Oxford University Hospitals NHS
NHS Foundation Trust

Trust Board Meeting in Public: Wednesday 11 November 2015

TB2015.138

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

Status	For discussion
History	The latest version of the full BAF and CRR was reported to the: • Audit Committee in April 2015 and Sept 2015. • Trust Board in May 2015 • Trust Management Executive on 9 July 2015 Extracts of relevant risks from the CRR and the BAF were reported to: • Quality Committee June, October, December 2014, February, (CRR) June and (CRR) August 2015. • Finance & Performance Committee June, October, December 2014, February, June and August 2015. Updates of relevant risks from the CRR were reported to: • Trust Management Executive on 27 August and 24 September 2015

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

Executive Summary

1. This paper presents the mid-year review of the 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.

2. This report highlights the changes made to the BAF and CRR and reflects all amendments to the BAF & CRR as approved by TME on 24 August 2015.

Recommendations

3. The Trust Board is asked to:

- Review the changes made to the BAF and highlight any further changes that may be required;
- Note the changes made to the CRR as set out in this paper and;
- Note the further proposals for a fuller review of the entire content of both documents to be commenced by the Trust Management Executive at its meeting on 12 November 2015.

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). The BAF and CRR have been reviewed in detail, with each risk owner.

1.2. The report provides a summary of changes to the BAF and CRR as approved by Trust Management Executive (TME) on 24 August 2015.

2. Changes to the BAF and CRR

2.1. As with previous reports, all changes to the BAF (Appendix 1) and the CRR (Appendix 2) have been highlighted in red and italics.

New Risks

2.2. A number of new risks were presented to the TME at its meetings in July 2015. These have been added to the CRR.

2.3. The CRR was subsequently presented to the Finance and Performance and Quality Committees on 12 August 2015. As a result of those meetings, new risks were recommended for inclusion onto the CRR. This was agreed at the TME meeting on 24 August 2015.

ID	Risk Description
1.27	Revalidation for Nurses and midwives and failure to comply with NMC Guidance
1.28	Failure to demonstrate compliance to the duty of candour
3.11	Potential risk of failing to respond to the results of diagnostic tests. (OCCG)
3.12	Potential risks to handover of treatment through poor communication of discharge summaries. (OCCG)
1.29	Unsuitable office and outpatient accommodation in Clinical Genetics Department at the Churchill
2.7	Potential failure to deliver the financial outturn agreed with the TDA

De-escalated and Archived Risks

2.4. The following risks were approved to be archived or de-escalated by the Trust Management Executive at its meetings in July and August 2015.

ID	Risk Description	Summary
5.3	Negative media coverage relative to our competitors. (Archived)	Considered no longer a valid risk
6.6	Failure of non-compliance to CQC Action Plan in relation to ratio of Supervisors of Midwives. (De-escalated).	Risk is now lower due to anticipated changes to legislation
7.10	Failure of laboratory accreditation process due to poor pathology sample store facilities. (Archived).	The pathology sample store has been outsourced and the original facility de-commissioned.
7.13	Failure to resolve Churchill PFI contractual and service performance issues	Contract now resolved so archive
7.14	UPS power supply in Churchill theatres fails to operate correctly	Recommended for Archive

3. Fundamental Risk Register Review

3.1. At its meeting on 16 September 2015 the Audit Committee highlighted the need to conduct a review of the entire content of the BAF and CRR. This review was commenced through the routine presentation of the BAF and CRR at TME on 8 October 2015.

3.2. On 8 October 2015 TME was asked to consider the BAF and CRR and in particular the questions posed by the Audit Committee. It was agreed at this meeting that further dedicated time was required on this subject. This was scheduled into the TME meeting on 12 November 2015. This meeting will consider all further proposed amendments to the CRR, as identified since the formal approval of the CRR at the end of August, and additional proposed actions for the review and development of the BAF & CRR.

4. Recommendations

4.1. The Trust Board is asked to:

- Review the changes made to the BAF and highlight any further changes that may be required;
- Note the changes made to the CRR as set out in this paper and;
- Note the further proposals for a fuller review of the entire content of both documents to be commenced by the Trust Management Executive at its meeting on 12 November 2015.

Eileen Walsh, Director of Assurance

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 2015/16 are:

SO1	To be a patient-centred organisation, providing high quality, compassionate care with integrity and respect for patients and staff – **"delivering compassionate excellence"** **Health and Social Care Act Regulations which may be affected by the risk:** Regulation 18, 4 and 12**,**
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 Regulations which may be affected by the risk:** Regulation 5, 12, 17 and 19
SO3	To meet the challenges of the current economic climate and changes in the NHS by providing efficient and cost-effective services – **"delivering better value healthcare"** **Health and Social Care Act Regulations which may be affected by the risk:** Regulation 12, 16 and 18
SO4	To provide high quality general acute healthcare to the people of Oxfordshire, including more joined-up care across local health and social care services – **"delivering integrated local healthcare"** **Health and Social Care Act Regulations which may be affected by the risk:** Regulation 4,6, 12, 13
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 specialised care for the people of Oxfordshire and beyond - **"excellent secondary and specialised care through sustainable clinical networks"** **Health and Social Care Act Regulations which may be affected by the risk:** Regulation 12
SO6	To lead the development of 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 Regulations which may be affected by the risk:** Regulations 4, 6 and18

