Trust Board Meeting in Public: Wednesday 12 September 2018

TB2018.92

Title	**Board Assurance Framework and Corporate Risk Register Update Report**

Status	For discussion
History	The BAF and CRR were reported to the: • Audit Committee in April, September 2017, February, April 2018 • Trust Board in May and November 2016, May 2017 and January , March 2018 • Trust Management Executive in April, August, October 2016, January, April, June, October and December 2017 and January, March and August 2018 Extracts of relevant risks from the CRR and the BAF were reported to: • Quality Committee in April, June, August, October and December 2017, February, April, 8th August 2018 • Finance & Performance Committee in April, June, August, October and December 2017, February, April and 8th August 2018

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 summary of the results of the review of the Board Assurance Framework [BAF] and the Corporate Risk Register [CRR]; and
   - A summary of changes to the CRR following the review of the Risk Register and Board Assurance Framework by Trust Management Executive in August.
2. **Corporate Risk Register**: The paper provides a complete summary of changes made to the CRR by TME in August including :
   - Risks which it was agreed would be de-escalated from the CRR to be held and managed through the divisional, and other relevant risk registers; and
   - Changes to risk scores, including those where a change was proposed but not agreed by TME.
3. **Board Assurance Framework:** This provides the current version of the BAF together with a summary of the assurance team's view, as agreed by the Executive Director owner.

Recommendation

4. The Trust Board is asked to:
   - Review and note the changes to the Corporate Risk Register, following approval by TME.

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).

2. Corporate Risk Register

2.1. The CRR was reviewed for the full year 2017/18 and the start of 2018/19, with the results of this review provided in detail to TME. This is summarised as Appendix 1 which provides a complete history of all risks on the CRR during the year 2017/18 to August 2018. This includes those previously escalated for tracking purposes and those escalated and archived during the year. In addition it includes a direct link to the Board Assurance Framework, providing a more explicit link between the CRR and the BAF.

Risks de-escalated from the Corporate Risk Register

2.2. As part of the review, TME agreed to de-escalate a number of risks from the CRR to divisional and other risk registers. These are summarised in the table below:

CRR ref	Risk Description / Summary
2.4	Out of hours care (Care 24/7) This was part of a national assessment process that has now been assessed as compliant with national standards so the risk has reduced to the target risk score.
3.7	Failure to meet HART Team capacity This risk has been tracked and actions have been developed to mitigate the risk, level of risk has reduced to the target risk score.
misc 3	Potential risk of having the Wrong Blood in Tube (WBIT) This risk has been tracked and actions have been developed to mitigate the risk, level of risk has reduced to the target risk score.
Esc SUON	Risk of incorrect dosage when administering medicines via 1 and 3ml syringes This risk has been tracked and actions have been developed to mitigate the risk, level of risk has reduced to the target risk score.
Esc C&W	Risk to screening performance from failure to provide NN4B's for new-borns, due to speed of IT system, which frequently times out. This risk has been tracked and actions have been developed to mitigate the risk, level of risk has reduced to the target risk score.
6.11	Ability to maintain services following the collapse of one of the trust's PFI providers This risk has been tracked and actions have been developed to mitigate the risk, level of risk has reduced to the target risk score.
Esc CSS	Potential failure to carry out some resuscitation training for staff due to issues with training environment (esc June report) This risk has been tracked and actions have been developed to mitigate the risk, level of risk has reduced to the target risk score.
Esc CSS	ITU Drainage: Poor estate with risk of ventilation failure, electrical backup and effluent ingress into clinical area This risk has been tracked and actions have been developed to mitigate the risk, level of risk has reduced to the target risk score.
4.3	Ability to deliver Carter/Patient Level Costing/Efficiency Programme This specific risk as this has been incorporated into other related risks in this strategic theme (see risks 4.1 & 4.2)
Esc MDO	Failure to comply with NICE Quality Standard 13 End of Life Care This risk has been tracked and the level of risk in relation to these standards has reduced, it is now part of a CQUIN and being managed via the MDO risk register.
Esc SUON	CAS Alert NPSA 2011/PSA001 Part A and CAS Alert NPSA 2011/PSA001 Part B these two separate risk were agreed to be removed and replaced by one new risk, described as: Patient may receive a medication via the wrong route The original risks in relation to each part of the NPSA alert were managed and the replaced by the residual risk that remained, this risk is monitored at Pharmacy Safety level and held within the Pharmacy risk register.
Esc Ops	Potential risk of non-disclosure of Trust waiting list position due to data quality issues with PTL. This was reported by Operational Team and included on CRR for monitoring, the risk has not materialised.
6.6	Ability to meet capital investment needs through a robust capital planning process This has been incorporated into other related risks in this strategic theme (see risks 6.2 & 6.4).
6.11	Ability to maintain services following the collapse of one of the trust's PFI Tracked and actions developed to mitigate the risk, level of risk has reduced or been avoided by actions
Esc Est	Risk of fire from potentially combustible materials at JR Trauma building Noted as part of the Estates development programme so proposed monitored via this route.
Esc C&W	Building issues in the Women's Centre could lead to patient safety issues Noted as part of the Estates development programme so proposed monitored via this route.

