Oxford University Hospitals NHS
NHS Trust

Trust Board Meeting: Wednesday 14 May 2014

TB2014.62

Title	**Board Assurance Framework and Corporate Risk Register Year End Review Report**

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

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

Executive Summary

1.	This paper presents the Year End Board Assurance Framework (BAF) and Corporate Risk Register (CRR) to the Committee. Both documents are subject to regular review by the Board sub-committees and the Trust Management Executive, this report provides the Trust Board with the opportunity to review both documents for the transition between financial year ends.
2.	**Recommendation** The Trust Board is asked to: • Review the BAF and the CRR and highlight any further changes that might be required to move the BAF and CRR forward into the new financial year. • Consider the development plans for future presentation of the CRR.

1. Introduction

1.1. The Board Assurance Framework (BAF) and Corporate Risk Register (CRR) have been reviewed in detail, with each risk owner. As a result of the transition from 2013/14 to 2014/15 year, this year-end review considered:

- The need to restate the strategic objectives and ensure the key risk areas reflect the current Trust Business Plan, reported to the Board in May.
- The need to re-score the current risks following an assessment of the controls in operation during 2013/14 and the operational delivery achieved at the year-end.
- The setting and monitoring of target risk scores going forward into the new financial year.
- Work to strengthen the analysis of actions needed to close the gap between the current risk score and the target risk score.
- The validity of risk proximity scores, the relationship with the risk target and risk proximity changes over time.

1.2. This year-end report provides an opportunity for the Trust Board to review the Board Assurance Framework (BAF) and Corporate Risk Register (CRR).

1.3. The Trust Board is asked to review the BAF and the CRR and highlight any further changes that might be required to move the BAF and CRR forward into the new financial year

2. Potential development for the future presentation of the CRR

2.1. As part of the conversations in relation to the development of the risk register, during the Board Away day, the potential need for the CRR to be split to show those strategic risks that directly affect the achievement of the trust strategic objectives and those risk that are corporate operational risks.

2.2. The Trust Board is asked if the CRR should be spilt as suggested.

3. Recommendation

3.1. The Trust Board is asked to:

- Review the BAF and the CRR and highlight any further changes that might be required to move the BAF and CRR forward into the new financial year.
- Consider the development plans for future presentation of the CRR.

