Board Assurance Framework
Public
Version: September 2020

Ref	Risk description	Gross (inherent) risk rating			Controls (Mitigating actions)	Assurances (audit, monitoring, reporting, scrutiny)	Current (residual) risk rating			Gaps in controls/assurance and actions to address gaps	Exec Lead	Target risk rating			Delivery status and action updates
		I	L	R			I	L	R			I	L	R	
1	**Strategic Objective 1: Driving Quality Improvement** Goals: patients will be safe from harm; patients will achieve the outcomes they want; and patients and carers will have excellent experiences														
1.1	Failure to: (i) meet consistently quality standards for clinical care; (ii) address variability across quality standards ; or (iii) reconcile conflicting quality standards or guidance, will result in poorer outcomes for patients and poorer patient safety and experience.	4	5	20	Patient experience controls include, but are not limited to: - Complaints and Patient Advice and Liaison Service (PALS) feedback; - feedback of patient experience (received through a mixed medium of postal feedback and also real-time feedback through electronic devices); - the People's Experience & Involvement Strategy 2019-21, developed with a high degree of patient involvement (including consultation with the Council of Governors and draft presented at the CoG Strategy Session on 28 February 2019) and approved at the Board meeting in May 2019. The aim of the strategy is to see an improvement in more people who use our services telling us that they have been given opportunities to be involved and empowered to make shared decisions about their care and treatment, as well as opportunities to work with staff in developments to services. Actions to progress the objectives of the strategy are set out in Appendix C of the strategy; - the Quality Committee; - Triangle of Care "two star" accreditation; - the strategy for friends, families and carers - "ICareYouCare" - launched in June 2017 and building on the Triangle of Care "two star" accreditation; the Trust is one of 10 NHS trusts to have achieved this accreditation and is working towards "three star" accreditation; and - the Oxford Healthcare Improvement Centre (reporting into the Quality Committee).	Patient experience monitoring by the Patient Feedback to Improve Care Group. The Group's objective is to ensure senior leadership on embedding collection and use of patient feedback across the Trust by monitoring the implementation of objectives from the Patient Experience Strategy. The Group formerly reported progress quarterly to the former Caring & Responsive quality sub-committee - now replaced by the Quality sub-committee since August 2020. Annual reporting on patient and carer experience, as well as on complaints, is provided to the Quality Committee e.g. most recently in July 2020. On a regular basis the Board also receives Quality Reporting with a particular focus on Patient Experience e.g. January and September 2020. The Council of Governors also operates a Patient Experience sub-group to review patient experience issues and provide assurance that patient experience is given due regard in the provision and evolution of Trust services.	4	3	12	GAP (patient experience assurance): the progress being made against well-established themes and areas for improvement in patient experience. The need to potentially invest further resources or realign resources around Quality Improvement and to drive forward the People's Experience & Involvement Strategy. The impact upon other priorities if more emphasis and resources are given to patient experience and involvement. ACTION: monitoring through the work of the Patient Feedback to Improve Care Group and reporting into Directorate Performance Review meetings and the Quality sub-committee. Monitoring through the Board and regular reporting on patient experience with a focused Patient Experience report to Board. OWNERS: Service and Clinical Directors; Patient Experience and Involvement Manager; and Head of Quality Governance	Chief Nurse - Oversight of HIGH risk through Quality Committee and quality sub-committees	4	2	8	People's Experience & Involvement Strategy 2019-21 approved at the Board in May 2019. Net/residual risk scores generally correlate to maintaining overall BAF current/residual risk rating of 12 (high) based on: - (1) scored impact 5, likelihood 3 (possible) = 15; and - (2) and (3) both scored impact 4, likelihood 3 = 12.
										GAP (safety): CQC rating of "requires improvement" on the question of whether services are Safe at CQC inspection in July-September 2019 (published December 2019) - and unchanged from previous CQC inspections in March 2018 and June 2016 and following comprehensive inspection in September/October 2015. Work continues to action recommendations. CQC noted that the Trust continued to have issues with recruitment and retention of staff. All wards were staffed to achieve safe staffing levels but this was achieved on some wards by staff working additional hours and shifts, use of temporary staff from the Trust's bank and agencies, and reducing beds on some wards. ACTION: progress CQC post-inspection improvement plan through the IC5 Group (reporting into the Quality Committee). Oxfordshire CCG is the lead commissioner to sign-off completion of actions across improvement plans through quarterly quality review meetings. OWNER: Head of Quality Governance; and Chief Nurse.					

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						External assurance in relation to patient experience also through CQC inspection process - most recently CQC inspection which reported in December 2019 and awarded an overall rating of 'Good' (unchanged since CQC inspections in 2018 and 2016). Inspection process included CQC discussing directly with patients and collecting feedback. With few exceptions, the patients they met spoke positively about the support they received from staff and their treatment.				GAP (across patient experience, safety and clinical and operational effectiveness controls): no-deal EU Exit/Brexit and impact of the risks identified in the Trust's EU Exit Operational Readiness Risk Assessment specifically in relation to: (1) shortages of medicines and vaccines; (2) shortages of medical devices and clinical consumables; and (3) shortages of non-clinical consumables, goods and services due to increased time for imports to clear customs. ACTION: mitigating activities as set out in the risk assessment as presented to the Board meeting in public on 31 January 2019 as appended to the CEO report at paper BOD 02(ii)-(iii)/2019. OWNERS: specific risks (1)-(3) owned by the Chief Pharmacist and the Director of Finance.					
					Safety controls include, but are not limited to: - improvement initiatives including through the Oxford Healthcare Improvement centre which is building improvement capability across the Trust through training, coaching and seminars. Oxford Healthcare Improvement's objectives are to: collaborate in improvement projects with Trust improvement leads, patients and families; build capacity and capability in the Trust; and communicate/share its experience and findings; - the Clinical Risk Management Strategy and Clinical Risk Assessment and Management training which now includes a component on suicide awareness; - the Central Alerting System (CAS) policy and procedure (April 2018). CAS is a web-based system for issuing patient safety alerts and other safety critical guidance; - the Risk Management strategy and policy 2018-21; - the Patient Safety Team (formerly Learning from Incidents Team); - the Quality sub-committee and the Quality Committee; and - the Mortality Review Group	Integrated internal learning across patient experience, safety, workforce and clinical and operational effectiveness through using data from incidents, complaints, claims and HR case work: - weekly monitoring of Serious Incidents, complaints, claims, inquests and HR casework at Clinical Standards Weekly Review Meeting; - Directorate monitoring of IIR and Serious Incident reports to ensure clinical needs are being addressed/incidents learned from; - the Board receives regularly/near quarterly Quality Reporting with a particular focus on Incidents/Mortality/Safety; - the Board also receives quarterly Quality Reporting with a particular focus on Effectiveness; and - external assurance through CQC inspection process - most recently in July-September 2019 (reported in December 2019) and prior to that in March 2018 and June 2016.								Overall CQC rating for the Trust as a service provider following inspection in July-September 2019 (reported December 2019) was "good" (unchanged since March 2018 and June 2016 but an improvement since the comprehensive inspection in September/October 2015 from the then overall rating of "requires improvement"). Quality Committee receives regular updates on progress to achieve MUST and core SHOULD CQC actions.
					Workforce controls include, but are not limited to: - day-to-day operational management structures, effective team working and application of Aston Team-based Working Approach; - optimal staffing levels; - processes to pick up exceptions/variations and for staff to raise concerns e.g. through the Whistleblowing policy; and - the People, Leadership & Culture Committee and the Quality Committee.	Regular integrated internal reporting on patient experience, safety, workforce, clinical and operational effectiveness and governance and leadership including: - to the Board as (publicly available) standing items at each meeting in public on Quality and Safety, Quality and Performance, Workforce Performance (recruitment activity, turnover, sickness and bank and agency use) and Safe Staffing Levels; - to the Board through a regular patient experience presentation at public Board meetings focusing on patient stories (with appropriate details anonymised to protect individuals'								

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					Clinical and operational effectiveness controls include, but are not limited to: - models of care for every service with clear standards of care and standard operating procedures; - clinical and managerial leaders focusing on achieving standards; - AIMS accreditation. As at July 2015, Adult Directorate acute and rehabilitation inpatient wards had all achieved AIMS (Accredititon for Inpatient Mental Health Services). AIMS is a nationally recognised standard from the Royal College of Psychiatry College Centre for Quality Improvement; and - the Quality sub-committee and the Quality Committee.	confidentiality and with permissions having been granted in all cases); - to the Quality Committee on clinical audit outcomes, Serious Incidents (SIs), complaints and PALS, patient experience and quarterly Quality Account updates. The Quality Committee also regularly receives directorate safety/quality reports from all clinical directorates to provide more detail on safety and quality developments within directorates and service lines; - through the quality sub-committees reporting into the Quality Committee from 2015: the Safety quality sub-committee, the Effectiveness quality sub-committee, the Caring and Responsive quality sub-committee and the Well Led quality sub-committee - replaced since August 2020 by the Quality sub-committee; - through Directorate Performance Reviews; - themed reports to the Extended Executive on complaints, incidents and patient experience; - reporting against standards at team to Board level. Trend analysis and prompt response to variation. Walkarounds by staff, safety walkabouts, Board walkabouts and visits at least annually for each team. Reporting on Board walkabouts to the Institute for Healthcare Improvement as part of the South of England Patient Safety Collaborative; - Internal Audit - as part of Internal Audit Plan 2015/16 reviews of Partnership Governance and Quality Governance; and - CQC inspection July-September 2019 (reported December 2019) and March 2018 and June 2016.									
					Governance and leadership controls include, but are not limited to: - dialogue with regulators to feedback on quality standards and inconsistencies or conflicts noted and their potential consequences. Ongoing dialogue with regulators with a view to inviting clarification or further guidance on reconciling or resolving potential inconsistencies or conflicts; - the Quality sub-committee and the Quality Committee; and - Board self-assessment and Well Led governance review March-June 2017.									
						Monitoring of the Trust Risk Register for specific potential risks around quality and safety e.g. that patients may not be protected from harm (including through pressure ulcers and suicides in the community), the impact of increased activity levels on district nursing services in Oxfordshire and the 111 service in Oxfordshire, learning from incidents.				GAP (safety controls): variation in application and adoption of Safer Care and Improvement methodology in Directorates to spread good practice across teams. ACTION: monitoring of Safety Performance and progress on Safer Care projects through the Quality sub-committee (and before that the Safety quality sub-committee which received assurance through Directorate quality reports, the Safety thermometer, the Safer Care report and other Safety reporting). OWNERS: Directorate Safety Representatives and Chief Nurse.					