3. 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). **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. • 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 • Public Health Strategy • Patient feedback system to be implemented. • Dementia Strategy	Reported to Board • Integrated Performance Reports (IPR) (L1). • Reports from Quality Committee to Board (L2). • 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 15*) • Reports from Quality Committee(L2) (May, *July 15*) • Audit Committee Report (L2) (May, *July 15*) • Quality Report (L1) (May, *July15*) • Patient Story Report (L1) (May, *July , Sept 15)* • Nurse staffing (L1) (in BQR) • Monitor Quality Governance Framework (L3) Update(May 15) • CQC Inspection Action Plan L3 (May 15) *Assurance in previous year* • *Annual H&S Report (L1) (Sept 14)* • *Complaints Annual Report (L1)(Sept 14)* • *Annual Safeguarding Report (L1)(Nov 14)* • *Public Health Action Plan (L1) (Nov 14)* • *National Ombudsman Complaints Report (L3) (Jan 15)* • *Mental Health Act Compliance (L1) (Jan 15)* Number of Assurances reported elsewhere • (Level 1: 24, Level 2:*10,* Level 3:5) • Audit Committee Deep Dive, (L1, Nov 14) • *KPMG Internal Audit (L3, June, Sept 15)*	Monitor QGAF actions to be addressed	Map to performance indicators and corporate score show no gaps identified at 5/10/2015	**Control Gap**: Implementation of Quality Strategy to be further embedded. Further actions to be monitored via Quality Committee **Action Owner:** TB / CS – 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 manage outstanding historic debt (2.5). • *Impact of changes to specialist services tariff (2.6)* • *Potential failure to deliver the financial outturn agreed with the TDA (2.7).* • 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. • *Transformation Team support in place.* • Performance Management Regime • Budget setting & business planning processes. • Quality Impact Assessment process. • Bi-weekly monitoring of CIP programme • *Transformation & CIP Steering Group established* • Revised project management arrangements • Contract monitoring process • PLICS in place – • SOs SFIs • Declaration of Interests • 6 facet survey completed. • Investment Policy	Reported to Board • Director of Finance and Procurement Reports to the Board (L1) • Finance and Performance Committee (L2). • Audit Committee Report to the Board (L2) • *HDD Report to the Board (L3)* Reported elsewhere • Internal Audit review of CIPs (L3) • IA review of Financial Management arrangements (L3). • CIP reports to Quality Committee (L2). • Data Quality reviews with commissioners (L2) • Assessment against Monitor Risk Assessment Framework	Reported to Board • Finance reports (L1) (May, July, Sept *15*) • F&P report to the Board (L2) (May, July, Sept15) • Audit Committee Report to the Board (L2) (May, July, Sept 15) • TME report (L2) (March, July, Sept *15)* • Trust Business Plan (L2) (May 15) • Annual Audit Letter (L3) (Sept 15) • Data Quality Report (L1) (May 15) • *HDD Report (L3) (Sept 15)* *Assurance in previous year* • *Finance Demand management (L1)* • *HDD Report (L3) (Nov 12)* Number of Assurances reported elsewhere (Level 1: 13, Level 2:12, Level 3:11) • Audit Committee Deep Dive, (L1, Feb 15) • Internal audit review of Service Line Management (L3) • Monitor reference costs audit (L3) • *KPMG Internal Audit (L3, June, Sept 15)*	None at 1/10/2015	Reporting and review of cross divisional QIA of CIPS.	Revised process and reporting implemented. **Action Owner:** MM - On-going	**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 s (3.3,3.4, 3.5, 3.6) • Failure to reduce delayed transfers of care (3.1). • Failure of accurate reporting and poor data due to implementation of EPR (3.2). • Inability to meet the Trust needs for capital investment (3.7) **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. • Loss in reputation. • Failure to meet contractual requirements.	• 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 • Supported Hospital Discharge Service • Clinical Services Strategy. • Outpatient re-profiling.	Reported to Board • Director of Finance Reports to the Board (L1). • Integrated Performance Reports (L1) • Director of Clinical Services reports re review of services (L1). • Emergency Planning Annual Report (L1) • Audit Committee Report (L2) Reported elsewhere • ACE (Appropriate care for everyone) Programme Board meetings (L2). • PCT monthly Monitoring Review meetings (L3). • Chief Executive's Meetings (L2).	Reported to Board: • Finance reports (L1). (May, *July 15, Sept 15*) • Integrated Performance Reports (L1) (May, *July,Sept 15*) • Audit Committee Report (L2) (May, July, 15) • TME Report (L2) March, May, *July, Sept* 15) • Foundation Trust Update (L2) (May, *July, Sept 15*) • Data Quality Report (L1) (May 15) • Operational Performance Trajectory(L1) (May 15) • *Business Case involving commissioner report (L1) (July 15)* *Assurance in previous year* • *Winter Plan(L1) (Sept 13)* • *Cardiac Surgery Review (L2) May 14)* • *Discharge Improvement Programme (L1) March 14)* • *Emergency Preparedness audit (L2) (May14, Sept 14)* • *Winter Preparedness (L1) Nov 14)* Number of Assurances reported elsewhere (Level 1: 1*8*, Level 2:5, Level 3:1) • Audit Committee Deep Dive, (L1, Nov 14) • *KPMG Audit (L3, June, 15, Sept 15)*	None at 5/10/2015	Board reporting of performance to be further reviewed for any potential gaps.	**Assurance Gap:** Development of Performance Information Team **Action owner:** AS – 31 March 2015	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*:* Failure to achieve sustainable contracts with commissioners								
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). • Failure to reduce activity through robust demand management plans (4.2) **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.	• 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 re outcome based commissioning. • IBP & LTFM informed by commissioner strategies. • Commissioner sign up to major business cases. • Full involvement in commissioner led reconfiguration initiatives. • System leadership structure under development. • Strategy refresh being undertaken	Reported to Board • CE reports to Board (L1) • Director of Clinical Services reports re review of services (L1). • Finance Reports include contractual and commissioning issues (Level1) • Agreeing contracts reported via Finance to Board annually (L1) • Business Cases involving commissioners reported, where these occur (L1) Reported elsewhere • Network meetings (L2). • Update reports from Community Partnership Network (L2). • Contract Review Meetings minutes (L2) • Finance and Performance Committee (L2)	Reported to Board: • CE reports to Board (L1) (May, *July, Sept* 15) • FPC Report (L2) (May, *Jul, Sept 15*) *Assurance in previous year* • *GP Engagement (L1) (July 2013)* Number of Assurances reported elsewhere (Level 1: 3, Level 2 :0,Level 3:0) • Audit Committee Deep Dive, (L1, Feb 15)	None at 5/10/2015	None at 5/10/2015	None at 5/10/2015	(**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 4	**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 (L1) • Director of Clinical Services reports re review of services (L1). • Chief Executive Reports include information re AHSN, where relevant (L1) Reported elsewhere • OUH won tender for integrated sexual health services (L1) • Report to Board workshop on collaborative work with OH (L1)	Reported to Board: • Finance reports to the Board (L1) (May, July, *Sept 15*). • CE Briefing (L1) (May, *July, Sept 15*) *Assurance in previous years* • *Review of Acute Medicine (L1) (Dec 2012)* Number of Assurances reported elsewhere (Level 1: 3, Level 2:*1*, Level 3:0) • Audit Committee Deep Dive, (L1, Sept 14)	Commercial strategy for new and existing services Standard response to tendering of services	None at 5/10/2015	**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 *5*	**Potential Cause:** • Difficulty in recruiting and retaining high-quality staff in certain 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. **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.	• OD and Workforce Strategy. • 'Values into Action' Programme established. • Improved recruitment and induction processes, including Value Based Recruitment. • Recruitment and Retention initiatives established. • Comprehensive programme of EU recruitment established. • Staff engagement and awareness programme in place. • Divisional Staff Survey Action Plans. • Education and development processes in place. • Appraisal compliance and training attendance monitored. • Safe Staffing reviews. • First Care absence management system implemented. • Employee Assistance Programme	Reported to Board • Director of Workforce Reports (L1), • Integrated Performance Report (L1). • Staff survey and values update via Quarterly workforce reports (L1). • Annual H&S Report (L1) Reported elsewhere • Quarterly Pulse surveys (Staff FFT) to Workforce Committee and Board reports. • Raising Concerns: Audit Committee (Feb 15) • Recruitment and Retention: Quality Committee (Feb 15)	Regular reports to Board: • Integrated Performance Report (L1) (May, *July, Sept 15*) • HR & Workforce Report (L1) (March, May 15) • IG Review (L1), May 15) • Nurse staffing (L1) (May, *July 15*) *Assurance from previous years* • *Education & Training Report (L1) Jan 14)* • *Medical Appraisal rates (L1) 13/14, March 14)* • *Cavendish Compliance (L1) March 14)* • *E&D annual report (L1) Mar14)* • *Staff Survey (L3) (Mar 14) Post Graduate Medical Education Report (L2) (July 14)* • *Annual H&S Report (L1) (Sept 14)* • *Leadership and Talent Development Strategy Framework (L1) (Sept 14)* Number of Assurances reported elsewhere (Level 1: 7 Level 2:0, Level 3:7) • Audit Committee Deep Dive, (L1, June 14)	Multi-Professional Education and Training Strategy. Medical Staff Engagement Strategy	None at 5/10/2015	Develop and implement a Multi-Professional Education and Training Strategy. **Action Owner**: MP Develop and implement a Medical Staff Engagement Strategy. **Action owner**: TB and MP	**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 6	**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 (L1), • Reports from Quality Committee (L2 • Director of Clinical Services reports re review of services (L1). • BGAF Internal Assessment (L1) External Assessment (L3) • Governance of Board Committees (L1) • Board Sub Committee appointments (L1) • Effectiveness of Board (L3) • Director of IM&T reports (L1) Reported elsewhere • Reports to Workforce Committee (L2) • Minutes of CIP Executive Group. (L2)	Regular reports: • Reports from Quality Committee (L2) (May, *July, 15*) *Assurance from previous years:* • *NOC PPE review (L1) (Jan 13)* • *BGAF (L1) Sept 12) (L3) (Nov 12)* • *Business Cases / reviews (L1) (Sept 13)* • *EPR Updates (L1) Jan 13, Feb 13)* • *Board Effectiveness (L1 May 13)* • *BGAF Evidence Review (L2) (May, Nov 14)* • *Annual Review of Risk Management Strategy (L1) (Nov 14)* • *Annual Review of Assurance Strategy (L1) Nov 14)* • *Care 24/7 Update (L1) (Nov 14)* • *Implementation of Expansion of IMRT (L1) (Nov 14)* Number of Assurances reported elsewhere (Level 1: 8, Level 2:4, Level 3:2) • Audit Committee Deep Dive, (L1, Sept 14)	Coherent programmes for leadership to be developed.	None at 5/10/2015	**Control Gap:** Leadership working group to be established **Action Owner:** LW – on-going	**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	**Potential Cause:** • Failure to sustain effective 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. • Oxford Biomedical Research Centre • Biomedical Research Unit • Oxford Brooks Joint working agreement • Better Care Fund LA engagement • Vascular Network development • Joint Strategic Objectives developed (OH OUH)	Reported to Board • Chief Executive reports to Board (L1). Reported elsewhere • Board to Board meetings with PCT (L2)	Reported to Board: • CE Briefing Strategic Partnership Update (L1) (Jan 15) • Oxford Academic Health Sciences Annual Report (L2) (May 15) *Assurance from previous year:* • *AHSN Update (L1) (Nov 13)* • *Annual R&D Governance and Performance Report (L1) (Sept 14)* • *BRC Report (L1) (Sept 14)* Number of Assurances reported elsewhere (Level 1: 1, Level 2:0, Level 3:2) • Audit Committee Deep Dive, (L1, Sept 14) • *KPMG Internal Audit (L3,June 15, Sept 15)*	Oxford Integrated Care Alliance (still in development)	None at 5/10/2015	Oxford Integrated Care Alliance (still in development) **Action Owner:** PB – On going	**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 1: Rolling 12 month view

