Trust Board: Thursday 3 November 2011

TB2011.63

Title	**Board Assurance Framework (BAF) 2011/2012 and Trust Risk Register**

Purpose of paper	The Board Assurance Framework for 2011/2012 is attached for review. The paper outlines the process used to populate the BAF and to establish the controls and assurances that the Board will require throughout the year. The Trust Board is asked to review and comment on the BAF and to note the Trust Risk Register attached as appendix 2. Both documents have been reviewed by the Trust Management Executive. The documents will continued to be updated and will take account of the current review by the Director of Assurance. Both the Audit and Finance Committee and the Quality Committee will review the documents prior to presentation to the Board in March 2012.
Board Lead (s)	Mrs Elaine Strachan-Hall, Chief Nurse

Key purpose	Strategy	**Assurance**	Policy	Performance
Strategic Objectives	All as outlined in the BAF			
Links to Board Assurance Framework/Trust Key Risks/CQC outcomes	All CQC outcomes BAF, TRR and Trust Business Plan (TBP) to be cross referenced			

Resource and financial impact	n/a
Consideration of legal/ equality /diversity/engagement/risk issues	As outlined in the BAF

Board Assurance Framework and Trust Risk Register

1. The Board Assurance Framework sets out the strategic objectives, identifies risks in relation to each strategic objective together with the controls in place and the assurances available on their operation. Risks included cover the safety and quality of the ORH's services, the integration with the NOC, the required compliance with CQC outcomes and other regulatory/ external bodies, the development of specialist services and the delivery of a successful FT application.

2. The framework is intended to drive the Board's agenda with its focus on the strategic direction of the organisation.

3. The ORH's strategic objectives for 2011/2012 are as follows:

   SO1 To provide high quality general acute healthcare services to the population of Oxfordshire;

   SO2 To provide high quality specialist services to the population of Oxfordshire and beyond;

   SO3 To be a patient-centred organisation providing high quality and compassionate care – "delivering compassionate excellence";

   SO4 To be a partner in a strengthened academic health sciences system with local academic, health and social care partners;

   SO5 To meet the challenges of the current economic climate and the changes in the NHS and become a resilient, flexible and successful Foundation Trust;

   SO6 To achieve the integration of the ORH and the NOC during 2011/2012, realising the benefits as set out in the business case.

4. The following process has been used to populate the BAF (Appendix 1):

   4.1. The corporate objectives (which cover the divisions and corporate directorates plans) set out in the 2011/2012 Business Plan have been reviewed and the potential principal strategic (rather than operational) risks assessed through discussions with the appropriate Executive Director Leads. Where possible, an assessment has also been made on the severity of the principal risk. In addition, potential risks have been consolidated (e.g. in relation to all aspects of medical and clinical education and training) to ensure that a manageable number of risks are included; (additional and more detailed operational risks are included within the Trust Risk Register).

   4.2. Controls and risk monitoring mechanisms have reviewed by the Trust Management Executive (TME), the Trust's executive decision–making committee with a specific responsibility for the identification and mitigation of risks.

   4.3. Potential sources of assurance from both internal and external sources (e.g. Board reports on Quality, Workforce; annual reports on Health and Safety,

Complaints and Clinical Risk, and CEAC and Audit Commission reports) have been included following discussions with Executives.

4.4. Key action points to note are included within the Framework together with an assessment of the status of the risk.

5. It should be noted that some objectives have already been achieved:

5.1. BRC renewal has been achieved and the Joint Working Agreement with the University of Oxford has been signed (BAF ref 4.1);

5.2. Integration of the NOC and the ORH took place on 1 November 2011 and the new organisation, the Oxford University Hospitals NHS Trust, came into being (BAF ref 6.1 and 6.2).

6. In addition, following review by TME, the status of BAF 2.2 relating to the provision of additional neonatal capacity in support of the clinical network and the OUH's role in that, has been amended to green reflecting the position in relation to the expansion scheme.

Trust Risk Register

7. The Trust Risk Register (appendix 2) is the more detailed operational risk register intended to assure the Board that an effective risk management approach is in operation within the Trust. It is supported by the detailed Divisional and Corporate Directorates risk registers which are reviewed, validated and monitored on a regular basis in line with the agreed procedure now being implemented across the Trust. It should be noted that there are also a number of risks that have been identified by the Divisions and corporate Directorates and are rated at 15. Account has also been taken of the risks identified for the new Musculoskeletal and Rehabilitation division.

8. The risks have been grouped into the categories shown on page 6.

9. TME has reviewed the consolidated Trust Risk Register (which includes risks with a risk rating number of 16 and above) in line with agreed procedure[1] and two risks (relating to appraisals and neonatal capacity) have been reviewed as mitigation plans are in place. A further update will be considered by TME at the end of November.