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						External assurance including: - CQC visits, surveys and inspections. Following CQC inspections in 2019,2018 and 2016, overall rating was "good" with ratings of "good" in 4 out of 5 quality measurements (caring, responsive, well-led and effective) and rating of "requires improvement" in the remaining 1 quality measurement (safe); - Oxfordshire CCG as lead commissioner and leading on sign-off of completion of CQC post-inspection improvement plans through existing quality review meetings. CQC will also continue to monitor progress through existing routine relationship meetings (quality); - Parliamentary Ombudsman letters and themed reports in response to patient feedback and complaints; - monthly contract and quality meetings with commissioners and closure meetings to review SIs. A detailed quality schedule was agreed with commissioners which included a comprehensive range of quality indicators and measures; and - external accreditation, peer review processes and external national clinical audits.				GAP (external assurance): as above gap re safety following CQC inspections in 2019, 2018 and 2016 ACTION: as above to implement improvement plans to address findings from CQC inspection OWNER: Head of Quality Governance; and Chief Nurse.					
						Other assurance through: - Essential Standards Audits; - the Safety Thermometers; - the Community Hospitals Assurance Tool and publication of the outcomes of the Friends and Family Test; - the National Reporting and Learning System relating to incidents; - national confidential inquiries into homicides and suicides; and - Internal Audit - previous reviews have included: Service Innovation and Business Development which included review of the Aston Team Working Programme; Making Every Contact Count; Tender Workshop; and Flexible Workforce Management Programme; Patient Experience - Complaints; Quality Strategy and Governance; CQC follow-up; and Medical Devices.									

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1.2	Failure of service models to deliver an integrated care pathway may mean that the individual needs of patients, including those with special needs and/or disabilities, are not met and that patients are not provided with appropriate access to, and transfer between, services.	4	4	16	Controls include but are not limited to: - Oxfordshire Mental Health Partnership with Mind, Response, Restore, Connection FS and Elmore - development of Recovery Colleges in Oxfordshire and Buckinghamshire; - Integrated Locality Teams in place and development continuing; - joint working with Oxfordshire GP Federations relating to joining up of Primary and Community Services. Agreement in place with all Oxfordshire GP Federations to explore joint enterprise model to deliver full multi-disciplinary primary care (fruition of location/neighbourhood integration) to maximise support to patients and reduce pressure on GP and community workforce; - Older People's OBC being advanced through the Oxfordshire System Winter Plan; - development of Urgent Mental Health Care in both Oxfordshire & Buckinghamshire (with South Central Ambulance Service (SCAS) and Thames Valley Police (TVP)). SCAS mental health nurse scheme established at ambulance control. Street Triage with TVP fully operational in both Oxfordshire & Buckinghamshire and ongoing work with TVP to provide appropriate mental health crisis response; - CAMHS (Child & Adolescent Mental Health Services) model in Buckinghamshire delivered in partnership with Barnardo's; - section 75 agreements with Oxfordshire County Council and Buckinghamshire County Council to provide health and social care service functions with a pooled provider budget. Governed through Joint Management Groups, reporting into Quality Committee; - since 2016/2017, Thames Valley and Wessex Forensic Mental Health New Care Model for adult forensic mental health (new provider-led commisioning approach for medium and low secure services). Overall aim of new care model to reduce lengths of stays in region, treat more people closer to home, reduce inpatient stays and reinvest in other out of hospital forensic mental health services. Trust leads network of other providers of specialist mental health care to coordinate services; - Trust also managing the commissioning of new care model for Adult Specialist Eating Disorders (inpatient and day patient services); and - since July 2017, Oxfordshire Learning Disability services (community and forensic) transitioned into the Trust from Southern Health NHS FT.	- Strategic partnerships' reporting and monitoring at: Directorate Level, Operations Senior Management Team (OPS SMT) meeting, Executive, Quality Committee and the Board (reporting to the Board on Strategic Partnerships since May 2016 and most recently in July 2020); - Reporting to the Quality Committee on section 75 Joint Management Groups - Board and Council of Governors (public and private) also received progress reports on Learning Disability Transformation and New Care Models (especially during transition periods in FY17 and FY18), then followed by reporting into Quality Committee - CQC Oxfordshire local system review during Q3 2017/18 (reported during Q4) - part of a programme of 20 targeted reviews of local authority areas to understand how people move through the health and social care system with a focus on the interfaces between services (followed by a national report for government that brings together key findings from the across the 20 local system reviews). Reported to Board in January 19 (prev in February 2018).	3	3	9	GAP (controls - service model reviews and development): development of integrated locality teams with social care. ACTION: appointment of programme director within OCCG working on behalf of all partners has progressed the development of integrated locality teams. Further development of work with GP federations ongoing. Cross-reference also to SO 4.2 and action updates against integrated partnership working. OWNERS: Service Director and Clinical Director from the Community Directorate GAP (controls - Oxfordshire Mental Health Partnership and Recovery Colleges) - Recovery College funding being met from Directorate budget as no additional funding for this project. £250,000 p.a. to the host, Restore. Gap highlighted by quarterly Strategic Partnerships reporting to Board. ACTION: source external or continue to provide funding. OWNER: Service Director - Oxfordshire Mental Health; and MD for Mental Health & Learning Disabilities GAP (controls) New Care Models e.g. Thames Valley and Wessex Forensic Mental Health New Care Model to be developed and monitored and then transitioned into Provider Collaborative ACTION: monitoring through Directorate Performance Reviews, Executive and Board. OWNER: Interim Thames Valley & Wessex Forensic Network Head of Programme; SRO Secure New Care Model and Director of Forensic Mental Health; and SRO CAMHS and Adult Eating Disorders New Care Model - Service Director Oxon & BSW Mental Health.	Managing Director for Mental Health & Learning Disabilities Oversight of HIGH risk through Quality Committee and quality sub-committees	3	2	6	

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1.3	Failure to manage change effectively may compromise: (i) quality and safety for patients during the transition from current to future service models; and (ii) staff morale and wellbeing during periods of transition, including during internal restructurings or organisational change, which may lead to staff being unable to deliver on objectives or drive quality improvement and/or lead to difficulties retaining staff.	4	4	16	Controls include but are not limited to: - programme structures including programme Board, workstream groups, programme risk register and robust contingency planning etc. For example, Oxfordshire Learning Disabilities - a Board with an independent chair was established to oversee the transformation of services for adults with Learning Disability (LD) in Oxfordshire. A new Learning Disabilities Programme Director started in post from 01 July 2016 to pick up the transformation of Oxfordshire LD services; - collaborative working with partner organisations; - the Trust's Chief Executive chairs the Oxfordshire Transformation Board and is a member of Healthy Bucks Leaders; - internal change management processes and joint working with Staff Side representatives	Refer back to Risk SO 1.1 above and the controls and assurances listed. The impact of change and change management on patient experience, safety, workforce and clinical and operational effectiveness will be assessed through the assurances set out in SO 1.1. Internal Audit programme has included review of the Quality Impact of Service Changes which found overall reasonable assurance. The review was to determine that when a Cost Improvement Plan work stream or major project was undertaken, there was both a clear initial Quality Impact Assessment and subsequent monitoring of qualitative impact through the life of the work stream or project.	4	3	12	GAP (controls - resourcing of programme structures): the Trust has been involved in a number of significant change projects e.g. **transformation of Oxfordshire Learning Disability**; and **Thames Valley and Wessex Forensic Mental Health New Care Model**. These opportunities also have a potential impact upon management time and regular service provision and can lead to interim management structures and backfilling of posts down the chain of command. The time and resource required to plan and undertake new activity could have a negative impact upon the Trust. Also a risk of issues emerging several months after the transition e.g. after the transfer of Learning Disability services following the experience of Southern Health as documented in the Verita2 report. ACTION: Board/senior management to think strategically about the the opportunity cost of these choices and developments. Executive has discussed the Trust's management capacity and capability to become involved in these developments and undertaken appropriate due diligence to understand the scale of the tasks involved. Different management teams were also involved in the developments with specialist commissioning and with learning disability so the same team(s) was not being put under pressure. OWNER: MD for Mental Health and Learning Disabilities; and Chief Executive	Managing Director for Mental Health & Learning Disabilities	2	2	4	

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										GAP (controls): **communication of change** internally to staff and externally to patients/stakeholders. Anticipate impact upon staff and services also of **senior leadership changes in key operational posts**. Anticipate the impact upon staff of consultation exercises/changes in models of care and pre-empt and respond to staff anxiety about what the future may hold e.g. with the upcoming public consultation on proposals for changes to health services in Oxfordshire (including community hospitals). Oxfordshire CCG attended the Board meeting in private on 29 March 2017 to present on the Phase 2 Consultation process which would be starting. Consultation will be the culmination of local discussions between NHS organisations, patients, the public, local groups and local councils. ACTION: The Chief Executive, as chair of the Oxfordshire Transformation Board, keeps the Board and senior management informed and involved. Active Comms through Comms team and Trust website. Information also available through Oxfordshire Transformation website. OWNER: MD for Mental Health & Learning Disabilities; and Chief Executive							
										GAP (controls): ongoing dialogue with partner organisations and impact of reviews such as the review conducted (2017) by Oxfordshire County Council into the Oxfordshire S.75 JMG (Joint Management Group) arrangements with the Trust for the provision of social care services to mental health service users. Options for outcome of S.75 JMG review could include continuing, going out to tender or the County Council taking all or part of the function back in-house. ACTION: Strategic links developed with partner organisations with a view to further development of joint service delivery. Board to be kept updated on outcome of Oxfordshire JMG review. Outcome by September 2018 of part of the function being taken back in-house by the County Council - Older Adult social workers TUPE-transferred back to the County Council with effect from 01 Sept 2018. OWNERS: MD for Mental Health & Learning Disabilities					

