Oxford University Hospitals NHS
NHS Foundation Trust

Trust Board Public Meeting: Wednesday 11 May 2016

TB2016.52

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

Status	For discussion
History	The latest version of the full BAF and CRR was reported to the: • Audit Committee in April 2015 and September 2015, February and April 2016 with a verbal update in November 2015. • Trust Board in May and November 2015. • Trust Management Executive on 9 July 2015 and 12 November 2015, 28 January 2016 and 28 April 2016. Extracts of relevant risks from the CRR and the BAF were reported to: • Quality Committee on June, October and December 2014; February 2015. CRR: June and August 2015, CRR and BAF: December 2015, February 2016 and April 2016 • Finance & Performance Committee on June, October and December 2014; February 2015. CRR: June and August 2015, CRR and BAF: December 2015, February 2016 and April 2016 Updates of relevant risks from the CRR were reported to Trust Management Executive on 2 and 7 August, 24 September and 8 October 2015

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

Executive Summary

1. This paper presents the current updated Board Assurance Framework (BAF) and Corporate Risk Register (CRR) to the Board for review. Both documents are subject to regular review by the Board sub-committees and the Trust Management Executive. The report presents the BAF and CRR as a result of the year-end review.

Recommendations

2. The Board is asked to:
    - Use the BAF as a prompt to consider how assured you are as a committee that the risks are being managed;
    - Use CRR to ensure that identified controls are appropriate to mitigate the risks to a level within the Trust's Risk Appetite.

1. Introduction

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

1.2. The BAF and CRR have been reviewed in detail, with each risk owner and both documents are subject to regular review by the Trust Management Executive and the Board Sub-committees throughout the year.

2. Year End Review

2.1. The CRR is a risk management tool, which reflects the Principal Risks (PR) which potentially could have an impact upon meeting OUH Strategic Objectives (SO), as set out in the IBP 2013/14 – 2017/18.

2.2. Since April 2015, a number of risks have reached their target and have been either archived or de-escalated from the CRR. As a result of this, there are currently no risks included in the CRR under PR5.

2.3. Following discussions at the Board Sub-Committees, a need for a fundamental review of the BAF and CRR was highlighted in order that the risk descriptions and controls adequately reflect the PRs, risks, controls and the interdependencies between the risks.

2.4. As a result of those discussions, the Assurance Team are actively reviewing the way risks are recorded, presented and reviewed by the Board and its Sub-Committees. Any new methodologies will be aligned to the strategic review and would take into account inter-dependencies between individual risks moving into 2016/17.

Movement towards target

2.5. As part of the year-end review, we looked at movement towards target since April 2015. The most significant moves towards target over 2015/16 are presented in table 4. Please note the trend is reported in relation to movement over the last two quarters.

ID	Risk Description	Proximity	Y/E 15	Y/E 16	Trend	Target	Movement to target
3.1	Failure to reduce delayed transfers of care	3 mth	20	12	↔	*9*	8
2.6	Impact of changes to specialist services tariff	12 <mth	16	9	↓	8	7
2.2	Failure to effectively control pay and agency costs.	3 mth	16	9	↓	9	7
1.26	Failure to comply with NICE Quality Standard 13 End of Life Care	3 mth	12	6	↓	3	6
1.28	Failure to demonstrate compliance to the duty of candour	3-12 mth		6	↓	3	6
1.15	Excessive use of agency staff may pose a risk to the quality of service delivered	3 mth	9	4	↓	4	5
6.1	Difficulty recruiting and retaining high-quality staff in certain areas.	3mth	16	12	↔	8	4
1.27	Revalidation for Nurses and midwives and failure to comply with NMC Guidance	3-12 mth		4	↔	2	4
1.9	CAS Alert NPSA 2011/PSA001 Part A	3-12 mth	8	4	↓	3	4
1.19	Pneumonia - Risk Summit	3-12 mth	8	4	↔	3	4

ID	Risk Description	Proximity	Y/E 15	Y/E 16	Trend	Target	Movement to target
6.7	Staffing in Theatres	3 mth	12	9	↔	3	3
7.12	Failure to Generate hot water and heat in retained parts of the Churchill estate	3 mth	12	9	↔	3	3
3.7	Inability to meet the Trust needs for capital investment	3-12 mth	12	9	↓	6	3
1.20	Diabetes - Risk Summit	3-12 mth	9	6	↔	3	3
3.4	Failure to deliver National Access targets 18 weeks incomplete	3-12 mth	9	6	↔	3	3
6.3	Insufficient provision of training, appraisals and development	3-12 mth	9	6	↔	3	3
7.9	Fire detection systems in the JR require upgrading	3 mth	9	6	↔	3	3
1.14	Poor clinical records management processes have a potential impact in quality and safety	3 mth	9	6	↓	4	3

Table 1 Movement to target

2.6. The biggest movement towards target has been in the reduction of delayed transfers of care, which began the financial year with a risk score of 20, with an initial target of 12. Activities towards controlling the risk including 'Breaking the Cycle, the DToC Programme and system-wide initiatives have been reported through TME and Board sub committees and supported the progress towards target. There has been a review of the target with the risk lead and a new target of 9 is proposed to the TME.

