Title | Board Assurance and Corporate Risk Register Report

| Status | For discussion |

| History | The BAF and CRR were reported to the:
- Audit Committee in April, September 2016, February and April 2017
- Trust Board in May and November 2016, May 2017 and January 2018
- Trust Management Executive in April, August, October 2016, January, April, June, October and December 2017 and 11 January 2018

Extracts of relevant risks from the CRR and the BAF were reported to:
- Quality Committee in April, December 2016 and February, April, June, August, October and December 2017
- Finance & Performance Committee in April and December 2016, February, April, June, August, October and December 2017
- Updates of the relevant risks from the CRR were reported to the Trust Management Executive in January, June and July 2017

| Board Lead(s) | Eileen Walsh, Director of Assurance |

| Key purpose | Strategy | Assurance | Policy | Performance |
**Executive Summary**

1. This paper provides the Trust Board with:
   - A further update from the papers presented to the Quality, Finance and Performance and Audit Committee’s in February 2018;
   - A summary of any further developments to the BAF and to the corporate risk register.

**Recommendations**

2. The Trust Board is asked to:
   - review and approve the current draft BAF, and
   - review and note the content of the current CRR.
1. Introduction

1.1. This paper provides an opportunity for the Trust Board to review the development of the Corporate Risk Register (CRR) and Board Assurance Framework (BAF).

1.2. The Trust Business Plan (2017/18) was re-drafted and presented to the Trust Board in July 2017 for approval. Following approval, the Assurance Team developed a draft assurance tool to reflect the changing contents of the Trust Business Plan with engagement from members of the Executive Team. This was presented to the Board at the seminar in November 2017.

2. Board Assurance Framework 2017/18

2.1. The BAF is being developed through consultations conducted with the Non-Executive and Executive Directors. The outline draft of the revised format Board Assurance Framework was presented at the Board Seminar in November 2017. The feedback from this session is being used to further develop and refine the BAF into a more focused and useable tool for the Board.

2.2. The first draft of the revised format document was provided to Trust Management Executive in December 2017. The next draft was presented to the Trust Board in January 2018. Since then further developments have been added to the current version.

2.3. The BAF includes a high level summary of the current papers presented to the Trust Board and board sub-committees.

2.4. As part of the planned annual review of the effectiveness of the Committee a full review of all papers presented to the Board and the board- sub committees is being conducted. This review will be used to add to the next iteration of the BAF.

2.5. The Trust Board is asked to review and approve the current draft of the BAF, provided as Appendix 1.

3. Corporate Risk Register 2017/18

3.1. The Board Seminars in September 2017 and in November 2017 identified a range of risks, mapped to the strategic themes; these are in the process of being further developed in conjunction with the Executive Directors.

3.2. The risk descriptions and key controls are being reviewed and developed further by each of the responsible Executive Directors. A summary of the risks as approved by the Trust Management Executive is shown in Appendix 2 for review and discussion.

3.3. As part of the further development of the presentation of the CRR to the Board Sub-committees an initial heat map summarising the makeup of the divisional risk registers has been compiled and presented below. This provides a summary of the five clinical divisional risk registers by risk score. This heat map is being reviewed and discussed at the board-subcommittees.
Changes to risk scores

3.4. A number of changes to risk scores were suggested as a result of the discussions at the Quality Committee and the Finance and Performance Committee. All the proposed changes were reviewed and discussed at the Trust Management Executive Committee in February and have been reflected in the summary included as Appendix 2.

4. Recommendations

4.1. The Trust Board is asked to:

- review and approve the current draft BAF, and
- review and note the content of the current CRR.

Eileen Walsh,
Director of Assurance,
March 2018

Prepared by Clare Winch Deputy Director Assurance
## SUSTAINABLE COMPLIANCE: Continuing to deliver sustainable compliance with statutory requirements

### SC.1 Key access standards/NIHSI investigation
- Ability to develop key access targets (including failure to deliver national access target 18 weeks incompatibility and target and failure to deliver 1% or less for diagnostic waits within 6 weeks)
  - Development and agree a demand and capacity plan and associated trajectories with NHSCI and commissioners for the RTT standard
  - Delivery of the plan
  - Agreement of an affordable and deliverable plan
  - Performance against agreed trajectory
  - Data Quality Indicators

