Trust Board Meeting: Wednesday 12 March 2014

TB2014.43

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

Status	For discussion
History	Current version of the Board Assurance and Corporate Risk Register were considered by: • Audit Committee in February 2014 • Trust Management Executive in February 2014 Extracts of relevant risks from the Corporate Risk Register were reported to: • Quality Committee February 2014 • Finance & Performance Committee February 2014.

Board Lead(s)	**Eileen Walsh, Director of Assurance**			
Key purpose	Strategy	**Assurance**	Policy	Performance

Executive Summary

1. This paper presents the updated Board Assurance Framework (BAF) and Corporate Risk Register (CRR) to the Trust Board. Both documents are subject to regular review by the Board sub-committees and the Trust Management Executive, this report highlights:

- The changes made to the BAF and CRR and
- How the potential risks that are emerging from the Peer Review process and other key sources will be reviewed and incorporated in to the CRR, where necessary.

2. Recommendation

The Trust Board is asked to:

- Review the BAF, noting the changes and highlight any further changes that may be required.
- Review the CRR and note the changes to the risk scores and consider if these changes are reasonable.
- Consider the themes identified and note those new risks that are under development.

1. Introduction

1.1. This report provides an opportunity for the Trust Board to review the Board Assurance Framework (BAF) and Corporate Risk Register (CRR), in order to provide an updated position to the Board.

1.2. The report provides a summary of changes to the BAF and CRR since the previous version presented to the Board Sub-Committees in February

2. Changes to the BAF

2.1. As with the previous reports all changes to the BAF (Appendix 1) have been highlighted in red and italics. A few minor changes have been made to the main body of the document as a result of the review but these have not been listed separately.

2.2. The Trust Board are asked to review the BAF note the changes made to it and highlight any further changes that may be required.

3. Changes to the CRR

3.1. As with previous reports all changes to the CRR (Appendix 2) have been highlighted in red and italics. A few minor changes have been made to the risk descriptions and controls in place as a result of the review these have not been listed separately. All changes, as approved by the Trust Management Executive, in risk scores are included in the table below:

Risk Ref	Description	Change in score	
		Jan 14	Feb14
1.7	Location of single faith prayer room	9	3
2.3	Failure to generate income from non- core healthcare activity.	9	6
3.3	Failure to deliver National A&E targets	9	16
3.4	Failure to deliver National Access targets 18 weeks	6	12
5.1	Loss of existing market share	8	4
5.2	Failure to gain share of new markets. / Lack of support for business cases.	9	6
6.1	Difficulty recruiting and retaining high-quality staff in certain areas.	8	6
7.1	Failure to maintain an open culture consistent with the Trust values.	8	6

3.2. The Trust Management Executive (TME) at its meeting on 27th February 2014 raised a query in relation to the risk below. The TME asked for the risk scoring to be reviewed in the light of the fact that funding for a long term solution to the risk had been included in the current years capital programme. The risk score has subsequently been reduced as a result.

Risk Ref	Description	Change in score	
		Jan 14	Feb14
7.11	Potential failure to provide adequate mortuary facilities at the Horton General Hospital.	12	6

3.3. The Trust Board is asked to review the CRR and note the changes to the risk scores and consider if these changes are reasonable.

4. New risks escalated and identified for inclusion onto the CRR

4.1. The Trust's Internal Peer Review work has been completed. All divisions have been asked to review the reports produced in relation to the peer reviews and ensure that their local risk registers adequately reflect the findings from the review, where necessary.

4.2. The Assurance Directorate have reviewed the findings of each report to ensure that any issues identified for remedial action are correctly considered at the following levels:

- Those actions that can be controlled at a divisional level involving one or more divisions. (highlighted in grey in the table below)
- Those actions that require a more thematic / trust wide approach. (highlighted in pink in the tables below)

4.3. The results of this review then determined the most appropriate risk register that those actions should be included in. Trust wide themes were formally considered for inclusion on the CRR by the Trust Management Executive at its meeting on 27 February 2014.

Potential Issue / Risk	Comment
Staffing vacancies across some areas	This cross references to risks 1.12 and 6.1
Standards of cleanliness and hand hygiene compliance in some areas	New Infection Control risk added to PR1:Quality – To ensure monitoring of local divisional actions
Suitability and maintenance of premises and lack of storage in some areas	Monitored at divisional Level
Ensuring routine checks of resuscitation trolleys are completed	Monitored at divisional Level
Management and availability and of patient records	This cross references to risk 1.14
Medicine Management – primarily the safe and secure storage of medicines in some areas	New Medicine Management risk added to PR1:Quality – To ensure monitoring of local divisional actions
Avoidable delays in discharge	This cross references to risk 3.1
Non-medical appraisal rates across each of the divisions	This cross references to risk 6.3. Monitored at divisional level
Patient transportation and co-ordination of care	New risks added to PR1: Quality

4.4. The review of the current iteration of the Integrated Business Plan and the need to link themes highlighted as a result of the Trust's new Risk Summit process also raised the following areas for inclusion on to the CRR.

Potential Issue / Risk	Comment
Pneumonia – Risk Summit	New risks added to PR1: Quality
Diabetes – Risk Summit	
The provision of adequate out of hours cover in some areas - Identified as part of the IBP, partly through Peer Review and identified as a future Risk Summit	Additional narrative added to risk 1.12
Capital Programme – Identified as part of the IBP and also noted as part of the review of the quality risks at the Quality Committee.	New risk added to PR2: Finance

4.5. The Trust Board are invited to consider the themes identified and note those new risks that are under development.

5. **Recommendation**

5.1. The Trust Board is asked to:

- Review the BAF, noting the changes and highlight any further changes that may be required.
- Review the CRR and note the changes to the risk scores and consider if these changes are reasonable.
- Consider the themes identified and note those new risks that are under development.

Eileen Walsh
Director of Assurance

Report Prepared By:

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March 2014

Appendix 1:
Board Assurance Framework

Assurance Summary / Assurance Dashboard

1. Board Assurance Framework for the delivery of Objectives

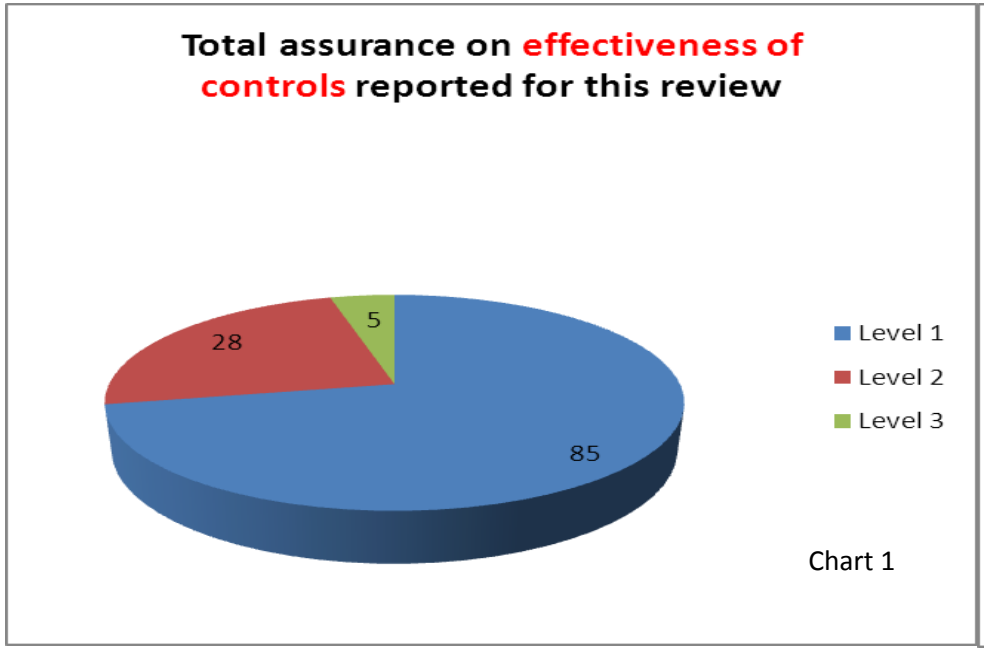
The Board has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate any significant risks which may threaten the achievement of the strategic objectives. Assurance may be gained from a wide range of sources, but where ever possible it should be systematic, supported 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.

