BOARD ASSURANCE FRAMEWORK MARCH 2023

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

REF.	LEAD EXEC. DIRECTOR (ED) / MONITORING COMMITTEE	RISK	CURRENT RATING	TARGET	MOVEMENT	REVIEW BY COMMITTEE
1. Quality - Deliver the best possible care and outcomes						
1.1	Chief Nurse / Quality Committee	**Triangulating data and learning to drive Quality Improvement** A failure to triangulate different sources of quality data and learning to inform and drive the quality improvement programme could result in patient harm, impaired outcomes, and/or poor patient experience.	9	8	↓	09/02/23
1.5	Exec MD for MH & LD / Quality Committee	**Unavailability of beds/demand and capacity (Mental Health inpatient and LD)** Unavailability of beds (across all mental health inpatient services, including Adult MH & LD, and CAMHS, PICU, ED & GAU) due to: demand outstripping capacity and/or absence of support services in the community to prevent admissions and/or facilitate prompt discharge, could lead to: (i) increase in out of area placements further from home, (ii) inappropriate inpatient placements; (iii) patients being unable to access specialist care required to support recovery; (iv) patients and carers/families having a poor experience; and (v) services falling below reasonable public expectations.	16	8	↔	09/02/23
1.6	Exec MD Primary Care & Community / Quality Committee	**Demand and capacity (Community Oxfordshire)** [*RISK UNDER REVIEW further to Executive discussion on 15 February 2023, to be refocused upon sustainability of Community services*] Risk that the population's continuously changing need for service exceeds the Trust's capability and capacity to respond in a timely way. Where there are instances of demand outstripping supply, there is a risk that waitlists will grow, quality and safety of care will be compromised, the needs of the service users could be insufficiently met and this will lead to poorer health outcomes and experiences.	16	12	↔	09/02/23
2. People - Be a great place to work						
2.1	Chief People Officer / PLC	**Workforce Planning** Insufficient or ineffective planning for current and future workforce requirements (including number of staff, skill-mix and training) may lead to: impaired ability to deliver the quantity of healthcare services to the required standards of quality; and inability to achieve the business plan and strategic objectives.	16	9	↔	26/01/23
2.2	Chief People Officer / PLC	**Recruitment** A failure to recruit to vacancies could lead to: the quality and quantity of healthcare being impaired; pressure on existing staff and decreased resilience, health & wellbeing and staff morale; over-reliance on agency staffing at high cost/premiums and potential impairment in service quality; and loss of the Trust's reputation as an employer of choice.	16	9	↔	26/01/23

2.3	Chief People Officer PLC	**Succession planning, organisational development and leadership development** Failure to maintain a coherent and co-ordinated structure and approach to succession planning, organisational development and leadership development may jeopardise: the development of robust clinical and non-clinical leadership to support service delivery and change; the Trust becoming a clinically-led organisation; staff being supported in their career development and to maintain competencies and training attendance; staff retention; and the Trust being a "well-led" organisation under the CQC domain	12	4	↔	26/01/23
2.4	Chief People Officer PLC	**Culture in line with Trust values** 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	↔	26/01/23
2.5	Chief People Officer PLC	**Retention of staff** 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	↔	26/01/23

3. Sustainability - Make the best use of our resources and protect the environment						
3.1	Executive Director of Strategy & Partnerships Quality Committee	**Failure of the Trust to: (i) engage in shared planning and decision-making at system and place level; and (ii) work collaboratively with partners to deliver and transform services at place and system-level** [Formerly - Failure of the Health and Social Care Place Based, Integrated Care Systems and Provider Collaboratives to work together] Failure of the Trust to: (i) engage in shared planning and decision-making at system and place level; and (ii) work collaboratively with partners to deliver and transform services at place and system-level. Such failure would lead to ineffective planning and unsuccessful delivery and transformation of services in the Systems we operate in, and in turn impact both the sustainability and quality of healthcare provision in these Systems and in the Trust.	12	9	↔	09/02/23
3.2	Executive Director of Strategy & Partnerships Quality Committee	**Governance of external partners** [*RISK UNDER REVIEW – see detail in main body*] 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	↔	09/02/23
3.4	Chief Finance Officer Finance & Investment	**Delivery of the financial plan and maintaining financial sustainability** 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	↔	21/03/23

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3.6	Director of Corporate Affairs & Co Sec Audit Committee	**Governance and decision-making arrangements** Failure to maintain and/or adhere to effective governance and decision making arrangements, and/or insufficient understanding of the complexities of a decision may lead to: poor oversight at Board level of risks and challenges; (clinical or organisational) strategic objectives not being established or achieved; actual or perceived disenfranchisement of some stakeholders (including members of the Board, Governors and/or Members) from key strategic decisions; or damage to the Trust's integrity, reputation and accountability.	12	4	↔	23/02/22
3.7	Executive Director of Strategy & Partnerships Finance & Investment	**Ineffective business planning arrangements** Ineffective business planning arrangements may lead to: the Trust failing to achieve its strategic ambition; problems and issues recurring rather than being resolved; reactive rather than pro-active approaches; decision-making defaulting to short-termism; and inconsistent work prioritisation, further exacerbated by the challenge of limited resources, impacting upon staff frustration and low morale.	12	6	↔	21/03/23
3.10	Chief Medical Officer & Chief Finance Officer Finance & Investment	**Information Governance & Cyber Security** Failure to protect the information we hold as a result of ineffective information governance and/or cyber security could lead to: personal data and information being processed unlawfully (with resultant legal or regulatory fines or sanctions), cyber-attacks which could compromise the Trust's infrastructure and ability to deliver services and patient care, especially if loss of access to key clinical systems; data loss or theft affecting patients, staff or finances; reputational damage.	12	9	↔	21/03/23
3.11	Executive Director for Digital & Transformation Finance & Investment	*RISK APPROVED FOR CLOSURE BY FINANCE & INVESTMENT COMMITTEE IN FEBRUARY 2023, WILL BE REMOVED FOLLOWING PUBLICATION AT END OF MARCH 2023* ~~**Business solutions in a single data centre**~~ ~~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.~~	4	4	↓	02/02/23
3.12	Director of Corporate Affairs & Co Sec Emergency Planning Group (sub-group to Executive Management Committee) and Audit Committee from 2022	**Business continuity and emergency planning** 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.	9	9	↓	23/02/22
3.13	Chief Finance Officer Finance & Investment	**The Trust's impact on the environment** A failure to take reasonable steps to minimise the Trust's adverse impact on the environment, maintain and deliver a Green Plan, and maintain improvements in sustainability in line with national targets, the NHS Long Term Plan and 'For a Greener NHS' ambitions (30%, 50% and 80% reduction in emissions by 2023, 2025 and 2030 respectively, and net zero carbon by 2040), could lead to: a failure to meet Trust and System objectives, reputational damage, loss of contracts, contribution to increased pollution within the wider community, and loss of cost saving opportunities.	9	3	↔	21/03/23