<table>
<thead>
<tr>
<th>Controls</th>
<th>Performance Indicators and Assurances</th>
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</thead>
</table>
| | Reported to the Board
| | Integrated Performance Report (L2)
| | Financial and Performance Reports (L1)
| | 2nd Stage RTT Activity Plan (L1)
| | TME report to the Board
| | Reported Elsewhere
| | Monitoring delivery of RTT Activity Plan (L1)

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<tr>
<th>Latest Paper ID</th>
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<td>FPC2017.21</td>
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<td>agenda item 18 (09/18)</td>
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### SC.2 Other key access standards
- Ability to deliver other key access standards (including delivery of National Access targets Cancer day Cancer Standard) (4 hour ED target)
  - Updating of action plans and trajectories for ED and Cancer performance
  - Delivery of the action plans
  - Agreement of affordable and deliverable plans
  - Performance against agreed trajectories

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<td>FPC2017.21</td>
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### SC.3 Financial sustainability
- Failure to deliver the in-year financial plan and NHSI Financial Control total plan
  - Centralisation of controls over discretionary spending + tight management of Divisions and Directorates net on track + tightening of capital and working capital Agreement with NHSCI of realistic in-year financial plan
  - Agreement of affordable and deliverable plans monthly financial monitoring reports to Board TME and EBITDA

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### SC.4 Financial sustainability
- Failure to deliver sustainable level of EBITDA over 3-5 years
  - Management of education programmes on EBITDA and financial sustainability + Increase capacity to deliver major change projects + Pursue commercial ventures which will cross subsidise NHSCare
  - Agreement of affordable and deliverable plans monthly financial monitoring reports to Board TME and EBITDA

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### SC.5 Quality sustainability
- Ability to deliver safe and effective clinical care to patients
  - High quality care for all patients in relation to Quality priorities, core of clinical policies, procedures and protocols that cover clinical activities. Clear clinical leadership, training and education. Safety culture and open incident reporting process
  - Monitoring via quality reporting, clinical audit, quality performance metrics regularly reviewed and reported through the governance structure of the Trust

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## BUILDING CAPABILITIES: Building the Trust’s capabilities to deliver its objectives

### SC.1 Building workforce capabilities
- Ability to recruit, retain and manage staff to work together to deliver compassionate excellence and fulfill their potential
  - Development of workforce / people strategy, recruitment and retention initiatives, Equality and diversity and inclusion updates, post graduate education reviews. Review of workforce and OD functions. Review of appraisal process, recruitment process and on-boarding
  - Agreed set of actions from recent staff survey to be monitored by TME
  - Agreed HR KPI performance monitored via ORBIT

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### SC.2 Building nursing workforce capabilities
- Delivery of nursing capacity and viability (via the school of nursing and Magnet accreditation)
  - Implementation of programme for Magnet accreditation, Agreement of project plan for School of Nursing + Implementation of the plan
  - Project plan agreed + Achievement of project milestones

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### SC.3 Organisational Training and development
- Insufficient provision of appropriate education and learning development opportunities
  - Further strengthening of leadership development and talent management strategies
  - Access to appropriate leadership development programmes
  - Increasing provision of high quality Education and Clinical Supervision
  - Ongoing implementation of the Care Certificate
  - Trust Apprenticehip Committee in place
  - To achieve Employer Provider Status to support investment of Apprenticeship Levy
  - Trust training needs analysis completed to maximise use of funding and targeted against need and priorities
  - Multi-professional Education and Learning Strategy approved and being implemented
  - Development of in-house academic accredited programmes
  - Ensure education commissioning focuses on quality and value for money
  - Education programmes and associated provision approved by Divisional Education leads
  - Provisional funding agreed to relocate Practice Development and Education leads

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### SC.4 Organisational Training and development
- Annual Health and Safety review and report to Board Monitoring through Education and Training Committee
- Monitoring through Nursing and Midwifery Board • Monitoring through Cross Divisional Education and Practice Development Forum • G4M surveys