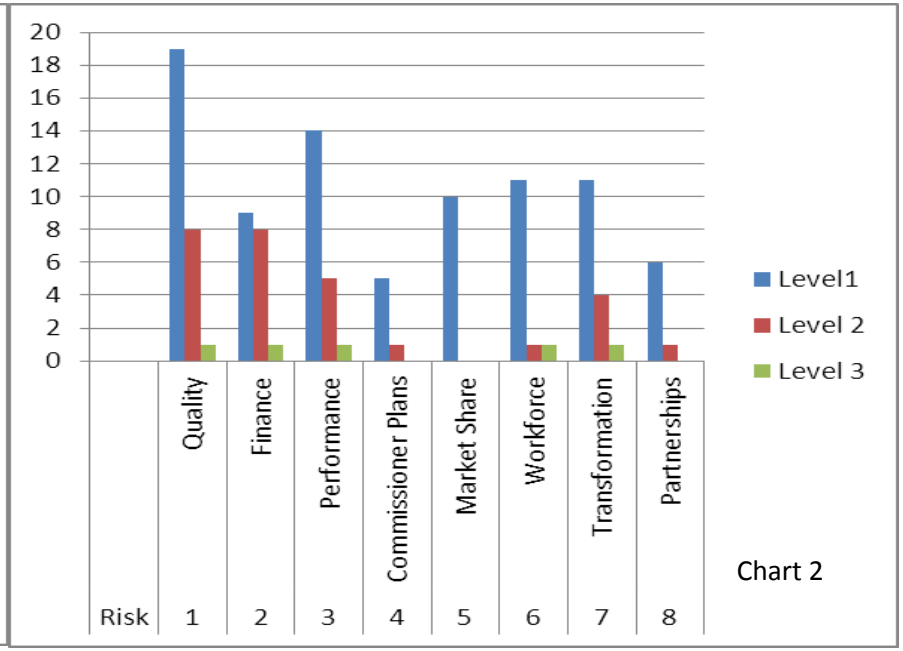
2. The Trust's Strategic Objectives for 2013/14 are:

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

The charts below provide a complete list of the assurances reported to the Board in the year to date. Chart one shows the total assurance currently reported by assurance level. Chart two shows the same information broken down by principle risk.





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	20	10	4
2	Finance	11	7	13
3	Performance	4	7	2
4	Commissioner Plans	3	2	0
5	Market Share	1	1	0
6	Workforce	5	1	2
7	Transformation	5	10	2
8	Partnerships	0	0	0
	Total assurances noted as Reported to Audit, Quality & F&P Committees to date	49	38	23

This table provides a summary of all other assurance currently noted as reported to the Audit Committee, Finance & Performance Committee and Quality Committee to date

4. 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 ref)	Key Controls	Sources of Assurance	Assurance on the Effectiveness of controls	Gaps in Control	Gaps in Assurance	Action Plans for gaps	Action plan / 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. • Friends & Family test • Incident reporting. • Trust 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 • Quality meetings between executives and PCT • Appraisal / revalidation • QA priorities • Pressure Ulcer Reduction Plan • Draft Public Health Strategy • *Patient Experience Strategy approved by the Trust Board on 22 January 2014*	Reported to Board • Integrated Performance Reports (IPR) (Level 1 (L1)). • Reports from Quality Committee to Board (L 2). • Audit Committee Report to the Board (L2) • Annual H&S Report (L1) Reported elsewhere • Annual nursing skill mix review (L1). • Picker Patient and Staff Surveys (L2). • PROMs (L3). • GMC Trainee survey (patient safety) (L3). • National Clinical Audits/ (L3). • Audit Committee review Clinical Audit (L2)	Reported to Board • IPR (L1) (May, July, Sept, *Nov* 13, *Jan 14)* • Reports from Quality Committee to Board (L2) (May July Sept *Nov*,13 *Jan 14)*) • Audit Committee Report to the Board (L2) (May, July 13 *Jan 14)*) • Quality Report (L1) (May, July Sept *Nov* 13 *Jan 14)*) • Patient Story Report (L1) (May, July, Sept *Nov* 13 *Jan 14)*) • CQC Inspection Report (L3) (May 13) • QGF Internal Assessment (L1) (Sept 2012, Jan 13) • Annual H&S Report (L1) (Nov 2012) • QGAF Report (L3)(Nov 12) • Francis Enquiry Response (L1) (Sept 13) • Complaint's Annual Report (L1) (Sept 13) • *Safeguarding (L1) Nov 13)*	Quality Strategy to be implemented Monitoring process of progress on local quality goals to be developed.	Map to performance indicators and corporate score show no gaps identified at 10/2/14	**Control Gap**: Implementation of Quality Strategy to be further embedded. Enhanced monitoring process to be developed to ensure local quality goals are attained. **Action Owner:** LW/TB – on-going	**Overall Risk Owner:** TB

Ref no.	Principal Risk Description (CRR ref)	Key Controls	Sources of Assurance	Assurance on the Effectiveness of controls	Gaps in Control	Gaps in Assurance	Action Plans for gaps	Action plan / 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, where necessary. • Performance Management Regime in place. • Budget setting & business planning processes. • Quality Impact Assessment process. • Bi-weekly monitoring of CIP programme • Contract monitoring process • PLICS in place – Trust part of DH PLICs based reference costing pilot • *Revisions to SOs SFIs presented to Board Jan 14* • *Declaration of Interests presented to Board Jan 14*	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) Reported elsewhere • Internal Audit review of CIPs (Level 3) • IA review of Financial Management arrangements (Level 3). • CIP reports to Quality Committee (Level 2). • Data Quality reviews with commissioners (Level 2) • Assessment against Monitor Risk Assessment Framework	Reported to Board • Finance reports and specific updates on aspects as required (e.g. Demand management) (L1) (May, July Sept *Nov* 13 *Jan 14)*) • F&P report to the Board (L2) (May, July Sept *Nov*, 13 *Jan 14)*) • Audit Committee Report to the Board (L2) (May, July 13 *Jan 14)*) • HDD Report (L3) (Nov 12) • Self-Certification Report (L1) (Sept 13 *Nov Jan 14)*)	None at 10/2/14	Capital Investment in terms of backlog maintenance is not supported by robust evidence	**Assurance Gap:** Estates 6 facet survey underway – this will provide additional evidence to capital investment **Action Owner:** MT	**Overall Risk Owner:** MM