3.14	Chief Finance Officer Finance & Investment	**Major Capital Projects** Insufficient programme infrastructure (or project management) to resource delivery of major capital projects or to support a necessary control environment and adherence to governance and decision-making arrangements may lead to: poorly planned and ultimately compromised capital projects; inability to proceed with capital projects; failure of capital projects to complete or to deliver against preferred outcomes; and unplanned expenses, delays and wasted resources, effectively amounting to constructive losses.	16	6	↔	21/03/23
4. Research & Education - Become a leader in healthcare research and education						
4.1	Chief Medical Officer Quality Committee	**Failure to realise the Trust's Research and Development (R&D) potential** 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	↔	09/02/23

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	06/02/23
Risk movement	↓
Date of next review	March 2023

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	5	20
Current risk rating	**3**	**3**	**9**
Target risk rating	4	2	8
Target to be achieved by			

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

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

Key Controls	Assurance	Gaps	Actions
- Use of TOBI (Trust Online Business Intelligence) data from ward to Board level; - Quality & Safety Dashboard; - Integrated Performance Report to Board; - Oxford Healthcare Improvement (**OHI**) Centre; - Quality Improvement (**QI**) Hubs, supported by QI Hub Programme Board and QI & Learning Group; - QI strategy implementation plan as part of wider Trust QI Strategy; - Clinical Audit team transferred to management under the Head of QI (since Q1 FY23); - Weekly Review Meeting triangulating incidents, complaints, deaths/inquests, claims, CAS alerts etc; - Mechanisms for feedback, including 'I Want Great Care' surveys, PALS, complaints and patient stories, and	**Level 1: reassurance** - QI Hubs meet monthly and report into QI & Learning Group to share progress and learning across Hubs; - Monthly Directorate Quality Groups; - Weekly Safety Forums; - Complex Review panels. **Level 2: internal** - Quality & Safety Dashboard regularly reported into Quality Committee; - Integrated Performance Report to Board; - Quality Committee; - Quality & Clinical Governance Sub-Committee; - Weekly Review Meeting (Clinical Standards); - Patient Safety Incident (PSI) updates and review reports at Quality Committee and private Board; - Patient Experience/ Experience & Involvement updates into Quality Committee;	GAP: The clinical system outage from August 2022, which resulted from the failure with third party supplier-hosted patient record systems, has led to a decreased focus upon local QI programmes of work (including Clinical Audit) whilst the Trust has been focusing upon the response to the critical incident. Some progress has been delayed on QI workstreams and members of the OHI had needed to be redeployed from usual roles, as part of the response. OWNER(s): Head of QI; and Chief Nurse 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	During Q2 FY23, QI activity continues to embed across the Trust and approx. 600 colleagues, service users and carers have received QI training since the launch of the training programme in 2021; all cohorts for QI training during October-November 2022 fully subscribed. Despite delays to some QI workstreams, high priority QI projects remained ongoing in relation to: Reducing Restrictive Practice; Involving Families and Carers; and Risk Assessment documentation and formulation. During Q2 FY23, 111 QI projects active (compared to 106 as at Q1). (1) Embed use of Quality Dashboard to identify areas for improvement and prioritise QI workstreams; (2) continued roll out of QI Hubs and QI Hub Programme

Trust-wide Experience & Involvement Group; - Experience & 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 & Freedom to Speak Up Guardian; - Journey to Outstanding internal review self-assessments.	- OHI Centre/QI updates into Quality Committee; - Annual Quality Account. **Level 3: independent** -- 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.	order to support ambition to embed QI. 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. OWNER(s): Head of QI; and Chief Nurse	Board as vehicles to pick up learning; (3) Engage & train frontline staff in use QI methodology to improve service concerns raised through PSIs. Q1 FY23 saw the launch of OHI Level 1 QI online training module for staff, service users and carers to increase the spread of awareness of QI; (4) External review from peer QI team to benchmark our 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.

Strategic Objective 1: Deliver the best possible care outcomes

1.5: Unavailability of beds/demand and capacity (Mental Health inpatient 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	January 2023
Risk movement	↔
Date of next review	March 2023

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

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

Key Controls	Assurance	Gaps	Actions
- Clinical oversight and review of patients considered to be in an inappropriate bed via Clinical Directors; - proactive management of flow and Out of Area Placements (OAPs); - single point of access for provider collaborative network beds; - robust CPA (Care Programme Approach) planning; - system partner calls to improve discharge; - Roll out of Crisis Resolution, Home Treatment, Early Intervention, Intensive Support and Hospital at Home teams to prevent admission and support earlier discharge; - SOPs/processes in place for any Young Person in seclusion or Long Term Segregation,	**Level 1: reassurance** - Directorate SMT monitoring; - Provider Collaborative Single Point of Access monitoring (weekly); - weekly regional calls for CAMHS **Level 2: internal** - 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; - OAPs trajectory monitoring internally through Directorate OMT and Executive; - Integrated Performance Report to Board (May 2022) highlighted that Acute	Restricted capacity and instances of long waits for young people requiring CAMHS & Psychiatric Intensive Care Unit (**PICU**) beds. PICU project paused in June 2021, subject to external review December 2021, actions subject to further follow-up January-April 2022 (through Finance & Investment Committee, Audit Committee and Board), likely to miss target of May 2022. Shortage of substantive nursing and therapy staff across the Trust (and in some teams difficulties recruiting medics e.g. CAMHS community, adult acute mental health and Adult Eating Disorder	Finance & Investment Committee (**FIC**) monitoring delivery of PICU project and BAF risk 3.14 on delivery of Major Capital Projects, such as the PICU. New target for PICU scheme to complete by June 2023. As at January 2023, all but one lessons learned action been completed; next reporting into FIC and Audit Committee in February 2023. Vacancies continue to be high at 12% in December 2022, despite recruitment. Turnover static at 16%. Agency use 13%. Details reported in the Quality and Safety Dashboard provided to the Quality Committee (and to the Board), as well as in highlight reporting from