3. Board Sub-Committee Discussions

3.1. At its meeting on 13 April the Quality Committee considered the principal risks assigned to the committee. The committee discussed a number of the issues in detail. At the end of the meeting the committee agreed that a number of issues discussed during the course of the business of the committee needed to be appropriately linked in the BAF and CRR. These included:

- Pressure on staff;
- Adequacy of resuscitation facilities in the Emergency Department
- Ability of staff to provide feedback when they leave the organisation
- Potential for patients to fall through the 'gaps' as identified in recent SIRIs and complaints.

3.2. The Finance and Performance Committee also received and reviewed the paper at its meeting on 13 April. The committee noted the content and agreed to consider the risks further following divisional presentations.

4. Recommendations

4.1. The Board is asked to:

- Use the BAF as a prompt to consider how assured you are as a committee that the risks are being managed;
- Use CRR to ensure that identified controls are appropriate to mitigate the risks to a level within the Trust's Risk Appetite.

Eileen Walsh

Director of Assurance

May 2016

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 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 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 , Nov 15 and Jan and Mar 16) • Reports from Quality Committee(L2) (May, July Sept, Nov 15 and Jan and Mar 16) • Audit Committee Report (L2) (May, July, Nov 15 and Jan 16) • Quality Report (L1) (May, July, Sept , Nov15) • Patient Story Report (L1) (May, July, Sept, Nov 15 and Jan and Mar 16) • Nurse staffing (L1) (in BQR) • Monitor Quality Governance Framework (L3) Update(May 15) • CQC Inspection Action Plan L3 (May 15) • Complaints & PALS Annual Report (L1)(Oct 15) *Assurance in previous year* • *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 3:7) KPMG Report (L3, June, Sept 15, Nov 15, Feb 16)	Monitor QGAF actions to be addressed	Map to performance indicators and corporate score show no gaps identified at 31/3/16	**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 surveys 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 , Nov 15 and Jan and Mar 16) • F&P report to the Board (L2) (May, July, Sept, Nov 15 and Jan and Mar 16) • Audit Committee Report to the Board (L2) (May, July, Sept Nov 15 and Jan 16) • TME report (L2) (March, July, Sept 15 Nov 15 and Jan and Mar 16) • 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, Nov 15, Feb 16)	None at 31/3/16	Reporting and review of cross divisional QIA of CIPS.	Revised process and reporting implement ed. **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. • Provider Action Plan (DTOC) • Monthly Chief Executives meetings. • Supported Hospital Discharge Service • Clinical Services Strategy. • Outpatient re-profiling. • Bi weekly performance meetings	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 • OCCG monthly Monitoring Review meetings (L3). • Chief Executive's Meetings (L2).	Reported to Board: • Finance reports (L1). (May, July 15, Sept Nov 15 and Jan and Mar 16 • Integrated Performance Reports (L1) (May, July, Nov 15)) • Audit Committee Report (L2) (May, July, Nov 15 and Jan 16) • TME Report (L2) March, May, July, Sept Nov 15 and Jan and Mar 16) • Foundation Trust Update (L2) (May, July, Sept 15) • Data Quality Report (L1) (May 15) • Operational Performance Trajectory(L1) (May, Sept 15) • Business Case involving commissioner report (L1) (July 15) • Emergency Preparedness (L2), Sept 15) • Urgent care improvement Plan • Winter Planning Nov 15) • Outpatients F&P *Assurance in previous year* • *Cardiac Surgery Review (L2) May 14)* Number of Assurances reported elsewhere (Level 1: 19, Level 2:5, Level 3:1) • KPMG Audit (L3, June, 15, Sept 15, Nov 15, Feb 16) • Audit Committee Deep Dive, (L1, Apr15)	None at 31/03/16	Board reporting of performance to be further reviewed for any potential gaps.	**Assurance Gap:** Development of Performance Information Team **Action owner:** AS – 31 March 2016	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, Nov15 and Jan and Mar 16) • Finance and Performance Report (L2) (May, Jul, Sept Nov15 and Jan, Mar 16) • Business Case involving commissioner report (L1) (July 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 31/03/16	None at 31/03/16	None at 31/03/16	(**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 Nov15 and Jan and Mar 16). • CE Briefing (L1) (May, July Nov15 and Jan and Mar 16) Number of Assurances reported elsewhere (Level 1: 4, Level 2:1, Level 3:0) • Audit Committee Deep Dive, (L1, Sept 14, Apr 15)	Commercial strategy for new and existing services Standard response to tendering of services	None at 31/03/16	**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, or Board sub-committee: • Integrated Performance Report (L1) (May, July, Nov 15;Jan, Mar 16) • HR & Workforce Report (L1) (May, Aug, Nov 15; Feb 16) • IG Review (L1), May, Nov 15) • Nurse staffing (L1) (May, Jul 15) • Medical Education Annual Report (L1 Sep 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)* • *Leadership and Talent Development Strategy Framework (L1) (Sept 14)* • *Education, Learning and Development Strategy (L1) (Nov 15)* 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 31/03/16	**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 fails 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, Nov15 and Jan and Mar 16) • Annual Review of Risk Management Strategy (L1) (Nov 15) • Annual Review of Assurance Strategy (L1) Nov 15) • Board Effectiveness (L1) (Jul 15) *Assurance from previous years:* • *Board Effectiveness (L1 May 13, Jul 15)* • *BGAF Evidence Review (L2) (May, 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 31/3/16	**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, Nov 15, Feb 16)	Oxford Integrated Care Alliance (still in developme nt)	None at 31/3/16	Oxford Integrated Care Alliance (still in developme nt) **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