Ref no.	Principal Risk Description (CRR ref)	Key Controls	Sources of Assurance	Assurance on the Effectiveness of controls	Gaps in Control	Gaps in Assurance	Action Plans for gaps	Action plan / Owner
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) (3.3,3.4, 3.5, 3.6) • Failure to reduce delayed transfers of care in the changing NHS environment (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	• Monthly Program Board, with representation from OUH, social services and the PCT at C.E. level. • Bi-weekly Project Team meetings at COO and equivalent level. • Internal weekly DToC meetings. • Supported Discharge Service in place with 8 work streams. • Provider Action Plan (DTOC) • Monthly Chief Executives meetings. • A&E Action Plan • Internal Urgent Care Programme Board • Urgent Care Task Force • Diagnostic Waits Action Plan	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). (May, July Sept *Nov* 13 *Jan 14)*) • Integrated Performance Reports (Level 1) (May, July Sept *Nov* 13 *Jan 14)*) • Audit Committee Report (Level 2) (May, July 13) *Jan 14)* • DTOC Provider Action Plan (Level 1) (Sept 2012) • Emergency Planning Annual Report (Level 1) (Nov 2012) • Winter Plan(L1) (Sept 13) • *Cardiac Surgery Review (L3) Nov 13)* • *Data quality internal audit?* :	None identified at 10/2/14	Board reporting of performance to be further reviewed for any potential gaps.	**Assurance Gap:** Board approved review of reports **Action owner:** Head of Corporate Governance to act as facilitator - on-going	N/A for action (**Risk Owner** : PB)

Ref no.	Principal Risk Description (CRR ref)	Key Controls	Sources of Assurance	Assurance on the Effectiveness of controls	Gaps in Control	Gaps in Assurance	Action Plans for gaps	Action plan / Owner
Principal Risk 4: Mismatch with commissioners plans.								
SO 2 SO 3 IBP Risk 4	**Potential Cause:** • Lack of robust plans across healthcare systems (4.2). • Loss of Commissioner alignment of plans between the Trust and the commissioner (4.3). **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.	• Compliant Contracts in place for 13/14. • Commissioner alignment meetings in place. • Contingency plans for withdrawal from some services developed, where necessary. • Quarterly review against plan.(Titration system) • Monthly meetings with local 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))	Reported to Board: • DTOC Provider Action Plan (Level 1) (Sept 2012) • CE reports to Board (Level 1) (May, Sept *Nov* 13 *Jan 14)*) • GP Engagement (Level 1) (July 2013)	None identified at 10/2/14	None identified at 10/2/14	None identified at 10/2/14	(**Risk Owner** : AS)

Ref no.	Principal Risk Description (CRR ref)	Key Controls	Sources of Assurance	Assurance on the Effectiveness of controls	Gaps in Control	Gaps in Assurance	Action Plans for gaps	Action plan / Owner
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). (May , July Sept *Nov* 13 *Jan 14)*) • CE Briefing (Level 1) (May Sept *Nov 1*3 *Jan 14)*) • Review of Acute Medicine (Level 1) (Dec 2012) :	Commercial strategy for new and existing services Standard response to tendering of services	None identified at 10-2/14	**Control Gap:** Director of Planning & Information: • Analysing current services to develop a clear strategy • Reviewing resource requirements re tendering responses. **Action owner:** AS on-going	N/A for action (**Risk Owner** : AS)

Ref no.	Principal Risk Description (CRR ref)	Key Controls	Sources of Assurance	Assurance on the Effectiveness of controls	Gaps in Control	Gaps in Assurance	Action Plans for gaps	Action plan / 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	Regular reports to Board: • Integrated Performance Report (Level 1) (May, July Sept *Nov* 13 *Jan 14)*) • Annual H&S Report (Level 1) (Nov 2012) • R&A Report to Board (Level 2) (July 2013) • HR & Workforce Report (L1) (Sept *Nov* 13) • *Information Governance Mid Year Review (l1) Nov 13)* Adhoc reports to Board: • Staff Survey (L3) (March 13) • Board Development (L1) March 2013 • *Medical Appraisal rates 12/13 (L1) Nov 13* • *Education & Training Annual Report Jan 14)*	Lack of local in year feedback in relation to staff views / staff surveys IPR to include information in relation to vacancy levels by division and by staff group	*Potential gaps in assurance include:* • *Lack of annual H&S report to Board*	**Control Gap:** Action plan in place to develop local staff survey approach. **Action Owner:** MP – on-going IPR to be included in Board approved review of reports **Action owner:** Head of Corporate Governance to act as facilitator – on-going	**Overall Risk Owner:** MP

Ref no.	Principal Risk Description (CRR ref)	Key Controls	Sources of Assurance	Assurance on the Effectiveness of controls	Gaps in Control	Gaps in Assurance	Action Plans for gaps	Action plan / Owner
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 an open culture consistent with the Trusts values (7.1). **Potential Effect:** • 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. • Performance issues. • Service fail to achieve long term sustainability.	• Quality Strategy and Implementation Plan • 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: • Reports from Quality Committee (L2) (May, *July* Sept *Nov* 13 *Jan 14)*) • Board Effectiveness (L1 May 13) • Annual Review of Risk Management Strategy (L1) (Sept 13) • *Annual Review of Assurance Strategy (L1) Nov 13)* Adhoc reports: • NOC PPE review (L1) (July 12, Jan 13) • BGAF (L1) Sept 12) (L3) (Nov 12) • Business Cases / reviews (L1) (Dec 12, March Sept 13) • EPR Updates (L1) Jan 13, Feb 13)	Coherent programmes for leadership to be developed. Leadership strategy?	None identified at 10/2/14	**Control Gap:** Leadership working group to be established **Action Owner:** LW - ongoing	**Overall Risk Owner:** PB

Ref no.	Principal Risk Description (CRR ref)	Key Controls	Sources of Assurance	Assurance on the Effectiveness of controls	Gaps in Control	Gaps in Assurance	Action Plans for gaps	Action plan / Owner
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 • Board to Board meetings with PCT (Level 2)	Reported to Board: • CE Briefing Strategic Partnership Update (Level 1) (May , July, Sept *Nov* 13 *Jan 14)*) • *AHSN Update (Level 1) (Nov 13)*	None identified at 10/2/14 Joint Strategic Objectives?	None identified at 10/2/14	No further action required at 10/2/14	**Overall Risk Owner:** AS

Appendix 2:
Corporate Risk Register

Key

esc	risk escalated from lower risk register
de-esc	risk de-escalated to a lower risk register
new	new risk identified through discussion

Trend

↑	risk score increasing
↔	risk score remains static for rolling 12 months
↓	risk score reducing
variable	risk score changes up and down overtime