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.	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. **Level 3: independent** NHSE reporting and monitoring of progress against OAPs trajectories. 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%)	services) i.e. vacancies continue to result in capacity pressures and increased reliance on agency staffing at a time when demand increasing. Ultimately can reduce capacity to see patients and families. Waiting lists and access to some services are rising as a result of increased demand, pressures in the wider system i.e. housing, shortage of staff and the aftermath of COVID-19. Some mental health community teams are also managing high numbers of patients unallocated to a care coordinator due to demand being higher than capacity. This impacts inpatient areas and creates the need to use Out of Area Placements (**OAPs**). The Trust used 414 inappropriate OAP bed days in October 2022 (171 inappropriate OAP bed days in Buckinghamshire, and 243 inappropriate OAP bed days in Oxfordshire). 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.	the Quality & Clinical Governance Sub-Committee to the Quality Committee. Mitigations via Retention and Recruitment workstreams and the Improving Quality Reducing Agency programme (monitored through the People, Leadership & Culture Committee). Monitoring arrangements and mitigations are in place at a team level overseen by each Directorate Senior Management Team. Operational risks also monitored through the Trust Risk Register at 1068 (mental health waiting times), 1024 (reporting on waits) and 1001 (OAPs). Monitoring also through highlight reporting from the Quality & Clinical Governance Sub-Committee to the Quality Committee. The directorates have been focused on reducing the use of OAPs to improve the quality of patient care and improve cost control. There had been minimal use of inappropriate OAPs from April through to November 2022 however December 2022 levels were relatively high following a significant spike in demand, the associated activity, and clinical complexity. This is also in part due to the reduction in commissioned/ externally contracted beds (appropriate OAPs) from 21 to 4 or a monthly bed day reduction of circa 500 days. Adult Eating Disorder (ED) service to extend and develop Day Hospital and Hospital at Home offerings. In March 2022 there was a surge in referrals to the Thames Valley T4 CAMHS Provider Collaborative (TVPC), particularly for ED services but as at May 2022 this had 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. 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 & Learning Disabilities
		National reduction in Assessment & Treatment Unit (ATU) beds and estate does not enable support for individuals with LD or autism requiring reasonable adjustments or a single person placement.	

Strategic Objective 1: Deliver the best possible care outcomes

1.6: Demand and capacity (Community Oxfordshire)

Date added to BAF	Pre-Jan 2021
Monitoring Committee	Quality Committee
Executive Lead	Executive MD for Primary Care and Community
Date of last review	February 2023
Risk movement	↔
Date of next review	March 2023

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

Risk Description:
[*RISK UNDER REVIEW further to Executive discussion on 15 February 2023, to be refocused upon sustainability of Community services*]

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

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

Key Controls	Assurance	Gaps	Actions
- A demand and capacity App has been developed within the Trust's Online Business Intelligence System (TOBI). This helps operational services to visualise patient demand based on previous activity and enables services to forecast their response based on workforce available. - 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. - The Trust is required to report activity to commissioners as part	**Level 1: reassurance** **Level 2: internal** - Integrated Performance Report to the Board (standing item) includes reporting on performance against National Oversight Framework, delivery of strategic Objective Key Results and Directorate highlights and escalations **Level 3: independent**	First Contact Care Service pressures. During November - December 2022, urgent care services (especially urgent community response, Out Of Hours GP (**OOH GP**) and Minor Injury Units) saw a substantial increase in referrals and other patient activity. Peak activity in the OOH GP service was 60% above the average activity levels which led to longer waiting times for some patients. This experience was mirrored by other providers and driven by surges in	Mutual Aid arrangements were put in place across the BOB ICS and additional staff were deployed in the service to improve safety and help manage capacity challenges. In response to the Group A strep outbreaks, point of care testing was deployed into all Trust OOH GP centres with good effect.

of a regular contract management process. Based on the output of these meetings, commissioners will use the information gathered to inform priority and investment decisions. - Recovery & Surge Planning: The Trust has set up a specific group to look at a co-ordinated approach to the recovery from COVID-19. - Contract oversight group for Provider Collaboratives		Group A Streptococcus, influenza, COVID-19 and other respiratory conditions and a large increase was seen in children presenting to the service. System and financial pressures as at December 2022/January 2023. Ongoing system pressures leading to: (i) continued capacity issues in preventive and planned care, children's services and first contact care pathways; and (ii) pressure on the financial plan, due system requests to increase staffing and capacity in response to ambulance handover delays, deteriorating Emergency Department performance and national Operational Pressures Escalation Level (OPEL) 4 status. As at December 2022/January 2023, continued discharge delays in community hospitals and rehabilitation services due to limited availability of home care / reablement. Ongoing development of new Oxfordshire NHS Provider Collaborative for Integrated Care.	Increased system working and collaboration amongst providers during periods of peak pressure, such as when OPEL 4 status declared during December 2022 (as at end of January 2023, BOB ICS had decreased to OPEL 3 level). Can involve daily system escalation calls leading to agreement on how to balance the risks across different provider organisations, including ambulance and acute services, and how to free up space to provide for patient discharge or flow through the system. Discussed and monitored through the Executive, especially in relation to the challenge of balancing demands on staff, finances and achievement of longer-term strategic goals. Directorate participating in a project with Adult Social Care (Oxfordshire County Council) and Oxford University Hospitals NHS FT (**OUH**) colleagues to develop a Transfer of Care team to facilitate more effective and timely hospital discharges. 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. May 2022, the Trust and OUH 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 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.

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	October 2022
Risk movement	↔
Date of next review	January 2023

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

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

Controls	Assurance	Gaps	Actions
- E-Rostering Governance Group to progress the movement of the Trust through NHSI/E E-Rostering attainment levels which supports short term management and review of workforce. - 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	**Level 1: reassurance** - E-Rostering Governance Group - Workforce Performance review (monthly) **Level 2: internal** - 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. **Level 3: independent**	Lack of Workforce Planning capability and capacity has been identified. .	As at December 2022, Head of Workforce Planning & Efficiencies role (reporting to the Director of Clinical Workforce Transformation and accountable to the Chief Nurse) being recruited to. HR priorities defined until the end of FY23/4 which will form the HR People Plan, as agreed at the People, Leadership & Culture Committee on the 7 July 2022. Three cross cutting themes of work to address the most pressing priorities: upskilling line managers to lead teams and increase engagement; a focus on new joiners to support attraction and retention; and strengthening data and systems to free up clinicians' time. 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. A piece of work has been undertaken to map out the workforce requirements for next 5-7 years, this will support future workforce planning decisions. This workforce tool will take into account current committed workforce education programmes such as nurse associate training, top up degrees and advanced clinical practice. Owner: Chief People Officer 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 Annual Planning Process started as at September 2022 (with the Executive Director of Strategy & Partnerships) and aiming to integrate Financial Planning,