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1.4	Failure to ensure patients and carers are involved in managing and leading on their own care could lead to compromising patient outcomes and not delivering sustainable health care.	4	4	16	Controls include but are not limited to: - ICareYouCare Strategy; and the People's Experience & Involvement Strategy 2019-21; - the Triangle of Care (the Carers Trust national scheme for improving outcomes for carers accessing mental health services) which recommends better partnership working between services users and their carers and organisations and is being rolled out across the Trust. The Triangle of Care being implemented and monitored via the Carers Strategy Group; - development of Recovery Colleges (Oxfordshire and Buckinghamshire); - well-established controls in psychological services; - service user groups in place on locality basis to provide ongoing input to service development for Adult services; - assessment processes within new Adult service models include carers' assessment, housing, employment and well-being of service users; - ongoing work within Adult services to transform patient experience including through the Forensic Patient Council, "have your say" sessions and CPA reviews. CPA guidance has been produced which was written by patients for patients; - work on outcomes with patients and carers is part of the implementation of clusters in mental health and part of the service remodelling; - technological developments such as OXTEXT for patient self-monitoring of mood and services such as CAMHS using facetime to connect with patients etc.; and - part of the implementation of the Next Generation Electronic Health Record will include a work programme on engaging patients with their electronic plans and records.	Internal and External assurances include: - involvement in developing care plans is monitored as part of Care Programme Approach metrics and reported to Commissioners; - the CQC monitors whether care plans have been shared with patients in mental health wards; - reporting to Commissioners since 2014 included quality indicators relating to patient and carer involvement in care planning; - each Directorate has Carers' Strategy action plans	3	3	9	GAP (controls - implementation and development of Next Generation Electronic Health Record): the work programme to engage patients with their electronic plans to commence as part of the implementation of the project. The replacement needed to take place first to build in capability. ACTION: replacement of Next Generation Electronic Health Record (see also SO 6.2). Go-live of Carenotes in October 2015 marked completion of the Transition Phase of the EHR Programme (moving away from RiO and SystmOne). Transformation Phase of the programme now commenced (updates also being provided to Council of Governors in 2018). User training highlighted as important for success of adoption and optimisation OWNERS: Director of Strategy & CIO GAP (controls): see gap at 1.2 above re Recovery College funding being met from Directorate budget as no additional funding for this project. £250,000 p.a. to the host, Restore.	Chief Nurse Oversight of HIGH risk through Quality Committee and quality sub-committees	2	3	6	

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1.5	Failure to care for patients in an appropriate inpatient placement or environment, due to bed pressures or absence of community or social care support, could lead to: - compromising patient outcomes; - patients and carers/families not having an excellent experience; and - services falling below reasonable public expectations with ensuing publicity and criticism of the organisation and the wider Health & Social Care system.	4	5	20	Controls include but are not limited to: - clinical oversight and review of patients considered to be in an inappropriate bed via Clinical Directors for relevant Directorates; - involvement with patients and carers in care planning; - robust CPA (Care Programme Approach) planning; - maintainance of safe staffing levels on wards; - review and overview of any incidents, including restraints, at a Trust-wide level through Weekly Review Meeting (Clinical Standards); - liaison and escalation to NHS England case managers and NHS England Specialist Commissioning, as may be appropriate.	Assurances include but are not limited to: - weekly reporting of incidents at the Trust-wide Weekly Review Meeting (Clinical Standards) and escalated to the Executive, as appropriate; - seclusion and long term segration is reported weekly and, for example in the Children & Young People's Directorate there are clear processes in place for any Young Person in seclusion or Long Term Segregration including Clinical Director reviews.	4	3	12	GAP (controls and assurances): in particular there have been instances in the Children & Young People's Directorate of Young People being cared for in the wrong Child & Adolescent Mental Health Service (CAMHS) inpatient environment due to lack of appropriate Psychiatric Intensive Care Unit (PICU) beds available nationally. Also an issue in terms of Young People who may not have a detainable mental health condition but require safe support within the community through Social Care (rather than healthcare) but may become admitted under section 136 in the absence of a safe community placement through Social Care. Highlighted as acute since September 2017. ACTION: Instances have resulted in: weekly calls to NHS England (NHSE) in attempts to source bespoke placements; the CQC reporting that issues do not lie with the Trust but with NHSE; NHSE Specialist Commissioning convening a quality summit to discuss the issue and consider short term increasing bed capacity for Tier 4 CAMHS and long term transfering responsibility for Tier 4 commissioning to provider consortia using the New Care Models approach. Focus since Sept 2017 but timescale to resolve commissioning and Social Care system issues difficult to anticipate. Feb 2019 Board in private approved business case to be submitted to NHS England for a CAMHS PICU to be built adjacent to the Highfield (further to PICU capital funding approved at STP level). OWNER: MD for Mental Health & Learning Disabilities; Service Director and Clinical Director - Oxon Mental Health	Managing Director for Mental Health & Learning Disabilities	4	1	3	
2	**Strategic Objective 2: Delivering Operational Excellence** Goals: our services will be effective and efficient; and we will deliver our financial plan														
2.1	Failure to put effective governance (both corporate and clinical) arrangements in place may lead to: - poor oversight at Board level of risks and challenges; - strategic objectives not being established or structures not in place to achieve those objectives; or - appropriate structures and processes not in place to maintain the Trust's integrity, reputation and accountability to its stakeholders.	4	4	16	Controls include but are not limited to: - the Trust's Constitution; - Council of Governors and Board Standing Orders; - Standing Financial Instructions and Scheme of Delegation; - Integrated Governance Framework (IGF); - Risk Management Strategy; Business continuity planning processes and emergency preparedness; - Board Assurance Framework; - Trust Risk Register and local risk registers at Directorate and departmental levels; and - the Director of Corporate Affairs/Company Secretary.	The Quality Committee and Audit Committee reviewing risks and key governance issues - reporting/escalating to Board as appropriate. Escalation reports from the Quality Sub Committee (and formerly from the 4 quality sub-committees) to Quality Committee and from Board committees to Board.	3	2	6	GAP (controls - business continuity planning processes): Board oversight of risks and challenges in the event of no-deal EU exit/Brexit. ACTION: business continuity planning has taken place in the context of the national response (the Department of Health & Social Care's national Operational Response Centre) and the Trust's local response as per the mitigating activities as set out in the risk assessment as presented to the Board meeting in public on 31 January 2019 as appended to the CEO report at paper BOD 02(ii)-(iii)/2019. OWNERS: Emergency Planning Lead and the Director of Corporate Affairs & Company Secretary	Chief Executive	2	2	4	

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		I	L	R			I	L	R			I	L	R	
						Internal Audit regular review of governance arrangements including annual review of the BAF and risk management arrangements. Internal Audit reviews have included reviews of Quality Strategy & Governance, the IGF, Clinical Audit, Electronic Health Record Programme Governance, the Research Governance Framework, Information Governance, the Board Assurance Framework, Risk and Quality Governance. Positive Head of Internal Audit opinion and External Audit reliance on same and on relevance of Annual Governance Statement Well Led governance review (PwC) completed, presented to the Board meeting in private in June 2017 and reported to Council of Governors in September 2017. Monitoring of action plan overseen by QSCWL. Well Led inspection (CQC) March 2018								
2.2	Ineffective business planning arrangements that do not integrate activities at all levels of the Trust may lead to: the Trust being in breach of regulatory and statutory obligations; or the Trust failing to achieve its annual objectives and consequently being unable to meet its strategic objectives.	4	4	16	The Strategic Framework sets out the key areas where appropriate plans and actions will deliver the Strategic Objectives. The business planning process, managed by the Business Services team, ensures that the top-down objectives and the bottom-up planned activities are aligned and that appropriate measures and targets are established to ensure that the Trust objectives can be met. The planning requirements of NHS Improvement (formerly Monitor), including the Quality Account, are integrated within the Trust's business planning requirements. Senior leaders within the Trust and other key stakeholders are consulted on the business plan proposals.	The Business Services team report regularly on business plan progress and achievement to Executive and Extended Executive meetings. Business planning is a key component of Extended Executive meetings with particular focus on progress review and plan themes development. Formal quarterly progress reports on the Operational/Business Plan are presented to the Executive and the Board for review of progress and assessment of achievement (in January, April, July and October of each year). The Council of Governors (CoG) is involved in the development of business planning and the CoG formally review and approve the Annual Business Plan.	4	2	8	GAP - cross-reference to gap at 2.1 above (controls - business continuity planning processes) in relation to Board oversight of risks and challenges in the event of no-deal EU exit/Brexit; and note mitigation in the business continuity planning which has taken place and presentation to the Board meeting in public on 31 January 2019. GAP: Insufficient consultation with stakeholders. ACTION: the schedule and process for developing the Business Plan has been amended to ensure all key stakeholders are identified and to allow time for effective consultation. OWNER: Director of Strategy/CIO and Director of Finance GAP: Key Performance Indicators (KPIs) not effectively aligned with strategic objectives and Business plans. ACTION: working with Performance teams and directorates to agree KPIs and method for reporting. KPIs continue to be developed in conjunction with PLICS, activity-based budgets and productivity management. PDRs in the process of review and will include alignment of personal objectives with those of the Trust. OWNER: Director of Strategy/CIO and Director of Finance	Director of Finance Oversight of HIGH risk through Finance and Investment Committee.	3	2	6	

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		I	L	R			I	L	R			I	L	R	
					Each year the Trust completes an Annual Strategic Plan which is approved by the Board and submitted to NHS Improvement. The annual planning process begins in the autumn and is "bottom-up" including consultation with internal and external stakeholders, working with Directorates, aligning priorities with the strategy and developing a Trust-wide Business Plan and Priorities.					GAP: Business Planning process and strategic objectives not sufficiently aligned with individual PDR processes. ACTION: working with L&D and HR to align processes. OWNER: Business Services Team and Director of Finance					
2.3	Risk of financial exposure (including, but not limited to, through non-delivery of CIP savings, failure to realise productivity gains, constraints of block contracts in the context of increasing levels of activity and demand and the impact of historic and/or ongoing underfunding of mental health services) may lead to: - failure to deliver the Trust's financial plans; - additional scrutiny and intervention by NHS Improvement; - insufficient cash generation to fund future capital programmes; and - failure to deliver health outcomes in particular in relation to achievement of the Mental Health Five Year Forward View	5	5	25	Regular reporting on Financial position and impact of wider financial system risks to Board (CEO report and Finance reports to public and private Board); and to the Finance & Investment Committee.	Governance and assurances include: - Strategic Delivery Group; - Finance and Investment Committee; - Internal Audit review; and - overall governance provided by the OHFT Board - monthly Finance, including CIP, reporting to the Board to provide assurance on progress and recovery actions.	4	4	16	GAP (impact of wider financial system risk): receipt of funding for the Mental Health Investment Standard given that normal commissioner funding flows to providers suspended during COVID-19; and needing to ensure that historic underfunding of mental health services in Oxfordshire is addressed in FY21 (as at April 2020, some contracts had not been finalised). Despite national encouragement to progress with NHS Long Term Plan ambitions, uncertainty persisting as at July 2020 as to whether Mental Health Investment Standard funding would materialise so as to support delivery of NHS Long Term Plan ambitions and transformation programme; potential system impact if it does not, including financial impact for Trust and commissioners. ACTION: Monitoring through Managing Director of Mental Health & LD and Director of Finance, with monthly updates to Board. OWNERS: Managing Director of Mental Health & LD and Director of Finance.	Director of Finance Oversight of EXTREME risk through regular reporting to the Finance and Investment Committee and the Board	4	4	16	Due to COVID-19, the financial regime of contracts and payments has been suspended and providers are receiving block payments from NHSE/I in advance to cover costs and cashflow from April to July 2020; this is intended to help to support providers to maintain breakeven positions. As the block payments are received a month in advance and in the middle of the month, they contribute significantly to a breakeven Income and Expenditure position and a healthy cash position. COVID-19 costs incurred can also be reclaimed from NHSE/I.

