSH accredited</li> </ul>	Currently no team/group focused on this work.	This work will be picked up by the new OD function being created as part of the HR department restructure. Dedicated team will determine strategy and action plan. Owner: Interim Director of HR/Chief People Officer <i>Update Sept 2021: Dedicated OD Lead role is approved and going out to advert for recruitment</i> Target Date: Jan 2022  Continued promotion and embedding “wellness culture” including via: wellbeing conversations; restorative Just Culture model, Civility & respect model, Mental Health First Aid training for managers enabling safe spaces and confidential support to all staff Owner: Interim Director of HR/Chief People Officer Target Date: Jan 2022.
	<b>Level 2: internal</b> <ul style="list-style-type: none"> <li>- People, Leadership &amp; Culture Committee (quarterly);</li> <li>- May 2021 Workforce data, as reported to PLC July 2021: Turnover <b>12%</b> (target &lt;10%); Sickness <b>4.15%</b> (target &lt;3.5%)</li> <li>PDR compliance <b>72%</b> (target &gt; 90%)</li> <li>- BAME staff <b>18.3%</b> (target 19%)</li> <li>- Staff engagement index score <b>73%</b></li> <li>- Quarterly People Pulse checks (measures of staff</li> </ul>	Need to improve staff experience and respond to issues identified by Staff Survey results in order to improve retention	

<p>- Communications bulletins &amp; intranet resources and news.</p>	<p>engagement) – data TBC when available.</p>		<p>Exec Team work with Staff Side, including ‘Ways of Working’ workshop Target: October 2021</p> <p>Development of Fair Treatment at Work Facilitators to provide confidential support to all staff.</p>
	<p><b>Level 3: external</b></p>		
	<p>- National Staff Survey results; - External endorsement of the Trust's wellbeing work via take-up of Trust’s model through BOB ICS.</p>		

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

**2.5: Retention of staff**

Date added to BAF	May 2021
Monitoring Committee	People Leadership and Culture Committee
Executive Lead	Chief People Officer
Date of last review	21/09/21
Risk movement	↔
Date of next review	November 2021

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	16
<b>Current risk rating</b>	<b>4</b>	<b>3</b>	<b>12</b>
Target risk rating	3	3	9
Target to be achieved by	July 2022		

**Risk Description:**

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

Controls	Assurance	Gaps	Actions
- Director of Clinical Workforce Transformation to lead quality improvement, aim to reduce agency costs and support recruitment and retention workstreams; - career development pathway for HCAs; - Learning from Exit Questionnaires/Interviews; - Health & Wellbeing, Equality, Diversity and Inclusivity, and Occupational Health strategies, groups, services and initiatives; - Freedom to Speak Up Guardians; - Training, supervision and Performance and Development Review (PDR) processes;	<b>Level 1: reassurance</b> - Quarterly review of leavers exit interview data by HR SMT.	High vacancy numbers, challenges recruiting to vacancies, and demands of recruitment upon operational management of recruitment can have negative impact on experience of existing staff;  Need to improve staff experience and respond to issues identified by Staff Survey results to improve retention.	New exit process (including questionnaire) for leavers to be implemented <i>Update: completed July 2021</i>  Development of Fair Treatment at Work Facilitators to provide confidential support to all staff;  Promotion and embedding of a “wellness culture” including: Team and manager focus on H&W support; wellbeing conversations (July 2021); Embedding Restorative Just Culture model (to commence August 2021); Embedding Civility & respect model ( to commence July 2021); Mental Health First Aid training for managers – (to commence August 2021); Enabling safe spaces and confidential support to all staff.
	<b>Level 2: internal</b> - Reports to Extended Executive (monthly); - Workforce performance reports as a standing item to the Board; - Reports to People Leadership and Culture Committee (quarterly); - Performance data May 2021: Turnover <b>12%</b> (target <10%); Vacancies <b>11.5%</b> (target <9%) Staff engagement index score <b>73%</b>		
	<b>Level 3: independent</b> National – BOB ICS recognition for R&R with Enhanced Occupational Health & Wellbeing Pilot Regionally - H&W key group member of R&R planning and new national resource.		