10. Both the BAF and the TRR are dynamic documents and will be regularly reviewed. Active review with the Divisional Directors is underway and all Divisions will be expected to review at least monthly and ensure that updates are provided through their reports to the Clinical Governance Committee. Both documents will be reviewed at least twice a year by the Board.

Recommendations

11. It should be noted that the future design and content of both documents will take account of the work now being done by the Director of Assurance on the development of the Board Assurance Framework and the Risk Register.

[1] As outlined in Risk Management Strategy approved August 2011

12. The Trust Board is asked to review the Board Assurance Framework and the Trust Risk Register.

Mrs Elaine Strachan–Hall, Chief Nurse
November 2011

KEY			
(red)	Risk(s) to achievement of objective remains high	DA	Director of Assurance
(amber)	Plans in place to mitigate risk(s) to objective	CN	Chief Nurse
(green)	Risk(s) to objective at reasonable/acceptable level	DCS	Director of Clinical Services
TB	Trust Board	DDE	Director of Development and the Estate
TME	Trust Management Executive	DFP	Director of Finance and Procurement
QC	Quality Committee	MD	Medical Director
A&FC	Audit and Finance Committee	DPI	Director of Planning and Information
CGC	Clinical Governance Committee	DW	Director of Workforce
IGG	Information Governance Group		

Risk Register categories 2011/2012	
Finance - F	**Reputation - Rep**
Performance - P	**Use of resources - UoR**
Quality/safety - Q/S	**Regulation - Reg**

CQC Outcomes related to the quality and safety of care	
Outcome 1: Respecting and involving people who use services	Outcome 10: Safety and suitability of premises
Outcome 2: Consent to care and treatment	Outcome 11: Safety, availability and suitability of equipment
Outcome 4: Care and welfare of people who use services	Outcome 12: Requirements relating to workers
Outcome 5: Meeting nutritional needs	Outcome 13: Staffing
Outcome 6: Cooperating with other providers	Outcome 14: Supporting workers
Outcome 7: Safeguarding people who use services from abuse	Outcome 16: Assessing and monitoring the quality of service provision
Outcome 8: Cleanliness and infection control:	Outcome 17: Complaints
Outcome 9: Management of medicines	Outcome 19: Records

Ref (& risk category)	TRR TBP	Lead	Principal risks	Risk mitigation/ control plans	Risk control & monitoring	Assurance on controls	Potential sources of assurance	Key action points	Status
SO1 - To provide high quality general acute healthcare services to the population of Oxfordshire									
1.1 **P, F, Q/S, Rep, Reg**	1a TRR5	DCS	System/CAHO/QIPP targets (e.g. admission avoidance, reduction in emergency admissions, changes in care pathways) are not achieved across the system with consequent impact on ORH operational performance Failure to agree with PCT will compromise FT application	Process in place for the development of jointly agreed plans across the health system (regular meetings with PCT; engagement in CAHO workgroups etc.) Operational performance plan in place with explicit performance compacts in place with Divisions	Monthly performance review meetings with Divisions - agreed actions monitored and escalated to TME as required Briefing to the Board as required	Trust Board monthly review of operational performance	Finance/operational performance report to the Board to include reports on delivery against compacts from end of Q2 Quarterly Workforce reports 6 monthly report to Board on delivery of corporate objectives	ORH to maintain engagement with CAHO groups - urgent care, planned care and long term conditions Board report to be updated to include reports on delivery (Nov/Dec) Report to Board January on delivery of corporate objectives following review of Q2 in November	
1.2 **P, Q/S, F**	1b TRR4 TRR5 TRR1	DCS	Collaboration will not deliver DTOC reductions with impact on quality of care for patients, operational and financial performance ORH internal systems and processes do not support effective discharge planning and preparation	ORH fully engaged with local partners: e.g. DTOC Board, with agreed plan for proper use of resources across the system (SHA Action Plan) Home for lunch scheme in place and regularly monitored ORH Supported Discharge scheme in place for October 2011	Regular updates to TME and minutes of meetings reviewed	Trust Board monthly review of operational performance and CQC action plan (Nov 2011)	Operational performance report highlights key performance issues: e.g. DTOC levels, length of stay, bed utilisation, discharge CQC Action Plan (Outcome 4)	Q1/Q2 targets met although DTOC remain above. Continued monitoring and engagement with local economy partners Continued focus on Home to Lunch and other internal processes - include regular updates to the Board	