Eileen Walsh
Director of Assurance

May 2014

Report Prepared By:
Clare Winch
Deputy Director of Assurance

Appendix 1:
Board Assurance Framework

Assurance Summary / Assurance Dashboard

1. Board Assurance Framework for the delivery of Objectives

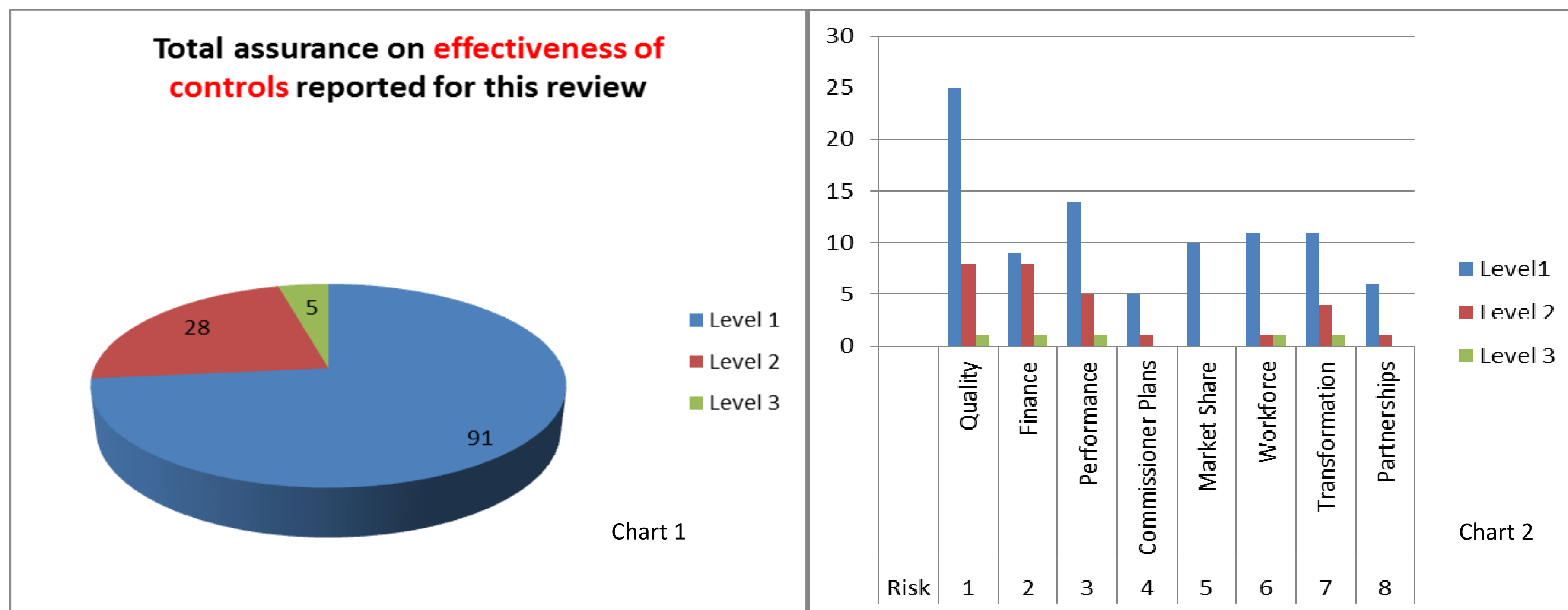
The Board has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate any significant risks which may threaten the achievement of the strategic objectives. Assurance may be gained from a wide range of sources, but where ever possible it should be systematic, supported 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	23	12	7
2	Finance	12	8	13
3	Performance	4	9	2
4	Commissioner Plans	3	2	0
5	Market Share	1	1	0
6	Workforce	5	2	2
7	Transformation	6	12	2
8	Partnerships	0	0	0
	Total assurances noted as Reported to Audit, Quality & F&P Committees to date	54	46	26

This table provides a summary of all other assurance currently noted as reported to the Audit Committee, Finance & Performance Committee and Quality Committee for the year. A total of 271 assurances were noted against the 8 principle risks for the year. The majority (58%) was level 1 assurance, all expected assurance was received in the year and a number of additional assurances were also reported and recorded during the course of the year.

