# Board Assurance Framework Risk Mitigation Summary Sheet – AUGUST 2023

**NHS Bradford District Care NHS Foundation Trust**

## SO1: Engaging with our patients, service users and wider community to ensure they are equal partners in care delivery (QSC)

| Ambition / risk — Executive Lead: Medical Director | M-12 Apr 2023 | M-11 May 2023 | M-10 Jun 2023 | M-9 Jul 2023 | M-8 Aug 2023 | M-7 Sep 2023 | M-6 Oct 2023 | M-5 Nov 2023 | M-4 Dec 2023 | M-3 Jan 2024 | M-2 Feb 2024 | M-1 Mar 2024 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1.1: Valuing lived experience, supporting the voice of under-represented groups / Your Voice Matters does not respond | 3-4 (12) | 3-4 (12) | 3-4 (12) | 3-4 (12) | 3-4 (12) | | | | | | | | 3-1 (3) |
| 1.2: Roles for people with lived experience across all areas of Trust activity / unable to demonstrate achievement | 3-4 (12) | 3-4 (12) | 3-4 (12) | 3-4 (12) | 3-4 (12) | | | | | | | | 3-1 (3) |
| 1.3: Increase number and diversity of volunteers / lack of capacity to deliver volunteering strategy | 3-2 (6) | 3-2 (6) | 3-2 (6) | 3-2 (6) | 3-1 (3) | | | | | | | | 3-1 (3) |
| 1.4: Supporting patients to be partners in their own care / fail to maximise relationships between professionals & SU | 3-4 (12) | 3-4 (12) | 3-4 (12) | 3-4 (12) | 3-4 (12) | | | | | | | | 3-1 (3) |

## SO2: Prioritising our people, ensuring they have the tools, skills and right environment to be effective leaders within a culture that is open, compassionate, improvement-focused and inclusive culture (WEC)

| Ambition / risk — Executive Lead: Chief People Officer | M-12 Apr 2023 | M-11 May 2023 | M-10 Jun 2023 | M-9 Jul 2023 | M-8 Aug 2023 | M-7 Sep 2023 | M-6 Oct 2023 | M-5 Nov 2023 | M-4 Dec 2023 | M-3 Jan 2024 | M-2 Feb 2024 | M-1 Mar 2024 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.1: Embedding a compassionate and inclusive culture / lack may result in higher levels of staff disengagement and increased turnover | 3-3 (9) | 3-3 (9) | 3-3 (9) | 3-3 (9) | 3-3 (9) | | | | | | | | 2-2 (4) |
| 2.2: Recognising & rewarding staff, sharing learning / reduction in morale, negative impact on discretionary effort, increased turnover | 3-3 (9) | 3-3 (9) | 3-3 (9) | 3-3 (9) | 3-3 (9) | | | | | | | | 2-2 (4) |
| 2.3: Ensuring staff have a voice that counts / lack of thriving networks, inability to demonstrate compliance with WRES and WDES standards | 3-3 (9) | 3-3 (9) | 3-3 (9) | 3-3 (9) | 3-3 (9) | | | | | | | | 2-2 (4) |
| 2.4: Staff are safe and healthy / increased staff absence and negative consequences for patient care | 3-3 (9) | 3-3 (9) | 3-3 (9) | 3-3 (9) | 3-3 (9) | | | | | | | | 2-2 (4) |

## SO3: Maximising the potential of services to deliver outstanding care to our communities (QSC)

| Ambition / risk — Executive Lead: Director of Nursing, Professions and Care Standards | M-12 Apr 2023 | M-11 May 2023 | M-10 Jun 2023 | M-9 Jul 2023 | M-8 Aug 2023 | M-7 Sep 2023 | M-6 Oct 2023 | M-5 Nov 2023 | M-4 Dec 2023 | M-3 Jan 2024 | M-2 Feb 2024 | M-1 Mar 2024 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3.1: Enabling every service to move towards its own excellence / targets are not sufficiently sensitive to recognise progress | 3-3 (9) | 3-3 (9) | 3-3 (9) | 3-3 (9) | 3-3 (9) | | | | | | | | 3-2 (6) |
| 3.2: Enhancing our approach to organisational learning / data quality and maturity is insufficient to support learning | 4-3 (12) | 3-3 (9) | 3-3 (9) | 3-3 (9) | 3-2 (6) | | | | | | | | 3-2 (6) |
| 3.3: Maximise opportunities to learn from best practice & research / lack of capacity due to operational pressures | 4-3 (12) | 4-3 (12) | 4-3 (12) | 4-3 (12) | 4-3 (12) | | | | | | | | 3-2 (6) |
| 3.4: Understand support needed for people to prevent harm whilst waiting for services / insufficient place-based offer | 4-4(16) | 4-4(16) | 4-4(16) | 4-4(16) | 4-4(16) | | | | | | | | 3-4 (12) |

## SO4: Collaborating to drive innovation and transformation, enabling us to deliver against local and national ambitions (Board)

| Ambition / risk — Executive Lead: Director of Integration & Transformation | M-12 Apr 2023 | M-11 May 2023 | M-10 Jun 2023 | M-9 Jul 2023 | M-8 Aug 2023 | M-7 Sep 2023 | M-6 Oct 2023 | M-5 Nov 2023 | M-4 Dec 2023 | M-3 Jan 2024 | M-2 Feb 2024 | M-1 Mar 2024 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4.1, 4.2, 4.3, 4.4: Working across place / ICS to develop a sustainable workforce; embed a culture of continuous improvement; transform services to reduce health inequalities and build community resilience; embed system leadership behaviours / insufficient capacity to develop strong relationships leading to lack of shared purpose, clarity, and misalignment of priorities | 3-3 (9) | 3-3 (9) | 3-3 (9) | 3-3 (9) | 3-3 (9) | | | | | | | | 3-2 (6) |

## SO5: To make effective use of our resources to ensure services are environmentally and financially sustainable and resilient (FBIC)

| Ambition / risk — Executive Lead: Director of Finance, Estates and Contracting | M-12 Apr 2023 | M-11 May 2023 | M-10 Jun 2023 | M-9 Jul 2023 | M-8 Aug 2023 | M-7 Sep 2023 | M-6 Oct 2023 | M-5 Nov 2023 | M-4 Dec 2023 | M-3 Jan 2024 | M-2 Feb 2024 | M-1 Mar 2024 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 5.1: Maximising internal/external opportunities to enable delivery of in-year & longer-term financial plans; best use of ICS £ / inability to maximise opportunities may result in regulatory interventions, reputational damage, and reduced quality of services | 4-5 (20) | 4-5 (20) | 4-5 (20) | 4-5 (20) | 4-5 (20) | | | | | | | | 4-3 (12) |
| 5.2: Embedding environmental sustainability to support ultimate ambition to be a carbon net zero organisation / inability to meet targets impact negatively on finances, quality of estates, wellbeing of our population and workforce and reputation | 4-5 (20) | 4-5 (20) | 4-5 (20) | 4-5 (20) | 4-5 (20) | | | | | | | | 2-2 (4) |

## SO6: To make progress in implementing our digital strategy to support our ambition to become a digital leader in the NHS (FBIC)

| Ambition / risk — Executive Lead: Chief Information Officer | M-12 Apr 2023 | M-11 May 2023 | M-10 Jun 2023 | M-9 Jul 2023 | M-8 Aug 2023 | M-7 Sep 2023 | M-6 Oct 2023 | M-5 Nov 2023 | M-4 Dec 2023 | M-3 Jan 2024 | M-2 Feb 2024 | M-1 Mar 2024 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 6.1: Strengthen our insights by improving data quality and understanding needs / do not fully understand data needs | 4-3 (12) | 4-3 (12) | 4-3 (12) | 4-3 (12) | 4-3 (12) | | | | | | | | 4-2 (8) |
| 6.2 Clinical Systems Transformation / lack of organisational readiness | 4-3 (12) | 4-3 (12) | 4-3 (12) | 4-3 (12) | 4-3 (12) | | | | | | | | 4-2 (8) |
| 6.3: Patient Engagement / Digitally enabled care / increased health inequalities caused by inequity of access | 4-3 (12) | 4-3 (12) | 4-3 (12) | 4-3 (12) | 4-3 (12) | | | | | | | | 4-2 (8) |
| 6.4: Digitally enabled workforce / training and education needs or workforce not being understood, barriers to capability | 4-3 (12) | 4-3 (12) | 4-3 (12) | 4-3 (12) | 4-3 (12) | | | | | | | | 4-2 (8) |
| 6.5: Strengthen our digital foundation / will not have the tools / confidence of stakeholders to deliver our ambitions | 4-3 (12) | 4-3 (12) | 4-3 (12) | 4-3 (12) | 4-3 (12) | | | | | | | | 4-2 (8) |

| Strategic Objective 1: Engaging with our patients, service users and wider community to ensure they are equal partners in care delivery | | | | | | | Lead Committee: Quality and Safety Committee<br>Executive Lead : Medical Director | | | | |

| In year ambition | | | | Key risk to achieving the ambition | | better lives, together | | Links to other objectives | | Linked operational risks (ref and brief descriptor) | | Lead Executive |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1.1 We will have an increased focus on embedding a curious practice in relation to lived experience and proactively seek out opportunities to make it easier for under-represented groups to influence decisions across our organisation, aligned to place and ICS involvement objectives | | | | There is a risk that Your Voice Matters does not adequately respond to our post-COVID learning and digital ambitions, and is not enacted in a timely manner | | Best Quality Care | | SO6:6.2 | | | | Director of Nursing, Professions & Care Standards |

| M-12<br>Apr 2023 | M-11<br>May 2023 | M-10<br>Jun 2023 | M-9<br>Jul 2023 | M-8<br>Aug 2023 | M-7<br>Sep 2023 | M-6<br>Oct 2023 | M-5<br>Nov 2023 | M-4<br>Dec 2023 | M-3<br>Jan 2024 | M-2<br>Feb 2024 | M-1<br>Mar 2024 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3-4 (12) | 3-4 (12) | 3-4 (12) | 3-4 (12) | 3-4 (12) | | | | | | | | 3-1 (3) |

| Management of Risk | Cause of Risk | Impact / consequence of risk |
|---|---|---|
| | Culture of involvement not 'mainstreamed' across services, including a lack of a common understanding of what involvement means.<br>Lack of relationships across the Trust with under-represented groups mean their voices are seldom heard<br>We do not currently maximise our relationships with the voluntary sector and organisations such as Health-Watch to understand how best to hear the voices of seldom heard groups | Lack of involvement may lead to limited insight and feedback on quality of services, worsening health inequalities and inadvertent exclusion of high need groups from services. |
| | **What controls are in place to manage the risk?** | **What gaps in controls are there?** |
| | Your Voice Matters involvement strategy and action plan<br>Procurement of new FFT provider (Captive Health) and introduction of wider range of feedback mechanisms with the new system<br>Involvement governance structures (P&IRG, TWIG, Carers Group etc.)<br>Introduction of online involvement mechanisms<br>Introduction of service user (expert by experience) and Co-Chair of TWIG<br>Young Dynamo's Young People's research group | Your Voice Matters Strategy requires review to reflect covid limitations and reset objectives<br>Review required on how FFT data collection is perceived by staff and aligned to other available data sources<br>Lack of strategic direction in developing relationships with Health Watch and the VCS in order to engage with seldom heard communities<br>Lack of engagement with involvement services across Bradford District & Craven<br>Lack of comprehensive structures to support involvement – (see progress for mitigating actions)<br>Leadership of the team is challenged due to unresolved processes within the Directorate restructure – this may affect the team until September / October. |

| Assurance of effectiveness of controls | | Sources of Assurance | Gaps in Assurance |
|---|---|---|---|
| | Level 1:<br>Operational oversight | FFT data recorded; local service involvement groups; DLM<br>Participation and Involvement Strategic Group reports (meets 6 times a year) including P&ISG dashboard<br>AAA Report to SLT (every 2 months)<br>Triangle of Care Accreditation Phase 2<br>Your Voice Matters and carer Development Groups<br>Involvement and Participation Strategy Group | Level 1:<br>Some potential gaps in FFT data presentation – undergoing review<br>Your Voice Matters delivery group has not met and ToR requires refresh |
| | Level 2:<br>Reports / metrics overseen by Board / Committee | FFT data in IPR and Quality Dashboard<br>Quality & Safety Committee reports (every 6 months)<br>Your Voice Matters strategy<br>Digital Strategy approved 9 December 2021 supporting plan to reduce digital exclusion | Level 2:<br>Some gaps in Reports / metrics overseen by Board / Committee and Routine audits to be reviewed by Clinical Board associated with the above gap. This is in part related to the impact of reduced face to face opportunities and capacity to promote FFT<br>No formal oversight metrics in place for Involvement (not FFT) |
| | Level 3:<br>Sources of external oversight / scrutiny | FFT data presented to NHSE<br>Narrative within Annual Report and Quality Report | Level 3:<br>Triangle of Care Phase 3 – future assessment due 2023<br>Potential gap in embeddedness of involvement & participation in transformation programmes – undergoing review |

| Mitigating Actions to address gaps in control and assurance | Nº | Actions | TARGET | Progress | COMPLETION |
|---|---|---|---|---|---|
| | 1 | Work to transfer PEIT team to the Nursing directorate to allow better alignment with the Patient Advice and Complaints Team | 31 Aug 2023 | June 2022 – underway. Transferred from Director of Corporate Affairs. Feb 2023 – formal consultation re restructure of DoN completed 24.02.23. One outcome will be to bring the PCEIT and PACs teams under one line management structure. Process unlikely to be complete until August 23.<br>Update June 2023 – SPEM role currently being advertised internally (closing date 05/06/23)<br>Update July 2023 – SPEM role recruited to, start date to be agreed<br>Update August 2023 – SPEM role to start on 25/09/23 and this action will then be complete | |
| | 2 | Establish objectives for PEIT and PACS team | 30 Jun 2023 | Update Feb 23 – objectives for PCEIT team currently being worked through in line with revised involvement framework and aligned to strategic priorities. Significant focus on hearing | 30 Jun 2023 |

| | | | | | |
|---|---|---|---|---|---|
| | | | | the voice of experience (assurance of quality / experience) and service user leadership – especially in the transformation space.<br>Draft objectives being codeveloped with team during June 2023<br>Update 30.06.23 Objectives agreed for team | |
| | 3 | Strengthen links with place based structured for engagement and gathering intelligence from service users and communities | 30 Sep 2023 | Deputy Director of PS, C&R member of place involvement steering group. Individual PEIT team members aligned to different place workstreams<br><br>This will need re-evaluating once the leadership of the team has been confirmed under the new structure<br>Workshop on 31/05/23 to look at relaunching place-based join understanding of patient experience. Discussions ongoing with place-based lead for involvement about working more closely together<br>Update July 2023 – workshop to be held during July to explore how best to engage with the emerging Citizen's Panel<br>Update August 23 – no further action on this, awaiting feedback from place – meeting to review in August was stood down due to lack of attendance. To be rescheduled in September | |
| | 4 | Review the focus of the Involvement and Participation Strategy Group to ensure alignment with recently updated strategic priorities | Feb 2023 | Refocus of IPSG completed. | February 2023 |
| | 5 | Systematic review required of patient involvement functions | ~~30 Jun 2023~~<br>December 2023 | Model of involvement developed. Buddying support for IPs developed and individuals who are interested in this have been identified. Best Fit Conversations underway.<br><br>Work still to do to embed new structures. This is ongoing<br>Update July 2023 – this is delayed due to impact of changes in leadership./ Work continues but at a slower pace than had originally been planned<br>Update August 23 – awaiting SPEM to come into place to deliver relaunch of refocussed involvement framework | |
| | 6 | Re-establish the Involvement Delivery Group | 30 Sep 2023 | Agreed that Carer Development Group can continue without revision as is fit for purpose. Separate delivery oversight group for YVM to be developed by end of March – current oversight is through tight daily grip and control of transformation work and resetting of priorities for delivery. Delay in re-establishing YVM delivery group, mitigating grip and control remains in place whilst this is reviewed.<br><br>Ongoing commitment from senior leadership to supporting the team, structures in place to enhance this. Commitment to resolve outstanding processes as quickly as possible.<br><br>This will need re-evaluating once the leadership of the team has been confirmed under the new structure<br>Update August 23 – Carer Development group stood down and replaced with new arrangements, with more focus on collaboration between carers and care champions and outward facing support from the carer's team.<br><br>Agreed involvement delivery group not to be reinstated. Instead, workstream meetings and robust oversight via team meetings in place to ensure workplan delivered. This action can now be closed | 31/07/23 |
| | 7 | Undertake initial review of 'spread' of involvement activity across the trust | 31 May 2023 | Involvement survey issued April 2023 – will close on 01/05/23. Initial analysis will be reported into IPSG on 17/05/23 with subsequent reporting into SLT and QSC during June. | 31 May 2023 |

| Risk appetite (key areas of risk to be considered when assessing management of risk from Financial risk; Regulatory risk; Quality risks; Reputational risks and People risks) | | | | | | |
|---|---|---|---|---|---|---|
| | 0 - None | 1 - Minimal | 2 - Cautious | 3 - Open | 4 - Seek | 5 - Significant |
| Quality | We have no appetite for decisions that may have an uncertain impact on quality outcomes. | We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings. | We prefer risk avoidance. But, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. | We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation. | We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains. | We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement. |
| Reputation | We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation. | Our appetite for risk taking is limited to those events where there is no chance of significant repercussions. | We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout. | We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders. | We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks. | We are comfortable taking decisions that may expose us to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes |

| Strategic Objective 1: Engaging with our patients, service users and wider community to ensure they are equal partners in care delivery | | Lead Committee: Quality and Safety Committee<br>Executive Lead : Medical Director | | | | |

| In year ambition | | Key risk to achieving the ambition | | better lives, together | Links to other objectives | Linked operational risks (ref and brief descriptor) | Lead Executive |
|---|---|---|---|---|---|---|---|
| 1.2 We will create a variety of roles for people with lived experience (including young people) at all levels within the trust ensuring this important voice is considered in areas such as recruitment, transformation, service redesign and delivery, and quality improvement. We will play an active role in wider service user and Carer involvement plans across place/ICS. | | There is a risk that we can only demonstrate a limited impact in achieving our ambitions. | | Best Quality Care | SO6:6.2 | | Medical Director |

| M-12<br>Apr 2023 | M-11<br>May 2023 | M-10<br>Jun 2023 | M-9<br>Jul 2023 | M-8<br>Aug 2023 | M-7<br>Sep 2023 | M-6<br>Oct 2023 | M-5<br>Nov 2023 | M-4<br>Dec 2023 | M-3<br>Jan 2024 | M-2<br>Feb 2024 | M-1<br>Mar 2024 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3-4 (12) | 3-4 (12) | 3-4 (12) | 3-4 (12) | 3-4 (12) | | | | | | | | 3-1 (3) |