Ref (& risk category)	TRR TBP	Lead	Principal risks	Risk mitigation/ control plans	Risk control & monitoring	Assurance on controls	Potential sources of assurance	Key action points	Status
			thereby contribution to delays in transfers of care the increased length of stay					Supported Discharge Scheme in place - October	
SO2 - To provide high quality specialist services to the population of Oxfordshire and beyond									
2.1 **Q/S**	**2a** **TRR1**	**DCS** **DPI**	Plans to develop specialist (and networked) services **regional trauma centre, acute stroke and vascular services** are not agreed (financial pressures on commissioners, outcome of engagement process) and services are compromised	Trust Business Plan monitoring system in place Agreed strategy in place for clinical services (linked to IBP) Strategic Planning Committee in place to monitor business case development and business plan delivery Business plans agreed with SHA support and engagement process completed Agreements in place with key commissioners across the South of England Cluster (income to support plans), supported by partnership agreements with key partner DGHs	Quarterly performance review of business plan objectives with Divisions and Corporate Directorates Key commissioner meetings Network development meetings with key partner DGHs in South of England Cluster Joint PCT/ORH meetings	Board monitoring	6 monthly report to Board on delivery of corporate objectives SHA performance review meetings	ORH response provided and outcome awaited Trauma centre approved subject to tariff changes and income delivery Acute stroke and vascular business care approved and being implemented Report to Board January on delivery of corporate objectives following review of Q2 in November Board Strategy Day September 15 held and further day planned 30 Nov/1 Dec	

Ref (& risk category)	TRR TBP	Lead	Principal risks	Risk mitigation/ control plans	Risk control & monitoring	Assurance on controls	Potential sources of assurance	Key action points	Status
				SHA support for ORH plans to develop services SHA support for drive to change funding mechanisms to recognise specialist services and reconfigurations					
2.2 UoR, Q/S, F	2a	DCS DDE	Solution for affordable Neonatal expansion not agreed because of lack of resources with potential loss of network status, income and impact on maternity services	Expansion plans agreed and capital and other resources identified Strategic Planning Committee in place to monitor delivery of business plan objectives	Quarterly performance review of business plan objectives with Divisions and Corporate Directorates Consideration at SPC November 2011	Board sign off Business Case for neonatal expansion	6 monthly report to Board on delivery of corporate objectives	Affordable solution agreed and Business Case to Board Dec 2011, Full Business Case Jan 2012 (Submission to SHA required)	
2.3 P, UoR, F	2a TRR17	DCS	Deliverable business model not agreed for the development of **pathology proposals** and potential loss of service/income as other suppliers enter the market	Agreed plan in place to modernise pathology services with partners Modernising pathology group in place Appropriate internal financial arrangements in place	Quarterly performance review of business plan objectives with Divisions and Corporate Directorates Discussions continuing with other potential NHS partners - outcome of recent tender (Reading and others) awaited	Board updates	6 monthly report to Board on delivery of corporate objectives	Report to Board January on delivery of corporate objectives following review of Q2 in November	
2.4	2b	DCS	Performance difficulties impact adversely on	Business Plan agreed (TME)	Quarterly performance review of business plan objectives with Divisions		6 monthly report to Board on delivery of corporate	Q1 targets met Report to Board January	

Ref (& risk category)	TRR TBP	Lead	Principal risks	Risk mitigation/ control plans	Risk control & monitoring	Assurance on controls	Potential sources of assurance	Key action points	Status
P, Rep F	TRR5 TRR3		progress towards repatriation of **cardiac cases** from London providers with impact on income and reputation.	Agreed plan and schedule for implementation during 2011/2012	and Corporate Directorates		objectives Annual report to Board on adult cardiac surgery outcomes Submissions on outcomes to CCAD	on delivery of corporate objectives following review of Q2 in November	
2.5 P, Q/S, F, Rep	2c TRR7 TRR18	DCS	Financial and activity/capacity pressures (including shortages of capital funding in year) impact on relocation of services and service provision (linked to reconfiguration plans for Churchill Hospital)	Agreed plans in place to deliver relocation to agreed option: process to include stakeholder engagement Plans in place for reconfiguration of Churchill clinical services and impact on John Radcliffe Hospital	Quarterly performance review of business plan objectives with Divisions and Corporate Directorates	Board to review in detail at November meeting	6 monthly report to Board on delivery of corporate objectives	Report to Board January on delivery of corporate objectives following review of Q2 in November Presentation of options to Board	
2.6 Rep, Q/S, F	2c	MD	Outcome from Safe and Sustainable impacts adversely on paediatric cardiology and supporting services and may have impact on similar services, e.g. paediatric neurosurgery (Southampton/ ORH)	Response to SaS from ORH Collaboration with SUHT in place with plan for future - dependent on final outcome of SaS. Communications plan agreed	TME review of progress with updates from relevant division(s) and Medical Director	Board submitted response June 2011	Outcome of consultation indicates support for preferred ORH/SUHT option as reported through CE's report to the Board Updates through Chief Executive's report to the Board	Continue positive development of service alliance proposals with SUHT pending outcome of Safe and Sustainable Monitor progress of work underway on paediatric neurosurgery learning from experience with paediatric cardiac surgery	