Key Risk Owners:

PB Director of Clinical Services (Paul Brennan)	TB Medical Director (Tony Berendt)
MP Director of OD Workforce (Mark Power)	EW Director of Assurance (Eileen Walsh)
AS Director of Planning & information (Andrew Stevens)	CS Chief Nurse (Catherine Stoddart)
MM Director of Finance and Procurement (Mark Mansfield)	

Risk Dashboard 1: Rolling 12 month view (including previously archived risks)

ID	Risk Description	Proximity	y/e 15	May-15	Jun-15	Jul-15	Oct-15	Jan-16	Mar-16 (Y/E)	Trend	Target	Distance from Target
1.1	Patients experience indicators show a decline in quality.	+ 12 mths	6	6	6	6	6	6	4	↓	2	2
1.2	Breach of CQC regulations	3-12 mth	4	4	4	4	4	4	4	↔	2	2
1.3	Failure to meet the Trust's Quality Strategy goals.	+ 12 mths	6	6	6	6	6	6	6	↔	4	2
1.6	Poor management of bed frames and other associated equipment	3-12 mth	9	9	9	9	9	4	archived Jan		4	
1.9	CAS Alert NPSA 2011/PSA001 Part A	3-12 mth	8	8	8	8	8	8	4	↓	3	1
1.10	CAS Alert NPSA 2011/PSA001 Part b	3-12 mth	12	12	12	12	12	12	12	↔	6	6
1.12	Staffing levels and skill mix consistently monitored and reported to Board	3-12 mth	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	6	↓	4	2
1.15	Excessive use of agency staff may pose a risk to the quality of service delivered	3 mths	9	9	9	9	9	6	4	↓	4	0
1.17	Medicine Management	3-12 mth	4	4	4	4	4	4	16	↑	3	13
1.18	Patient transportation and co-ordindation of care	3-12 mth	6	6	6	6	6	4	archived Jan		4	
1.19	Pneumonia - Risk Summit	3-12 mth	8	8	8	8	8	4	4	↔	3	1
1.20	Diabetes - Risk Summit	3-12 mth	9	9	9	9	9	6	6	↔	3	3
1.21	Out of hours care (Care 24/7)	3-12 mth	9	9	9	9	9	9	9	↔	4	5
1.22	Storage of Cylinders in Neonatal	3-12 mth	8	8	8	9	9	9	9	↔	6	3
1.23	Failure in the Picture Archiving and Communication System (PACS)	3-12 mth	9	9	desc						8	
1.24	TIE failure between EPR and CRIS poses a risk to accurate data recording and reporting	3-12 mth	6	6	6	6	6	6	6	↔	3	3
1.26	Failure to comply with NICE Quality Standard 13 End of Life Care	3 mths	12	12	12	12	12	9	6	↓	3	3
1.27	Revalidation for Nurses and midwives and failure to comply with NMC Guidance	3-12 mth			esc	8	6	4	4	↔	2	2
1.28	Failure to demonstrate compliance to the duty of candour	3-12 mth			esc	12	9	9	6	↓	3	3
1.29	Unsuitable office and outpatient accommodation in Clinical Genetics Department at the Churchill	3 mths			Esc Jul	15	15	15	15	↔	3	12
2.1	Failure to deliver the required levels of CIP	3-12 mth	16	16	16	16	16	12	16	↑	9	7
2.2	Failure to effectively control pay and agency costs.	3 mths	16	16	16	16	16	12	9	↓	9	0
2.4	Services display poor cost-effectiveness	3-12 mth	6	6	6	6	6	6	6	↔	4	2
2.5	Failure to manage outstanding debtors	3-12 mth	6	4	desc						4	
2.6	Impact of changes to specialist services tariff	over 12 mths	16	16	16	16	16	16	9	↓	8	1
2.7	Potential failure to deliver the financial outturn agreed with the TDA	3 mths				new	16	12	9	To archive	9	0
3.1	Failure to reduce delayed transfers of care	3 mths	20	20	15	15	15	12	12	↔	*9*	3
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	↔	4	2
3.3	Failure to deliver National A&E targets	3-12 mth	16	16	12	12	12	12	16	↑	6	10
3.4	Failure to deliver National Access targets 18 weeks incomplete	3-12 mth	9	9	9	9	9	6	6	↔	3	3
3.6	Failure to deliver National Access targets Cancer,	3-12 mth	9	9	9	9	9	9	9	↔	6	3
3.7	Inability to meet the Trust needs for capital investment	3-12 mth	12	9	9	9	9	12	9	↓	6	3
3.9	Access to hospital site and current car parking constraints across the trust	3 mths	9	9	9	9	9	9	9	↔	6	3
3.10	Capacity of AICU/CICU does not meet demand	3 mths	12	12	12	12	12	12	12	↔	6	6