| | Cause of Risk | Impact / consequence of risk |
|---|---|---|
| | This is an area of significant complexity with many influencing programmes of working both internal and external to the trust. | Lack of demonstrable progress may lead to disengagement from stakeholders, with an attendant reputational risk |

| | What controls are in place to manage the risk? | What gaps in controls are there? |
|---|---|---|
| Management of Risk | Introduction to Involvement (i2i) training<br>Involvement governance structures (P&IRG, TWIG, Carers Group etc.)<br>Involvement Partner involvement in strategic programmes<br>Introduction of online involvement mechanisms<br>Introduction of service user (expert by experience) and Co-Chair of TWIG<br>Young Dynamo's Young People's research group | Oversight of work progressing at place, and how we are engaging with this<br>Utilisation of Council of Governors to support different ways of involving and engaging people with lived experience at all levels within the Trust<br>Oversight of work with KPO team and transformation team to ensure people with lived experience are at the centre of change |

| | | Sources of Assurance | | Gaps in Assurance |
|---|---|---|---|---|
| Assurance of effectiveness of controls | Level 1: Operational oversight | Participation and Involvement Strategic Group reports (meets 6 times a year) including P&ISG dashboard<br>AAA Report to SLT (every 2 months)<br>Triangle of Care Accreditation Phase 2 | | Level 1: No specific metrics looking at the role and number of involvement opportunities<br>Your Voice Matters Delivery Group has not met therefore no oversight of operational delivery of involvement |
| | Level 2: Reports / metrics overseen by Board / Committee | Quality & Safety Committee reports (every 6 months)<br>Your Voice Matters strategy<br>Digital Strategy approved 9 December 2021 supporting plan to reduce digital exclusion | | Level 2:<br>No formal mechanism for understanding the satisfaction of involvement partners combined with relevant questions on FFT.<br>Currently no strategy to review the possibility of creating a Patient Director role on BDCFT Board |
| | Level 3: Sources of external oversight / scrutiny | FFT data presented to NHSE<br>Narrative within Annual Report and Quality Report | | Level 3:<br>Triangle of Care Phase 3 – future assessment due 2023<br>External progress reports on place based engagement strategies |

| | Nº | Actions | TARGET | Progress | COMPLETION |
|---|---|---|---|---|---|
| Mitigating Actions to address gaps in control and assurance | 1 | Strengthen links with place based oversight of service user and community involvement | 30 Sep 2023 | Nov 22: Deputy Director of PS, C&R member of place involvement steering group. Individual PEIT team members aligned to different place workstreams<br><br>This will need re-evaluating once the leadership of the team has been confirmed under the new structure<br><br>Discussions ongoing with place-based lead for involvement about working more closely together<br>Update July 2023 – workshop to be held during July to explore how best to engage with the emerging Citizen's Panel<br>Update August 23 – no further action on this, awaiting feedback from place – meeting to review in August was stood down due to lack of attendance. To be rescheduled in September | |
| | 2 | Review if we need more involvement partners within core services or we need to be better at supporting how we hear the voice of people who use our services | 30 Jun 2023<br>30 Dec 2023 | New model of involvement has been developed, with brief guides being developed to support staff, alongside clear accountability structures. Case for investment in apprentice Involvement Enabler roles to be considered as part of wider operational planning discussions. Plans in place to audit involvement activity across the trust during April – on an annual or 6 month basis following this. | |

| | | | | |
|---|---|---|---|---|
| | | | Involvement survey issued April 2023 – will close on 01/05/23. Initial analysis will be reported into IPSG on 17/05/23 with subsequent reporting into SLT and QSC during June.<br><br>Update July 2023 – still awaiting confirmation of funding for the Involvement Enabler pilot<br>Update August 23 – no movement on this | |
| 3 | Consideration of implementation of Patient Director Role by April 2024 | On-hold | Agreed not in position to progress this as yet. However paid roles currently in development (Involvement enablers) to be aligned to the sub care groups and discussions with corporate governance about potential alternatives eg NED roles? | |
| 4 | Review opportunities for the creation of a Youth Board (or similar) at Place to support a joined up approach to youth involvement | 30 Sep 2023 | Discussions being held at place and within the trust to inform potential models of youth involvement – commenced Oct 22– consideration of alignment with apprenticeship work ongoing at place<br>This will need re-evaluating once the leadership of the team has been confirmed under the new structure<br>Initial discussions held to map scope of ambition. Workshop to be held in July 2023 as part of Youth Involvement event to start to co-create what this might look like<br>Update august 23 – celebration event held 22/08/23 – also collated ideas on how to develop youth involvement. This work to be taken forward by EH within the PCEI team. | |
| 5 | Strengthen links between PEIT and KPO teams | | Joint role developed and in place to work between PEIT and KPO teams. Purpose of this to be reviewed and consideration of whether this is a priority in light of developments to do with new roles and funding constraints. This role is in place until July 2023. KPO training changed to include involvement as part of the training. First training sessions on CTW delivered to IPs during March 23. | 31 Mar 2023 |
| 6 | Development of paid Involvement enabler roles | ~~30 September 2023~~<br>31 December 2023 | Draft role descriptions produced, ready for testing. Conversation with COO / DDops during May to agree funding streams for 18 month pilot, currently planned to begin in September 2023<br>Further exploration being undertaken of similar roles being created across place to support Healthy Communities work<br><br>Update July 2023 – still awaiting confirmation of funding for the Involvement Enabler pilot<br>Update August 23 – no movement on this | |

| Risk appetite (key areas of risk to be considered when assessing management of risk from Financial risk; Regulatory risk; Quality risks; Reputational risks and People risks) | | | | | | |
|---|---|---|---|---|---|---|
| | 0 - None | 1 - Minimal | 2 - Cautious | 3 - Open | 4 - Seek | 5 - Significant |
| Quality | We have no appetite for decisions that may have an uncertain impact on quality outcomes. | We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings. | We prefer risk avoidance. But, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. | We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation. | We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains. | We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement. |
| Reputation | We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation. | Our appetite for risk taking is limited to those events where there is no chance of significant repercussions. | We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout. | We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders. | We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks. | We are comfortable taking decisions that may expose us to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes |

| Strategic Objective 1: Engaging with our patients, service users and wider community to ensure they are equal partners in care delivery | Lead Committee: Quality and Safety Committee<br>Executive Lead : Medical Director |
|---|---|

| In year ambition | Key risk to achieving the ambition | better lives, together | Links to other objectives | Linked operational risks (ref and brief descriptor) | Lead Executive |
|---|---|---|---|---|---|
| 1.3 We will increase the number of volunteers and the diversity of their roles across the organisation. We will do this by making volunteering opportunities more accessible and attractive, including by developing pathways leading from volunteering and peer support roles to paid employment and opportunities to engage in professional career pathways. | There is a risk that we will not have the capacity to deliver the key objectives of the volunteering strategy. | Best Place to Work | SO2:2.1 | 2652 – Conflict and Breakaway training for volunteers insufficient Conflict and breakaway training available to volunteers resulting in significant delays in volunteers starting in role | Director of Nursing, Professions & Care Standards |

| M-12<br>Apr 2023 | M-11<br>May 2023 | M-10<br>Jun 2023 | M-9<br>Jul 2023 | M-8<br>Aug 2023 | M-7<br>Sep 2023 | M-6<br>Oct 2023 | M-5<br>Nov 2023 | M-4<br>Dec 2023 | M-3<br>Jan 2024 | M-2<br>Feb 2024 | M-1<br>Mar 2024 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3-2 (6) | 3-2 (6) | 3-2 (6) | 3-2 (6) | 3-1 (3) | | | | | | | | 3-1 (3) |

| | Cause of Risk | Impact / consequence of risk |
|---|---|---|
| Management of Risk | Due to operational capacity and demand and the ongoing impact of COVID pressures, capacity is constrained in both the volunteering team and in the clinical teams to design and support delivery of volunteering opportunities.<br>Impact of COVID reducing and more volunteer opportunities being developed.<br>Volunteer To Career – current funding ends in March 23, currently looking to secure funding for the clinical lead beyond April.<br>NHS Cadets – current programme ends in March – national sustainability and local capacity for future delivery an issue | Little or no progress is made in broadening the role and impact of volunteers across the trust, leading to lack of engagement with stakeholders, potential reputational consequences and loss of opportunities relating to the positive impacts of volunteers. |

| | What controls are in place to manage the risk? | What gaps in controls are there? |
|---|---|---|
| | Volunteering strategy – approved by Trust Board September 2021<br>Strategy supports embedding volunteering as part of recovery, both through the provision of meaningful activity to support recovery and enabling individuals to volunteer as part of their recovery journey. | Linked oversight with the activities of the HR recruitment team, the apprenticeship team and LEND team to ensure a coordinated approach to pathways for volunteers<br>Linked oversight with clinical recovery and discharge pathways to ensure a coordinated approach to enabling patients and service users to volunteer to support recovery. |

| | | Sources of Assurance | Gaps in Assurance |
|---|---|---|---|
| Assurance of effectiveness of controls | Level 1:<br>Operational oversight | Volunteer Governance Group (meets 6 times a year)<br>Participation and Involvement Strategic Group reports (meets 4 times a year) including P&ISG dashboard<br>AAA Report to SLT (every 2 months)<br>Growth within staff team over 18months means capacity to deliver strategy now established<br>Recruitment of volunteers into post no longer impacted by COVID and returned to business as usual<br>Volunteer to Career post secured for a further 12 months to ensure embedding across HR, LEND, Apprenticeships team.<br>Children's Service Coordinator post made substantive.<br>Funding identified for Volunteer Coordinator for Community Mental Health to ensure volunteering continues to support recovery across community and inpatients.<br>NHS Cadets programme continuing led by ST John Ambulance<br>All groups – network meeting, Vol SG and I&PSG established with Assemble enabling real time data and oversight | Metrics to be developed associated with new roles and development pathways |
| | Level 2:<br>Reports / metrics overseen by Board / Committee | Quality & Safety Committee reports (every 6 months)<br>Volunteering Strategy | |
| | Level 3:<br>Sources of external oversight / scrutiny | Narrative within Annual Report and Quality Report<br>System Quality Committee Reports<br>The rapid growth/model of the Volunteer Service has gained national recognition through an NHSEI event and Helpforce article. | |

| Mitigating Actions to address gaps in control and assurance | Nº | Actions | TARGET | Progress | COMPLETION |
|---|---|---|---|---|---|
| | 1 | To develop a strategy and programme to support volunteer to career | | Volunteer to Career programme supporting the ongoing development of career pathways. | Completed 27.4.23 |
| | 2 | To develop as part of the strategy a therapeutic programme for volunteers | May 2023 | Therapeutic Volunteering programme developing recovery focused volunteer opportunities | 27.4.23 |
| | 3 | To develop a volunteer co-ordinator who will work across children's services and support services to develop roles | May 2023<br>31 Jul 2023 | Children's Services Volunteer Coordinator in post to grow and embed volunteering across children's services. | 29.8.23 |

| | | | | | |
|---|---|---|---|---|---|
| | | | | Discussed within children's services – role to be progressed
Children's Services Volunteer Coordinator Role now substantive | |
| | 4 | To develop Volunteer Coordinator role for smaller Trust services including corporate based volunteer roles | | new Volunteer Coordinator post to support Volunteering across smaller trust services including corporate based volunteer roles. Post recruited to in December 2022.
Update August 23: additional Community MH volunteer role in post from July 23 | 30.07.23 |
| | 5 | To encourage/improve recruitment strategies for entering into the volunteer to career pathways as part of the strategic plan | | 65 active vols and 80 in recruitment process across Trust Services, 124 active volunteers with Well Together. The Volunteer to Career pathway has attracted national attention and positive recognition through Helpforce article. The Trust has worked alongside services and successfully achieved 5 volunteers who have achieved a care certificate and been recruited into permanent positions across the health economy. The service continues to grow and is part of the strategic plan to develop the workforce | 27.4.23 |
| | 6 | To integrate the volunteer co-ordinator and service manager into the nursing and quality directorate, which will include all professionals within the directorate | | Clinical Leads within the Nursing and Quality Directorate have worked alongside the nursing, Social Work and AHP teams to develop career pathways from entry level Band 2 to apprenticeships in Occupational Therapy, Social Work and  in discussions to support a Peer Support Apprenticeship programme | 27.4.23 |
| | 7 | Recruit second VtC Clinical Lead to work on the Best 1001 Days VtC project | | VtC Clinical Lead in post June 2023 | 29.8.23 |
| | 8 | Recruit a Healthy Minds Volunteer Coordinator to support CMHT transformation | | New Healthy Minds Volunteer Coordinator in post July 23 | 29.8.23 |

| Risk appetite (key areas of risk to be considered when assessing management of risk from Financial risk; Regulatory risk; Quality risks; Reputational risks and People risks) | | | | | | |
|---|---|---|---|---|---|---|
| | 0 - None | 1 - Minimal | 2 - Cautious | 3 - Open | 4 - Seek | 5 - Significant |
| Quality | We have no appetite for decisions that may have an uncertain impact on quality outcomes. | We will avoid anything that may impact on quality outcomes unless absolutely  essential. We will avoid innovation unless established and proven to be effective in a variety of settings. | We prefer risk avoidance. But, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. | We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation. | We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains. | We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement. |
| People | We have no appetite for decisions that could have a negative impact on our workforce development, recruitment / retention. Sustainability is our primary interest. | We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere. | We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision. | We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff. | We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve their skills /capabilities. We recognize innovation is likely to cause short term disruption with the possibility of long-term gains | We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change. |

| Strategic Objective 1: Engaging with our patients, service users and wider community to ensure they are equal partners in care delivery | | | | Lead Committee: Quality and Safety Committee<br>Executive Lead : Medical Director | | |

| In year ambition | | Key risk to achieving the ambition | better lives, together | Links to other objectives | Linked operational risks (ref and brief descriptor) | Lead Executive |
|---|---|---|---|---|---|---|
| 1.4 We will continue to focus on supporting patients and carers to be equal partners in their own care, focusing on areas such as patient-led care planning and shared decision making. We will ensure all parties to decisions have the right information on which to base those decisions and that our clinical systems and processes support our staff to embed this approach. | | There is a risk that we fail to maximise the relationship between professionals and people we are working with resulting in patients and carers not being involved in their own care. | Best Quality Care | SO6:6.2 | | Medical Director |

| | M-12<br>Apr 2023 | M-11<br>May 2023 | M-10<br>Jun 2023 | M-9<br>Jul 2023 | M-8<br>Aug 2023 | M-7<br>Sep 2023 | M-6<br>Oct 2023 | M-5<br>Nov 2023 | M-4<br>Dec 2023 | M-3<br>Jan 2024 | M-2<br>Feb 2024 | M-1<br>Mar 2024 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 3-4 (12) | 3-4 (12) | 3-4 (12) | 3-4 (12) | 3-4 (12) | | | | | | | | 3-1 (3) |

| | Cause of Risk | Impact / consequence of risk |
|---|---|---|
| **Management of Risk** | Inconsistent understanding of the meaning of equal partnership with service users ad constraints on professionals ability/capacity to drive meaningful conversations about the holistic needs and wants of service users when cooperatively agreeing and reviewing treatment and support packages<br><br>The move from CPA approach to new model of collaborative care planning | Patients become dissatisfied with the treatment they receive and/or the treatment fails to meet the entirety of need for the patient, resulting in increased non-compliance and/or missed opportunities for meaningful support and associated clinical risk.<br><br>There is an increase in incidents and complaints and outcomes for patients are not as good as they should be.<br><br>There is an increased risk of regulatory scrutiny due to failings in care.<br><br>Potential for workforce to be not fully trained in new model of collaborative care planning |

| | What controls are in place to manage the risk? | What gaps in controls are there? |
|---|---|---|
| | Routine audit of care plans/risk plans to demonstrate engagement of service users, patient's and cares in their own care<br>Oversight at relevant Professional Councils, including maximising the leadership of the Clinical Director for Patient Safety and the Clinical Director for Quality | Engagement with education providers about ongoing professional development in this area<br><br>No definitive agreement on new model of care planning and subsequent training requirements |

| | | Sources of Assurance | Gaps in Assurance |
|---|---|---|---|
| **Assurance of effectiveness of controls** | Level 1:<br>Operational oversight | Audit reports to Clinical Board<br>CTW report outs to SLT meetings<br>Outcome of FFT<br>Triangle of Care reports | Oversight of professional education relevant to this specific area<br>Your Voice Matters Delivery Group has not met therefore no oversight of operational delivery of involvement |
| | Level 2:<br>Reports / metrics overseen by Board / Committee | Audit outcomes to quality & Safety Committee and Board as part of the IPR<br>Outcome of FFT reported to Board and Committee | |
| | Level 3:<br>Sources of external oversight / scrutiny | Outcomes of MHA visits by CQC | |

| **Mitigating Actions to address gaps in control and assurance** | Nº | Actions | TARGET | Progress | COMPLETION |
|---|---|---|---|---|---|
| | 1 | Replace CPA (with exception of forensic services nationally) by April 2023 - Explore national exemplars of models which could replace CPA | 30 Apr 2023 (original)<br><br>30 Nov 2023 (new) | CMHT Transformation group currently visiting external organisations to see models in place with a view to assessing benefits for BDCFT and compatibility with clinical systems (SystemOne)<br>Visit completed September 2022 / Decision making oct/nov 2022<br>Work ongoing to develop new model and EQIA<br>Final proposal to Healthy Minds Board in November 2023 | |
| | 2 | Training plan to be in place by January 2023 | 31 Jan 2023<br>31 Dec 2023 (new) | Ongoing engagement and training needs analysis to be confirmed following final development of model | |
| | 3 | Audit plan to be considered and developed once model and training decisions finalised | tbc | tbc following completion of actions 1 and 2 | |

| Risk appetite (key areas of risk to be considered when assessing management of risk from Financial risk; Regulatory risk; Quality risks; Reputational risks and People risks) | | | | | | |
|---|---|---|---|---|---|---|
| | 0 - None | 1 - Minimal | 2 - Cautious | 3 - Open | 4 - Seek | 5 - Significant |
| Quality | We have no appetite for decisions that may have an uncertain impact on quality outcomes. | We will avoid anything that may impact on quality outcomes unless absolutely essential. | We prefer risk avoidance. But, if necessary, we will take decisions on quality where there is a | We are prepared to accept the possibility of a short-term impact on quality outcomes with | We will pursue innovation wherever appropriate. We are willing to take decisions on | We seek to lead the way and will prioritize new innovations, even in emerging fields. We |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | We will avoid innovation unless established and proven to be effective in a variety of settings. | low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. | potential for longer-term rewards. We support innovation. | quality where there may be higher inherent risks but the potential for significant longer-term gains. | consistently challenge current working practices in order to drive quality improvement. |
| Regulatory | We have no appetite for decisions that may compromise compliance with statutory, regulatory or policy requirements. | We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential. | We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision | We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully | We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks | We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders. |

| Strategic Objective 2: Prioritising our people, ensuring they have the tools, skills and right environment to be effective leaders within a culture that is open, compassionate, improvement-focused and inclusive | | | | | Lead Committee: Workforce & Equality Committee
Executive Lead: Chief People Officer | | | | | | | | |

| In year ambition | | | Key risk to achieving the ambition | | better lives, together | Links to other objectives | Linked operational risks (ref and brief descriptor) | | | | | Lead Executive |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.1 We will focus on embedding a compassionate and inclusive culture with accessible staff development programmes, a focus on talent management and ensuring staff are appropriately skilled and empowered to make decisions | | | If we don't embed a compassionate and inclusive culture, we may experience higher levels of staff disengagement, which may lead to increased turnover. | | Best Place to Work | SO1:1.3 | | | | | | Chief People Officer |

| M-12 Apr 2023 | M-11 May 2023 | M-10 Jun 2023 | M-9 Jul 2023 | M-8 Aug 2023 | M-7 Sep 2023 | M-6 Oct 2023 | M-5 Nov 2023 | M-4 Dec 2023 | M-3 Jan 2024 | M-2 Feb 2024 | M-1 Mar 2024 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3-3 (9) | 3-3 (9) | 3-3 (9) | 3-3 (9) | 3-3 (9) | | | | | | | | 2-2 (4) |

| | Cause of Risk | Impact / consequence of risk |
|---|---|---|
| | Failure to attract, retain and develop a diverse leadership. A culture that perpetuates the current inequalities through a lack of understanding of privilege and how this manifests in recruitment, talent management and succession planning processes.