Ref (& risk category)	TRR TBP	Lead	Principal risks	Risk mitigation/ control plans	Risk control & monitoring	Assurance on controls	Potential sources of assurance	Key action points	Status
SO3 To be a patient-centred organisation providing high quality and compassionate care "delivering compassionate excellence"									
3.1 **P, F, Q/S, Reg**	3a TRR2 TRR4 TRR14 TRR13	**DCS** **DFP**	Clinically led organisation does not deliver required quality, activity and operational performance objectives with consequent impact on financial/operational performance and quality (CQC compliance) (impact of CIPs/capacity and capability)	Agreed performance compacts and monitoring process in place for Divisions and corporate directorates Agreed rules for autonomy in place and used.	Monthly performance review meetings with Divisions - agreed actions monitored and escalated to TME as required Compacts to be put in place for corporate divisions	Trust Board monthly review of operational performance	Finance/operational performance report to the Board to include reports on delivery against compacts from end of Q2 Quarterly Workforce reports	Q1 and Q2 targets met AFC to review 1 year of clinically led Dec 2011 - approach to be agreed Board reports to be updated to include reports on delivery (Nov/Dec) Report to Board January on delivery of corporate objectives following review of Q2 in November	
3.2 **UoR, P, Q/S, Reg, Rep**	3a TRR4 TRR14	**DW** **CN**	Failure to deliver sustainable approach to **staff engagement** compromises operational performance and quality Failure to engage staff in operational objectives (potential impact from focus on	Staff engagement framework agreed and plan for 2011/2012 implemented Team brief in place with regular feedback being reported through Divisions to TME	Timetable in place with agreed milestones for review by TME	QC and TB assurance reviews with supporting evidence on actions to deliver milestones	Staff survey and values refresh work (reported specifically and through Quarterly workforce reports) Agreement on values and plan for implementation Team brief and feedback sessions reported through to	Refresh values work completed end September Implementation plan agreed	

Ref (& risk category)	TRR TBP	Lead	Principal risks	Risk mitigation/ control plans	Risk control & monitoring	Assurance on controls	Potential sources of assurance	Key action points	Status
			operational CIPs - challenge to staff capacity and morale)				TME and Board		
3.3 P	3a	DCS DFP DPI	GP/consortium partnerships do not develop during the year and ORH not recognised as major partner with impact on future commissioning	Development of strong relationships with Clinical Commissioners through development of joint sessions	Joint strategy session October for Divisional Directors and Clinical Commissioning Group Regular reports to TME	Report to Board from session		Update to Board from October session Continue joint approach to local healthcare needs with clinical commissioning consortium Inclusion of outcomes in Clinical Services Strategy and IBP Board development programme sessions	
3.4 Q/S	3b TRR8 TRR11	CN MD	Agreed patient safety, patient experience, environment, customer care and effectiveness priorities are not delivered with consequent impact on clinical care, patient safety and reputation and could also impact on CQC outcomes and	Quality Account with agreed priorities in place CQC Action Plan in place with actions monitored and delivered to plan Robust clinical governance systems and processes in place as part of performance compacts Quality Reports covering compliance with CQC outcomes to each Clinical	Monitoring framework in place to include TME, QC and TB TME to monitor CQC action plan monthly TME review of Clinical Governance Committee minutes	Quality Account published 30 June 2011 with plans for 2011/2012 Board monthly review in Quality Report Development of Quality	Quality Account/Quality Reports Range of reports e.g. patient experience/ Complaints/ HSMR etc. to Clinical Governance Committee and Quality Committee Inspection regime	Quality Committee in depth quarterly review from Dec onwards Bi-monthly updates to TB on CQC action plan (Nov) Patient engagement event planned for early Audit Committee review of internal audit reports and implementation of	

Ref (& risk category)	TRR TBP	Lead	Principal risks	Risk mitigation/ control plans	Risk control & monitoring	Assurance on controls	Potential sources of assurance	Key action points	Status
			compliance status	Governance Committee Assurance process in place for Quality Committee and Board		Committee assurance review for CQC actions	reports Divisional quality reports/reports to Quality Committee CQC Quality and Risk Profile and Compliance reviews Ombudsman reports External Audit of Quality Account Internal audits (including Revalidation of Doctors, Patient Records, Quality Accounts, and Clinical Coding)	recommendations Development of inspection reports Regular review of quality through Clinical Governance Committee Agreed committee structure in place to support Clinical Governance Committee	
3.5 P, F, Q/S, Rep, Reg	3b TRR5 TRR8 TRR1 TRR13 TRR14	DCS	Operational performance does not meet agreed standards with impact on financial performance, clinical quality, CQC outcomes, safety, reputation and FT application)	Performance review framework agreed in place with Divisions and TME Inspection regime in place	Quarterly performance review of business plan objectives with Divisions and Corporate Directorates	Monthly performance reports and specific updates on aspects as required (e.g. Demand management)	6 monthly report to Board on delivery of corporate objectives Quarterly Workforce Reports Annual Reports from TME Sub Committees	Report to Board January on delivery of corporate objectives following review of Q2 in November Board Development programme in place	