	Risk Description	Proximity	Sep-14	Oct-14	Nov-14	Feb-15	Mar-15	y/e 15	May-15	Jun-15	Jul-15	Aug-15	Trend	Target	Link to SO
1.1	Patients experience indicators show a decline in quality.	+ 12 mths	6	6	6	6	6	6	6	6	6	6	↔	4	SO1 SO5
1.2	Breach of CQC regulations	3-12 mth	4	4	4	4	4	4	4	4	4	4	↔	2	
1.3	Failure to meet the Trust's Quality Strategy goals.	+ 12 mths	6	6	6	6	6	6	6	6	6	6	↔	4	
1.6	Poor Bed Management equipment replacement and decontamination facilities impact on patient safety	3-12 mth	9	9	9	9	9	9	9	9	9	9	↔	4	
1.9	Negative media coverage relative to our competitors	3-12 mth	8	8	8	8	8	8	8	8	8	8	↔	3	
1.10	CAS Alert NPSA 2011/PSA001 Part b	3-12 mth	12	12	12	12	12	12	12	12	12	12	↔	6	
1.12	Staffing levels and skill mix consistently monitored and reported to Board	3-12 mth	4	4	4	4	4	3	3	desc				3	
1.14	Poor clinical records management processes have a potential impact in quality and safety	3 mths	9	9	9	9	9	9	9	9	9	9	↔	4	
1.15	Excessive use of agency staff may pose a risk to the quality of service delivered	3 mths	9	9	9	9	9	9	9	9	9	9	↔	6	
1.16	Infection Control	3-12 mth	6	6	4	desc								4	
1.17	Medicine Management	3-12 mth	5	5	4	4	4	4	4	4	4	4	↔	3	
1.18	Patient transportation and co-ordindation of care	3-12 mth	9	9	6	6	6	6	6	6	6	6	↔	4	
1.19	Pneumonia - Risk Summit	3-12 mth	8	8	8	8	8	8	8	8	8	8	↔	3	
1.20	Diabetes - Risk Summit	3-12 mth	12	12	9	9	9	9	9	9	9	9	↔	3	
1.21	Out of hours care (Care 24/7)	3-12 mth	12	12	9	9	9	9	9	9	9	9	↔	4	
1.22	Storage of Cylinders in Neonatal	3-12 mth	8	8	8	8	8	8	8	8	8	8	↔	6	
1.23	Failure in the Picture Archiving and Communication System (PACS)	3-12 mth	16	16	16	9	9	9	9	desc				8	
1.24	TIE failure between EPR and CRIS poses a risk to accurate data recording and reporting	3-12 mth	9	9	9	9	9	6	6	6	6	6	↔	3	
1.26	Failure to comply with NICE Quality Standard 13 End of Life Care	3 mths	esc	tbc	12	12	12	12	12	12	12	12	↔	3	
1.27	Revalidation for Nurses and midwives and failure to comply with NMC Guidance	3-12 mth								esc	8	8	↔	2	
1.28	Faiure to demonstrate compliance to the duty of candour	3-12 mth								esc	12	12	↔	3	
1.29	Unsuitable office and outpatient accommodation in Clinical Genetics Department at the Churchill	03-Dec									esc	15	new	3	
2.1	Failure to deliver the required levels of CIP	3-12 mth	16	16	16	16	16	16	16	16	16	16	↔	9	
2.2	Failure to effectively control pay and agency costs.	3 mths	16	16	16	16	16	16	16	16	16	16	↔	9	
2.4	Services display poor cost-effectiveness	3-12 mth	6	6	6	6	6	6	6	6	6	6		4	SO3 SO5
2.5	Failure to manage outstanding debtors	3-12 mth	6	6	6	6	6	6	4	desc				4	
2.6	Impact of changes to specialist services tariff	3-12 mth					new	16	16	16	16	16		8	
2.7	Potential failure to deliver the financial outturn agreed with the TDA	03-Dec									new	16	new	9	
3.1	Failure to reduce delayed transfers of care	3 mths	20	20	20	20	20	20	20	15	15	15	↔	12	
3.2	Failure of accurate reporting & poor data quality due to implementation of the EPR	3-12 mth	6	6	6	6	6	6	6	6	6	6	↔	4	
3.3	Failure to deliver National A&E targets	3-12 mth	16	16	16	16	16	16	16	12	12	12	↔	6	
3.4	Failure to deliver National Access targets 18 weeks	3-12 mth	12	12	12	12	12	9	9	9	9	9	↔	3	
3.6	Failure to deliver National Access targets Cancer,	3-12 mth	9	9	12	12	12	9	9	9	9	9	↔	6	
3.7	Inability to meet the Trust needs for capital investment	3-12 mth	12	12	12	12	12	12	9	9	9	9	↔	6	SO1 SO2 SO3 SO4
3.8	Long delays for patients accessing Spinal Services	3 mths	12	12	12	9	desc							3	
3.9	Access to hospital site and current car parking constraints across the trust	3 mths	esc	tbc	12	12	12	9	9	9	9	9	↔	6	
3.10	Capacity of AICU/CICU does not meet demand	3 mths				esc	12	12	12	12	12	12	↔	6	
3.11	potential risk of failing to respond to the results of diagnostic tests	tba								esc	8	8	↔	tba	
3.12	potential risks to handover of treatment through poor communication of discharge summaries'	tba								esc	tbc	tbc	new	tba	
4.2	Lack of robust plans across healthcare systems	3-12 mth	16	16	16	16	16	16	16	12	12	12	↔	6	SO2 SO3
4.3	Loss of Commissioner alignment of plans between the Trust and commissioner	+ 12 mths	6	6	6	desc								6	
5.3	Negative media coverage relative to our competitors	+ 12 mths	4	4	4	4	4	4	4	4	archive			3	SO3 SO5
6.1	Difficulty recruiting and retaining high-quality staff in certain areas.	3-12 mth	16	16	16	16	16	16	16	16	16	16	↔	8	
6.2	Low levels of staff satisfaction, health & wellbeing and staff engagement	3-12 mth	8	8	8	8	8	8	8	8	8	8	↔	6	
6.3	Insufficient provision of training, appraisals and development	3-12 mth	9	9	9	9	9	9	9	9	9	9	↔	3	SO1 SO3 SO5
6.5	Staffing in maternity service	3-12 mth	9	9	9	9	9	9	9	9	9	9	↔	4	
6.6	Failure to comply with current supervisor of midwives ratios	3-12 mth	12	12	12	12	12	12	12	12	desc			4	
6.7	Staffing in Theatres	3 mths			esc	12	12	12	12	9	9	9	↔	3	
7.5	Failure to obtain the clinical advantages from EPR	3-12 mth	8	8	8	8	8	8	8	8	8	8	↔	6	
7.8	Building issues in the Women's Centre could lead to patient safety issues	3 mths	12	12	12	12	12	12	12	12	12	12	↔	3	
7.9	Fire detection systems in the JR require upgrading	3 mths	12	12	12	12	12	9	9	9	9	9	↔	3	
7.10	Failure of laboratory accreditation process due to poor pathology sample store facilities	3 mths	12	12	12	12	12	12	12	12	archive			3	SO2 SO3 SO4
7.12	Failure to Generate hot water and heat in retained parts of the Churchill estate	3 mths	12	12	12	12	12	12	9	9	9	9	↔	3	
7.13	Failure to resolve Churchill PFI contractual and service performance issues	3-12 mth	12	12	12	12	12	12	12	12	12	archive		6	
7.14	UPS power supply in Churchill theatres fails to operate correctly	tba								esc	10	archive		5	
8.1	Failure to establish sustainable regional networks	+ 12 mths	4	4	4	4	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	6	6	6	↔	3	