Risk Dashboard

View 1: Risk Score Trend – Rolling 12 months

Risk/Lead	ID	Risk Description	Proximity	Score							Trend	Target	Link to SO
				Mar-13	May-13	Aug-13	Oct-13	Nov-13	Jan-14	Feb-14			
PR 1: (TB)	1.1	Patients experience indicators show a decline in quality.	+ 12 mths	6	6	6	6	6	6	6	↔	4	SO1 SO5
	1.2	Breach of CQC regulations	3-12 mth	6	6	6	6	6	6	6	↓	3	
	1.3	Failure to meet the Trust's Quality Strategy goals.	+ 12 mths	6	6	6	6	6	6	6	↓	3	
	1.4	Failure to deliver the quality aspects of contracts with the commissioners	de-esc	6	6							6	
	1.5	CIPs impact on safety or unacceptably reduce service quality	de-esc	6	6	6	6					6	
	1.6	Poor Bed Management equipment replacement and decontamination facilities impact on patient safety	3-12 mth	16	12	9	9	9	9	9	↓	6	
	1.7	Location of single faith prayer room	3 mths	esc	9	9	9	9	9	3	↓	3	
	1.8	Management of 24hr paediatric airways during resus and trauma calls	3-12 mth	esc	10	10	10	10	10	10	↔	6	
	1.9	CAS Alert NPSA 2011/PSA001 Part A	3-12 mth	esc	8	8	8	8	8	8	↔	3	
	1.10	CAS Alert NPSA 2011/PSA001 Part b	3-12 mth	esc	12	12	12	12	12	12	↔	3	
	1.11	Fire safety issue - fire protection Churchill PFI	de-esc		esc	9	9					3	
	1.12	Staffing levels and skill mix consistently monitored and reported to Board	3-12 mth		esc	6	6	6	6	6	↔	3	
	1.13	Hot weather poses risk to staff and infection processes in sterile services	de-esc		esc	9	9					3	
	1.14	Poor clinical records management processes have a potential impact in quality and safety	3 mths		new	9	9	9	9	9	↔	3	
	1.15	Excessive use of agency staff may pose a risk to the quality of service delivered	3 mths		new	9	9	9	9	9	↔	6	
	1.16	Infection Control	new						new	tbc	**new**	tbc	
	1.17	Medicine Management	new						new	tbc	**new**	tbc	
	1.18	Patient transportation and co-ordindation of care	new						new	tbc	**new**	tbc	
	1.19	Pneumaonia - Risk Summit	new						new	tbc	**new**	tbc	
	1.20	Diabetes - Risk Summit	new						new	tbc	**new**	tbc	
PR2: (MM)	2.1	Failure to deliver the required levels of CIP	3-12 mth	9	12	9	9	9	9	9	variable	9	SO3 SO5
	2.2	Failure to effectively control pay and agency costs.	3 mths	9	12	9	9	9	9	9	variable	9	
	2.3	Failure to generate income from non- core healthcare activity.	3-12 mth	9	9	9	9	9	9	6	↓	6	
	2.4	Services display poor cost-effectiveness	3-12 mth	9	8	6	6	6	6	6	↓	4	
	2.5	Failure to manage outstanding debtors	3-12 mth	9	9	6	6	6	6	6	↓	4	
PR3: (PB)	3.1	Failure to reduce delayed transfers of care	3 mths	16	16	16	20	20	20	20	↑	12	SO1 SO2 SO3 SO4
	3.2	Failure of accurate reporting & poor data quality due to implementation of the EPR	3-12 mth	8	8	8	8	8	8	8	↓	6	
	3.3	Failure to deliver National A&E targets	3-12 mth	9	9	9	9	9	9	16	↑	6	
	3.4	Failure to deliver National Access targets 18 weeks	3-12 mth	new	6	6	6	6	6	12	↑	6	
	3.5	Failure to deliver National Access targets 18 weeks in Surgical Directorate	3-12 mth				esc	9	9	9	↔	6	
	3.6	Failure to deliver National Access targets Cancer,	3-12 mth						new	9	**new**	6	
	3.7	Capital Programme	new						new	tbc	**new**	tbc	
PR 4: (AS)	4.1	Activity levels unaffordable to the health economy due to the failure to deliver QIPP levels.	archive	6	6							6	SO2 SO3
	4.2	Lack of robust plans across healthcare systems	3-12 mth	12	12	12	12	12	12	12	↔	6	
	4.3	Loss of Commissioner alignment of plans between the Trust and commissioner	+ 12 mths	6	8	8	16	16	16	16	↑	6	
	4.4	Inability to respond to requirements to flex capacity	archive	8	6							6	
PR5: (AS)	5.1	Loss of existing market share	3-12 mth	6	8	8	8	8	8	4	↓	4	SO3 SO5
	5.2	Failure to gain share of new markets. / Lack of support for business cases.	3-12 mth	9	9	9	9	9	9	6	↓	6	
	5.3	Negative media coverage relative to our competitors	+ 12 mths	4	4	4	4	4	4	4	↓	3	
PR6: (PJ)	6.1	Difficulty recruiting and retaining high-quality staff in certain areas.	3-12 mth	8	8	8	8	8	8	6	↓	8	SO1 SO3 SO5
	6.2	Low levels of staff satisfaction, health & wellbeing and staff engagement	3-12 mth	6	8	6	6	8	8	8	variable	6	
	6.3	Insufficient provision of training, appraisals and development	3-12 mth	6	6	6	6	6	6	6	↓	3	
	6.4	Staffing in maternity service	3-12 mth	esc	20	9	9	9	9	9	↓	5	
PR7: (PB)	7.1	Failure to maintain the development of organisational culture	3 mths	8	8	8	8	8	8	6	↓	6	SO2 SO3 SO4
	7.2	Failure to maintain capacity and focus on longer term planning.	de-esc	6	6	de-esc						6	
	7.3	Organisational barriers create potential blockers to ability to apply research to models of care	archive	6	6	de-esc						6	
	7.4	Low levels of staff involvement in the Trust agenda	de-esc	9	9	6	6					6	
	7.5	Failure to obtain the clinical advantages from EPR	3-12 mth	6	8	8	8	8	8	8	↓	6	
	7.6	Failure to establish robust governance and assurance processes.	3 mths	9	9	9	9	9	6	6	↓	6	
	7.7	Failure to solve legionella issues in the retained estate.	3-12 mth				esc	15	15	15	↔	6	
	7.8	Building issues in the Women's Centre could lead to patient safety issues	3 mths				esc	16	12	12	↓	3	
	7.9	Fire detection systems in the JR require upgrading	3 mths				esc	16	16	16	↔	3	
	7.10	Failure of laboratory accreditation process due to poor pathology sample store facilities	3 mths				esc	16	12	12	↓	3	
	7.11	Failure to provide adequate mortuary facilities at the Horton	3 mths				esc	16	12	6	↓	3	
PR8: (AS)	8.1	Failure to establish sustainable regional networks	+ 12 mths	6	4	4	4	4	4	4	↓	2	SO5 SO6
	8.2	Failure to provide adequate support for education.	3-12 mth	6	6	6	6	6	6	6	↔	3	
	8.3	Failure to support research and innovation.	3-12 mth	4	4	4	4	4	4	4	↓	3	

View 2: Risks sorted by risk score (highest risk first)

