

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

REF.	LEAD EXEC. DIRECTOR (ED)	RISK	CURRENT 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	<b>Triangulating data and learning to drive Quality Improvement</b>	12	8	↔	10/02/22
	Quality Committee	A failure to triangulate different sources of quality data and learning to inform and drive the quality improvement programme could result in patient harm, impaired outcomes, and/or poor patient experience.				12/05/22
<a href="#">1.3</a>	Exec MD for MH & LD [and/or Director of Strategy & Partnerships]	<b>Transformation and effective management of change</b> [RISK UNDER REVIEW]	12	8	↔	10/02/22
	Quality Committee	Failure to deliver transformation, and/or resource and manage change effectively both within the Trust and with system partners could compromise: (i) quality, safety and experience for patients during the transition from current to future service models; (ii) ability to recruit or retain staff, staff morale and wellbeing, and (iii) delivery of the NHS Long Term Plan.				12/05/22
<a href="#">1.5</a>	Exec MD for MH & LD	<b>Unavailability of beds across mental health inpatient services and LD</b>	12	4	↔	10/02/22
	Quality Committee	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.				12/05/22
<a href="#">1.6</a>	Exec MD Primary Care & Community	<b>Demand and capacity</b>	16	12	↔	18/05/22
	Quality Committee	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.				12/05/22
<b>2. People - Be a great place to work</b>						
<a href="#">2.1</a>	Chief People Officer	<b>Workforce Planning</b>	16	9	↔	
	PLC	Insufficient or ineffective planning for current and future workforce requirements (including number of staff, skill-mix and training) may lead to: impaired ability to deliver the quantity of healthcare services to the required standards of quality; and inability to achieve the business plan and strategic objectives.				05/05/22
<a href="#">2.2</a>	Chief People Officer	<b>Recruitment</b>	16	9	↔	
	PLC	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.				05/05/22

<a href="#">2.3</a>	Chief People Officer	<b>Succession planning, organisational development and leadership development</b> Failure to maintain a coherent and co-ordinated structure and approach to succession planning, organisational development and leadership development may jeopardise: the development of robust clinical and non-clinical leadership to support service delivery and change; the Trust becoming a clinically-led organisation; staff being supported in their career development and to maintain competencies and training attendance; staff retention; and the Trust being a "well-led" organisation under the CQC domain	12	4	↑	
	PLC					05/05/22
<a href="#">2.4</a>	Chief People Officer	<b>Culture in line with Trust values</b> A failure to develop and maintain our culture in line with the Trust values and the NHS people promise which includes: being compassionate and inclusive, recognition and reward, having a voice that counts, health, safety & wellbeing of staff, working flexibly, supporting learning & development, promoting equality, diversity & inclusivity and fostering a team culture. The absence of this could result in; harm to staff; an inability to recruit and retain staff; a workforce which does not reflect Trust and NHS values; and poorer service delivery.	9	4	↔	
	PLC					05/05/22
<a href="#">2.5</a>	Chief People Officer	<b>Retention of staff</b> A failure to retain permanent staff could lead to: the quality of healthcare being impaired; pressure on staff and decreased resilience, health & wellbeing and staff morale; over-reliance on agency staffing at high cost/premiums and potential impairment in service quality; and loss of the Trust's reputation as an employer of choice.	12	9	↔	
	PLC					05/05/22

### 3. Sustainability - Make the best use of our resources and protect the environment

<a href="#">3.1</a>	Exec MD for MH & LD (or Director of Strategy & Partnerships)	<b>Failure of the Health and Social Care Place Based, Integrated Care Systems and Provider Collaboratives to work together [RISK UNDER REVIEW]</b> 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.	16	9	↔	10/02/22
	Quality Committee					12/05/22
<a href="#">3.2</a>	Director of Strategy & Partnerships	<b>Governance of external partners</b> Failure to manage governance of external partners effectively, could: compromise service delivery and stakeholder engagement; lead to poor oversight of risks, challenges and relative quality amongst partners; and put at risk the Trust's integrity, reputation and accountability to its stakeholders and credibility as a system leader and partner of choice.	9	9	↔	07/07/22
	Quality Committee					12/05/22
<a href="#">3.4</a>	Director of Finance	<b>Delivery of the financial plan and maintaining financial sustainability</b> Failure to deliver financial plan and maintain financial sustainability, including, but not limited to: through non-delivery of CIP savings; budget overspends; under-funding and constraints of block contracts in the context of increasing levels of activity and demand, could lead to: an inability to deliver core services and health outcomes; financial deficit; intervention by NHS Improvement; and insufficient cash to fund future capital programmes.	16	12	↔	03/11/21
	Finance & Investment					17/05/22

3.6	Director of Corporate Affairs & Co Sec Audit Committee	<p><b>Governance and decision-making arrangements</b></p> <p>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.</p>	12	4	↑	12/01/22 23/02/22
3.7	Director of Strategy & Partnerships Finance & Investment	<p><b>Ineffective business planning arrangements and performance management</b></p> <p><i>[RISK UNDER REVIEW – see detail in main body]</i></p> <p>Ineffective business planning arrangements and performance management may lead to: the Trust failing to achieve its strategic ambition; problems and issues recurring rather than being resolved; reactive rather than pro-active approaches; decision-making defaulting to short-termism; and inconsistent work prioritisation, further exacerbated by the challenge of limited resources, impacting upon staff frustration and low morale.</p>	12	6	↔	07/07/22 22/03/22
3.10	Executive Director for Digital & Transformation Finance & Investment	<p><b>Protecting the information we hold</b></p> <p>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.</p>	12	9	↔	14/05/21 22/03/22
3.11	Executive Director for Digital & Transformation Finance & Investment	<p><b>Business solutions in a single data centre</b></p> <p>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.</p>	12	4	↔	13/07/21 22/03/22
3.12	Director of Corporate Affairs & Co Sec Emergency Planning Group (sub-group to Executive Management Committee) and Audit Committee from 2022	<p><b>Business continuity and emergency planning</b></p> <p>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.</p>	12	9	↔	28/10/21 23/02/22
3.13	Executive Director for Digital & Transformation Finance & Investment	<p><b>The Trust's impact on the environment</b></p> <p>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.</p>	9	3	↔	04/07/22 18/01/22

**4. Research & Education - Become a leader in healthcare research and education**

<a href="#">4.1</a>	Chief Medical Officer	<b>Failure to realise the Trust's Research and Development (R&amp;D) potential</b> Failure to fully realise the Trust's academic and Research and Development (R&D) potential may adversely affect its reputation and lead to loss of opportunity.	6	3	↔	22/02/22
	Quality Committee					12/05/22