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

Strategic Objective 2: Be a great place to work

2.2: Recruitment

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

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

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

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

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

Strategic Objective 2: Be a great place to work

2.3: Succession planning, organisational development and leadership development

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

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

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

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

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

			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 & Learning Disabilities; and Chief Nurse
		GAP (controls): Equality and Diversity. National picture of little progress having been made in the past 20 years to address the issue of discrimination (BAME and other groups including LGBT, people with disabilities and religious groups) in the NHS.	ACTION: work of the Equality & Diversity Lead. NHS Workforce Race Equality Standard reporting. Focus at Board level. Ongoing work with HR to develop routine statistical analysis to identify key areas for actions and follow-up. Development of Quality Improvement Race Equality programme OWNER: Head of OD

Strategic Objective 2: Be a great place to work

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

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

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

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

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

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

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

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	18/11/22
Risk movement	↔
Date of next review	January 2023

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

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

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

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

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

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

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

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

Date added to BAF	Pre-Jan 2021 Refocused and revised in July 2022
Monitoring Committee	Quality Committee
Executive Lead	Executive Director of Strategy & Partnerships
Date of last review	10/02/23
Risk movement	↔
Date of next review	April/May 2023

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

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

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

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

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

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

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

Date added to BAF	Pre-Jan 2021
Monitoring Committee	Quality Committee
Executive Lead	Executive Director of Strategy & Partnerships
Date of last review	30/09/22
Risk movement	↔
Date of next review	February 2023

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

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

Controls	Assurance	Gaps	Actions
- Trust maintains a central register of all partnerships; - 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.	**Level 1: reassurance** - Partnership Management Group **Level 2: internal** - Future reporting to Quality Committee; - JMG reports to Quality Committee (quarterly). **Level 3: independent** - PWC Audit of partnership working in May 2019. Key recommendations of the audit have been completed; - quality assurance peer-to-peer reviews within Oxford Mental Health Partnership.	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	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

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

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

3.4: Delivery of the financial plan and maintaining financial sustainability

Date added to BAF	11/01/21
Monitoring Committee	Finance and Investment Committee
Executive Lead	Chief Finance Officer
Date of last review	17/03/23
Risk movement	↔
Date of next review	March 2023

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	5	5	25
Current risk rating	**4**	**4**	**16**
Target risk rating	4	3	12
Target to be achieved by	[tbc for FY24]		

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
- Financial culture means skills and ownership to manage budgets over the medium term are widespread; - Annual Financial Plan and Budget produced, and approved by FIC and the Board; - Standing Financial Instructions and Financial Policies; - regular reporting on Financial position and impact of wider financial system risks to FIC and Board; - active management of Capital Programme; and - monthly reporting to, and monitoring by, NHSE.	**Level 1: reassurance** - Monthly finance review meetings within Finance team and with directorates; - Capital Programme Sub-Committee (monthly); and - monthly cash-flow reports. **Level 2: internal** - Exec team and Strategic Delivery Group discussions; - Finance and Investment Committee (every 2 months); - Monthly Finance, including CIP, reporting to the Board to provide assurance on progress and recovery actions. February 2023 (Month 11): - I&E forecast **£4.7m** better than plan (up from £3m better than plan in December 2022); and - Capital Expenditure forecast is **£1.5m** above plan (down from £2.6m above plan in December 2022). **Level 3: independent** - Internal Audit reviews;	Funding pressures - underfunding of Oxfordshire community services contract is endemic, and there were shortfalls in Specialised Commissioning and Mental Health Investment Standard funding in 22/23. The expected withdrawal of COVID-19 funding, and the failure of NHS funding to match inflation exacerbate medium-term financial sustainability challenges. Agency spend – the Trust's workforce challenges are leading to excess agency usage and spend which puts pressure on ability to remain within budget	Financial challenges to be escalated to the ICS and NHSE through annual planning process. FY24 Budget Setting and Annual Plan update to be delivered by end of March 2023 and linked to operational and workforce plans owned by directorates. Refresh of the Long Term Financial Plan to be scheduled. (a) Community Services Strategy to be completed, followed by (b) costs analysis, and (c) structured discussions about funding gaps with Commissioners. Improving Quality Reducing Agency (IQRA) work programme aimed at addressing underlying drivers of agency use. Owner: Chief Nurse

	- External Audit review pf financial statements; - Monthly reporting to, and monitoring by, NHSE and the Integrated Care System (ICS).		

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	15/02/23
Risk movement	↔
Date of next review	May 2023

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

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

Controls	Assurance	Gaps	Actions
In accordance with the NHS Code of Governance, the delivery of good governance is controlled through an effective Board of directors, with an appropriate balance of skills and experience to enable them to discharge their respective duties and responsibilities effectively. The purpose of the organisation and the vision set by the Board are the starting point for the system of governance. Board and Executive Team Development programme to ensure balanced and collaborative relationship and to question status quo.	**Level 1: reassurance** The Nominations, Remuneration and Terms of Service Committee (NEDs) and Nominations and Remuneration Committee (Governors) review the composition, balance, skills and experience annually as per minutes of meetings and Board refresh. Board self assesses (and CoG) against various statements and declarations with evidence of compliance to include – AGS, Corporate Governance Statement, Annual Report declarations, Code of Governance comply or explain, EPRR statement and various Annual Reports –	GAP (assurances and review/oversight): delays to Psychiatric Intensive Care Unit (**PICU**) project may suggest issues with oversight mechanisms or lack of understanding of complexities of project. Risk that there might be a lack of specialist knowledge and/or expertise amongst decision makers in relation to a significant decision or transaction. PICU project was paused in June 2021; subject to external review December 2021; actions monitored through Finance & Investment Committee (FIC), Audit Committee and Board) during 2022. Missed original target of May 2022;	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; actions monitored through Finance & Investment Committee (FIC), Audit Committee and Board) during 2022 and assurance received that programme and project governance strengthened. Monthly Programme Board now in place. Major Capital Projects risk also included on the BAF at 3.14 to monitor PICU and Warneford redevelopment (see 3.14 for more detail).