Failure to address the persisting inequalities across all protected characteristic groups of staff in terms of access to promotion, career progression and promotion, and over-representation of staff from minority ethnic groups in formal HR processes

Staff uptake of the vaccine during Covid and being impacted by the virus is worst amongst staff from a minority ethnic background

Belief system based on leadership as being invested in positional power rather than personal power

Leadership styles that do not reflect the Trust's values and behaviours around listening, inclusivity and engagement

Failure to embed and model the values and behaviours of the Trust consistently and create confidence in speaking up culture and processes | Workforce especially at senior levels will not reflect diverse nature of local community and any specific needs and cultural issues which may impact on staff, patient experience and outcomes

Turnover and sickness absence will remain above target

Staff will not raise concerns reducing the opportunity to improve quality and staff and patient experience and with attendant risks around staff motivation, morale and productivity.

The Trust's reputation will be compromised impacting on recruitment and retention |

| | What controls are in place to manage the risk? | What gaps in controls are there? |
|---|---|---|
| Management of Risk | Board and Workforce and Equality Committee Dashboards reporting against People Development Strategy, and action plans/KPIs and Belonging and Inclusion Plan and underpinning delivery plan. and key workforce metrics
Staff Survey, Quarterly Pulse Surveys
Strategic EDI Staff Partnership
Staff Networks
Best Place to Work AGG and enabling programmes in place with escalation/assurance to PPI SLT
Freedom to Speak Up Guardian and processes
Triangulation of data
Care Trust Way methodology including coaching and iCare programme | Diagonal slice leadership reporting into Board suspended during the pandemic
Lack of systematic approach to talent management and succession planning
(see risk to strategic objective 2)
Embedding of Trust Values consistently at every level and within all key systems and processes
Group of Care Group and Corporate directorate EDI Champions to ensure agreement and local ownership of EDI objectives to create a diverse workforce, leadership and inclusive culture |

| | | Sources of Assurance | Gaps in Assurance |
|---|---|---|---|
| Assurance of effectiveness of controls | Level 1: Operational oversight | Staff Survey and Quarterly Pulse Survey Results
Workforce data on leadership profile
Participation in leadership development programmes
WRES, WDES, EDS Frameworks and Gender Pay Gap reporting
Moving Forward Plus minority ethnic staff Leadership Programme
Just R contract and agreed targeted recruitment campaigns and retention actions including exit interviews to create a diverse workforce through a strategic approach to recruitment
Senior leaders accessing the ICS BAME Fellowship Programme
Values based recruitment approach in place
People development strategy actions and KPI's agreed at November PPI SLT – for formal approval at WEC Feb 2022 | Plan to ensure a values-based culture is embedded consistently across all areas of the Care Group/Corporate Directorate
Talent Management and Succession Plans |
| | Level 2: Reports / metrics overseen by Board / Committee | Leadership and Management Development Passport Suite of Modular Programmes and evaluation data re access and quality
Staff Survey and Quarterly Pulse Survey results
Workforce data on leadership profile
WEC Dashboard including Gender Pay Gap Reporting
Workforce Race Equality Standard reporting and Disability Workforce Equality Reporting
Belonging and Inclusion Plan approved | Plan to ensure a values-based culture is embedded consistently across all areas of the Trust

Trust Talent Management and Succession Plan |

| | Level 3:<br>Sources of external oversight / scrutiny | Integrated People Board<br>Health and Social Care Economic Partnership Board<br>Bradford, Airedale, Wharfedale and Craven Equalities Group | | None currently | |
|---|---|---|---|---|---|
| **Mitigating Actions to address gaps in control and assurance** | **Nº** | **Actions** | **TARGET** | **Progress** | **COMPLETION** |
| | 1 | Implement new Fair and Compassionate Culture programme including roll out of toolkit | Actions and associated target dates will be reviewed as part of the BAF refresh work currently ongoing.<br><br>All SO will be reviewed and re-launched in a new format from October and those in SO2 will align to the updated strategic priorities | Materials in place, programme to commence in line with reset/recovery plans. Roll out of support and toolkit to support conversations in teams across the Trust<br>Development of the Beyond Words Campaign 2<br>Anti-racist toolkit launched<br>Trust has invested in a relationship with 'Be Kind' organisation which will provide toolkit resources supporting the move to an empathetic, compassionate and appreciative culture.<br>SLT workshop delivered in April 2022. Complete (Aug 2022) | 31 August 2022 |
| | 2 | Commence Talent Management pilots | | see strategic objective 2 | |
| | 3 | Launch and Embedding of the Belonging and Inclusion Plan and delivery plan 2021-25 to strengthen links to national People Plan priorities, Chief Executive Pledges and ensuring a sense of belonging | | Crowdsourcing engagement work and workshops have concluded, new Belonging and Inclusion Plan and Delivery plan discussed at the EDI Strategic Staff Partnership in November having been received at SLT and approved at November 2021 Board. Plan received at WEC. Complete (Aug 2022) | 31 August 2022 |
| | 4 | Identification of Belonging and Inclusion Champions | | Launch of EDI Influencers programme (new name) due October 2022 but delayed due to workforce capacity | |
| | 5 | Implementation of the Equality Assessment Matrix and identification of service level priority objectives for improvement | | a/w update | |
| | 6 | Implementation of quarterly pulse/staff surveys | | The NHS People Pulse quarterly staff survey is now implemented. Complete – BAU as quarterly survey . Outcomes to WEC. | |
| | 7 | Review and re-commence the Diagonal Slice Leadership Group – NED and ED led | | Leadership event planned and delivered 6 October 2022. Complete. | 31 October 2022 |
| | 8 | Creation of Belonging and Inclusion Group fostering the development and local ownership of EDI objectives to create a diverse organisation and senior leadership. | | Strategic Staff EDI Partnership established. Meets bi-monthly, reports to WEC. | |
| | 9 | Roll out of the Equality Assessment Matrix to support identification of service level EDI objectives. | | Job share postholder to the Head of EDI leaving organisation further work on skill mix and functional leadership underway. Recruitment underway to two new roles in EDI team. | |

**Risk appetite (key areas of risk to be considered when assessing management of risk from Financial risk; Regulatory risk; Quality risks; Reputational risks and People risks)**

| | 0 - None | 1 - Minimal | 2 - Cautious | 3 - Open | 4 - Seek | 5 - Significant |
|---|---|---|---|---|---|---|
| People | We have no appetite for decisions that could have a negative impact on our workforce development, recruitment / retention. Sustainability is our primary interest. | We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere. | We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision. | We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff. | We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve their skills /capabilities. We recognize innovation is likely to cause short term disruption with the possibility of long-term gains | We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change. |
| Quality | We have no appetite for decisions that may have an uncertain impact on quality outcomes. | We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings. | We prefer risk avoidance. But, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. | We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation. | We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains. | We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement. |

| **Strategic Objective 2:** Prioritising our people, ensuring they have the tools, skills and right environment to be effective leaders within a culture that is open, compassionate, improvement-focused and inclusive | | | | | | | **Lead Committee:** Workforce & Equality Committee<br>**Executive Lead:** Chief People Officer | | | | | | |

| **In year ambition** | | | | **Key risk to achieving the ambition** | | better lives, together | Links to other objectives | **Linked operational risks (ref and brief descriptor)** | | | | | **Lead Executive** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.2 We will continue to ensure staff are recognised and rewarded, sharing learning, celebrating success and supporting staff to share best practice | | | | If we do not acknowledge, reward and celebrate achievements, we may see a subsequent reduction in morale and a negative impact on discretionary effort and increased turnover. | | Best Place to Work | SO3:3.2 | | | | | | Chief People Officer |

| M-12<br>Apr 2023 | M-11<br>May 2023 | M-10<br>Jun 2023 | M-9<br>Jul 2023 | M-8<br>Aug 2023 | M-7<br>Sep 2023 | M-6<br>Oct 2023 | M-5<br>Nov 2023 | M-4<br>Dec 2023 | M-3<br>Jan 2024 | M-2<br>Feb 2024 | M-1<br>Mar 2024 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3-3 (9) | 3-3 (9) | 3-3 (9) | 3-3 (9) | 3-3 (9) | | | | | | | | 2-2 (4) |

| | **Cause of Risk** | **Impact / consequence of risk** |
|---|---|---|
| | Failure to recruit and retain the right number of people at the right level, with the right skill mix year by year.<br>The Pandemic has seen retirement remain as a leading reason for staff turnover<br>Staff fatigue/burnout during the pandemic whether delivering and managing care or providing support services.<br>Stress, anxiety and depression remains a top reason for long term sickness absence.<br>Some staff who are homeworkers reporting isolation/deterioration in mental health<br>Lack of certainty around future ways of working and work environments and concerns around individual needs being considered in decision making<br>Shortage of key professionals and occupations in specific roles<br>No succession planning to mitigate risks when key staff leave and encourage staff retention.<br>Staff dissatisfaction with the level of engagement, involvement and communication with team leaders and senior leadership leading to low motivation, drop in productivity<br>Poor levels of engagement and motivation which are correlated with lower patient satisfaction and outcomes | Costs of bank, agency and contract staff to fill any gaps in the workforce<br><br>Deterioration in quality of service/patient experience linked to lack of continuity of care/staffing<br><br>High labour turnover and sickness absence putting pressure on remaining staff and impacting on staff health and wellbeing, patient satisfaction, staff satisfaction with implications for quality of care and achievement of objectives<br><br>Poor Trust reputation impacting on ability to recruit as well as retain staff |

| | **What controls are in place to manage the risk?** | **What gaps in controls are there?** |
|---|---|---|
| **Management of Risk** | Board and Workforce and Equality Committee (WEC) Dashboards reporting against People Development Strategy, action plans and KPI's and the Belonging and Inclusion Plan and Delivery Plan supporting it.<br>DLM reports on workforce metrics, temporary staff usage, and agency spend. Regular meetings between the bank and rostering leads and service manager to review performance and improvements.<br>Annual Staff Survey, Quarterly Pulse Surveys, Care Trust Way RPIWs,<br>Recruitment & Retention Plan RPIW 30,60,90 (11/19) Zero vacancies HCSW NHSE/I programme<br>Best Place to Work AGG and enabling programmes in place with escalation/assurance to PPI SLT through to WEC and Board where indicated.<br>Smarter Working group in place engaging with workforce to create a plan for type of worker/ways of working/alongside estate and digital plans to support. Smarter Working Group reporting into PPI SLT and WEC on actions to support staff to work differently in a hybrid model through and beyond the pandemic developing a short medium and longer term plan that delivers workforce, estates and financial benefits.<br>Workforce Planning process/annual cycle with a five year time horizon (to deliver short, medium and longer terms plans)<br>Extensive HWB programme including Salary Finance scheme and Staff Support Fund and Staff Support and Therapy Service<br>Fast track access to Physio Med<br>Reward and Recognition Schemes<br>Process for picking up and addressing wherever possible dissatisfaction in new starters before they decide to leave in place<br>Comprehensive nurse preceptorship (local pathways and InsideOut programme) established and embedded.<br>Meetings of the Director of Nursing and Professions/Deputy with newly qualified nurses on joining the Trust.<br>Practice Educator role (pilot) for newly qualified nurses in Mental Health (visible role picking up pastoral and education needs) | Systematic process throughout the Trust to support staff development, and career progression (Talent Management)<br><br>Embedded processes for medium and longer term workforce planning mechanisms with links to transformation<br><br>Near completion of work to deliver new ways of working / smarter working, during and post pandemic/as we exit lockdown – scoping impact of risks for phase 2 (implementation in community services) ongoing currently<br><br>Managing WTD breaches and management of rosters<br><br>Clinical Workforce Strategy and Corporate Workforce Strategy to be developed that will overarch existing and new Professions Strategies.<br><br>Medical workforce Strategy to be developed |

| | **Sources of Assurance** | | **Gaps in Assurance** |
|---|---|---|---|
| **Assurance of effectiveness of controls** | **Level 1:** Operational oversight | QUOPs provide local ownership and oversight of workforce pressures, metrics and staff survey results<br>Best Place to Work Accountability and Governance Group reporting into the People Plan and Innovation SLT<br><br>Senior level succession plan | Care Group and Corporate Directorate Medium and Longer Term Workforce Plans including talent management and succession plan<br><br>Plan to support staff to work in new ways post pandemic |
| | **Level 2:** Reports / metrics overseen by Board / Committee | Monitoring by W&EC (9/20 4/21), deep dive reports; FBIC People Development Strategy approved (9/19), Workforce deep dive (9/19), sickness deep dive April 21 WEC, Brexit assurance, Preceptorship progress, assurance re apprenticeship targets<br>RPIW on starters & leavers process (9/19); zero HCSW target update WEC (4/21)<br>Staff Survey reports and action update (11/19, 1/20, 3/20, 5/20, 3/21, 10/9<br>Quarterly staff pulse surveys | Trust Medium and Longer Term Workforce Plan and Talent Management Plan<br><br>Trust Plan to support staff to work in new ways post pandemic in accordance with the expectations of the NHS People Plan |

| | | Freedom to Speak Up Guardian Board / WEC Committee Reports – 6 monthly and annually<br>Regular meetings for new starters with a member of the Executive team, for nursing and AHP this is with the Director of Nursing and Professions (or Deputy)<br>Deep dive into sickness absence being presented to joint committee 16/12/21<br>Full Internal Audit opinion given on the Workforce Planning processes to deliver a 5 year plan aligned to People Development Strategy | |
| | **Level 3:**<br>Sources of external oversight / scrutiny | Place Integrated People Board and Integrated People Plan<br>Place System Planning Group and Trust One Year Workforce Plan | Review being undertaken of the governance arrangements for Workforce at Place with work being undertaken to establish a Workforce Committee, establish ongoing resourcing for this workstream and streamline the governance below Committee level. |

| **Mitigating Actions to address gaps in control and assurance** | **Nº** | **Actions** | **TARGET** | **Progress** | **COMPLETION** |
|---|---|---|---|---|---|
| | 1 | Design and implementation of a systematic approach to Talent Management | | Talent Management process developed, and appraisal paperwork redesigned to support Talent Management conversations. Pilot of the process complete in IT Services, further work planned in Older Peoples Mental Health and Payroll Services. Latter pilots on hold through the pandemic.<br>Further talent management pilots will be confirmed as part of the next steps recovery plan. Appraisal paperwork now launched and in use across organisation.<br>Non recurring funding being sought for time limited consultancy to identify next steps in roll out of talent systems development. Complete (Aug 2022) | 31 August 2022 |
| | 2 | Development of preceptorship programme, career workshops, stay conversations and transfer process | | Comprehensive 12-month preceptorship Inside Out programme in place for newly qualified nurses. Career workshops in place. Complete (Aug 2022) | 31 August 2022 |
| | 3 | Implementation of refreshed process for understanding new starters experiences | | Timetable of director meetings with new starters now in place. Complete (Aug 2022) | 31 August 2022 |
| | 4 | Clear processes for workforce planning beyond one year, linked to business and financial planning cycles. Workforce Plans in place to support transformation in Care Groups and Corporate Directorates, with associated recruitment, training and apprenticeship programmes and career pathways for HCSWs and embedding of Advanced Clinical Practitioners/NAs/new and blended roles. | Actions and associated target dates will be reviewed as part of the BAF refresh work currently ongoing.<br><br>All SO will be reviewed and re-launched in a new format from October and those in SO2 will align to the updated strategic priorities | Business case/paper drafted for EMT on HR/OD function resourcing needs - level of funding required not available, some investment and non recurring investment made in fixed term posts whilst options for delivering and strengthening the HROD Directorate are explored. Complete (Aug 2022)<br><br>Revision of HR OD directorate establishment and funding to be concluded by end September 2022. Business case for revised establishment to EMT Cost pressures session March 2023. Business case approved by EMT with recommendation for Board approval in April 2023. | 31 August 2023 |
| | 5 | Recruitment and Retention established and participation in the NHSE/I zero HSCW vacancies programme | | New Exit Questionnaire based on the People Promise available in ESR Self Service functionality from Oct 21 Complete (Aug 2022) | 31 August 2022 |
| | 6 | Establish a new ways of working/hybrid working strategic programme | | Workforce planning group now established with cross section of operational, HR and professional leads. First meeting held June 2021. The group's aim is to establish a systematic approach and templates to guide the development of medium and long term workforce plans and associated recruitment and training schedules. Check in meeting took place 5 August 2021 to ensure planning was on track and project plan with timeline in place received at FBIC and WEC to deliver 5 year workforce plans for 1 April 22 Progress reported to 2/3/22 at PPI SLT and work is on track. Complete (Aug 2022)<br><br>Clinical Workforce Strategy approved at PPI SLT 2/3/22 and will be presented to WEC for ratification in April 2022. Complete (Aug 2022)<br><br>Recruitment & retention practices under review following requirements set out in NHS people Plan.<br>Plans to W&EC (9/20) for feedback on progress. Longer term recruitment and retention strategy being developed alongside a refreshed Recruitment and Retention Plan. Recruitment and Resourcing HR business partner in place in addition, separate Corporate directorate/workforce Business Partner in place. Complete (Aug 2022)<br><br>Working group now in place chaired by DDo Estates and DDoHR/OD, ToR agreed, fieldwork for corporate and administrative services commenced. Group reports into strategic SLT. Project management and support resources agreed as part of the sustainability work. Plans signed off and being implemented for non-clinical corporate staff. Next phase clinical workforce and staff who work in support in clinical services. Smarter Working phase 1 (corporate) completed (Aug 2022)<br>Next phase (Clinical) 'Smarter Places' commenced July 2022 – updates on progress through Strategic Service Transformation AGG | |