ID	Risk Description	Proximity	Score	Trend	Target
			Feb-14		
3.1	Failure to reduce delayed transfers of care	3 mths	20	↑	12
3.3	Failure to deliver National A&E targets	3-12 mth	16	↑	6
4.3	Loss of Commissioner alignment of plans between the Trust and commissioner	+ 12 mths	16	↑	6
7.9	Fire detection systems in the JR require upgrading	3 mths	16	↔	3
7.7	Failure to solve legionella issues in the retained estate.	3-12 mth	15	↔	6
1.10	CAS Alert NPSA 2011/PSA001 Part b	3-12 mth	12	↔	3
3.4	Failure to deliver National Access targets 18 weeks	3-12 mth	12	↑	6
4.2	Lack of robust plans across healthcare systems	3-12 mth	12	↔	6
7.8	Building issues in the Women's Centre could lead to patient safety issues	3 mths	12	↓	3
7.10	Failure of laboratory accreditation process due to poor pathology sample store facilities	3 mths	12	↓	3
1.8	Management of 24hr paediatric airways during resus and trauma calls	3-12 mth	10	↔	6
1.6	Poor Bed Management equipment replacement and decontamination facilities impact on patient safety	3-12 mth	9	↓	6
1.14	Poor clinical records management processes have a potential impact in quality and safety	3 mths	9	↔	3
1.15	Excessive use of agency staff may pose a risk to the quality of service delivered	3 mths	9	↔	6
2.1	Failure to deliver the required levels of CIP	3-12 mth	9	variable	9
2.2	Failure to effectively control pay and agency costs.	3 mths	9	variable	9
3.5	Failure to deliver National Access targets 18 weeks in Surgical Directorate	3-12 mth	9	↔	6
3.6	Failure to deliver National Access targets Cancer,	3-12 mth	9	new	6
6.4	Staffing in maternity service	3-12 mth	9	↓	5
1.9	CAS Alert NPSA 2011/PSA001 Part A	3-12 mth	8	↔	3
3.2	Failure of accurate reporting & poor data quality due to implementation of the EPR	3-12 mth	8	↓	6
6.2	Low levels of staff satisfaction, health & wellbeing and staff engagement	3-12 mth	8	variable	6
7.5	Failure to obtain the clinical advantages from EPR	3-12 mth	8	↓	6
1.1	Patients experience indicators show a decline in quality.	+ 12 mths	6	↔	4
1.2	Breach of CQC regulations	3-12 mth	6	↓	3
1.3	Failure to meet the Trust's Quality Strategy goals.	+ 12 mths	6	↓	3
1.12	Staffing levels and skill mix consistently monitored and reported to Board	3-12 mth	6	↔	3
2.3	Failure to generate income from non- core healthcare activity.	3-12 mth	6	↓	6
2.4	Services display poor cost-effectiveness	3-12 mth	6	↓	4
2.5	Failure to manage outstanding debtors	3-12 mth	6	↓	4
5.2	Failure to gain share of new markets. / Lack of support for business cases.	3-12 mth	6	↓	6
6.1	Difficulty recruiting and retaining high-quality staff in certain areas.	3-12 mth	6	↓	8
6.3	Insufficient provision of training, appraisals and development	3-12 mth	6	↓	3
7.1	Failure to maintain the development of organisational culture	3 mths	6	↓	6
7.6	Failure to establish robust governance and assurance processes.	3 mths	6	↓	6
7.11	Failure to provide adequate mortuary facilities at the Horton	3 mths	6	↓	3
8.2	Failure to provide adequate support for education.	3-12 mth	6	↔	3
5.1	Loss of existing market share	3-12 mth	4	↓	4
5.3	Negative media coverage relative to our competitors	+ 12 mths	4	↓	3
8.1	Failure to establish sustainable regional networks	+ 12 mths	4	↓	2
8.3	Failure to support research and innovation.	3-12 mth	4	↓	3
1.7	Location of single faith prayer room	3 mths	3	↓	3
1.16	Infection Control	new	tbc	new	tbc
1.17	Medicine Management	new	tbc	new	tbc
1.18	Patient transportation and co-ordindation of care	new	tbc	new	tbc
1.19	Pneumaonia - Risk Summit	new	tbc	new	tbc
1.20	Diabetes - Risk Summit	new	tbc	new	tbc
3.7	Capital Programme	new	tbc	new	tbc

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Jan 14)		Current risk rating (Feb 2014)		TREND	Last Review Date	Target
						L	C	L	C			
Principal Risk 1: Failure to maintain the quality of patient services.												
1.1	LW	IBP	Patients may 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.	**Controls** • 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. • Quality Walk round process • Pressure Ulcer Reduction Plan in place. • Patient Experience Strategy in development	Over 12 months	2	3	2	3	↔	14/2/14	4
						6		6				
1.2	EW	IBP	Potential 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. • Trust fails to recognise and react to potential safety issues. **Impact:** • Potential loss of licence to practice. • Poor Monitor Governance Risk Rating. • Potential financial impact of specialist derogations	**Controls** • CQC Action Plan (s) in place • Health Assurance Rollout Plan progressing to time – QA process in place. • HealthAssure system used to report CQC compliance at Divisional level • 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 • Director of Clinical Services routinely reports on safety issues, changes in service reported to the Board	3 -12 months	2	3	2	3	↔	14/2/14	3
						6		6				
1.3	TB	IBP	Potential failure to meet the Trust's Quality Strategy goals. **Cause:** • Lack of staff knowledge in relation to the Quality	**Controls** • Quality Strategy in place. • Implementation Plan to embed Strategy to	Over 12 months	2	3	2	3	↔	14/2/14	3
						6		6				

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Jan 14)	Current risk rating (Feb 2014)	TREND	Last Review Date	Target
			Strategy. **Effect:** • Front line staff fail to monitor and measure quality in line with the strategy. **Impact:** • Potential loss of reputation. • Goals are not achieved.	be monitored to ensure momentum is maintained. • Implementation permissive of localisation of Trust priorities to maximise relevance to clinical teams • Quality strategy to be embedded into employment processes, performance management and reward systems • Development off local metrics to monitor achievement of local quality goals. • Quality priorities for 2013/14 linked to Quality Strategy and the contract • Safety Thermometer to be developed to monitor Trust wide goals (e.g. pressure ulcer reduction – link to 1.1)						
1.6	LW	RA	Poor management of bed frames and other associated equipment and the area used for storage, repair including decontamination facilities 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.	**Controls** • Mattress management, proposals for centralised budget to manage stock and mattress management guidance in place. • Current store location managed by named individual in operations team. • Process for the tender of bed contract initialising. **Contingency** • Bed frame contract tender being scoped	3 -12 months	3 3 9	3 3 9	↔	14/2/14	6
1.7	LW	Esc	Location of single faith prayer room: **Cause:** Location of the single faith prayer room within the Newborn Care Unit adversely affects the safe and efficient delivery of care to new born infants as non-neonatal unit staff currently enter the Unit. **Effect / Impact:** The risks include: Child protection concerns as those staff accessing the prayer room are unlikely to have an	**Controls** • General signage to state corridor is for staff only. However, non-Newborn Care Unit staff will still be able to access the area. New swipe access fitted to the door to the corridor leading to the room. • Staff advised never to leave offices unlocked when not in use. Also not to leave confidential documents on desks	Within 3 months	3 3 9	1 3 3	↓	14/2/14	3

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Jan 14)	Current risk rating (Feb 2014)	TREND	Last Review Date	Target
			enhanced CRB check. Increased infection control through lack of appropriate facilities such as washrooms to accommodate people using the prayer room; .security risk to personal and office items in offices down the corridor, as area accessed by a lot of staff, and risk of theft of, or damage to valuable equipment on the neonatal unit which currently needs to be stored in a public corridor, due to the lack of storage facilities.	when no one in the office. Equipment to be stored in the most appropriate place. **Contingency** • Multi-faith prayer room building works commencing February/March 2014 for JR and HH sites. Funding secured, interim arrangements planned						
1.8	TB	Esc	Management of 24 hour paediatric airways during paediatric resuscitations and paediatric trauma calls is potentially unsafe. **Cause:** Reduction of the number of medical staff confident in dealing with children's airway problems when children are admitted to areas outside of the Children's Directorate. The bleep system for contacting medical staff with appropriate skills is not sufficiently robust. **Effect / Impact:** Patient safety could be effected	**Controls** • A designated clinician should be part of or immediately available to the paediatric resuscitation team, the paediatric trauma team, and be readily accessible for other requests for urgent paediatric airway assistance. • The provision of a dedicated bleep holder for airway support (ie training and basic skills in paediatric airway management and anaesthesia	3 -12 months	2 5 10	2 5 10	↔	14/2/14	6
1.9	TB	Esc	CAS Alert NPSA 2011/PSA001: Safer spinal (intrathecal), epidural and regional devices Part A **Cause:** Risk of wrong route of administration due to compatibility of epidural, spinal and regional infusion devices with intravenous Luer connectors. There is a national supply issue affecting all hospitals; at this time the Trust is unable to implement NPSA recommendations re introduction of safe connectors. **Effect** • Failure to comply with national guidance **Impact** • Patient safety and potential loss of reputation	**Controls** Epidural guidelines are in place and reviewed regularly; staff training and competency assessments by the acute pain team; monthly audits of epidural guidelines and results reported to the directorates as a quality metric.	3 -12 months	2 4 8	2 4 8	↔	14/2/14	3
1.10	TB	Esc	CAS Alert NPSA 2011/PSA001: Safer spinal (intrathecal), epidural and regional devices Part B **Cause:** Risk of wrong route of administration due to compatibility of epidural, spinal and regional infusion devices with intravenous Luer connectors. There is a national supply issue affecting all hospitals; at this time	**Controls** Epidural guidelines are in place and reviewed regularly; staff training and competency assessments by the acute pain team; monthly audits of epidural guidelines and results reported to the directorates as a quality metric.	3 -12 months	3 4 12	3 4 12	↔	14/2/14	6