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TB2018.35 Board Assurance Framework and Corporate Risk Register Report Page 5 of 9
## Risk ID | Work Programme Link to Strategic Risk | Risk Description (for more detail see CRR) | Controls | Performance Indicators and Assurances | Assurance from What? (papers / metrics ) | Latest Paper ID | No of papers for last date (Jan 18) |
|---|---|---|---|---|---|---|---|
| HSH.1 | Rebalancing the System | Ability of the Trust to work effectively with other health and social care providers to ensure patients are cared for in the right place at the right time. | Controls:  
• Increase recruitment in HART  
• Increase the number of care hours delivered beyond 110,000 threshold  
• Recruitment promotion activities and advertising campaigns to increase applications  
• Complete the integration of supported discharge  
• Seven week cycle of bespoke training programmes for new starters in HART  
• HART Team development, expansion and embedding of processes to ensure capacity and quality standards met  
• Partnership working (Quality Priority)  
• Accountable care working principles  
• STP work streams to address DTOC and Flow issues  
• Urgent care improvement plan  
• Values into action project  
• Emergency Planning | • Number of DTOC/ED performance/patient experience  
• Performance Reports to TME and Board  
• Divisional meetings  
• Complaints and patient experience Board Reports  
• Urgent Care Dashboard  
• Monthly Contract Review  
• A&E delivery board  
• Data Quality Indicators  
• Recruitment and Retention figures monitored  
• Data following the revised approach to presentation of nurse staffing data based on no of care hours per patient per day to be reported at Quality Committee |  
*Board*  
*Quality Committee Report (L2)*  
*Audit Committee Report to the Board (L2)*  
*TME Report to the Board (L2)*  
*Annual H&S Report (L1)*  
*Workflow and Organizational Development Papers (G2&Q4) (L1)*  
*Patient Perspective / Patient Story (L3)*  
*Annual Patient experience, Complaints and PALIS (L3)*  
*Quality Priority monitoring* |  
*TB2018.09 (01/18)*  
*TB2018.05 (01/18)*  
*TB2018.11 (01/18)*  
*TB2018.12 (01/18)*  
*TB2017.114 (11/17)*  
*TB2017.109 (11/17)*  
*TB2018.04 (01/18)*  
*TB2017.95 (09.17)*  
*Elsewhere* |  
*TB2017.72*  
*TB2017.688*  
*n/a*  
*QC2017.18*  
*presentation Oct17* |
| HSH.2 | Bed and service reconfiguration | Potential risk to the implementation of the reconfiguration of beds and services (including ICU, Infectious disease, and ambulatory model developments) | Controls:  
• Reconfiguration plan to better align services  
• Release of additional acute beds following public consultation  
• Critical care strategy being devised  
• Project Plan for delivery of ID move  
• Plans for the reconfiguration of AUU, Rowan Day case Unit and SEU being devised and delivered |  
*PROJECT TIMESHEET*  
*Number of DTOC/ED performance/patient experience*  
*Weekly monitoring programme of 4 hour wait and urgent care* |  
*Reported to Board*  
*Patient Perspective (L3)*  
*Audit Committee Report to the Board (L2)*  
*Integrated Performance Reports (IPR) (L1)*  
*Quality Committee Report (L2)*  
*TME Report to the Board (L2)* |  
*TB2018.09 (01/18)*  
*TB2018.05 (01/18)*  
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*TB2018.06 (01/18)*  
*TB2018.12 (01/18)*  
*TB2018.04 (01/18)*  
*TB2017.95 (09.17)*  
*n/a*  
*QC2017.18*  
*presentation Oct17* |
| HSH.3 | Implement the agreed service proposals of phase one of the Oxford Transformation Programme consultation | Ability to implement the agreed service proposals from phase one of the Oxford Transformation Programme consultation | Controls:  
• Plans for the development of an outpatient and diagnostic unit, following public consultation at the Horton  
• Development of options for the reconfiguration of patients from Oxford to the Horton  
• Business Case gone to TME 23.11.17  
• Cancer pathway review to reduce time between patient encounters and improve patient experience (Quality Priority)** on hold pending DTOC decision ** |  
*AGREEMENT AND DELIVERY OF A PROJECT TIMETABLE*  
*Number of patients rehydrated*  
*Patient experience indicators* |  
*Reported to Board*  
*Update on Oxfordshire Transformation Programme (L1)*  
*Annual Patient experience, Complaints and PALIS (L3)*  
*Patient Perspective (L3)*  
*TME Report to the Board (L2)*  
*Finance and Performance Report (L3)* |  
*TB2017.109 (11/17)*  
*TB2018.08 (01/18)*  
*TB2017.110 (11/17)*  
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*TB2018.08 (01/18)*  
*n/a*  
*n/a*  
*n/a*  
*n/a* |
| HSH.4 | Oxfordshire Transformation Programme | Ability to contribute effectively to the Oxfordshire Transformation Programme | Supports the continued work associated with the phase one consultation  
*Contribute to the phase two consultation |  
*SUCCESSFUL COMPLETION OF THE CONSULTATION PHASE.*  
*Initiation of phase two in 2017/18* |  
*Reported to Board*  
*Update on Oxfordshire Transformation Programme (L1)*  
*Integrated Performance Reports (IPR) (L1)*  
*Quality Committee Reports to the Board (L2).*  
*Board Quality Report (L2)* |  