			<p>OWNER: Chief People Officer &amp; Head of Health &amp; Wellbeing</p> <p>Training for managers to ensure that everyone is getting meaningful appraisals.</p> <p>See also linked risk 2.2 for actions relating to recruitment.</p>
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**Strategic Objective 3: Make the best use of our resources and protect the environment**

**3.1: Failure of the Health and Social Care Place Based, Integrated Care Systems and Provider Collaboratives to work together**

Date added to BAF	Pre-Jan 2021
Monitoring Committee	Quality Committee
Executive Lead	Managing Director for Mental Health & Learning Disabilities
Date of last review	19/11/2021
Risk movement	↔
Date of next review	February 2022

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	5	5	25
<b>Current risk rating</b>	<b>4</b>	<b>4</b>	<b>16</b>
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 Transformation, the Long-Term Plan, integrated care, maintain financial equilibrium and share risk responsibly may impact adversely on the operations of the Trust and compromise service delivery.

Controls	Assurance	Gaps	Actions
<ul style="list-style-type: none"> <li>- BOB MH &amp; LD Oversight Group;</li> <li>- Oxfordshire MH, LD &amp; A Delivery Board;</li> <li>- Buckinghamshire MH, LD &amp; A Delivery Board;</li> <li>- BSW Thrive Board;</li> <li>- Joint work / operational processes with CCGs, local authorities and other partners including PCNs;</li> <li>- Development of alliances and partnerships with other organisations, including the voluntary sector, to deliver services into the future e.g. Oxfordshire Mental Health Partnership;</li> <li>- Exec to Exec discussions with BHFT &amp; OUH &amp; AWP;</li> <li>- Provider Collaborative Governance arrangements;</li> <li>- Participation in key strategic, operational and contracting meetings;</li> </ul>	<p><b>Level 1: reassurance</b></p> <ul style="list-style-type: none"> <li>- Reporting through Directorate SMTs and OMT.</li> </ul>	<p>Absence of system-wide data sets and aligned reporting.</p> <p>Currently no place-level governance board/group in Oxon</p> <p>Financial pressure on CCGs, ICS, County Councils and Social Care impacting adversely on required MH &amp; LD investment.</p>	<p>Work ongoing to understand data and identify reporting inconsistencies. OWNER: Director for Strategy &amp; Partnerships</p> <p>Working with place based and local partners to ensure place and system governance OWNER: Executive Managing Directors and Chief Executive</p> <p>Ensuring engagement in funding dialogue with CCGs and ICSs for system clinical and financial planning. OWNER: Director Finance and MD for Mental Health &amp; LD</p>
	<p><b>Level 2: internal</b></p> <ul style="list-style-type: none"> <li>- Reporting through: Executive Management Committee; and Trust Board.</li> </ul>		
	<p><b>Level 3: independent</b></p> <ul style="list-style-type: none"> <li>- BOB MH &amp; LD Oversight Group;</li> <li>- BSW ICS Board;</li> <li>- BSW Thrive Board;</li> <li>- Oxfordshire MH, LD &amp; A Delivery Board;</li> <li>- Buckinghamshire MH, LD &amp; A Delivery Board;</li> <li>- Provider Collab Chief Exec Steering Groups x3 (secure, CAMHS &amp; ED)</li> </ul>		

- Whole system working across each county to deliver Integrated Care.			
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### Strategic Objective 3: Make the best use of our resources and protect the environment

#### 3.2: Governance of external partners

Date added to BAF	Pre-Jan 2021
Monitoring Committee	Quality Committee
Executive Lead	Director for Strategy and Partnerships
Date of last review	14/05/21
Risk movement	↔
Date of next review	February 2022

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	16
<b>Current risk rating</b>	<b>3</b>	<b>3</b>	<b>9</b>
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
<ul style="list-style-type: none"> <li>- Trust maintains a central register of all partnerships;</li> <li>- Central coordination of partnership arrangements by Business Services Team;</li> <li>- Development and use of Trust Partnership Standard;</li> <li>- Partnership Risk Assessments (for existing partners) undertaken in 2019 and risk-assessment process in place for new partnerships;</li> <li>- Section 75 agreements in place for Oxfordshire and Buckinghamshire, with monitoring and collaboration through Section 75 Joint Management Groups (JMGs);</li> </ul>	<b>Level 1: reassurance</b>	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.	<b>COMPLETED ACTIONS:</b> Partnership standard developed and in use; risk assessment process for partnership working implemented; central coordination of partnership arrangements now sits with Business Services Team.  <b>ONGOING ACTIONS:</b> (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.
	- Partnership Management Group		
	<b>Level 2: internal</b>		
	- Partnerships updates to the Board (in private) (most recently in July 2020); - Future reporting to Quality Committee; - JMG reports to Quality Committee (quarterly).		
	<b>Level 3: independent</b>		
	- 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.		