2.3. Discussions at Quality Committee following the presentation of the Board Quality Report and the End of Life Update report highlighted the need to consider a new risk to be included on the Corporate Risk Register. This relates to ensuring that the Trust has fully considered risks associated with changes in the national guidance related to supporting bereaved families and carers.

2.4. Similarly, discussions at the Finance and Performance Committee highlighted the need to consider the following areas as potential new risks:

- Access to performance information and analytics capacity in the Trust;
- The link to the Sustainability and Transformation Plan [STP] and how this shapes the Trust's strategic plans, governance arrangements and wider partnership working.

2.5. Trust Management Executive agreed that these new risks would be added to the CRR. These are therefore in the process of being developed with the relevant risk owners and will appear on the next iteration of the Register to be presented to TME as part of the routine quarter 2 report in October.

Changes to risk scores

2.6. The following of changes to risk scores were agreed by TME at its meeting on 23 August.

CRR ref	Risk Description	Y/E score	Jul-18	Aug 18	Trend	Target
1.2	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)	16	16	20	↑	4
1.3	Ability to deliver other key access standards (including delivery of National Access targets Cancer – 62 day Cancer Standard)	9	9	12	↑	6
2.6	Risk that outdated Trust Policies may have an impact upon the quality of care	12	6		↓	3
5.3	Potential failure to obtain the clinical advantages of EPR	8	6		↓	6
6.8	Access to hospital site and current car parking constraints across the Trust has impact on operational performance	16	12		↓	6
6.10	Ability to re-provide dedicated major trauma centre accommodation.	9	8		↓	2

2.7. In addition to the changes above, the proposal to reduce risk scores in relation to risk reference 1.1 *'Failure to deliver National A&E targets and increasing level of delay impacting on patient flow'* and risk reference 2.1: '*Ability to recruit, retain and engage staff to work together to deliver compassionate excellence and fulfil their potential'* were rejected and these scores were considered by TME but remained the same.

2.8. As part of this paper a full copy of the Corporate Risk Register (CRR) is provided to the Board.

2.9. The discussions, following the presentation of the BAF and CRR paper at the latest Quality Committee, Finance and Performance Committee and Trust Management Executive, recognised that staffing presented the Trust's biggest challenge. It was agreed that the risks relating the staffing currently held on the Corporate Risk Register required a more detailed review and might benefit from being reframed. This work is currently underway and the changes will be reflected in the CRR when it is next reported to TME.

2.10. In addition it was recognised that the CRR does not fully reflect the emerging risks associated with delivery of the NHSI Integrated Improvement Programme. The five

Improvement Plans each have their own risk register. Once the plans have been formally approved a cross reference will be added to the CRR. The need to reflect the most significant risks from the programme will then be considered.

3. Board Assurance Framework

3.1. The BAF was developed throughout the 2017/18 year, through consultations conducted with 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 was used to further develop and refine the BAF, including the addition of an assurance team view, to provide an assessment of current assurance reported to the Board.

3.2. The annual review of the effectiveness of the Board subcommittees included a full review of all papers presented to the Trust Board and the Board subcommittees during 2017/18. This review has been used as part of the assurance view assessment of the BAF. The assurance team view was then discussed and agreed with the relevant Executive Directors, who own individual aspects of the BAF, as shown in Appendix 2.

3.3. A summary of the ratings is provided in the table presented as Appendix 3.

3.4. The analysis work highlighted the following key points in terms of assurance reported to the Trust Board and Board subcommittees:

- There are a few areas where limited assurance (assessed as red) could be gained by the Board. These related to:
  - The Oxfordshire Transformation Programme – This was mainly due to the conclusion from the phase one consultation and the subsequent delay.
  - The Focus on Excellence Strategic Theme – This was linked to the refresh of the Performance Management Framework, the development of accountable care units and the current climate in which the Trust is operating.
- The following aspects where partial assurance (amber) could be gained by the Board were highlighted:
  - Delivery of nursing capacity and capability (via the school of nursing and Magnet accreditation) – This was mainly a result of the way in which staffing information was presented across a number of Board reports (e.g. Board Quality Report and Workforce Report). The review and development of the performance information in Board reports will address this.
  - The implementation of the reconfiguration of beds and services – There have been individual business cases presented on a case-by-case basis. However the need to provide a strategic overview of the requirement for service reconfiguration has been recognised and work has commenced in relation to this.
  - The ability to develop positive partnerships with GPs and primary care – This links to the development of the urgent and elective care programmes and reporting of the progress against these programmes will ensure that partnership working is highlighted and addressed.
  - The use of population health data and the implementation of the patient portal system across healthcare services – It was considered that as these aspects were still under development and there had only been limited reporting through the Trust's normal governance structure at this stage. The oversight of these developments was reported through to the Digital Delivery Board, which has a reporting route to TME through the Health Informatics Committee. This will be addressed by the review of the reporting from TME subcommittees to TME.