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		I	L	R			I	L	R			I	L	R	
2.4	Risk of non-delivery of Productivity Improvement Programme/Cost Improvement Programme (PIP/CIP) savings and difficulty in maintaining financial sustainability or being able to offset the annual deflator including, but not limited to, through: - relatively high levels of efficiency already achieved; - the cumulative impact of underfunding of mental health services combined with increasing demand and activity; - increasing complexity of conditions; and - inability to recruit and/or retain staff to match demand with capacity	5	5	25	Overall CIP target is set as part of the financial planning process for the annual plan and long-term plan. Each Directorate and Corporate Function identifies themes that are developed into project plans and any gap to the overall target is identified and mitigations considered within the overall review of risks and opportunities for the financial plan. Where possible, provisions are made for some underachievement. Since September 2017, a new Strategic Delivery Group has been operating which includes CIP Delivery.	Governance and assurances include: - Strategic Delivery Group; - Finance and Investment Committee; - Internal Audit reviews; and - overall governance provided by the OHFT Board - monthly Finance, including PIP/CIP, reporting to the Board to provide assurance on progress and recovery actions.	4	5	20	GAP (assurances): key question in relation to PIP/CIP is about deliverability of targets and ability to identify suitable mitigations. However, COVID-19 has also impacted confidence of directorates in previously planned delivery of FY21 schemes. ACTION: This is a constant feature of Strategic Delivery Group discussions. To be monitored on an ongoing basis. OWNER: Director of Strategy & CIO	Director of Strategy & CIO Oversight of EXTREME risk through regular reporting to the Finance and Investment Committee and the Board	4	4	16	PIP/CIP schemes on hold during COVID-19 and NHSE/I not expecting delivery against them. Schemes starting up again July 2020 and work taking place to revisit pre-COVID delivery estimates, in alignment with COVID recovery planning work and the Operational Plan.
2.5	PLACEHOLDER for risk to be developed around (or existing risk to be adapted to cover): adequacy of funding for mental health services and achievement of the Mental Health Five Year Forward View, subject to the conclusion of funding and contracting discussions with commissioners, and risk appetite in this area in relation to what stance the Trust may be prepared to take. May be part of a wider discussion involving the relationship between demand, workforce and financial challenges														Awaiting conclusion of FY21 contract discussions.

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		I	L	R			I	L	R			I	L	R	
2.6	There is a risk that increasing **demand for services** continues as an open-ended driver of cost and staffing pressures which the Trust is limited from being able to mitigate because a health and social care system-wide plan and action is required to influence this pattern of demand and it still may take 2-3 years to have a positive impact. In the meantime, **demand for services will continue to increase** whilst **capacity to provide services remains, or becomes further, insufficient** in terms of both funding and workforce which could result in: • inability to deliver services in a sustainable or safe way; • pressure upon staff to manage resources in the context of increasing need; and • a deteriorating financial position if the Trust continues to bear the cost of high levels of demand and activity.	4	5	20	Oversight at Board level Increasing health and social-care system recognition of the challenges e.g. 29 January 2019 the Trust hosted a presentation from the NHS Benchmarking Network on Mental Health Analytics and the outcome of the independent review conducted by Trevor Shipman on mental health investment in Oxfordshire (which evidenced historic underinvestment). Stakeholders and partner organisations attended, including from OUH NHS FT, Oxfordshire CCG and the voluntary sector	Regular updates from the Chief Executive through his reports to Board.	4	4	16	GAP: insufficient funding from commissioner contracts. ACTION: Buckinghamshire contracts for FY20 agreed. Oxfordshire contractual discussions ongoing within the context of increasing understanding of what lower than planned additional income from commissioners could mean in terms of potential reduction in Trust activity. Oxfordshire CCG have accepted that, as at the end of FY19, the level of underfunding of Oxfordshire mental health services was £12 million. The Trust's position on this is that although £12 million is short of the level of underfunding established in the Trevor Shipman review, it is still sufficient to underpin the current level of activity delivered and to start the process of service development (but still issue because that amount will fall short of the requirement to implement the range of service provision and capacity to achieve the access targets set out in the NHS Long Term Plan). OWNER: Director of Finance GAP: insufficient funding from specialist commissioning contracts. ACTION: contract negotiations ongoing. Due to NHS England Specialist Commissioning engaging late in the contract review process, some contractual matters remain to be resolved particularly in relation to New Care Models. In the meantime, Trust has participated in the interviews for the next phase of New Care Models (due to commence from April 2020) as a preliminary to the development of business cases for more detailed proposals in November 2019. GAP: Oxfordshire County Council mental health budget cuts and anticipated reduction in funding by 2022. ACTION: in recognition of the response to the consultation on original proposals in December 2018/January 2019, the County Council amended its proposal by: removing entirely the originally proposed £1 million reduction in the Council's contribution to the NHS mental health budget; and delaying the proposed £600,000 saving against mental health social workers by a year. However, still issues with the remaining £600,000 proposed saving, even if delayed by a year and especially as spend on children's social care had nearly doubled since 2011, with a significant amount funding children's Out of Area Placements (OAPs). Challenge: if services could provide more mental health and social care support to families then they may be able to improve the environment for children and young people such that fewer children's OAPs would be required.	Chief Executive	4	3	12	

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3	**Strategic Objective 3: Delivering Innovation, Learning and Teaching** Goals: the impact of the AHSN, AHSC and CLAHRC will be maximised; we will collaborate in research and innovation; and we will deliver high quality teaching														
3.1	Failure to fully realise the Trust's academic and Research and Development (R&D) potential may adversely affect its reputation and lead to loss of opportunity.	3	3	9	Controls include: - work to improve governance in R&D both locally and through the Oxford Collaboration for Leadership in Applied Health Research and Care (Oxford CLAHRC); - participation in clinical trials and working with bodies such as the National Institute for Health Research (NIHR); - membership of the Oxford Academic Health Science Network (Oxford AHSN) and the Oxford Academic Health Science Centre (Oxford AHSC) to maintain a prominent academic and R&D profile; - academic collaborations such as OAHSN - Psychological Perspectives in Education and Primary Care (PPEPCare) with Operational Management Group established to oversee project implementation; - expansion of the R&D team to improve patient recruitment into studies which would benefit current studies and future bids for new studies (including commercial studies); - collaborative work with the Joint Research Office at OUH; - Bio-medical Research Centre (BRC) - September 2016, successful joint bid by the Trust and the University of Oxford for one of only two BRCs across the counrty dedicated to mental health and dementia; and - application for Collaborative Research Fund (CRF) - potential positive impact upon funding.	Internal reporting including: - to the Board as (publicly available) twice yearly reports on R&D covering KPIs on the number of patients recruited to studies and the number of studies underway/planned - see September 2019 and March 2020; and - Research Management Group reporting to the Effectiveness quality sub-committee. External assurance through: - benchmarking of Trust performance by the Thames Valley Comprehensive Local Research Network; and - Internal Audit, including review of the Research Governance Framework.	3	2	6	GAP (controls - participation in clinical trials): no-deal EU Exit/Brexit and impact of the risks identified in the Trust's EU Exit Operational Readiness Risk Assessment specifically in relation to: (6) EU rules covering clinical trials will no longer apply. ACTION: mitigating activities as set out in the risk assessment as presented to the Board meeting in public on 31 January 2019 as appended to the CEO report at paper BOD 02(ii)-(iii)/2019. Note that this risk in particular unlikely to have an immediate effect and the Trust is linked in with the NIHR in relation to potential impacts. OWNERS: specific risk (6) owned by the Head of R&D. GAP (controls): expansion of R&D team may still not result in increased/sufficient patient recruitment for studies. ACTION: outcomes to be kept under review. Results will fluctuate due to the low numbers of studies (typically 10). However, R&D still struggling to meet the time to target for recruiting a set number of patients for individual studies within the recruitment period (25%). This will take time to change as studies generally run over a minimum of 12 to 24 months. OWNER: Head of R&D GAP (controls): how collaboratively governance processes work with the Joint Research Office at OUH. ACTION: R&D is working collaboratively with the Joint Research Office at OUH, under agreement, and, for example, is receiving support to ensure that research contracts are reviewed and drawn up appropriately. Work is taking place to streamline processes and working practices across the organisations. OWNER: Head of R&D and Medical Director	Medical Director	3	1	3	Successful joint bid by the Trust and the University of Oxford for a new National Institute for Health Research Biomedical Research Centre (NIHR BRC), one of only two across the country dedicated to mental health and dementia. Over five years, the centre will receive £12.8 million pounds to fund its research. Research at the new NIHR Oxford Health BRC aims to enable the NHS to routinely use innovations such as using an app to track mood changes to help diagnose and personalise treatments for mood disorders, treat paranoia using virtual reality simulations, treat psychotic disorders using neuroimmunology and deliver therapy over the internet for conditions such as anxiety.