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Jan 14)	Current risk rating (Feb 2014)	TREND	Last Review Date	Target
			the Trust is unable to implement NPSA recommendations re introduction of safe connectors. **Effect** • Failure to comply with national guidance **Impact** • Patient safety and potential loss of reputation							
1.12	LW	Esc	Potential failure to deliver and maintain safe staffing levels and skill mix , *including out of hours cover.* **Cause:** • Current processes are in the process of development and partially address Keogh recommendations on reporting to Board **Effect:** • Lack of transparency in reporting **Impact:** • Board may be unaware of potential staffing issues • Impact on quality and safety • Reputational risk • Potential financial pressure of meeting changing national staffing ratios	**Controls** • Daily real time monitoring of safe staffing levels at all sites. Hard copy audit trail in place. Electronic tool designed, tested and being rolled out. Escalation SOP drafted and being consulted. • Safer Nursing Care tool used to calculate nursing establishments against professional judgement and quality assurance processes. • Quality Nurse Sensitive Indicators and HR metric dashboard designed and being developed • All of the above for board reporting on wards. • Status of nurse staffing levels in Trust, paper to private Trust Board 22/1/14 and Public Board on 12/3/14.	April 14	3 2 6	3 2 6	↔	14/2/14	3
1.14	TB	New	Poor clinical records management processes may have a potential impact in quality and safety **Cause & Effect:** • Temporary & multiple notes • Transportation on notes between sites and notes availability • Security of notes storage in some areas • EPR rollout – effects completeness of notes and raises questions around the links with other systems. **Impact:** • Quality and safety may be effected	**Controls** • Tracking system in place • EPR Roll-out continues, risks reviewed and included on EPR risk register as identified • Training programme in place and delivered. • Links to other IT systems being addressed.		3 3 9	3 3 9	↔	14/2/14	3
1.15	LW	New	Excessive use of agency staff may pose a risk to the quality of service delivered **Cause**	**Controls** • Daily monitoring of safe staffing levels at all sites and staff moved to mitigate		3 3 9	3 3 9	↔	14/2/14	6

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Jan 14)	Current risk rating (Feb 2014)	TREND	Last Review Date	Target
			• Negative experiences reported through patient feedback (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	clinical risk. • Redeployment of staff to areas required • Use of recognised agencies to ensure competencies as assessed • Local induction of agency staff. • Recruitment campaign overseas and local; recruited 108 EU nurses. Vacancy rates much improved. Induction programme in place and 'English' support. • Vacancy levels monitored monthly. • Long lines of rostered bank/agency I n place.						
1.16	*TB*	*new*	*Infection Control*	*Under development*						
1.17	*Tbc*	*new*	*Medicine Management*	*Under development*						
1.18	*Tbc*	*new*	*Patient transportation and co-ordination of care*	*Under development*						
1.19	*TB*	*new*	*Pneumonia – Risk Summit*	*Under development*						
1.20	*TB*	*new*	*Diabetes – Risk Summit*	*Under development*						
Principal Risk 2: Failure to maintain financial sustainability.										
2.1	MM	IBP	Potential failure to deliver the required levels of CIP. **Cause**: • High levels of local cost pressures. • Lack of engagement within clinical teams. • Poor financial planning process. **Effect**: • Additional CIPS may need to be identified and delivered. **Impact:** • Reductions in services or the level of service provision in some areas. • Potential loss in market share +/ external intervention.	• CIP Steering Group • Reports to TME & Board • DoC and Director of Efficiency oversee CIP process. • Performance Management Process (1/4ly review meetings across all divisions) • CIP Operational Group • Business Planning process • Contract negotiation.	3 -12 months	3 3 9	3 3 9	↔	14/2/14	9
2.2	MM	IBP	Potential failure to effectively control pay and agency costs. **Cause:** • Tariff reduction requires internal efficiencies that	• Sickness management and monitoring • Workforce plans • Vacancy controls • Business Planning	Within 3 months	3 3 9	*3 3 9*	↔	14/2/14	9

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Jan 14)	Current risk rating (Feb 2014)	TREND	Last Review Date	Target
			may not be sustainable. • Lack of knowledge re safe staffing levels. **Effect:** • Poor financial controls destabilise the financial position. **Impact:** • Employee engagement and perceptions of safety							
2.3	MT	IBP	Potential of 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. • Failure to deliver clinical services from a smaller footprint. **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 completed • Development of Estates Strategy Update: Interim strategy approved by the Board in November, 6 facet survey report received used to inform longer term strategy and infrastructure investment programme • Carbon energy cash releasing scheme in development during 13/14 to generate income from 14/15.	3 -12 months	3 3 9	3 2 6	↓	14/2/14	6
2.4	MM	IBP	Services display poor cost-effectiveness. **Cause:** • Ineffective and insufficiently granular planning. **Effect:** • Services not able to remain within existing budgets **Impact:** • Further cost pressures and need for additional CIPS • Potential financial impact is pension cost pressures are not recognised and funded within the tariff.	• Budget setting processes in place linked to business planning. • Divisional efficiency meetings • Performance review process • Service Line Reporting • PLICS Steering Group and Project Plan • PLICS information mandatory to support all new business cases.	3 -12 months	3 2 6	3 2 6	↔	14/2/14	4
2.5	MM		Failure to manage outstanding debtors. **Cause:** Lack of robust debt management processes **Effect:** • Increased need to make further savings **Impact:** • Potential loss in market share and or external intervention.	• Development of LTFM • Reporting to Board and F&P Committee • Cashflow forecasting • Debt Control Meetings weekly • Internal Audit review of process	3 -12 months	2 3 6	2 3 6	↔	14/2/14	4

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Jan 14)	Current risk rating (Feb 2014)	TREND	Last Review Date	Target
Principal Risk 3: Failure to maintain operational performance										
3.1	PB	IBP	Potential 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. • 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. • Financial impact through increased penalties • Quality of care provided to patients may fall. • Loss in reputation.	**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 • Opened escalation beds • Reviewed Escalation Procedures • Health Liaison meeting with health & social care partners • Implemented system wide discharge pathway for frail & elderly patients • Capacity escalation procedures in place **External:** • CEO & DCS attendance at ~~ACE~~ joint provider programme Board, & OP/JAP joint commissioning/provider meetings. • DTOC Provider COO's meetings established to over se implementation of 8 workstreams – prime object to reduce DTOC	Within 3 months	5 4 = 20	5 4 = 20	↔	14/2/14	12
3.2	AS	IBP	Potential 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	**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	3-12 months	2 4 = 8	2 4 = 8	↔	14/2/14	6