Ref (& risk category)	TRR TBP	Lead	Principal risks	Risk mitigation/ control plans	Risk control & monitoring	Assurance on controls	Potential sources of assurance	Key action points	Status
3.6 P, Q/S, Rep	3d TRR6 TRR14	DCS	Plans to develop core medical and surgical services at the **Horton General Hospital in support of Horton Vision** are not implemented because of lack of resource/ local agreement and commissioner support Loss of training posts in obstetrics and gynaecology would compromise delivery of maternity services in the longer term	Agreed plans in place for 24/7 medical, surgical and trauma services - Commissioner and local stakeholder agreements in place through Community partnership network Plan for future delivery of service and retention of training posts in place and agreed with Deanery, SHA and Clinical Commissioning Group	Reports to TME and cross-divisional working Regular meetings being held to discuss options with SHA, Deanery, Clinical Commissioning Group and ORH	Reports from Community partnership network and events	Minutes of Network meetings Update reports from Community Partnership Network in late Autumn Outcomes from meetings with SHA etc.	Public engagement workshop in late Autumn - outputs to the Board for review Contribution to IBP and clinical strategy work	
SO4 To be a partner in a strengthened academic health sciences system with local academic, health and social care partners									
4.1 Rep	4a	CEO	The ORH/OU partnership is not formalised with consequent delays in strengthening of the partnership and may impact on reputation Implementation of the new name and associated branding is delayed through	Working agreement/ License documents finalised, signed, sealed and enacted. Committee structure in place through preparation of legacy document from NOC Delivery of BRC plans from 1 April 2012 to next	Joint Executive Group and reporting specialist groups in place with agreed terms of reference and membership	Strategic Partnership Board Trust Board	Formal documentation supporting partnership	First meeting of Joint Executive Group (designate) 14 September held and plans in place for formal delivery of JWA from 1 November 2011	

Ref (& risk category)	TRR TBP	Lead	Principal risks	Risk mitigation/ control plans	Risk control & monitoring	Assurance on controls	Potential sources of assurance	Key action points	Status
			delay in integration	renewal					
4.2 UoR, Rep, P	4c	MD CN	Failure to agree strategy and implement plans for all aspects of in service and postgraduate education and training compromises staff capability, recruitment and retention. Failure to develop partnership with HEIs for non-medical healthcare professional education and training	Education and training strategy agreed with plans in place for delivery of agreed milestones in 2011/2012 covering all aspects including postgraduate medical and non-medical education ORH full partner in HIEC Agreed partnerships in place with key academic partners and specifically Oxford Brookes University	Education Committee in place Workforce Committee in place TME receives reports from sub committees	Education report to TB/QC Workforce reports Annual Report to the Deanery	Annual Report on Education and Training	Work with Thames Valley providers and Universities to develop common strategy for Local Education Training Board.	
SO5 To meet the challenges of the current economic climate and the changes in the NHS and become a resilient, flexible and successful Foundation Trust									
5.1 F, P, Rep, Reg	5b TRR2	DFP DPI	Failure to deliver agreed financial plan and CIP compromises stability of ORH in 2011/2012 and impacts on preparation and viability of LTFM	Robust and comprehensive performance framework in place PMO in place with whole programme (covering all significant projects) in place and embedded	Quarterly performance review of business/finance plan objectives with Divisions and Corporate Directorates CIP Steering group	Board review of financial plan updates and CIP progress Board review of workforce	6 monthly report to Board on delivery of corporate objectives Internal Audit Review of CIP	Financial Plan update to Board November SOs and SFIs for new organisation to Board November Report to Board January on delivery of corporate	