		New process for partnership management is not well tested as only one new partnership has been entered into since implementation of new processes.	Continue monitoring of adequacy of partnership governance via Business Services Team and reporting to Quality Committee & the Board.
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### Strategic Objective 3: Make the best use of our resources and protect the environment

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

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

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	5	5	25
<b>Current risk rating</b>	<b>4</b>	<b>4</b>	<b>16</b>
Target risk rating	4	3	12
Target to be achieved by	31 March 2022		

#### 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
<ul style="list-style-type: none"> <li>- Annual Financial Plan and Budget produced, and approved by FIC and the Board;</li> <li>- Standing Financial Instructions;</li> <li>- Budgetary Control Policy (CORP03);</li> <li>- Procurement Policy (CORP04) and Procurement Procedure Manual;</li> <li>- Investment Policy (CORP10);</li> <li>- Treasury Management Policy (CORP09);</li> <li>- Counter Fraud Policy (CORP11);</li> <li>- Robust cash management arrangements;</li> <li>- Active management of Capital Programme;</li> <li>- Regular reporting on Financial position and impact of wider financial system risks to FIC and Board;</li> <li>- Monthly reporting to, and monitoring by, NHSE/I.</li> </ul>	<p><b>Level 1: reassurance</b></p> <ul style="list-style-type: none"> <li>- Weekly finance team meeting;</li> <li>- Monthly finance review meetings with directorates;</li> <li>- Capital Programme Sub-Committee (monthly)</li> <li>- daily cash balance reports to DoF, and weekly and monthly cash-flow reports.</li> </ul>	<p>Underfunding of Oxon community services contract</p> <p>Uncertainty around NHS financial regime from October 2021 onwards</p> <p>Agency spend – the Trust is an outlier in terms of agency usage and spend which puts</p>	<p>(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 &amp; Primary Care Services, and Director of Finance. TARGET: currently unclear. Position to be reviewed Sept 2021</p> <p>Close attention paid to guidance issued by NHSE/I, involvement in NHSE/I and ICS planning meetings for latest updates, involvement in any consultation meetings on proposed financial regime, close monitoring of internal forecast for 2021-22 with clear assumptions around income. OWNER: Director of Finance</p> <p>Work to be carried out to review financial controls and</p>
	<p><b>Level 2: internal</b></p> <ul style="list-style-type: none"> <li>- Strategic Delivery Group;</li> <li>- Finance and Investment Committee (every 2 months);</li> <li>- Monthly Finance, including CIP, reporting to the Board to provide assurance on progress and recovery actions.</li> </ul> <p>May 2021:</p> <ul style="list-style-type: none"> <li>- £479k spent on <b>OAPs (+106% FY19/20 monthly average, an improvement on April 2021)</b></li> <li>- £4270k spent on <b>Agency (+110% FY19/20 monthly average and an increase on April 2021)</b></li> </ul>		



	<p>June 2021:</p> <ul style="list-style-type: none"> <li>- EBITDA performance <b>£0.4m surplus</b> (£1.0m adverse to plan)</li> <li>- I&amp;E performance <b>£0.4m deficit</b> (£0.9m adverse to plan)</li> <li>- CIP/PIP <b>£0.1m</b> (£0.1m adverse to plan)</li> <li>- Capital expenditure <b>£42k</b> (£0.9m favourable to plan)</li> <li>- Cash <b>£55.1m</b> (increase of £0.8m)</li> </ul> <p>Year to date:</p> <ul style="list-style-type: none"> <li>- EBITDA performance <b>£2.9m surplus</b> (£1.3m adverse to plan)</li> <li>- I&amp;E performance <b>£0.3m surplus</b> (£1.2m adverse to plan)</li> <li>- CIP/PIP <b>£0.4m</b> (£0.3m adverse to plan)</li> <li>- Capital expenditure <b>£42k</b> (£0.9m favourable to plan)</li> <li>- Cash <b>£55.1m</b></li> </ul> <p><b>Level 3: independent</b></p> <ul style="list-style-type: none"> <li>- Internal Audit review,</li> <li>- External Audit supported financial statement for FY 20/21 and <b>Going Concern Statement</b></li> <li>- Financial Plan submitted to NHSE/I;</li> <li>- Monthly reporting to, and monitoring by, NHSE/I.</li> </ul>	<p>pressure on ability to remain within budget</p>	<p>assurance around agency use and monitoring. Owner: Director of Finance</p> <p>IQRA work programme, led by Matt Edwards, commenced to cover 7 workstreams aimed at addressing underlying drivers of agency use. Owner: Chief Nurse</p>
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### Strategic Objective 3: Make the best use of our resources and protect the environment