| **Risk appetite (key areas of risk to be considered when assessing management of risk from Financial risk; Regulatory risk; Quality risks; Reputational risks and People risks)** | | | | | | |
|---|---|---|---|---|---|---|
| | **0 - None** | **1 - Minimal** | **2 - Cautious** | **3 - Open** | **4 - Seek** | **5 - Significant** |
| People | We have no appetite for decisions that could have a negative impact on our workforce | We will avoid all risks relating to our workforce unless absolutely essential. Innovative | We are prepared to take limited risks with regards to our workforce. Where attempting to | We are prepared to accept the possibility of some workforce risk, as a direct result from | We will pursue workforce innovation. We are willing to take risks which may have | We seek to lead the way in terms of workforce innovation. We accept that innovation can be |

| | | | | | | |
|---|---|---|---|---|---|---|
| | development, recruitment / retention. Sustainability is our primary interest. | approaches to recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere. | innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision. | innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff. | implications for our workforce but could improve their skills /capabilities. We recognize innovation is likely to cause short term disruption with the possibility of long-term gains | disruptive and are happy to use it as a catalyst to drive a positive change. |
| Quality | We have no appetite for decisions that may have an uncertain impact on quality outcomes. | We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings. | We prefer risk avoidance. But, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. | We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation. | We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains. | We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement. |

| **Strategic Objective 2:** Prioritising our people, ensuring they have the tools, skills and right environment to be effective leaders within a culture that is open, compassionate, improvement-focused and inclusive | | | | | | | **Lead Committee:** Workforce & Equality Committee <br> **Executive Lead:** Chief People Officer | | | | | |

| In year ambition | | Key risk to achieving the ambition | | better lives, together | Links to other objectives | Linked operational risks (ref and brief descriptor) | | | | Lead Executive | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.3 We will continue to ensure staff have a voice that counts, and feel part of a team supporting people to be leaders in their own sphere through embedding of the Care Trust Way, encouraging engagement in formal and informal networks and strengthening our engagement between front line delivery of services and Board | | If we do not support speaking out and inclusion, we will not have thriving staff networks and the Trust will not be able to demonstrate compliance with WRES and WDES standards. | | Best Place to Work | SO3:3.1 | | | | | Chief People Officer | |

| M-12 <br> Apr 2023 | M-11 <br> May 2023 | M-10 <br> Jun 2023 | M-9 <br> Jul 2023 | M-8 <br> Aug 2023 | M-7 <br> Sep 2023 | M-6 <br> Oct 2023 | M-5 <br> Nov 2023 | M-4 <br> Dec 2023 | M-3 <br> Jan 2024 | M-2 <br> Feb 2024 | M-1 <br> Mar 2024 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3-3 (9) | 3-3 (9) | 3-3 (9) | 3-3 (9) | 3-3 (9) | | | | | | | | 2-2 (4) |

| | **Cause of Risk** | **Impact / consequence of risk** |
|---|---|---|
| | Reluctance of staff to speak up and speak out, based on mistrust, fear of reprisals and lack of confidence that concerns or ideas will be listened to and acted upon. <br> Bank have little /no routes to speak out.   Very few have access to Trust laptops and therefore Trust Connect pages (bank are given Trust emails but rarely use them as they can only be accessed with a Trust laptop) <br> Volunteers as a cohort are also without a direct route to speak up or any access to much of the Trust comms. <br> BDCT training is not always made easily accessible to bank workers, nor is any e-learning training paid for. <br> Career pathways / internal jobs are not regularly communicated to bank workers/ volunteers and so opportunities are missed to recruit via this route <br> Lack of specific Line manager training especially with operational skills i.e attendance management etc which impacts on staff feeling unsupported by managers and this impacting on morale, attendance and conduct. <br> Lack of robust system to support with job matching/ consistency checks leading to staff queries/ concerns <br> Missed opportunities of training/ supervision / 121's and appraisals due to clinical pressures. Our appraisal compliance shows that staff investment this may be lower on the agenda than we would like and by having regular 121's supervision this can support problems at an early stage and mitigate escalation <br> Managers not encouraging feedback, suggestions and ideas from their teams <br> Staffing pressures resulting in teams having limited resources to set up staff engagement activities <br> Staffing pressures resulting in staff struggling to attend engagement activities | Concerns go unreported and lead to lowering of quality standards and potentially patient safety. <br><br> Staff feel unsupported by managers and this may impact on morale, attendance and conduct. <br><br> Staff disengage from general communications. <br> Workers without an easy and known pathway to voice opinions often feel marginalised and do not feel part of a cultivated shared purpose.   Shared learning of experiences and understanding opportunities may be missed. <br> Temporary workers are rarely promoted into leadership roles because they are not employees of the Trust and there is no current structure or budget in place to offer career guidance/pathway support or to train/retrain these workers. In short, we are missing a large potential talent pool. <br> Wellbeing is diminished. <br> Less shifts are filled as workers feel disengaged and not part of the wider organisation <br> Lower retention of staff. <br> Managers feel vulnerable if not trained / equipped to do their job. Staff feel equally vulnerable and lack confidence in their line manager. <br> Staff feel disengaged and not listened to which impacts morale. |

| | **What controls are in place to manage the risk?** | **What gaps in controls are there?** |
|---|---|---|
| **Management of Risk** | Freedom to Speak Up Guardian well-publicised, with emphasis on confidentiality. <br> Reinforce confidentiality of pulse and annual staff surveys. <br> Temporary workers are contacted regularly by the staff bank team (each has a dedicated team member) with the aim to provide Line Management, pastoral support and build an open and honest relationship. This requires a huge amount of resource to maintain <br> This year we have initiated a project to offer bank workers the chance to train and become FTSU ambassadors in the hope this will not only bring an increased understanding of their needs and issues, but also provide a line of support potentially more readily available and accessible to bank workers. <br> Creation of a monthly newsletter for bank workers. <br> Scoping out of an electronic system to manage JE so decisions are auditable and transparent. Consistency checks can then ensue. <br> Better use/ advertising of staff networks <br> First line manage training has been developed in association with OD/HR teams to support the learning gaps in newly appointed managers <br> Staff Networks and support from EMT, Kindness into action project, Bullying and harassment officers, Fair and Compassionate Culture, Board walkabouts – Go See visits, Reward and recognition schemes – You're A Star Awards, Thanks a Bunch, Living the Values, Long Service Awards, Care Trust Way training and promotion, Leadership and management training | A better understanding of why bank workers are leaving and what we can do to mitigate – i.e. a better, well-structured off-boarding process and leavers interview for all temporary workers. <br> Drop-in sessions for temporary workers so they can speak with their manager face to face or have the opportunity to air their grievances in person. There is currently no considered robust route to manage concerns. <br> A comprehensive overhaul of the contacts page on Bank Staff is needed so that personal emails are the primary email.   This would mean that bank workers will see all of the communications that are sent out by the Trust. This would alleviate a lot of the risks identified. <br> Bank workers do not have personal worker agreements as part of the Smarter Working project. <br><br> No current system to manage JE so currently no robust auditable process. <br> Exec sponsor at board level for Appraisal compliance review of supervision and audit ( Bob will explain this in an email!) |

| | **Sources of Assurance** | | **Gaps in Assurance** |
|---|---|---|---|
| **Assurance of effectiveness of controls** | **Level 1:** <br> Operational oversight | WRES/ WDES annual report <br> Staff survey (and pulse surveys) <br> Bank reports such as not worked report/spreadsheet reporting <br> ER tracker to highlight trends in complaints <br> Periodic compliance reports for appraisal compliance and other people associated KPI's QUOPS <br> QUOPs provide local ownership and oversight of workforce pressures, metrics and staff survey results <br> Best Place to Work Accountability and Governance Group reporting into the People Plan and Innovation SLT | |

| | | |
|---|---|---|
| **Level 2:**<br>Reports / metrics overseen by Board / Committee | Monitoring by W&EC deep dive reports; FBIC People Development Strategy approved Workforce deep dive (9/19), sickness deep dive April 21 WEC, Brexit assurance, Preceptorship progress<br>Assurance re apprenticeship targets<br>Staff Survey reports and action plans<br>Quarterly staff pulse surveys<br>Freedom to Speak Up Guardian Board / WEC Committee Reports – 6 monthly and annually<br>Regular meetings for new starters with a member of the Executive team, for nursing and AHP this is with the Director of Nursing and Professions (or Deputy)<br>Deep dive into sickness absence being presented to joint committee | |
| **Level 3:**<br>Sources of external oversight / scrutiny | WRES/WDES for HEE<br>Deputy Director Forum / HRD forums<br>Place Integrated People Board and Integrated People Plan<br>Place System Planning Group and Trust One Year Workforce Plan | |

| Mitigating Actions to address gaps in control and assurance | Nº | Actions | TARGET | Progress | COMPLETION |
|---|---|---|---|---|---|
| | 1 | Staff from across the Trust to be trained to deliver the Kindness into action workshops | Actions and associated target dates will be reviewed as part of the BAF refresh work currently ongoing.<br><br>All SO will be reviewed and re-launched in a new format from October and those in SO2 will align to the updated strategic priorities | Recruitment of staff to undertake train the trainer programme so they can deliver the kindness into action workshops. Complete – train the trainer programme now BaU | 31 July 2023 |
| | 2 | Consultation with wide range of staff across the Trust in the development of the Belonging and Inclusion Plan involving attendance at team meetings, staff networks and consultation via the crowd sourcing portal. | | Production of the Belonging and Inclusion Plan (completed) | 31 July 2023 |
| | 3 | Strengthening and promotion of the staff networks | | The staff networks are regularly featured in the weekly Executive broadcasts and through other communication channels e.g. Yammer, e-update, vlogs etc. Staff networks represented at Strategic Staff EDI forum (bi-monthly see ambition 2.2)<br>August 2023 update: each network has an executive and non-executive director sponsor and recurring non pay budget for expenditure on promotional materials | 31 August 2023 |

| Risk appetite (key areas of risk to be considered when assessing management of risk from Financial risk; Regulatory risk; Quality risks; Reputational risks and People risks) | | | | | | |
|---|---|---|---|---|---|---|
| | 0 - None | 1 - Minimal | 2 - Cautious | 3 - Open | 4 - Seek | 5 - Significant |
| People | We have no appetite for decisions that could have a negative impact on our workforce development, recruitment / retention. Sustainability is our primary interest. | We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere. | We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision. | We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff. | We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve their skills /capabilities. We recognize innovation is likely to cause short term disruption with the possibility of long-term gains | We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change. |
| Quality | We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation | Our appetite for risk taking is limited to those events where there is no chance of significant repercussions. | We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout. | We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders | We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks | We are comfortable taking decisions that may expose us to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes |

| **Strategic Objective 2:** Prioritising our people, ensuring they have the tools, skills and right environment to be effective leaders within a culture that is open, compassionate, improvement-focused and inclusive | **Lead Committee:** Workforce & Equality Committee<br>**Executive Lead:** Chief People Officer |
|---|---|

| In year ambition | Key risk to achieving the ambition | better lives, together | Links to other objectives | Linked operational risks (ref and brief descriptor) | Lead Executive |
|---|---|---|---|---|---|
| 2.4 We will ensure our staff are safe and healthy, by continuing to strengthen our staff wellbeing offer, ensuring we provide and maintain safe working environments and that staff have the appropriate skills and training to work safely and effectively in a complex care environment. | If we do not support our staff to be safe and healthy, we may suffer from increased staff sickness absence and the negative impact that will have on service user care. | Healthy as Possible | SO3:3.1 | | Chief People Officer |

| M-12<br>Apr 2023 | M-11<br>May 2023 | M-10<br>Jun 2023 | M-9<br>Jul 2023 | M-8<br>Aug 2023 | M-7<br>Sep 2023 | M-6<br>Oct 2023 | M-5<br>Nov 2023 | M-4<br>Dec 2023 | M-3<br>Jan 2024 | M-2<br>Feb 2024 | M-1<br>Mar 2024 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3-3 (9) | 3-3 (9) | 3-3 (9) | 3-3 (9) | 3-3 (9) | | | | | | | | 2-2 (4) |

| | Cause of Risk | Impact / consequence of risk |
|---|---|---|
| **Management of Risk** | Pressure of workload<br>High acuity of patients<br>Higher use of agency workers<br>Target driven culture<br>Less than optimal work environments, as in aging estate<br>Lack of access to skills development<br>Lack of access to meal breaks and rest periods<br>Lack of management skills in supporting staff | Burn out, sickness absence and early leaving from organisation.<br>Revise establishments to manage increased acuity of care and quality.<br>Higher operating costs and inconsistency of care.<br>Lowering morale.<br>Staff incidents and accidents and near misses.<br>Lowering of quality of care and career progression prospects<br>High turnover. |
| | **What controls are in place to manage the risk?** | **What gaps in controls are there?** |
| | Comprehensive health and wellbeing offer delivered by Wellbeing@Work<br>Staff Support and Therapy Service now permanently funded<br>Health and Safety input re safe working environment<br>Ongoing monitoring of mandatory and role specific training compliance<br>Planning of all mandatory and role specific training to meet demand<br>Occupational health service<br>Safer Staffing Group<br>Safe working environment<br>Mandatory training<br>M&H risk assessments for individual patients<br>Policies – risk assessments, moving and handling,<br>Smarter Spaces project<br>Infection prevention controls<br>Health and wellbeing room<br>Multi faith rooms<br>Lively up yourself programme | Lack of compliance with mandatory training<br>Accessibility<br>Workload pressures reducing opportunities to participate<br>Policies not being followed<br>Managers not attending management development and leadership training |

| | | Sources of Assurance | Gaps in Assurance |
|---|---|---|---|
| **Assurance of effectiveness of controls** | **Level 1:**<br>Operational oversight | QUOPs provide local ownership and oversight of workforce pressures, metrics and staff survey results<br>Best Place to Work Accountability and Governance Group reporting into the People Plan and Innovation SLT<br>Compliance reports for mandatory training and appraisal produced monthly<br>Health and Safety Group Meetings<br>Management information from Occupational Health Service<br>Management information from Employee Assistance Programme (EAP) | |
| | **Level 2:**<br>Reports / metrics overseen by Board / Committee | Monitoring by W&EC deep dive reports; FBIC People Development Strategy approved<br>Preceptorship progress<br>Staff Survey reports and action plans<br>Quarterly staff pulse surveys<br>Freedom to Speak Up Guardian Board / WEC Committee Reports – 6 monthly and annually<br>Regular meetings for new starters with a member of the Executive team, for nursing and AHP this is with the Director of Nursing and Professions (or Deputy)<br>Wellbeing Guardian ?? Have we one now?<br>Safer Staffing Reports – where do they go? | |

| | | | |
|---|---|---|---|
| **Level 3:**<br>Sources of external oversight / scrutiny | | Place Integrated People Board and Integrated People Plan<br>Place System Planning Group and Trust One Year Workforce Plan | |

| **Mitigating Actions to address gaps in control and assurance** | **Nº** | **Actions** | **TARGET** | **Progress** | **COMPLETION** |
|---|---|---|---|---|---|
| | 1 | Regular review of the staff health and wellbeing offer to ensure it meets the needs of staff. This involves liaison and involvement at a local, regional and national level. | Actions and associated target dates will be reviewed as part of the BAF refresh work currently ongoing.<br><br>All SO will be reviewed and re-launched in a new format from October and those in SO2 will align to the updated strategic priorioties | Membership of Pillar 1 – at PLACE. Attendance at regional NHSE/I events as well as NHS Employers events around health and wellbeing. CPO now elected as Y&H representative on National Staff Council<br>reviewed through People and Culture Committee quarterly | 31 August 2023 |
| | 2 | Establishment and opening of the staff health and wellbeing room at Moorlands View, Lynfield Mount Hospital | | Installation of sink and furniture completed. Securing of equipment to be carried out by Estates prior to opening. Complete. | 31 July 2023 |
| | 3 | Involvement with initiatives funded on a regional basis e.g. Men in Health project funded by the West Yorkshire Mental Wellbeing Hub | | Men in Health group have met with various male staff in various departments e.g. Estates, acute wards etc.<br>funded through regional wellbeing hub | 31 August 2023 |
| | 4 | Ongoing recruitment of wellbeing champions to ensure representation across the Trust | | Regular communications to wellbeing champions and ongoing promotion of the role. Non Executive identified in role of Wellbeing Guardian, to be ratified at WEC in April 2023 NED wellbeing guardian identified | 31 August 2023 |
| | 5 | Attendance at face to face team development events | | Ongoing attendance at face to face events to promote the staff health and wellbeing offer, the role of health and wellbeing champions and to gather feedback from staff on the offer and any suggestions around health and wellbeing offers they would like to see in place. Wellbeing Hub room now open at LMH providing a range of facilities and resources.<br>Regular slot during Trust induction established | 31 August 2023 |
| | 6 | Identification of any hot spot areas in relation to sickness absence and low scores with regard to health and wellbeing in the staff survey | | Review to be conducted by 31/03/23 Sickness absence hot spots shallow dive undertaken and presented to WEC in April 2023. | 31 August 2023 |

**Risk appetite (key areas of risk to be considered when assessing management of risk from Financial risk; Regulatory risk; Quality risks; Reputational risks and People risks)**

| | 0 - None | 1 - Minimal | 2 - Cautious | 3 - Open | 4 - Seek | 5 - Significant |
|---|---|---|---|---|---|---|
| People | We have no appetite for decisions that could have a negative impact on our workforce development, recruitment / retention. Sustainability is our primary interest. | We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere. | We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision. | We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff. | We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve their skills /capabilities. We recognize innovation is likely to cause short term disruption with the possibility of long-term gains | We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change. |
| Regulatory | We have no appetite for decisions that may compromise compliance with statutory, regulatory or policy requirements. | We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential. | We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision | We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully | We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks | We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders. |

NHS Bradford District Care NHS Foundation Trust

| Strategic Objective 3: Maximising the potential of services to deliver outstanding care to our communities | Lead Committee: Quality & Safety Committee |
|---|---|
| | Executive Lead: Director of Nursing, Professions and Care Standards |

| In year ambition | | Key risk to achieving the ambition | | better lives, together | Links to other objectives | Linked operational risks (ref and brief descriptor) | | Lead Executive |
|---|---|---|---|---|---|---|---|---|
| 3.1 We will continue to focus on innovation to improve our services where this is the right thing to do. Using the techniques and approaches of the Care Trust Way, we will facilitate every part of the organisation to move towards its own excellence, ensuring that we develop 'communities of care' around services on their improvement journey | | There is a risk that targets are not sufficiently sensitive to recognise the progress made by individual services recognising their capacity to deliver change | | Best Quality Care | SO6:6.1 | | | Director of Nursing, Professions & Care Standards |

| M-12 Apr 2023 | M-11 May 2023 | M-10 Jun 2023 | M-9 Jul 2023 | M-8 Aug 2023 | M-7 Sep 2023 | M-6 Oct 2023 | M-5 Nov 2023 | M-4 Dec 2023 | M-3 Jan 2024 | M-2 Feb 2024 | M-1 Mar 2024 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3-3 (9) | 3-3 (9) | 3-3 (9) | 3-3 (9) | 3-3 (9) | | | | | | | | 3-2 (6) |

| | Cause of Risk | Impact / consequence of risk |
|---|---|---|
| | Data quality of our clinical systems can limit the information that is collected and can be used to scrutinise quality improvement. Capacity within quality governance teams to review and inspect in order to identify key intelligence is constrained | Inability to deliver safe, effective, well led services, high quality services.