Ref (& risk category)	TRR TBP	Lead	Principal risks	Risk mitigation/ control plans	Risk control & monitoring	Assurance on controls	Potential sources of assurance	Key action points	Status
			Impact of PFI costs on I & E position	CIP steering group in place Agreed plan for achieving required FT risk ratings (including liquidity etc.) Estates rationalisation plan in place with agreed milestones SOs and SFIs in place	meetings TME fortnightly review	proposals SHA/PCT/ORH reviews Audit and Finance Committee review		objectives following review of Q2 in November	
5.3 P, F, Rep, Reg	5c TRR16	DPI	EPR go live date is not met with consequent knock on impact on performance, reputation and capacity of organisation to deliver FT timetable Insufficient staff numbers are trained to support go live Cultural engagement not achieved with impact on programme success	Agreed process for gateways including internal gateways and use of external agencies incl. Office of Government Commerce EPR Governance and project management structure in place Explicit agreement on engagement/training plans across ORH Sustained internal staff engagement process in place Additional resources in place to support development, training and	TME review EPR project structure monitoring and agreed gateways in place High level engagement maintained with contractor/SPfIT/ and SHA/Cerner/BT – 2-weekly conference calls Formal recognition of lessons learned from other sites' implementations (e.g. NOC and Bath)	TB monthly review Individual Board member meetings with Dr Altman, Clinical Director, Health Informatics, ORH	Office of Government Commerce (regular reviews) External governance/ assurance in place through use of gateways	Continued updates to Board in advance of November 'go live' date Training/implementation plans underway supported by communication programme	

Ref (& risk category)	TRR TBP	Lead	Principal risks	Risk mitigation/ control plans	Risk control & monitoring	Assurance on controls	Potential sources of assurance	Key action points	Status
				implementation plans					
5.4 Rep	5d TRR2	DPI	Insufficient progress made on FT application during 2011/2012 with impact on agreed date for FT	FT Project office and project structure in place and resourced including FT Programme Director (appointed August 2011) TFA signed by all parties and milestones being delivered IBP and LTFM on target for end 2011/2012 Robust project plan in place with agreed milestones for review	FT Project structure in place with review of milestones TME review and Exec Team engagement Work with SHA Provider Development Unit	TB monthly review Board Development events (e.g. on FT compliance framework, financial regime etc.)	SHA Provider Development Unit - e.g. QA review process TFA in place FT/DH/Monitor process	Board development programme underway to cover all aspects of FT application process TFA signed with DH and SHA - update to Board November 2011 Membership Strategy to BiC November 2011 Draft IBP to Board Nov and December 2011	
5.5 F, P, Q/S	5f	DDE DCS	Commercial opportunities, including pps, are not taken forward and financial and other opportunities are lost with impact on service performance, service quality and financial performance	Commercial strategy in place and agreed covering (inter alia) pps, site rationalisation and utilisation etc.) See also above	TME review and development through Sub Committees	Regular Board review	SHA QA process Internal Audit review on private patients	Development for inclusion in IBP	

Ref (& risk category)	TRR TBP	Lead	Principal risks	Risk mitigation/ control plans	Risk control & monitoring	Assurance on controls	Potential sources of assurance	Key action points	Status
SO6 To achieve the integration of the ORH and the NOC during 2011/2012, realising the benefits as set out in the business case									
6.1 Rep	6a	DPI	**Failure to convince approval body (Transactions Board) and advisory bodies on benefits of integration compromises timeline for integration, impacts on staff morale and the development of governance arrangements for the new organisation (FT delay may result)**	Business case with strong and deliverable benefits in place NOC Programme office in place with appropriate resources and governance arrangements Robust integration plan in place with flexibility to manage external factors and changes	Work underway with SHA Provider Development Unit to respond to any negative outcome from CCP and to contribute to SHA submissions to the Transactions Board IEG in place with regular updates from work stream leads Risk Register in place for integration Agreement on all necessary legal documentation/processes	Regular reports to Board	SHA support at DH Due Diligence report and associated action plan **Business Transfer Agreement signed** **Secretary of State signing of SIs etc.**	Integration due to be effected from 31 October with new organisation coming in to place 1 November 2011 with new name. Legacy document delivered by NOC	
6.2 Rep	6a	DPI	Plans not in place to mark successful integration and new brand and identity compromise success of integration	Plans in place for celebration, communications, branding and staff engagement	IEG in place with regular updates from work stream leads	Regular reports to Board incl November 2011	As above	Plans in place for immediate events and for the development of the branding. e.g. events planned for 1 November on 4 sites circulation of key information for change of name and identify Reception to be held 10	

Ref (& risk category)	TRR TBP	Lead	Principal risks	Risk mitigation/ control plans	Risk control & monitoring	Assurance on controls	Potential sources of assurance	Key action points	Status
								November with University of Oxford to mark the Joint Working Agreement	
6.3 Rep, UoR	6a	DPI DCS	Failure to take forward clinical and other benefits impact on reputation, service improvements and estates use	As above with agreed plan for clinical and other benefits realisation, and full engagement of the Divisions Strategic Planning Committee oversight	IEG in place with regular updates from work stream leads	Regular reports to Board		Work continues on benefits particularly with reference to spinal services for adults and children Strategic Planning Committee November 2011	