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*n/a*  
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*n/a* |
| HSH.5 | Working with GPs and primary care | Ability to develop positive partnerships with GPs and primary care | Controls:  
• Identify opportunities for supporting the sustainability of primary care  
• Improvement of GP engagement channels  
• Implementation and delivery of Care 24/7 project and monitoring of action plans  
• Implementation and monitoring of quality priority 2: safe discharge and priority 4: stakeholder engagement and partnership working |  
*DEPLOYMENT OF SPECIFIC PROJECTS*  
*GP satisfaction*  
*Quality priority monitoring* |  
*Reported to Board*  
*Board Quality Report (L2)*  
*National Audit of four priority standards for Emergency categories (Bi-Annual March/Aug) (L3)*  
*Quality Committee Report to the Board (L2)*  
*Care 24/7 Monitored through TME quarterly* |  
*TB2018.06 (01/18)*  
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<tr>
<td>HQCL1</td>
<td>Quality priorities/account</td>
<td>Ability to deliver the Quality Priorities due to competing demands between quality and finance</td>
<td>• Patient and public consultation to reflect on performance 2016/17 and inform 2017/18 priorities • Agreement of the 2017/18 quality priorities/account delivered to timeframe • Deliver quality improvements against the quality priorities/account • Implementation plan to embed strategy to be developed Leadership Development • Quality priorities linked to Quality Strategy and the contract • Built a safety culture of learning through Magnet Process, SIRI Forum and Leadership programmes • Development of Improvement Champions for Change • Introduction and monitoring of Quality Improvement toolkit/Updated escalation processes</td>
<td>• Quality strategy to be embedded into employment processes, performance management and reward systems • HQCL Programme and Link with Carter and Girth • Refreshing the Quality Strategy to be delivered in Q4. • Details of Quality Priorities and delivery Development of local metrics to monitor achievement of local quality goals • RAG rated matrix in Board Quality Report • Safety Thermometer developed to monitor Trust wide goals (e.g. pressure ulcer reduction – link to 1.1) • HSRM and SHMR Review • Clinical Governance Committee review • Annual Quality Report monitored at Board and Committee • Strategic review with development of improvement champions • CQC Assurance • Data Quality Indicators • Patient surveys</td>
<td>Reported to Board • Integrated performance Report (IPR) (L1) • Quality Account • Quality Committee Report (L2) • Board Quality Report (Rag ratings) (L2) • Clinical Governance Ctee Review • SIRI Forum results • Peer Review / CQC Assurance • Champions for Change Project updates • Workforce and Organisational Development Performance Report (Q4, 16/17)</td>
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<tr>
<td>HQCL2</td>
<td>CQUINs</td>
<td>Contractual targets for CQUIN not met and CQUIN funding not available</td>
<td>• Monthly contract review meeting held between the Trust &amp; Commissioners • Internal weekly Business Planning meetings • Internal weekly business planning meetings to monitor compliance and potential financial impact of non-delivery • Collaboration with Oxford Health to achieve the CQUIN target</td>
<td>• CQUINs agreed with commissioners • Metrics on the % of CQUINs delivered • Detailed Financial Monitoring suite via SLAM • The delivery and monitoring of 2017/18 CQUINs through CQC Monthly contract review between the Trust and Commissioners to monitor compliance</td>
<td>Reported to the Board • Oxford AHSN Annual Report (L2)</td>
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<td>HQCL3</td>
<td>Carter/ Patient Level</td>
<td>Ability to deliver Carter/ Patient Level Costing/Efficiency Programme</td>
<td>• Board level workshop by Lord Carter • Continued strengthening of the alignment between quality, performance and efficiency</td>
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<td>Board Quality Report (Rag ratings) (L2)</td>
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<td>System-wide quality improvement</td>
<td>Ability to influence system-wide quality improvement</td>
<td>• Develop a system-wide quality dashboard • Establish with partners a system-wide quality improvement programme • Quality priorities 2017/18 for partnership working reviewed and monitored</td>
<td>• Development of a system-wide quality dashboard monitored</td>
<td>Board Quality Report (Rag ratings) (L2)</td>
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<tr>
<td>GD DIGITAL</td>
<td>Leveraging electronic health records, data and technology to innovate and join up how we provide patient care across organisational boundaries and support self-care and research</td>
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<td>GD.1</td>
<td>Clinical Documentation – moving to paper free working</td>
<td>Ability to improve timeliness, accuracy and safety of clinical records.</td>
<td>• Paper light working across NOTSS, ceasing to pull specialty notes • Nursing documentation implementation ceasing to use paper based documentation in most areas and will be fully paperless by August 2017 ED</td>