RISK ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating July 2015 L	Risk Rating July 2015 C	Risk Rating Sept 2015 L	Risk Rating Sept 2015 C	Trend	Last Review	Target L	Target C
Principal Risk 1: Failure to maintain the quality of patient services.													
1.1	CS	IBP	Patients experience indicators may show a decline in satisfaction with quality. **Cause:** • Negative experiences reported through annual national CQC Patient Survey Programmes and friends and family test **Effect:** • Failure to meet CQUIN goals **Impact:** • Potential loss of reputation & patient experience. • Negative media coverage	**Controls** • Improvements planned for improved patient feedback systems via a tender process due to complete December 2014. • Numerous examples at service level of patient experience information being collected and acted upon (patient stories). • Quality metrics in monthly Divisional Quality Reports • Peer review. • Patient feedback via complaints, complements & claims	Over 12 Mths	2	3	2	3	↔	09/15	2	2
						6		6				4	
1.2	E W	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 and regular monitoring by TME • Quality Strategy and implementation plan • Values • Internal Peer Review Programme phase two being developed. • Monthly quality dashboards and other quality data relating to ward care • Divisional inspection visits & declaration of compliance. • Director walk round process • Executive Director reports on safety issues and changes in service reported to the Board • CQC Assure being reviewed and evaluated for new regulations	3 -12 mths	2	2	2	2	↔	09/15	1	2
						4		4				2	
1.3	TB	IBP	Potential failure to meet the Trust's Quality Strategy goals. **Cause**: • Lack of staff knowledge in relation to the Quality Strategy. **Effect**:	**Controls** • Quality Strategy in place being reviewed and update (Jan 15). • Implementation Plan to embed Strategy monitored via Quality Account.	Over 12 mths	2	3	2	3	↔	09/15	2	2
						6		6				4	

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			• Front line staff fails to monitor and measure quality in line with the strategy. **Impact:** • Potential loss of reputation • Goals are not achieved.	• 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 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) • Risk Summits • HSMR and SHMI Review • Clinical Governance Committee review • Updated escalation processes								
1.6	PB	RA	Poor management of bed frames and other associated equipment **Cause** • Bed Frames: Centred on the change to regulations due to take place from April 2013. **Effect** • Bed Store / Repair sites: In relation to the suitability of the current locations. **Impact** • Risks to compliance with CQC, H&S and Fire regulations	**Controls** • Current store location managed by named individual in operations team. • Process for the tender of bed contract underway **Contingency** • Bed frame contract tender being scoped and specification in place to include Lo beds, bariatric and birthing beds	3 -12 mths	3	3 9	3	3 9	↔	09/15	2	2 4
1.9	TB	Esc	CAS Alert NPSA 2011/PSA001: Safer spinal (intrathecal), epidural and regional devices Part A (applies to non-chemotherapy spinal (intrathecal) bolus doses and lumbar puncture) **Cause:** • Risk of wrong route of administration	• Steering group for this alert has an action plan to introduce safer devices first within anaesthesia (from October 2014), then within neurosciences and for lumbar puncture. This follows a clinical evaluation and a change to non	3 -12 mths	2	4 8	2	4 8	↔	09/15	1	3 3