Appendix 2

Oxford University Hospitals

Trust Risk Register																
TRR	RISK CATEGORY	Source	Description of risk	L	C	RRS	Summary of risk reducing plan	Actions to be taken following TME/ Board discussion	Lead	Expected end date	Review dates	Monitored at and by	L	C	RRR
TRR16	Use of Resources	DPI C and W	Potential disruption to services arising from the implementation of EPR; this may cause loss of income, impact on the Trust's reputation and performance. Risks remain through duplication of records (e.g. for children). Pressures on service delivery as staff are trained	5	5	25	Continue to test and establish gateways to manage risks; provide sufficient resource to ensure that any disruption can be managed within the services; provide robust project management and identify problems in advance of them occurring Plans in place for scanning of records to reduce multiple records Plans in place to manage release of staff for training (1900 trained to date)		DPI	01/12/2011	Weekly and then daily during 'go live'	EPR Programme Board Gold and Silver Command Board updates	3	4	12
TRR7	Performance	All divisions	Capacity shortfalls impact on delivery and performance standards and operational and financial stability (e.g. Theatres and ITU capacity for transplantation) Note also that use of additional capacity increases workforce costs	4	5	20	Details in place within Divisional registers Regular review through performance review meetings and TME with updated to the Board		DCS DDs	31/03/2012	at least monthly	Divisions TME and Board updates	4	4	16
TRR2	Finance	F&P EMTA CCTADP S and O CTV	Inflationary pressures lead to excess non pay costs (includes impact of rising PFI costs on I & E position) CIP pressures and cost pressures across divisions impact on bottom line and LTFM	5	4	20	CIP targets in LTFM include cover for RPI cost pressures Preliminary discussions being held with DH on potential revenue opportunities that might offset capitation gap		DFP DDE	31/03/2012	at least fortnightly	CIP Steering Group Performance Reviews TME Board updates	4	4	16
TRR4	Finance/ performance	F&P DCS EMTA CCTADP S and O CTV	Failure to deliver operational equilibrium leads to crowding of elective activity by emergency workload with loss of income	5	4	20	Working with partners to address demand pressures and number of DTOC. Internal measures being taken - e.g. service process improvements in emergency care, home for lunch discharge and ORH supported discharge scheme.		DFP DCS	31/03/2012	at least monthly	Performance review meetings TME Board updates	4	4	16

TRR	RISK CATEGORY	Source	Description of risk	L	C	RRS	Summary of risk reducing plan	Actions to be taken following TME/ Board discussion	Lead	Expected end date	Review dates	Monitored at and by	L	C	RRR
TRR5	Performance	All Divisions	Specific issues relating to DTOC and all key standards (4 hrs., 18 week, 62 day etc.) covering all divisions: EMTA, S and O (including gastro OPs) , CTV (EP patients), radiology and diagnostics performance,	5	4	20	Details in place within Divisional registers including, e.g. cancer action plan, DTOC work across local health system. Regular updates to the Board Continued work with other agencies. Whole system review of pathways, including ACE Programme Board. SDS starts at the end of October		DCS DDs	31/03/2012	at least fortnightly	Performance review TME Board updates	4	4	16
TRR18	Use of Resources	DDE All divisions	Shortages and limitations in equipment impact on service delivery. Funds limited for replacement because of pressures on equipment/capital replacement programme (e.g. Radiology, ENT scopes, heart valve bank)	4	5	20	Local proposals being developed to tackle specific areas of concern. Details contained within Divisional registers Capital programme monitored		DDE	31/03/2011	tbc	Strategic Planning Committee TME	4	4	16
TRR8	Q/S	All Divisions	Patient safety issues may impact on patient care, experience and service delivery Specifics are included within Divisional Risk registers	5	4	20	Detailed plans in place within Divisions with regular reviews of risks and delivery of agreed mitigating actions Patient Safety Committee established reporting to Clinical Governance Committee Clinical Risk Management Committee in place Clinical Governance Committee in place reporting to TME		MD DCS CN	On-going	at least monthly	Clinical Governance Committee monthly with inclusion in monthly Board Quality reports Quality Committee oversight	3	4	12
TRR12	Q/S	S and O	CH site Out of Hours Medical Cover- sometimes gaps in cover and lack of co-ordination of service - this poses significant clinical risk to patients and additional workload and stress to staff on duty when gaps occur.	5	4	20	A review of the Hospital at Night Service to take place and Divisional Directors to ensure that suitable mechanisms are in place to cover in the event of gaps in the rota. These mechanisms to be communicated to clinical leads and consultants		DCS DDs	30/11/2011	monthly	Divisional Board TME	2	4	8