Honest self reflection through such as True for Us curiosity and Well Led Framework self assessments; Policy and Procedure frameworks to include: - Trust Constitution and Standing Orders for the Board and Council (CORP01); - Standing Financial Instructions and Scheme of Delegation; - Integrated Governance Framework (IGF); - Engagement Policy (significant transactions); - Procurement Policy (CORP04) and Procurement Procedure Manual; Investment Policy (CORP10), Treasury Management Policy (CORP09); - Trust Strategic Objectives and setting of key focus areas for achieving objectives (New Strategy approved April 2021); - Maintenance of key Trust registers (e.g. declarations of interest, receipts of gifts); - Processes for capturing meeting minutes to log: consideration of discordant views, discussion of risks, and decisions; - Risk Management Strategy/Policy; - 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; - Speak up systems embedded – whistleblowing, F2SUG, Wellbeing Guardian	H&S, Infection Control, Safeguarding, Quality Accounts etc **Level 2: internal** - Annual Governance Statement reviewed by Audit Committee and Auditors;; - Strategic Objectives approved by Board, with progress against objectives reported to Board Committees and Board; - Quality Committee, Finance & Investment Committee, People, Leadership & Culture Committee and Audit Committee review management of significant risks and key governance issues; - Escalation reports from the Sub Committees to Board Committees and on to Board; - Annual Report and reports for Council of Governors to demonstrate engagement with FT members. **Level 3: independent** - Internal Audit review of governance arrangements;. Internal Audit reviews have included reviews of Quality Strategy & Governance, 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 inspection (CQC) March 2018; and - Well Led review focused on Quality Governance, conducted by the Good Governance Institute (reported in December 2022, presented to the Board in December 2022-January 2023)	new target of completion after March 2023. GAP (controls): systemic tendency towards short-termism and not looking 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 since 2021/22 – discussion 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. GAP: Control – Risk Appetite Statement agreed by Board to support sound decision making and avoid inopportune risk taking or overly cautious approaches stifling growth/development. COG working groups paused for COVID-19 pandemic	OWNERS: Director of Corporate Affairs & Co Sec, and Executive Director for Digital & Transformation Executive Director of Strategy & Partnerships in post from April 2022 and has refocused BAF risk 3.7 on ineffective business planning arrangements which may lead to the Trust failing to achieve its strategic ambition etc. Draft Trust Annual Plan 2023/24 provided to the Board in private in January 2023, bringing together draft Directorate service priorities and financial position. Once finalised by the end of March 2023, the Annual Plan will provide a single view of the Trust's key priorities for 2023/24 to inform internal decision-making and better influence the healthcare systems in which the Trust operates. The finalisation of the strategic planning work with the Board will drive reviews of the BAF and the IPR including the focus of the Board on variance/exception. OWNERS: Director of Corporate Affairs & Co Sec, and Executive Director of Strategy & Partnerships. TARGET DATE: APRIL 23 Operational Plans; JUNE 23 Strategic Plan; BAF review against agreed strategic plan JUNE/JULY 23 Risk Appetite considered with Board and Audit Committee (last in March 21) and to be revisited in Q1 22/23 beginning with AC in Feb23. OWNER: Director of Corporate Affairs & Co Sec/Board of Directors TARGET DATE: April 2023 COG working groups being reinstated during 2022 and being re-formulated for

(NED), PALS & Complaints, compliments, surveys, IWGC, governors.			2023. Invitations to Board Committees will continue with the potential to make old sub group structures redundant. OWNER: Director of Corporate Affairs & Co Sec. TARGET: March 2023

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

3.7: Ineffective business planning

Date added to BAF	Pre-Jan 2021 Risk description revised July and September 2022
Monitoring Committee	Finance and Investment Committee
Executive Lead	Executive Director of Strategy & Partnerships
Date of last review	30/09/2022
Risk movement	↔
Date of next review	January 2023

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

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

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

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

Controls	Assurance	Gaps	Actions
- Strategic Framework including 5-Year Strategy 2021-26 and Digital Health and Care Strategy 2021-26; - Business Services, Performance Team and Service Change (Programme & Project Management) functions. - Annual Planning process jointly led by Finance and Strategy started, as at end of September 2022, and	**Level 1: reassurance** Board Strategy Days – April, July, October/November 2022. Board Strategy days and half day workshops in February, April, June and October 2023. **Level 2: internal** Integrated Performance Report to the Board in public – on delivery against the strategic objectives, key focus areas and Objective Key Results.	Action plan to address challenges in the short, medium and long term.	Draft Trust Annual Plan 2023/24 provided to the Board in private in January 2023, bringing together draft Directorate service priorities and financial position. Once finalised by the end of March 2023, the Annual Plan will provide a single view of the Trust's key priorities for 2023/24 to inform internal decision-making and better influence the healthcare systems in which the Trust operates.

involving: Finance team, Strategy team, Workforce planning team, Performance team.	Integrated Annual Planning Process co-lead by Finance and Strategy and reporting to Executive Management Committee **Level 3: independent**	No clear business plans yet set for individual services for current FY. Trust could benefit from medium term (3 year) plan to tie together finance and service improvement/sustainability, workforce planning etc. (particularly in the context of operating within ICS) more clearly and create an implementation for the Trust strategy. 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 & System Partnerships Lead; and Director of Finance	The Draft Annual Plan follows planning developed over summer 2022, 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 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 Annual Plan process started, as at end of September 2022, to produce integrated plan between workforce, finance and activity for 2023/24. Draft Annual Plan provided to the Board in private in January 2023.

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

3.10: Information Governance & Cyber Security

Date added to BAF	12/01/21
Monitoring Committee	Finance & Investment Committee
Executive Lead	Chief Medical Officer & Chief Finance Officer (formerly Executive Director for Digital & Transformation)
Date of last review	01/02/2023
Risk movement	↔
Date of next review	January 2023

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

Risk Description:

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

Controls	Assurance	Gaps	Actions
- Information Governance Team; - GDPR Group workshops; - Mandatory IG training for all staff Trust wide, plus ad hoc training with clinical focus on sage info sharing; - Information assets and systems are risked assessed using standard Data Protection Impact Assessment (DPIA) tool; - Appointment of Cyber Security Consultant (2020); - Membership of Oxfordshire Cyber Security Working Group; - 'Third Party Cyber Security Assessment' (checklist & questionnaire) developed, to provide a systems requirement specification and to ensure any new Information Systems being	**Level 1: reassurance** - Information Management Group (IMG); - Monthly Cyber Security activities review via Oxford Health Cyber Security Working Group. **Level 2: internal** - Finance & Investment Committee receives reports from IMG (most recently July 2022); - Monitoring of IG training attendance; - Incident management and response process (enhanced to meet DSPT requirements) through which data and cyber security incidents are monitored and reviewed; - Programme of independent penetration testing of systems/services (annual from 2020);	In August 2022, IT failure with patient record systems provided and externally hosted by a third party supplier led to staff being unable to access patient record systems and clinical information, thereby leading to risks to staff and patient harm. Trust internal operational and cyber security not compromised. The clinical system outage, which resulted from the failure with third party supplier-hosted patient record systems, has prevented the Trust from submitting mandatory data-set information and contractual information to commissioners, which could lead to contractual and	Major incident response set up to manage contingency plans, resolve the technical issue and provide alternative access to clinical information. Patient safety risk and more detailed incident-related risks maintained at Trust Risk Register and Silver Command level. Cyber assessments for alternative solutions fast tracked so as to be implemented without delay.