3.11	potential risk of failing to respond to the results of diagnostic tests	3 mths			esc	8	8	8	8	↔	4	4
3.12	potential risks to handover of treatment through poor communication of discharge summaries'	3 mths			esc	15	15	15	15	↔	4	11
4.2	Lack of robust plans across healthcare systems	3-12 mth	16	16	12	12	12	12	16	↑	6	10
6.1	Difficulty recruiting and retaining high-quality staff in certain areas.	3mths	16	16	16	16	16	12	12	↔	8	4
6.2	Low levels of staff satisfaction, health & wellbeing and staff engagement	3-12 mth	8	8	8	8	8	6	6	↔	3	3
6.3	Insufficient provision of training, appraisals and development	3-12 mth	9	9	9	9	9	6	6	↔	3	3
6.5	Staffing in maternity service	3-12 mth	9	9	9	9	9	9	9	↔	4	5
6.6	Failure to comply with current supervisor of midwives ratios	3-12 mth	12	12	12	archive					4	
6.7	Staffing in Theatres	3 mths	12	12	9	9	9	9	9	↔	3	6
7.5	Failure to obtain the clinical advantages from EPR	3-12 mth	8	8	8	8	8	8	8	↔	6	2
7.8	Building issues in the Women's Centre could lead to patient safety issues	3 mths	12	12	12	12	12	12	12	↔	3	9
7.9	Fire detection systems in the JR require upgrading	3 mths	9	9	9	9	6	6	6	↔	3	3
7.10	Failure of laboratory accreditation process due to poor pathology sample store facilities	3 mths	12	12	12	archive					3	
7.12	Failure to Generate hot water and heat in retained parts of the Churchill estate	3 mths	12	9	9	9	9	9	9	↔	3	6
7.13	Failure to resolve Churchill PFI contractual and service performance issues	3-12 mth	12	12	12	12	archived Aug				6	
7.14	UPS power supply in Churchill theatres fails to operate correctly	tba			esc	10	archived Aug				5	
8.1	Failure to establish sustainable regional networks	+ 12 mths	4	4	4	4	6	6	6	↔	2	4
8.2	Failure to provide adequate support for education.	3-12 mth	6	6	6	6	3	3	archived Jan		3	

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-16 L..C	Risk Rating Mar-16 L..C	Trend	Last Review	Target L..C
Principal Risk 1: Failure to maintain the quality of patient services										
1.1	CS	IBP	**Risk:** 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:** • Poor patient experience and standards of care **Impact:** • Potential loss of reputation & patient experience. • Negative media coverage	**Controls:** • Numerous examples at service level of patient experience information being collected and acted upon (patient stories). • Quality metrics in monthly Board • Quality Reports • Quarterly Divisional Dashboards • Peer review. • Patient feedback via complaints, complements and claims • Piloting individual action plans for extreme and high graded complaints • Developing a multidepartment triangulated approach to intelligence gathering in relation to safety, claims, inquests, patient experience, complaints and PALS • Structured review of monthly patient experience section of Divisional Quality Report presented at monthly Clinical Governance Committee.	Over 12 Mths	2 3 6	2 2 4	↓	05/04/16	1 2 2
1.2	EW	IBP	**Risk:** 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 4	2 2 4	↔	22/03/16	1 2 2
1.3	TB	IBP	**Risk:** Potential failure to meet the Trust's Quality Strategy goals. **Cause:** • Lack of staff knowledge in relation to the Quality Strategy. **Effect:** • Front line staff fail to monitor and measure quality in line with the strategy. **Impact:**	**Controls:** • Quality Strategy in place • Implementation Plan to embed Strategy monitored via Quality Account. • 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 of local metrics to monitor achievement of local quality goals. • RAG rated matrix in Board Quality Report	Over 12 Mths	2 3 6	2 3 6	↔	22/03/16	2 2 4