3.5. A number of general observations were recorded in discussions with individual Executive Directors in relation to the assurance team view. Based on these the presentation of all papers are to be improved by considering the following:

- The link to the BAF and CRR;
- The granularity of the information presented and the need to exception report;
- The timing of certain reports: there is a need for a clearly agreed monthly and quarterly reporting cycle;
- The reporting needs of the receiving committee (the purpose of reporting); and
- Consideration of the impact of the actions proposed and the mechanisms needed to provide the Board with sufficient assurance of delivery.

3.6. The assurance team view assessment is used to identify potential gaps in assurance and is linked to the committee cycle of business to ensure that future agenda setting considers the best time to receive updates across all strategic themes.

4. Recommendation

4.1. The Trust Board is asked to:

- Review and note the changes to the Corporate Risk Register following approval by TME.

Eileen Walsh, Director of Assurance,

September 2018

Prepared by:

Clare Winch Deputy Director Assurance

	CRR ref	Risk Description	Mar-17	Jun-17	Aug-17	Oct-17	Dec/ Jan 18	Feb-18	Year end score	Jul-18	Aug-18	Trend	Target
SC	**SUSTAINABLE COMPLIANCE**												
SC.1	1.1	Failure to deliver National A&E targets and increasing level of delay impacting on patient flow (noted as specifically discussed June report)	20	20	20	20	20	20	20	20	20	↔	9
SC.1	1.2	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)	16	16	16	9	16	16	16	16	20	↑	4
SC.1	1.3	Ability to deliver other key access standards (including delivery of National Access targets Cancer – 62 day Cancer Standard)	9	9	9	9	9	9	9	9	12	↑	6
N/A		Potential failure to deliver CIP	16	16	16	16	removed						
N/A		Services display poor cost effectiveness	9	9	9	9	removed						
N/A		Potential failure to effectively control pay and agency costs	9	9	9	9	removed						
SC.2	1.4	Failure to deliver the in-year financial plan and NHSI Financial Control total plan (Dec paper)				new	16	16	20	20	20	↔	8
SC.2	1.5	Risk of not hitting financial targets or operational trajactories to access STP Funding	16	16	16	16	16	16	20	20	20	↔	9
SC.2	1.6	Inability to deliver sustainable level of EBITDA over 3-5 years (Sept / Nov board seminar)				new	12	16	16	16	16	↔	4
SC.3	1.7	Ability to strengthen trust safeguarding processes (from November Board seminar in Jan 18 report)					new (9)	9	9	9	9	↔	6
SC.3	1.8	Adverse impact on the Trust through the ability to achieve and maintain full compliance with CQC regulations (discussed under item AOB March 2018)							new (4)	4	4	↔	1
BC	**BUILDING CAPABILITIES**												
BC.1	2.1	Ability to recruit, retain and engage staff to work together to deliver compassionate excellence and fulfil their potential (in Oct report)				new	20	20	20	16	20	↑	8
BC.1	Esc	Potential for reduced staffing levels in maternity service	12	12	12	12	12	6	6	6	6	↔	4
BC.1	Esc MRC	Emergency Department (both JR and HGH) risk to middle grade rota as insufficient permanent team	9	9	9	9	9	9	9	9	9	↔	3
BC.2	2.2	Delivery of nursing capacity and capability (via the school of nursing and Magnet accreditation) (in Oct report, noted as TBC Dec report)				new	tbc	tbc	9	9	9	↔	3
BC.3	2.3	Insufficient provision of appropriate education and learning development opportunities	6	6	6	6	6	6	6	6	6	↔	3
N/A	2.4	Out of hours care (Care 24/7)	6	6	6	6	6	6	de-esc				3
SC.3	2.5	Excessive use of agency staff may pose a risk to the quality of service delivered	4	4	4	4	4	4	4	4	4	↔	2
SC.3	2.6	Risk that outdated Trust Policies may have an impact upon the quality of care	12	12	12	12	12	12	12	6	6	↔	3
HSH	**HOME SWEET HOME**												
HSH.1	3.1	Lack of robust plans across healthcare systems / Failure to reduce activity through robust demand management plans	16	16	16	16	16	20	20	20	20	↔	6
HSH.1	3.2	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. (in Oct report from Sept Seminar)				new (9)	9	9	9	9	9	↔	6
HSH.2	3.3	Potential risk to the implementation of the reconfiguration of beds and services (in Oct report)				new (12)	12	12	12	12	12	↔	8
HSH.4	3.4	Ability to implement the agreed service proposals from phase one of the Oxford Transformation Programme consultation (in Oct report)				new (9)	9	9	9	9	9	↔	9
HSH.4	3.5	Ability to contribute effectively to the Oxfordshire Transformation Programme (in Oct report)				new (16)	16	20	20	20	20	↔	12
HSH.5	3.6	Ability to develop positive partnerships with GPs and primary care (in Oct report)				new (9)	9	9	9	9	9	↔	6
N/A	3.7	Failure to meet HART Team capacity	6	6	6	6	6	6	de-esc				4
HQCL	**HIGH QUALITY COSTS LESS**												
HQCL.1	4.1	Unable to deliver the Quality Priorities due to competing demands between quality and finance	6	6	6	6	6	6	6	6	6	↔	4
HQCL.1	4.2	Contractual targets for CQUIN not met and CQUIN funding not available	12	12	12	12	12	12	12	12	12	↔	4
HQCL.1	4.3	Ability to deliver Carter/Patient Level Costing/Efficiency Programme				new	tbc	tbc	de-esc				
HQCL.1	4.4	Ability to influence system-wide quality improvement				new (16)	16	16	16	16	16	↔	8