procured adhere to DSPT Cyber Security standards; - AppLocker and restrictions to ensure desktop applications are controlled and centrally approved; - Systems access control and audit managed by way of: programme of penetration testing (annually from 2020); cyber security assessed and tested prior to implementation of new systems; USB device controls; use of external cyber security scoring and scanning tools and services (e.g. NHS Digital's BitSight, VMS Vulnerability Management Service, Nessus Vulnerability Scanning, Microsoft Defender Advanced Threat Protection); - GCHQ-certified Cyber Security Board Briefing delivered by NHS Digital and the IT team to the Board Seminar on 14 February 2019; - Mail filtering system to flag or block suspicious, malicious of unsafe communications, to limit the flow of phishing emails, malware and/or unsafe URLs; - Implementation of Multi-Factor Authentication (MFA) has significantly reduced Office 365 user compromises; - Cyber Security Awareness and Cyber Security SharePoint sites.	- NHS Digital Data Security and Protection Toolkit (DSPT) annual self-assessment. - Cyber Security updates to Audit Committee (most recent February 2022); - Data Quality Maturity Index **98.1%** (Dec 2020) (target 95%) **Level 3: independent** - Improved NHS Digital's BitSight cyber rating, which exceeds peers in benchmarking and is in top 30% of organisations globally; - VMS Vulnerability Scanning, and NSCN WebCheck Service, with identified vulnerabilities monitored and remediated or mitigated; -NHS Digital penetration test (July 2020) and Data Security Onsite Assessment Non 2020); -Microsoft Defender ATP Threat & Vulnerability Management (TVM) tools and process. The lower our TVM score, the more secure our estate; - Secure messaging accreditation achieved (NHS Digital DCB1596); - ICO investigation of referrals made by data subjects; - 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.	reputational consequences. R&D Trials will also face some delays due to gaps in data. Penetration testing undertaken in May 2020 (with OUH), July 2020 (NHS Digital), and NHSD Data Security Onsite Assessment (CE+ & DSPT) in Nov 2020 identified a few low to medium risk information system and user account weaknesses; Trust does not yet have National Cyber Security Centre Cyber Security Essentials Plus certification; MFA cannot be applied to all local systems and backup authentication. Desktop Third Party Software Patch Management is currently reactive only via ATP and internal resource fails to keep pace with the requirements. Training and awareness As Cyber Security hardening such as assessments, penetration testing and other enhancements are being developed, the Cyber	Log4Shell Cyber Security vulnerability update provided to Audit Committee on 23 February 2022; assurance provided on the Trust's response. 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. Though Server Team, IAOs and suppliers have addressed the most significant threats, some low vulnerability supplier remediation is still required and forms part of long term programme of work. OWNER: Executive Director for Digital & Transformation Focus remains on achieving Cyber Essentials Plus (CE+) certification. Work is ongoing ahead of the mandatory deadline of June 2021 to be CE+ certified. OWNER: Executive Director for Digital & Transformation and Cyber Security Consultant. Privileged Access Management (PAM) and conditional access are being developed by the Server Team. Software patch management solutions are being

		and Server management resource available to ensure the trust will meet the June 2021 DSPT/CE+ deadline and offer wider support such as awareness training is reduced. Additional Cyber Security and Server Management resource is required to address those needs and maintain and adequate pace.	investigated by the Desktop & Apps Team. Business justification for procurement of awareness training package for staff has been submitted; Consider re-delivering further GCHQ-certified Cyber Security Board Briefing during 2021. OWNER: Executive Director for Digital & Transformation and Cyber Security Consultant. Funding bid for cyber security apprentice has been submitted.

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

RISK APPROVED FOR CLOSURE BY FINANCE & INVESTMENT COMMITTEE IN FEBRUARY 2023, WILL BE REMOVED FOLLOWING PUBLICATION AT END OF MARCH 2023

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	25/01/23
Risk movement	↓
Date of next review	**Recommended to be closed as at January/February 2023**

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

RISK APPROVED FOR CLOSURE BY FINANCE & INVESTMENT COMMITTEE IN FEBRUARY 2023

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

Controls	Assurance	Gaps	Actions
- 'Cloud first' approach where key financial and clinical systems are hosted externally within supplier Public or Private Cloud infrastructures. These systems would not be affected directly by a data centre outage; - Trust hosts a data room within the Whiteleaf Centre where certain systems have resilient hardware; - Clinical business continuity processes in place in the event of a failure over the short term.	**Level 1: reassurance** **Level 2: internal** Reporting to the Audit Committee, the Finance & Investment Committee and the Board **Level 3: independent** Internal Audit review by PwC due from late February 2023.		Movement to new Data Centre (delayed from anticipated completion in December 2021) achieved by September 2022 with new Data Centre live and disaster recovery resilience in place. As at January 2023, the new Data Centre is fully operational with resilience via a separately located Disaster Recovery Data Centre. The Internal Audit review, being conducted by PwC on behalf of the Audit Committee, is due to report in late February 2023. There is no further Capital funding assigned to this project for FY23. It is recommended that objective be closed with assurance being managed by

			the Audit Committee's review of the Internal Audit review from PwC from February 2023.