<td>• Metrics on numbers of notes not being pulled • Metrics on numbers of referral letters being scanned • Monitoring of the CQC Should Do Action Plan</td>
<td>Reported to Board • TME Report to the Board (L2)</td>
<td>TB2017.1107 (02/18)</td>
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<tr>
<td>GD.2</td>
<td>Population Health</td>
<td>Failure to use population health data to understand patient flow into ED and Cancer pathways and RTT planning</td>
<td>• Population health platform in place for 13 practices • HIE in place broadly replacing the Oxfordshire Care summary</td>
<td>• Population wide platform available for testing • HIE working as planned • Data Quality Indicator</td>
<td>Reported to the Board • Integrated Performance Report (IPR) (L1) • Finance and Performance Report (L1) • Internal Audit Report • RTT Activity Plan • TME Report to the Board (L2)</td>
<td>TB2018.09 (01/18)</td>
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<td>GD.3</td>
<td>Patient Portal</td>
<td>Ability to implement the patient portal system across healthcare services</td>
<td>• Implement the Portal system for appointment booking, receipt of letters and review of parts of the clinical record (for limited numbers) • Plan for mass use in place and starting to be executed</td>
<td>• Core functionality built and tested • Plan agreed and resources to deliver in place</td>
<td>Reported to Board • Information Governance and Data Quality Group Bi-annual Review (L2)</td>
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**Notes:**
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- **Reported Elsewhere:** The report is reported elsewhere but not to the Board.
- **Board:** The report is presented to the Board.
- **Elsewhere:** The report is reported elsewhere but not to the Board.
- **TB2018.09 (01/18):** The report was presented in the Board meeting on January 9, 2018.
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<tr>
<td><strong>Masters Planning</strong> - Long term estates planning - intended to support future investment in infrastructure to support clinical services, research and education endeavour for the Trust</td>
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| **MP.1** | Create a progressive Trust Master Plan from 2017 – 2047 | The Trust Master Plan from 2017 – 2047 may not be developed to point of delivery | • Link with stakeholders across the Oxfordshire footprint to create a Master Plan that maximises the opportunities out of synergies with local council and commercial partnerships  
• To identify internal resources that can be responsive to the needs of the Trust in developing capital schemes. Currently funding is only available to work up proposed schemes with no flexibility to support flexibility work.  
• Resources identified to support internal mechanisms to generate high level costs for those cases involving capital expenditure, approved to be developed beyond FY0 stage | • Demonstration of collaborative plans for travel/ transport, key working housing and relocation of services closer to the patient.  
• Monitoring of Capital schemes funding | Reported to the Board  
• Update on Oxfordshire Transformation Programme (L1)  
• Accountable Care System (L1) | TB2017.110 (11/17)  
2 | 1 |
| **MP.2** | Premises Development - to support service capacity requirements / Identify a Policy and Process for the management of space in the OUIH | Ability to develop and use premises sufficiently to support service capacity requirements | • Undertake a Trust wide space utilisation review to identify opportunities for reuse and redistribution of space  
• Review of existing estate to maximise opportunities for services identified within the Focus on Excellence to expand  
• Prepare and submit for approval a space allocation/ management policy (including agreed principles as per the Space Lab recommendations) that can be used across the Trust to manage its estate  
• Set up space allocation group to oversee the process | • Areas identified achieve CQC approval  
• A database of suboptimal facilities will be configured with planned works to address issues raised | Reported to the Board  
• Audit Committee Report to the Board (L2)  
• CQC Action Plans (L1) | TB2017.106  
TB2017.108 | 3 |
| **MP.3** | Improving our healthcare environments – a plan for change | Ability to assess and improve the healthcare environments to maintain regulatory compliance | • Identify those areas whose environment is not meeting CQC (regulatory) standards  
• Address suboptimal facilities through revision and reconfiguration of space | • An estates strategy is available (NOTE LT OBJ: master Plan clearly articulated to staff)  
• Detailed plans for sequencing of relocations, investment and demolitions is available (NOTE LT OBJ: >40 yr. Master Plan is delivered with forward view of 5-10 in pipeline) | Reported to the Board  
• Audit Committee Report to the Board (L2)  
• Capital Programme Updates (L2)  
• Update on new Capital Programme | TB2017.109 | 2 |