Inability to demonstrate that risks are managed effectively, learning and improvements are delayed, poor clinical outcomes, leading to a difficulty in recruitment and retention of staff, poor service user satisfaction, enforcement action, prosecution, financial penalties causing reputational damage, loss of confidence. |

| | What controls are in place to manage the risk? | What gaps in controls are there? |
|---|---|---|
| Management of Risk | • Care Group/Service Quality Improvement plans developed which include CQC actions (must and should dos) with oversight from Compliance and Risk Group (CRG), SLT and respective committees<br>• Go See Framework embedded with a range of proactive and reactive visits including quality and safety visits and exec/director visits<br>• Timetable for Go See visit established and revised<br>• Quality Assurance Framework templates developed –quality indicators used in January 2022 in 0-19 services. Workplan being developed for other services over 2022<br>• standard operating procedure developed to support the Go See Framework which will identify key learning and opportunities for quality improvement programmes<br>• oversight of action plans from complaints/incidents by SLT | Ongoing improvements to ensure that learning, innovation and changes in practice are fully embedded |

| | Sources of Assurance | | Gaps in Assurance |
|---|---|---|---|
| Assurance of effectiveness of controls | Level 1: Operational oversight | Rapid improvement events led by the KPO office to enhance system development - feedback to Care Group Quality & Operational Meetings and SLT on progress and impact.<br>Patient Safety Specialist working group as a Place based approach<br>Reports on delivery of actions plans monthly into SLT<br>Triangulation of quality/safety data through DLM structures, PSLG, Safer Staffing group<br>Assurance visit schedule planned to explore issue of closed cultures<br>Consideration of closed cultures during reviews of patient safety intelligence | |
| | Level 2: Reports / metrics overseen by Board / Committee | Quality and Safety Committee receive reports from QAF reviews<br>Quality and safety information as part of Board and Committee IPR<br>Triangulation of quality/safety data through Compliance and Risk, Learning report<br>Links between WEC and QSC on quality data<br>FTSU reporting and open house sessions in place<br>Process for self-assessment of well led established, including Internal Audit process<br>Triangulation of data from Q&S visits and Clinical Audit programme established | Quality metrics as part of quality dashboard not totally reflective of complete quality assurance oversight. A full review of quality dashboard and reporting metrics to committee is underway and will be approved in September 2023 |
| | Level 3: Sources of external oversight / scrutiny | CQC inspections<br>External quality awards and reviews | Peer reviews by other organisations<br>External accreditation scheme outcomes<br>Unfamiliarity with new CQC inspection process due to be embedded 2023/23 (Postponed by CQC) |

| | Nº | Actions | TARGET | Progress | COMPLETION |
|---|---|---|---|---|---|
| Mitigating Actions to address gaps in control and assurance | 1 | Reviewing learning from initial QAF assessments to determine capacity to deliver | | Quality Assurance Framework pilot completed and a plan agreed for 2023 to implement a quarterly full Quality Assurance Framework. (QAF) across the services with Heads of Nursing. The implementation of a bi-monthly mini QAF. The service is identified through the weekly/ monthly data received at weekly report outs. This intelligence is used to identify any variations outside of normal range, and a short QAF to understand d the reason ns for the variation n along with recommendations, which are monitored through QUOPs.<br>Closed Cultures visits identified the need for unannounced night visits to also take place. A quarterly plan for 2023 has been generated and agreed. | 27 Apr 2023 |
| | 2 | Reviewing clinical leadership structure to determine how to strengthen and align more closely to Nursing Directorate priorities around quality and safety | | | 27 Apr 2023 |

| | | | | | |
|---|---|---|---|---|---|
| | 3 | Review Go See Framework to align with QAF and ensure triangulation with other intelligence | | Links with quality governance clarified and dates for new framework visits in place | 27 Apr 2023 |
| | 4 | Develop well led self-assessment framework | | Well led self-assessment document in development & board development session completed October 2022 | 27 Apr 2023 |
| | 5 | Review and evaluate QAF process in line with planned schedule and other visit schedules | | Evaluation complete and will become embedded part of process | 27 Apr 2023 |
| | 6 | Review the Trusts clinical leadership and line management under the Heads of Nursing | 31 May 2023 31 August 2023 | A review of structure and recruitment in relation to this is now complete. | 22 Aug 2023 |
| | 7 | Undertake the well-led self assessment | 28 Feb 2024 | Internal Audit plan in place for Well-Led Assessment Framework in Q3. | |

| Risk appetite (key areas of risk to be considered when assessing management of risk from Financial risk; Regulatory risk; Quality risks; Reputational risks and People risks) | | | | | | |
|---|---|---|---|---|---|---|
| | 0 - None | 1 - Minimal | 2 - Cautious | 3 - Open | 4 - Seek | 5 - Significant |
| Quality | We have no appetite for decisions that may have an uncertain impact on quality outcomes. | We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings. | We prefer risk avoidance. But, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. | We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation. | We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains. | We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement. |
| Regulatory | We have no appetite for decisions that may compromise compliance with statutory, regulatory or policy requirements. | We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential. | We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision | We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully | We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks | We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders. |

| Strategic Objective 3: Maximising the potential of services to deliver outstanding care to our communities | Lead Committee: Quality & Safety Committee |
|---|---|
| | Executive Lead: Director of Nursing, Professions and Care Standards |

| In year ambition | Key risk to achieving the ambition | better lives, together | Links to other objectives | Linked operational risks (ref and brief descriptor) | Lead Executive |
|---|---|---|---|---|---|
| 3.2 We will continue to focus on enhancing our approach to organisational learning, maximising our utilisation of data and intelligence, including staff and service user feedback, external (e.g. regulatory) feedback, learning from national guidance and enquiries, patient safety information, clinical outcomes and population health metrics to support decision making and shared learning | There is a risk that the data quality and maturity is insufficient to provide meaningful intelligence to support organisational learning | Best Quality Care | SO1:1.2 SO5:5.5 SO6:6.2 SO6:6.3 | | Director of Nursing, Professions & Care Standards |

| M-12 Apr 2023 | M-11 May 2023 | M-10 Jun 2023 | M-9 Jul 2023 | M-8 Aug 2023 | M-7 Sep 2023 | M-6 Oct 2023 | M-5 Nov 2023 | M-4 Dec 2023 | M-3 Jan 2024 | M-2 Feb 2024 | M-1 Mar 2024 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4-3 (12) | 3-3 (9) | 3-3 (9) | 3-3 (9) | 3-2 (6) | | | | | | | | 3-2 (6) |

| | Cause of Risk | Impact / consequence of risk |
|---|---|---|
| | Data quality of our clinical systems can limit the information that is collected and can be used to scrutinise quality improvement. Capacity within quality governance teams to review and inspect in order to identify key intelligence is constrained and there are inconsistent links with forums to identify national learning<br><br>Media interest and coverage of poor quality care in some organisations has increased attention and awareness of closed cultures | Service fail to improve to their maximum extent and time is wasted 'reinventing the wheel', resulting in avoidable lapses in quality across the organisation.<br>Safety may become avoidably compromised with the attendant regulatory and reputational risks. Staff will become demoralised, impacting on the ability to provide a good working environment<br>If closed cultures aren't identified and addressed quality of care will deteriorate |

| | What controls are in place to manage the risk? | What gaps in controls are there? |
|---|---|---|
| Management of Risk | Robust governance of risk management processes and systems in place as part of the Risk Management Strategy<br>Integrated Governance Guide to support corporate governance and action in management of key committees and Board<br>Risk and compliance group<br>Embedded change in practice from patient safety incidents discussed at Patient Safety and Learning Group<br>Quality and Safety Committee<br>Mental Health Legislation Committee<br>Senior Leadership Team Meeting<br>Integrated performance report and committee dashboards – including mental health and community care group priorities<br>Daily Lean Management processes embedded<br>Bradford Leadership Management Programme<br><br>CRG has oversight of all organisational risks on a bi-monthly basis and any actions are implemented and monitored via QUOPS<br>The early implementation of the revised serious incident investigation processes and systems – moving to a systems based learning approach from RCA in line with national strategy | Agreed and adaptable methods for sharing learning from quality and safety activity that are informed and developed by service need<br><br>Controls in place – but continuous improvement ongoing to review the process and system for the Senior Leadership meetings, including workplans, to support Committees |

| | | Sources of Assurance | Gaps in Assurance |
|---|---|---|---|
| Assurance of effectiveness of controls | Level 1: Operational oversight | Monthly oversight of care group performance against waiting lists and other key performance and quality performance metrics reported to Senior Leadership Team (SLT) Meeting (Business Performance and Planning and Quality, Safety & Governance)<br>Process in place to report Category 4 Pressure Ulcers via STEIS where the SI criteria has been met monitored via MDCRG and 6 monthly report to QSC established<br>Process in place to report Category 4 Pressure Ulcers via STEIS where the SI criteria has been met monitored via MDCRG and 6 monthly report to QSC established<br>Stand alone duty of candour policy developed and ratified<br>Exploration of the application of professional curiosity now in standard ToR for PSII's<br>Duty of Candour articulated in templates<br>Governance process for following up actions from quality improvement programmes, serious incident investigations, complaints, staff network feedback and Go See visits established and feed into Quality Improvement plans, managed through QUOPS<br>Work to embed a professional curiosity approach within services is complete and the application of this will be a standard part of any incident response review | Establish a governance process for following up actions from quality improvement programmes, serious incident investigations, complaints, staff network feedback and Go See visits<br>A revision of the Quality Assurance Framework tool including quality statements is currently being undertaken |
| | Level 2: Reports / metrics overseen by Board / Committee | Report of Serious Incidents, Duty of Candour and Learning from Deaths summary provided to QSC on a monthly basis, with AAA escalation report to Board<br>Report of complaints activity to QSC on a monthly basis, with AAA escalation report to Board<br>Learning from Deaths and incidents reporting established for Quality and Safety Committee – quality data pack and reports from Care Groups<br>Mental Health Legislation Committee – oversees quality and improvement with regards to the Mental Health Act and Mental Capacity Act requirements<br>Compliance and Risk Group established with revised Terms of Reference which reports into Board | Scoping of reporting and oversight of internal core metrics and learning relating to complaints complete, developments needed to support embedded reporting |

| | | Monthly Quality dashboard to QUOPS and Committees<br>Monthly reporting of safer staffing levels to Board and relevant committees<br>Review of committees reporting structures complete to ensure correct assurance is being received and reviewed at the correct committees for the correct level of overview and scrutiny | |
|---|---|---|---|
| | **Level 3:**<br>Sources of external oversight / scrutiny | System Quality Committee established<br>Ethics Committee established<br>Feedback from CQC and the CCG on quality and learning<br>Established relationship with Coroner's office with Medical and Nursing Directors<br>Trust Strategy review to commence | **Level 3:** Establish joint training with Coroner's Office and progress discussions about the future direction of patient safety. Further embed and develop collaborative working.<br>Sustain strong relationships during changes within CQC inspection and relationship management |

| Mitigating Actions to address gaps in control and assurance | Nº | Actions | TARGET | Progress | COMPLETION |
|---|---|---|---|---|---|
| | 1 | Business continuity plans revised to establish key metrics and priorities for services including quality metrics | | These were reviewed by the board in March 2020 and October 2020 and continue to be reviewed via Quality and Operational Care group meetings and on a risk-based approach through Silver Command and SLT meetings. Review of SLT governance completed 25 June 2020. Complete | 25 June 2020 |
| | 2 | Key lines of enquiry and establishment of a quality assurance framework (QAF) | | Draft report published and out for consultation with the Board and Senior Leaders, self assessment against QAF due to be completed by end of June 2021. QAF dashboard developed, but population currently in progress therefore completion date moved to end of October 2021. Reviewed with General Managers November 2021. First pilot QAF undertaken 8 Feb 2022 and workplan in place. Complete | 08 Feb 2020 |
| | 3 | KPO support provided to teams to ensure care trust way is facilitated and RPIW re-commenced | | Re-established programme of work for RPIW and Care Trust Way Training. Complete monthly CTW guidance group re-established from Sept 2022 to drive programme forward | 27 Apr 2023 |
| | 4 | Review of the Trusts Risk appetite and tolerance | 31 May 2023 | Review underway – Board session complete October 2022 and January 2023.<br>Work to be progressed by 31/03/23 – delayed and conversations to be undertaken with Trust Secretary on way forward by 31/5/23 This is part of the full review of quality dashboard and reporting metrics to committee which is underway and will be approved in September 2023 | |
| | 5 | Review the BAF presentation and commentary received at Board | | BAF cover paper now includes specific reference to changes in risk scoring for approval at committees complete | 27 Apr 2023 |
| | 6 | Deliver enhanced quality assurance framework in response to recent media highlight on MH in-patient care | | Schedule of assurance visits undertaken to review safety and quality of inpatient services - complete | 27 Apr 2023 |
| | 7 | Regular night visit schedule to be developed to maintain the assurance visits | | Ongoing monitoring visit schedule to be presented to QSC once established | 27 Apr 2023 |
| | 8 | Patient Safety & Learning Group to be reviewed following Directorate re-structure | 31 Oct 2023 | Head of Quality Assurance appointed – HR process ongoing<br>PSLG revised ToR in progress<br>Update August 23 – PSLG ToR approved by Clinical Board and ratified at SLT. New arrangements to be in place from September.<br>Head of Quality Assurance commences 04/09/23<br>This item can now be closed | 22 August 23 |
| | | | | | |

| Risk appetite (key areas of risk to be considered when assessing management of risk from Financial risk; Regulatory risk; Quality risks; Reputational risks and People risks) | | | | | |
|---|---|---|---|---|---|
| | 0 - None | 1 - Minimal | 2 - Cautious | 3 - Open | 4 - Seek | 5 - Significant |
| Quality | We have no appetite for decisions that may have an uncertain impact on quality outcomes. | We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings. | We prefer risk avoidance. But, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. | We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation. | We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains. | We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement. |
| Reputation | We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation. | Our appetite for risk taking is limited to those events where there is no chance of significant repercussions. | We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout. | We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders. | We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks | We are comfortable taking decisions that may expose us to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes |

| Strategic Objective 3: Maximising the potential of services to deliver outstanding care to our communities | | | | | Lead Committee: Quality & Safety Committee<br>Executive Lead: Director of Nursing, Professions and Care Standards | | |

| In year ambition | | Key risk to achieving the ambition | | better lives, together | Links to other objectives | Linked operational risks (ref and brief descriptor) | | Lead Executive |
|---|---|---|---|---|---|---|---|---|
| 3.3 We will continue to maximise opportunities to learn from and embed best practice, including benchmarking ourselves against other high performing organisations, maximising opportunities to undertake research and put this into practice and engaging in local and national collaboratives with the intention of improving the care we deliver. | | There is a risk that operational pressures result in a lack of capacity to engage in and embed a culture of proactive learning across services | | Best Quality Care | SO4:4.4 | | | Director of Nursing, Professions & Care Standards |

| M-12<br>Apr 2023 | M-11<br>May 2023 | M-10<br>Jun 2023 | M-9<br>Jul 2023 | M-8<br>Aug 2023 | M-7<br>Sep 2023 | M-6<br>Oct 2023 | M-5<br>Nov 2023 | M-4<br>Dec 2023 | M-3<br>Jan 2024 | M-2<br>Feb 2024 | M-1<br>Mar 2024 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4-3 (12) | 4-3 (12) | 4-3 (12) | 4-3 (12) | 4-3 (12) | | | | | | | | 3-2 (6) |

| Management of Risk | Cause of Risk | Impact / consequence of risk |
|---|---|---|
| | Continues pressures due to capacity and demand limit the availability of clinical staff to engage in proactive learning. | Learning is not widely disseminated, and a culture of 'blame' is able to persist as a result of this lack of shift in culture |
| | **What controls are in place to manage the risk?** | **What gaps in controls are there?** |
| | participation in the 'Learn Together' PSII research study<br>system approach to learning from safety events embedded in investigative processes<br>membership of, and engagement with, local (Place) patient safety networks, Y&H Safety Collaboratives, National MH PS Collaborative and National Patient Safety Specialists programme to maximise opportunities to share best practice and improvement initiatives | |

| Assurance of effectiveness of controls | | Sources of Assurance | Gaps in Assurance |
|---|---|---|---|
| | Level 1:<br>Operational oversight | Learning from deaths, incidents and complaints process established with weekly Mortality and Duty of Candour meetings established.<br>Mortality and DoC improvement post in Place October 2022<br>Complaints Assurance and Review Panel established (fortnightly)<br>Monthly complaints report to Board developed<br>Patient Safety Specialist working group as a Place based approach<br>Human Factors training for clinical managers commissioned and produced<br>Learning site live with links to Patient Safety Strategy and PSIRF.<br>NHSE Patient Safety training modules established on ESR<br>Network of Patient Safety Allies (PS strategy goal) established | Expansion of Learning site ongoing and embedding wider use<br><br>Provision of PSIRF specific training (as per NHSE framework requirements) not yet funded/in place |
| | Level 2:<br>Reports / metrics overseen by Board / Committee | Weekly Executive Patient Safety Approval panel and joint learning events attended by Senior Leadership and Executives<br>Key quality and safety issues discussed at exec to exec meetings (LA, other NHS providers)<br>Revision of investigation quality standards in progress<br>Patient Safety and Learning Group established – reports into Quality & Safety Committee<br>Reporting Framework for Serious Incident investigations and patient safety and learning continues to be revised in light of changes to internal standards<br>Implementation Group established for the transition to PSIRF<br>BDCFT Patient Safety Strategy published | Controls in place – but continuous improvement ongoing to review the process and systems for how joint learning events are held, how deep dive explorations are developed,<br><br>PSIRF Implementation plans underway, gaps will remain until full transition to new framework complete and tested |
| | Level 3:<br>Sources of external oversight / scrutiny | Patient safety collaboratives<br>Learning from deaths workstream at System Quality Committee<br>Review of joint programmes of learning and quality dashboards<br>Quality Summits – share learning from incidents involving acute providers<br>Joint reporting<br>Feedback from CQC and CCG on learning<br>LfD audit report 2022 – significant assurance | Network of Patient Safety Partners to be established and recruited at Place – current challenges in recruiting<br>No movement on this – ICB lead to discuss at SQC |

| Mitigating Actions to address gaps in control and assurance | Nº | Actions | TARGET | Progress | COMPLETION |
|---|---|---|---|---|---|
| | 1 | Agree programme of delivery on Human Factors training for staff and Board Members to support E-Learning already available | 31 Oct 2023 | Review underway in line with all training requirements under the PSIRF implementation project Paper proposing PSIRF training requirements (with mandatory requests) to be presented to SLT May 2023<br>Human factors specific training superseded by PSIRF training<br>Update August 23 – PSIRF training (non mandatory) available on ESR. Programme of mandatory / non mandatory training being worked through as part of PSRIF implementation plan. Additional discussions ongoing with MH provider collaborative in relation to sourcing training provision across the collaborative. | |

| | | | | | |
|---|---|---|---|---|---|
| | 2 | Develop network of Patient Safety Allies to support the Patient Safety Lead and PSLG workplan | | work ongoing with peer organisation review of safety champion models. Comms and launch of PS alliance for PS Ally's (champions) complete September 2022. A network of 54 Ally's now recruited – management of network business as usual, with plans to provide training and sessions to support them in championing patient safety. | 27 Apr 2023 |
| | 3 | Progress the preparation for PSIRF through the Implementation Group and develop transition plan for National framework publication | 31 Dec 2023 | implementation group established. PSIRF published 16 August 2022<br>PSIRF implementation Task and finish groups established and commenced<br>data analysis complete – next step to review and create the BDCFT safety profile for informing the PSIRP<br>Update August 23 – PSIRP has been developed in draft and to be presented to committee /Board for approval. Paper on PSIRF progress and the PSIRP will be presented September 2023. Potential sign off plans November 2023 with transition end 2023/early 2024 dependent on internal and ICB/Place based transition plan. | |
| | 4 | Work with Place based Patient Safety Specialists, and internal partners to progress the development of the Patient Safety Partner role | tbc | model discussed at PSS meetings current challenges in recruiting via ICB<br>a/w update from SQC conversation with ICB<br>August – ICB continues to pursue recruitment, currently looking at voluntary sector partner options | |
| | 5 | LfD action plan – minor recommendations made | | all actions now complete, new Mortality and DoC improvement post successfully recruited to | 27 Apr 2023 |
| | 6 | Prepare organisation systems for transition from NRLS to LFPSE | 26 September 2023 | Risk Management team engaged in national discussions and testing plans.<br>All components of configuring Safeguard for transition complete or on track for deadlines.<br>Transition to LFPSE will go live 26 September 2023.<br>Plan for comms and training in place. | |