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
Executive Lead	Director of Corporate Affairs & Co Sec
Date of last review	22/02/2023
Risk movement	↓
Date of next review	October 2023

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	5	3	15
Current risk rating	**3**	**3**	**9**
Target risk rating	3	3	9
Target to be achieved by			

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

Key Controls	Assurance	Gaps	Actions
- Accountable Emergency Officer (currently Director of Corporate Affairs & Co Sec), supported by nominated Non-Executive lead and a clinical director; - Designated Emergency Planning Lead, supporting the executive in the discharge of their duties; - Emergency Planning Group 3 x per year oversees emergency preparedness work programme with representation from directorates, HR, and estates & facilities.	**Level 1: reassurance** - Emergency Planning Resilience and Response (EPRR) Group 3 x per year; - Psychosocial response group (sub-group of Emergency Planning group); - Service Business Continuity Plans signed off by heads of service via relevant directorate/corporate committee. **Level 2: internal** - Annual Emergency Planning, Resilience and Response report (most recently to the Audit	On 2020 Self-assessment against NHSE/I EPRR Core Standards, Trust had been only partially compliant with 4 of 54 standards (fully compliant with other 50).	Further to improvement plan for actions against the 4 core standards against which the Trust had not been compliant (actioned over 2020-21), by October 2022 reporting, Trust had achieved full compliance with NHSE core standards for EPRR (as set out in annual report to the Audit Committee and the Board in November 2022). OWNER: Director of Corporate Affairs & Co Sec, and Emergency Planning Lead

- Psychosocial Response Group (subgroup reporting to Emergency Planning Group); - Trust wide Pandemic Plan first approved 2012, updated annually, and updated multiple times in 2020 to reflect Covid-19 workstreams, operational changes and learning from Covid-19 pandemic; - Response Manual incident response plan - emergency preparedness, resilience and response) (updated July 2021) provides emergency response framework; - On call system; - 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 & electricity); severe weather; flooding/water leak; water supply disruption; fuel shortage; lockdown; infection control; food supply; pharmacy supply; - Completion and updating of BCPs supported and monitored by Emergency Planning Lead, with register of BCPs held centrally; - BCPs are reviewed annually or following an incident; - Training for directors on call; - Undertaking of exercises (live exercise every three years, tabletop exercise every year and a test of communications cascades every six months (NHS England emergency preparedness framework, 2015)). Lessons incorporated into major incident plans, business continuity plans and shared with partner organisations;	Committee and the Board in Nov 2022); - EPRR Exercises, with learning incorporated into major incident plans, business continuity plans and shared with partners; - Self-assessment against NHSE/I EPRR Core Standards Based on the quality of response to the following, reputation and resilience have been safeguarded through 'no surprises' – No serious harms from Major Incident of IT clinical systems outage; from Strike Action; from COVID response, from OOH business continuity incident, from locality floods etc **Level 3: independent** - Self-assessment examined and accepted by CCG on behalf of NHSE/I; - Improvement plan for actions against the 4 core standards with which Trust was not compliant was presented to CCG (Oct 2020). By October 2022 reporting, Trust had achieved full compliance with NHSE core standards for EPRR (as set out in annual report to the Audit Committee and the Board in November 2022).		

- training scenarios on intranet for services to use to exercise business continuity plans; - Engagement with Thames Valley Local Health Resilience partnership, and Membership of Oxon & Bucks Resilience Groups; - Horizon scanning and review of National and Community Risk registers by Emergency Planning Group.			

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	Chief Finance Officer (formerly Executive Director for Digital & Transformation)
Date of last review	17/11/22
Risk movement	↔
Date of next review	March 2023

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

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

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

Key Controls	Assurance	Gaps	Actions
- Trust Green Plan/Strategy 2022-25; - Executive Lead for Sustainability (Director of Finance); - Commitment by Board to Zero Carbon Oxford Charter (Jan 2021);	**Level 1: reassurance** - 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. Action: to develop Sustainability Governance structure and sub groups. OWNER: Executive Lead for Sustainability and Sustainability Lead	Green Delivery Plan meetings scheduled in key focus areas: buildings; travel; procurement; medicines; sustainable health & green space / biodiversity. Green Task Force Group will meet Quarterly to deliver Green

- 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, - Developments to BREEAM (building sustainability assessments) and Part L (building regs).	**Level 2: internal** - Green Task Force Group to deliver Green Plan chaired by Chief Finance Officer; Green Task Force to meet Quarterly. - Sustainability Steering Group meets quarterly; - Annual Travel Survey monitoring against base-line; - Annual C02 emissions against previous year (to measure trend); - Building Energy Surveys to identify areas of improvement; - New ways of working questionnaires gathering information from services. - As at 31 March 2021, reduced carbon emissions by **38% (exceeding NHS target)** against baseline year of 2014-15; - FY 20/21 **reduced business mileage by 60%** when compared to 19/20; - Direct Carbon emissions for FY21 were **4,793 Co2e** (6,522 in FY19/20). **Level 3: external** - BOB ICS Net Zero Program Board - Total Carbon Footprint Plus now reported by NHS England (54,000Tco2)	TARGET: Sept 2022 (completed Sept/Nov 2022). Energy crisis 2022 has brought into sharp focus reducing the Estates energy demand. 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. Additional resources to be considered (Sustainable Travel Officer /Sustainability Coordinator) Lack of visibility/reporting to Board Committees and/or the Board re sustainability &	Plan, from November 2022 chaired by Chief Finance Officer. As at November 2022, 2-year Sustainable travel Trial (EV for Community Nursing Team) supported by National Greener NHS Team . As at November 2022, Energy Policy required to meet challenges of Energy crisis; draft complete and ready for Trust sign-off. During September 2022, proposals developed for the installation of energy efficient LED lighting, building insulation and Solar PV. The Trust is also part of ZCOP sprint group with Oxford University to review how to adapt our building estate to climate change risk e.g extreme heat, floods. New Trust Green Plan 2022-25 (roadmap to net zero carbon) been developed through Sustainable Development Management Group and recommended by the Executive. Trust Green Plan approved by the Board on 25 May 2022 and presented to the Council of Governors on 15 June 2022. Green Plan reviewed for financial impact with Chief Finance Officer in October 2022. Green Task Force Group will meet Quarterly to deliver Green Plan, from November 2022 chaired by Chief Finance Officer. Increased resource as at June/July 2022. 5 Sub groups (Workforce, Assets/Travel, Green Space, Supply Chain, Sustainable Models of Care) reporting into Sustainability Steering Group. Sub-groups to develop action plans and establish resource needs to deliver.

		environmental data. Data is captured by Sustainability Manager and Estates Team, but not currently escalated. Progress in last FY may be reversed if news ways of working are not extended/ maintained post- Covid-19. Approach to limit business miles and use of cars to get to work (Note C-19 pandemic has seen a dramatic reduction in business miles).	OWNER: Sustainability Manager & Director of Finance TARGET: Sept 2022 Securing grants and central funding for sustainability projects; OWNER: Director of Estates and Facilities/Sustainability Manager. New ways of working to be extended/maintained; OWNER: Head of Property Services/Service Director.