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

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

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

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

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

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

Key Controls	Assurance	Gaps	Actions
<ul style="list-style-type: none"> <li>- Use of TOBI (Trust Online Business Intelligence) data from ward to Board level;</li> <li>- Quality &amp; Safety Dashboard;</li> <li>- Integrated Performance Report to Board;</li> <li>- Oxford Healthcare Improvement (OHI) Centre;</li> <li>- Quality Improvement (QI) Hubs, supported by QI Hub Programme Board and QI &amp; Learning Group;</li> <li>- QI strategy implementation plan as part of wider Trust QI Strategy;</li> <li>- Clinical Audit team transferred to management under the Head of QI (since Q1 FY23);</li> <li>- Weekly Review Meeting triangulating incidents, complaints, deaths/inquests, claims, CAS alerts etc;</li> <li>- Mechanisms for feedback, including 'I Want Great Care' surveys, PALS, complaints and patient stories, and</li> </ul>	<p><b>Level 1: reassurance</b></p> <ul style="list-style-type: none"> <li>- QI Hubs meet monthly and report into QI &amp; Learning Group to share progress and learning across Hubs;</li> <li>- Monthly Directorate Quality Groups;</li> <li>- Weekly Safety Forums;</li> <li>- Complex Review panels.</li> </ul>	<p>GAP (controls): embedding QI as part of Trust culture still an ongoing process; and appropriate resourcing required to support and maintain the OHI Centre in order to support ambition to embed QI.</p> <p>ACTIONS: To sustain momentum and support continuous and sustainable improvements a review of OHI Centre resource and capacity was undertaken during Q4 FY22 with an options appraisal presented in Q1 FY23 to the Executive to consider support and direction for QI going forwards; options appraisal decision in progress.</p> <p>OWNER(s): Head of QI; and Chief Nurse</p>	<p>QI activity as at Q1 FY23: 165 staff, service users and carers had attended QI training during Q1; and 106 QI projects underway (more detailed QI reporting provided into the Quality Committee in July 2022).</p> <p>(1) Embed use of Quality Dashboard to identify areas for improvement and prioritise QI workstreams;</p> <p>(2) continued roll out of QI Hubs and QI Hub Programme Board as vehicles to pick up learning;</p> <p>(3) Engage &amp; train frontline staff in use QI methodology to improve service concerns raised through PSIs. Q1 FY23 saw the launch of OHI Level 1 QI online training module for staff, service users and carers to increase the spread of awareness of QI;</p> <p>(4) External review from peer QI team to benchmark our</p>
	<p><b>Level 2: internal</b></p> <ul style="list-style-type: none"> <li>- Quality &amp; Safety Dashboard regularly reported into Quality Committee;</li> <li>- Integrated Performance Report to Board;</li> <li>- Quality Committee;</li> <li>- Quality &amp; Clinical Governance Sub-Committee;</li> <li>- Weekly Review Meeting (Clinical Standards);</li> <li>- Patient Safety Incident (PSI) updates and review reports at Quality Committee and private Board;</li> <li>- Patient Experience/ Experience &amp; Involvement updates into Quality Committee;</li> </ul>		

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

Date added to BAF	Pre-Jan 2021
Monitoring Committee	Quality Committee
Executive Lead	Executive Managing Director for Mental Health & Learning Disabilities [and/or Director of Strategy & Partnerships]
Date of last review	10/02/22
Risk movement	↔
Date of next review	July 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:**

*Risk description under review and subject to change*

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>- Trust participation in development of BOB ICS FY23 Operational 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;</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> </ul>	<ul style="list-style-type: none"> <li>Board developments: (i) substantive post holder into role of Executive Managing Director for Mental Health &amp; Learning Disabilities joined in March 2022; and (ii) new Director of Strategy &amp; Partnerships joined in April 2022.</li> <li>Draft Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care System (ICS) Operational Plan shared with Trust Board out-of-session during April 2022, final submission for review by Board in private session in May-July 2022.</li> <li>Clarify extent of protected time required to lead transformation;</li> <li>See actions in relation to BAF risk 2.2 (Recruitment);</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>- Provider Collaborative update report into the Quality Committee;</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> </ul>		

<p>- multi-year and multi-system financial plans and forecasts;                  - new Executive Director role of Director of Strategy &amp; Partnerships from April 2022.</p>	<p>- Network oversight groups monthly;                  - Quarterly SE region deep dives.</p>	<p>Disconnect between Long Term Plan for MH indicative funding allocations and investment provided (e.g. Mental Health Investment Standard, MHIS), compounded by significant non-recurrent transformation pots (spending review and system transformation);</p> <p>Immature infrastructure at system (BOB) level with increasing demand from region and national team falling on the Trust.</p>	<p>Ongoing shared ownership of the gap at each place and at BOB level;</p> <p>CEO, as chair of BOB Board, and Interim Executive Managing Director for Mental Health &amp; Learning Disabilities to keep BOB SLG, Trust Board and senior management team informed and involved.</p>
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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	Executive Managing Director for Mental Health & Learning Disabilities
Date of last review	10/02/22
Risk movement	↔
Date of next review	July 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 (**OAPs**) further from home, (ii) inappropriate inpatient placements; (iii) patients being unable to access specialist care required to support recovery; (iv) patients and carers/families having a poor experience; and (v) services falling below reasonable public expectations.

Key Controls	Assurance	Gaps	Actions
<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>	<p>Restricted capacity and instances of long waits for young people requiring CAMHS &amp; Psychiatric Intensive Care Unit (<b>PICU</b>) beds. PICU project paused in June 2021, subject to external review December 2021, actions subject to further follow-up January-April 2022 (through Finance &amp; Investment Committee, Audit Committee and Board), likely to miss target of May 2022.</p> <p>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.</p>	<p>Board reviewed PICU project at its meeting in private in May 2022 and received assurance that programme and project governance strengthened. Monthly Programme Board now in place. New target for PICU scheme to complete by 2023.</p> <p>Adult Eating Disorder (ED) service to extend and develop Day Hospital and Hospital at Home offerings. In March 2022 there was a surge in referrals to the Thames Valley T4 CAMHS Provider Collaborative (TVPC), particularly for ED services</p>
	<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 (May 2022)</li> </ul>		