#### 3.6: Governance and decision-making arrangements

Date added to BAF	Pre-Jan 2021
Monitoring Committee	Audit Committee
Executive Lead	Director of Corporate Affairs & Co Sec
Date of last review	22/11/2021
Risk movement	↑
Date of next review	February 2022

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	16
<b>Current risk rating</b>	<b>4</b>	<b>3</b>	<b>12</b>
Target risk rating	2	2	4
Target to be achieved by	April 2022		

#### 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	
<ul style="list-style-type: none"> <li>- Trust Constitution and Standing Orders for the Board and Council (CORP01);</li> <li>- Standing Financial Instructions and Scheme of Delegation;</li> <li>- Integrated Governance Framework (IGF);</li> <li>- Procurement Policy (CORP04) and Procurement Procedure Manual;</li> <li>- Investment Policy (CORP10), Treasury Management Policy (CORP09);</li> <li>- Trust Strategic Objectives and setting of key focus areas for achieving objectives (New Strategy approved April 2021);</li> <li>- Maintenance of key Trust registers (e.g. declarations of interest, receipts of gifts);</li> <li>- Processes for capturing meeting minutes to log: consideration of discordant views, discussion of risks, and decisions;</li> <li>- Revised Risk Management Strategy (May 2021);</li> </ul>	<b>Level 1: reassurance</b>	Risk that there might be a lack of specialist knowledge and/or expertise amongst decision makers in relation to a significant decision or transaction.  Constitution, Standing Orders and Scheme of Reservation and Delegation of Powers are in the process of being updated.  Stand-alone Conflicts of Interest Policy in development	Appropriate independent expert, internal audit and/or legal advice to be obtained to support decisions relating to significant transactions (e.g. as part of significant capital projects such as PICU build and Warneford redevelopment projects), and decision makers to be fully sighted on such independent advice. OWNERS: Director of Corporate Affairs & Co Sec, and Director of Finance.  Review of Constitution, Standing Orders and Scheme of Reservation and Delegation of Powers OWNER: Director of Corporate Affairs & Co Sec. TARGET: December 2021  Conflict of Interests Policy to be finalised and approved. OWNER: Director of Corporate Affairs & Co Sec. TARGET: December 2021	
	<b>Level 2: internal</b>			<ul style="list-style-type: none"> <li>- Annual Governance Statement;</li> <li>- Strategic Objectives approved by Board, with progress against objectives reported to Board Committees and Board;</li> <li>- Quality Committee, Finance &amp; Investment Committee, and Audit Committee review risks and key governance issues;</li> <li>- Escalation reports from the Sub Committees to Board Committees and on to Board;</li> <li>- Annual Report and reports for Council of Governors to demonstrate engagement with FT members.</li> </ul>
	<b>Level 3: independent</b>			<ul style="list-style-type: none"> <li>- Internal Audit review of governance arrangements;. Internal Audit reviews have included reviews of Quality Strategy &amp; Governance, the IGF, Clinical Audit, Electronic</li> </ul>

<ul style="list-style-type: none"> <li>- Board Assurance Framework;</li> <li>- Trust Risk Register and local risk registers at directorate and departmental levels;</li> <li>- Business continuity planning processes and emergency preparedness;</li> <li>- Council of Governors (COG), COG Working Groups;</li> <li>- Membership Involvement Group, Membership Development Strategy, and membership development responsibilities through the Communications function.</li> </ul>	<p>Health Record Programme Governance, the Research Governance Framework, Information Governance, the Board Assurance Framework, Risk and Quality Governance;</p> <ul style="list-style-type: none"> <li>- Annual External Audit (including review of governance);</li> <li>- 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;</li> <li>- Well Led inspection (CQC) March 2018.</li> </ul>	<p>COG working groups paused for Covid-19 pandemic</p>	<p>COG working groups to be reinstated with new COG OWNER: Director of Corporate Affairs &amp; Co Sec. TARGET: December 2021</p>
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### Strategic Objective 3: Make the best use of our resources and protect the environment