RISK ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating July 2015 L	Risk Rating July 2015 C	Risk Rating Sept 2015 L	Risk Rating Sept 2015 C	Trend	Last Review	Target L	Target C
			due to compatibility of spinal devices with intravenous Luer connectors. **Effect** • Failure to comply with national guidance • Patient harm **Impact:** • Patient safety and potential loss of reputation • Noncompliance with core safety standards e.g. CGC rating	Leur devices for chemotherapy this July. • Confirming where spinal needles are used for other indications to provide a suitable alternative device									
1.10	TB	*Esc*	CAS Alert NPSA 2011/PSA001: Safer spinal (intrathecal), epidural and regional devices Part B (applies to spinal infusions, all epidural and regional blocks) **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 fully implement NPSA recommendations re introduction of safe connectors as some components are not commercially available. (NB. The epidural infusions currently available either use an iv spike to connect the infusion bag hence an iv medication could be given via the wrong route. Or the epidural infusion available with a different connector do not offer a local anaesthetic and opiate combination so would require addition in clinical areas which conflicts with NPSA alert on epidural infusions [2007]) **Effect** • Failure to comply with national guidance • Patient harm **Impact** • Patient safety and potential loss of reputation • Noncompliance with core safety standards e.g. CGC rating	• Epidural guidelines are in place for children and adults and reviewed regularly; staff training and competency assessments by the acute pain team; audits of epidural guidelines and results reported to the directorates as a quality metric. • Nerve block guidance is in development led by the Pain team. • Compliant epidural/regional block infusion devices for trust been purchased (but not meet full requirements of the alert). • Steering Group to work on an action plan to enable compliance once suitable devices and infusions are available. • Lead Pain Service Consultant and Nurse, Medicines Safety Pharmacist to meet 5.09.14 to review strategies to mitigate risk. • Action plan to be reviewed as ISO standard on non Leur connectables published, but not anticipated to be commercially available before early 2016.	3 -12 mths	3	4	4	4	↔	09/15	2	3
						12		12				6	

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1.14	TB	TME	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	• 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 • CQC Action Plan includes actions in relation to records Additional control added (TME 28 8/14): • E Learning Training Package to be implemented • E prescribing roll out in progress	3-12 mths	3	3	3	3	↔	09/15	2	2
						9		9				4	
1.15	CS	RA	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 • Loss of income from CQUIN targets	• Management of temporary workforce efficiency reported to Workforce Optimisation Group Chaired by the Director of OD and Workforce. • Daily monitoring of safe staffing levels at all sites and staff moved to mitigate clinical risk. • Monitoring of all temporary staff including medical locums and nursing on the NHSP platform and reporting to the temporary staffing Workforce Optimisation Group • Use of recognised agencies in framework , with exception of Thornbury. • Local induction of agency staff according to Policy and documented • Recruitment campaign in EU • Vacancy levels monitored monthly both through ESR and manually via shared drive by matrons and divisional nurses. • Long lines of rostered bank/agency I n place, and most	within 3 mths	3	3	3	3	↔	09/15	2	3
						9		9				6	

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				expensive agency staff replaced by new recruits.									
1.17	TB	Peer review	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 • Loss of income from CQUIN targets	• TME to ensure monitoring of local divisional actions (good progress noted) • 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. • Positive outcome from CQC Report • Latest Quality Report to Board showed positive results across range of medicine matrix	3 -12 mths	4	1	4	1	↔	09/15	3	1
						4		4				3	
1.18	PB	Risk summit	Patient transportation and co-ordination of care **Cause:** • 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	• Deputy Director of Clinical Services consulting with both CCGs and 3rd Party providers on contractual agreements • Formal meeting held with ARIVA, Oxford CCG and Trust to discuss actions • Long term plan for contract(s) to be held between Trust and Service Provider • OCCG consultation about their non-urgent patient transport which ended on 8th August 2014 outcome being reviewed • Monthly meetings with SCAS and	3-12 mths	2	3	2	3	↔	09/15	2	2
						6		6				4	

RISK ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating July 2015 L	Risk Rating July 2015 C	Risk Rating Sept 2015 L	Risk Rating Sept 2015 C	Trend	Last Review	Target L	Target C
				CCG regarding transport issues • Internal handover of patients across site addressed by Care 24/7 project – actions completed									
1.19	TB	Risk summit	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 pneumonia • National clinical audits suggested local deficiencies in documentation of risk stratification scores, and poor adherence with antimicrobial guidelines. **Cause:** • Poor clinical coding practice does not support assurance of quality of management. **Effect / Impact:** • suboptimal clinical outcomes • Reputational damage. • Loss of income from CQUIN targets	• Recognition that coding practice (and over use of term 'acute bronchitis' in this patient group) was a contributory factor – improved training of medical staff [on-going]. • Revision of antibiotic guidelines [complete]. • Introduction of Care Bundle [on-going]. • Develop standard in relation to radiology reporting times for admission chest x-rays [on-going]. • Develop improved level 2 care facilities on the John Radcliffe site [on-going]. • Respiratory Review presented to TME in November 2014.	3-12 mths	2	4 8	2	4 8	↔	09/15	1	3 3
1.20	TB	Risk summit	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.	• Implementation of Think Glucose approach across the Trust [on-going] • Enhanced staffing [business case approved] • Enhanced training and revision in training model [on-going] • Use of IT to facilitate identification and management of patients with diabetes [on-going] Additional control added (TME 28 8/14):	3-12 mths	3	3 9	3	3 9	↔	09/15	1	3 3

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			• Reputational damage· .	• TME monitor progress against action plan • Actions built into CQC Action Plans and also monitored via TME									
1.2 1	PB	Risk summit	Out of Hours Care (Care 24/7 Project) **Cause:** • 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 areas. **Effect / Impact:** • suboptimal clinical outcomes, • poor staff and patient experience • reputational damage	• A series of risk summits held to agree principles and identify solutions for each site • Care 24/7 Programme in place monitored via TME Additional control added (TME 28 8/14): • A series of work streams are in place and programme managed by Associate Director of Clinical Services • Out of hours rota now available via the Intranet to improved communication • Key site leads in place	3-12 mths	3 9	3	3 9	3	↔	09/15	2 4	2
1.2 2	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 **Impact:** • Reputation of the Trust and financial penalty possible	• Clear identification of current cylinder storage areas • Sharing gas cylinder storage belonging to A&E dept. (located adjacent to PICU storage room.). • Raised with Estates, recognised as wider problem and escalated	3-12 mths	2 8	4	2 8	4	↔	09/15	2 6	3
1.2 4	AS	Esc	Failure of accurate reporting & poor data quality due to implementation of the Electronic Patient Record (EPR) Tie failure between EPR and CRIS **Cause:** • Lack of adequate training on EPR • Ad hoc solutions offered to each service without understanding the consequences **Effect** • Consultants not added to CRIS in a timely fashion	• Radiology is reporting all ward tie failures, new consultants to IM&T for resolution. • Radiology is no longer rejecting requests without first contacting the clinician to ensure that they are aware of the issues. • Teams advised to revert to Pink cards (if OP) as this is not live yet, until the issues are resolved. • Meetings scheduled 20th June to discuss the Tie failures with CRIS	3-12 mths	2 6	3	2 6	3	↔	09/15	1 3	3