<p>including Clinical Director reviews;                  - Transformation programme to improve flow and reduce length of stay.                  - 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.</p>	<p>highlighted that Acute OAPs continued to be a challenge and the combined appropriate and inappropriate OAPs for April 2022 were higher than any month in the previous year. Following recent NHSE guidance the Trust has reviewed the use of OAPs and is assured that continuity of care principles adhered to. April 2022 locally reported usage was <b>13 OAP bed days in Bucks</b>, and <b>192 OAP bed days in Oxon</b>, an increase from February 2022 data when inappropriate <b>OAPs Oxon 84, Bucks 0</b></p>	<p>National reduction in Assessment &amp; Treatment Unit (ATU) beds and estate does not enable support for individuals with LD or autism requiring reasonable adjustments or a single person placement.</p>	<p>but as at May 2022 this had settled. There was a similar increase in other South East areas; the TVPC achieved the biggest reduction in pre-admission demand between March-May. The TVPC established the Hospital at Home ED (H@H ED) pilot with views to reducing the need for T4 admission for ED treatment. As at May 2022, pilot has been successful and the H@H ED is expanding and will recruit further nurses.</p>
<p><b>Level 3: independent</b>                  NHSE reporting and monitoring of progress against OAPs trajectories.</p> <p>South East Integrated Performance Report (06 May 2022):                  - Trust Adult bed occupancy lowest in the region (averaging 87% compared to region average of 96.1%);                  - Older Adult bed occupancy amongst highest in the region (averaging 92% compared to region average of 89.3%);                  - PICU bed occupancy amongst lowest in region (averaging 64% compared to region average 78.1%)</p>	<p><b>Level 3: independent</b>                  NHSE reporting and monitoring of progress against OAPs trajectories.</p> <p>South East Integrated Performance Report (06 May 2022):                  - Trust Adult bed occupancy lowest in the region (averaging 87% compared to region average of 96.1%);                  - Older Adult bed occupancy amongst highest in the region (averaging 92% compared to region average of 89.3%);                  - PICU bed occupancy amongst lowest in region (averaging 64% compared to region average 78.1%)</p>	<p>Reduced bed capacity as a result of Infection Prevention Control (IPC) guidance; up to 15% less capacity in the Adult and Older Adult Mental Health wards. The interim closure of beds has resulted in additional OAPs which have been mitigated by purchasing block contract beds.</p>	<p>Business plans for revenue and capital has commenced. LD services to continue to provide specialist LD support to mainstream mental health wards to facilitate reasonable adjustments. OWNER: Executive MD for Mental Health &amp; Learning Disabilities</p> <p>Work with partners within place and at BOB level to secure a specialist LD/autism beds and local crash pads;                  OWNER: Executive MD for Mental Health &amp; Learning Disabilities;                  Target date: March 2022</p> <p>In April 2022, changes to IPC guidance have allowed the facilitation of patients who have completed their 14 day period of isolation and are COVID negative to be repatriated to vacant Trust beds, therefore, maximising bed capacity and reducing the need to purchase further inappropriate OAP.</p>

## 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	
Executive Lead	Executive MD for Primary Care and Community			Rating	
Date of last review	18/05/22	Gross (Inherent) risk rating	4	5	20
Risk movement	↔	<b>Current risk rating</b>	<b>4</b>	<b>4</b>	<b>16</b>
Date of next review	July 2022	Target risk rating	4	3	12
		Target to be achieved by			

**Risk Description:**

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

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

Key Controls	Assurance	Gaps	Actions
<ul style="list-style-type: none"> <li>- A demand and capacity App has been developed within the Trust's Online Business Intelligence System (TOBI). This helps operational services to visualise patient demand based on previous activity and enables services to forecast their response based on workforce available.</li> <li>- Demand and Capacity Management - the Trust has invested and now deployed a system for the management and rostering of staff. This enables operational managers to plan shift patterns and to identify and resolve gaps in staffing.</li> <li>- The Trust is required to report activity to commissioners as part of a regular contract management process. Based on the output of these meetings,</li> </ul>	<b>Level 1: reassurance</b> Board Seminar on 20 October 2021 received an update on 'Demand and Capacity – findings from the work so far'	The Trust is lead provider for 3 Provider Collaboratives: Adult secure services (For Me); CAMHS Inpatient services; and Adult Eating Disorder services. There is a risk that contract management arrangements/information is not sufficient both during the shadow period and after the go-live. Risk of under-reporting patient activity highlighted to the Finance & Investment Committee in January 2022.  Ongoing development of new Oxfordshire NHS Provider Collaborative for Integrated Care.	The Trust has been developing the Provider Collaboratives from shadow form into live operations. A Provider Collaborative Group has been setup for each service area and regularly meets; regular reporting on the Provider Collaboratives is also provided into the Quality Committee.  As at end of May 2022, the Trust and Oxford University Hospitals NHS FT (OUH) have signed a Memorandum of Understanding (MoU) to support closer working for Oxfordshire patients and communities. The MoU identifies urgent care and end of life care
	<b>Level 2: internal</b> - Integrated Performance Report to the Board (standing item) includes reporting on performance against waiting times targets, inpatient admission and length of stay		
	<b>Level 3: independent</b>		

<p>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-19.</li> <li>- Contract oversight group for Provider Collaboratives</li> </ul>		<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>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</p>	<p>as early priorities for collaboration. MoU reviewed and supported by Trust Board in March 2022 and also approved by OUH Board. MoU is not legally binding and both organisations will continue to operate within current governance frameworks.</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. As at May 2022, the Trust was taking part in a southeast region collaboration to benchmark waiting times and share learning on management strategies.</p> <p>Further to the action above, the Trust has developed an online training course to accompany the demand and capacity App. This is being rolled out to all Operational Managers and will help them to better manage their services.</p> <p>The work to complete the rollout of the workforce management system should be completed ASAP.</p> <p>As at March 2022, the system remained highly challenged from a demand and capacity perspective. Services, especially community hospitals, Urgent Community Response, District Nurses, and Community Therapy staff continued to work hard to support system flow and ensure patients were cared for as close</p>
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		<p>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>Insufficient funding from commissioner contracts. (including specialised services)</p> <p>As discussed at Audit Committee in May 2022, there are examples of good risk management in many services, but a recent review indicates a more systematic and data driven QI approach would be of benefit. There may also be a need for more protected resource and expertise to enable root cause analysis of capacity gaps and targeted work on monitoring the impacts of waiting times on patients in certain services.</p>	<p>to home as possible. Pressure on primary and community care services across Oxfordshire continued to be impacted due to steady increases in COVID-19 related staff absences. The Community Services Directorate led a successful system day aimed to prevent conveyance to hospital and instead maintain patients safely at home.</p> <p>As at May 2022, risks with sustaining the Out-Of-Hours GP Service at peak times due to high demand and ongoing workforce and rota challenges. Additional management support being put in place to respond to identified issues, with support from HR team on rota issues.</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> <p>Strategic developments over 2022-23 will focus on optimising capacity and efficiency (e.g. Provider Collaborative and Oxfordshire integrated improvement programmes).</p>
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**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	May 2022
Risk movement	↔
Date of next review	September 2022