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) *Assurance in previous year* • *QGAF (L1) (Sept 2012, Jan 13)* • *Annual H&S Report (L1) (Nov 2012)* • *QGAF Report (L3)(Nov 12)*	Reported to Board • IPR (L1) (May, July, Sept, Nov 13, Jan 14, March 14) • Reports from Quality Committee(L2) (May July Sept Nov,13 Jan 14, March 14) • Audit Committee Report (L2) (May, July 13 Jan 14, March 14) • Quality Report (L1) (May, July Sept Nov 13 Jan March 14) • Patient Story Report (L1) (May, July, Sept Nov 13 Jan March14) • CQC Inspection Report (L3) (May 13) • Francis Enquiry Response (L1) (Sept 13) • Complaint's Annual Report (L1) (Sept 13) • Safeguarding (L1) Nov 13) • Nurse staffing (L1) March14) • Cavendish Compliance(L1) March 14) • Peer Review (L2) March 14)	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 31/3/14	**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 • 6 facet survey completed.	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*, Mar 14) • F&P report to the Board (L2) (May, July Sept Dec 13, Feb March 14) • Audit Committee Report to the Board (L2) (May, July 13, Nov 13, Feb 14) • HDD Report (L3) (Nov 12) • Self-Certification Report (L1) (Sept 13 Nov 13, Jan 14, Mar 14) • TME report (L2) March 14)	None at 31/3/14	None at 31/3/14	None at 31/3/14	**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 March14) • Integrated Performance Reports (Level 1) (May, July Sept Nov 13 Jan March14) • 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) • Discharge Improvement Programme (L1) March 14) • TME Report (L2) March 14)	None identified at 31/3/14	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 Proposed change for 2014/15 • 14/15 contract set at outturn for OCCG • Compliant 14/15 contract with specialist commissioners • Initial business cases for QIPP developed by OCCG • OUH to sit on QIPP Steering Group • External contracts to be operationalised internally • Monthly meetings with commissioners	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) • Scrutiny from Finance and Performance Committee (L2)	Reported to Board: • DTOC Provider Action Plan (Level 1) (Sept 2012) • CE reports to Board (Level 1) (May, Sept Nov 13 Jan 14, Mar 14) • GP Engagement (Level 1) (July 2013) • FPC Report (L2) March 14)	None identified at 31/3/14	None identified at 31/3/14	None identified at 31/3/14	(**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 • Collaborative approach with OH	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 • OUH won tender for integrated sexual health services (Level 1) • Report to Board workshop on collaborative work with OH (Level 1)	Reported to Board: • Finance reports to the Board (Level 1). (May , July Sept Nov 13 Jan 14, Mar 14) • CE Briefing (Level 1) (May Sept Nov 13 Jan 14, Mar 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 31/3/14	**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 maintaining appropriate staffing levels in all areas (6.1). • Low levels of staff satisfaction, (6.2). • Insufficient provision of appropriate education and learning development opportunities (6.3) • Failure to establish effective leadership and talent development interventions. (6.4) • Size and complexity of the organisation makes communication and consistency of interventions difficult. **Potential Effect:** • Low levels of involvement and engagement in the trust's agenda. • Higher vacancy rates. • Poor staff health & wellbeing **Potential Impact:** • Poor patient experience and outcomes and 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 (L1) (May, July Sept Nov 13 Jan March14) • Annual H&S Report (L1) (Nov 2012) • R&A Report (L2) (July 2013) • HR & Workforce Report (L1) (Sept Nov 13) • IG Mid Year Review (I1) Nov 13) Adhoc reports to Board: • Staff Survey (L3) (Mar 13) (Mar 14) • Board Development (L1) March 2013 • Medical Appraisal rates 12/13 (L1) Nov 13 for 13/14 March 14) • Education & Training Report (L1) Jan 14) • Nurse staffing (L1) Mar 14) • Cavendish Compliance (L1) March 14) • E&D annual report (L1) Mar14)	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 **Assurance Gap:** Annual H&S report added to forward agenda for the Board. **Action owner:** Head of Corporate Governance	**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 March 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.	None identified at 31/3/14	**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, Mar 14) • AHSN Update (Level 1) (Nov 13)	None identified at 31/3/14 Joint Strategic Objectives to be developed	None identified at 31/3/14	No further action required at 31/3/14	**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 ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Feb 14)		Current risk rating (Mar 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	↔	31/3/14	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	↔	31/3/14	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	↔	31/3/14	3
						6		6				

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Feb 14)			Current risk rating (Mar 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	↔	31/3/14	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	**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	2	3	6	↓	31/03/14	3

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Feb 14)		Current risk rating (Mar 2014)		TREND	Last Review Date	Target
			to have an 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. • Increase risk of slips, trips and falls due to wet surfaces during Friday Prayers	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. Opening was due in April, but this has been moved to May 2014								
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 • Business case has been put forward to increase the number of anaesthetists in paediatric care.	3 -12 months	2	5	2	3	↓	31/03/14	6
						10		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	2	4	↔	31/3/14	3
						8		8				

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Feb 14)		Current risk rating (Mar 2014)		TREND	Last Review Date	Target
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 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	3	4	3	4	↔	31/3/14	6
						12		12				
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 /electronic 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	2	2	↓	31/3/14	3
						6		4				
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	**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.		3	3	3	3	↔	31/3/14	3
						9		9				

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Feb 14)	Current risk rating (Mar 2014)	TREND	Last Review Date	Target
			• EPR rollout – effects completeness of notes and raises questions around the links with other systems. **Impact:** • Quality and safety may be effected	• Links to other IT systems being addressed.						
1.15	LW	New	Excessive use of agency staff may pose a risk to the quality of service delivered **Cause** • 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	**Controls** • Daily monitoring of safe staffing levels at all sites and staff moved to mitigate 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. • Review undertaken of the EU nurse recruitment campaign and an additional tender in process • Multi strata recruitment design to focus on Horton site and specialist posts including AHPs • Vacancy levels monitored monthly. • Long lines of rostered bank/agency I n place, and most expensive agency staff replaced by new recruits.		3 3 9	2 3 6	↓	31/3/14	6
1.16	TB	new	Infection Control **Cause:** Peer review identified some areas where cleanliness and adherence to correct procedures required improvement. **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 reputation & patient experience	**Controls** • TME to ensure monitoring of local divisional actions • Each division has policies and procedures in place, as well as monitoring processes to ensure that standards of cleanliness are maintained. • Divisions have taken immediate action to improve staff awareness. Hand hygiene training sessions have been held and the senior management walk rounds, as well as routine monitoring are being used to monitor and improve current practice,	*3 -12 months*	*n/a*	3 2 6	*n/a*	31/3/14	3