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		I	L	R			I	L	R			I	L	R	
										GAP (controls - governance processes): move to the Health Research Authority (HRA), through which all research studies will need to be approved, and ongoing work to integrate changes to governance processes. HRA will be providing NHS permission for studies that cover the whole of the NHS and these are not site specific. This has the potential to give the green light to researchers to start studies and approach Trust clinical teams without coming through the R&D department and puts the Trust at risk of being unaware what studies are taking place within the organisation. ACTION: to be managed through the Research Governance Group. OWNER: Head of R&D					
3.2	Failure to be sufficiently innovative and leading edge in its practice may lead to the Trust not being able to keep current contracts or realise its potential in a competitive market.	4	4	16	Provision of high quality services through effective and innovative evidence-based service models e.g. in Mental Health and Interface Medicine, which result in good patient outcomes. Development of Outcomes Based Commissioning in Mental Health and Older Peoples services.	In relation to the provision of high quality services, cross-reference to assurances under BAF risk SO 1.1.	3	2	6	GAP (controls - service models) & ACTION: service remodelling complete but outcomes to be reviewed and evaluated by the Executive. Also cross-reference to gaps/actions in controls/assurance for BAF risk SO 1.1 and 1.2. OWNERS: Chief Operating Officer and Executive Directors	Medical Director Oversight of HIGH risk by the Board directly and through extended Board strategy sessions as appropriate	3	2	6	In July 2016 the Trust was successful in leading an application to develop a new model of care for low and medium secure adult mental health services - the Thames Valley and Wessex Forensic Mental Health New Care Model. One of the rationales for developing the new model of care was to promote innovation in service commissioning, design and provision that joins up care across in-patient and community pathways across and beyond the NHS. The Trust will work in a network with the following providers of specialist mental health care to coordinate inpatient and community based services: Berkshire Healthcare NHS FT, Southern Health NHS FT, C&NWL NHS FT, Dorset Healthcare NHS FT, Solent NHS Trust and Response (voluntary sector provider promoting independent and
					Use of innovative tools e.g. roll-out of Clinical Record Interactive Search (CRIS).	Monitoring through CRIS oversight group meetings attended monthly to discuss submitted applications and monitor the audit of CRIS searches. The group is chaired by the Medical Director and Caldicott Guardian and is attended by the CRIS Coordinator, Director of IT, Head of Information Governance, Head of R&D, two Carer/patient representatives, representatives from the trust Clinical Directorates, Trust Audit Team and University.									
					Restructured R&D governance processes to improve effectiveness and promote innovation.	R&D reporting being monitored through Board (cross-reference to SO 3.1).									
					An Innovation sub-group of the Drugs and Therapeutics Group (DTG) has been established with the aim of discussing proposals for the development of innovative treatments. Work has been undertaken to produce a standardized format for submissions. It is planned that this sub-group will link closely with the R&D Department to consider how innovation may lead to future research. Recent innovation has, for instance, included collaborative work with the University of Oxford on the first UK study into the use of ketamine intravenous infusions for people with treatment-resistant depression. A clinic has also been established for the therapeutic use of ketamine in the treatment of depression.	The establishment of the Innovation sub-group may increase interest amongst academic staff at the University Department of Psychiatry, who may not otherwise attend the DTG. Those submitting proposals will be invited to present to the sub-group and engage in the subsequent discussion, to help the sub-group consider any ethical and governance issues. The Innovation sub-group will be monitored through the DTG.									

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					Participation in the Oxford CLAHRC, Oxford AHSN and Oxford AHSC and use of these structures to improve and innovate systems around Dementia, Early Intervention, patient experience and patient reported outcomes, better management of medical-psychiatric comorbidity and patient self-management of chronic disease.	The Trust hosts the Oxford CLAHRC and is a partner in the Oxford AHSC with Oxford Brookes University, Oxford University Hospitals NHS Trust and the University of Oxford.									community living). As at Feb 2019, the collaborative is performing strongly and the learnign will be adapted to support similar successes with ED NCM and Tier 4 CAMHS
					Development and maintenance of good relationships with commissioners through understanding and meeting their targets.	External assurance through contract review meetings with Commissioners to discuss outcomes and awards.									
					Developing strategic partnerships within the NHS and indepedent sector, for example the work taking place with Oxfordshire CCG, Oxford University Hospitals Trust and Oxfordshire County Council for older people on the outcomes based single contract focused on the acute assessment/admission and discharge/reablement pathway. Development with social care and federated primary care relating to integrated locality community services; all reporting through to the Oxfordshire Transformation Board. In Buckinghamshire all transformational work reported via Healthy Bucks Leaders.										

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		I	L	R			I	L	R			I	L	R	
4	**Strategic Objective 4: Developing Our Business through Collaboration and Partnerships** Goals: we will work in collaborative partnerships; we will maintain and grow our services where we add value; and we will have strong relationships with our stakeholders														
4.1	Failure of the Health and Social Care Systems in which we work to act together to deliver integrated care, maintain financial equilibrium and share risk responsibly may impact adversely on the operations of the Trust and compromise service delivery, especially during transition to Integrated Care Systems and from internal models of delivery to new ways of working in alliance and partnerships	5	5	25	Oxfordshire Transformation Board and membership of Healthy Bucks Leaders. Executive Directors and Service/Clinical Directors engage strategically and operationally, working jointly with all CCGs, local authorities and other partners including GP providers to understand strategic issues facing CCGs and provide input and support to delivering integrated services within the context of high levels of change within the health and social care systems.	Reporting through OPS SMT, Executive Team and Board. Participation in key strategic, operational and contracting meetings by Service Directors, Clinical Directors and Chief Operating Officer	4	4	16	GAP: (assurances - whole system working and collaborative planning for care) - **Delayed Transfers of Care (DToCs)** remain unresolved; wider system not working effectively to support patients to be sent home. ACTION: since September 2017, DToCs highlighted to the Quality Committee and to the Board as a mounting pressure especially for the wider system although the Trust has been able to demonstrate progress in managing those DToCs which were solely in its control. In October 2019, bed days lost to DToCs in Mental Health reduced from 214 in Sept to 207 (equivalent to 7 beds), however, this was still above the rolling 12-month average of 183 (6 beds); Community DToCs increased by 235 days in October 2019 to 1317 bed days lost (equivalent to 43 beds), with a rolling 12-month average of 1304 days per month (42 beds). OWNERS: MD for Mental Health & Learning Disabilities and Chief Executive.	Managing Director for Mental Health & Learning Disabilities Oversight of HIGH risk through the Board directly and Board strategy sessions as appropriate	3	3	9	
										GAP (assurances) - see **new risk at SO 1.5** around **failure to care for patients** in an appropriate inpatient placement **due to absence of community or social care support**. ACTIONS and OWNER as per SO 1.5.					
					Development of alliances and partnerships with other organisations, including the voluntary sector, to deliver services into the future. Development of Oxfordshire Integrated Locality Teams. Oxfordshire Mental Health Partnership - development of Recovery College completed and outcome measures being monitored monthly through contract meetings and reported monthly to CCG via schedule 4 and OBC measures.	Whole system working across each county to deliver Integrated Care. Improved whole systems working and process with good engagement with Partners demonstrated through the Oxfordshire Transformation Board, Healthy Bucks Leaders and System Resilience groups.				GAP (controls - engagement and joint working): concern around overlaps between OBC processes and the impact of the Better Care Fund (government pooled fund to promote integrated care). ACTION: ensuring engagement in national Better Care Fund dialogue at a national and local level. Strategic linking of Outcomes Based Commissioning with the Better Care Fund. OWNERS: MD for Mental Health & Learning Disabilities, Director of Finance and Chief Executive					
					Progressing discussions with Oxfordshire's GP Federations to establish opportunities for more formal partnerships and collaborations. PML, OxFed and Oxford Health FT are exploring a united approach to new models of delivery and contracting, to be operational across much of the County . More recently that discussion has also involved colleagues at OUH. Proposals will describe how community services can be integrated with primary care to provide a genuine 'place' based service, addressing population management, prevention and access, and in addition how the relationship with the urgent care pathway and hospital based services will work in the short term and longer term.	Reporting to/discussions with Oxfordshire CCG and Trust Board.				GAP (controls - Oxfordshire GP Federation engagement): since October 2016, written outline of proposals and Memorandum of Understanding being developed to describe proposals. ACTION: Development continued with: updates to Board Seminars including in September 2017 and February 2019; attendance by GP Federations at Board workshop in private on 27 June 2019; and review at Board meeting in private in September 2019, OWNER: Service Director - Oxon Community Services; and Chief Executive					

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					Ability to deliver integrated care through collaboration and Partnership e.g. Mental Health OBC, Talking Space. Older People's OBC being advanced through Winter Planning.	External assurance including: collaborative planning with OUH; delivering on commissioners' strategic intent through initiatives such as moving to 7-day working via the service remodelling; and partnership approaches on Mental Health and OP services. Joint working with commissioners on new models of care and extension of contracts and MCP processes.				GAP (controls - engagement and joint working): financial pressure on County Councils and Social Care impacting adversely on Health. ACTION: Executive Directors and other directors engage in whole system clinical and financial planning. Engagement with NHS Improvement (Monitor) and introducing them into system-wide discussion with commissioners. OWNERS: MD for Mental Health & Learning Disabilities and Executive Directors					
4.2	Failure to work collaboratively and effectively with external partners and to ensure that effective governance arrangements are in place in partnerships and to support new ways of working may: - compromise service delivery and stakeholder engagement; - lead to poor oversight of risks, challenges and relative quality amongst partners; and - put at risk the Trust's integrity, reputation and accountability to its stakeholders and credibility as a system leader and partner of choice	4	4	16	Controls include but are not limited to: - Section 75 agreements in place for Oxfordshire and Buckinghamshire; - developmental work with Police colleagues e.g. joint working with Thames Valley Police on mental health street triage and Section 136 suites; - the Multi-Agency Safeguarding Hubs (MASHs) in Oxfordshire and Buckinghamshire to bring together Health, Social Services, the Police, Education and Youth Offending services in an integrated multi-agency team to share information appropriately and securely on safeguarding children or adults in order to take timely and appropriate action to safeguard them from harm; - development of Mental Health Crisis Concordat across Thames Valley to improve outcomes for people experiencing mental health crisis through local partnerships of health, criminal justice and local authority agencies. Crisis Concordats signed in both Oxfordshire and Buckinghamshire; and - mental health resilience funding for one year projects achieved for: (i) enhancing the Emergency Department Psychiatric Service based at the John Radcliffe and Horton Hospitals; (ii) providing additional funding for the Psychiatric Inreach Liaison Service in Buckinghamshire; (iii) implementing a street triage programme in Buckinghamshire to provide mental health support and advice to Thames Valley Police; and	Monitoring and collaboration through Section 75 Joint Management Groups (JMGs) in place in both Oxfordshire and Buckinghamshire. Oxfordshire now has service user representation and quarterly joint meetings with the commissioning JMG. MH OBC contracts agreed and signed September 2015. Sub contracts developed between the Trust and partners and legal partnership agreement being developed. Alliance between OUH and the Trust developed and governance work progressing. Oversight by the Board and reporting to the Board (in private session) on partnerships - most recently in July 2020. Future reporting may be to Quality Committee and/or Finance & Investment Committee.	3	4	12	GAP: high level strategic aims been developed for partnership working but up to early 2016 not yet a supportive governance framework and a list of partnerships is not in place. Updates on partnership working not reported to Board on a regular basis (and would help to inform future development of partnership working). ACTION: since May 2016 the Board now receives updates on Strategic Partnerships including partnership performance and innovations and effectiveness. Aim of reporting to: underpin development of individual partnership working arrangements and any wider development; providing some supporting definition; and identify any further steps that might be required. A list of contractual partnerships and working alliances has also been developed (private reporting to Board in July 2020). OWNERS: Director of Strategy & CIO	Director of Strategy & CIO Oversight of HIGH risk by the Board directly and through Board strategy sessions as appropriate	3	3	9	
					New service models include integration with social care for Older People's (OP) physical health services. Partnership agreements to be put in place between NHS and voluntary sector organisations to implement.	Problems in Practice Group reviewed, links to JMG to ensure health and social care and commissioning approach to Section 136 issues.									