	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			

**Risk Description:**

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

Controls	Assurance	Gaps	Actions
- E-Rostering Governance Group to progress the movement of the Trust through NHSI/E E-Rostering attainment levels which supports short term management and review of workforce. - Weekly Review Meeting led by Nursing and Clinical Governance reviewing staffing levels and incidents - BOB ICS 'People' workstream has focus on system wide workforce planning capability and capacity	<b>Level 1: reassurance</b> - E-Rostering Governance Group - Workforce Performance review (monthly)	Lack of Workforce Planning capability and capacity has been identified.	The Learning & Development and HR teams integrated from 01 April 2022 which will provide opportunities for developing a more integrated approach to leadership, workforce planning, career development, OD and systems.  Workforce Planning capability to be added to HR team. As at January 2022, a Workforce Planning role is being recruited to which will support the process to ensure budgets are accurate. A piece of work has been undertaken to map out the workforce requirements for next 5-7 years, this will support future workforce planning decisions. This workforce tool will take into account current committed workforce education programmes such as nurse associate training, top up
	<b>Level 2: internal</b> - People Leadership and Culture Committee Workforce Report; - Safe Staffing reporting via Quality dashboard into Quality Committee; - Weekly Review Meeting led by Nursing and Clinical Governance reviewing staffing levels and incidents.		
	<b>Level 3: independent</b>		

		<p>degrees and advanced clinical practice. Owner: Chief People Officer</p> <p>Detailed plans to be put in place once Workforce Planning resource is in place. However, the Improving Quality and Reducing Agency Programme already has several workstreams which aim to improve the quality of services whilst reducing agency spend. One of the workstreams, Retention, will focus on improving retention which will be supported by the new HR Structure with a greater emphasis on organisational development, culture, development and succession planning. Work is also in progress to review the budgeted establishments across inpatient units this is likely to result in an increase in vacancies. Owner: Chief People Officer</p>
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**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	May 2022
Risk movement	↔
Date of next review	September 2022

	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
<p>- 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);</p> <p>- Improving Quality, Reducing Agency Programme Board;</p> <p>- the development of an overarching recruitment plan for each service to address areas of candidate attraction and retention;</p> <p>- 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;</p> <p>- proactive virtual career events at universities, recruitment fairs and for attracting those new to health and care services</p> <p>- Apprenticeship Programme, career development pathway for HCAs, 'grow your own' model.</p>	<p><b>Level 1: reassurance</b></p> <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>	<p>Dealing with national and local recruitment challenges, (including: possibility of higher turnover due to health &amp; wellbeing post Covid-19; lack of LD nurse training places in the local area; high costs of living).</p> <p>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.</p>	<p>Additional HR resource to support recruitment. As at March 2022, the Recruitment Campaign Consultants (started in post in January 2022 to focus on proactive recruitment in hotspot areas) are in the process of contacting the services that have been identified as hotspot areas for recruitment to discuss their challenges in recruiting and to start the development of campaigns to address these. A clear process has been agreed following the successful landing of international nurses to reduce the Trust's reliance on agency workforce and ending lines of work or negotiating reduced agency pay rates where appropriate.</p> <p>As at March 2022, the Improving Quality and Reducing Agency Programme recruitment workstream is undertaking a piece of work to map out the career pathways for clinical registered, non-registered and administrative staff, this will identify any gaps with the training that is available as well as become a tool to facilitate career conversations with both new and existing staff which will feed through to a talent pipeline.</p> <p>OWNER: Chief People Officer</p>
	<p><b>Level 2: internal</b></p> <ul style="list-style-type: none"> <li>- Improving Quality, Reducing Agency Programme Board</li> <li>- Reports to Extended Executive (monthly);</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; retention and workforce transformation projects, bids and workstreams;</li> <li>December 2021 Workforce data, as reported to PLC February 2022:</li> <li>- December 2021 was a low volume month for substantive recruitment, due to staff shortages (illness &amp; annual leave) and low new vacancies added;</li> <li>- Agency spend decreased by <b>0.3%</b> in December 2021</li> <li>- Bank spend increased in December up to <b>40.9%</b> of temporary staffing spend;</li> <li>- Agency as % total temporary staffing <b>59.1%</b></li> </ul>	<p>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>	
	<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	May 2022
Risk movement	↑
Date of next review	September 2022

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	16
<b>Current risk rating</b>	<b>3</b>	<b>4</b>	<b>12</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
- service model review and modifications of pathways across Operations (cross-reference to 1.2 and the risk against failure to deliver integrated care); - completed restructuring of Operations Directorates to provide for development of clinical leadership and for a social care lead in each directorate; - "planning the future" programme and ongoing Aston Team Working programme; - effective team-based working training in place with L&D; - multi-disciplinary leadership trios within clinical directorates to support and develop clinical leadership; - the Organisational and Leadership Development Strategy Framework (approved by the Board, October 2014) - aims to maximise effectiveness of	<b>Level 1: reassurance</b>	GAP (assurance – recording of PDRs, mandatory training and supervision on new Online Training Record (OTR)): PDR compliance reduced to 34% as at February 2022, then down to 32% in March and 28% in April 2022. Some low compliance may be an issue of lack of recording, rather than lack of undertaking, on the new OTR; and PDRs also not seen as a priority during COVID-19. Other factors - a review of training matrices, renewable training courses for previous once only courses and the introduction of the new OTR system. The L&D team will continue to monitor the new system and revise the training matrices for the small number of teams that are still outstanding and work with teams and areas where compliance is particularly low. <b>The priority for the</b>	On mandatory training compliance as at May 2022, Trust-wide training matrix review has reduced number of matrices from 4,000 to 450 and service level scrutiny of data to address hot spots (but still not large enough impact on compliance). A Task and Finish Group chaired by the Interim Heads of HR will establish the key workstreams for this work and monitor the actions and progress. Mandatory training rates also subject to monthly review at the Executive and reporting into the PLC and as part of Integrated Performance Reporting to the Board in public.  As at May 2022, Head of HR Systems & Reporting has identified potentially 1500 'ghost' records on the system for review and potentially data cleansing, which may
	<b>Level 2: internal</b>		
	- People, Leadership & Culture Committee; - Use of annual staff survey to measure progress and perception of leadership development; and - staff appraisals; - OKRs/performance indicators April 2022: - PDR compliance <b>28%</b> in April, down from <b>32%</b> March, down from <b>34%</b> in February (target >90%). - Clinical supervisions <b>31%</b> in April, from <b>30%</b> in March and down from <b>34%</b> in February (target >85%) - mandatory training performance up from 66% compliance in January 2022 to <b>73%</b> compliance in April 2022 but still below target (target >90%).		
	<b>Level 3: independent</b>		
	- CQC reviews - a rating of "good" was achieved in the		