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Feb 14)	Current risk rating (Mar 2014)	TREND	Last Review Date	Target
				where required.						
1.17	TB	new	Medicine Management **Cause:** Aspects of medicines management were identified as an area that required improvement during the reviews across all divisions. This mainly related to the safe and secure storage of medicines. **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 reputation & patient experience	**Controls** • TME to ensure monitoring of local divisional actions • Divisions have taken some immediate actions to ensure medicines are held securely. They have also begun to implement actions to improve staff's knowledge and awareness of the policies and procedures by disseminating 'At a glance' versions and ensuring staff have attended medicines training. • Monitoring is being undertaken by ward sisters and matrons through weekly checks to ensure staff are complying with the procedures and team meetings are being used to reinforce learning.	3 -12 months	*n/a*	5 | 1 5	*n/a*	31/3/14	3
1.18	PB	new	Patient transportation and co-ordination of care **Cause** • ARIVA and SCAS are 3rd party providers of transportation under contract to the CCGs in Swindon and Oxford respectively **Effect/Impact:** • Poor patient experience with patients left waiting for transport to arrive and subsequently late for appointments • Patient safety in delays of dialysis • Reputational damage	**Controls** • Deputy Director of Clinical Services consulting with both CCGs and 3rd Party providers on contractual agreements currently in place • Formal meeting planned with ARIVA, Oxford CCG and Trust to discuss actions • Long term plan for contract(s) to be held between Trust and Service Provider	3-12 months	n/a	5 | 3 15	n/a	31/3/14	3
1.19	TB	new	Community Acquired Pneumonia in Adults • Benchmarked outcome data for mortality was adverse – 5% higher than national mean (from Dr Foster Intelligence / HSMR). • Recognised that patients with CAP are found across many services such that the Trust's clinical management structure is not ideally placed to provide assurance as to the quality of management. • Recognised that the respiratory service (Churchill) does not manage the majority of cases of	**Controls** • Recognition that coding practice (and over use of term 'acute bronchitis' in this patient group) was a contributory factor – improved training of medical staff [ongoing]. • Revision of antibiotic guidelines [complete]. • Introduction of Care Bundle [ongoing]. • Develop standard in relation to radiology reporting times for admission chest x-rays	3-12 months	n/a	2 | 4 8	n/a	31/3/14	3

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Feb 14)	Current risk rating (Mar 2014)	TREND	Last Review Date	Target
			pneumonia. • National clinical audits suggested local deficiencies in documentation of risk stratification scores, and poor adherence with antimicrobial guidelines. The risk initially related to : **Cause:** • Poor clinical coding practice does not support assurance of quality of management. **Effect / Impact:** • suboptimal clinical outcomes • Reputational damage.	[ongoing]. • Develop improved level 2 care facilities on the John Radcliffe site [ongoing].						
1.20	TB	new	Management of Inpatient Diabetes **Cause:** • The annual national inpatient diabetes audit benchmarks and self-reported local information against national self-reported data. In the 2011 and 2012 rounds highlighted deficiencies with regard to: high medication errors, low involvement of diabetes specialists in care, and high rates of hypoglycaemia. Effect / Impact: • suboptimal clinical outcomes. • Reputational damage.	**Controls** • Implementation of Think Glucose approach across the Trust [ongoing] • Enhanced staffing [business case approved] • Enhanced training and revision in training model [ongoing] • Use of IT to facilitate identification and management of patients with diabetes [ongoing]	3-12 months	n/a	3 4 12	n/a	31/3/14	3
1.21	PB	new	Out of Hours Care **Cause:** • This is a national issue but potential risk around multi-site working and super-specialization can favour silo working • Team working out of hours may be less advanced than in some other areas. **Effect / Impact:** • suboptimal clinical outcomes, • poor staff and patient experience • reputational damage	**Controls** • A series of risk summits has been proposed (31 March, 11 April) in order to agree principles and identify solutions for each site	3-12 months	n/a	4 4 16	n/a	31/3/14	4
1.22	PB	Esc	Storage of oxygen cylinders in Neonatal **Cause:** Storage of gas cylinders does not fully comply with health and safety guidelines **Effect:** Potential for H&S review and penalties	Current Controls: • Clear Identification of current cylinder storage areas. • Sharing gas cylinder storage belonging to A&E dept. (located adjacent to PICU storage room.)		n/a/	2 4 8	n/a	31/3/14	6