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			• Referrals not entered accurately or processed (if order comm) to the correct referrer • Incorrect referral location sent to CRIS • Examinations are not booked and reports not sent to the appropriate referrer **Impact:** • Negative patient experience and impact on care • Potential loss of reputation	and ensure a pathway between EPR and CRIS. • Project initiated to reconcile consultant list on CRIS with that on the EPR and to put in place arrangements to keep it up to date. • Divisional risk score reduced.									
1.26	TB	Esc	Failure to comply with NICE Quality Standard 13 End of Life Care for Adults. The following standards are currently non-compliant: **Standard 1**:.identified in a timely way **Standard 9:** experience a crisis at any time receive prompt, safe and effective urgent care appropriate to their needs and preferences. **Standard 11**:.have their care coordinated and delivered in accordance with their personalised care plan, including rapid access to holistic support, equipment and administration of medication. **Standard 16:** Generalist and specialist services providing care have a multidisciplinary workforce sufficient in number and skill mix to provide high-quality care and support.	**Key controls**: • Guidance sought from Leadership Alliance for care of dying people following withdrawal of the Liverpool Care Pathway • Business case for increase in specialist palliative care provision • Group led by Medical Director and Chief Nurse to address the issue	within 3 mths	4	3 12	4	3 12	↔	09/15	1	3 3
1.27	CS	ESC	Revalidation for nurses and midwives – failure to comply with national NMC guidance. **Cause:** • Processes and infrastructure not in place and unclear guidance. **Effect:** • Nurses will be unvalidated and unregistered **Impact:**	• Revalidation working group has been established to scope the NMC requirements, resources required and planning for 2016 • Business case for resources is being submitted to TME in April 15. Benchmarked against the Shelford Group. • Lead Nurse for Safe Staffing and Deputy Chief Nurse have led a	3-12 mths	4	2 8	4	2 8	↔	09/15	1	2 2

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			• Reputational damage and nurses not registered to practice as professional nurses. Service impact due to lack of registered practitioners	communication strategy across the Trust which is ongoing • Pilot sites review awaited Spring 15 • Implementation plan scoped working with HR lead • Updated Trust position with preparedness papers presented to Executive Directors and TME March 15 • *KPMG audit highlights actions									
1.28	TB	ESC	Failure to demonstrate compliance to the duty of candour **Cause:** • Lack of a robust system to capture data **Effect:** • Difficult to track and demonstrate level of compliance **Impact:** • Compliance with Duty of Candour regulations	• It is proposed that DATIX be developed to capture data on conversations held and follow up letters	3-12 mths	4	3 12	4	3 12	↔	09/15	1	3 3
1.29			*Unsuitable office and outpatient accommodation in Clinical Genetics Department at the Churchill* ***Cause:*** • *Poor facilities, extremely adverse estate and poor environment* ***Effect:*** • *Potential and actual damage to equipment and patient records.* • *Poor working conditions which are uncomfortable for staff.* • *Inability to perform effective patient consultations due to uncomfortable temperature and requirement to go elsewhere to take blood samples.* ***Impact:*** • *Unsatisfactory patient experience*	• *Heaters and fans are available to support staff with extreme temperatures.* • *Alternative phlebotomy space identified in the Respiratory Day Case Unit to enable blood samples to be taken in an appropriate environment without the need for patients to return for a future appointment with the phlebotomy service.* • *New accommodation scoped with the Estates department and plans are being drawn up for the service to relocate to the NOC site. However, there is no firm plan for space nor a move date confirmed.* • *A business case has been drafted*	3-12 mths		Esc	**5**	**3** **15**	new	09/15	2	1 3

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			leading to complaints. *Poor morale of staff which also impacts on patient experience*	*for the relocation.* • *Problems with lack of progress have been escalated to executive level and a further update is awaited.* *Plan to archive notes underway to reduce trip hazards in the department.*									
Principal Risk 2: Failure to maintain financial sustainability.													
2.1	M M	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. • Over-performance on contract against non-elective & A&E activity • If the Trust carries out levels of activity that exceed those within the OCCG contract **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. • Business continuity • Revised CIP QIA process • Improved reporting of cross divisional CIPs • CIP Steering Group • Revised project management arrangements	3 -12 mths	4	4 16	4	4 16	↔	09/15	3	3 9
2.2	M M	IBP	Potential failure to effectively control pay and agency costs. **Cause:** • Tariff reduction requires internal efficiencies that may not be sustainable. • Pension cost pressures not funded in tariff • Negative changes to specialist services tariffs • Lack of knowledge re safe staffing levels. **Effect:** • Poor financial controls destabilise the financial position.	• Sickness management and monitoring • Workforce plans • Vacancy controls • Business Planning • Individual divisional mitigations recorded and in place – to be monitored and reported via TME (as noted 7/8/14) • Additional financial controls around tighter signoff of agency usage at a higher level. • Strategy over use of financial	Within 3 mths	4	4 16	4	4 16	↔	09/15	3	3 9

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			Impact: • Employee engagement and perceptions of safety	• contingency • Full range of policies improved to help with the management of agency spend.									
2.4	M M	IBP	Services display poor cost-effectiveness. **Cause:** • Ineffective and insufficiently granular planning. • Pension cost pressures not funded in tariff • Negative changes to specialist services tariffs **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. Additional control added (TME 28 8/14): • Individual divisional mitigations recorded and in place – to be monitored and reported via TME (as noted 7/8/14) • Additional financial controls around budget management and review of financial position • Strategy over use of financial contingency	3 -12 mths	3 6	2	3 6	2	↔	09/15	2 4	2
2.6	M M	IBP	Impact of changes to specialist services tariff **Cause:** Lack of certainty in tariff **Effect**: Ability to accurately financial plan **Impact:** Uncertainty in financial position, further costs pressures lead to increase CIP Schemes	• Increased scenario planning , consideration of options. • Budget setting processes in place linked to business planning. • Divisional efficiency meetings • Sensitivity analysis for all plans / business cases relating to specialist services	3 - 12 mths	4 16	4	4 16	4	↔	09/15	2 8	4
2.7	*M* *M*	*IBP*	*Potential failure to deliver the financial outturn agreed with the TDA* ***Cause*** • *Failure to effectively control Pay and non-pay expenditure and remain within agreed budgets* • *Failure to deliver agreed CIP Targets* • *Failure to deliver agreed Commissioning*	***Internal:*** • *Vacancy and Agency Control procedures* • *Monthly performance review with each division* • *Monthly CIP Tracker review* • *Strategy over use of financial*	Within 3 mths	Esc		4 16	4	N e w	09/15	3 9	3

RISK ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating July 2015 L	Risk Rating July 2015 C	Risk Rating Sept 2015 L	Risk Rating Sept 2015 C	Trend	Last Review	Target L	Target C
			Income Targets ***Effect*** • *Additional controls and mitigating actions to be introduced* ***Impact*** • *Potential reputational damage to the Trust* • *Failure to meet contractual requirements* • *Failure to gain FT status* • *Reductions in services or the level of service provision in some areas* *Employee engagement and perceptions of safety*	*contingency* • *Monthly Finance reports to Trust Board / FPC.* • *Monthly review by Transformation and CIP Steering Group and by Income Group* ***External:*** • *Monthly reporting to TDA* • *Monthly reporting to commissioners* • *Actions taken:* • *Controls on agency expenditure tightened* • *Controls on authorisation of expenditure tightened* • *Q1 "wash-up" process with revised targets set for each division for the current financial year* • *Specialist advice brought in to maximise pharmacy savings this yr* • *Review of financial flexibilities undertaken*								
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	**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	Within 3 mths	5	3 = 15	5	3 = 15	↔	09/15	3	4 = 12