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Jan 14)	Current risk rating (Feb 2014)	TREND	Last Review Date	Target
			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 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.	• 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. • Data Quality dashboard in place to monitor weekly progress • Independent audits – Internal audit report actions to be completed, deep dive methodology to be developed and used this year. • Director Walkarounds. • Data Quality Board & Data Quality Assurance Review Process DQ tool to be rolled out • Integrated performance Report – assessment of data quality made on each indicator. Data Quality processes for non-standard reporting items developing **External** • CEO led Supplier & NHS meeting • Monthly PCT contract meeting • External reporting to SHA						
3.3	PB	IBP	Failure to deliver National Access targets in relation to A/E and the increasing level of delays impacting on patient flow **Cause:** • Lack of sufficient capacity/workforce • 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 **Effect:** • Patients waiting longer – NHS Constitution • Poor patient experience • Loss of Reputation	**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	3-12 months	3 3 9	4 4 16	↑	14/2/14	6

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Jan 14)	Current risk rating (Feb 2014)	TREND	Last Review Date	Target
			• High costs of temp capacity & workforce • 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. • Financial impact through increased penalties	at Board • Review of Incidents at Board • Board walk rounds **External** • OUH senior manager attendance at Urgent Care taskforce, Planned care Programme Board & Long Term Conditions. • Monthly Contract meeting with PCT • Weekly SHA teleconference calls • Weekly South Central Ambulance meeting						
3.4	PB	IBP	Failure to deliver National Access targets 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 **Effect:** • Patients waiting longer – NHS Constitution • Poor patient experience • Loss of Reputation • High costs of temp capacity & workforce • 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 • Increased costs of temporary staff & in additional capacity.	**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 **External** • OUH senior manager attendance at 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	3-12 months	2 3 6	3 4 12	↑	14/2/14	6

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Jan 14)	Current risk rating (Feb 2014)	TREND	Last Review Date	Target
3.5	PB	Esc	18 week target. **Cause:** Failure to deliver for Surgical Directorate as required by PCT due to insufficient clinic theatre and bed capacity. **Effect/ Impact:** • Financial penalty • Poor patient experience • FT application may be delayed	• Additional lists, • Weekend lists, • Recruiting locum and extra theatre lists to clear backlog,	3-12 months	3 3 9	3 3 9	↔	14/2/14	6
3.6	PB	new	Failure to deliver National Access targets Cancer **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 **Effect:** • Patients waiting longer – NHS Constitution • Poor patient experience • Loss of Reputation • High costs of temp capacity & workforce • 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 • Increased costs of temporary staff & in additional capacity.	**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 **External** • OUH senior manager attendance at 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	3-12 months	n/a	3 3 9	new	27/2/14	6
3.7	*PB*	*new*	*Capital Programme*	*Under development*						
Principal Risk 4: Mismatch with commissioners plans.										
4.2	AS	IBP	Lack of robust plans across healthcare systems. / Failure to reduce activity through robust demand management plans.	• QIPP Programme Framework. • Risk management provisions in contract • Collaboration with Oxford Health.	3-12 months	3 4 12	3 4 12	↔	22/1/14	6

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Jan 14)	Current risk rating (Feb 2014)	TREND	Last Review Date	Target
			Cause: • Lack of clear leadership. • Poor culture across the health economy. • Inter-organisational barriers. • Changing commissioning structures increase the risks **Effect:** • Unaffordable levels of care demanded. **Impact:** • Financial deficits for commissioners and OUH. • Adverse impact on quality and service performance.							
4.3	AS	IBP	Loss of Commissioner alignment of plans between the Trust and the commissioners. **Cause:** • Lack of trust. • Changing commissioning structures increase the risks. • Trust stance in relation to contracted activity levels may increase this risk • Better Care Fund **Effect:** • PCT / CCG fails to support FT application. **Impact:** • FT application not allowed to progress.	• Commissioner alignment meetings. • Relationship management process. • Further letters of support from commissioners in relation to FT application	Over 12 months	4 4 16	4 4 16	↔	14/2/14	6
Principal Risk 5: Loss of share of current and potential markets.										
5.1	AS	IBP	Potential loss of existing market share. **Cause:** • Poor quality care. • High cost care. • Health & Social Care Act asks for more services to be subject to tender. **Effect:** • Loss of income. **Impact:** • Clinical sustainability. • Financial sustainability	• Financial monitoring processes and financial reporting. • Clinical network meetings • AHSN • Analysis of services be undertaken to develop a commercial strategy • Development of trust response to service retendering. – Trust response to GUM tendering to be used as a pilot. Activity continues to grow • Specialist services specifications leading to more work transferring to OUH	3-12 months	2 4 8	2 2 4	↓	14/2/14	4

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Jan 14)	Current risk rating (Feb 2014)	TREND	Last Review Date	Target
5.2	AS	IBP	Potential failure to gain share of new markets. / Lack of support for business cases. **Cause:** • Poor quality care. • High cost care. • Poor relationship management. **Effect:** • Services are not able to expand. **Impact:** • Financial sustainability. • Operational performance.	• Business case process • Clinical network meetings • Alignment with commissioners plans • AHSN • AHSC • Engagement in Commissioner led service reconfiguration into expanded catchment • Active DGH relationship management and partnership working. • The GUM tender was won	~~Within 3 months~~ 3-12 months	3 3 9	2 3 6	↓	14/2/14	6
5.3	AS	IBP	Potential of negative media coverage relative to our competitors. **Cause:** • Poor performance. • Poor media handling. • Poor handling of service reconfiguration **Effect:** • Loss of confidence in services provided. • Loss of support from commissioners and referrers. **Impact:** • Reduced referrals threaten clinical and financial sustainability.	• Performance management process • Relationship management process with commissioners • Communications team in place. • Stakeholder engagement strategy in place • Strategic communications strategy being developed	Over 12 months	2 2 4	2 2 4	↔	14/2/14	3
Principal Risk 6: Failure to sustain an engaged and effective workforce.										
6.1	MP	IBP	Difficulty recruiting and retaining high-quality staff in certain areas. **Cause:** • Lack of suitable candidates • High cost of living locally. • Failure to promote reputation as a good employer. **Effect:** • Higher than average vacancy rate and agency usage. • Reduction in service provision / quality. • Increased financial pressure on workforce costs to retain key staff **Impact:** • Increased pressure on remaining staff. • Services become less cost-effective.	• Recruitment & Selection Policy • SOPs to cover above • Absence Management processes • Occupational Health Service • Workforce Plans • Development of local recruitment plans and local contingency plans. • Running waiting lists. • Investment in marketing • Consider the use of pay premiums • Consider effectiveness of recruitment training for managers. • Value based interviewing project.	Within 3 months	2 4 8	2 3 6	↓	14/2/14	8