**Risk appetite (key areas of risk to be considered when assessing management of risk from Financial risk; Regulatory risk; Quality risks; Reputational risks and People risks)**

| | 0 - None | 1 - Minimal | 2 - Cautious | 3 - Open | 4 - Seek | 5 - Significant |
|---|---|---|---|---|---|---|
| Quality | We have no appetite for decisions that may have an uncertain impact on quality outcomes. | We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings. | We prefer risk avoidance. But, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. | We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation. | We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains. | We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement. |
| Reputation | We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation. | Our appetite for risk taking is limited to those events where there is no chance of significant repercussions. | We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout. | We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders. | We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks | We are comfortable taking decisions that may expose us to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes |

| Strategic Objective 3: Maximising the potential of services to deliver outstanding care to our communities | Lead Committee: Quality & Safety Committee |
| | Executive Lead: Director of Nursing, Professions and Care Standards |

| In year ambition | Key risk to achieving the ambition | better lives, together | Links to other objectives | Linked operational risks (ref and brief descriptor) | Lead Executive |
|---|---|---|---|---|---|
| 3.4 Recognising the increased demand for services, we will work with our communities to understand the support people need to prevent further harm whilst waiting for services and to deliver this in partnership with organisations across 'place'. | There is a risk that there is an insufficient offer across place to prevent harm for people waiting for services | Best Quality Care | SO1:1.1 SO1:1.2 SO4:4.1 SO4:4.3 | | Chief Operating Officer |

| M-12 Apr 2023 | M-11 May 2023 | M-10 Jun 2023 | M-9 Jul 2023 | M-8 Aug 2023 | M-7 Sep 2023 | M-6 Oct 2023 | M-5 Nov 2023 | M-4 Dec 2023 | M-3 Jan 2024 | M-2 Feb 2024 | M-1 Mar 2024 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4-4(16) | 4-4(16) | 4-4(16) | 4-4(16) | 4-4(16) | | | | | | | | 3-4 (12) |

| Cause of Risk | Impact / consequence of risk |
|---|---|
| Failure to respond to the increased demand for services following the Covid-19 pandemic including increased acuity. Services have reported demand has doubled in many areas compounded by staff recruitment and retention challenges. | Quality and wellbeing of services users.<br><br>Receiving timely access to right care and support.<br><br>Impact on staff wellbeing |

| Management of Risk | What controls are in place to manage the risk? | What gaps in controls are there? |
|---|---|---|
| | Robust Covid – 19 reporting and monitoring across all services<br>The Trust has enhanced the governance arrangements in place for emergency planning including updated on call arrangements.<br>Services recovery planning including demand and capacity, review of all waiting lists and QIA completed.<br>Risk and compliance group<br>Quality and Safety Committee<br>Senior Leadership Team Meeting<br>Integrated performance report and committee dashboards – including mental health and community care group priorities<br>Daily Lean Management processes embedded<br>Care Trust Way (CTW) Accountability and Guiding Group overseeing embedding of the quality improvement methodology, and delivery of training<br>Business continuity plans – prioritise activity & redeployment<br>Monitoring of 'deferred' activity<br>Clinical assessment of need of those awaiting intervention/support, accompanied by standardised approach (by service) to prioritisation where appropriate<br>Communication to individuals regarding waits for support to include how to seek support should their situation change, signposting to appropriate support services, support that can be offered whilst waiting<br>Standardized approach to maintaining contact to those waiting<br>Identification and mobilisation of waiting list initiatives to include outsourcing, commissioned support whilst waiting (VCSE led)<br>Recruitment and retention – revising skill mix and models of delivery, recruiting and retaining staff in the right number and skills and competence to reduce waits<br>Transforming services to deliver differently across a transformed workforce – links to all strategic programmes<br>Digitally enabling the workforce and clinical pathways to increase capacity and deliver effectively<br>Recovery programmes established to support the management of waiting lists – actions in place to support service users/patients on current waiting lists<br>EQIA process established to ensure that any impacts (positive or negative) are considered in any operational and transformational service changes. | Capacity to address long waits due to demands on workforce and increasing numbers of referrals |

| Assurance of effectiveness of controls | Sources of Assurance | | Gaps in Assurance |
|---|---|---|---|
| | Level 1: Operational oversight | Monthly oversight of care group performance against waiting lists and other key performance and quality performance metrics reported to Senior Leadership Team (SLT) Meetings<br><br>A Review of the oversight and assurance structures overseeing performance has been undertaken with a refreshed accountability structure now in place. This is supported by the Triumvirate leadership model and corporate business partners.<br><br>Rapid improvement events led by the KPO office to enhance system development - feedback to Care Group Quality & Operational Meetings and SLT on progress and impact.<br><br>Daily lean management – monitoring & responding to emerging fluctuations. | • Lack of reporting/visibility of inequalities in access and waits – focus for 23/24 around service level data and intelligence to understand inequalities in access and waits for service, to inform service change and tackle where inequalities exist. |

| | **Level 2:** Reports / metrics overseen by Board / Committee | Quality and Safety Committee – quality data pack and reports from Care Groups. Compliance and Risk Group established with revised Terms of Reference which reports into Board.<br><br>Board receives updates on the implementation of the Care Trust way in line with reporting on other strategic enabling programmes.<br><br>Monthly Quality dashboard to QUOPS and Committees. - A Review of the oversight and assurance structures overseeing performance has been undertaken with a refreshed accountability structure now in place aligning to committee structures and Board. This is supported by the Triumvirate leadership model and corporate business partners.<br><br>Monthly reporting of safer staffing levels to Board and relevant committees.<br><br>Integrated performance report to Board.<br><br>Robust review of waiting lists as part of mental health and community planned recovery plans complete and to be discussed at EMT 31/08/22 then present at QSC and Board – planned bi annual report on waits within services to be added to the workplan for QSC and into Board for 23/24.<br><br>Reporting of progress and impact of strategic programmes reporting into Board and appropriate committees | • Lack of reporting/visibility of any inequalities in access and waits. – focus for 23/24 around service level data and intelligence to understand inequalities in access and waits for service, to inform service change and tackle where inequalities exist.<br><br>• Lack of visibility of internal waits for Allied Health Professionals and Psychological therapies<br><br>• Robust performance metrics from Rapid improvement events led by the KPO office to enhance system development require developing for QSC/Board<br><br>• Performance Dashboard not reflective of all activity – review underway |
|---|---|---|---|
| | **Level 3:** Sources of external oversight / scrutiny | System Quality Committee established.<br><br>Bradford and Craven Finance and Performance Committee – access, waiting lists and waiting times.<br><br>NHSE/BDCFT review of out of are placements complete August 2022 | Lack of reporting/visibility of any inequalities in access and waits. |

| Mitigating Actions to address gaps in control and assurance | Nº | Actions | TARGET | Progress | COMPLETION |
|---|---|---|---|---|---|
| | 1 | Strategic Programmes and workstreams to link to operational planning for 23/24 to ensure alignment to actions addressing waits and managing future modelled demand to include focus on reducing inequalities in access | 31 Aug 2023 31 Dec 2023 (revised) | Strategic Programmes underway with revised oversight, governance and reporting now commenced. All strategic programmes have addressing inequalities as a core benefit and outcome. Action remains open until dashboards have matured to a point to provide consistent data and intelligence. | |
| | 2 | Expansion of health inequalities data (e.g. ethnicity, deprivation, gender) for core metrics including access and waits to support services in understanding service access inequalities and then establish priority areas and associated actions as part of operational planning 23/24 and linked to strategic programmes. | 31 Aug 2023 31 Dec 2023 (revised) | Workforce plans in development – supported by HR workforce planning role. Business case progressing for provision of better software to support consistent data and intelligence | |
| | 3 | Quality Improvement Initiatives both internal and external to be utilised to support addressing waits and delivering future models to address demand; to include Royal College of Psychiatry national initiative commencing January 23 | 31 Aug 2023 31 Dec 2023 (revised) | Deputy Director for Integration and Change now in post to support delivery of transformation and create greater opportunities for integration and system innovation<br>Service recovery plans for services with waiting list are being completed including having QIA completed and will be a priority for delivery within Operational plan 23/24<br>Royal College of Psychiatry initiative commenced and is an 18 month programme therefore target date removed to reflect. | |
| | 4 | Scoping opportunities to deliver services across place or WY footprint where it improves outcomes and waits for individuals | 31 Dec 2023 | Data dashboards and oversight of waits continues to develop to include work with external consultancy company to look at modelling tools within MH Inpatients & 0-19 services | |
| | 5 | Development of robust of long term workforce plans to include recruitment, retention & wellbeing aligned to operational plans and strategic programmes | 31 Dec 2023 | Improvement trajectories on target to reduce waits within psychological therapies by March 23 WY | |
| | 6 | Community Mental Health Transformation Programme underway | 31 Dec 2023 | Partnership delivery model designed and now being mobilised to deliver Adult Autism Assessment and Diagnosis in partnership with SWYFT to reduce waits to target trajectory by July 2023 | |

**Risk appetite (key areas of risk to be considered when assessing management of risk from Financial risk; Regulatory risk; Quality risks; Reputational risks and People risks)**

| | 0 - None | 1 - Minimal | 2 - Cautious | 3 - Open | 4 - Seek | 5 - Significant |
|---|---|---|---|---|---|---|
| Quality | We have no appetite for decisions that may have an uncertain impact on quality outcomes. | We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings. | We prefer risk avoidance. But, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. | We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation. | We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains. | We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement. |
| Reputation | We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation. | Our appetite for risk taking is limited to those events where there is no chance of significant repercussions. | We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout. | We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders. | We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks | We are comfortable taking decisions that may expose us to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes |

| Strategic Objective 4: Collaborating to drive innovation and transformation, enabling us to deliver against local and national ambitions | | | | | Lead Committee: Board of Directors | |
|---|---|---|---|---|---|---|
| | | | | | Executive Lead: Director of Integration & Transformation | |

| In year ambition | | Key risk to achieving the ambition | better lives, together | Links to other objectives | Linked operational risks (ref and brief descriptor) | Lead Executive |
|---|---|---|---|---|---|---|
| 4.1 We will work across place and ICS to support a sustainable workforce by creating new roles and opportunities across pathways in partnership with other health and social care organisations | | Effective partnerships founded on strong relationships are the key to successful collaboration. There is a risk that without sufficient capacity to develop strong relationships, differences in the maturity of partnerships may result in lack of shared purpose, lack of clarity of communication and a misalignment of priorities. | Best Place to Work | SO2:2.3 | | Director of Integration / Chief People Officer |
| 4.2 We will work with partners across the Bradford and Craven place to develop and embed a culture of continuous improvement, supported by recognised quality improvement methodologies, across all our care pathways. We will use this approach to contribute to the emerging CQC assurance process for integrated care systems and places. | | | Best Quality Care | SO3:3.1 SO3:3.2 SO3:3.3 | | Medical Director |
| 4.3 We will continue to transform our services from the perspective of Community Partnerships and/or early help and prevention in localities. We will do this in collaboration with partners at place / ICS to reduce health inequalities and build community resilience in line with local and national strategies. | | | Healthy as Possible | SO1:1.2; SO2:2.3 SO3:3.1; SO3:3.2 SO3:3.3 ;SO3:3.4 | | Director of Integration |
| 4.4 We will proactively seek opportunities to lead, collaborate and learn in order to support the embedding of system leadership behaviours across place bringing place partners together, sharing insights and national best practice, listening to people's voices and promoting Act as One. | | | Best Quality Care | | | Director of Integration (and All) |

| M-12 Apr 2023 | M-11 May 2023 | M-10 Jun 2023 | M-9 Jul 2023 | M-8 Aug 2023 | M-7 Sep 2023 | M-6 Oct 2023 | M-5 Nov 2023 | M-4 Dec 2023 | M-3 Jan 2024 | M-2 Feb 2024 | M-1 Mar 2024 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3-3 (9) | 3-3 (9) | 3-3 (9) | 3-3 (9) | 3-3 (9) | | | | | | | | 3-2 (6) |

| | | Cause of Risk | Impact / consequence of risk |
|---|---|---|---|
| | | Failure to invest appropriately in strategic relationships or in system transformation programmes. This is investment both in terms of specific posts to lead projects and programmes but also investment of our staff and manager's time in these programmes to build on-going ownership and partnerships. | Our workforce and those of our partners will not be invested in the success of system transformation programmes and patients and their families will not benefit from these. |
| | | Lack of strategic and operational discussion and agreement on shared priorities between partners leads to unequal investment of time and resources. | Partners will start to question the partnership arrangements and equity of investment, leading to delays in progress, cessation of programmes or failure to imbed these as 'business as usual'. |
| | | Delays to the redistribution of system staff to the newly agreed system priorities, including mental health transformation and community health and care integration leads to programme delays | The initiation of formal programmes of work may be delayed until partnership staffing issues are resolved appropriately using HR policies and procedures |
| | | Failures of leadership elsewhere in the system impact progress and relationships on specific shared programmes. | Relationships and shared endeavours will be damaged to the detriment of patients and the public. |
| | | Failure to embed and model the values and behaviours of the Trust consistently and create confidence in speaking up culture and processes. | The Trust's reputation will be compromised impacting on recruitment and retention. |
| | | Failure to achieve planned financial savings associated with transformation | Overspend for the Trust requiring mitigation elsewhere |

| Management of Risk | | What controls are in place to manage the risk? | What gaps in controls are there? |
|---|---|---|---|
| | | Joint Director of Integration post with the local authority, linked to the wider system partnership Deputy Director of Integration and Transformation overseeing programme and managing partnership commissioners Healthy Minds and Healthy Communities Partnership Boards to oversee our key system priorities Place based partnership meetings, forums, committees and boards Regular programme and project level meetings between participating partners Documented programme and project plans and strategic priorities agreed by partners Planned organisational development approach with front-line teams and managers Financial plans now integrated with transformation plans – with the links understood | Healthy Minds Strategy to be formally signed off by Partnership Board in November 2023 Ensure communications in place to keep ALL system partners appraised of progress Section 75 funding agreements – two-year plan agreed to renew between the council and NHS partners Need a baseline of business processes, metrics and protocols to change-manage from |

| Assurance of effectiveness of controls | | | Sources of Assurance | Gaps in Assurance |
|---|---|---|---|---|
| | Level 1: Operational oversight | | AGG Groups Project and programme documentation Involvement in all system boards and committees Ops and transformation senior management meetings Regular reporting into Trust EMT including budget savings discussions Good links with other strategic priority transformation senior responsible officers | Overall Trust transformation strategy soon to be agreed – direction of travel understood Dependencies between programmes not yet fully mapped, but progressing well |
| | Level 2: Reports / metrics overseen by Board / Committee | | Strategic transformation work overseen by Trust Board Healthy Minds and Healthy Communities Partnership Board in the wider partnership Programme docs to be owned by Deputy Director of Integration and Transformation Joint outcome measure KPIs overseen by boards with support from Partnership performance staff Evaluation criteria developed for each agreed transformation project | Outcome measures and benefits are in final draft for agreement in October Transformation plan for community health now in development and PM in place from 5 Sept |

| | Level 3: Sources of external oversight / scrutiny | Narrative within Annual Report and Quality Report<br>Partnership oversight by relevant Partnership Boards and PLE<br>CQC narrative and inspection including system review<br>System Finance and Performance Committee | National assurance mechanism for ICS' not yet known | |
|---|---|---|---|---|

| Mitigating Actions to address gaps in control and assurance | Nº | Actions | TARGET | Progress | COMPLETION |
|---|---|---|---|---|---|
| | 1 | Section 75 arrangement being agreed by Wellbeing Board | Oct 2023 | Reports in final draft | |
| | 2 | Operational transformation meetings convened including wider system colleagues | Sept 2023 | Healthy Minds PB development day pencilled in for 1 Nov | |
| | 3 | Joint KPIs to be developed and agreed by the Partnership | Oct 2023 | | |
| | | | | | |