| **MP.4** | A review of opportunities for Investment/ Acquisition and Disposal | Ability to take the right opportunities for Investment/ Acquisition and Disposal | • Prepare an Estates Strategy for the OUIH that aligns with its Master Plan  
• Prepare a plan which includes identification of sites for investment/ acquisition and disposal | • An estates strategy is available (NOTE LT OBJ: master Plan clearly articulated to staff)  
• Detailed plans for sequencing of relocations, investment and demolitions is available (NOTE LT OBJ: >40 yr. Master Plan is delivered with forward view of 5-10 in pipeline) | Reported to the Board  
• Audit Committee Report to the Board (L2)  
• Capital Programme Updates (L2)  
• Update on new Capital Programme | TB2017.109 | 2 |
| **MP.5** | Review all contracts and leases involving the estate | Ability to assess and improve the management of all contracts and leases involving the estate | • Set up a focus group to review all of the existing contracts and leases involving the estate.  
• Database to record lease and contract information  
• Work will be undertaken to maximise the potential to increase rental income from those agreements  
• Maximize potential for joint partnerships | • A database of all contracts and leases set up and metrics data from National Eric Reports  
• An increased target rental income of 5% is achieved through renegotiation of contracts | Reported to the Board  
• National Reports on Estates Return Information Collection (ERIC) (L3)  
• Capital Programme Updates (L2)  
• Transformation Programme Updates (L1)  
• TME Report to Board (L2) | TB2017.107 (01/18)  
TB2017.107 (01/18) | 5 |
| **MP.6** | Establish an effective Capital Planning structure and process for 2018/ 19 and for prioritisation of capital investment | Ability to meet capital investment needs through a robust capital planning process | • Agree a structure and process with key stakeholders  
• Agree criteria to be used to assess cases for investment of capital.  
• Establish a mechanism for devolution of capital fund  
• Agree with key stakeholders the amount of capital available to the Trust and undertake prioritisation to ensure that funding is utilised to its best effect.  
• The requests for capital investment will be reviewed and filtered against the following criteria to ensure that informed decisions are made as to where the Trust will see the best ROI. | • Structure and process approved by TME Mar 2017  
• Assessment criteria for capital expenditure agreed Mar 2017  
• Capital funding available agreed by TME  
• The amount of capital to carry forward is agreed with Divisions and a capital investment plan agreed by the end of Mar 2017  
• Process for filtering business cases to build feasible options to be developed and agreed  
• Quality, operational and financial performance data | Reported to the Board  
• Integrated report on quality, operational and financial performance  
• Finance and Performance Reports (L1)  
• Capital Programme Updates (FPC) (L1)  
• Capital Programme Board (TME) (L1)  
• Transformation Programme Updates (CPR) (L1)  
• Audit Committee Report to the Board (L2)  
• TME Report to the Board (L2)  
• TME Report to the Board (L2) | TB2017.54  
TB2017.08 (01/18)  
TB2017.109  
TB2017.105 (01/18)  
TB2017.107 (01/18) | 1  
5  
5  
5  
5 |
| **FOCUS ON EXCELLENCE: Prioritising investment in services, developing world-class excellence** | | | | | | | |
| **FOE.1** | Realising the benefits of the initial assessment of services / refining the process for the future | Ability to realise the benefits of the FOE initial assessment of services into business as usual | • Agree action list to address corporate learning points  
• FOE initial assessment for cross-cutting themes:  
1st phase – Urgent care, urology, orthopaedics, GP communications  
2nd phase Critical Care Bradstology  
Define the ‘bar’ which all OUIH services are expected to meet  
• Improve the use of clinical outcome measures | • Agreed set of actions monitored by TME  
• Improved KP performance  
• Agreed metrics and methodology for measurement against the bar which forms part of earned autonomy and selection of centres of Excellence  
• Agreed set of clinical outcome measures for each service | Reported to Board  
• Champions for Change Project updates  
• Workforce and Organisational Development Performance Report (Q4, 16/17)  
• Workforce and Organisational Development Performance Report (Q4, 16/17) | TB2018.09 (01/18)  
TB2017.102  
TB2017.102 | 1  
*  
* |
| **FOE.2** | Joint Strategy with Universities | Failure to develop robust plans to support the Trust’s Joint Strategy with Universities | • Identify issues on which skills, expertise and resources of local universities have potential to make an invaluable contribution to effective and innovative solutions  
• Address issues which are a result of the interface between the Trust and the University of Oxford  
• Transformation Programme to be underpinned by research | • Monitoring agreed set of issues with action plans through joint partnership structure (note: Agreed consistent recruitment process.) | Reported to Board  
• Chief Executive update reports  