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Jan 14)	Current risk rating (Feb 2014)	TREND	Last Review Date	Target
6.2	MP	IBP	Low levels of staff satisfaction, health & wellbeing and staff engagement. **Cause:** • Low staffing levels. • Increased pressures of work and inability to support good working environment / practices. **Effect:** • Low levels of staff involvement in service redesign. • Poor staff motivation. • Potentially higher sickness rates **Impact:** • Failure to deliver required activity levels • Loss of reputation • Inability to embed new ways of working. • Increased costs in relation to agency spend to cover potential increases in sickness.	• Induction programme in place. • Statutory / Mandatory training via e'learning in place. • Appraisal process. • Raising a concern at work policy • JSCNC/LNC • H&S Committee • CIP process assesses impact of change on capacity for training • Health & Wellbeing Committee • Listening into Action Programme • Occupational Health Service • Divisional Staff Survey Action Plans. • Development of local staff surveys and exit interview process	3-12 months	2 4 8	2 4 8	↔	14/2/14	6
6.3	MP	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 now on ELMS. • CPD and access to courses	3-12 months	2 3 6	2 3 6	↔	14/2/14	3
6.4	LW	Esc	Potential of poor staffing levels within the Maternity Service **Cause:** • Peaks in workload are managed using on call hospital and the community staff. This creates a knock on effect for the community service and can mean postnatal visits and clinics are delayed or cancelled and continuity of care is affected. • During busy times staff who are working non-clinically are moved to cover clinical areas which affects their workload and performance.	• Zero hours staff are available to cover shifts • Intrapartum toolkit in use to measure acuity of workload. • Two hospitals on-call per night and additional community midwives can be called in to ensure the unit is safe. • Delays are discussed with the bleep holder, manager and consultant on call and plan put in place. • Managerial support needed to close any	3-12 months	3 3 9	3 3 9	↔	14/2/14	5

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Jan 14)	Current risk rating (Feb 2014)	TREND	Last Review Date	Target
			Effect / Impact: • Midwives may be unavailable to support junior midwifery staff • A delay to elective delivery beyond the optimum time is a potential risk for mothers and babies. • This is a potential reputational risk to the Trust • Workflow and specialist services such as the bereavement service may be effected • Staff may be at increased risk of stress and related issues.	clinical area. • Monitoring of sickness and occupational health input when appropriate. • Repeated attempts have been made to fill the available posts. • Recruitment of midwives on-going but majority in post from maternity business case • Birth Rate + used to monitor acuity of patients against staff levels.						
Principal Risk 7: Failure to deliver the required transformation of services.										
7.1	PB	IBP	Potential of failure to maintain an open culture consistent with the Trust values. **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 • Staff survey provide positive evidence • Corporate Induction promotes open culture and organisations values • Values based interviewing promotes positive culture • Peer Review process assesses staff attitude and behaviours in relation to caring • FFT provides indicator of values in action	Over 12 months	2 4 8	2 3 6	↓	14/2/14	6
7.5	AS	IBP	Potential failure to obtain the clinical advantages from EPR. **Cause:** • Lack of clinical engagement • Poor data quality • Poor implementation • Poor system build • Lack of successful and timely re-procurement exercise	• Clinical roll-out not implemented until stabilisation achieved. • Service repositioned as a service transformation project with operational leadership from Director of Clinical Services. • New level of engagement and implementation being adopted. • Development of cadre of champions	3-12 months	2 4 8	2 4 8	↔	14/2/14	6

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Jan 14)	Current risk rating (Feb 2014)	TREND	Last Review Date	Target
			• Failure to continue to invest in the clinical aspects of the system due to resources implications **Effect:** • Failure to deliver clinical benefits • Need to maintain inefficient patient pathways. **Impact:** • Additional costs and reduced efficiency • Negative impact on morale and patient experience • Heightened clinical risk • Reputational damage	(including visit of staff to Cerner Health Conference) • Project management processes to continue. • Review of IM&T being undertaken						
7.6	EW	IBP	Potential 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 improvements in control. **Effect:** • Failure to establish sound assurance systems and processes. **Impact:** • Reliability of the quality and performance indicators received by the Trust.	• Risk Management and Assurance Strategies approved by the Board in Aug 2012. • Strategy Implementation plans in place. • HealthAssure Rollout Plan monitored • Board & Sub Committees processes reviewed • ToR for TME and sub committees being reviewed • Positive assurance from IA re Divisional Governance processes • Risk Toolkit in place • Peer Review Programme implemented.	Within 3 months	3 3 = 9	2 3 = 6	↓	14/2/14	6
7.7	MT	ESC	Failure to solve legionella issues in the retained estate. **Cause:** • Poor estate infrastructure. **Effect:** • Potential for higher rates of legionella in routine monitoring of system. **Impact:** • Potential impact on patients.	A paper was taken to TME November 2013 and recommendation approved to carry out remedial works to the highest risk issues. Detailed work ~~is on-going~~ was undertaken to identify the extent ~~and potential costs to~~ of works to remediate and reduce this risk. This has now been included in the capital programme for 13/14 (£500k) and 14/15 (£300k to complete all works).	3-12 months	3 5 = 15	3 5 = 15	↔	14/2/14	6
7.8	MT	ESC	Building issues in the Women's Centre could lead to patient safety issues, poor practice could lead to effluent blockages.	**Current controls:** • Additional education in relation to good practice processes • Regular monitoring of potential issues.	Within 3 months	3 4 = 12	3 4 = 12	↔	14/2/14	3
7.9	MT	ESC	Potential risk posed by the fire detection systems in the	**Current controls**:	Within	4 4	4 4	↔	14/2/14	3

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Jan 14)	Current risk rating (Feb 2014)	TREND	Last Review Date	Target
			JR that require upgrading	• Increase to regular testing of alarm system • Monitoring of all alarms and response when activated, with RCA to evaluate response times etc. **Comments** Additional work in relation to fire detection system identified from a future capital programme.	3 months	16	16			
7.10	PB	ESC	Failure of laboratory accreditation process due to poor pathology sample store facilities	**Current Controls:** • Advice sought from H&S team for safe working requirements (actions implemented) **Comments** • Issue raised through clinical governance • Enquiries made with commercial companies for off site solutions (not preferred option due to difficulties accessing material at the time of enquiry) • Numerous temporary / permanent solutions sought on Churchill site (permanent solution unsuccessful as yet, temporary solution possible in old radiology basement)	Within 3 months	3 4 12	3 4 12	↔	14/2/14	3
7.11	PB	ESC	Potential failure to provide adequate mortuary facilities at the Horton.	**Current controls:** • Arrangements in place with undertakers to provide temporary solution if needed or to source a temporary mortuary facilities. **Comments:** • Business case submitted January 2013 – funding approved • *Funding included in 13/14 capital programme to address this risk (Once works completed the risk will be reduced to its target score)*	Within 3 months	3 4 12	2 3 6	↓	3/3/14	3
Principal Risk 8: Failure to deliver the benefits of strategic partnerships.										
8.1	PB	IBP	Potential failure to sustain effective regional networks. **Cause:** • Poor quality care.	• Clinical network meetings. • Development of AHSN • Marketing and market research	Over 12 months	2 2 4	2 2 4	↔	14/2/14	2

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Jan 14)	Current risk rating (Feb 2014)	TREND	Last Review Date	Target
			• 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.	• Performance review process.						
8.2	JM	IBP	Potential 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	↔	14/2/14	3
8.3	JM	IBP	Potential 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	2 2 4	2 2 4	↔	14/2/14	3

Key Risk Owners:

PB Director of Clinical Services (Paul Brennan)
MP Director of Workforce & Organisation Development (Mark Power)
MT Director of Development and the Estate (Mark Trumper)
TB Medical Director (Ted Baker)

AS	Director of Planning & information (Andrew Stevens)
MM	Director of Finance and Procurement (Mark Mansfield)
EW	Director of Assurance (Eileen Walsh)
LW	Acting Chief Nurse (Liz Wright)