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-16 L..C	Risk Rating Mar-16 L..C	Trend	Last Review	Target L..C
			• Potential loss of reputation • Goals are not achieved	• Quality priorities linked to Quality Strategy and the contract • Safety Thermometer-developed to monitor Trust wide goals (e.g. pressure ulcer reduction – link to 1.1) • HSMR and SHMI Review • Clinical Governance Committee review • Updated escalation processes • SIRI Forum embedded • Quality Report revised and endorsed by QC went to public Board Jan 16 • Strategic review with development of improvement champions • CQC Assurance						
1.9	TB	Esc	**Risk:** 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 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	**Controls:** • Implementation of the change to non Luer connectors for spinal anaesthesia commenced 7 March with Obstetrics, JR; with the NOC then Churchill planned over the following weeks. Clinical champions leading within each clinical area with support from the company during roll out. • Luer spinal connectors have been removed from clinical area at time of change, with clear communication aimed to prevent loan or borrowing between clinical areas to manage the risk of two different connector systems existing in close proximity until all clinical areas converted to non Luer spinal devices. • Collating information during implementation on where and why spinal needles are used for non-spinal indications to agree suitable alternative devices. • Suitable devices and clinical champions for lumbar puncture identified. Implementation to start at Churchill to co-incide with spinal roll out. • Meeting 4th April to review progress and plan strategy for JR and HGH. □Lack of commercially available devices for full compliance with intraventricular drains (contributor in a recent closed SIRI)	3-6 mths	2 4 8	1 4 4	↓	22/03/16	1 3 3
1.10	TB	Esc	**Risk:** 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	**Controls:** • 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. • Adult Nerve infusion guidance in place, including use of intralipid for local anaesthetic induced cardiac arrest. • Medicines for neuraxial and intravenous route stored separately, additional safeguards on those areas permitted to keep neuraxial infusions as ward stock. • Compliant epidural/regional block infusion devices for trust been	12-24 mths suspect longer for neuroscience issues	4 4 12	4 4 12	↔	10/03/2016	2 3 6

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-16 L..C	Risk Rating Mar-16 L..C	Trend	Last Review	Target L..C
			introduction of safe connectors as some components are not commercially available. Adoption of the ISO 80369 standard has added further complexity to this issue. (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	purchased. • Steering Group to review action plan after Part A of alert implemented keeping abreast of communication from clinical advisory group advising NHS England on the safe introduction of device with non Leur connectors. ISO compliant devices are not anticipated to be commercially available before 2017. • Keep abreast of the development of alternative 'non –iv bag spike' • Following recent near miss incident the Pain Service Lead has contacted the Medical Director to request communication of the risks and existing safeguards.						
1.14	TB	Esc	**Risk:** Poor clinical records management processes may have a potential impact in quality and safety **Cause & Effect:** • Temporary & multiple notes • Transportation on notes between sites and notes availability • Security of notes storage in some areas • EPR rollout – effects completeness of notes and raises questions around the links with other systems. **Impact:** • Quality and safety may be effected	**Controls:** • Tracking system in place • EPR Roll-out continues, risks reviewed and included on EPR risk register as identified • Training programme in place and delivered. • Links to other IT systems being addressed • CQC Action Plan includes actions in relation to records now complete Additional control added (TME 28 8/14): • E Learning Training Package in place • E prescribing roll out completed With the exception of maternity at the JR, all E-Prescribing has been rolled out across the inpatient services throughout the Trust	3-12 mths	3 3 9	2 3 6	↓	22/02/16	2 2 4
1.15	CS	RA	**Risk:** 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:**	**Controls:** • Workforce Cost Improvement Group meeting with revised terms of reference .Chaired by Director of OD and Workforce • Twice daily monitoring of safe staffing levels on all sites and staff moved to mitigate clinical risk, shift by shift. • Monitoring of all temporary staff including medical locums and nursing on the NHSP platform and reporting to Workforce Optimisation Group • Use of recognised framework agencies. • Local induction of agency staff • Recruitment campaign in EU	within 3 mths	2 3 6	2 2 4	↓	03/04/16	2 2 4