• Workforce and Organisational Development Performance Report (Q4, 16/17)  
• Workforce and Organisational Development Performance Report (Q4, 16/17) | TB2017.107 (01/18)  
TB2017.107 (01/18) | 1  
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<th>CRR ref</th>
<th>Risk Description</th>
<th>Risk Score Oct 2017</th>
<th>Revised Score Dec/ Jan 18</th>
<th>Revised Score Feb 18</th>
<th>Trend</th>
<th>Target Risk Score</th>
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<td>1.1</td>
<td>Failure to deliver National A&amp;E targets and increasing level of delay impacting on patient flow</td>
<td>20</td>
<td>20</td>
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<td>1.2</td>
<td>Ability to deliver key national access targets (including failure to deliver national access target 18 weeks incompletes target and failure to deliver 1% or less for diagnostic waits within 6 weeks)</td>
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<td>16</td>
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<td>1.3</td>
<td>Ability to deliver other key access standards (including delivery of National Access Targets Cancer – 62 day Cancer Standard)</td>
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<td>1.4</td>
<td>Failure to deliver the in-year financial plan and NHSI Financial Control total plan</td>
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<td>1.5</td>
<td>Risk of not fitting financial targets or operational trajectories to access STP Funding</td>
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<td>1.6</td>
<td>Ability to deliver sustainable level of EBITDA over 3-5 years</td>
<td>n/a</td>
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<td>1.7</td>
<td>Ability to strengthen trust safeguarding processes</td>
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<td>BUILDING CAPABILITIES</td>
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<td>2.1</td>
<td>Ability to recruit, retain and engage staff to work together to deliver compassionate excellence and fulfil their potential</td>
<td>tbc</td>
<td>20</td>
<td>20</td>
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<td>2.2</td>
<td>Delivery of nursing capacity and capability (via the school of nursing and Magnet accreditation)</td>
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<td>2.3</td>
<td>Insufficient provision of appropriate education and learning development opportunities</td>
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<td>2.4</td>
<td>Out of hours care (Care 24/7)</td>
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<td>2.5</td>
<td>Excessive use of agency staff may pose a risk to the quality of service delivered</td>
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<td>4</td>
<td>4</td>
<td>↔</td>
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<td>2.6</td>
<td>Risk that outdated Trust Policies may have an impact upon the quality of care</td>
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<td>12</td>
<td>12</td>
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<td>HOME SWEET HOME</td>
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<td>3.1</td>
<td>Lack of robust plans across healthcare systems / Failure to reduce activity through robust demand management plans</td>
<td>16</td>
<td>16</td>
<td>20</td>
<td>↑</td>
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<tr>
<td>3.2</td>
<td>Ability of the Trust to work effectively with other health and social care providers to ensure patients are cared for in the right place at the right time.</td>
<td>16</td>
<td>16</td>
<td>20</td>
<td>↑</td>
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<td>3.3</td>
<td>Potential risk to the implementation of the reconfiguration of beds and services (including ICU, infectious diseases, and ambulatory model developments)</td>
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<td>12</td>
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<td>3.4</td>
<td>Ability to implement the agreed service proposals from phase one of the Oxford Transformation Programme consultation</td>
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<td>9</td>
<td>9</td>
<td>←</td>
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<td>3.5</td>
<td>Ability to contribute effectively to the Oxfordshire Transformation Programme</td>
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<td>16</td>
<td>20</td>
<td>↑</td>
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<td>3.6</td>
<td>Ability to develop positive partnerships with GPs and primary care</td>
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<td>←</td>
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<td>3.7</td>
<td>Failure to meet HART Team capacity</td>
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<td>HIGH QUALITY COSTS LESS</td>
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<td>4.1</td>
<td>Unable to deliver the Quality Priorities due to competing demands between quality and finance</td>
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<td>6</td>
<td>6</td>
<td>←</td>
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<td>4.2</td>
<td>Contractual targets for CQUIN not met and CQUIN funding not available</td>