<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>- Inspire Network (replaced Linking Leaders conferences) event focused on Organisational Development on 10 March 2022 and considered Staff Survey results; and</li> <li>- Trainee Leadership Board - most recent cohort presented to the Executive on 28 March 2022</li> </ul>	<p>Well Led domain in 2015 CQC inspection.</p>	<p><b>next period will be to agree a plan on how mandatory training rates are to be increased</b>, with an assessment of the barriers in relation to implementation so that these can be removed.</p> <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 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>then provide for a more accurate baseline of user accounts to be included in performance data (especially for PDR compliance).</p> <p>Head of Organisational Development has set up a working group to improve PDR compliance. The group is reviewing the PDR process and form, in order to make more user friendly. PDR process already been linked to Pay Progression policy so that a PDR is a required gateway to be evidenced before staff can progress in pay scale.</p> <p>Teams and managers been able to record PDRs on the new OTR from December 2021. Has been a communication and training package to support this. The L&amp;D department will provide additional guidance to teams where the level of completion is low. Work underway as at May 2022 to resolve technical issues related to OTR, oversight through Head of Workforce Systems. OWNERS: Learning &amp; Development team and Head of Workforce Systems. Responsibility for Learning &amp; Development moved to sit with the Chief People Officer from 01 April 2022.</p> <p>HR OD function created as part of HR department restructure. New Head of OD started in post January 2022. The OD Team are facilitating organisation-wide action on areas identified as needing particular attention from the 2021 Staff Survey feedback – including PDRs which will be a Trust-wide Quality Improvement project.</p>
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			<p>The Learning &amp; Development and HR teams integrated from 01 April 2022 which will provide opportunities for developing a more integrated approach to leadership, workforce planning, career development, OD and systems. Merger also provides for the expertise from the HR Workforce systems teams to be applied to the L&amp;D recording system.</p> <p>Inspire Network event focused on Organisational Development on 10 March 2022 and considered Staff Survey results. Staff Survey results also reported to the Board in public in May 2022.</p> <p>ACTION: development of individual professional leadership strategies. Nursing Strategy developed and launched in November 2015. However, risk that may not be sufficient capacity to deliver Nursing Strategy in a timely way. Also, talent management dependent upon PDR system roll-out. New appraisal process and training delayed following feedback from Extended Executive. More recently appointment of Associate Director of Clinical Education and Nursing who will review progress against development and delivery of leadership pathways. OWNERS: Executive 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>
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			OWNER: Equality & Diversity Lead
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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	May 2022
Risk movement	↔
Date of next review	September 2022

	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			

**Risk Description:**

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

Key Controls	Assurance	Gaps	Actions
<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>	<p><b>Level 1: reassurance</b></p> <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; (all reporting to PLC Committee quarterly);</li> <li>- H&amp;S group SEQOSH accredited</li> </ul>	<p>Until 2022, no team/group focused on this work.</p> <p>Need to improve staff experience and respond to issues identified by Staff Survey results in order to improve retention.</p>	<p>This work will be picked up by the new OD function created as part of the HR department restructure. New Head of OD started in post January 2022. In March 2022, the OD Team facilitated organisation-wide action on the areas identified as needing particular attention from the 2021 staff survey feedback: PDRs will be a Quality Improvement project; the Improving Quality Reducing Agency (IQRA) Board is putting measures in place to support teams capacity; and a Flexible Working Project Change Team is in place reporting into the IQRA Retention Workstream. Staff Survey results also reported into the Board in public in May 2022. In June 2022, the OD team commenced a review of workplace culture, with initial results to be</p>
	<p><b>Level 2: internal</b></p> <ul style="list-style-type: none"> <li>- People, Leadership &amp; Culture Committee (quarterly);</li> <li>- Quarterly People Pulse checks (measures of staff engagement) – data TBC when available.</li> </ul>	<p>GAP (controls): further to discussion at PLC on 03 February 2022, having an Estate that is fit for purpose for staff returning to work having Worked At Home during the pandemic and <u>providing sufficient flexible working arrangements</u> to prevent reliance on the Estate going forwards.</p> <p>OWNER: Executive Director for Digital &amp; Transformation</p>	
	<p><b>Level 3: external</b></p> <ul style="list-style-type: none"> <li>- National Staff Survey results;</li> <li>- External endorsement of the Trust's wellbeing work via take-up of Trust's model through BOB ICS.</li> </ul>		

<p>- Communications bulletins &amp; intranet resources and news.</p>			<p>reported into the PLC in July 2022.                  Owner: Chief People Officer</p> <p>Promotion and embedding of a “wellness culture” including: Team and manager focus on H&amp;W support; wellbeing conversations (July 2021); Embedding Restorative Just Culture model (August 2021); Embedding Civility &amp; respect model (July 2021); Mental Health First Aid training for managers – (August 2021); Enabling safe spaces and confidential support to all staff.                  OWNER: Chief People Officer &amp; Head of Health &amp; Wellbeing</p> <p>Development of Fair Treatment at Work Facilitators to provide confidential support to all staff.</p>
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## 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	May 2022
Risk movement	↔
Date of next review	September 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	3	3	9
Target to be achieved by			

#### Risk Description:

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

Controls	Assurance	Gaps	Actions
<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;</li> <li>- career development pathway for HCAs;</li> <li>- Learning from Exit Questionnaires/Interviews;</li> <li>- Health &amp; Wellbeing, Equality, Diversity and Inclusivity, and Occupational Health strategies, groups, services and initiatives;</li> <li>- Freedom to Speak Up Guardians;</li> <li>- Training, supervision and Performance and Development Review (PDR) processes;</li> </ul>	<b>Level 1: reassurance</b>	<p>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.</p> <p>Need to improve staff experience and respond to issues identified by Staff Survey results to improve retention.</p>	<p>Recruitment and Retention workstream of the Improving Quality Reducing Agency Programme will focus on improving retention which will be supported by the new HR Structure with a greater emphasis on organisational development, culture, development and succession planning. The new Head of OD started at the beginning of January. A Workforce Planning role is also being recruited to which will support the process to ensure budgets are accurate.</p> <p>Vaccination as a Condition of Deployment (VCOD)) paused in February 2022. At the beginning of March the Government announced consultation and its intention to revoke the regulations across all health and social care settings. Staff no longer anticipated to leave due to VCOD.</p>
	<b>Level 2: internal</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>New exit process (including questionnaire) for leavers to be implemented  <i>Update: completed July 2021</i></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 [UNDER REVIEW]**

Date added to BAF	Pre-Jan 2021
Monitoring Committee	Quality Committee
Executive Lead	Executive Managing Director for Mental Health & Learning Disabilities [or Director of Strategy & Partnerships]
Date of last review	10/02/22
Risk movement	↔
Date of next review	July 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:**