#### 3.7: Ineffective business planning and/or inadequate mechanisms to track delivery of plans and programmes

Date added to BAF	Pre-Jan 2021
Monitoring Committee	Finance and Investment Committee
Executive Lead	Director of Finance
Date of last review	04/11/2021
Risk movement	↑
Date of next review	November 2021

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	16
<b>Current risk rating</b>	<b>4</b>	<b>3</b>	<b>12</b>
Target risk rating	3	2	6
Target to be achieved by	April 2022		

#### 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
<ul style="list-style-type: none"> <li>- Strategic Framework;</li> <li>- The planning requirements of NHS Improvement, including Quality Account, are integrated within the Trust's business planning requirements;</li> <li>- Annual Strategic &amp; Operational Plans approved by the Board and submitted to NHS Improvement;</li> <li>-;</li> <li>- Annual planning more focused on financial planning. Trust agreed 5 year strategy with key focus areas.</li> <li>- Business Services, Performance Team and Service Change (Programme &amp; Project Management) functions.</li> <li>- Operational planning has changed over 20/21. Split in two. April – September is Half 1 (H1) and BOB is finalising Half 2 (H2) to the end of the year. Trust have submitted revised workforce forecasts and are completing</li> </ul>	<b>Level 1: reassurance</b>	No clear business plans yet set for individual services for current FY. Trust could benefit from medium term (3 year) plan to tie together finance and service improvement/sustainability, workforce planning etc. (particularly in the context of operating within ICS) more clearly and create an implementation for the Trust strategy.	Business plans to be developed with services to set defined deliverables. Target: September 2021 Owner(s): Director of Finance and Contracts and Performance Manager.  The Trust has submitted revised workforce forecasts and are completing a winter workforce resilience return. Peter and Mike also involved in a finance system group.
	<b>Level 2: internal</b>		
	<ul style="list-style-type: none"> <li>- Business planning is a key component of Extended Executive meetings with particular focus on progress review and plan themes development;</li> <li>- Strategic Delivery Group;</li> <li>- Formal progress reports on the Operational/ Business Plan presented to the Executive and the Board;</li> <li>- The Council of Governors (CoG) is involved in the development of business planning and the CoG formally review and approve the Annual Business Plan.</li> </ul>		
	<b>Level 3: independent</b>		
	<ul style="list-style-type: none"> <li>- Annual Strategic Plan submitted to NHS I.</li> </ul>		

a winter workforce resilience return. Once BOB finalise the return, this will be available for individual organisations to review and circulated to the Board for information.			
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### 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 Partnerships
Date of last review	14/05/21
Risk movement	↔
Date of next review	February 2022