## Risk appetite (key areas of risk to be considered when assessing management of risk from Financial risk; Regulatory risk; Quality risks; Reputational risks and People risks)

| | 0 - None | 1 - Minimal | 2 - Cautious | 3 - Open | 4 - Seek | 5 - Significant |
|---|---|---|---|---|---|---|
| Quality | We have no appetite for decisions that may have an uncertain impact on quality outcomes. | We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings. | We prefer risk avoidance. But, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. | We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation. | We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains. | We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement. |
| Reputation | We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation. | Our appetite for risk taking is limited to those events where there is no chance of significant repercussions. | We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout. | We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders. | We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks | We are comfortable taking decisions that may expose us to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes |

| **Strategic Objective 5:** To make effective use of our resources to ensure services are environmentally and financially sustainable and resilient | **Lead Committee:** Finance, Business & Investment Committee<br>**Executive Lead:** Director of Finance, Estates and Contracting |
|---|---|

| In year ambition | Key risk to achieving the ambition | better lives, together | Links to other objectives | Linked operational risks (ref and brief descriptor) | Lead Executive |
|---|---|---|---|---|---|
| 5.1 We will maximise our internal and external opportunities for efficiency through transformation and reduction of waste to deliver against our in-year and longer term financial plans; working with operational services to manage and contain cost pressures and demand; working alongside partners across system and place to ensure delivery of services that are value for money and make best use of the 'ICS pound' | If we do not maximise our opportunities to make effective use of our resources this may result in regulatory interventions, reputational damage and impacts on quality of services | Best Quality Care | SO2:2.3<br>SO4:4.3<br>SO4:4.4<br>SO6:6.1 | 2553: Re-procurement of Wakefield 0-19 contract 5-5(15)<br>2672: Lynfield Mount Hospital Estate 4-5(20) | Director of Finance, Contracting and Estates |

| M-12<br>Apr 2023 | M-11<br>May 2023 | M-10<br>Jun 2023 | M-9<br>Jul 2023 | M-8<br>Aug 2023 | M-7<br>Sep 2023 | M-6<br>Oct 2023 | M-5<br>Nov 2023 | M-4<br>Dec 2023 | M-3<br>Jan 2024 | M-2<br>Feb 2024 | M-1<br>Mar 2024 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4-5 (20) | 4-5 (20) | 4-5 (20) | 4-5 (20) | 4-5 (20) | | | | | | | | 4-3(12) |

| Cause of Risk | Impact / consequence of risk |
|---|---|
| - Potential under-achievement of recurrent efficiency targets (at unprecedented high levels)<br>- Ongoing financial pressures and risks, especially in relation to:<br>  o Impact of COVID on IPC, and on volume and acuity of demand<br>  o Competing priorities across the PLACE and ICS<br>  o Shared system risk resulting from evolution of ICS governance and financial frameworks<br>  o Significant financial deficit plans across Place, ICS and England<br>  o Increasing political and economic uncertainty and likelihood of a return to public sector austerity<br>  o Out of area placements<br>  o Impact of workforce constraints on bank and agency spend and on out of area placements<br>  o Under-funding of pay awards<br>  o Potential procurement of 0 -19 service Bradford (in 2023)<br>  o Continued lack of strategic capital funding | - Regulatory intervention<br>- Merger with / acquisition by other organisations<br>- Adverse impact on the quality and range of services that the Trust can deliver<br>- Poorer mental and physical health outcomes for our population including risk of patient harm<br>- Adverse effect on staff wellbeing in turn exacerbating recruitment, retention and sickness issues<br>- Lack of resources to meet local and national targets<br>- Knock-on adverse impact on PLACE and ICS partners'<br>  o Financial performance<br>  o Performance targets<br>  o Health outcomes<br><br>- Inability to address serious failings in physical estate especially in relation to the proposed rebuild of Lynfield Mount Hospital, leading to significant ongoing financial pressures and quality concerns |

| | What controls are in place to manage the risk? | What gaps in controls are there? |
|---|---|---|
| **Management of Risk** | - 2023/24 Trust financial and operational plans in place<br>- Existing contracts<br>- Contract negotiations<br>- ICS and PLACE plans and agreed priorities<br>- Existing programme (Act as One, Strategic Programmes and CIP)<br>- Budget setting and monitoring processes in place<br>- Additional vacancy control and regulatory measures in place<br>- Contract performance management and reporting in place<br>- Workforce plans, controls, and monitoring in place<br>- Provider collaborative contracts agreed | - 5-year Trust financial plan (revenue and capital)<br>- Data and business intelligence quality improvements<br>-<br>- No identified alternative capital funding source for LMH since NHP programme rejection<br>- System wide agreements about equitable distribution of costs, e.g. between Local Authority and NHS<br>- Balanced financial plans across Place and ICS. |

| | | Sources of Assurance | Gaps in Assurance |
|---|---|---|---|
| **Assurance of effectiveness of controls** | **Level 1:**<br>Operational oversight | - EMT<br>- SLT<br>- Provider collaborative contract management groups<br>- CPIG<br>- QuOps<br>- AGG's<br>- Lynfield Mount Project Board | None currently |
| | **Level 2:**<br>Reports / metrics overseen by Board / Committee | - Board<br>- FBIC<br>- Workforce committee<br>- Audit committee<br>- Quality & Safety Committee<br>- Provider collaborative joint committees | None currently |

| | Level 3:<br>Sources of external oversight / scrutiny | - PLACE and ICS meetings<br>- Committees in common<br>- Response to regulatory intervention activity | | Evolving operating framework at PLACE/ICS | |
|---|---|---|---|---|---|
| **Mitigating Actions to address gaps in control and assurance** | **Nº** | **Actions** | **TARGET** | **Progress** | **COMPLETION** |
| | 1 | Finalise 2023/2024 financial plans | Original 31/03/23<br>Revised 04/05/23 | Completed March 2023 | 31/03/23 |
| | 2 | Approval of medium term financial plans | tbc | National timetable for medium term plans published; plans due Summer 2023, waiting for detailed guidance | |
| | 3 | Approval of detailed deliverables and implementation plans for all efficiency programmes | 80% complete 31/03/23 | High level plans c80% complete at March 2023 – work ongoing re detailed delivery plans | 80% complete 31/03/23 |
| | 4 | Implementation of community estates plan | ongoing | Final draft plan to FBIC in July 2022 and Shipley implementation sub-group established. Programme being re-phased with accelerated delivery plans. | |
| | 5 | Workforce strategy revised/approved | 31 July 2023 | Workforce Strategy reviewed and complete<br>Action superseded by full Trust strategy refresh – final strategy due for presentation to Board July 2023 | |
| | 6 | Roll out appointment/booking data quality tool across all relevant teams | Sept 2023 | Presented to FBIC November 2022; roll out to rest of Trust by Summer 2023. | |
| | 7 | Development of integrated reporting and planning tool | Feb 2023 | Q2 – Q4 Handover of proof of concept tool completed early Feb 2023. Next steps to operationalise the tool. | Feb 2023 |
| | 8 | Implementation of business partnering and corporate services review | March 2023 | Q2 – Q4 Interim business partnering solutions in place during 2023/24 planning round | March 2023 |
| | 9 | Update LMH outline business case and designs | Sept 2022 (preferred)<br>Alternative options May 2023 | Completed for preferred option. In parallel, work underway on "Plan B".<br>Alternative options identified and outline plans and costings completed | Sept 2022 (preferred)<br>31/5/23 |
| | 10 | submitted LMH NHP funding bid to DHSC | Sept 2022 | Complete | Sept 2022 |
| | 11 | Continued lobbying activity with external bodies, influencers and decision makers in relation to the Lynfield Mount Hospital Estate | ongoing | ongoing | ongoing |

| Risk appetite (key areas of risk to be considered when assessing management of risk from Financial risk; Regulatory risk; Quality risks; Reputational risks and People risks) | | | | | | |
|---|---|---|---|---|---|---|
| | 0 - None | 1 - Minimal | 2 - Cautious | 3 - Open | 4 - Seek | 5 - Significant |
| Financial | We have no appetite for decisions or actions that may result in financial loss. | We are only willing to accept the possibility of very limited financial risk.. | We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern. | We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor | We will invest for the best possible return and accept the possibility of increased financial risk. | We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks. |
| Regulatory | We have no appetite for decisions that may compromise compliance with statutory, regulatory or policy requirements. | We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential. | We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision | We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully | We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks | We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders. |

| Strategic Objective 5: To make effective use of our resources to ensure services are environmentally and financially sustainable and resilient | | | | Lead Committee: Finance, Business & Investment Committee<br>Executive Lead: Director of Finance, Estates and Contracting | | |
|---|---|---|---|---|---|---|
| **In year ambition** | | **Key risk to achieving the ambition** | better lives, together | Links to other objectives | **Linked operational risks (ref and brief descriptor)** | **Lead Executive** |
| 5.2 We will embed environmental sustainability in everything we do to support the delivery of our Green Plan targets and ultimate ambition to be a carbon net zero organisation | | If we do not maximise our opportunities to make effective use of our resources this may result in significant negative impact on our finances, quality of estates, wellbeing of our population and workforce and reputational damage | Best Place to Work | SO6:6.1 | | Director of Finance, Contracting and Estates |

| M-12<br>Apr 2023 | M-11<br>May 2023 | M-10<br>Jun 2023 | M-9<br>Jul 2023 | M-8<br>Aug 2023 | M-7<br>Sep 2023 | M-6<br>Oct 2023 | M-5<br>Nov 2023 | M-4<br>Dec 2023 | M-3<br>Jan 2024 | M-2<br>Feb 2024 | M-1<br>Mar 2024 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4-5 (20) | 4-5 (20) | 4-5 (20) | 4-5 (20) | 4-5 (20) | | | | | | | | 2-2(4) |

| | **Cause of Risk** | **Impact / consequence of risk** |
|---|---|---|
| | - Potential under achievement of internal carbon reduction targets making it harder to meet NHSE targets as detailed in the Green Plan.<br>- Potential to not complete environmental requirements of the NHS Standard Contract (which are transposed into the Green Plan).<br>- Impact of Covid and IPC requirements to reduce our environmental impacts, e.g. increased ventilation & heating use, volume of PPE, restrictions on car-sharing.<br>- Competing priorities across the PLACE and ICS<br>- Lack of resource to achieve the targets | - Adverse impact on the environment<br>- Lack of resources to meet local and national targets<br>- Adverse impact on ICS partners' and delivery of the ICS Green Plan<br>- Increase in consumption of gas and electricity to ventilate and heat buildings. Larger utility bills<br>- Realistic estimates of reduction will not help to achieve our goals, meaning more radical intervention will be needed, which will challenge the status quo. |

| | **What controls are in place to manage the risk?** | **What gaps in controls are there?** |
|---|---|---|
| **Management of Risk** | - Green Plan approved by Board and regularly reviewed<br>- Heat decarbonisation review completed, actions to be progressed<br>- Carbon Literacy training available to all staff – completed by majority of SLT<br>- Sustainability team action planning<br>- Community Estates Review<br>- TWICS and KPO projects (sustainable quality improvement)<br>- Carbon Reduction Plan in place | - Completion of Heat Decarbonisation actions<br>- Take up of carbon literacy or internal green champion training has been low in clinical teams and Board members (expect to be due to conflicting demands and time pressure rather than lack of interest).<br>- Lack of clinical resource/support to embed green agenda<br><br>July update: some stalling to overall ambition due to:<br>• Lack of capital investment<br>• Delays to Smarter Spaces<br>• Slow progress on heat decarbonisation<br>• Slow progress on transformational projects in embedding environmental sustainability within services and communicating the importance. |

| | | **Sources of Assurance** | **Gaps in Assurance** |
|---|---|---|---|
| **Assurance of effectiveness of controls** | **Level 1:** Operational oversight | - SLT<br>- Facilities Management Team | None currently |
| | **Level 2:** Reports / metrics overseen by Board / Committee | - Board<br>- FBIC<br>- Green Strategy Group | None currently |
| | **Level 3:** Sources of external oversight / scrutiny | - ICS operational climate change meetings<br>- ICS Sustainable Procurement Group meetings | Embryonic ICS team |

| Mitigating Actions to address gaps in control and assurance | Nº | Actions | TARGET | Progress | COMPLETION |
|---|---|---|---|---|---|
| | 1 | Annual review of Green Plan | Mar 2023 | Completed March 2022 – next review due by March 2023 | Mar 2023 |
| | 2 | Finalise carbon reduction plan | Aug 2022 | Completed in August 2022 | Aug 2022 |
| | 3 | 100 staff members complete Carbon Literacy training | Mar 2023 | Complete by March 2023 | tbc |
| | 4 | The Community Estates Strategy (reduction in footprint) with progress as "5 year plan 2022-2027" | tbc | Annual progress as per the 5-year plan | |
| | 5 | Director of Finance to lobby Board members to take up carbon literacy training | Feb 2023 | NED training session planned 8 June 2023 | |

| | | | | Executive Directors completed carbon literacy training with the exception of two new Board members who will be offered this in June/July 2023 <br> July update: NED training (with 4 of 8) completed – to support questions about embedding sustainability in the different forums NED's participate in. | |
|---|---|---|---|---|---|
| | 6 | Green Strategy Group to work up options for wider training programme including potential mandatory modules | tbc | Carbon literacy (2 hour) training module (2 hour) developed and ready to deliver to wider audience (than just execs) audience once dates set <br> Paper to support training as mandatory presented to Clinical Board December 2022 | |

### Risk appetite (key areas of risk to be considered when assessing management of risk from Financial risk; Regulatory risk; Quality risks; Reputational risks and People risks)

| | 0 - None | 1 - Minimal | 2 - Cautious | 3 - Open | 4 - Seek | 5 - Significant |
|---|---|---|---|---|---|---|
| Financial | We have no appetite for decisions or actions that may result in financial loss. | We are only willing to accept the possibility of very limited financial risk.. | We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern. | We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor | We will invest for the best possible return and accept the possibility of increased financial risk. | We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks. |
| Regulatory | We have no appetite for decisions that may compromise compliance with statutory, regulatory or policy requirements. | We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential. | We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision | We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully | We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks | We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders. |

| Strategic Objective 6: To make progress in implementing our digital strategy to support our ambition to become a digital leader in the NHS | | | | | Lead Committee: Finance Business & Investment | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Executive Lead: Chief Information Officer | | | | | | | |

| In year ambition | | | | Key risk to achieving the ambition | | | better lives, together | Links to other objectives | Linked operational risks (ref and brief descriptor) | | | Lead Executive |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **6.1 Data & Analytics:**<br><br>1. To provide high quality data that is understood and can be confidently used and shared to support care delivery across our Place and the West Yorkshire Region.<br><br>2. Use the same high-quality data to deliver self-service analytics and capabilities that are tailored to user roles and support decision making, performance management, quality improvement and a better understanding of our population. | | | | Data quality is a key enabler to support the Trust towards improved decision making, performance management and quality improvement. The primary risk for data and analytics services is to ensure that the continued collaboration with the Trusts clinical and business stakeholders is maintained to drive effective and scalable data quality initiatives forward.<br><br>There is also a degree of dependency in relation to SO6:6.2 Clinical systems Transformation | | | Best Quality Care | SO3:3.2<br>SO5:5.1<br>SO6:6.2 | To be identified | | | Chief Information Officer |

| M-12<br>Apr 2023 | M-11<br>May 2023 | M-10<br>Jun 2023 | M-9<br>Jul 2023 | M-8<br>Aug 2023 | M-7<br>Sep 2023 | M-6<br>Oct 2023 | M-5<br>Nov 2023 | M-4<br>Dec 2023 | M-3<br>Jan 2024 | M-2<br>Feb 2024 | M-1<br>Mar 2024 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4-3 (12) | 4-3 (12) | 4-3 (12) | 4-3 (12) | 4-3 (12) | | | | | | | | 4-2 (8) |

| | Cause of Risk | Impact / consequence of risk |
|---|---|---|
| **Management of Risk** | • Data entry: Inaccurate / completeness, due to staff shortages, workload, connectivity, rationale, purpose of data.<br>• Application limitations due to ineffective design and or in-built system capabilities<br>• Ability to record timely data in community to improve accuracy (application and process)<br>• Inconsistent pathway processes in conflict with existing system design<br>• Absence of an agreed data quality framework to support data quality maturity and oversight | • Potential for patient safety implications<br>• Financial / activity loss<br>• Inaccurate or incomplete data affecting optimal care provision<br>• Suboptimal service planning due to informational gaps<br>• Reputational risk<br>• Failure to meet professional GMC/NMC and IG obligations re record keeping, CQC |
| | **What controls are in place to manage the risk?** | **What gaps in controls are there?** |
| | • Training & support available at individual service level to enable accurate timely information recording.<br>• Identified Information Asset Owners (IAO's) | • Data quality framework (to be implemented)<br>• Visualisation of data quality have been progressed for a handful of services, not yet fully rolled out<br>• Specific data quality roles and accountability to be defined<br>• Disconnection between clinical processes system usage and training |

| Assurance of effectiveness of controls | | Sources of Assurance | Gaps in Assurance |
|---|---|---|---|
| | **Level 1:**<br>Operational oversight | • QUOPS Mental Health<br>• QUOPS Community Services<br>• SLT<br>• Digital and Data AGG | |
| | **Level 2:**<br>Reports / metrics overseen by Board / Committee | • EMT<br>• FBIC | |
| | **Level 3:**<br>Sources of external oversight / scrutiny | • Bi-lateral discussions between BDCFT and Local Authority Digital Teams | • Digital and Data not fully aligned at ICS levels |

| Mitigating Actions to address gaps in control and assurance | Nº | Actions | TARGET | Progress | COMPLETION |
|---|---|---|---|---|---|
| | 1 | To establish a task and finish group to define a work programme to deliver a data quality framework and approach. | 28 Feb 2023 | Data quality reports generated for five services. | 28 Feb 2023 |
| | | | | Initial identification of key data items requiring intervention (missing appointment status, missing contact method) | 25 Apr 2023 |
| | | | | New SIM devices laptop equipment to support contemporary data entry in the community 280+ rolled out to date | 25 Apr 2023 |
| | | | | Ongoing improvements to SystmOne across care groups<br>5 priority areas for 2023/24 and associated action plan on data quality presented to FBIC May 2023 | |

| Risk appetite (key areas of risk to be considered when assessing management of risk from Financial risk; Regulatory risk; Quality risks; Reputational risks and People risks) | | | | | | |
|---|---|---|---|---|---|---|
| | 0 - None | 1 - Minimal | 2 - Cautious | 3 - Open | 4 - Seek | 5 - Significant |
| Quality | We have no appetite for decisions that may have an uncertain impact on quality outcomes. | We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings. | We prefer risk avoidance. But, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. | We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation. | We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains. | We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement. |
| Reputation | We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation. | Our appetite for risk taking is limited to those events where there is no chance of significant repercussions. | We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout. | We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders. | We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks | We are comfortable taking decisions that may expose us to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes |

| **Strategic Objective 6:** To make progress in implementing our digital strategy to support our ambition to become a digital leader in the NHS | **Lead Committee:** Finance Business & Investment<br>**Executive Lead:** Chief Information Officer |
|---|---|

| **In year ambition** | **Key risk to achieving the ambition** | better lives, together | Links to other objectives | **Linked operational risks (ref and brief descriptor)** | **Lead Executive** |
|---|---|---|---|---|---|
| **6.2 Clinical Systems Transformation:**<br><br>1. To improve the overall user experience and maturity of the Trusts primary clinical information system (SystmOne)<br><br>2. To achieve the minimum digital foundations (MDF) as set out by the national standards for EPR maturity. | • Absence of a strategic and operational vision for SystmOne architecture design across care groups and services.<br><br>• Agreeing a framework for prioritisation and oversight (clinically led)<br>Ongoing investment | Best Quality Care Seamless Access | SO3:3.3<br>SO3:3.4<br>SO5:5.2 | | Chief Information Officer |