*Risk description under review and subject to change*

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 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> </ul>	<b>Level 1: reassurance</b> - Reporting through Directorate SMTs and OMT.	Absence of system-wide data sets and aligned reporting.  Currently no place-level governance board/group in Oxon	Work ongoing to understand data and identify reporting inconsistencies.  Working with place based and local partners to ensure place and system governance OWNER: Executive Managing Directors and Chief Executive
	<b>Level 2: internal</b> - Reporting through: Executive Management Committee; and Trust Board.		
	<b>Level 3: independent</b> - BOB MH & LD Oversight Group; - BSW ICS Board; - BSW Thrive Board; - Oxfordshire MH, LD & A Delivery Board; - Buckinghamshire MH, LD & A Delivery Board; - Provider Collab Chief Exec Steering Groups x3 (secure, CAMHS & ED)	Financial pressure on ICSs, County Councils and Social Care impacting adversely on required MH & LD investment.	Ensuring engagement in funding dialogue with ICSs for system clinical and financial planning. OWNER: Director of Finance and Executive MD for Mental Health & LD

<ul style="list-style-type: none"> <li>- Participation in key strategic, operational and contracting meetings;</li> <li>- Whole system working across each county to deliver Integrated Care.</li> <li>- new Executive Director role of Director of Strategy &amp; Partnerships from April 2022.</li> </ul>			
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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 of Strategy & Partnerships
Date of last review	07/07/22
Risk movement	↔
Date of next review	September 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
- Trust maintains a central register of all partnerships; - Central coordination of partnership arrangements by Business Services Team; - Development and use of Trust Partnership Standard; - Partnership Risk Assessments (for existing partners) undertaken in 2019 and risk-assessment process in place for new partnerships; - Section 75 agreements in place for Oxfordshire and Buckinghamshire, with monitoring and collaboration through Section 75 Joint Management Groups (JMGs); - new Executive Director role of Director of Strategy & Partnerships from April 2022.	<b>Level 1: reassurance</b> - Partnership Management Group	GAP (Assurances) – lack of reporting on partnerships activity. Formerly partnerships updates were provided to the Board (in private) (most recently in July 2020) but the Board determined that future reporting should go into the Quality Committee and this has yet to be established with regularity.  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.	Director of Strategy & Partnerships now in post from April 2022.  COMPLETED ACTIONS: Partnership standard developed and in use; risk assessment process for partnership working implemented; central coordination of partnership arrangements now sits with Business Services Team.  ONGOING ACTIONS: (1) Development and use of performance related action logs to monitor progress of partnerships; work is ongoing in Business Services to
	<b>Level 2: internal</b> - 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.		

		<p>New process for partnership management is not well tested as only one new partnership has been entered into since implementation of new processes.</p>	<p>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.</p> <p>Continue monitoring of adequacy of partnership governance via Business Services Team and reporting to Quality Committee &amp; the Board.</p>
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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	July 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	4	3	12
Target to be achieved by	[tbc for FY23]		

**Risk Description:**

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

Controls	Assurance	Gaps	Actions
<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.</li> </ul>	<b>Level 1: reassurance</b> <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>	Underfunding of Oxon community services contract  Uncertainty around NHS financial regime from October 2021 onwards	FY23 Budget Setting and Annual Plan update delivered to the FIC on 22 March 2022 and the Board in private on 30 March 2022 (further to FIC review in January 2022 of performance against FY22 Plan and review of capacity to manage aggregate financial risk, including utilisation of reserves and risks and opportunities not included in the current forecast).  Update on the Long Term Financial Plan to the private Board workshop on 15 December 2021. Included FY22 plan update, FY23 outline plan, 5 year plans and discussion of key deliverables.  (a) Community Services Strategy to be completed, followed by (b) costs analysis, and (c) structured discussions about funding
	<b>Level 2: internal</b> <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> May 2022 (Month 2): <ul style="list-style-type: none"> <li>- EBITDA performance <b>£1.9m surplus</b> (£0.1m favourable to plan for the Month but £0.2m adverse to plan for the Year to date)</li> <li>- I&amp;E performance <b>£0.8m surplus</b> (£0.1m adverse to plan)</li> </ul>		

	<ul style="list-style-type: none"> <li>- CIP/PIP <b>£0.2m</b> (£0.5m adverse to plan)</li> <li>- Cash decrease £13.5m (£8.2m adverse to plan)</li> </ul> <p>Year to date:</p> <ul style="list-style-type: none"> <li>- EBITDA performance <b>£3.4m surplus</b> (£0.2m adverse to plan)</li> <li>- I&amp;E performance <b>£1.5m surplus</b> (£0.3m adverse to plan)</li> <li>- CIP/PIP <b>£0.5m</b> (£0.9m adverse to plan)</li> <li>- Cash <b>£71.1m</b> (£8.2m adverse to plan)</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 statements for FY 20/21 and <b>Going Concern Statement</b></li> <li>- Financial Plan submitted to NHSE;</li> <li>- Monthly reporting to, and monitoring by, NHSE.</li> </ul>	<p>Agency spend – the Trust is an outlier in terms of agency usage and spend which puts pressure on ability to remain within budget</p>	<p>gaps with Commissioners. Update to the Board meeting in private on 09 June 2021. OWNER: Director of Community &amp; Primary Care Services, and Director of Finance.</p> <p>Close attention paid to guidance issued by NHSE, involvement in NHSE and ICS planning meetings for latest updates, involvement in any consultation meetings on proposed financial regime, close monitoring of internal forecast for 2021-22 with clear assumptions around income. OWNER: Director of Finance</p> <p>Work to be carried out to review financial controls and 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	January 2022
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>	<p><b>Level 1: reassurance</b></p>	<p>GAP (assurances and review/oversight): Note delays to Psychiatric Intensive Care Unit (<b>PICU</b>) project may suggest issues with oversight mechanisms or lack of understanding of complexities of project. Risk that there might be a lack of specialist knowledge and/or expertise amongst decision makers in relation to a significant decision or transaction.</p>	<p>Appropriate independent expert, internal audit and/or legal advice to be obtained to support decisions relating to significant transactions (e.g. as part of significant capital projects such as PICU build and Warneford redevelopment projects), and decision makers to be fully sighted on such independent advice. Current risk rating increased in November 2021 to overall rating of 12, pending assurance that gaps resolved. Internal Audit (PwC) report on PICU received and reviewed by Audit Committee, December 2021, with follow-up planned for January-February 2022. OWNERS: Director of Corporate Affairs &amp; Co Sec, and Director of Finance.</p>
	<p><b>Level 2: internal</b></p> <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, People, Leadership &amp; Culture 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>		
	<p><b>Level 3: independent</b></p> <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</li> </ul>		
		<p>GAP (controls): systemic tendency towards short-termism and not looking</p>	<p>Being discussed and explored through Audit Committee workshops on 01 and 08</p>

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

Date added to BAF	Pre-Jan 2021 Risk description revised July 2022
Monitoring Committee	Finance and Investment Committee
Executive Lead	Director of Strategy & Partnerships (previously Director of Finance)
Date of last review	04/11/2021
Risk movement	↔
Date of next review	September 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	3	2	6
Target to be achieved by	2023		

#### Risk Description:

##### Revised risk description, July 2022:

Ineffective business planning arrangements and performance management may lead to: the Trust failing to achieve its strategic ambition; problems and issues recurring rather than being resolved; reactive rather than pro-active approaches; decision-making defaulting to short-termism; and inconsistent work prioritisation, further exacerbated by the challenge of limited resources, impacting upon staff frustration and low morale.