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-16 L..C	Risk Rating Mar-16 L..C	Trend	Last Review	Target L..C
			• Failure to meet quality and safety standards • Negative media coverage **Impact:** • Potential loss of Safety and quality of care	• Induction programme in place for EU staff • Recruitment campaign ongoing for EU 2016-2017 • Plans in place to recruit outside of the EU for 100 specialist nurses •Divisional GM sign up for EU recruitment •Review undertaken of the EU nurse recruitment campaign has led to improvements to be shorter corporate induction 4-6 wks supernumery in the workplace •Multi strata recruitment design • Vacancy levels monitored monthly both through ESR and manually on EWE drive and compared to ESR • NHS England directive to have non-framework agencies reduced usage from 16% - 1% at OUH • Long line agency staff being gradually reduced as well as high cost agency • Government target of Nursing agency cap to be 8% of current workforce costs (*7% Dec 16*)						
1.17	TB	Peer Review	**Risk:** Aspects of medicines management were identified as an area that required improvement during the reviews across all divisions **Cause:** • This mainly related to include 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	**Controls:** • 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 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. • Trust-wide and Divisional action plans monthly monitoring via CGC.	3-12 mths	4 1 4	4 4 16	↑	22/03/ 16	3 1 3
1.19	TB	Risk Summit	**Risk:** 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	**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 [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].	3-12 mths	1 4 4	1 4 4	↔	22/03/ 16	1 3 3

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-16 L..C	Risk Rating Mar-16 L..C	Trend	Last Review	Target L..C
			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.	• Develop improved level 2 care facilities on the John Radcliffe site [on-going]. • Respiratory Review presented to TME in November 2014 .• Care bundle being implemented • Respiratory IP service now relocated to JR with potential to substantially improve on site options						
1.20	TB	Risk Summit	**Risk:** 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 [on-going] • Enhanced staffing in place • Enhanced training and revision in training model in place • Use of IT to facilitate identification and management of patients with diabetes [on-going • Diabetes Quality Group in place, meeting bi-monthly • TME monitor progress against action plan • Frequent Diabetes Group input to SIRI Forums and CGC • Diabetes Group input to SIRI Forums and CGC and development of governance framework [ongoing]	3-12 mths	2 3 6	2 3 *6*	↔	22/03/16	1 3 3
1.21	PB	Risk Summit	**Risk:** 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	**Controls:** • A series of risk summits held to agree Principals and identify solutions for each site • Care 24/7 Programme in place monitored via TME • 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 • Project Rolled out at the Horton and to be rolled out across the Trust • Phase 2 roll out to the Churchill Hospital near completion and will be followed by 6 month evaluation • Feedback from National Survey met 100% of emergency categories	3-12 mths	3 3 9	3 3 9	↔	23/03/16	2 2 4
1.22	PB	Esc	**Risk:** Storage of oxygen cylinders in Neonatal	**Controls:** • Clear identification of current cylinder storage areas	3-12	3 3 9	3 3 9	↔	23/03/	2 3 6

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-16 L..C	Risk Rating Mar-16 L..C	Trend	Last Review	Target L..C
			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	• Sharing gas cylinder storage belonging to A&E dept. (located adjacent to PICU storage room.). • Raised with Estates, recognised as wider problem and escalated • Empty gas cylinders to be recalled by all areas in Trust (currently a number of unreturned empty canisters leading to insufficient supply • All porters to use satellite storage areas and not take cylinders from critical care areas at any time • Emergency back-up cylinders to be chipped and tracked • Oxygen cylinders to be scanned in and out by porters to keep an audit trail • All porters to ensure they have sufficient ID access to the satellite storage area	mths				16	
1.24	AS	Esc	**Risk:** 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 • 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	**Controls:** • 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 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.	3-12 mths	2 3 6	2 3 6	↔	22/03/ 16	1 3 3
1.26	TB	Esc	**Risk:** Failure to comply with NICE Quality Standard 13 End of Life Care for Adults. The following standards are partially compliant with standards 1, 9, 11 and 16 not yet met 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.	**Controls:** • Guidance sought from Leadership Alliance for care of dying people following withdrawal of the Liverpool Care Pathway • Group led by Medical Director • Agreement with Sobell House charity fund for 2 years to support EOLC • EOLC Group meet monthly • EOLC Symposium late 2015	within 3 mths	3 3 9	2 3 6	↓	22/03/ 16	1 3 3

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-16 L..C	Risk Rating Mar-16 L..C	Trend	Last Review	Target L..C
			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.							
1.27	CS	Esc	**Risk:** Revalidation for nurses and midwives – failure to comply with national NMC guidance. **Cause:** • Processes and infrastructure not in place and unclear guidance. • NMC guidance stipulates that there is a 'grace period' to lapsed registrations and the 'readmission process' could be lengthy. Nurses cannot work as their registered licence during this time period. **Effect:** • Nurses will be unvalidated and unregistered **Impact:** • Reputational damage and nurses not registered to practice as professional nurses. Service impact due to lack of registered practitioners	**Controls:** • Revalidation working group established to scope and monitor the NMC requirements and compliance. • Business case for resources approved at TME in July 2015 and benchmarked against the Shelford Group. • Lead Nurse for Safe Staffing and Deputy Chief Nurse have led a communication strategy across the Trust which is ongoing • Pilot sites review published • Implementation plan scoped working with HR lead • Updated Trust position being presented to Trust Board in Jan 16 • KPMG audit undertaken with Good Assurance and actions completed • Implementation of Business Case including staff resources, monitoring, reporting and quality assuring nurses and midwives in the trust (4,750) are revalidation on time. • NMC confirmation revalidation commenced April 16 • Revalidation tool close now in use since December 15 and well-liked by staff, designed.in collaboration with ELMS supplier and Southern Health NHSFT. Roll out and training plan successful with support for lead nurse for safe staffing and nursing & midwifery regulation.. • Communication and Training Strategy in place and ongoing. • Quality Assurance panel established Feb 16 to monitor and advise on borderline cases and cases of concern for managers • HR personnel x 1 to be in post by April 16 to support monitoring of nurses undergoing revalidation and compliance and those imminently due to lapse	Within 3 mths	2 2 4	2 2 4	↔	03/04/ 16	1 2 2
1.28	TB	Esc	**Risk:** Failure to demonstrate compliance to the duty of candour **Cause:** • Lack of a robust system to capture data **Effect:**	**Controls:** • DATIX has been developed to capture data on conversations held and follow up letters. • Actions to address gaps in follow up letters • Siri Forum minutes verbal and written DoC on a weekly basis • CGC monitor DoC on Datix	3-12 mths	3 3 9	2 3 6	↓	22/03/ 16	1 3 3

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-16 L..C	Risk Rating Mar-16 L..C	Trend	Last Review	Target L..C
			• Difficult to track and demonstrate level of compliance **Impact:** • Compliance with Duty of Candour regulations	• Policy under development						
1.29	MM	Esc	**Risk:** 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:** • Poor morale of staff which also impacts on patient experience (alternative interim accommodation was sourced but staff refused to move).	**Controls:** • 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 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. • more alternative proposals have been worked up but are awaiting a decision from the capital reprioritisation group as to whether this can proceed. • Revised masterplan for Churchill Site in conjunction with 'Better Space for Patients'	3-12 mths	5 3 **15**	5 3 15	↔	23/03/16	2 1 3
Principal Risk 2: Failure to maintain financial sustainability										
2.1	MM	IBP	**Risk:** 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.	**Controls:** • Two year rolling CIP programme with contingencies in place • Transformation Team support in place • Divisional ownership of schemes • Budget setting and Performance Management Process (1/4ly review meetings across all divisions) • Contingency / mitigation plans formulated • Business Planning process • Contract negotiation. • Transformation & CIP Steering Group established • Strengthened Quality Impact Assessment process documented and introduced • Improved reporting of cross divisional CIPs • Periodic review by Internal Audit	Within 3 mths	4 3 *12*	*4 4* *16*	↑	31/03/16	3 3 9

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-16 L..C	Risk Rating Mar-16 L..C	Trend	Last Review	Target L..C
			• Potential loss in market share / external intervention							
2.2	MM	IBP	**Risk:** 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. **Impact:** • Employee engagement and perceptions of safety	**Controls:** • Sickness management and monitoring • Workforce plans • Vacancy controls • Enhanced vacancy control procedure including all vacancy control forms are reviewed by the Paul Brennan, Director of Clinical Services for approval • 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 contingency • Full range of policies improved to help with the management of agency spend. • Introduction of price caps & central controls over agency rates	within 3 mths	3 4 12	3 3 9	↓	31/03/16	3 3 9
2.4	MM	IBP	**Risk:** Services display poor cost-effectiveness. **Cause:** • Ineffective and insufficiently granular planning. • Pension cost pressures not funded in tariff • Negative changes to specialist services tariffs • service delivery is inefficient **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. • Potential cessation of activity	**Controls:** • 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	2 3 6	2 3 6	↓	31/03/16	2 2 4
2.6	MM	IBP	**Risk:** 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	**Controls:** • 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	Over 12 months	4 4 16	3 3 9	↓	31/03/16	2 4 8