BC.1	4.5	Low retention of non-medical workforce in some clinical areas leading to ongoing recruitment challenges	12	12	12	12	12	12	12	12	12	↔	8
BC.1	4.6	Implementation of HGH contingency plan results in potential adverse outcomes for parents and children	10	10	10	10	10	10	10	10	10	↔	10
SC.3	Esc CSS	Inadequate storage for the deceased	15	15	15	15	15	15	15	15	15	↔	1
SC.3	4.7	Inability to continue to supply stock medicine to wards and medicines to all of the Trust's dispensaries	12	12	12	12	12	12	12	12	12	↔	2
SC.3	Esc	Potential risk of failing to respond to the results of diagnostic tests	8	8	8	8	8	8	8	8	8	↔	4
SC.3	Esc	Potential risks to handover of treatment through poor communication of discharge summaries'	8	8	8	8	8	8	8	8	8	↔	4
SC.3	Esc	Aspects of Medicine Management identified as needing improvement	5	5	5	5	5	5	5	5	5	↔	3
N/A	misc 3	Potential risk of having the Wrong Blood in Tube (WBIT)	9	9	9	9	9		de-esc				3
N/A	Esc	Risk of incorrect dosage when administering medicines via 1 and 3ml syringes (esc June report)		esc	9	9	9		de-esc				1
N/A	Esc	Failure to comply with NICE Quality Standard 13 End of Life Care (now a CQUIN)	6	6	6	6	6		de-esc				3
N/A	Esc	CAS Alert NPSA 2011/PSA001 Part A (replaced by one new risk below)	4	4	4	4	replaced		replaced				
N/A	Esc	CAS Alert NPSA 2011/PSA001 Part b (replaced by one new risk below)	12	12	12	12	replaced		replaced				
N/A	Esc	Patient may receive a medication via the wrong route (confusion between neuraxial and intravenous routes)					New (4)	4	de-esc				4
GD	**GO DIGITAL**												
GD.1	5.1	Poor clinical records management processes have a potential impact in quality and safety	6	6	6	6	6	6	6	6	6	↔	4
GD.1	5.2	Potential failure of accurate reporting and poor data quality due to implementation of EPR	6	6	6	6	6	6	6	6	6	↔	4
GD.1	Esc	Potential risk of non-disclosure of Trust waiting list position due to data quality issues with PTL		esc	new	tbc			de-esc				
GD.1	5.3	Potential failure to obtain the clinical advantages of EPR	8	8	8	8	8	8	8	6	6	↔	6
GD.1	Esc	Risk to screening performance from failure to provide NN4B's for new-borns, due to speed of IT system, which frequently times out.		esc	12	12	12	8	8	de-esc			8
GD.1	5.4	Ability to improve timeliness, accuracy and safety of clinical records. (in Oct report)				new (6)	6	6	6	6		↔	3
GD.2	5.5	Failure to use population health data to understand patient flow into ED and Cancer pathways and RTT planning (in Oct report)				new	tbc		4	4		↔	2
GD.3	5.6	Ability to implement the patient portal system across healthcare services (in Oct report)				new	tbc			6		↔	3
MP	**MASTER PLANNING**												
MP.1	6.1	The Trust Master Plan from 2017 – 2047 may not be developed to point of delivery (in Oct report)				new	tbc			6	6	↔	3
MP.1	6.2	Ability to develop and use premises sufficiently to support service capacity requirements (in Oct report)				new	tbc			4	4	↔	2
MP.3	6.3	Ability to assess and improve the healthcare environments to maintain regulatory compliance (in Oct report)				new (9)	9	9	9	9	9	↔	6
MP.2	6.4	Ability to take the right opportunities for Investment/ Acquisition and Disposal (in Oct report)				new	tbc			4	4	↔	2
MP.1	6.5	Ability to assess and improve the management of all contracts and leases involving the estate (in Oct report)				new	tbc		4	4	4	↔	2
MP.3	6.6	Ability to meet capital investment needs through a robust capital planning process	9	9	9	9	9	9	9	de-esc			6
MP.3	6.7	Major Business Cases may not be delivered as expected	16	16	16	16	16	16	16	16	16	↔	12
MP.1	6.8	Access to hospital site and current car parking constraints across the Trust has impact on operational performance	9	9	9	9	9	16	16	12	12	↔	6
MP.1	6.9	Capacity of AICU/CICU does not meet demand	12	12	12	12	12	12	12	12	12	↔	6
MP.1	6.10	Ability to re-provide dedicated major trauma centre accommodation. (esc in January 2018 report)				n/a	esc	9	9	8	8	↔	2
MP.2	6.11	Ability to maintain services following the collapse of one of the trust's PFI providers (discussed as AOB March 2018)						tbc	4	de-esc			1
MP.2	Esc Est	Risk of fire from potentially combustible materials at JR Trauma building (June report)		esc	15	15	12		de-esc				4
MP.2	Esc	West Wing stair well poses potential risk	15	15	15	15	15	15	15	15	15	↔	4
MP.2	Esc Est	Failure to generate hot water and heat in retained parts of the Churchill estate	9	9	9	9	9	9	9	9	9	↔	3
MP.2	Esc CSS	Potential failure to carry out some resuscitation training for staff due to issues with training environment (esc June report)		esc	20	20	20		de-esc				1
MP.2	Esc	Building issues in the Women's Centre could lead to patient safety issues	12	12	12	12	12		de-esc				3
MP.2	Esc CSS	ITU Drainage: Poor estate with risk of ventilation failure, electrical backup and effluent ingress into clinical area	9	9	9	9	9	9	de-esc				5
FOE	**FOCUS ON EXCELLENCE**												
FOE.1	7.1	Ability to realise the benefits of the FOE's initial assessment of services into the Trust's business as usual activities. (in Oct report)				new		6	6	6	6	↔	4
FOE.2	7.2	Failure to develop robust plans to support the Trust's Joint Strategy with Universities, including clarity on the clincial strategy (in Oct report)				new (9)	9	9	9	9	9	↔	6