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

3.14 Major Capital Projects

Date added to BAF	20/09/22
Monitoring Committee	Finance and Investment Committee
Executive Lead	Chief Finance Officer (and formerly Executive Director for Digital & Transformation)
Date of last review	26/01/23
Risk movement	↔
Date of next review	January 2023

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

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

Key Controls	Assurance	Gaps	Actions
- Programme Boards for key capital projects e.g. PICU Programme Board and Warneford Park Programme Board - Standing Financial Instructions and Scheme of Delegation;	**Level 1: reassurance** - Strategic Delivery Group (designed to oversee the delivery of the Trust's programmes and projects); - Capital Programme sub-committee (to review project progress and capital spend,	GAP (assurances): Psychiatric Intensive Care Unit (**PICU**) project delayed and with budget overspend. PICU project paused in June 2021; subject to external review December 2021; actions subject to further follow-up	Finance & Investment Committee meeting on 20 September 2022 agreed that the Current Risk Rating should be 16 (extreme/red-rated) in light of further delays around the PICU. However, this extreme risk

- Estates Strategy; - Capital Programme Plan; - Estates & Facilities team; - Service Change & Delivery team (projects and programme support for transformational projects and service change internally and with external partners);	can escalate issues to the Finance & Investment Committee); and - Warneford Park Project Board **Level 2: internal** - Finance & Investment Committee (**FIC**) review of Capital Programme Plan and projects and approval of business cases; -FIC monitors work of the Capital Programme sub-committee; - FIC receives updates on/minutes of the Warneford Park Project Board for the Warneford redevelopment project **Level 3: independent** Internal Audit report on PICU project (December 2021) - highlighted actions to strengthen the PICU project	January-November 2022 (through Finance & Investment Committee (**FIC**), Audit Committee and Board); and missed original target of May 2022. Revised target of completion by 2023 unlikely to be met. New target of completion after March 2023. May remain a Gap pending evidence that lessons learned been embedded. GAP (assurances): Warneford redevelopment project still in negotiation and development phase.	rating may be a short-term position and if there is evidence of improvement then the Current Risk Rating may improve, although the strategic risk may still remain for monitoring. Internal Audit PICU project review report reviewed by Audit Committee, December 2021 and actions undertaken January-September 2022. Board reviewed PICU project at its meeting in private in May 2022 and received assurance that programme and project governance strengthened. Monthly Programme Board now in place. As at November 2022 and reporting into FIC, new target for PICU scheme to complete by June 2023. As at January 2023, all but one lessons learned action been completed; next reporting into FIC and Audit Committee in February 2023. OWNERS: Executive Director for Digital & Transformation Regular updates into the FIC and the Board meeting in private on the progress of the Warneford redevelopment. Board kept updated on negotiations, Memorandum of Understanding and legal agreements; at its meeting in private in June 2022, the Board confirmed creation of a Warneford Park Programme Board (chaired by a Non-Executive Director). Further updates to Board in private during 2022 and in January 2023; project on track and Strategic Outline Case due for review by Board in February 2023. Appropriate independent expert and/or legal advice to be obtained to support decisions relating to

			significant transactions (e.g. as part of significant capital projects such as PICU build and Warneford redevelopment projects), and decision makers to be fully sighted on such independent advice. OWNERS: Director of Corporate Affairs & Co Sec, Executive Director for Digital & Transformation, and Chief Finance Officer.

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

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

Date added to BAF	Pre-Jan 2021
Monitoring Committee	Quality Committee
Executive Lead	Chief Medical Officer
Date of last review	January 2023
Risk movement	↔
Date of next review	March 2023

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

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

Controls	Assurance	Gaps	Actions
- Director of R&D; - NIHR Infrastructure Managers Group (formerly the Research Management Group (RMG)) which provides an opportunity for managers of the NIHR awards and the R&D Director to meet regularly; - Clinical Research Facility (CRF) and Biomedical Research Centre (BRC) - BRC Steering Committee (BRC-SC); - Oxford Applied Research Collaboration Oxford and Thames Valley (OxTV) (ARC); - ARC Management Board; - The R&D Director sits on the OUH Joint R&D committee. In December 2021 the Oxford Joint Research Office (JRO) was expanded with the Trust and Oxford Brookes University formally joining with the University of Oxford and OUH;	**Level 1: reassurance** **Level 2: internal** - Research updates and R&D reporting into the Quality Committee; - R&D reports to Board (at least twice a year, most recently a Research and NIHR Infrastructure update in November 2022 and on the Oxford Health BRC in January 2023); - progress reporting on the Toronto – Oxford Psychiatry Collaboration also provided to the Board **Level 3: independent** - The BRC, CRF, ARC and MIC report annually to the National Institute for Health Research (NIHR); - R&D is audited by the Thames Valley & South Midlands Clinical Research Network (TV&SM- CRN) annually;	GAP: The clinical system outage from August 2022, which resulted from the failure with third party supplier-hosted patient record systems, has prevented the Trust from submitting data-set information and contractual information which could lead to contractual and reputational consequences. R&D Trials will also face some delays due to gaps in data. GAP (Controls): Clinical Research Facility (**CRF**) bid renewal in 2022. GAP (Controls): Biomedical Research Centre (**BRC**) bid renewal (otherwise the BRC award would have finished at the end of November 2022). BRC renewal key in developing and embedding a culture of research across the Trust. It will also be an	The loss of CareNotes and the move to RiO has the potential to impact all areas of research from set-up and participant recruitment through to study delivery. The Research Informatics Manager is part of the RiO programme board. The new CRF award (£4 million) started in September 2022 and will run until August 2027. BRC funding (£35.5 million, increased from £15.7 million previously) was renewed for five years from 1 December 2022 to November 2027 with the Oxford Health BRC now including 11 additional partner universities and NHS Trusts across England

- representation and collaboration via these groups help to ensure that OHFT maximises the opportunities to fully realise its academic and research potential; - 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		attractive feature in recruitment and may lead to the appointment of more clinical academics. GAP (Controls): Warneford redevelopment – to progress. Complicated capital project and is being carefully monitored by the Finance & Investment Committee and with regular updates to the Board in private session. GAP (Controls): R&D Strategy in development.	operating as a national network of centres of excellence focusing on brain health. BRC impact report provided to the Board in public in January 2023. Monitoring through reporting into the Finance & Investment Committee (FIC) and the Board. FIC also monitoring BAF risk 3.14 on delivery of Major Capital Projects, such as the Warneford. 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.

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%

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

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

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

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