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4.3	If the Trust does not proactively engage with its membership, patients and the wider public then this may compromise its ability to listen and respond to feedback, involve stakeholders proactively and communicate effectively and transparently.	3	3	9	Controls include but are not limited to: - Council of Governors and working groups of the Council e.g. the Working Together Group initially and now the Membership Involvement Group; - Communications function part of the Director of Corporate Affairs/Company Secretary's Directorate; - management of the membership database and membership development responsibilities through the Communications function; - Trust website (content managed by Communications); - People's Experience & Involvement Strategy 2019-21; - the development of a single members' database, increased working with the voluntary sector and review of the Use of Volunteers Policy; - development of Community Involvement Framework including Fundraising Strategy and Volunteering Services Strategy; - establishment of local/divisional patient groups; - Complaints service, PALS surgeries and results of patient experience surveys; - Membership Development Strategy approved by MIG for recommendation to CoG at its Jan19 meeting. Presented at Mar19 CoG meeting	Annual report and reports for Council of Governors demonstrate engagement with FT members. Internal reporting including to the Quality sub-committee (formerly to the Caring & Responsive quality sub-committee) and the Quality Committee on complaints, PALS, patient experience and involvement; and weekly monitoring of complaints at Clinical Standards Weekly Review Meeting. Charity Committee monitoring development of Community Involvement Framework including Fundraising Strategy and Volunteering Services Strategy. Service redesign project briefs include engagement element.	2	3	6	GAP (controls): Trust website to be updated. ACTION: new template for the Trust website deployed since July 2015 and offering a more picture-led user friendly interface for people to find out about our services. A better search index has been implemented and this will continue to have incremental improvements. There have also been improvements to categorised search results and there is ongoing investigation into additional deep search solutions. Web Strategy Group meetings (with membership from Comms, IT, directorates and membership invited from HR and PALS). The group has agreed and implemented processes, in line with the Trust's web strategy, to take on oversight and governance of current and future developments, as well as the work of the web editorial group. A recent example of this in practice is a decision to develop a new web area to promote OHFT's research and development work. OWNERS: Director of Communications and Engagement and Chief Information Officer GAP (controls): Membership Development Strategy remains in development OWNERS: Director of Comms and Engagement and CoCA/CS GAP (controls): strategic frameworks for patient participation /involvement /engagement and Community Involvement/Fundraisingto be developed ACTION: Cross-reference to the gap/action at SO 1.1 above. People's Experience & Involvement Strategy 2019-21 in place. Actions in relation to membership and volunteers development to be progressed but work around volunteering developing and being monitored through the Charity Committee. OWNER: Director of Corporate Affairs & Company Secretary GAP (controls - Council and membership engagement): if the member attrition rate is high and levels of engagement are low then the Council/membership will not fulfil its purpose and the Trust will not only lose the significant power of voice, but is likely to be more removed from the needs of the community and will risk breaching its authorisation. ACTION: Community involvement. Work with membership to develop 2-way commuication (i.e. learn from each other); develop mutually beneficial relationships with current membership and ensure cohesive approach in dealing with local partnerships; ongoing recruitment of new members; evolve members into volunteers, donors, supporters and ambassadors. OWNER: Director of Corporate Affairs & Company Secretary	Director of Corporate Affairs & CoSec	2	2	4	

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5	**Strategic Objective 5: Developing Leadership, People and Culture** Goals: staff will be satisfied with the quality of their work; staff and teams will be high-performing; and we will recruit and retain an excellent workforce														
5.1A	Insufficient or ineffective planning for current and future workforce requirements (including number of staff, skillmix and training) may lead to: impaired ability to deliver the quantity of healthcare services to the required standards of quality; and inability to achieve the business plan and strategic objectives	5	3	15	Controls include but are not limited to: - robust recruitment processes and retention measures; - on-going staff development through resources such as the Learning and Development training matrix which defines subject areas and frequency of training for staff and provides access to appropriate e-learning; - the Performance Framework including the Performance & Development Review Policy and supporting process; - Directorate workforce plans are linked to Business plan/savings plans with regular processes for review; - Senior HR Business Partners are trained in the principles and approach to the Trust workforce planning process developed with input from L&D and Finance; - workforce planning also included as part of service remodelling which will then inform workforce plans for the next three years; - analysis of leaving questionnaires; - Workforce Development manage training programmes for Health Visitors in line with plan; - Medical staffing workforce plan; - implementation of flexible Workforce Management System and centralised Bank of staff. Provides detailed management information to drive efficiencies in staffing use and control of temporary staffing spend; - increased HR activity on Attraction and Recrutiment measures including: advertising through Twitter and Instagram accounts, regular meetings with Job Centre Plus, organising recruitment open days and attending job fairs and careers events, advertising through "Jobs the Word"/RCN/Stonewall, meetings with agency staff to explore barriers to moving to substantive roles; and - increased HR activity on Recruitment efficiency measures including increased notice periods, introduction of a temporary candidate pipeline manager, introduction of in-house recruitment database.	Monitoring and reporting include, but are not limited to: - reports to individual managers, teams, directorates and to the Board enable monitoring of leavers, vacancies and recruitment, absence/sickness and training status; - the Board receives as a public standing item a HR/Workforce Performance Report which considers: recruitment activity; turnover; sickness; and bank and agency use; - reporting to the Board on inpatient safe staffing levels; - information is reviewed and actions determined at Operations SMT; - Recruitment Action Group; - Staff Movement Form introduced July 2016 which requests more detailed information from line managers (to inform Retention strategies and to support information available through Leaver Forms, Exit Questionnaires and Exit Interviews); and - the HR senior management team hold a performance review each month.	4	4	16	GAP (controls in relation to local workforce planning activities generally being impacted by national developments): no-deal EU Exit/Brexit and impact of the risks identified in the Trust's EU Exit Operational Readiness Risk Assessment specifically in relation to: (4) shortage of staff members due to EU nationals leaving the UK. Total EU staff members at the Trust = 355. ACTION: mitigating activities as set out in the risk assessment as presented to the Board meeting in public on 31 January 2019 as appended to the CEO report at paper BOD 02(ii)-(iii)/2019. Actions included participation in pilot programme to enable EU staff members to apply for settled status. OWNERS: specific risk (4) owned by the Director of HR. GAP (controls and assurances): retention/recruitment balance - high staff turnover continues. More strategic solutions required to address retention issues in order to have more positive impact upon recruitment issues. Lack of information re retention issues - reasons for leaving on Leaver Form are restricted and uptake of Exit Questionnaires and Exit Interviews has been poor therefore quantity of information available needs to be improved. Need to also respond to Staff Survey results (see Gap under risk SO 5.1B below). ACTIONS: options in relation to reward, retention, leadership and engagement being considered. Number of initiatives implemented to include Apprenticeships, Nursing Associate Trainees etc - monitored via Learning Advisory Group. OWNER: Director of HR GAP (controls): despite implementation of Workforce Management System (WFMS), agency spend still high and/or above the ceiling imposed by NHS Improvement. Need to also increase recruitment of Flexible Workers to meet demand and consider whether aim to ultimately reduce demand for temporary staffing or embrace development of more flexible staffing opportunities so can be offered as a career alternative/opportunity. ACTION: complete implementation and rollout and monitor impact of usage. Develop improved	Director of HR Oversight of HIGH risk through HR/workforce reporting to Board	3	3	9	Presented and discussed at the Board meeting in public on 31 January 2019, including workforce impact. Activity re Settled status and qualifications included in staff communications Q1 FY19. Net/ residual risk scores do not add further to overall BAF current/residual risk rating of 16 (extreme) and if anything indicate low likelihood: impact 4 (high) and likelihood 2 (unlikely) = risk score of 8 (high). Recruitment campaign led by the Chief Nurse at the start of COVID-19, resulted in 745 contacts following press advertisements in Oxfordshire, Buckinghamshire & Wiltshire and general advertising; all were contacted to discuss possible roles; as at July 2020, 134 had been recruited as a result of the campaign.

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										monitor impact of usage. Develop improved reporting in conjunction with Performance team to drive efficiencies in staffing use. Develop website and use social media to actively advertise and recruit Flexible Workers. OWNER: Director of HR					
5.1B	Inability to recruit to vacancies or to retain permanent staff may lead to: the quality and quantity of healthcare being impaired; pressure on staff and decreased resilience, health & wellbeing and staff morale; over-reliance on agency staffing at high cost/premiums and at a potential increased risk of incidents and poorer patient outcomes; and loss of the Trust's reputation as an employer of choice	4	4	16	Controls include: - robust recruitment processes including the introduction of values based recruitment - values based questions are embedded in job application forms and work continues on developing recruitment materials; - minimising staff absence; - making the Trust a great place to work and publicising the fact; - the development of an overarching recruitment plan for each service to address areas of candidate attraction and retention; - collaboration with other local NHS trusts to understand the overall employment marketplace and take joint pre-emptive action where possible; - recruitment candidate pipeline to monitor effectiveness of recruitment stages; - creative aproaches to recruitment including intensive attendance at recruitment fairs and training programmes in place for HVs, DNs, Nurses, some AHP, Associate Practitioners, Doctors and Psychologists; - Apprenticeship Programme; - development pathway for HCAs; - meetings with Directorates to continue work on open days and job rotations; and - Recruitment Action Group meetings on improving links with universities.	Monitoring and reporting include, but are not limited to: - reports to individual managers, teams, directorates and to the Board enable monitoring of vacancies and recruitment effectiveness; - weekly reporting of vacancy levels and fill rates to SMT and the Service Directors; - reporting on inpatient safe staffing levels to SMT on a weekly basis; - integrated activity plan in place and is managed daily and reviewed weekly by HR and reviewed by the Operations SMT monthly; - reporting to the Extended Executive on a monthly basis regarding recruitment activity and planned actions; - the HR senior management team hold a performance review each month to review recruitment activity, including leavers exit interview data; - quarterly reporting to Health & Safety; - submission of workforce performance report as a standing item to the Board; and - monitoring through Trust Risk Register and Directorate risk registers.	4	4	16	GAP - cross-reference to gap at 5.1A above (controls) in relation to risk of shortage of staff members due to EU nationals leaving the UK in the event of no-deal EU exit/Brexit; and note mitigation in the business continuity planning which has taken place and presentation to the Board meeting in public on 31 January 2019. GAP (controls - recruitment processes): dealing with national and local recruitment challenges and the impact on pressure on staff numbers, work-related stress, spend with agencies and quality of care provided. Also linked to the Trust's ability to retain staff. Use of agency staff in order to maintain minimum staffing levels to remain safe to deliver patient care also amplifies the complexity of the work to do especially to carry out improvement work which should be led by substantive staff. ACTION: options in relation to reward, retention, leadership and engagement being considered. OWNER: Director of HR GAP (controls - recruitment processes): impact upon operational management of constant advertising and interviewing and time away from the day job. Also impact because of increase in the number of acting up/secondment roles in order to cover vacancies - leads to chains of staff acting up and additional staffing gaps being created. Impact upon HR of increased candidate pipelines due to the number of vacancies at any one time - HR resourcing required in order to take forward change activities and support the recruitment process. ACTION: increase recruitment efficiency e.g. through increased notice periods, introduction of a temporary candidate pipeline manager and introduction of in-house recruitment database. OWNER: Director of HR	Director of HR Oversight of HIGH risk through HR/workforce reporting to Board	3	3	9	