TRR	RISK CATEGORY	Source	Description of risk	L	C	RRS	Summary of risk reducing plan	Actions to be taken following TME/ Board discussion	Lead	Expected end date	Review dates	Monitored at and by	L	C	RRR
TRR10	Q/S	CTV	An unpredictable need for airway management of PPCI patients in a given 24 hour period impacts on emergency service across the John Radcliffe site :	5	4	20	Options being explored with CCTA to provide specific anaesthetic support service for cardiac services that provides adequate resources to manage the immediate emergency and on going care to allow the PPCI procedure as appropriate. Task and Finish group established to work through over 6 weeks		DD	30/11/2011	Monthly	Divisional Board Directorate Board CSU Meetings	2	3	6
TRR1	Finance	DF&P DCS	Failure to deliver agreed financial plan impacts on FT application and reputation.	4	5	16	Regular performance reviews across all areas, linked to delivery of CIP and management of cost pressures (see also below)		DF&P	31/03/2011	at least fortnightly	Performance review meetings TME Board updates	4	4	16
TRR17	Use of Resources	NTSS S&O	Limitations of IT systems impact on service delivery - e.g. in endoscopy and LIMS	4	4	16	LIMS proposals under review pending implementation of EPR system (see also below) Replacement of endoscopy system included in business case for 5th room		DPI	31/03/2011	tbc	tbc	4	4	16
TRR15	Use of Resources	DDE All divisions	Affordability of space and inadequacy of buildings: failure to rationalise estate utilisation increases costs and has impact on quality of care. Costly inappropriate accommodation needs to be removed from the asset base and more appropriate accommodation made available. Potential H&S issues and impact on clinical care e.g. Pathology, Same Sex accommodation), patient experience (specifics included within Divisions risk registers)	4	4	16	Options being explored for reconfiguration of clinical services at the Churchill Hospital for review by TME and the Board. Plans in place to review opportunities for cross site utilisation on completion of ORH/NOC integration Work on Horton vision underway Space utilisation review underway to include four sites post integration Division specific plans in place relating to particular environmental issues, e.g. OCDEM, Tarver, John Warin, Chest Unit, Pathology, Theatres, Radiopharmacy, Pharmacy, Aseptic services,		DDE	31/03/2012	Monthly	SUG, Strategic Planning Committee, TME and Board updates	4	4	16

TRR	RISK CATEGORY	Source	Description of risk	L	C	RRS	Summary of risk reducing plan	Actions to be taken following TME/ Board discussion	Lead	Expected end date	Review dates	Monitored at and by	L	C	RRR
TRR6	Performance	C and W S and O EMTA	Plans to develop core medical and surgical services at the Horton General Hospital in support of Horton Vision are not implemented because of lack of resource/ local agreement and commissioner support. Loss of training posts in obstetrics and gynaecology would compromise delivery of maternity services in the longer term	4	4	16	Agreed plans in place for 24/7 medical, surgical and trauma services Commissioner and local stakeholder agreements in place through Community partnership network Work continuing on development of paediatric services and maternity services (covering medical training issues)		DCS DDs	2013-2015	Monthly	Divisions TME Board updates	3	4	12
TRR3	Finance	CTV	Potential loss of income arising from changes in NHS Blood and Transplant (NHSBT) from 1 October 2011 (Homograft service) (target income 500K per annum)	4	4	16	Liverpool NHSBT service started 1st Oct 2011. Oxford & Royal Brompton Heart Valve Banks agree to collaborate to agree terms for Service level agreement with same legal advisors. Plans in place to deliver compensatory income streams. Shortage of staff also affecting income - plans in place to recruit end October		DD/GM	31/12/2011	Monthly	Divisional Board Directorate Board CSU Meetings	3	4	12
TRR14	Use of Resources	Workforce All Divisions	Insufficient staff to provide high quality care during periods of change and resource constraint - highlighted areas include radiation physics, physios, perfusionists, radiotherapy, medical oncologists, surgical staff (Horton) and Occupational T , obstetricians, endoscopy, anaesthetists. (details contained within individual Divisional registers)	4	4	16	Trust wide and Divisional detailed workforce plans in place to support Trust and divisional business plan. Risks and mitigation actions identified. Regularly monitored through TME and Divisional Performance meetings. Board review on workforce issues November 2011		DoW DDs DCS	31/03/2012	Monthly	Performance Reviews TME Trust Board	3	4	12

TRR	RISK CATEGORY	Source	Description of risk	L	C	RRS	Summary of risk reducing plan	Actions to be taken following TME/ Board discussion	Lead	Expected end date	Review dates	Monitored at and by	L	C	RRR
TRR13	Regulation	**All Divisions and Corporate Directorates**	Failure to achieve and maintain compliance with regulations - e.g. CQC outcomes, NHSLA and other statutory requirements	4	4	16	Detailed action plan in place to achieve CQC compliance. Plans in place to achieve required NHSLA standards for maternity (level 1 achieved for acute services). Action plan monitored regularly by Divisions, TME and the Board		MD DA CN	on going	Monthly	Divisional Boards TME Trust Board	3	3	9