RISK ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating July 2015 L	Risk Rating July 2015 C	Risk Rating Sept 2015 L	Risk Rating Sept 2015 C	Trend	Last Review	Target L	Target C
			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.	• 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 • Integrated Care Alliance in development phase **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 work streams – 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.	**Internal** • Data quality overseen by Information Governance and Data Quality Group • Weekly EPR meetings with clinical & operational staff & Suppliers • Clear programme of work to improve data quality, workflow, training & fixes into EPR. • Data Quality benchmarked against other Trusts • Risk assessed key clinical areas to reduce impact of patient care • Regular operational performance meetings address RTT data quality	3-12 mths	2	3	2	3	↔	09/15	2	2
						6		6				4	

RISK ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating July 2015 L	Risk Rating July 2015 C	Risk Rating Sept 2015 L	Risk Rating Sept 2015 C	Trend	Last Review	Target L	Target C
			• 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. • Regular data quality internal audits undertaken. • Programme of Divisional data quality audits undertaken on a quarterly cycle. • Director Walk rounds. • 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 • Update paper provided to Board on six-monthly basis • False or Misleading Information provisions incorporated within data quality assurance framework • Data quality, quality account and PBR audits reported to Audit Committee **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:**	**Internal `** • Daily & weekly monitoring of key access targets; Weekly EPR meetings; Monthly EPR	3-12 mths	3 4 12		3 4 12		↔	09/15	2 3 6	

RISK ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating July 2015 L	Risk Rating July 2015 C	Risk Rating Sept 2015 L	Risk Rating Sept 2015 C	Trend	Last Review	Target L	Target C
			• 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	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 • Whole system plan to reduce emergency activity in place								
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	**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	3-12 mths	3	3 9	2	3 9	↔	09/15	1	3 3

RISK ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating July 2015 L	Risk Rating July 2015 C	Risk Rating Sept 2015 L	Risk Rating Sept 2015 C	Trend	Last Review	Target L	Target C
			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.	• Monthly Divisional performance meetings; Monthly reporting & monitoring access targets through Trust Management executive & Trust Board; • Implemented MSK Hub for demand management • Plans in place to deliver improved performance with clear trajectory into new financial year. **External** • OUH senior manager attendance at Planned care Programme Board & Long Term Conditions • Bimonthly OCCG/Clinical Directors meeting for Planned Care delivering QIPP • Weekly 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 • Poor staff morale	**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; • Plans in place to deliver improved performance with clear trajectory into new financial year. **External** • OUH senior manager attendance at Planned care Programme Board & Long Term Conditions	3-12 mths	3	3 9	3	3 9	↔	9/7/15	2	3 6

RISK ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating July 2015 L	Risk Rating July 2015 C	Risk Rating Sept 2015 L	Risk Rating Sept 2015 C	Trend	Last Review	Target L	Target C
			• Patients not seen in a timely way **Impact:** • Failure to meet contractual requirements, • Failure to gain FT status increased costs. • Increased costs of temporary staff & in additional capacity.	• Bimonthly OCCG/Clinical Directors meeting for Planned Care delivering QIPP • Monthly Contract meeting with PCT • Weekly teleconference calls									
3.7	PB	IBP	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	• Robust business planning approval processes • Strong financial case to justify investments • Board review of investments to ensure affordability over time • Investment Policy (for post FT authorisation) • Approval of Littlemore planning application	3-12 mths	3 9	3	3 9	3	↔	09/15	2 6	3
3.9	MT	ESC	Access to hospital site and current car parking constraints across the trust have an impact on operational performance. **Cause:** Poor access to hospitals sites **Effect**: Patient experience delays in getting on site **Impact**: Poor patient experience, complains and late running of appointments	• Interim arrangements being put in place to address short term road / building works • Longer term negotiations with council re potential solutions. • Trust Management Executive approved introduction of barriers, other recruitment and retention initiatives in relation to access to site for staff. • Consideration should be given to the re-profiling of outpatient clinics to better balance demand over the course of the week	within 3 mths	3 9	3	3 9	3	↔	09/15	2 6	3
3.10	PB	ESC	Capacity of AICU/CICU does not meet demand **Cause**: 19 level 3 ICU beds funded within CSS across JR and CH. There is no dedicated HDU at JR and CH. This does not meet demand and when benchmarked against other Shelford Trusts, the number of beds is 50% less. **Effect**: The service often runs over 100%	• Business case being written to support the funding required to open the remaining five unfunded beds on AICU/CICU • Critical care strategy being devised supporting a vision for critical care within OUH, this includes short term plans for the opening of a high dependency	within 3 mths	3 12	4	3 12	4	↔	09/15	2 6	3

RISK ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating July 2015 L	Risk Rating July 2015 C	Risk Rating Sept 2015 L	Risk Rating Sept 2015 C	Trend	Last Review	Target L	Target C
			capacity and at times does not meet demand. **Impact:** • Patients requiring critical care may be unable to access, • financial loss to the Trust, • increased staff turnover, sickness.	unit • Agreed process in place for the bed management team to ensure that ICU patients are discharged in a timely manner • Attempt to bring in 'long lines' of agency to supplement staffing, particularly over winter									
3.11	PB	OCCG Risk	Potential risk of failing to respond to the results of diagnostic tests **Cause:** • Inconsistencies in the endorsement of results process at the OUHT **Effect:** • **Impact:** •	TBA – new risk under development	tba	4	2 8	4	2 8	↔	09/15		tba
3.12	PB	OCCG Risk	Potential risks to handover of treatment through poor communication of discharge summaries **Cause:** • Delays in the discharge summary process and a lack of a comprehensive system to manage test results at the OUHT	TBA – new risk under development	tba		Esc		TBC	new	09/15		tba
Principal Risk 4: Failure to achieve sustainable contracts with commissioners													
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 • Loss of income from CQUIN targets • Over-performance on contract against non-elective and A&E activity **Impact:**	• QIPP Programme Framework. • Risk management provisions in contract • Collaboration with Oxford Health. • Commissioner alignment meetings • Relationship management process. • Further letters of support from commissioners in relation to FT application • IBP & LTFM informed by commissioner strategies. • Commissioner sign up to major business cases.	3-12 mths	3	4 12	3	4 *12*	↔	09/15	2	3 6