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	5	4	20
<b>Current risk rating</b>	<b>4</b>	<b>3</b>	<b>12</b>
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
<ul style="list-style-type: none"> <li>- Information Governance Team;</li> <li>- GDPR Group workshops;</li> <li>- Mandatory IG training for all staff Trust wide, plus ad hoc training with clinical focus on sage info sharing;</li> <li>- Information assets and systems are risked assessed using standard Data Protection Impact Assessment (DPIA) tool;</li> <li>- Appointment of Cyber Security Consultant (2020);</li> <li>- Membership of Oxfordshire Cyber Security Working Group;</li> <li>- 'Third Party Cyber Security Assessment' (checklist &amp; questionnaire) developed, to provide a systems requirement specification and to ensure any new Information Systems being procured adhere to DSPT Cyber Security standards;</li> <li>- AppLocker and restrictions to ensure desktop applications are controlled and centrally approved;</li> </ul>	<p><b>Level 1: reassurance</b></p> <ul style="list-style-type: none"> <li>- Information Management Group (IMG);</li> <li>- Monthly Cyber Security activities review via Oxford Health Cyber Security Working Group.</li> </ul>	<p>Penetration testing undertaken in May 2020 (with OUH), July 2020 (NHS Digital), and NHSD Data Security Onsite Assessment (CE+ &amp; DSPT) in Nov 2020 identified a few low to medium risk information system and user account weaknesses;</p> <p>Trust does not yet have National Cyber Security Centre Cyber Security Essentials Plus certification;</p> <p>MFA cannot be applied to all local systems and backup authentication.</p> <p>Desktop Third Party Software Patch Management is currently reactive only via</p>	<p>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.</p> <p>OWNER: Director for Strategy &amp; Partnerships</p> <p>Focus remains on achieving Cyber Essentials Plus (CE+) certification. Work is ongoing ahead of the mandatory deadline of June 2021 to be CE+ certified.</p> <p>OWNER: Director for Strategy &amp; Partnerships and Cyber Security Consultant.</p> <p>Privileged Access Management (PAM) and conditional access are being developed by the Server Team.</p> <p>Software patch management solutions are being</p>
	<p><b>Level 2: internal</b></p> <ul style="list-style-type: none"> <li>- Quality Committee receives reports from IMG (most recently Nov 2020);</li> <li>- Monitoring of IG training attendance;</li> <li>- Incident management and response process (enhanced to meet DSPT requirements) through which data and cyber security incidents are monitored and reviewed;</li> <li>- Programme of independent penetration testing of systems/services (annual from 2020);</li> <li>- NHS Digital Data Security and Protection Toolkit (DSPT) annual self-assessment.</li> <li>- Cyber Security updates to Audit Committee (most recent April 2021) - no significant threats, breaches</li> </ul>		



**Strategic Objective 3: Make the best use of our resources and protect the environment****3.11: Business solutions residing in a single data centre**

Date added to BAF	Pre-Jan 2021
Monitoring Committee	Finance and Investment Committee
Executive Lead	Director for Strategy and Partnerships
Date of last review	13/07/21
Risk movement	↔
Date of next review	November 2021

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	16
<b>Current risk rating</b>	<b>4</b>	<b>3</b>	<b>12</b>
Target risk rating	2	2	4
Target to be achieved by	31 December 2021		

**Risk Description:**

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

Controls	Assurance	Gaps	Actions
<ul style="list-style-type: none"> <li>- '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;</li> <li>- Trust hosts a data room within the Whiteleaf Centre where certain systems have resilient hardware;</li> <li>- Clinical business continuity processes in place in the event of a failure over the short term.</li> </ul>	<b>Level 1: reassurance</b>		Movement to new data centre [delayed, now due to complete December 2021] Owner: Director for Strategy & Partnerships Target: January 2022
	<b>Level 2: internal</b>		
	Reporting to the Audit Committee, the Finance & Investment Committee and the Board		
	<b>Level 3: independent</b>		



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

#### 3.12: Business continuity and emergency planning

Date added to BAF	19/01/21				
Monitoring Committee	Emergency Planning Group (sub-group to Executive Management Committee)	Impact	Likelihood	Rating	
Executive Lead	Director of Corporate Affairs & Co Sec	Gross (Inherent) risk rating	5	3	15
Date of last review	28/10/2021	Current (residual) risk rating	4	3	12
Risk movement	↔	Target risk rating	3	3	9
Date of next review	September 2021	Target to be achieved by	April 2022		