| M-12<br>Apr 2023 | M-11<br>May 2023 | M-10<br>Jun 2023 | M-9<br>Jul 2023 | M-8<br>Aug 2023 | M-7<br>Sep 2023 | M-6<br>Oct 2023 | M-5<br>Nov 2023 | M-4<br>Dec 2023 | M-3<br>Jan 2024 | M-2<br>Feb 2024 | M-1<br>Mar 2024 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4-3 (12) | 4-3 (12) | 4-3 (12) | 4-3 (12) | 4-3 (12) | | | | | | | | 4-2 (8) |

| | **Cause of Risk** | **Impact / consequence of risk** |
|---|---|---|
| | • SystmOne Community is over a decade old, and the overall design is reflective of this. Multiple services changes leading to inconsistent and inefficient system design, functionality, and capabilities, resulting in a poor user experience.<br><br>• SystmOne Mental Health is relativity new (4 years) and suffered from poor initial process design which has led to inconsistencies, duplication, deferring standards and ongoing ownership.<br><br>• Reliability of change management control has led to localised changes impacting on wider system functionality and standardisation.<br><br>• Availability and capacity of specialist roles to support system developments | • A further reduction in user confidence and morale that will have a direct impact on our ability to transform and delivery digitally enabled services.<br>• Patient safety and quality of care<br>• Reduced productivity<br>• Retention of staff (Clinical / Administrative and Developers) |

| **Management of Risk** | **What controls are in place to manage the risk?** | **What gaps in controls are there?** |
|---|---|---|
| | • Established Clinical Information Systems Governance Group<br>• Change Management process in place for system developments<br>• Identified Strategic Programmes across Mental Health and Community which require optimisation and transformational activities across SystmOne.<br>• National funding allocated to enable the minimum digital foundation to be delivered.<br>• A focus on data quality to help drive system improvements.<br>• | • Straightforward means for clinicians to identify clinical systems problems<br>• Development of more breadth in clinical information officers and liaison/champions<br>• Change management controls at a clinical level |

| **Assurance of effectiveness of controls** | | **Sources of Assurance** | **Gaps in Assurance** |
|---|---|---|---|
| | **Level 1:**<br>Operational oversight | • Technology Group<br>• SystmOne User Group<br>• Clinical Systems Governance Group<br>• Tasking and Sharing Steering Group<br>• Information Governance Group / Information Asset Owners Group<br>• Digital AGG | • Absence of a Clinical Safety Officer is impacting on ensuring that change will consider all the patient safety requirements. |
| | **Level 2:**<br>Reports / metrics overseen by Board / Committee | • SLT<br>• FBIC<br>• Digital Steering group | |
| | **Level 3:**<br>Sources of external oversight / scrutiny | • ActAsOne – active participation to the DSU, Development and Standards Unit | |

| **Mitigating Actions to address gaps in control and assurance** | Nº | **Actions** | **TARGET** | **Progress** | **COMPLETION** |
|---|---|---|---|---|---|
| | 1 | Review and agree the investment cases for CMHT and Community (Digital AGG January 2023) | 31 May 2023 | Engaged with an external SystmOne implementation partner to scope out the work programme for Mental Health Community Transformation. Not progressed - no further action. | 25 Apr 2023 |
| | | | | Key resources identified – affordability still to be determined - Completed | 25 Apr 2023 |
| | | | | Engaged with external consultancy to support unplanned and planned work across Community Services. In progress – due for completion 30 June 2023 | |
| | 2 | Prioritisation of systemone change activity with both care groups ongoing | 30 Apr 2023 | understanding priorities expected by 30/4/23 - ongoing | |

| | 3 | Recruit EPR transformation team through allocated NHSE national funding to support the deliver of minimum digital foundations across EPR | 30 Sep 2023 | Recruitment process commenced – campaign for release 6 June 2023 | |
| --- | --- | --- | --- | --- | --- |
| | | | | Initiated engagement work with key stakeholders with regards to the re procurement of the Trust EPR. Contract variation negotiations under consideration throughout June 2023 | |

| Risk appetite (key areas of risk to be considered when assessing management of risk from Financial risk; Regulatory risk; Quality risks; Reputational risks and People risks) | | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| | 0 - None | 1 - Minimal | 2 - Cautious | 3 - Open | 4 - Seek | 5 - Significant |
| Financial | We have no appetite for decisions or actions that may result in financial loss. | We are only willing to accept the possibility of very limited financial risk.. | We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern. | We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor | We will invest for the best possible return and accept the possibility of increased financial risk. | We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks. |
| Quality | We have no appetite for decisions that may have an uncertain impact on quality outcomes. | We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings. | We prefer risk avoidance. But, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. | We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation. | We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains. | We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement. |

| **Strategic Objective 6:** To make progress in implementing our digital strategy to support our ambition to become a digital leader in the NHS | **Lead Committee:** Finance Business & Investment<br>**Executive Lead:** Chief Information Officer |
|---|---|

| **In year ambition** | **Key risk to achieving the ambition** | better lives, together | Links to other objectives | **Linked operational risks (ref and brief descriptor)** | **Lead Executive** |
|---|---|---|---|---|---|
| **6.3 Patient Engagement & Digitally Enabled Care:**<br><br>To introduce inclusive digital solutions that empower people who use our services to care for themselves and to prevent ill health.<br><br>Develop a digital service offer where virtual care solutions operate seamlessly with face-to-face care in a way that is appropriate to the needs of people who use our services. | Failure to engage with services and service users in the design and adoption of potential digital service offers which may lead to increased health inequalities caused by inequity of access | Best Quality Care Seamless Access | SO3:3.3<br>SO3:3.4<br>SO5:5.2 | | Chief Information Officer |

| M-12<br>Apr 2023 | M-11<br>May 2023 | M-10<br>Jun 2023 | M-9<br>Jul 2023 | M-8<br>Aug 2023 | M-7<br>Sep 2023 | M-6<br>Oct 2023 | M-5<br>Nov 2023 | M-4<br>Dec 2023 | M-3<br>Jan 2024 | M-2<br>Feb 2024 | M-1<br>Mar 2024 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4-3 (12) | 4-3 (12) | 4-3 (12) | 4-3 (12) | 4-3 (12) | | | | | | | | 4-2 (8) |

| **Management of Risk** | **Cause of Risk** | **Impact / consequence of risk** |
|---|---|---|
| | • Defining the service delivery ambition and the need and placement for digital products and services<br>• Potential for digital fatigue and the need to resume pre pandemic service deliver models of care<br>• Potential for a clinical presence rather than patient need in the adoption of digital technologies to support care<br>• Population factors, variability in access to virtual care<br>• Design and investment may require external collaboration with ICP/ICS level | • Postcode lottery access to care<br>• Differential virtual offers for different services, within the Trust and within the wider community<br>• Inability to monitor long-term conditions in community, reduced wasted staff time, reduced traveling benefiting economic, environmental, wellbeing |

| | **What controls are in place to manage the risk?** | **What gaps in controls are there?** |
|---|---|---|
| | • The principle of User Centred Design<br>• Access to Patient and Involvement Partners<br>• Considerations around digital inclusion/exclusion at Act as One level<br>• Strategic Programmes and Operational priorities<br>Interim video-consultation solutions in place funded and managed regionally requiring extension or replacement | • Community based access/joint approaches with LA, CCG to enable access to virtual services<br>• Engagement with Voluntary sector organisations and their access to appropriate patient record systems<br>• No agreed common patient engagement platform(s) across healthcare and social care |

| **Assurance of effectiveness of controls** | **Sources of Assurance** | | **Gaps in Assurance** |
|---|---|---|---|
| | **Level 1:**<br>Operational oversight | • Digital AGG<br>• Digital Strategy Group | |
| | **Level 2:**<br>Reports / metrics overseen by Board / Committee | • Clinical Board<br>• SLT<br>• Innovation & Improvement Group<br>• FBIC | |
| | **Level 3:**<br>Sources of external oversight / scrutiny | • BD&C Digital Programme | No independent external scrutiny/oversight in place |

| **Mitigating Actions to address gaps in control and assurance** | Nº | **Actions** | **TARGET** | **Progress** | **COMPLETION** |
|---|---|---|---|---|---|
| | 1 | Patient Communication Project Initiation and Business Case (Q4) | 30 Sep 2023 | Supplier demonstration sessions and draft specification, original business case drafted to support Patient Communications ambition. In progress | |
| | 2 | A review to identify where digital enabled care is being utilised and where the opportunities exist. | 31 Dec 2023 | Video-consultation trial at Place level to support a solution post March 2023. – completed<br>Further year procured of video platform – complete<br>Review of overall need for digitally enabled service delivery - ongoing | |

| **Risk appetite (key areas of risk to be considered when assessing management of risk from Financial risk; Regulatory risk; Quality risks; Reputational risks and People risks)** | | | | | | |
|---|---|---|---|---|---|---|
| | 0 - None | 1 - Minimal | 2 - Cautious | 3 - Open | 4 - Seek | 5 - Significant |
| People | We have no appetite for decisions that could have a negative impact on our workforce development, recruitment / retention. Sustainability is our primary interest. | We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to recruitment and retention are not a priority and will only be adopted if | We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where | We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for | We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve their skills /capabilities. We recognize | We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change. |

| | | established and proven to be effective elsewhere. | similar actions had been successful elsewhere before taking any decision. | improved recruitment and retention, and developmental opportunities for staff. | innovation is likely to cause short term disruption with the possibility of long-term gains | |
|---|---|---|---|---|---|---|
| Quality | We have no appetite for decisions that may have an uncertain impact on quality outcomes. | We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings. | We prefer risk avoidance. But, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. | We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation. | We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains. | We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement. |

| **Strategic Objective 6:** To make progress in implementing our digital strategy to support our ambition to become a digital leader in the NHS | **Lead Committee:** Finance Business & Investment  **Executive Lead: C**hief Information Officer |
|---|---|

| **In year ambition** | **Key risk to achieving the ambition** | better lives, together | Links to other objectives | Linked operational risks (ref and brief descriptor) | Lead Executive |
|---|---|---|---|---|---|
| **6.4 Digital Workforce/Workplace:** (Employee Experience)<br><br>a) To create a competent digital workforce (organisational level) by developing digital skills training, embedding the use of digital champions, and planning long term education strategies, such as Topol Review and supporting the Workforce strategy<br>b) To provide the tools and capabilities to support a digital workplace and workforce requirements<br>c) To harness develop and retain a digital and data workforce to support the organisation | Failure to engage with staff may result in the training and education needs or the workforce being misunderstood, leading to barriers to digital literacy and capability.<br><br>Absence of sufficient financial investment to support our digital workforce, workplace ambitions. | Best Place to Work<br>Best Quality Care | SO4:4.1 | | Chief Information Officer |

| M-12 Apr 2023 | M-11 May 2023 | M-10 Jun 2023 | M-9 Jul 2023 | M-8 Aug 2023 | M-7 Sep 2023 | M-6 Oct 2023 | M-5 Nov 2023 | M-4 Dec 2023 | M-3 Jan 2024 | M-2 Feb 2024 | M-1 Mar 2024 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4-3 (12) | 4-3 (12) | 4-3 (12) | 4-3 (12) | 4-3 (12) | | | | | | | | 4-2 (8) |

| | **Cause of Risk** | **Impact / consequence of risk** |
|---|---|---|
| | • Staff reluctant to make time for non-mandatory training due to pressure of workload<br>• Failure to communicate relevance of improving digital skills- real-world skills, recognised transferable qualifications?<br>• Variation in uptake by different staff groups, variation in needs of each.<br>• Appropriate levels of investment to support digital services and staff development and retention<br>• Low uptake of automation technologies | • Unable to meet our vision for digitally enabled services<br>• Low digital skills maturity may impact on best place to work and associated recruitment and retention<br>• Reduced productivity and efficiency gains. |
| **Management of Risk** | **What controls are in place to manage the risk?**<br>• The objectives and deliverables of this ambition are linked to the Digital AGG, Digital Strategy Group and Workforce Strategy<br>• Continued expansion of digital training offering for all staff<br>• Digital & Data Staff, British Computer Society Membership<br>• Improved Digital Service Support (Hornbill) and further adoption/expansion to other services | **What gaps in controls are there?**<br>• Identification and enrolment of Digital champions<br>• Staff recruitment processes and job descriptions to support Digital skills requirements<br>• Office365 Group – Agile group with no formal Terms of Reference but ensure engagement of interested parties on common Office365 concerns/configurations/usage<br>• Connect Group no longer formally meeting since transfer to new Office365 platform, but on-going improvement managed within Business as Usual and Continuous Improvement processes<br>• Digital Skills workstream not fully established, may also focus on Digital staff rather than digital skills of staff within organisations |

| **Assurance of effectiveness of controls** | | **Sources of Assurance** | **Gaps in Assurance** |
|---|---|---|---|
| | **Level 1:** Operational oversight | • Office365 Group<br>• Connect Group<br>• Technology Group<br>• Smarter Working / Smarter Places Programme | |
| | **Level 2:** Reports / metrics overseen by Board / Committee | • Digital Strategy Group<br>• Digital AGG | • Further HR and OD involvement may help strengthen the engagement from recruitment to on-boarding |
| | **Level 3:** Sources of external oversight / scrutiny | TBC | |

| **Mitigating Actions to address gaps in control and assurance** | Nº | Actions | TARGET | Progress | COMPLETION |
|---|---|---|---|---|---|
| | 1 | HR reviewing the new starter process – Perfect start – which may be an opportunity to align the digital assessment and training offering for new starters based on their competencies and help identifying champions | 30 Sep 2023 | a/w update | |
| | 2 | Recruitment of a Lead Digital Nurse to support the Digital Strategy | 30 Sep 2023 | JD developed – linked to the resourcing approval requirements. Recruitment campaign commences 6 June 2023. | |

| Risk appetite (key areas of risk to be considered when assessing management of risk from Financial risk; Regulatory risk; Quality risks; Reputational risks and People risks) | | | | | | |
|---|---|---|---|---|---|---|
| | 0 - None | 1 - Minimal | 2 - Cautious | 3 - Open | 4 - Seek | 5 - Significant |
| Regulatory | We have no appetite for decisions that may compromise compliance with statutory, regulatory or policy requirements. | We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential. | We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision | We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully | We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks | We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders. |
| Reputation | We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation. | Our appetite for risk taking is limited to those events where there is no chance of significant repercussions. | We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout. | We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders. | We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks | We are comfortable taking decisions that may expose us to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes |

| **Strategic Objective 6:** To make progress in implementing our digital strategy to support our ambition to become a digital leader in the NHS | | | | | **Lead Committee:** Finance Business & Investment<br>**Executive Lead:** Chief Information Officer | | |

| **In year ambition** | | **Key risk to achieving the ambition** | better lives, together | Links to other objectives | Linked operational risks (ref and brief descriptor) | | Lead Executive |
|---|---|---|---|---|---|---|---|
| **6.5 Digital Infrastructure and Security:**<br><br>We will strengthen our digital foundations by optimising and maintaining our digital infrastructure and security | | Ongoing investment / Infrastructure, tools and capabilities and people. | Best Quality Care Seamless Access | SO1:1.4<br>SO4:4.3 | | | Chief Information Officer |

| M-12<br>Apr 2023 | M-11<br>May 2023 | M-10<br>Jun 2023 | M-9<br>Jul 2023 | M-8<br>Aug 2023 | M-7<br>Sep 2023 | M-6<br>Oct 2023 | M-5<br>Nov 2023 | M-4<br>Dec 2023 | M-3<br>Jan 2024 | M-2<br>Feb 2024 | M-1<br>Mar 2024 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4-3 (12) | 4-3 (12) | 4-3 (12) | 4-3 (12) | | | | | | | | | 4-2 (8) |

| | **Cause of Risk** | **Impact / consequence of risk** |
|---|---|---|
| **Management of Risk** | • Increased cyber threats due to the global and economic disruption<br>• Continued and sustained investment in the supporting infrastructure<br>• Shift from capital expenditure to revenue across digital services<br>Recruitment and retention of digital and data resources | • Staff unable to perform due high levels of remote and agile working and the heavy reliance on the supporting infrastructure<br>• Reduced digital and data services due to under investment<br>• Disruption of clinical and business services in case of cyber incident |

| **What controls are in place to manage the risk?** | **What gaps in controls are there?** |
|---|---|
| • National compliance level and expectations on cyber risk management<br>• Cybersecurity monitoring and response to changing global risk<br>• Progression of sharing processes in collaboration with local partners<br>• Engagement with YHWARP (Yorkshire & Humber Warning, Alert and Reporting Point)<br>• Capital investment plan | • Monitoring automated tools funded non-recurrently<br>• Lack of Cyber tools which may limit Trust ability to quickly respond to threat or breach<br>• ActAsOne – Cyber and Resilience workstream to be fully established<br>• Shortages of cyber security skills and expertise in the region (impacting on our resources being asked to support others) |

| **Assurance of effectiveness of controls** | | **Sources of Assurance** | **Gaps in Assurance** |
|---|---|---|---|
| | **Level 1:**<br>Operational oversight | • Digital AGG<br>• Technology Group<br>• Information Governance Group<br>• Digital Steering group<br>• Clinical Systems Governance Group | |
| | **Level 2:**<br>Reports / metrics overseen by Board / Committee | • SLT<br>• FBIC | |
| | **Level 3:**<br>Sources of external oversight / scrutiny | • ActAsOne – Cyber and Resilience workstream<br>• Internal Audit programme of Toolkit | No independent external scrutiny/oversight in place |

| **Mitigating Actions to address gaps in control and assurance** | Nº | **Actions** | **TARGET** | **Progress** | **COMPLETION** |
|---|---|---|---|---|---|
| | 1 | Completion of the Digital Maturity Assessment (Feb 2023) | 28 Feb 2023 | NHSE release delayed so assessment now due March 2023 – Completed and submitted as part of the first phase submission. | 31 Mar 2023 |
| | 2 | Complete Data Security Protection Toolkit | 30 June 2023 | Evidence being compiled for submission currently | |

| **Risk appetite (key areas of risk to be considered when assessing management of risk from Financial risk; Regulatory risk; Quality risks; Reputational risks and People risks)** | | | | | | |
|---|---|---|---|---|---|---|
| | 0 - None | 1 - Minimal | 2 - Cautious | 3 - Open | 4 - Seek | 5 - Significant |
| Regulatory | We have no appetite for decisions that may compromise compliance with statutory, regulatory or policy requirements. | We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential. | We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision | We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully | We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks | We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders. |
| Reputation | We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation. | Our appetite for risk taking is limited to those events where there is no chance of significant repercussions. | We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout. | We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders. | We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks | We are comfortable taking decisions that may expose us to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes |