Trust Board Meeting: Wednesday 13 March 2013

TB2013.49

Title	**Board Assurance Framework (BAF) 2012/13 and Corporate Risk Register**

Status	The paper provides an update to the Committee on the BAF and the CRR.
History	Previous iteration was considered in • Trust Board in November • Quality Committee in December • Audit Committee in January • TME in February • Finance & Performance Committee in February The current version has been updated to reflect assurance received up to 28 February 2013.

Board Lead	Ms Eileen Walsh, Director of Assurance			
Key purpose	Strategy	**Assurance**	Policy	Performance

Summary	The paper presents the updated Board Assurance Framework and Corporate Risk Register to the Committee. The Committee is asked to review the changes as highlighted in the paper. Approve the general risk appetite statement for presentation to the Board.

Section 1: Board Assurance Framework and Corporate Risk Register

Introduction

1. This is the next iteration of the BAF and CRR presented to the Committee. The main purpose of this report is to:

   1.1. Outline the process used to update the previous approved version presented to the Trust Board in November.

   1.2. Highlight the proposed changes to the BAF and CRR for information.

2. The following process has been used to update the BAF and the CRR:

   2.1. The previous version of the BAF & CRR was submitted to TME, in February 2013, for discussion and;

   2.2. A complete review of all papers reported to the Trust Board, Audit, Quality and Finance and Performance Committees was undertaken, by the Head of Assurance, as part of the updating process.

Key points to note

3. The following changes should be noted:

   3.1. **Changes to the BAF**: All changes to the BAF (Annex 1) have been included in red and italics the table below provides a summary of the changes made. Additional detail in relation to action to address gaps in control and gaps in assurance are provided in the Executive Summary Report on page 10.

<table>
<tr><th>Risk</th><th>Change</th></tr>
<tr><td>(1) Quality.(shown on page 14)</td><td>• New risk description added as risk ref 1.6
• Additional assurances added as reported to the, Audit Committee, Finance & Performance Committee and Quality Committee</td></tr>
<tr><td>(2) Finance (shown on page 15)</td><td rowspan="4">Additional assurances added as reported to the, Audit Committee, Finance & Performance Committee and Quality Committee</td></tr>
<tr><td>(3) Performance (shown on page 16)</td></tr>
<tr><td>(6) Workforce (shown on page 19)</td></tr>
<tr><td>(7) Strategic Partnerships (shown on page 21)</td></tr>
</table>

   3.2. **Changes to the CRR:** As with the BAF all changes to the CRR (Annex 2) have been highlighted in red and italics. The CRR has been reviewed and of the 32 risks included on the CRR five have been subject to a reduction in risk score:

   - 1.2 (page 23) breach of CQC regulations.
   - 7.6 (page 31) failure to establish robust governance and assurance processes.
   - Risks 1.2, and 7.6 had updates to their controls that supported the revised risk score. The remaining risks were unchanged.

- A number of risks have been de-escalated from the CRR as they have reached the risk target and remained on target for 2 quarters (page 11).
- As highlighted in the BAF section a new risk in relation to Bed Management has been added as risk reference 1.6 (page 10)

Section 2: Developmental area: Risk Appetite

4. The initial risk appetite paper was presented to the Board in November 2012. Following discussions at that meeting it was decided to add further clarity in relation to the specific risks as described on the CRR and that this level of risk should be used to form an assessment of risk appetite. This was presented to all Board sub-committees over November and December and finally to TME on 28 February 2013.

Definition of Risk Appetite

5. *'The amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time'.*

   (HM Treasury - 'Orange Book' 2006)

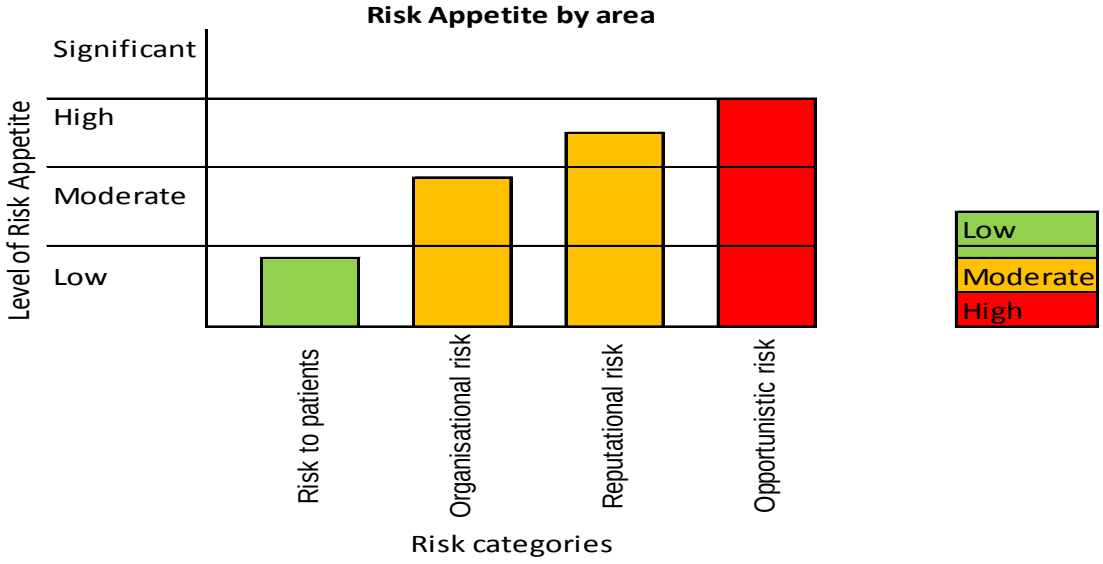
General Risk Appetite Statement

6. The results of the work to date on individual risk appetite levels were used as the starting point for revising the Trust's general risk appetite statement. The proposed general risk appetite statement was discussed at TME and is included below.

7. It should be noted that the general risk appetite statement has been drawn up using a complete map of each individual risk description and the current view of risk appetite.

   'The Trust recognises that its long term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners.

   As such, the Trust will not accept risks that materially impact on patient safety. However the Trust has a greater appetite to take considered risks in terms of their impact on organisational and reputational issues. The Trust has greatest appetite to pursue innovation and challenge current working practices in terms of its willingness to take opportunities where positive gains can be anticipated. This statement is depicted in the chart below"



Recommendations

8. The Committee is asked to:

   8.1. Note the revisions to the BAF and CRR, as set above.

   8.2. Approve the general risk appetite statement.

Mrs Clare Winch, Head of Assurance
Ms Eileen Walsh, Director of Assurance,
March 2013

Appendix 1: Executive Summary

Section 1: Assurance Summary / Assurance Dashboard

1. Board Assurance Framework for the delivery of Objectives

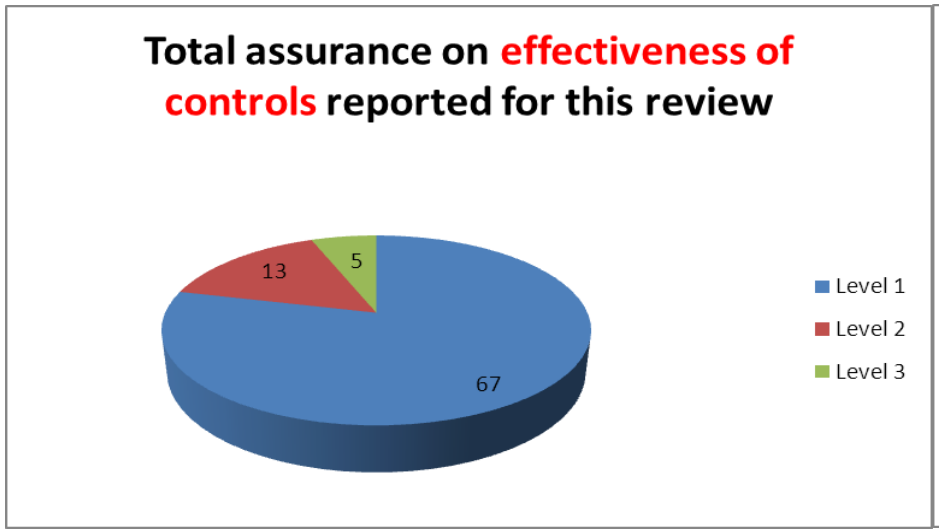
The Board has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate any significant risks which may threaten the achievement of the strategic objectives. Assurance may be gained from a wide range of sources, but where ever possible it should be systematic, supported by evidence, independently verified, and incorporated within a robust governance process. The Board achieves this, primarily through the work of its Assurance committees, through use of Audit and other independent inspection and by systematic collection and scrutiny of performance data, to evidence the achievement of the objectives.

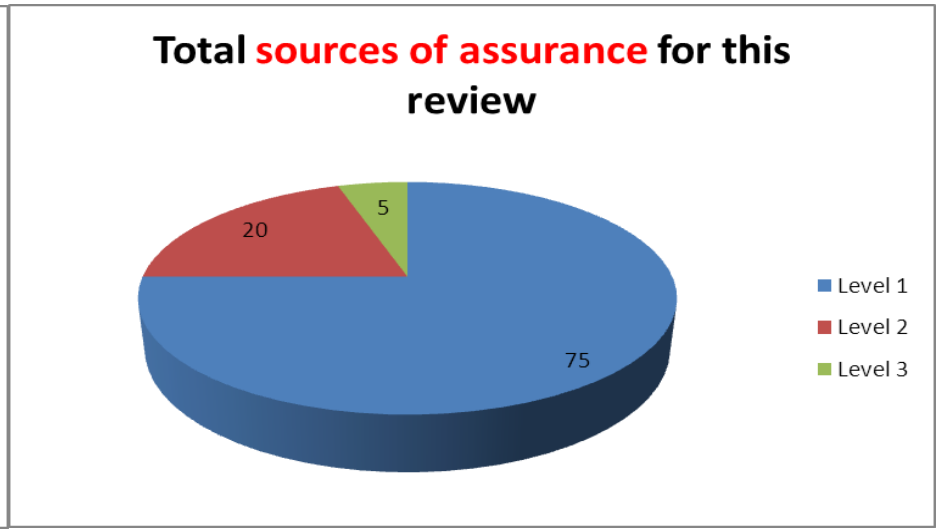
2. The Trust's Strategic Objectives for 2012/13 are:

SO1	To be a patient-centred organisation, providing high quality and compassionate care, within a culture of integrity and respect for patients and staff – **"delivering compassionate excellence"** ***Health and Social Care Act Regulation and CQC outcomes which may be affected by the risk:*** *Regulation 22; Outcome 13, reg 24 Outcome 6, reg 10 Outcome 16*
SO2	To be a well governed organisation with high standards of assurance, responsive to members and stakeholders in transforming services to meet future needs – **"a well governed and adaptable organisation"** ***Health and Social Care Act Regulation and CQC outcomes which may be affected by the risk:*** *Regulation 10, Outcome 16 Regulations 20 & 23, Outcomes 14 & 21*
SO3	To meet the challenges of the current economic climate and changes in the NHS by providing efficient and cost-effective services and better value healthcare – **"delivering better value healthcare"** ***Health and Social Care Act Regulation and CQC outcomes which may be affected by the risk:*** *Regulation 10, Outcome 16 Regulations 20 & 23, Outcomes 14 & 21*
SO4	To provide high quality general acute healthcare services to the population of Oxfordshire, including more joined up care across the local health and social care economy – **"delivering integrated healthcare"** ***Health and Social Care Act Regulation and CQC outcomes which may be affected by the risk:*** *Regulation 24; Outcome 6, 10, 16*
SO5	To develop extended clinical networks that benefit our partners and the people they serve. This will support the delivery of safe and sustainable services throughout the network of care that we are part of and our provision of high quality specialist are to the population of Oxfordshire and beyond – **"excellent secondary and specialist care through sustainable clinical networks"** ***Health and Social Care Act Regulation and CQC outcomes which may be affected by the risk:*** *Regulation 10, Outcome 16*
SO6	To lead the development of a durable partnerships with academic, health and social care partners and the life sciences industry to facilitate discovery, and implement its benefits – **"delivering the benefits of research and innovation to patients"** ***Health and Social Care Act Regulation and CQC outcomes which may be affected by the risk:*** *Regulations 21, 22 & 23, Outcomes 12, 13, 14*

3. Assurance Dashboard

Following feedback from the Board and sub-committees the pie charts previously included have been updated to ensure they present a consistent view of the assurance levels of documents reported to the Board. The titles have been amended to draw an explicit link to the columns contained within the Assurance Framework document (Annex 1).





The Trust Board has defined the overarching levels of assurance noted as follows: **Level 1** – Operational (Management) **Level 2** – Oversight functions (Committees) **Level 3** – Independent (Audits / Reviews / Inspections etc.)

Ref. no.	Assurance ON THE EFFECTIVENESS of CONTROLS	Level1	Level 2	Level 3
1	Quality	19	2	3
2	Finance	8		1
3	Performance	3		2
4	Commissioner Plans			
5	Market Share			
6	Workforce	1		
7	Transformation			1
8	Partnerships			
	Total assurances noted as reported to Audit, Quality &	31	2	7

This table provides a summary of all other assurance currently noted as reported to the Audit Committee, Finance & Performance Committee and Quality Committee to 28 February 2013, as noted in the assurance on effectiveness column of the Assurance Framework document.

F&P Committees to date			

4. Gaps in control or assurance to consider:

As part of the review and update to the Board Assurance Framework a complete review of all papers reported to the Board, Audit, Quality and Finance and Performance Committees was performed. The results of the review of papers was analysed and a range of potential gaps were highlighted. The table below provides an update of progress in relation to those gaps.

Principal Risk	Reason for potential gap in control / action
(2) Failure to maintain financial sustainability	CIP monitoring to be further developed to strengthen weekly monitoring. Plans in place to introduce weekly monitoring shortly. (Action lead Director of Finance & Procurement)
(4) Mismatch with commissioner plans	Not all the current identified sources of assurance appeared to be reported directly to the Trust Board or Board subcommittee. Head of Assurance and Director of Planning and Information have met and additional narrative has been added in the source of assurance column
(5) Loss of share of current and potential markets	ACE Programme Board and AHSN Programme assurance flows do not appear to be reported directly to the Trust Board or subcommittee. Head of Assurance and Director of Planning and Information have met to consider potential assurance gap. As a result of this discussion minor amendments have been made to reflect the current reporting more accurately.
(8) Failure to deliver the benefits of strategic partnerships.	Lack of formal reporting from Strategic Partner Board to the Trust Board. Head of Assurance and Director of Planning and Information have met to consider the potential assurance gap (links to principal risk 5). The Chief Executive briefing to the Board has been amended to provide a prompt to raise any issues as a result of Strategic Partner Board meetings as a matter of course, thus improving this aspect of assurance reporting.

Section 2: Risk Summary – Risk Dashboard

Since the previous report in January where risks 2.3, 3.2 & 4.3 were reduced a further 2 risk have been subject to a reduction in risk score (1.2 & 7.6), the remaining risks were unchanged. Those highlighted in grey have been de-escalated from the CRR with approval by TME.

Risk/ Lead	ID	Risk Description	Score Sep-12	Score Dec-12	Trend	Target	Link to SO
PR 1: (TB)	1.1	Patients experience indicators show a decline in quality.	6	6	new	4	SO1 SO5
	1.2	Breach of CQC regulations	9	6		3	
	1.3	Failure to meet the Trust's Quality Strategy goals.	9	9		3	
	1.4	Failure to deliver the quality aspects of contracts with the commissioners	6	6		6	
	1.5	CIPs impact on safety or unacceptably reduce service quality	9	9		6	
	1.6	Poor Bed Management processes impact on patient safety	N/A	16		6	
PR2: (MM)	2.1	Failure to deliver the required levels of CIP	9	9	↓	9	SO3 SO5
	2.2	Failure to effectively control pay and agency costs.	12	12		9	
	2.3	Failure to generate income from non- core healthcare activity.	12	8		8	
	2.4	Services display poor cost-effectiveness	9	9		9	
	2.5	Failure to manage outstanding historic debt	9	9		9	
PR3: (PB)	3.1	Failure to reduce delayed transfers of care	16	16	↓	12	SO1 SO2 SO3 SO4
	3.2	Failure of accurate reporting & poor data quality due to implementation of the EPR	12	9		6	
	3.3	Failure to deliver National Access targets including A/E, Cancer, 18 weeks	9	9		6	
PR 4: (AS)	4.1	Activity levels unaffordable to the health economy due to the failure to deliver QIPP levels.	12	12	↓	6	SO2 SO3
	4.2	Lack of robust plans across healthcare systems	12	12		6	
	4.3	Loss of Commissioner support	8	6		6	
	4.4	Inability to respond to requirements to flex capacity	8	8		6	
PR5: (AS)	5.1	Loss of existing market share	9	9	↔	4	SO3 SO5
	5.2	Failure to gain share of new markets. / Lack of support for business cases.	12	12		6	
	5.3	Negative media coverage relative to our competitors	6	6		3	
PR6: (SD)	6.1	Difficulty recruiting and retaining high-quality staff in certain areas.	8	8	↔	8	SO1 SO3 SO5
	6.2	Low levels of staff satisfaction, health & wellbeing and staff engagement	6	6		6	
	6.3	Insufficient provision of training, appraisals and development	9	9		3	
PR7: (PB)	7.1	Failure to maintain the development of organisational culture	8	8	↓	6	SO2 SO3 SO4
	7.2	Failure to maintain capacity and focus on longer term planning	6	6		6	
	7.3	Organisational barriers create potential blockers to the Trust's ability to apply research to models of care	6	6		6	
	7.4	Low levels of staff involvement in the Trust agenda	12	12		6	
	7.5	Failure to obtain the clinical advantages from EPR	6	6		6	
	7.6	Failure to establish robust governance and assurance processes.	12	9		6	
PR8: (AS)	8.1	Failure to establish sustainable regional networks	8	8	↔	2	SO5 SO6
	8.2	Failure to provide adequate support for education.	6	6		3	

	8.3	Failure to support research and innovation.	6	6		3	

1. Risk Profile / Risk Target

The risk profile shows all risks from the CRR as one picture, so that readers of the report can gain an overall impression of the total exposure to risk and changes to the risk profile over time.

Risk Profile (risk reference)

		Likelihood				
Consequence		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
Catastrophic	5					
Major	4		(2.3),(4.4) (6.1),(7.1) (8.1)	(4.1), (4.2), (7.4)	(3.1) (1.6)	
Moderate	3		(1.1), (1.2), (1.4), (4.3), (6.2), (7.5)	(1.3), (1.5), (2.1), (2.4), (2.5), (3.2), (3.3), (5.1), (6.3), (7.6)	(2.2), (4.2), (5.2),	
Minor	2			(5.3), (7.2), (7.3), (8.2), (8.3)	(6.1)	
Negligible	1					

2. Risk Escalation / De-escalation

The following risk has been escalated to the Corporate Risk Register following discussion at TME in February.

Risk ID	Risk Register	Description	Current controls	Risk Score	Risk Treatment Plan / Reason for potential escalation
CRR 1.6	Nursing	The Bed and Mattress Task Group have identified a number of risks in relation to: • Static Foam Mattresses: Principally in relation to the replacement, disposal and maintenance processes. • Bed Frames: Centred on the change to regulations due to take place from April 2013. • Bed Store / Repair sites: In relation to the suitability of the current locations. Risks to compliance with CQC, H&S and Fire regulations,	• Existing Equipment Replacement Contract on place. • Current store location assessed but not fit for purpose.		Two separate Business Cases are in the process of being progressed. • Bed Store Site solution – Due to be completed for end March to be presented to TME following completion of the Business Case. • Foam Mattresses – Business Cases presented to TME this month Due to the nature of the risks and the fact that this is a Trust wide issue it has been recommended for

Risk ID	Risk Register	Description	Current controls	Risk Score	Risk Treatment Plan / Reason for potential escalation
		infection control and decontamination processes, with related issues to patient safety.			inclusion on to the CRR, as part of Principle Risk 1 : Quality

A number of risks on the CRR had been at their planned target level for 2 quarters TME agreed that these risks should de-escalated from the CRR to other more appropriate Risk Registers.

Risk ID	Description	Risk Score
1.4	Failure to deliver the quality aspects of contracts with the commissioners.	6
2.1	Failure to deliver the required levels of CIP.	9
2.4	Services display poor cost-effectiveness.	9
2.5	Failure to manage outstanding historic debt.	9
6.1	Difficulty recruiting and retaining high-quality staff in certain areas.	8
6.2	Low levels of staff satisfaction, health & wellbeing and staff engagement**.**	6
7.2	Failure to maintain capacity and focus on longer term planning.	6
7.3	Organisational barriers create potential blockers to the Trust's ability to apply research to innovative models of care and across patient pathways.	6
7.5	Failure to obtain the clinical advantages from EPR.	6

3. Emerging Risks / External Issues

The following emerging issues have been noted to date:

Source	Issue Summary	Action to date
Finance and Performance Committee (October)	Potential risk from the movement of commissioning from local to specialist commissioning groups	This is being tracked by the Director of Finance & Procurement any change to the BAF and CRR will be highlighted in a future version as considered necessary by the Director of Finance & Procurement.
Standing rule regulation from CE Bulletin (December)	NHS Commissioning Board to insert a contractual duty of candour into the NHS standard contract ensuring that organisations disclose to patients or their representatives when they have been involved in a patient safety incident, building on the principles of the NPSA *Being Open* policy	This issue is currently being review by the Medical Director and an update will be provided in due course.

Annex 1:
Board Assurance Framework
March 2013

Assurance Framework Legend

The Assurance Framework has the following headings:

Principal Risk:	What could prevent the objective from being achieved? Which area within organisation does this risk primarily impact on – clinical, organisational or financial?
Key Controls:	What controls / systems do we have in place to assist secure delivery of the objective?
Sources of Assurance:	Where can we gain evidence relating to the effectiveness of the controls / systems which we are relying on?
Assurances on the Effectiveness of controls:	What does the evidence tell us in relation to the effectiveness of the controls / systems which are being relied on?
Gaps in control:	Are there any gaps in the effectiveness of controls/ systems in place?
Gaps in assurance:	Where can we improve evidence about the effectiveness of one or more of the key controls / systems which we are relying on?
Action Plans:	Plans to address the gaps in control and / or assurance and indicative completion dates

Ref no.	Principal Risk Description (CRR risk ref)	Key Controls	Sources of Assurance	Assurance on the Effectiveness of controls	Gaps in Control	Gaps in Assurance	Action Plans for gaps in control or assurance	Action plan update / Owner
Principal Risk 1: Failure to maintain the quality of patient services.								
SO 1 SO 5 IBP Risk 1	**Potential Cause:** • Failure to meet the Trust's Quality Strategy goals (1.3). • Failure to deliver the quality aspects of contracts with the commissioners (1.4). • Patients experience indicators show a decline in quality (1.1). • Breach of CQC regulations (1.2). • CIPs impact on safety or unacceptably reduce service quality (1.5). • *Poor Bed Management processes impact on patient safety (1.6)* **Potential Effect:** • Poor patient experience and standards of care. • Inaccurate or inappropriate media coverage. **Potential Impact:** • Potential loss of licence to practice. • Potential loss of reputation. • Financial penalties may be applied. • Poor Monitor Governance Risk Rating.	• Quality metrics in monthly Divisional Quality Reports • 'Safety Thermometer' data • 'Observations of care' reviews. • Patient feedback via complaints & claims. • Incident reporting. • Articulation of organisational values • Quality Strategy • CQUIN & Contract monitoring process. • Quality impact review process of all CIP plans. • Whistleblowing policy • M&M / clinical governance meetings at service level • Benchmarked outcomes data (e.g. Dr Foster) • Quality meetings between executives and PCT • Appraisal / revalidation • QA priorities	Reported to Board • Integrated Performance Reports (IPR) (Level 1 (L1)). • Reports from Quality Committee to Board (L 2). • QGF Internal Assessment to (L1) External Assessment (L3) • Audit Committee Report to the Board (L2) • Annual H&S Report (L1) Reported elsewhere • Annual nursing skill mix review (L1). • Internal Audit to review Quality Governance (L3). • External review / audit of the QA (PCT, Audit Commission) (L3). • Picker Patient and Staff Surveys (L2). • PROMs (L3). • GMC Trainee survey (patient safety) (L3). • National Clinical Audits/ (L3). • Audit Committee to review Clinical Audit (L2)	Reported to Board • IP R (L1) (July 2012, Sept 2012, Nov 2012, Jan 13, Feb 13) • Reports from Quality Committee to Board (L2) (Sept 2012, Nov 2012, Jan 13) • QGF Internal Assessment (L1) (Sept 2012, Jan 13) • Audit Committee Report to the Board (L2)(Sept 2012, Feb 13) • Annual H&S Report (L1) (Nov 2012) • QGAF Report (L3)(Nov 12) • CQUIN Report (L1) (Jan 13) • Quality Report (L1) (Feb 13) Reported elsewhere • *Total of 19 level 1 and 2 level 2 and 3 level 3 assurances reported to board sub committees*	Quality Strategy to be implemented	None identified at 14/12/2012.	**Control Gap**: Implementation of Quality Strategy to be progressed. **Action Owner:** ESH/TB	**Overall Risk Owner:** TB

Ref no.	Principal Risk Description (CRR risk ref)	Key Controls	Sources of Assurance	Assurance on the Effectiveness of controls	Gaps in Control	Gaps in Assurance	Action Plans for gaps in control or assurance	Action plan update / Owner
Principal Risk 2: Failure to maintain financial sustainability.								
SO 3 SO 5 IBP Risk 2	**Potential Cause**: • Failure to deliver the required levels of CIP (2.1). • Failure to effectively control pay and agency costs (2.2). • Failure to generate income from non-core healthcare activities (2.3). • Failure to manage outstanding historic debt (2.5). • Services display poor cost-effectiveness (2.4). **Potential Effect**: • Additional CIPS may need to be identified and delivered. **Potential Impact:** • Reductions in services or the level of service provision in some areas. • Potential loss in market share and or external intervention.	• Two-year rolling CIP with contingencies in place. • Divisional ownership of schemes. • Programme office support of schemes. • Contingency plans for strategic disinvestments and sale of assets in place. • Performance Management Regime in place. • Budget setting & business planning processes. • Quality Impact Assessment process. • Contract monitoring process	Reported to Board • Director of Finance and Procurement Reports to the Board (Level 1) • Finance and Performance Committee (Level 2). • Audit Committee Report to the Board (Level 2) • HDD Report (L3) Reported elsewhere • Internal Audit to review CIPs (Level 3) • IA to review Financial Management arrangements (in outline plan) (Level 3). • CIP reports to Quality Committee (Level 2). • Data Quality reviews with commissioners (Level 2)	Reported to Board • Finance reports and specific updates on aspects as required (e.g. Demand management) (L1) (April 2012 x 2, July 2012, Sept 2012, Nov 12, Jan 13, Feb 13) • F&P report to the Board (L2) Sept 2012, Nov 2012, Jan 13) • Audit Committee Report to the Board (L2)(Nov 2012) • HDD Report (L3) (Nov 12) Reported elsewhere • Service Line Reports to TME (L1) • *2 L 1 assurance to Quality Committee* • *Total of 5 L1* and 1 L3 assurance to Audit Committee • Total of 2 L1 assurances reported to F&P	CIP monitoring to be further developed to strengthen weekly monitoring.	Quality Impact assessment to continue to conclusion	**Control Gap:** Plans in place to introduce weekly monitoring shortly **Action Owner:** MM **Assurance Gap:** Quality Impact assessment to continue to conclusion. **Action Owner:** ESH/TB	**Overall Risk Owner:** MM

Ref no.	Principal Risk Description (CRR risk ref)	Key Controls	Sources of Assurance	Assurance on the Effectiveness of controls	Gaps in Control	Gaps in Assurance	Action Plans for gaps in control or assurance	Action plan update / Owner
				Committee				
Principal Risk 3: Failure to maintain operational performance								
SO 1 SO 2 SO 3 SO 4 IBP Risk 3	**Potential Cause**: • Failure of national performance target (ED, cancer, RTT) (3.3) • Failure to reduce delayed transfers of care (3.1). • Failure of accurate reporting and poor data due to implementation of EPR (3.2). **Potential Effect:** • High numbers of people waiting for transfer from inpatient care. • Delays in patient flow, patients not seen in a timely way. • Reduced patient experience. • Failure of KPI's and self-certification. **Potential Impact**: • Services may be unaffordable. • Quality of care provided to patients may fall. • Loss in reputation. • Failure to meet contractual requirements. • Failure to gain FT status	• Detailed Work Program • Monthly Program Board, with representation from OUH, social services and the PCT at C.E. level. • Bi-weekly Project Team meetings at COO level. • Internal weekly DToC meetings. • Supported Discharge Service in place with 8 work streams. • Provider Action Plan • Monthly Chief Executives meetings.	Reported to Board • Director of Finance Reports to the Board (Level 1). • Integrated Performance Reports (Level 1) • Director of Clinical Services reports re review of services (Level 1). • Emergency Planning Annual Report (Level 1) • Audit Committee Report (Level 2) Reported elsewhere • ACE (Appropriate care for everyone) Programme Board meetings (Level 2). • PCT monthly Monitoring Review meetings (Level 3). • Chief Executive's Meetings (Level 2).	Reported to Board • Finance reports (Level 1). (April 2012 x 2, July 2012, Sept 2012, Nov 2012, Jan 13, Feb 13) • Integrated Performance Reports (Level 1) (July 2012, Sept 2012, Nov 2012, Jan 13, Feb 13) • DTOC Provider Action Plan (Level 1) (Sept 2012) • Emergency Planning Annual Report (Level 1) (Nov 2012) • Audit Committee Report (Level 2) (Jan 13) Reported elsewhere • 1 level 1 and 1 level 2 assurance reported to Quality Committee • 1 level 1 and 1 level 3 assurance reported to Audit Committee • Total of 2 level 1 assurances	None identified at 14/12/2012	None identified at 14/12/2012	No further action required at 14/12/12	N/A for action (**Risk Owner** : PB)

Ref no.	Principal Risk Description (CRR risk ref)	Key Controls	Sources of Assurance	Assurance on the Effectiveness of controls	Gaps in Control	Gaps in Assurance	Action Plans for gaps in control or assurance	Action plan update / Owner
				reported to F&P Committee				
Principal Risk 4: Mismatch with commissioners plans.								
SO 2 SO 3 IBP Risk 4	**Potential Cause:** • Activity levels unaffordable to the health economy due to the failure to deliver QIPP levels (4.1). • Lack of robust plans across healthcare systems (4.2). • Loss of Commissioner support (4.3). • Inability to respond to requirements to flex capacity (4.4). **Potential Effect:** • Loss of existing market share. • Stranded fixed costs due to poor demand management / QIPP. • Difficult to manage capacity plans. **Potential Impact:** • Reduced financial sustainability. • Inability to meet quality goals. • Reduced operational performance.	• Strategy developed with commissioners. • Contracts in place. • Commissioner alignment meetings in place. • Contingency plans for withdrawal from services developed. • Quarterly review against plan.(Titration system) • Monthly meetings with PCT Cluster and CCG • Creating a Healthier Oxfordshire Board • Lavender statements in place.	Reported to Board • CE reports to Board (Level 1) • Director of Clinical Services reports re review of services (Level 1). • Finance Reports include contractual and commissioning issues, where relevant. (Level1) • Progress of agreeing contracts reported via Finance to Board annually (Level 1) • Business Cases involving commissioners reported, where these occur (Level 1) Reported elsewhere • Minutes of Network meetings (Level 2). • Update reports from Community Partnership Network (Level 2). • Minutes of Monthly Contract Review Meetings (Level 2) • Letters of support for Integrated Business Plan and Long Term Financial Model from	Reported to Board • Update on Oxford Health & Well Being Board Consultation presented to the Board in July 2012 (Level 1). • DTOC Provider Action Plan (Level 1) (Sept 2012)	None identified at 14/12/2012	Not all current identified sources of assurance appeared to be reported direct to Board or Board subcommittee	**Assurance Gap:** Head of Assurance and Director of Planning and Information have met and additional narrative has been added in the source of assurance column. **Action Owner:** AS/CW	(**Risk Owner** : AS)

Ref no.	Principal Risk Description (CRR risk ref)	Key Controls	Sources of Assurance	Assurance on the Effectiveness of controls	Gaps in Control	Gaps in Assurance	Action Plans for gaps in control or assurance	Action plan update / Owner
			PCT Cluster and Specialist Commissioners (L2)					
Principal Risk 5: Loss of share of current and potential markets.								
SO 3 SO 5 IBP Risk 5	**Potential Cause:** • Loss of existing market share (5.1). • Failure to gain share of new markets (5.2). • Negative media coverage relative to our competitors (5.3). • Lack of support for business cases (5.2). **Potential Effect:** • Poor staff morale. • Stifles innovative developments / ability to redesign services. **Potential Impact:** • Reduced influence/ reputation across the health economy. • Reduction in overall income reduced financial stability.	• Commissioner approved Network Strategies • Clinical Network meetings • Oxford Health collaborative arrangements. • Contingency plans for withdrawal from services. • Continued monitoring and engagement with local economy partners as set out in Risk 3. • AHSN Programme	Reported to Board • Income element of Finance Report to Board (Level 1) • Director of Clinical Services reports re review of services (Level 1). • Chief Executive Reports include information re AHSN, where relevant (Level 1) Reported elsewhere • ACE Programme Board meetings (Level 2). • Letters of support for Integrated Business Plan and Long Term Financial Model from PCT Cluster and Specialist Commissioners (Level 2)`	Reported to Board • Finance reports to the Board (Level 1). (April 2012, July 2012, Sept 2012, Nov 2012, Jan 13, Feb 13) • Review of Acute Medicine (Level 1) (Dec 2012) • CE Briefing (Level 1) (Jan 13)	None identified at 14/12/2012	AHSN Programme assurance flows did not appear to be reported direct to the Board or subcommittee	**Assurance Gap:** Head of Assurance and Director of Planning and Information have met and additional narrative has been added in the source of assurance column. **Action Owner:** AS/CW	N/A for action (**Risk Owner** : AS)

Ref no.	Principal Risk Description (CRR risk ref)	Key Controls	Sources of Assurance	Assurance on the Effectiveness of controls	Gaps in Control	Gaps in Assurance	Action Plans for gaps in control or assurance	Action plan update / Owner
Principal Risk 6: Failure to sustain an engaged and effective workforce.								
SO 1 SO 3 SO 5 IBP Risk 6	**Potential Cause:** • Difficulty recruiting and retaining high-quality staff in certain areas (6.1). • Low levels of staff satisfaction, health & wellbeing and engagement (6.2). • Insufficient provision of training, appraisals and development (6.3). **Potential Effect:** • Low levels of staff involvement and engagement in the trust's agenda. • High than average vacancy rates. • Failure to deliver required activity levels / poor staff effectiveness **Potential Impact:** • Poor patient experience and outcomes. • Poor CQC assessment results. • Poor patient survey results. • Loss of reputation • Reduced ability to embed new ways of working.	• 'Values into Action' / Listening into Action Programme in place. • Improved recruitment and induction processes. • Staff engagement and awareness programme in place. • Divisional Staff Survey Action Plans. • Value based interviewing project. • Education and development processes in place. • Appraisal compliance and training attendance monitored.	Reported to Board • Director of Workforce Reports to Board (Level 1), • Integrated Performance Report to the Board (Level 1). • Staff survey and values update work reported specifically and through Quarterly workforce reports (Level 1). • Annual H&S Report (Level 1 Reported elsewhere • Internal Audit to review training (in outline plan) (Level 3)	Regular reports to Board: • Quarterly workforce reports (Level 1) (Sept 2012, Nov 2012, Feb 13) • Integrated Performance Report (Level 1) (July 2012, Sept 2012, Nov 2012, Jan 13, Feb 13) • Annual H&S Report (Level 1) (Nov 2012) Adhoc reports to Board: • Update 'values into action', and staff engagement (L1) (April 12). • Staff Engagement update (L1) (July 12) • Staff Survey 2011 (L3) (May 12) *Reported elsewhere* • *1 level 1 assurance reported to Quality*	Lack of local in year feedback in relation to staff views / staff surveys	None identified at 14/12/2012	**Control Gap:** Action plan in place to develop local staff survey approach. **Action Owner:** SD	**Overall Risk Owner:** SD

Ref no.	Principal Risk Description (CRR risk ref)	Key Controls	Sources of Assurance	Assurance on the Effectiveness of controls	Gaps in Control	Gaps in Assurance	Action Plans for gaps in control or assurance	Action plan update / Owner
				Committee				
Principal Risk 7: Failure to deliver the required transformation of services.								
SO 2 SO 3 SO 4 IBP Risk 7	**Potential Cause:** • Failure to maintain the development of organisational culture (7.1). • Failure to maintain capacity and focus on longer term planning (7.2). • Organisational barriers impede the Trust's ability to apply research to innovative models of care and patient pathways (7.3). **Potential Effect:** • Low levels of staff involvement / engagement in service redesign (7.4). • Failure to increase utilisation of high value resources and inability to reduce delivery costs. • Failure to deliver new patient pathways. • Failure to obtain the clinical advantages from EPR (7.5). • Failure to embed robust governance and assurance processes (7.6). **Potential Impact:** • Patient experience. • Operational performance. • Service fail to achieve long term sustainability.	• Quality Strategy and Implementation Plan • Strategy to be built in to recruitment, appraisal and performance management processes • Clinical management structure • Learning & development framework. • Job planning • Appraisal • Leadership programmes • Enhanced patient involvement • Service Improvement Programmes. • Workforce Strategy. • Implementation Programmes with strategic documents.	Reported to Board • Director of Workforce Reports to Board (Level 1), • Reports from Quality Committee to Board (Level 2 • Director of Clinical Services reports re review of services (Level 1). • BGAF Internal Assessment (Level 1) External Assessment (L3) • Governance of Board Committees (Level 1) • Board Sub Committee appointments (Level 1) • Effectiveness of Board (L3) • Director of IM&T reports (L1) Reported elsewhere • Reports to Workforce Committee (Level 2) • Minutes of CIP Executive Group. (Level 2)	Regular reports to Board: • Quarterly workforce reports (L1) (Sept Nov 12,Feb 13) • Reports from Quality Committee (L2) (Sept, Nov 12,Jan 13) Adhoc reports to Board • NOC PPE review (L1) (July 12, Jan 13) • BGAF (L1) Sept 12) (L3) (Nov 12) • Governance of Comm (L1) (Sept 12) • Board Sub comm appointments (L1) (Nov 12) • Effectiveness of Board (L3) (Nov 12) • Review of Acute Medicine (L1) (Dec 12) • EPR Updates (L1) Jan 13, Feb 13) *Reported elsewhere* • *1 L3 assurance*	Co-ordinated strategy to create transformation not yet in place. Coherent programmes for leadership to be developed.	None identified at 14/12/2012	**Control Gap:** Leadership working group to be established **Action Owner:** ESH	**Overall Risk Owner:** PB

Ref no.	Principal Risk Description (CRR risk ref)	Key Controls	Sources of Assurance	Assurance on the Effectiveness of controls	Gaps in Control	Gaps in Assurance	Action Plans for gaps in control or assurance	Action plan update / Owner
				to Quality Committee				
Principal Risk 8: Failure to deliver the benefits of strategic partnerships.								
SO 5 SO 6 IBP Risk 8	**Potential Cause:** • Failure to establish sustainable regional networks (8.1). • Failure to provide adequate support for education (8.2). • Failure to support research and innovation (8.3). **Potential Effect:** • The emergence of more effective or innovative leaders elsewhere. • Failure to develop innovative services. **Potential Impact**: • Threat to sustainability of specialist services. • The possible requirement to scale back some services.	• Joint working agreement with Oxford Universities. • Strategic Partner Board 1/4ly meetings (Joint Chair Dame Fiona Caldicott) • Education and training strategy. • Lead role in AHSC – Local Oxford partners • Lead role in AHSN – Wider network partners • Clinical network groups. • Engagement strategy • DoC Trust Lead with CCGs, Oxford Health, SS in relationship management process.	Reported to Board • Chief Executive reports to Board (Level 1). Reported elsewhere • Internal Audit to review Partnership Working (outline audit plan) (Level 3). • Board to Board meetings with PCT (Level 2)	Reported to Board • Oxford Health Academic Consortium update Report (Level 1) (May 12). • Academic Health Science Network EoI presented to the Board in July 2012 (Level 1). • CE Briefing (Level 1) (Jan 13) • CE Briefing: Strategic Partnership Update (Level 1) (Feb 13)	None identified at 14/12/2012	Lack of formal reporting from Strategic Partner Board to the Trust Board.	**Assurance Gap:** Head of Assurance and Director of Planning and Information and the Chief Executive briefing to the Board has been amended to provide a prompt to raise any issues as a result of Strategic Partner Board meetings as a matter of course, thus improving this aspect of assurance reporting. **Action Owner:** AS/CW	**Overall Risk Owner:** AS

Annex 2:
Corporate Risk Register
March 2013

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Sept 2012)		Current risk rating (Dec 2012)		TREND	Review Date	Risk Target
						L	C	L	C			
Principal Risk 1: Failure to maintain the quality of patient services.												
1.1	ESH	IBP	Patients experience indicators show a decline in quality. **Cause:** • Negative experiences reported through annual Picker patient survey (for example, net promoter score) and other externally benchmarked feedback exercises. • Failure to provide adequate staffing trained at an appropriate level. **Effect:** • Failure to meet CQUIN goals • Negative media coverage **Impact:** • Potential loss of reputation & patient experience.	• Improvements planned to Trust systems of patient feedback. • Numerous examples at service level of patient experience information being collected and acted upon. Quality metrics in monthly Divisional Quality Reports • 'Safety Thermometer' data • 'Observations of care' reviews. • Patient feedback via complaints & claims. • Incident reporting.	Over 12 months	2	3	2	3	↔	14/12/12	4
						6		6				
1.2	ESH	IBP	Breach of CQC regulations. **Cause:** • Failure to maintain compliance with any one of the CQC's 16 essential Outcomes. **Effect:** • Patient experience and standards of care. • Financial penalties could be applied. **Impact:** • Potential loss of licence to practice. • Poor Monitor Governance Risk Rating.	• CQC Action Plan (s) in place • Health Assurance Rollout Plan progressing to time • Quality Strategy and implementation plan • Values • Internal inspection visits • Monthly quality dashboards and other quality data relating to ward care • 'Mystery shopper' and other initiatives. • Divisional inspection visits & declaration of compliance. • Director walkround process	3 -12 months	3	3	2	3	↓	14/12/12	3
						9		6				
1.3	TB	IBP	Failure to meet the Trust's Quality Strategy goals. **Cause:** • Lack of staff knowledge in relation to the Quality Strategy. **Effect:** • Front line staff fail to monitor and measure quality in line with the strategy.	• Quality Strategy in place. • Implementation Plan to embed Strategy with launch event planned • Implementation permissive of localisation of Trust priorities to maximise relevance to clinical teams • Quality strategy to be embedded into	3 -12 months	3	3	3	3	↔	14/12/12	3
						9		9				

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Sept 2012)	Current risk rating (Dec 2012)	TREND	Review Date	Risk Target
			Impact: • Potential loss of reputation. • Goals are not achieved.	employment processes, performance management and reward systems						
1.4			On target and de-escalated to relevant risk register						28/02/13	
1.5	TB	IBP	CIPs impact on safety or unacceptably reduce service quality. **Cause:** • Poor Quality Impact Assessment Process. • CIPS fail to deliver transformational change. • Interrelationship of CIPS creates cumulative risk **Effect:** • Lack of buy-in to schemes. **Impact:** • Standards of patient care drop. • Potential loss of reputation	• Quality Impact Assessment process per Monitor guidance embedded within proposal template for cost improvement programmes including sign-off by lead clinicians and definition of relevant metrics by which quality impact will be monitored. • Peer review of CIPs • Formal sign off mechanism by Chief Nurse and Medical Director. • Monitoring at monthly performance compact meetings. • Results reported via Quality Committee.	3 -12 months	3 3 / 9	3 3 / 9	↔	14/12/12	6
1.6	*ESH*	*RA*	*Poor Bed Management processes impact on patient safety* *The Bed and Mattress Task Group have identified a number of risks in relation to:* • *Static Foam Mattresses: Principally in relation to the replacement, disposal and maintenance processes.* • *Bed Frames: Centred on the change to regulations due to take place from April 2013.* • *Bed Store / Repair sites: In relation to the suitability of the current locations.* *Risks to compliance with CQC, H&S and Fire regulations, infection control and decontamination processes, with related issues to patient safety.*	• *Existing Equipment Replacement Contract on place.* • *Current store location assessed but not fit for purpose.*		*N/A*	4 4 / 16	new	28/02/13	6
Principal Risk 2: Failure to maintain financial sustainability.										
2.1			On target and de-escalated to relevant risk register						28/02/13	
2.2	MM	IBP	Failure to effectively control pay and agency costs. **Cause:**	• Sickness management and monitoring • Workforce plans	Within 3	4 3 / 12	4 *3* / 12	↔	14/12/12	9

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Sept 2012)	Current risk rating (Dec 2012)	TREND	Review Date	Risk Target
			• Tariff reduction requires internal efficiencies that may not be sustainable. • Lack of knowledge re safe staffing levels. **Effect:** • Poor financial controls destabilise the financial position. **Impact:** • Employee engagement • Perceptions of safety	• Vacancy controls • Business Planning	months					
2.3	MT	IBP	Failure to generate income from non- core healthcare activity. **Cause:** • Inability of clinical services transforming in order to deliver services across a smaller footprint. • Private sector appetite to utilise land opportunities. • Internal capacity and capability to generate and deliver revenue income generating schemes. **Effect:** • Delivery costs not met by core clinical income. **Impact:** • Increased financial pressures**.**	• Reorganisation and development of the Estates Directorate, with the addition of new roles to enable the development of commercial opportunities. Update: New structure confirmed 1 Dec 12. Recruitment of new Heads of Strategic Asset Management now underway. • Development of Estates Strategy Update: Interim strategy approved by the Board in November, 5 facet survey planned for Q4 12/13 to inform longer term strategy and infrastructure investment programme	3 -12 months	3 4 12	2 4 8	↓	14/12/12	8
2.4			On target and de-escalated to relevant risk register						28/02/13	
2.5			On target and de-escalated to relevant risk register						28/02/13	
Principal Risk 3: Failure to maintain operational performance										
3.1	PB	IBP	Failure to reduce delayed transfers of care. **Cause**: • High numbers of people waiting for transfer from inpatient care. • Demography – ageing population with multiple long-term conditions • Failure of a joint approach to resolve delayed transfers of care across commissioners & provider organisations. • Recruitment difficulties in social care.	**Internal:** Daily monitoring of DToC & escalation beds; Monthly Divisional Performance Reviews; Reporting & monitoring to Trust Management Executive & Trust Board monthly. **Actions taken** • Implemented Trust Supported Discharge scheme • Implemented Step-down wards within JR and Horton	Within 3 months	4 4 16	4 4 16	↔	14/12/12	12

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Sept 2012)	Current risk rating (Dec 2012)	TREND	Review Date	Risk Target
			• Poor access to community beds or provision care to maintain patients in their own home **Effect:** • Poor patient experience • Failure to meet Monitor standard • Loss of reputation • Capacity used exceeds plan • High costs of temporary capacity • Inpatient episodes funded at only 30% marginal rate • Delays in patient flow, patients not seen in a timely way. **Impact**: • Prevents reduction in acute capacity and costs • Delays to service integration and site moves • Financial impact from the requirement to maintain additional beds. • Quality of care provided to patients may fall. • Loss in reputation.	• Opened escalation beds • Reviewed Escalation Procedures • Reviewing Winter Plans 2012/13 • Health Liaison meeting with health & social care partners • Discussion with Oxford Health FT about integrating care provision • Capacity escalation procedures in place **External:** • Month contact meetings with PCT- Sought to manage risks through contract • CEO & DCS attendance at ACE programme Board, & OP/JAP joint commissioning/provider meetings. • DTOC Provider Board - set up DTOC Providers programme in March 2012 with 8 workstreams – prime object to reduce DTOC – PID to Trust Board 6/9/12						
3.2	AS	IBP	Failure of accurate reporting & poor data quality due to implementation of the Electronic Patient Record(EPR) **Cause:** • Poor data to manage key access targets • Poor data quality • Implementation of EPR has led to or has been perceived by the PCT/CCG to have led to deterioration in data quality. **Effect:** • Patients not seen in a timely way, poor patient experience. • Board does not have sufficient assurance on service and financial performance. • Trust will have a reduced rating on external	**Internal** • Weekly EPR meetings with clinical & operational staff & Suppliers • Clear programme of work to improve data quality, workflow, training & fixes into EPR. • Risk assessed key clinical areas to reduce impact of patient care • Monthly EPR Operational Steering & EPR Programme oversight meetings in place. • Trust Board and Audit Committee to have specific updates from Programme Board. • Quality reports have reported on operational issues.	3-12 months	3 4 12	3 3 9	↓	14/12/12	6

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Sept 2012)	Current risk rating (Dec 2012)	TREND	Review Date	Risk Target
			assurance. • Trust will fail service and financial targets because managers do not have adequate information. • Reputational damage • Loss of commissioning income. • Loss of support from PCT/CCG **Impact:** • Failure to meet contractual requirements, increased costs. • Failure to gain FT status • Failure of ED Monitor standard – Red Flag • Increased costs of temporary staff & in additional capacity. • Unable to manage key access targets • Potential loss of credibility with commissioners. • Failure to gain FT status.	• Data Quality dashboard in place to monitor weekly progress • Independent audits • Director Walkarounds. • Data Quality Board &Data Quality Assurance Review Process • Integrated performance Report – assessment of data quality made on each indicator. **External** • CEO led Supplier & NHS meeting • Monthly PCT contract meeting • External reporting to SHA						
3.3	PB	IBP	Failure to deliver National Access targets including A/E, Cancer, 18 weeks. **Cause:** • Lack of sufficient capacity/workforce • Implementation of Electronic Patient Record (EPR) disrupted data • Increase in demand or failure of health system to divert patients. • Poor bed availability due to delayed transfers of care. • Failure to deliver efficient patient pathways. • Poor Productivity • Failure to deliver QIPP 2012/13 **Effect:** • Patients waiting longer – NHS Constitution • Poor patient experience • Loss of Reputation • High costs of temp capacity & workforce	**Internal** • Daily & weekly monitoring of key access targets; Weekly EPR meetings; Monthly EPR Operational & Monthly EPR Programme Board meetings • Daily whole system teleconference calls • Contingency & Recovery plans in place • Fortnightly performance meetings • Monthly Divisional performance meetings; Monthly reporting & monitoring access targets through Trust Management executive & Trust Board; • Implemented MSK Hub for demand management • Reviewed complaints/Patient experience at Board • Review of Incidents at Board • Board walk rounds	3-12 months	3 3 9	3 3 9	↔	14/12/12	6

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Sept 2012)	Current risk rating (Dec 2012)	TREND	Review Date	Risk Target
			• Failure of access targets and Monitor's compliance standards. • Poor staff morale • Patients not seen in a timely way • **Impact:** • Failure to meet contractual requirements, increased costs. • Failure to gain FT status • Failure of ED Monitor standard – Red Flag • Increased costs of temporary staff & in additional capacity.	**External** • OUH senior manager attendance at Urgent Care taskforce, Planned care Programme Board & Long Term Conditions. • Bimonthly OCCG/Clinical Directors meeting for Planned Care delivering QIPP • Monthly Contract meeting with PCT • Weekly SHA teleconference calls • Weekly South Central Ambulance meeting						
Principal Risk 4: Mismatch with commissioners plans.										
4.1	AS	IBP	Activity levels unaffordable to the health economy due to the failure to deliver QIPP levels. **Cause:** Commissioner QIPP Programmes may be unachievable. **Effect:** Stranded fixed costs due to poor demand management / QIPP. **Impact:** • Financial sustainability. • Ability to meet quality goals. • Operational performance.	• Detailed paper identifying where the risk lies between the Trust and PCT. • Trust Action Plan (QIPP) covering those areas in relation to Trust agreed responsibilities • Income and Contract Summary reports. • Monthly contract review meeting held between the Trust and the PCT. • Internal weekly Business Planning meetings. • Contract contains risk management provisions	3-12 months	3 4 12	3 4 12	↔	14/12/12	6
4.2	AS	IBP	Lack of robust plans across healthcare systems. **Cause:** • Lack of clear leadership. • Poor culture across the health economy. • Inter-organisational barriers. **Effect:** • Unaffordable levels of care demanded.	• QIPP Programme Framework. • Risk management provisions in contract • Collaboration with Oxford Health.	3-12 months	3 4 12	3 4 12	↔	14/12/12	6

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Sept 2012)	Current risk rating (Dec 2012)	TREND	Review Date	Risk Target
			Impact: • Financial deficits for commissioners and OUH. • Adverse impact on quality and service performance.							
4.3	AS	IBP	Loss of Commissioner support. **Cause:** • Lack of trust. **Effect:** • PCT / CCG fails to support FT application. **Impact:** • FT application not allowed to progress.	• Commissioner alignment meetings. • Relationship management process. • *Letters of support from commissioners in relation to FT application*	Over 12 months	2 4 = 8	2 3 = 6	↓	14/12/12	6
4.4	PB	IBP	Inability to respond to requirements to flex capacity. **Cause:** • Difficult to manage capacity plans. **Effect:** • Inability to increase or reduce beds in line with demand. **Impact:** • Financial sustainability. • Ability to meet quality goals. • Operational performance.	• Strengthened bed management process • Flexible working practices. • Business planning processes	Over 12 months	2 4 = 8	2 4 = 8	↔	14/12/12	6
Principal Risk 5: Loss of share of current and potential markets.										
5.1	AS	IBP	Loss of existing market share. **Cause:** • Poor quality care. • High cost care. **Effect:** • Loss of income. **Impact:** • Clinical sustainability. • Financial sustainability	• Financial monitoring processes and financial reporting. • Clinical network meetings • AHSN	3-12 months	3 3 = 9	3 3 = 9	↔	14/12/12	4
5.2	AS	IBP	Failure to gain share of new markets. / Lack of support for business cases. **Cause:**	• Business case process • Clinical network meetings • Alignment with commissioners plans	Within 3 months	4 3 = 12	4 3 = 12	↔	14/12/12	6

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Sept 2012)	Current risk rating (Dec 2012)	TREND	Review Date	Risk Target
			• Poor quality care. • High cost care. • Poor relationship management. **Effect:** • Services are not able to expand. **Impact:** • Financial sustainability. • Operational performance.	• AHSN						
5.3	AS	IBP	Negative media coverage relative to our competitors. **Cause:** • Poor performance. • Poor media handling. **Effect:** • Loss of confidence in services provided. • Loss of support from commissioners. • Loss of support from referrers. **Impact:** • Reduced referrals threaten clinical and financial sustainability.	• Performance management process • Relationship management process with commissioners • Communications team in place.	Over 12 months	2 3 6	2 3 6	↔	14/12/12	3
Principal Risk 6: Failure to sustain an engaged and effective workforce.										
6.1			On target and de-escalated to relevant risk register						28/02/13	
6.2			On target and de-escalated to relevant risk register						28/02/13	
6.3	SD	IBP	Insufficient provision of training, appraisals and development. **Cause:** • Insufficient funding causes inability to support training and development. **Effect:** • Poor staff motivation. • Poor staff morale. **Impact:** • Failure to deliver required activity levels. • Unsafe practices • Loss of reputation	• Induction programme in place. • Statutory / Mandatory training via e'learning in place. • Appraisal process. • CPD and access to courses	3-12 months	3 3 9	3 3 9	↔	14/12/12	3

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Sept 2012)	Current risk rating (Dec 2012)	TREND	Review Date	Risk Target
Principal Risk 7: Failure to deliver the required transformation of services.										
7.1	PB	IBP	Failure to maintain the development of organisational culture. **Cause:** • Failure to communicate and embed Quality Strategy **Effect:** • Failure to realise a unified goal of provision of high quality care and good financial resource management **Impact:** • Failure to deliver cost improvements whilst maintaining quality • Risks CQC registration • Reputational damage	• Job planning & Appraisal • Clinical management structure • Training and leadership development • Implementation of quality strategy and embedding within employment processes • Strategy to be built in to recruitment, appraisal and performance management processes	Over 12 months	2 4 8	2 4 8	↔	14/12/12	6
7.2			On target and de-escalated to relevant risk register						28/02/13	
7.3			On target and de-escalated to relevant risk register						28/02/13	
7.4	SD	IBP	Low levels of staff involvement in the Trust agenda. **Cause:** Due to lack of staff engagement with the FT process. **Effect:** The continued work on the Trust Foundation Trust application could be compromised. **Impact:** Impact on patient care could lead to a failure to achieve Foundation Trust status.	• FT Project office and project structure in place. • FT Programme Director. • IBP v3 and LTFM on target. • BGAM submitted for review. • Quality Governance Framework submitted for review.	3 – 12 months	3 4 12	3 4 12	↔	14/12/12	6
7.5			On target and de-escalated to relevant risk register						28/02/13	
7.6	EW	IBP	Failure to establish robust governance and assurance processes. **Cause:** • Due to lack of staff engagement and failure to develop and implement key policies in relation to governance. • Lack of staff capacity to deliver proposed	• Risk Management and Assurance Strategies approved by the Board in Aug 2012. • Strategy Implementation plans in place. • HealthAssure Rollout Plan progressing • Risk Toolkit in place	Within 3 months	4 3 12	3 3 9	↓	14/12/12	6

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Sept 2012)	Current risk rating (Dec 2012)	TREND	Review Date	Risk Target
			improvements in control. **Effect:** • Failure to establish sound assurance systems and processes. **Impact:** • Reliability of the quality and performance indicators received by the Trust.							
Principal Risk 8: Failure to deliver the benefits of strategic partnerships.										
8.1	PB	IBP	Failure to establish sustainable regional networks. **Cause:** • Poor quality care. • High cost care. • Poor relationship management. **Effect:** • Loss of support from referrers. • Aggressive competitive behaviour of other organisations. **Impact:** • Reduced referrals threaten clinical and financial sustainability.	• Clinical network meetings. • Development of AHSN • Marketing and market research • Performance review process.	Over 12 months	2 4 8	2 4 8	↔	14/12/12	2
8.2	PB	IBP	Failure to provide adequate support for education. **Cause:** • Failure to adequately prioritise education requirements in planning. **Effect:** • Criticism of educational provision by external reviews. **Impact:** • Removal of support for education placements within organisation.	• Joint working agreement with Oxford Universities. • Strategic Partner Board 1/4ly meetings (Joint Chair Dame Fiona Caldicott) • Education and training strategy. • Lead role in AHSC – Local Oxford partners • Lead role in AHSN – Wider network partners • Clinical network groups. • Engagement strategy • DoC Trust Lead with CCGs, Oxford Health, SS in relationship management process.	3-12 months	3 2 6	3 2 6	↔	14/12/12	3

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Sept 2012)		Current risk rating (Dec 2012)		TREND	Review Date	Risk Target
8.3	PB	IBP	Failure to support research and innovation. Cause: • Failure to adequately plan and resource research and innovation. Effect: • Failure to secure additional research programmes with associated income. Loss of potential benefits of new technologies and innovation. Impact: • Loss of income and lack of improvements in quality and efficiency.	• Joint working agreement with Oxford Universities. • Strategic Partner Board 1/4ly meetings (Joint Chair Dame Fiona Caldicott) • Lead role in AHSC – Local Oxford partners • Lead role in AHSN – Wider network partners • Clinical network groups. • Engagement strategy • DoC Trust Lead with CCGs, Oxford Health, SS in relationship management process.	3-12 months	3	2	3	2	↔	14/12/12	3
						6		6				

Key Risk Owners:

PB	Director of Clinical Services (Paul Brennan)	MT	Director of Development and the Estate (Mark Trumper)
SD	Director of Workforce (Sue Donaldson)	TB	Medical Director (Ted Baker)
AS	Director of Planning & information (Andrew Stevens)	EW	Director of Assurance (Eileen Walsh)
MM	Director of Finance and Procurement (Mark Mansfield)	ESH	Chief Nurse (Elaine Strachan-Hall)