##### Potential enablers in order to mitigate the risk:

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

##### Previous wording:

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

Controls	Assurance	Gaps	Actions
- Strategic Framework including 5-Year Strategy 2021-26 and Digital Health and Care Strategy 2021-26;  - Business Services, Performance Team and Service Change (Programme & Project Management) functions.  - Working group set up to start designing new business planning process	<b>Level 1: reassurance</b>	Action plan to address challenges in the short, medium and long term.	As at June/July 2022, outline plan being developed by Director of Strategy & Partnerships, with short, medium and long-term actions and expected outputs. Internal delivery architecture will comprise: - high-level Strategy and clear articulation of strategic objectives and their achievement; - medium-term (2-3 years) Strategic Plan to bridge the
	Board Strategy Days – April, July, October/November 2022		
	<b>Level 2: internal</b>		
	Integrated Performance Report to the Board in public – on delivery against the strategic objectives, key focus areas and Objective Key Results.		
	<b>Level 3: independent</b>		

		<p>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.</p> <p>Operational planning process changed due to impact of being part of the ICS and part of an ICS submission to NHS England. Individual organisations no longer provide individual Operational Plan returns to NHS England. OWNERS: Strategy &amp; System Partnerships Lead; and Director of Finance</p>	<p>gap between daily operations and the Strategy; - in-year Strategic Plan with in-year priorities supported by regularly reported metrics and an integrated operational plan</p> <p>The Trust has submitted revised workforce forecasts and a winter workforce resilience return. Director of Finance and Deputy Director of Finance also involved in a finance system group.</p> <p>Draft Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care System (ICS) Operational Plan shared with Trust Board out-of-session during April 2022, final submission for review by Board in private session in May-July 2022.</p>
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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	Finance & Investment Committee
Executive Lead	Executive Director for Digital & Transformation
Date of last review	14/05/21
Risk movement	↔
Date of next review	May 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>Log4Shell Cyber Security vulnerability update provided to Audit Committee on 23 February 2022; assurance provided on the Trust's response.</p> <p>ICO Data Protection audit (achieved 'Reasonable' assurance), November 2021, conducted as part of the ICO's routine audit programme and reported into the Audit Committee in December 2021. Purpose to provide independent assurance of compliance with Data Protection legislation.</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: Executive Director for Digital &amp; Transformation</p>
	<p><b>Level 2: internal</b></p> <ul style="list-style-type: none"> <li>- Finance &amp; Investment Committee receives reports from IMG (most recently September 2021);</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</li> </ul>		

<p>- Systems access control and audit managed by way of: programme of penetration testing (annually from 2020); cyber security assessed and tested prior to implementation of new systems; USB device controls; use of external cyber security scoring and scanning tools and services (e.g. NHS Digital's BitSight, VMS Vulnerability Management Service, Nessus Vulnerability Scanning, Microsoft Defender Advanced Threat Protection);</p> <p>- GCHQ-certified Cyber Security Board Briefing delivered by NHS Digital and the IT team to the Board Seminar on 14 February 2019;</p> <p>- Mail filtering system to flag or block suspicious, malicious of unsafe communications, to limit the flow of phishing emails, malware and/or unsafe URLs;</p> <p>- Implementation of Multi-Factor Authentication (MFA) has significantly reduced Office 365 user compromises;</p> <p>- Cyber Security Awareness and Cyber Security SharePoint sites.</p>	<p>significant threats, breaches or other security-based issues encountered during Q4 2020/21;</p> <p>- Data Quality Maturity Index <b>98.1%</b> (Dec 2020)(target 95%)</p> <hr/> <p><b>Level 3: independent</b></p> <p>- Improved NHS Digital's BitSight cyber rating, which exceeds peers in benchmarking and is in top 30% of organisations globally;</p> <p>- VMS Vulnerability Scanning, and NSCN WebCheck Service, with identified vulnerabilities monitored and remediated or mitigated;</p> <p>-NHS Digital penetration test (July 2020) and Data Security Onsite Assessment Non 2020);</p> <p>-Microsoft Defender ATP Threat &amp; Vulnerability Management (TVM) tools and process. The lower our TVM score, the more secure our estate;</p> <p>- Secure messaging accreditation achieved (NHS Digital DCB1596);</p> <p>- ICO investigation of referrals made by data subjects;</p> <p>- ICO Data Protection audit (achieved 'Reasonable' assurance), November 2021, conducted as part of the ICO's routine audit programme and reported into the Audit Committee in December 2021. Purpose to provide independent assurance of compliance with Data Protection legislation.</p>	<p>ATP and internal resource fails to keep pace with the requirements.</p> <p>Training and awareness</p> <p>As Cyber Security hardening such as assessments, penetration testing and other enhancements are being developed, the Cyber and Server management resource available to ensure the trust will meet the June 2021 DSPT/CE+ deadline and offer wider support such as awareness training is reduced. Additional Cyber Security and Server Management resource is required to address those needs and maintain an adequate pace.</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: Executive Director for Digital &amp; Transformation 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 investigated by the Desktop &amp; Apps Team.</p> <p>Business justification for procurement of awareness training package for staff has been submitted;</p> <p>Consider re-delivering further GCHQ-certified Cyber Security Board Briefing during 2021.</p> <p>OWNER: Executive Director for Digital &amp; Transformation and Cyber Security Consultant.</p> <p>Funding bid for cyber security apprentice has been submitted.</p>
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**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	Executive Director for Digital & Transformation
Date of last review	13/07/21
Risk movement	↔
Date of next review	May 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	31 December 2021 (delayed and to be reassessed)		

**Risk Description:**

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

Controls	Assurance	Gaps	Actions
- 'Cloud first' approach where key financial and clinical systems are hosted externally within supplier Public or Private Cloud infrastructures. These systems would not be affected directly by a data centre outage; - Trust hosts a data room within the Whiteleaf Centre where certain systems have resilient hardware; - Clinical business continuity processes in place in the event of a failure over the short term.	<b>Level 1: reassurance</b>		Movement to new data centre [delayed from anticipated completion in December 2021] Owner: Director of Strategy & Partnerships Target: January 2022 (target date to be reassessed)  New Data Centre was due to be subject to an Internal Audit review as part of FY23 Internal Audit plan but now delayed as transfer not complete in December 2021.
	<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) and moving to Audit Committee from 2022	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</li> </ul>	<b>Level 1: reassurance</b>	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. <b>OWNER:</b> 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>
	<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>		
	<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 2021). Aim to bring annual EPRR reporting to the Audit Committee, before final submission to the Board, starting in late 2022;</li> <li>- EPRR Exercises, with learning incorporated into major incident plans,</li> </ul>		