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Feb 14)			Current risk rating (Mar 2014)			TREND	Last Review Date	Target
			Impact: Reputation of the Trust and financial penalty possible	• Raised with Estates, recognised as wider problem and escalated										
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	4	3	12	↑	31/3/14	9
2.2	MM	IBP	Potential failure to effectively control pay and agency costs. **Cause:** • 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 and perceptions of safety	• Sickness management and monitoring • Workforce plans • Vacancy controls • Business Planning	Within 3 months	3	3	9	4	3	12	↑	31/3/14	9
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.	• 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	3 -12 months	3	2	6	3	2	6	↔	31/3/14	6

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Feb 14)	Current risk rating (Mar 2014)	TREND	Last Review Date	Target
			Impact: • Increased financial pressures.	• Carbon energy cash releasing scheme in development during 13/14 to generate income from 14/15.						
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	↔	31/3/14	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	↔	31/3/14	4
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	**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	Within 3 months	5 4 20	5 4 20	↔	31/3/14	12

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Feb 14)		Current risk rating (Mar 2014)		TREND	Last Review Date	Target
			• 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.	• 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								
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 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	**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. • 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	3-12 months	2 8	4	2 8	4	↔	31/3/14	6

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Feb 14)		Current risk rating (Mar 2014)		TREND	Last Review Date	Target
			• 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.	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 • 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	**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 Urgent Care taskforce, Planned care Programme Board & Long Term Conditions. • Monthly Contract meeting with PCT • Weekly SHA teleconference calls • Weekly South Central Ambulance meeting	3-12 months	4	4	4	4	↔	31/3/14	6
						16		16				
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	**Internal** • Daily & weekly monitoring of key access targets; Weekly EPR meetings; Monthly EPR Operational & Monthly EPR Programme Board meetings	3-12 months	3	4	3	4	↔	31/3/14	6
						12		12				

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Feb 14)	Current risk rating (Mar 2014)	TREND	Last Review Date	Target
			• 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.	• 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						
3.6	PB	Esc	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.	**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	↔	31/3/14	6

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Feb 14)		Current risk rating (Mar 2014)		TREND	Last Review Date	Target
			• 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.	**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								
3.7	PB	new	Inability to meet the Trust needs for capital investment Cause: • Potential for insufficient capital to finance the trust's various requirements. • Potential failure to obtain a capital loan at the required level • Potential growth of costs of specific projects. • Potential failure to obtain charitable funding to support projects	Controls • Robust business planning approval processes • Strong financial case to justify investments • Board review of investments to ensure affordability over time	3-12 months	n/a		3	4	*n/a*	31/3/14	6
								12				
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. **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.	• QIPP Programme Framework. • Risk management provisions in contract • Collaboration with Oxford Health.	3-12 months	3	4	3	4	↔	22/1/14	6
						12		12				
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.	• Commissioner alignment meetings. • Relationship management process. • Further letters of support from commissioners in relation to FT application	Over 12 months	4	4	4	4	↔	31/3/14	6
						16		16				

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Feb 14)		Current risk rating (Mar 2014)		TREND	Last Review Date	Target
			• 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.									
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	2	2	2	↓	31/3/14	4
						4		4				
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	3-12 months	3	3	2	3	↓	31/3/14	6
						9		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.	• 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	2	2	↔	31/3/14	3
						4		4				

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Feb 14)			Current risk rating (Mar 2014)			TREND	Last Review Date	Target
			• Loss of support from commissioners and referrers. **Impact:** • Reduced referrals threaten clinical and financial sustainability.											
Principal Risk 6: Failure to sustain an engaged and effective workforce.														
6.1	MP	IBP	Difficulty maintaining appropriate staffing levels in all 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	3	6	2	3	6	↓	31/3/14	8
6.2	MP	IBP	Low levels of staff satisfaction **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	↔	31/3/14	6
6.3	MP	IBP	Insufficient provision of appropriate education and learning development opportunities **Cause:**	• Induction programme in place. • Statutory / Mandatory training via e'learning in place.	3-12 months	2	3	6	2	3	6	↔	31/3/14	3