#### 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
<ul style="list-style-type: none"> <li>- Accountable Emergency Officer (currently Director of Corporate Affairs &amp; Co Sec), supported by nominated Non-executive lead and a clinical director;</li> <li>- Designated Emergency Planning Lead, supporting the executive in the discharge of their duties;</li> <li>- Emergency Planning Group 3 x per year oversees emergency preparedness work programme with representation from directorates, HR, and estates &amp; facilities.</li> <li>- Psychosocial Response Group (subgroup reporting to Emergency Planning Group);</li> <li>- Trust wide Pandemic Plan first approved 2012, updated annually, and updated multiple times in 2020 to reflect Covid-19 workstreams, operational changes and learning from Covid-19 pandemic;</li> </ul>	<b>Level 1: reassurance</b> <ul style="list-style-type: none"> <li>- Emergency Planning Resilience and Response (EPRR) Group 3 x per year;</li> <li>- Psychosocial response group (sub-group of Emergency Planning group);</li> <li>- Service Business Continuity Plans signed off by heads of service via relevant directorate/corporate committee.</li> </ul>	On 2020 Self-assessment against NHSE/I EPRR Core Standards, Trust was only partially compliant with 4 of 54 standards (fully compliant with other 50). Partial compliance in respect of: <ul style="list-style-type: none"> <li>- command and control standard (training of on-call staff)</li> <li>- Training and exercising standard (EPRR training for heads on call &amp; strategic and tactical responder training for heads on call)</li> <li>- Response standard (loggists).</li> </ul>	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 <b>Update</b> on four areas of partial compliance (July 2021): <ul style="list-style-type: none"> <li>- Training: OMT agreed in May 2021 that EPRR training should form part of local induction. Next step is to work with directorates to enable this.</li> <li>- Loggists: Training delivered to PAs and directors on call (who would lead incident response).</li> </ul>
	<b>Level 2: internal</b> <ul style="list-style-type: none"> <li>- Annual Emergency Planning, Resilience and Response report (most recently to Board in Nov 2020);</li> <li>- EPRR Exercises, with learning incorporated into major incident plans, business continuity plans and shared with partners;</li> <li>- Self-assessment against NHSE/I EPRR Core Standards (For 2020 Trust was fully compliant with 50/54 standards, partially compliant with remaining 4).</li> </ul>		

<ul style="list-style-type: none"> <li>- Response Manual incident response plan - emergency preparedness, resilience and response) (updated July 2021) provides emergency response framework;</li> <li>- On call system;</li> <li>- Directorate/service specific Business Continuity Plans (BCPs) in place for services, in respect of: Reduced staffing levels (for any reason e.g pandemic); evacuation; technology failure; interruption to power supplies (gas &amp; electricity); severe weather; flooding/water leak; water supply disruption; fuel shortage; lockdown; infection control; food supply; pharmacy supply;</li> <li>- Completion and updating of BCPs supported and monitored by Emergency Planning Lead, with register of BCPs held centrally;</li> <li>- BCPs are reviewed annually or following an incident;</li> <li>- Training for directors on call;</li> <li>- 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;</li> <li>- training scenarios on intranet for services to use to exercise business continuity plans;</li> <li>- Engagement with Thames Valley Local Health Resilience partnership, and Membership of Oxon &amp; Bucks Resilience Groups;</li> <li>- Horizon scanning and review of National and Community Risk registers by Emergency Planning Group.</li> </ul>	<p style="text-align: center;"><b>Level 3: independent</b></p> <ul style="list-style-type: none"> <li>- Self-assessment examined and accepted by CCG on behalf of NHSE/I;</li> <li>- Improvement plan for actions against the 4 core standards with which Trust was not compliant was presented to CCG (Oct 2020).</li> </ul>		
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### Strategic Objective 3: Make the best use of our resources and protect the environment

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

Date added to BAF	09/02/21
Monitoring Committee	Finance & Investment
Executive Lead	Director for Strategy and Partnerships
Date of last review	13/07/21
Risk movement	↔
Date of next review	November 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	2023		

#### Risk Description:

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

Key Controls	Assurance	Gaps	Actions
<ul style="list-style-type: none"> <li>- Environmental Sustainability Policy (CORP26);</li> <li>- Sustainability Strategy 2021;</li> <li>- Executive Lead for Sustainability (Director of Finance);</li> <li>- Commitment by Board to Zero Carbon Oxford Charter (Jan 2021);</li> <li>- Full time Sustainability Manager post within Estates &amp; Facilities Team;</li> <li>- Sustainability Group;</li> <li>- Benchmarking and annual emissions reporting;</li> <li>- Active Travel Plan to transfer vehicle fleet to 100% electric by 2028 (required date by NHSE);</li> <li>- Procurement Policy – sets out sustainability commitments required by suppliers;</li> <li>- Green Energy Supplier for electricity via CCS,</li> </ul>	<b>Level 1: reassurance</b> <ul style="list-style-type: none"> <li>- Monitoring of deliverables by Sustainability Manager via dashboards;</li> <li>- Sustainability sub-groups (which report on to SDMG).</li> </ul>	Sustainability Policy and Plan are outdated; currently no suite of clear and concise action plans with clear delivery targets;  Current resource likely to be insufficient to implement Green Plan.  Progress in last FY may be reversed if new ways of working are not extended/maintained post- Covid-19. Approach to limit business miles and use of cars to get to work ( <b>Note</b> C-19 pandemic has seen a dramatic reduction in business miles).  Lack of visibility/reporting to Board Committees and/or the Board re sustainability & environmental data. Data is	New Green Plan and Environmental Sustainability Policy to be approved by SDMG;  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.
	<b>Level 2: internal</b> <ul style="list-style-type: none"> <li>- Sustainable Development Management Group, 'SDMG', quarterly (reporting to Board – frequency TBC);</li> <li>- Annual Travel Survey monitoring against base-line;</li> <li>- Annual CO2 emissions against previous year (to measure trend);</li> <li>- Building Energy Surveys to identify areas of improvement;</li> <li>- New ways of working questionnaires gathering information from services.</li> <li>- As at 31 March 2021, reduced carbon emissions by <b>54% (exceeding NHS target)</b></li> </ul>		