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<td>12</td>
<td>12</td>
<td>←</td>
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<tr>
<td>4.3</td>
<td>Ability to deliver Carter/Patient Level Costing/Efficiency Programme</td>
<td>tbc</td>
<td>tbc</td>
<td>tbc</td>
<td>new</td>
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<tr>
<td>4.4</td>
<td>Ability to influence system-wide quality improvement</td>
<td>16</td>
<td>16</td>
<td>16</td>
<td>←</td>
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<tr>
<td>4.5</td>
<td>Low retention of non-medical workforce in some clinical areas leading to ongoing recruitment challenges</td>
<td>12</td>
<td>12</td>
<td>12</td>
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<tr>
<td>4.6</td>
<td>Implementation of HfH contingency plan results in potential adverse outcomes for parents and children</td>
<td>10</td>
<td>10</td>
<td>10</td>
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<td>4.7</td>
<td>Inability to continue to supply stock medicine to wards and medicines to all of the Trust’s dispensaries</td>
<td>12</td>
<td>12</td>
<td>12</td>
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<td>GO DIGITAL</td>
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<td>5.1</td>
<td>Poor clinical records management processes have a potential impact in quality and safety</td>
<td>6</td>
<td>6</td>
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<td>5.2</td>
<td>Potential failure of accurate reporting and poor data quality due to implementation of EPR</td>
<td>6</td>
<td>6</td>
<td>6</td>
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<tr>
<td>5.3</td>
<td>Potential failure to obtain the clinical advantages of EPR</td>
<td>8</td>
<td>8</td>
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<tr>
<td>5.4</td>
<td>Ability to improve timeliness, accuracy and safety of clinical records.</td>
<td>6</td>
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<tr>
<td>5.5</td>
<td>Failure to use population health data to understand patient flow into ED and Cancer pathways and RTT planning</td>
<td>tbc</td>
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<tr>
<td>5.6</td>
<td>Ability to implement the patient portal system across healthcare services</td>
<td>tbc</td>
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<td>MASTER PLANNING</td>
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<tr>
<td>6.1</td>
<td>The Trust Master Plan from 2017 – 2047 may not be developed to point of delivery</td>
<td>tbc</td>
<td>tbc</td>
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<td>6.2</td>
<td>Ability to develop and use premises sufficiently to support service capacity requirements</td>
<td>tbc</td>
<td>tbc</td>
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<td>6.3</td>
<td>Ability to assess and improve the healthcare environments to maintain regulatory compliance</td>
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<td>9</td>
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<td>6.4</td>
<td>Ability to take the right opportunities for Investment/ Acquisition and Disposal</td>
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<td>6.5</td>
<td>Ability to assess and improve the management of all contracts and leases involving the estate</td>
<td>tbc</td>
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<tr>
<td>6.6</td>
<td>Ability to meet capital investment needs through a robust capital planning process</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>←</td>
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<tr>
<td>6.7</td>
<td>Major Business Cases may not be delivered as expected</td>
<td>16</td>
<td>16</td>
<td>16</td>
<td>←</td>
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<td>6.8</td>
<td>Access to hospital site and current car parking constraints across the Trust has impact on operational performance</td>
<td>9</td>
<td>9</td>
<td>16</td>
<td>↑</td>
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<td>6.9</td>
<td>Capacity of A&amp;E/CCU does not meet demand</td>
<td>12</td>
<td>12</td>
<td>12</td>
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<td>6.10</td>
<td>Ability to re-provide dedicated major trauma centre accommodation.</td>
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<td>n/a</td>
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<td>6.11</td>
<td>Ability to maintain services following the collapse of one of the trust’s PFI providers (under development)</td>
<td>tbc</td>
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<td>FOCUS ON EXCELLENCE</td>
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<tr>
<td>7.1</td>
<td>Ability to realise the benefits of the FOE’s initial assessment of services into the Trust’s business as usual activities.</td>
<td>n/a</td>
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<td>new</td>
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<td>7.2</td>
<td>Failure to develop robust plans to support the Trust’s Joint Strategy with Universities, including clarity on the clinical strategy</td>
<td>9</td>
<td>9</td>
<td>←</td>
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</table>