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										GAP (controls - making the Trust a great place to work): need to improve staff experience and respond to issues identified by Staff Survey results in order to improve retention and take pressure off recruitment. Health & Wellbeing to be addressed. ACTION: respond to Staff Survey results e.g.training for managers to ensure that everyone is getting meaingful appraisals; and development of Fair Treatment at Work Facilitators to provide confidential support to all staff. Health & Wellbeing Action Group empowering health and wellbeing in the workplace and using Champions to create intiatives at a local level. OWNER: Director of HR					
										GAP: Brexit (see also gap aginst 5.1A above) - and impact of pending Brexit upon recruitment in the run-up to 29 March 2019 as well as impact post-Brexit upon available pool of staff to recruit from. ACTION: [tbc] OWNER: Director of HR					
5.2	Failure to maintain a coherent and co-ordinated structure and approach to succession planning, organisational development and leadership development may jeopardise: - the development of robust clinical and non-clinical leadership to support service delivery and change; - the Trust becoming a clinically-led organisation; - staff being supported in their career development and to maintain competencies and training attendance; staff retention; and - the Trust becoming a "well-led" organisation under the	4	4	16	Controls include but are not limited to: - service model review and modifications of pathways across Operations (cross-reference to SO 1.2 and the risk against failure to deliver integrated care); - completed restructuring of Operations Directorates to provide for development of clinical leadership and for a social care lead in each directorate; - "planning the future" programme and ongoing Aston Team Working programme; - effective team-based working training in place with L&D; - multi-disciplinary leadership trios within clinical directorates to support and develop clinical leadership; - the Organisational and Leadership Development Strategy Framework (approved by the Board, October 2014) - aims to maximise	Internal monitoring and scrutiny includes: - the People, Leadership & Culture Committee; - a regular Trust Awards event to be scheduled to recognise leadership and achievement; - use of the annual staff survey to measure progress and perception of leadership development; and - staff appraisals and ad hoc staff satisfaction surveys.	3	2	6	GAP (controls - application of Strategy Framework): coherent Trust-wide learning from existing leadership development projects. Localised good performance and good practice may not be picked up across the Trust. Although it may not always be necessary or appropriate for all Trust-wide learning in this area to be consistent, as opposed to tailored to meet specific leadership development requirements, it should be more coherent and delivered with more purpose. Unwarranted variation without justification may be a gap rather than variation itself. ACTION: Senior Leaders and Team away days. Increased leadership focus through the Executive and Senior Leaders' groups. Leadership Engagement through Linking Leaders Conferences (x4 per year). OWNER: Director of HR	Chief Executive Oversight of HIGH risk through specific reporting to Board in July 2015 on organisational and leadership development	2	2	4	The Trainee Leadership Board (TLB) is an idea developed by the Director of Medical Education, the Associate Director of Strategy & OD, the Strategic OD Lead and trainee doctors. TLB objectives to offer a small group of next generation clinical leaders an opportunity to learn about the current leadership of the Trust, work as a leadership team on a real problem the Trust faces and also an

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	[illegible] CQC domain				[illegible] effectiveness of staff at every level of the Trust by coordinating a range of activities which will promote their ability to deliver high quality services and patient care and by ensuring that structures are in place to enable their effective delivery; - individual professional review and development through development of individual professional leadership strategies e.g. Nursing Strategy (updates provided into the Quality Committee, most recently in July 2020); - the People, Leadership & Culture Committee; - Linking Leaders conferences aimed at developing strong team networks across the middle tier of management throughout the Trust and supporting the development of a positive organisational culture (running since June 2015 across the Trust's geography and localities with the aim of improving communication and developing networks across the middle tier of management); and - Trainee Leadership Board -most recent cohort presented to the Board (private Seminar session) on 09 September 2020.					GAP (controls - individual professional review and development): co-ordinated direction of career pathways to steer staff to gain wider experiences. Note also links to Gap at SO 5.1A above re staff and career development. ACTION: development of individual professional leadership strategies. Nursing Strategy developed and launched in November 2015. However, risk that may not be sufficient capacity to deliver Nursing Strategy in a timely way. Also, talent management dependent upon PDR system roll-out. New appraisal process and training delayed following feedback from Extended Executive. More recently appointment of Associate Director of Clinical Education and Nursing who will review progress against development and delivery of leadership pathways. OWNERS: MD for Mental Health & Learning Disabilities; and Chief Nurse					[illegible] opportunity for the current leadership of the Trust to see how a different leadership group tackles a problem the organisation faces. First cohort ran from October 2016 to April 2017 (and presented findings to the Board Seminar on 08 March 2017); most recent cohort ran 2019-20 (and presented findings to the Board Seminar on 09 September 2020).
						External Assurance: - CQC reviews. Following CQC inspection in September/October 2015, a rating of "good" was achieved in the domain/quality measurement of being Well Led.				GAP (controls): Equality and Diversity. National picture of little progress having been made in the past 20 years to address the issue of discrimination (BAME and other groups including LGBT, people with disabilities and religious groups) in the NHS. ACTION: work of the Equality & Diversity Lead. NHS Workforce Race Equality Standard reporting. Focus at Board level. Ongoing work with HR to develop routine statistical analysis to identify key areas for actions and follow-up. OWNER: Equality & Diversity Lead and Associate Director of Strategy & OD					

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6	**Strategic Objective 6: Getting the most out of Technology** Goals: our patients and staff will have the right technology available; our workforce will have the necessary IT skills to do their jobs well; an outstanding IT service will be delivered														
6.1	Poor quality clinical data and/or lack of data completeness. Data quality issues may be caused by poor recording and/or as a result of IT systems not having the required level of functionality to enable good quality and complete recording. Incomplete or poor quality data may result in inaccurate reporting, misinformation and inadequate monitoring. The impact may result in less effective planning and decision-making; lesser control over service safety and quality; lesser ability to drive improvements in safety, quality and productivity. With the introduction and much more heavy reliance on nationally reported data, there is increased risk that incorrect data will be used or reported on in national forums. In addition failure to pull data required as part of contract monitoring and compliance may result in contract penalties.	4	5	20	~ Ongoing cycle of review of Standard Operating Procedures for the extraction and reporting of information ~ The Board receives monthly Performance Reports which capture performance against key targets (contractual and non-contractual) and other key performance indicators and the reports highlight where data quality is a facor that impacts on Trust performance. ~ Contract performance reports to commissioners are provided in a consistent format and the reports all flow through the Business Services team, which acts as the single front door to the commissioners. ~ Integrated Information Governance Policy - includes high level expectations for data quality re validity, completeness, consistency, coverage, accuracy and timeliness. ~ Data Quality and Business Intelligence Strategy has been developed. ~ EHR is fully implemented. ~ An Information Governance toolkit is in place. ~ A Trust Performance Assurance framework is in place including monthly Trust Performance Review meetings. ~ There has been the implementation of Data Quality Strategy governance framework which includes a Data Quality Improvement Group (DQIG), established in summer 2019. ~ The data quality framework has prioritised areas of data quality/completeness and oversees improvements.	~ A KPI is randomly selected and audited periodically to ensure that the data is accurate (this came out of a PwC internal audit). ~ Regular performance reporting to Operations Senior Management Team and within directorates and also Performance Review meetings. ~Reporting to QCSC Well Led from Data Quality Improvement Group identifies data quality issues and challenges. ~ Areas of focus are highlighted as part of audit recommendations. ~ Monthly reporting to CQUIN Board around Mental Health Data Quality Maturity Index; updates provided to the CQUIN Board around 36 indicators and escalating areas of risk from non-compliance.	3	4	12	GAP (controls): no-deal EU Exit/Brexit and impact of the risks identified in the Trust's EU Exit Operational Readiness Risk Assessment specifically in relation to: (7) Electronic data which is held on EU servers may be inaccessible. ACTION: mitigating activities as set out in the risk assessment as presented to the Board meeting in public on 31 January 2019 as appended to the CEO report at paper BOD 02(ii)-(iii)/2019; in the case of this risk, detailed risk assessment noted as ongoing through the Director of Strategy & CIO. OWNERS: specific risk (7) owned by the Director of Strategy & Chief Information Officer. EHR is fully implemented; an Information Governance toolkit is in place; a Trust Performance	Director of Strategy & Chief Information Officer Oversight of HIGH risk through Quality Committee and quality sub-committee	3	3	9	Confirmation required that no Trust data is held on EU servers.
										GAP (controls & assurances): **core systems data collection compliance and quality requires significant improvement**. Development of Information Intelligence Reports to enable operational services to take appropriate actions in order to improve the quality of data need to be developed. Focus is on developing information as part of the Trust Online Business Intelligence Project (TOBI).					
										GAP (controls): no overarching document to provide assurance on data quality of Performance Report indicators. Performance data not consistently signed off by indicator owners. Formalised programme of audit for performance report indicators not in place. Performance report indicators not RAG rated for data quality. Risk of inaccurate information being reported or unexplained disparities between Performance Reports and source spreadsheets. ACTION: data assurance scheme/schedule to be developed to detail source of data, data validation and audit cycle for each performance indicator. As part of development of overarching data assurance scheme, all Performance Report indicators to be RAG rated for data quality and target dates for resolving data quality issues to be included in the scheme as appropriate. OWNER: Director of Strategy & CIO					Query if the DSIG propose to aim to have in place an overarching document along these lines.