<p>- Developments to BREEAM (building sustainability assessments) and Part L (building regs).</p>	<p>against baseline year of 2014-15;                  - FY 20/21 <b>reduced business mileage by 60%</b> when compared 19/20;                  - Direct Carbon emissions for FY21 were <b>4,793tCo2e</b> (6,522 in FY19/20).</p> <p><b>Level 3: external</b></p> <p>- Estates Return Information Collection (ERIC) data reports and benchmarking;                  - Annual SDATT submission (NHSE).</p>	<p>captured by Sustainability Manager and Estates Team, but not currently escalated;</p>	<p>New ways of working to be extended/maintained;                  OWNER: Head of Property Services/Service Director.</p> <p>Sub-groups to develop action plans and establish resource needs to deliver.                  OWNER: Sustainability Manager &amp; 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.                  Further update: New governance and reporting structure in place; reporting via SDMG and on to Board. SDMG and sub-groups' TORs to be developed.</p>
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### Strategic Objective 4: Become a leading organisation in healthcare research and education

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

Date added to BAF	Pre-Jan 2021
Monitoring Committee	Quality Committee
Executive Lead	Medical Director
Date of last review	12/11/21
Risk movement	↔
Date of next review	February 2022

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	3	3	9
<b>Current risk rating</b>	<b>3</b>	<b>2</b>	<b>6</b>
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
<ul style="list-style-type: none"> <li>- Research Management Group (RMG);</li> <li>- BRC Steering Committee (BRC-SC), reports into RMG;</li> <li>- ARC Management Board, reporting into the Quality Committee and the RMG;</li> <li>- The R&amp;D Director sits on the OUH Joint R&amp;D committee;</li> <li>- Representation and collaboration via these groups help to ensure that OHFT maximises the opportunities to fully realise its academic and research potential.</li> <li>- Stability/Continuity in the R&amp;D Department</li> <li>- Director of R&amp;D recruited in early November 2021</li> </ul>	<b>Level 1: reassurance</b>	<ul style="list-style-type: none"> <li>Outcome of the CRF bid is expected in January 2022</li> <li>Outcome of the BRC bid due May 2022</li> </ul>	<ul style="list-style-type: none"> <li>Director of R&amp;D recruited in early November 2021</li> </ul>
	<b>Level 2: internal</b>		
	<ul style="list-style-type: none"> <li>- R&amp;D reports to Board (twice a year);</li> <li>- Research updates to Quality Committees in July and November 2021.</li> </ul>		
	<b>Level 3: independent</b>		
	<ul style="list-style-type: none"> <li>- The BRC, CRF, ARC and MIC report annually to the National Institute for Health Research (NIHR);</li> <li>- R&amp;D is audited by the Thames Valley &amp; South Midlands Clinical Research Network (TV&amp;SM- CRN) annually;</li> <li>- In December 2018 R&amp;D was subject to a two audits by the Department for Health and Social Care where no areas of concern were raised.</li> </ul>		

## 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
<b>Impact on the safety of patients, staff or public (physical/psychological harm)</b>	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
<b>Quality/ Complaints/audit</b>	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
<b>Human resources / organisational development / staffing / competence</b>	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
<b>Statutory duty / inspections</b>	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
<b>Adverse publicity / reputation</b>	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
<b>Business objectives / projects</b>	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
<b>Finance including claims</b>	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
<b>Service/business interruption Environmental impact</b>	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
<b>Additional examples</b>	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 known 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