<p>reflect Covid-19 workstreams, operational changes and learning from Covid-19 pandemic;</p> <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> </ul>	<p>business continuity plans and shared with partners;</p> <ul style="list-style-type: none"> <li>- Self-assessment against NHSE/I EPRR Core Standards</li> </ul> <hr/> <p><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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- Horizon scanning and review of National and Community Risk registers by Emergency Planning Group.			
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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	Executive Director for Digital & Transformation
Date of last review	04/07/22
Risk movement	↔
Date of next review	September 2022

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

**Risk Description:**  
 A failure to take reasonable steps to minimise the Trust’s adverse impact on the environment, maintain and deliver a Green Plan, and maintain improvements in sustainability in line with 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
- Trust Green Plan/Strategy 2022-25; - Executive Lead for Sustainability (Director of Finance); - Commitment by Board to Zero Carbon Oxford Charter (Jan 2021); - Full time Sustainability Manager post within Estates & Facilities Team; - Sustainability Group; - Benchmarking and annual emissions reporting; - Active Travel Plan to transfer vehicle fleet to 100% electric by 2028 (required date by NHSE); - Procurement Policy – sets out sustainability commitments required by suppliers; - Green Energy Supplier for electricity via CCS,	<b>Level 1: reassurance</b> - Monitoring of deliverables by Sustainability Manager via dashboards; - Sustainability sub-groups (which report on to Sustainability Steering Group).	GAP: Green Delivery Plan – Sustainability Governance Structure.  Sustainability Policy and Plan were outdated and needed a suite of clear and concise action plans with clear delivery targets.  GAP: current resource may be insufficient to implement Green Plan.	Action: to develop Sustainability Governance structure and sub groups. OWNER: Executive Lead for Sustainability and Sustainability Lead TARGET: Sept 2022  New Trust Green Plan 2022-25 (roadmap to net zero carbon) been developed through Sustainable Development Management Group and recommended by the Executive. Trust Green Plan approved by the Board on 25 May 2022 and presented to the Council of Governors on 15 June 2022.  Increased resource as at June/July 2022. 5 Sub groups (Workforce, Assets/Travel, Green Space, Supply Chain,
	<b>Level 2: internal</b> - Sustainability Steering Group meets quarterly; - Annual Travel Survey monitoring against base-line; - Annual CO2 emissions against previous year (to measure trend); - Building Energy Surveys to identify areas of improvement; - New ways of working questionnaires gathering information from services. - As at 31 March 2021, reduced carbon emissions by		



<p>- Developments to BREEAM (building sustainability assessments) and Part L (building regs).</p>	<p><b>38% (exceeding NHS target)</b> against baseline year of 2014-15;                  - FY 20/21 <b>reduced business mileage by 60%</b> when compared to 19/20;                  - Direct Carbon emissions for FY21 were <b>4,793 Co2e</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>Lack of visibility/reporting to Board Committees and/or the Board re sustainability &amp; environmental data. Data is captured by Sustainability Manager and Estates Team, but not currently escalated.</p> <p>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 (Note C-19 pandemic has seen a dramatic reduction in business miles).</p>	<p>Sustainable Models of Care) reporting into Sustainability Steering Group.</p> <p>Sub-groups to develop action plans and establish resource needs to deliver.                  OWNER: Sustainability Manager &amp; Director of Finance                  TARGET: Sept 2022</p> <p>Securing grants and central funding for sustainability projects;                  OWNER: Director of Estates and Facilities/Sustainability Manager.</p> <p>New ways of working to be extended/maintained;                  OWNER: Head of Property Services/Service Director.</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	Chief Medical Officer
Date of last review	22/02/22 (comments from Chief Executive)
Risk movement	↔
Date of next review	July 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>- Director of R&amp;D;</li> <li>- NIHR Infrastructure Managers Group (formerly the Research Management Group (RMG)) which provides an opportunity for managers of the NIHR awards and the R&amp;D Director to meet regularly;</li> <li>- Clinical Research Facility (CRF) and Biomedical Research Centre (BRC)</li> <li>- BRC Steering Committee (BRC-SC);</li> <li>- Oxford Applied Research Collaboration Oxford and Thames Valley (OxTV) (ARC);</li> <li>- ARC Management Board;</li> <li>- The R&amp;D Director sits on the OUH Joint R&amp;D committee. In December 2021 the Oxford Joint Research Office (JRO) was expanded with the Trust and Oxford Brookes University formally joining with the University of Oxford and OUH;</li> </ul>	<b>Level 1: reassurance</b>	GAP (Controls): R&D Strategy in development.  GAP (Controls): Outcome of the Clinical Research Facility (CRF) bid is expected in early 2022.  GAP (Controls): Outcome of the Biomedical Research Centre (BRC) bid (otherwise the current BRC award will finish at the end of November 2022). BRC renewal will be key in	R&D Strategy and future goals discussed at the Inspire Network event on 09 June 2022 (themed on 'R&D: Today's Research, Tomorrow's Care'). The Inspire Network event covered how research was embedded in services and how staff could get involved. A future goal was for the R&D Strategy to support clinical strategy in the Trust and to increase the amount of translational research.  In February 2022 the NIHR confirmed that the CRF application had been successful and just over £4m had been awarded.  Interviews for the Trust's BRC application took place in April 2022. NIHR will announce outcome and any funding awards in May 2022.
	<b>Level 2: internal</b> <ul style="list-style-type: none"> <li>- Research updates and R&amp;D reporting into the Quality Committee;</li> <li>- R&amp;D reports to Board (at least twice a year, most recently in March 2022 and next due in July 2022);</li> <li>- progress reporting on the Toronto – Oxford Psychiatry Collaboration also provided to the Board (most recently in the Reading Room for the Board meeting in public in January 2022)</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> </ul>		

<p>- representation and collaboration via these groups help to ensure that OHFT maximises the opportunities to fully realise its academic and research potential;</p> <p>- Toronto – Oxford Psychiatry Collaboration under a Memorandum of Understanding between the Trust, University of Oxford, the University of Toronto and the Centre for Addiction and Mental Health in Toronto</p>	<p>- 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.</p>	<p>developing and embedding a culture of research across the Trust. It will also be an attractive feature in recruitment and may lead to the appointment of more clinical academics.</p> <p>GAP (Controls): Warneford redevelopment – to progress. Complicated capital project and is being carefully monitored by the Finance &amp; Investment Committee and with regular updates to the Board in private session.</p>	<p>Recent reporting on the Warneford into the Extraordinary Board (private session) in March 2022 and to the Board in private in May and June 2022. Also reporting into the FIC in January and July 2022.</p>
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## 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