Risk ID	Work Programme Link to Strategic Risk	Risk Description (for more detail see CRR; CRR ref included)	Controls	Performance Indicators and Assurances	Assurance from What? (papers / metrics) : summary of reports	Assurance team view	Executive Director view
SUSTAINABLE COMPLIANCE: Continuing to deliver sustainable compliance with statutory requirements							
SC.1	Key access standards/NHSI investigation (sustainable performance)	Ability to deliver key 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 (1.2), the delivery of National Access targets Cancer – 62 day Cancer Standard (1.3) and the 4 hour ED target (1.1))	• Develop and agree a demand and capacity plan and associated trajectories with NHSI and commissioners for the RTT standard • Delivery of the plan • Updating of action plans and trajectories for ED and Cancer performance • Delivery of the action plans	• Agreement of an affordable and deliverable plan • Performance against agreed trajectory • Data Quality Indicators • Agreement of affordable and deliverable plans • Performance against agreed trajectories	**Reported to the Board** • Integrated Performance Report (L2) • Finance and Performance Reports (L2) • 2nd Stage RTT Activity Plan (L1) • TME report to the Board **Reported Elsewhere** • Monitoring delivery of RTT Activity Plan (L1) Monitoring delivery of performance in relation to urgent care and cancer (L1) • Urgent Care Pathway 2017/18 - Improving patient flow (L1)	Moderate	Moderate
SC. 2	Financial sustainability	Ability to deliver the in-year financial plan (1.4) and NHSI Financial Control total plan and to continue to deliver a sustainable level of EBITDA over 3-5 years (1.6) impacts on ability to access STP funding (1.5)	Centralisation of controls of over discretionary spending • Tight performance management of Divisions and Directorates not on track. • Tight management of capital and working capital • Agreement with NHSI of realistic in-year financial plan • Management of education programmes on EBITDA and Financial sustainability • Increase capacity to deliver major change projects • Pursue commercial ventures which will cross subsidise NHS care	• Agreement of affordable and deliverable plans monthly financial monitoring reports to Board TME and FPC	**Reported to the Board** • Finance Reports (L2) • Financial Planning / Forcesting (L2) **Reported Elsewhere** • Finance Reports (L2) to FPC • Financial Planning / Forcesting (L2) to FPC • Financial governance (SO/SFI, changes to accounting practice to Audit Committee) L2	Significant	Significant
SC.3	Quality sustainability	Ability to deliver safe,and effective clinical care to patients, impacts on ability to comply with CQC regulations (1.7 & 1.8) (2.6)	See high quality costs less for notes in relation to quality priorities, suite of clinical policies, procedures and protocols that cover clinical activities. Clear clinical leadership, training and education. Safety culture and open incident reporting process, compliance with CQC regulations	Monitoring via quality reporting, clinical audit, quality performance metrcis regulary reviewed and reported through the governance structure of the Trust.	**Reported to Board** •Quality Account • Quality Committee Report (L2) • Board Quality Report (Rag ratings) (L2) •Clinical Governance Cttee Review •Siri Forum results	Significant	Significant
BUILDING CAPABILITIES: Building the Trust's capabilities to deliver its objectives							
BC.1	Building workforce capabilities	Ability to recruit, retain and engage staff (2.1) to work together to deliver compassionate excellence and fulfil their potential, leads to excessive use of agency staff that might compromise quality (2.5)	Development of workforce / people strategy, recruitment and retention intitatives, 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 suvey to be monitored by TME •agreed HR KPI performance monitored via ORBIT • Further developments in relation to the People Strategy to be reviewed and reported via committee structure	**Reported to Board** • TME Report to the Board (L2) • Quarterly Workforce and Organisational Development Report (Q2&Q4) (L1) • Equality and Diversity Annual Report (L2) •People Strategy reprot to Board • **Reported elsewhere** • Annual Staffing Review (L1). • Staff Surveys (L2). • Nurse staffing data (care hours per patient) (L2) • Update on Nursing Workforce Retention & Contingency Plan (L1) • Workforce Planning update to FPC	Moderate	Moderate
BC.2	Building nursing workforce capabilities	Delivery of nursing capacity and capability (via the school of nursing and Magnet accreditation) (2.2)	• Implementation of programme for Magnet accreditation, Agreement of project plan for School of Nursing • Implementation of the plan •Foundation programme implementation • Delivery Compassionate Excellence Programmes	• Project plan agreed • Achievement of project milestones	**Reported to Board** • Workforce and Organisational Development Papers (Q2&Q4) (L1) • Staff survey result and actions **Reported elsewhere** • Annual Staffing Review (L1). • Staff Surveys (L2). • Nurse staffing data (care hours per patient) (L2) • Update on Nursing Workforce Retention & Contingency Plan (L1)	Partial	Partial
BC.3	Organisational Training and development	Insufficient provision of appropriate education and learning development opportunities (2.3)	• 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 Apprenticeship 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 acredited 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, Back Care, and Learning and Development Teams to the Churchill Hospital site and establish an Education Centre in what was Geoffrey Harris Ward. • To develop a second year Foundation programme to build upon current year one programme. • HMC • Supervision / Mentorship	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 • GMC surveys Key staff in post (Nursing education) and Organisational Development • Skills for Managers (including people priorities for 18/19)	**Reported to the Board** • Annual H&S Report (L1) • IPR and BQR record statutory & mandatory training rates by staff group / division **Reported elsewhere** • NHSI Operating Productivity paper to FPC	Moderate	Moderate