RISK ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating July 2015 L	Risk Rating July 2015 C	Risk Rating Sept 2015 L	Risk Rating Sept 2015 C	Trend	Last Review	Target L	Target C
			• Financial deficits for commissioners and OUH • Adverse impact on quality and service performance. • Fines and denial of CQUIN funding by Wessex and other Commissioners	• Full involvement in commissioner led reconfiguration initiatives. • System leadership structure in place • Strategy refresh being undertaken • Development of system-wide strategy initiated									
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:** • National shortages in some staff categories • Economic - cost of living; transport; proximity of other markets (e.g. London) • Failure to attract staff with the requisite skills and experience • Failure to provide sufficient personal and professional development opportunities • Access to site and current car parking arrangements **Effect:** • High-vacancy rate and agency staff use • Potential impact on continuity of care and quality outcomes, with additional pressure on staff • Increased additional costs **Impact:** • Potential impact on service provision, quality of care and patient experience • Potential increases in sickness absence • Potential impact on ability to deliver aspects of the Annual Plan .	Targeted interventions focused in six key areas: • Increasing the substantive workforce • Mitigating high cost of living • Applying targeted recruitment and retention incentives • Widening participation • Improving professional development and career opportunities • Creating and sustaining the right environment Associated action plan established. Overseas nurse recruitment programme Workforce Optimisation Steering Group (NB controls fully reviewed and updated) (NB specific initiatives in certain Divisions)	Within 3 mths	4	4 16	4	4 16	↔	09/15	2	4 8
6.2	MP	IBP	Low levels of staff satisfaction **Cause:** • Poor local leadership and management practices • Poor staff engagement • Insufficient recognition • Pressures of work	• Comprehensive staff engagement interventions established • Staff Recognition Awards scheme expanded • Range of retention initiatives being implemented • Partnership working via JSCNC	3-12 mths	2	4 8	2	4 8	↔	09/15	2	3 6

RISK ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating July 2015 L	Risk Rating July 2015 C	Risk Rating Sept 2015 L	Risk Rating Sept 2015 C	Trend	Last Review	Target L	Target C
			• Working environment • Economic factors, such as levels of pay **Effect:** • Low levels of staff involvement. In decision-making and change initiatives • Poor staff motivation potentially higher sickness rates and increased staff turnover **Impact:** • Failure to deliver required activity levels and loss of reputation • Inability to embed new ways of working. • Increased costs in relation to agency spend to cover potential increases in sickness.·	and LNC • Established Staff Health and Wellbeing Strategy and Committee • Comprehensive Occupational Health Service • Divisional Staff Survey Response Plans. • Development of local staff surveys and exit interview process • Regular Pulse surveys • Employee Assistance Programme purchased and being implemented								
6.3	MP	IBP	Insufficient provision of appropriate education and learning development opportunities **Cause:** • Insufficient funding causes inability to support training and development **Effect:** • Reduced staff motivation and morale • Increased staff turnover **Impact:** • Potential impact on ability to attract, recruit and retain high quality staff • Potential impact on quality of care and patient experience • Loss of reputation	• CPD and access to national development programmes • Multi-professional Education and Training Strategy in development • Education and Training Committee	3-12 mths	3 9	3	3 9	3	↔	09/15	1 *3*	3
6.5	CS	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	• Zero hours staff are available to cover shifts • Intrapartum toolkit in use to measure acuity of workload on a 4 hourly basis • Two hospitals covered by a senior member of staff on-call out of hours, with the rotation into acute from community midwives dependent upon activity levels determined through the use of Birth Rate+ tool .Gaps in staffing	3-12 mths	3 9	3	3 9	3	↔	09/15	2 4	2

RISK ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating July 2015 L	Risk Rating July 2015 C	Risk Rating Sept 2015 L	Risk Rating Sept 2015 C	Trend	Last Review	Target L	Target C
			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· .	are mitigated to ensure the unit is safe • Delays are discussed with the bleep holder, manager and consultant on call and plan put in place. • Escalation to Executive level to close any clinical area • Monitoring of sickness and occupational health input when appropriate • Recruitment is on-going with current vacancies 5.31 WTE and 3.33 waiting to start. • Current ratio of women to midwives 1:30 • Birth Rate + used to monitor acuity of patients against staff levels								
6.7	PB	ESC	Staffing in Theatres **Cause:** High staff turnover in theatres management. **Effect:** Poor morale, poor performance, potential for decrease in theatre efficiency. **Impact:** Loss of management control of theatres. Higher potential for cancellations. Impact of patient experience and ability to maintain operational targets.	• CSS Division reviewed CCTA structure and have split CCTA Directorate into 2 Directorates • Each Directorate will have business management support. • The 2 Clinical Director posts advertised and interview dates are confirmed. • A number of other vacant posts: to be recruited through an external agency / head hunters. • An Interim Theatre and Sterile Services Manager is in post until February 2015. • The Theatre Sister is acting up into Deputy Theatre Manager role.	3-12 mths	3	3 9	3	3 9	↔	09/15	1	3 3
Principal Risk 7: Failure to deliver the required transformation of services													
7.5	AS	IBP	Potential failure to obtain the clinical advantages from EPR. **Cause:** • Lack of clinical engagement	• Clinical roll-out commenced with order communications and admissions, discharges and transfers.	3-12 mths	2	4 8	2	4 8	↔	09/15	2	3 6

RISK ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating July 2015 L	Risk Rating July 2015 C	Risk Rating Sept 2015 L	Risk Rating Sept 2015 C	Trend	Last Review	Target L	Target C
			• 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 • 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	• Roll-out of e-Prescribing currently planned for September 2014 • 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 action plan being developed and signed off by TME 11/09/14) • Deep-dive benefits realisation project being undertaken with HSCIC. • New benefits realisation infrastructure being set up. Additional control added (TME 28 8/14): • Action Plans in place • Reported through Quality Matters • Roll-out of electronic prescribing and medicines management commenced on 6 October 2014. This will help to drive improvements in clinical engagement and data quality.								
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	• Additional education in relation to good practice processes • Regular monitoring of potential issues.	Within 3 mths	3	4 12	3	4 12	↔	09/15	1	3 3
7.9	MT	Esc	Potential risk posed by the fire detection	• Increase to regular testing of	Within	3	3	3	3	↔	09/15	1	3

RISK ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating July 2015 L	Risk Rating July 2015 C	Risk Rating Sept 2015 L	Risk Rating Sept 2015 C	Trend	Last Review	Target L	Target C
			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.	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. • Increased testing programme implemented • Power supply issues now addressed • Women's Centre systems upgraded. • Quote obtained for upgrade of level 0 and level 1 for potential inclusion in 15/16. Revised risk assessment in progress.	3 mths	9		9				3	
7.12	MT	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.	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. TDA approved CEF Full Business Case. Main in-patient areas in the retained estate are proposed to be progressively vacated over time. Day Surgery Re-development presented to TME November 2014.	Over 12 mths	3 3 9		3 3 9		↔	09/15	1 3 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. • High cost care • Poor relationship management. **Effect:** • Loss of support from referrers. • Aggressive competitive behaviour of	• Clinical network meetings. • Development of AHSN • Marketing and market research • Performance review process Additional control added (TME 28 8/14): • Internal processes developed to maintain partnership links	Over 12 mths	2 2 4		2 2 4		↔	09/15	1 2 2	

RISK ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating July 2015 L	Risk Rating July 2015 C	Risk Rating Sept 2015 L	Risk Rating Sept 2015 C	Trend	Last Review	Target L	Target C
			other organisations **Impact:** • Reduced referrals threaten clinical and financial sustainability.										
8.2	MP	IBP	Potential failure to provide adequate support for education via partnership arrangements. **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 • Improvement changes in TVHETV • Positive GMC survey results and monitoring of progress	3-12 mths	3	2	3	2	↔	09/15	1	3
						6		6				3	

Key Risk Owners:

PB	Director of Clinical Services (Paul Brennan)	MT	Director of Development and the Estate (Mark Trumper)
MP	Director of OD Workforce (Mark Power)	TB	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)	CS	Chief Nurse (Catherine Stoddart)