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Feb 14)			Current risk rating (Mar 2014)			TREND	Last Review Date	Target
			• 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	• Appraisal process now on ELMS. • CPD and access to courses										
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. **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.	• 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 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.	3-12 months	3	3	9	3	3	9	↔	31/3/14	5
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	• 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	Over 12 months	2	3	6	2	3	6	↔	31/3/14	6

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Feb 14)		Current risk rating (Mar 2014)		TREND	Last Review Date	Target
			management **Impact:** • Failure to deliver cost improvements whilst maintaining quality • Risks CQC registration • Reputational damage	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								
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 • 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	• 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 (including visit of staff to Cerner Health Conference) • Project management processes to continue. • Review of IM&T being undertaken	3-12 months	2	4	2	4	↔	31/3/14	6
						8		8				
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:**	• 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	Within 3 months	2	3	2	3	↓	31/3/14	6
						6		6				

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Feb 14)	Current risk rating (Mar 2014)	TREND	Last Review Date	Target
			• Failure to establish sound assurance systems and processes. **Impact:** • Reliability of the quality and performance indicators received by the Trust.	• ToR for TME and sub committees being reviewed • Positive assurance from IA re Divisional Governance processes • Risk Toolkit in place • Peer Review Programme implemented.						
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 was undertaken to identify the extent 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	2 3 10	↓	31/3/14	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. **Cause:** • Poor practice in terms of items flushed **Effect:** • Potential for infrastructure failures. **Impact:** Potential impact on patients.	**Current controls:** • Additional education in relation to good practice processes • Regular monitoring of potential issues.	Within 3 months	3 4 12	3 4 12	↔	31/3/14	3
7.9	MT	ESC	Potential risk posed by the fire detection systems in the JR that require upgrading **Cause:** • Poor estate infrastructure. **Effect:** • Potential for increased risk if fire should break out. **Impact:** Potential impact on patients.	**Current controls**: • 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.	Within 3 months	4 4 16	4 4 16	↔	31/3/14	3
7.10	PB	ESC	Failure of laboratory accreditation process due to poor	**Current Controls:**	Within	3 4	3 4	↔	31/3/14	3

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Feb 14)		Current risk rating (Mar 2014)		TREND	Last Review Date	Target
			pathology sample store facilities **Cause:** • Poor estate infrastructure. **Effect:** • Potential for samples to degrade over time. **Impact:** Potential impact on trust reputation.	• 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) • Potential off-site facility under review	3 months	12		12				
7.11	PB	ESC	Potential failure to provide adequate mortuary facilities at the Horton. **Cause:** • Poor estate capacity **Effect:** • Potential for facilities to be full and contingency arrangements may be required. **Impact:** Potential impact on reputation, poor experience for relatives	**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	2	3	2	3	↔	31/3/14	3
						6		6				
7.12	PB	ESC	Failure to generate hot water and heat in retained parts of Churchill estate **Cause:** • Poor estate infrastructure. **Effect:** • Potential for temporary loss of services in some areas **Impact:** Potential impact on patients.	**Current controls:** • An outline business case for primary plant replacement (under the Carbon Energy Fund scheme) is to be taken to the board, with a view to installation in the summer 2015. • Main in-patient areas in the retained estate are proposed to be progressively vacated over time	Over 12 months	n/a		3	4	n/a	31/3/14	3
								12				
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	2	2	↔	31/3/14	2
						4		4				

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Previous risk rating (Feb 14)		Current risk rating (Mar 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	3	2	↔	31/3/14	3
						6		6				
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	2	2	↔	31/3/14	3
						4		4				

Key Risk Owners:

PB Director of Clinical Services (Paul Brennan)

MT Director of Development and the Estate (Mark Trumper)

MP	Director of Workforce & Organisation Development (Mark Power)	TB	Interim Medical Director (Tony Berendt)
AS	Director of Planning & information (Andrew Stevens)	EW	Director of Assurance (Eileen Walsh)
MM	Director of Finance and Procurement (Mark Mansfield)	LW	Acting Chief Nurse (Liz Wright)