Risk ID	Work Programme Link to Strategic Risk	Risk Description (for more detail see CRR; CRR ref included)	Controls	Performance Indicators and Assurances	Assurance from What? (papers / metrics) : summary of reports	Assurance team view	Executive Director view
HOME SWEET HOME: Achieving local healthcare integration to deliver excellent care							
HSH.1	Rebalancing the System	Ability of the Trust to work effectively with other health and social care providers (3.1 & 3.2) to ensure patients are cared for in the right place at the right time, and influence system quality improvement (3.7).	• 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 • 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	•Number of DTOCs/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	**Reported to Board** • Integrated Performance Reports (IPR) (L1). • Quality Committee Report (L2) • Audit Committee Report to the Board (L2) • TME Report to the Board (L2) • Annual H&S Report (L1) • Workforce and Organisational Development Papers (Q2&Q4) (L1) • Patient Perspective / Patient Story (L3) • Annual Patient experience, Complaints and PALS (L3) **Reported elsewhere** • Annual Staffing Review (L1). • Patient and Staff Surveys (L2). • PROMs (L3). • Audit Committee review Clinical Audit (L2) • Network meetings (L2). • Update reports from Community Partnership Network (L2). • Contingency Planning Reports (L1) • Weekly monitoring programme (L1) • Nurse staffing data (care hours per patient) (L2) • Update on Nursing Workforce Retention & Contingency Plan	Moderate	Moderate
HSH.2	Bed and service reconfiguration	Potential risk to the implementation of the reconfiguration of beds and services (3.3)	• 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 reconfiuration of AAU, Rowan Day case Unit and SEU being devised and delivered	• Project timetables met • Number of DTOCs/ED performance/patient satisfaction • Weekly monotoring 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) **Reported elsewhere** • Winter Planng to TME and QC (L1) • Urgent Care and Canncer Planning to TME (L1)	Partial	Partial
HSH.4	Oxfordshire Transformation Programme	Ability to implement the agreed service proposals from phase one of the Oxford Transformation Programme consultation (3.4) and to continue to contribute effectively to the Oxfordshire Transformation Programme (3.5)	• Plans for the development of an outpatient and diagnostic unit, following public consultation at the Horton • Development of options for the repatriation of patients from Oxford to the Horton • Business Case to TME • Cancer pathway review to reduce time between patient encounters and improve patient experience (Quality Priority)** on hold pending OCCG decision ** • Support the continued work associated with the phase one consultation • Contribute to the phase two consultation	• Agreement and delivery of a project timetable • Number of patients repatriated • Patient experience indicators Successful completion of the consultation phase. Initiation of phase two in 2017/18 (subject to delay)	**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)	Limited	Limited
HSH.5	Working with GPs and primary care	Ability to develop positive partnerships with GPs and primary care (3.6)	• 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	• Delivery 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) **Reported Elsewhere** • Care 24/7 Monitored through TME quarterly	Partial	Partial
HIGH QUALITY COSTS LESS: "Quality is our Business" – this strategic theme is about quality as an organising principle, and about making a business success out of quality.							
HQCL.1	Quality priorities/account / quality improvement	Ability to deliver the Quality Priorities (4.1), CQUINS (4.2), and cost effective initiatives (4.4) (such as PLC / Carter/ Quality Improvement initiatives) (4.3) due to competing demands between quality and finance	• Patient and public consultation to reflect on performance 2017/18 and inform 2018/19 priorities • Agreement of the quality priorities/account delivered to timeframe (annually) • 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 • Monthly contract review meeting held between the Trust & Commissioners • Internal weekly business planning meetings to monitor compliance and potential financial impact of non-delivery • Collaboration with Oxford Health to achieve the CQUIN target	• 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) • HSMR and SHMI 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	**Reported to Board** • Integrated performance Report (IPR) (L1) •Quality Account • Quality Committee Report (L2) • Oxford AHSN Annual Report (L2) •Board Quality Report (Rag ratings) (L2) •Clinical Governance Cttee Review •Siri Forum results •Peer Review / CQC Assurance •Champions for Change Project updates • Workforce and Organisational Development Performance Report (Q4, 16/17) **Reported Elsewhere** • Annual Inpatient Survey (2016 - published 31st May 17) • Leadership Development Meetings (L1) • • Lessons and Achievements of the Human Factors CQUIN (L1) • Update on CQUIN (L1) • Report from Clinical Governance Committee (L2)	Signifcant	Signifcant