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6.2	Failure to meet the key objectives of the project to replace the Electronic Health Record (EHR) system may lead to: inaccurate patient records; inefficient use of clinicians' time; less safe and lesser quality of care; increased cost of operation through lost opportunities to improve productivity.	4	3	12	Ensure actual end users are involved in the construction of the specification of requirements and selection of the solution. Approval of the final specification of requirements at many levels including: clinical, Directorate management and Executive Team. Ensure supplier(s) commit to delivering against the processes of care (scenarios), Trust objectives and required benefits, and not just system 'widgets'.	A formal Project has been established using the established Prince2 methodology and including a gateway process. The Project Executive is the Trust's Chief Executive Officer. Regular Project and Programme meetings are taking place with good representation from corporate and clinical areas. Extensive workshops are occurring with clinical services to determine the system configuration required to support the clinical processes. Monitoring by the Executive, Finance & Investment Committee and the Board (meeting in private).	4	3	12	GAP (controls): ongoing work required with system supplier to improve overall performance ACTION: work taking place to develop action plan to confirm the roadmap for Carenotes over the coming years. The Trust has taken the lead in creating an online forum for other product users to take a coordinated approach to aid development. OWNER: Director of Strategy & CIO	Director of Strategy & CIO Oversight of HIGH risk through regular reporting to Finance and Investment Committee and the Board in private	3	2	6	CareNotes live since October 2015. Risk: to achieve objectives and performance, ongoing commitment and engagement from directorates required together with support and resource of software provider. Contract negotiations during 2018 agreed that e-prescribing be separated out and separately tendered. Revised e-Prescribing and Medicines Administration (ePMA) business case (with a separate supplier) approved by the Finance & Investment Committee in September 2020.
6.3	Failure to keep pace with evolving cyber security threats and to maintain mature cyber security controls and training may lead to: - cyber-attacks which could compromise the Trust's infrastructure and ability to deliver services and patient care; - data theft and other business continuity risk events which could compromise patients and staff and lead to regulatory fines or sanctions; and - failure to act as a system leader with Global Digital Exemplar status	5	4	20	Cyber-security maturity roadmap for the Trust - based on the SANS Institute CIS Critical Security Controls. Progress updates reported into the Board in private. In relation to Data Security Protection - work taking place to achieve Cyber Essentials Plus certification. Recent reviews have recommended Cyber Essentials Plus as the minimum standard for healthcare providers and partners to demonstrate that they have implemented the most basic cyber security controls. National Cyber Security Centre, National Data Guardian Review and Smart review highlight the need for all organisations to achiever Cyber Essentials Plus certification by 2021.	Reporting into Audit Committee and the Board (recently to the Audit Committee in September 2020). WannaCry impact on OHFT well mitigated by existing controls. GCHQ-certified Cyber Security Board Briefing delivered by NHS Digital and the IT team to the Board Seminar on 14 February 2019.	4	3	12		Director of Strategy & Chief Information Officer	3	3	9	

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6.4	The Trust has an extensive amount of business solutions residing in a single data centre. The data centre and the infrastructure within it has high levels of resilience and redundancy built-in. However, there is a vulnerability as the data centre is on a single site, owned and managed by another provider. For those systems that are housed locally this risk concerns the failure of that single data centre and, on that failure happening, the un-availability of many of the Trust's IT systems. The consequence is that the Trust's IT systems will not be available to staff, with the Trust having no direct control over the restoration of services.	3	5	15	The Trust has adopted a 'Cloud first' approach to systems implementation over the preceding years resulting in a situation where many key systems, particularly those of a clinical and financial nature, are hosted externally within supplier Public or Private Cloud infrastructures. These systems would not be affected directly by a data centre outage. In addition the Trust hosts a data room within the Whiteleaf Centre where certain systems have resilient hardware. This position is not wholly aligned with the true business criticality of those systems however. In the event of a failure over the short term, the Trust has reasonable clinical business continuity processes in place.	Reporting to the Audit Committee, the Finance & Investment Committee and the Board.	2	4	8	Actions to address gaps: In light of recent events relating to the data centre and its reliability as the facility ages, the Trust IM&T Department has been in detailed discussions with other Data Centres in order to create a fully-costed proposal for migrating all Trust-hosted systems to a commercial data centre, including geographical resilience for those systems which require it on the basis of true business-criticality.	Director of Strategy & Chief Information Officer	1	3	3	Finance & Investment Committee in September 2020 approved the business case to relocate the Data Centre to a professionally managed alternative data centre.

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7	**Strategic Objective 7: Using our Estate efficiently** Goals: patients and staff will benefit from safe and appropriate environments; our estate will be sustainable and environmentally-friendly; and our estate will be cost effective														
7.1	Facilities being unsuitable or unfit for purpose may lead to: increased risk to patient safety; lesser quality of care and patient experience; increased cost of operation; breach of statutory requirements.	5	5	25	Controls include: - statutory compliance monitoring and reporting in place; - risk register established to identify significant risks and identify levels of investment required. Management and resolution of risks is being reviewed and prioritised by individual site/property. Used to develop FY15 Capital Programme and currently being used to develop FY16 Capital Programme including LCC requirements; - fire risk assessments have been completed by an external consultant and the Fire Advisors have in place review plans to ensure fire safety is not compromised; - ligature risks have been risk assessed using the Manchester Tool approach and the Executive has agreed the phase 1 works to be undertaken; - Annual PLACE (Patient-Led Assessments of the Care Environment) inspections for 2014 completed; - Estates Strategy in place having been approved by the Board in November 2013; - since June 2014, Estates & Facilities business plan for FY15-17 in place including workstreams for: providing safe and secure environments through risk-based prioritisation of investment; a new CAS alert process (COMPLETED); establishing a PPM programme (WORKS UNDERTAKEN); undertaking regular surveys of properties (SURVEY COMPLETED); developing a property database (COMPLETED); providing assurance through a detailed CQC Standard 10 assessment (ASSESSMENT PROCESS DEVELOPED AND UTILISED - ISSUES IDENTIFIED AND ACTION PLAN TO RESOLVE DEVELOPED); establishing a Senior Estates and Facilities meeting and working with the Services & Estates Committee (COMPLETED) and performance meetings (monthly and quarterly) (COMPLETED); - Environmental Sustainability Policy and Sustainable Development Management Plan; and - Asset condition survey now in place to enable infrastructure investment to be determined.	Internal reporting: - CQC Compliance is submitted to the Safety quality sub-committee (this includes statutory compliance); - progress re health and safty works i.e. ligatures/CAS alerts reported to the Safety quality sub-committee; - progress re delivery of capital projects required to reduce risks reported to the Capital Programme Board; - Estates Strategy is monitored via 6 monthly reports to the Finance and Investment Committee (FIC). Estates Strategy implementation report most recently received by the FIC in November 2017; - annual reporting on the Safety of the Physical Estate to the Quality Committee, most recently in September 2016; - monthly performance report undertaken with Executive lead; - monthly Estates and Facilities Senior Management Team meeting at which Safe Environment Reports presented; - Estates function now included in quarterly Directorate Performance Reviews, since July 2014 and ongoing; and - Internal Audit programme. The Internal Audit Plan 2014/15 included internal audit reviews of estates procurement and statutory compliance. Internal Audit Plan 2015/16 included review of Estates Maintenance Compliance (which achieved substantial assurance).	4	2	8	GAP (controls): incomplete information on statutory compliance of rented properties where the obligation sits with the landlord. Information has been received from some landlords - 39% of properties complete. ACTION: establish a register and process for regular update. Estates & Facilities business plan FY15-17 developed including workstreams to undertake regular surveys of properties and to develop a property database. OWNER: Director of Estates & Facilities	Director of Finance Oversight of HIGH risk through regular reporting to Finance and Investment Committee	3	2	6	Work ongoing re NHSPS specification, action plan for the rest. NHSPS will not be providing Soft FM services for CHP from July 2018. Other landlords - need to progress and follow-up for information. January 2018 - work in progress. February 2018 - letter sent to CEO of NHSPS. April-May 2018 NHSPS are engaged; verbal assurance around compliance; and by May improvement seen with NHSPS performance. June 2018 - remains at risk level 8; work continues with NHSPS. November 2018 - still ongoing but some improvement. January 2019 - NHSPS improving and data being supplied. February 2019 - NHSPS have restructured and a compliance manager is in post; not yet fully assured.
										GAP (controls): Manchester Tool works Phases 1 and 2 to be undertaken. ACTION: Phase 1 is on site; Associate Director of Estates to develop Phase 2 work plan to allow start on site of works in FY17. Deputy Director of Nursing to ensure all staff are aware of remaining ligature risks. 24.02.17 Marlborough House, Swindon wants o/s phase 2 FY18. Patient accessible non-ward areas to mt'd by GB & SH to establish phase 2. 21 March 2018 - completed. Phase 3 starting in March 2019. OWNER: Associate Director of Estates; Deputy Director of Nursing; and all Service Directors.					Phase 1 Manchester Tool works complete as at March 2017. From July 2017 - Phase 2 works. As at March 2018, Phase 2 completed. As at February 2019 - Phase 3 works on plan. As at March 2019 - audits finished by the end of March; once complete then Phase 4 work plan to be agreed.

Ref	Risk description	Gross (inherent) risk rating			Controls (Mitigating actions)	Assurances (audit, monitoring, reporting, scrutiny)	Current (residual) risk rating			Gaps in controls/assurance and actions to address gaps	Exec Lead	Target risk rating			Delivery status and action updates
		I	L	R			I	L	R			I	L	R	
										GAP (controls): Environmental Sustainability Policy and Sustainable Development Management Plan to be developed. ACTION: completed and Environmental Sustainability Policy and Sustainable Development Management Plan approved by the Quality Committee in July 2015. Quarterly meetings to be held to review SDMP delivery progress. Progress to also be reported in monthly performance reports. OWNER: Director of Estates and Facilities					Electrical Safety Policy and Safe Environment - Operational Policy developed. Energy Efficiency schemes being identified, including solar panel installation at Whiteleaf. Oxon bikes installed at Warneford and Littlemore sites.
										GAP (assurances): outcome of CQC inspection which took place September-October 2015 and reported in January 2016. Improvements are required in safety to ensure that across all trust services the same high standards are observed. Inspectors noted that some of the Trust's older estate, especially inpatient mental health settings at the Warneford Hospital, was outdated for the delivery of modern mental health care. ACTION: the Trust has long been aware of the challenge of operating from Victorian buildings and a working group is currently developing options for future development of the Warneford Hospital site in particular to better address modern health care needs. OWNER: Director of Estates and Facilities					A joint development group has been established with the university to redevelop the Warneford site. Architects have been engaged and a master plan developed. Initial consultation with interested groups undertaken. As at March 2019 - plans/works to redevelop the site ongoing.