Risk ID	Work Programme Link to Strategic Risk	Risk Description (for more detail see CRR; CRR ref included)	Controls	Performance Indicators and Assurances	Assurance from What? (papers / metrics) : summary of reports	Assurance team view	Executive Director view
GO DIGITAL: 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							
GD.1	Clinical Documentation – moving to paper free working	Ability to improve timeliness, accuracy and safety of clinical records (via EPR development and implementation). (5.1, 5.2, 5.3, 5.4)	• 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 paperlight over time	•Metrics on numbers of notes not being pulled •Metrics on numbers of referral letters being scanned • Monitoring of the CQC Should Do Action Plan	**Reported to Board** • TME Report to the Board (L2) **Reported Elsewhere** • Aspect of GD agenda reported to TME (L1) - primarily GDPR, Cyber security, Information Governance (L2)	Moderate	Moderate
GD.2	Population Health	Failure to use population health data to understand patient flow into ED and Cancer pathways and RTT planning (5.5)	• Population health platform in place for 13 practices • HIE in place broadly replacing the Oxfordshire Care summary	•Population wide platform available for testing •HIE working as planned • Data Quality Indicator	**Reported to the Board** • Integrated Performance Report (IRP) (L1) • Finance and Performance Report (L1) • Internal Audit Report • RTT Activity Plan • TME Report to the Board (L2) **Reported Elsewhere** • Aspect of GD agenda reported to TME (L1) - primarily GDPR,	Partial	Partial
GD.3	Patient Portal	Ability to implement the patient portal system across healthcare services (5.6)	• 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	•Core functionality built and tested •Plan agreed and resources to deliver in place	**Reported to the Board** • Information Governance and Data Quality Group Bi-annual Review (L2) **Reported Elsewhere** • Lessons Learnt from NHS Cyber Attack (L2) • Information Governance and Data Quality Group Bi-annual Review (L2)	Partial	Partial
MASTER PLANNING: Long term estates planning – intended to support future investment in infrastructure to support clinical services, research and education endeavour for the Trust							
MP.1	Create a progressive Trust Master Plan from 2017 - 2047 (to includes premises development, space management, contracts management and leasing)	The Trust Master Plan from 2017 – 2047 may not be developed to point of delivery (6.1) (to include a shorter term plan to develop and use premises (6.2) sufficiently to support service capacity requirements (6.5))	• 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 approved schemes with no flexibility to support feasibility work. • Resources identified to support internal mechanisms to generate high level costs for those cases involving capital expenditure, approved to be developed beyond PID stage • 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 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 • Maximise potential for joint partnerships	•Demonstration of collaborative plans for travel/ transport, key working housing and relocation of services closer to the patient. •Monitoring of Capital schemes funding •MiCAD data base 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** • Update on Oxfordshire Transformation Programme (L1) • Accountable Care System (L1) • National Reports on Estates Return Information Collection (L3) • Capital Programme Updates (L2) • Transformation Programme Updates (L1) • TME Report to Board (L2) **Reported Elsewhere** • Oxfordshire CCG • Proposal to strengthen the capital planning group, governance structure and processes • Update on Capital Programme • Investment Committee reports	Moderate	Moderate
MP.2	Improving our healthcare environments – a plan for change	Ability to assess and improve the healthcare environments to maintain regulatory compliance (6.3)	• Identify those areas whose environment is not meeting CQC (regulatory) standards • Address suboptimal facilities through revision and reconfiguration of space	•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) •Business Cases (L1) •Investment Committee reports to Board (L2) **Reported Elsewhere** • Proposal to strengthen the capital planning group, governance structure and processes • Update on Capital Programme	Moderate	Moderate
MP.3	Establish an effective capital planning structure and process for 2018/ 19 and for prioritisation of capital investment	Ability to meet capital investment (6.4) needs through a robust capital planning process (6.7) and to take the right opporunities for investment, acquisition and disposal (based on plans)	• 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 funds • 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. • Prepare an Estates Strategy for the OUH that aligns with its Master Plan • Prepare a plan which includes identification of sites for investment/ acquisition and disposal	•Structure and process approved by TME •Assessment criteria for capital expenditure •Capital funding available agreed by TME • The amount of capital to carry forward is agreed with Divisions and a capital investment plan agreed • 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 (CPB) (L1) • Audit Committee Report to the Board (L2) • TME Report to the Board (L2) **Reported Elsewhere** • Internal Audit - Divisional Financial Governance (L3) • Update on Implementation of Internal audit recommendations (L2) • Delivery Performance Improvement Plans (L1) • Update on NHS Improvement Enforcement (L1) • Update on NHS Improvement Investigation into Trust Finances	Significant	Significant

Risk ID	Work Programme Link to Strategic Risk	Risk Description (for more detail see CRR; CRR ref included)	Controls	Performance Indicators and Assurances	Assurance from What? (papers / metrics) : summary of reports	Assurance team view	Executive Director view
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's initial assessment of services into business as usual (7.1)	• Agree action list to address corporate learning points • Actions agreed for cross-cutting themes: - 1st phase – Urgent care, urology, orthopaedics, GP communications - 2nd phase Critical Care &radiology Define 'the bar' which all OUH services are expected to meet • Improve the use of clinical outcome measures	• Agreed set of actions monitored by TME • improved KPI 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 • Quarterly Workforce and Organisational Development Performance Report (Q4) **Reported Elsewhere** • Annual Inpatient Survey L3 • Leadership Development Meetings (L1)	Limited	Limited
FOE.2	Joint Strategy with Universities	Failure to develop robust plans to support the Trust's Joint Strategy with Universities (7.2)	• 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) **Reported Elsewhere** • Limited information on new developments to FPC •	Limited	Limited

Assurance Team view	Outline descriptor
No / Limited	The report highlights weaknesses in the design or operation of controls that might have a significant impact on the delivery of the strategic objectives. **Limited** assurance can be given on the system to prevent risks from impacting on the achievement of the strategic objectives. Assurance indicates low effectiveness of controls. **Or** The volume of reporting and assurance levels of those reports do not enable a meaningful assurance view to be gained ***KPMG definition****: Means the system has not been designed effectively and is not operating effectively. Audit work has been limited by ineffective system design and significant attention is needed to address the controls. Might be indicated by one or more priority one recommendations and fundamental design or operational weaknesses in the area under review. (i.e. the weaknesses identified have a fundamental and immediate impact preventing achievement of strategic aims and/or objectives; or result in an unacceptable exposure to reputation or other strategic risks).*
Partial	The report highlighted some weaknesses in the design or operation of controls that might have an impact on the delivery of the some of the strategic objectives. **Partial** assurance can be given on the system to prevent risks from impacting on the achievement of the strategic objectives. **Or** The volume of reporting and assurance levels of those reports enables only a partial level assurance view to be gained. ***KPMG definition:*** *Means both the design of the system and its effective operation need to be addressed by management. Might be indicated by one or more priority one, or a number of priority two recommendations that taken cumulatively suggest a weak control environment. (i.e. the weakness or weaknesses identified have a significant impact preventing achievement of strategic aims and/or objectives; or result in an unacceptable exposure to reputation or other strategic risks).*
Moderate	The report did not highlight any weaknesses in the design or operation of controls that would in overall terms impact on the delivery of the strategic objectives. However some control weaknesses that might impact on certain objectives were identified. **Moderate** assurance can be given on the system to prevent risks from impacting on the achievement of the strategic objectives. Some assurance in place or still maturing so the effectiveness cannot be fully assessed but is likely to improve. **Or** The volume of reporting and assurance levels of those reports enables a fuller assurance view to be gained. ***KPMG definition:*** *Means the system is generally well designed however minor improvements could be made and some exceptions in its operation have been identified. Might be indicated by one or more priority two recommendations or a number of priority three recommendations (i.e. that there are weaknesses requiring improvement but these are not vital to the achievement of strategic aims and objectives –however, if not addressed the weaknesses could increase the likelihood of strategic risks occurring).*
Significant	The report did not highlight any weaknesses in the design or operation of controls that would in overall terms impact on the delivery of the strategic objectives. Some low impact control weaknesses were identified and if addressed would improve overall performance. **Significant** assurance can be given on the system to prevent risks from impacting on the achievement of the strategic objectives. High level of assurance can be provided over the effectiveness of controls **Or** The volume of reporting and assurance levels of those reports enables a meaningful assurance view to be gained and provides an evidence base to support a significant assurance view. ***KPMG definition:*** *Means the system is well designed and only minor low priority recommendations have been identified in relation to its operation. No recommendations or priority three recommendations. (i.e. any weaknesses identified relate only to issues of good practice which could improve the efficiency and effectiveness of the system or process).*