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-16 L..C	Risk Rating Mar-16 L..C	Trend	Last Review	Target L..C
			pressures lead to increase CIP Schemes							
Principal Risk 3: Failure to maintain operational performance										
3.1	PB	IBP	**Risk:** Potential failure to reduce delayed transfers of care. **Cause:** • High numbers of people waiting for transfer from inpatient care. • Demography – ageing population with multiple long-term conditions • Failure of a joint approach to resolve delayed transfers of care across commissioners & provider organisations. • Recruitment difficulties in social care. • Poor access to community beds or provision care to maintain patients in their own home **Effect:** • Poor patient experience • Failure to meet Monitor standard • Loss of reputation • Capacity used exceeds plan • High costs of temporary capacity • Inpatient episodes funded at only 30% marginal rate • Delays in patient flow, patients not seen in a timely way. **Impact:** • Prevents reduction in acute capacity and costs • Delays to service integration and site moves • Financial impact from the requirement to maintain additional beds. • Financial impact through increased penalties • Quality of care provided to patients may fall. • Loss in reputation. • Direct impact on patient flow, 4 hour access standard	**Controls:** Management Executive & Trust Board monthly. Actions taken • Implemented Trust Supported Discharge scheme • Implemented Step-down wards within JR and Horton • Reviewed Escalation Procedures and triggers • 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: • DTOC Provider COO's meetings established to oversee implementation of 8 work streams – prime object to reduce DTOC • system closure group • Integrated Urgent Care Improvement Plan monitored by F&P and TME • System-wide DTOC plan implemented on 3 Dec 15 and runs until 31 March 16.	within 3 mths	4 3 12	4 3 12	↔	01/04/ 16	3 3 9
3.2	AS	IBP	**Risk:** 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	**Controls:** 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.	3-12 mths	2 3 6	2 3 6	↔	22/03/ 16	2 2 4

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-16 L..C	Risk Rating Mar-16 L..C	Trend	Last Review	Target L..C
			• 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 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.	• 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 • 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 rolled out • Integrated performance Report – assessment of data quality made on each indicator. Data Quality processes for non-standard reporting items developing. Reported to each Board meeting. • 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-CCG contract meeting • External reporting Monitor						
3.3	PB	IBP	**Risk:** 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	**Controls:** Internal ` • Weekly, Daily & weekly monitoring of key access targets; •Weekly internal DCS meeting • Daily whole system teleconference calls • Contingency & Recovery plans in place • Fortnightly performance meetings • Bi-Monthly Divisional performance meetings; Monthly reporting & monitoring access targets through Trust Management executive & Trust Board • Reviewed complaints/Patient experience at Board	3-12 mths	3 4 12	4 4 16	↑	01/04/ 16	2 3 6

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-16 L..C	Risk Rating Mar-16 L..C	Trend	Last Review	Target L..C
			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	• Review of Incidents at Board • Board walk rounds Monthly elective and Urgent Care Programme Board External • Monthly Contract meeting with CCGs • Weekly South Central Ambulance meeting operational in ED • Whole system plan to reduce emergency activity in place • Escalation triggers in place in ED, EAU and SEV • Urgent care improvement plan • Weekly CEO / COOs meeting • Weekly CCG meeting						
3.4	PB	IBP	**Risk:** Failure to deliver national access target 18 weeks incomplete' **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 • National requirement changed in October 2015 **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	**Controls:** Internal • 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; External • Bimonthly OCCG/Clinical Directors meeting for Planned Care delivering QIPP • Weekly teleconference calls • Director of Clinical Services attendance at resilience group • Monthly contract meeting with CCG • Weekly TDA conference calls • Weekly external monitoring at RTT • 18 week improvement plan	3-12 mths	2 3 6	2 3 6	↔	01/04/ 16	1 3 3

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-16 L..C	Risk Rating Mar-16 L..C	Trend	Last Review	Target L..C
			Impact: • Failure to meet contractual requirements, increased costs • Increased costs of temporary staff & in additional capacity.							
3.6	PB	Esc	**Risk:** Failure to deliver National Access targets Cancer Cause: • Lack of sufficient capacity/workforce • Implementation of Electronic Patient Record (EPR) disrupted data • Increase in demand or failure of health system to divert patients. • Poor bed availability due to delayed transfers of care. • Failure to deliver efficient patient pathways • Poor Productivity Effect: • Patients waiting longer – NHS Constitution • Poor patient experience • Loss of Reputation • High costs of temp capacity & workforce • Failure of access targets and Monitor's compliance standards • Poor staff morale • Patients not seen in a timely way Impact: • Failure to meet contractual requirements, • Increased costs of temporary staff & in additional capacity.	**Controls:** Internal • 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 • Monthly Contract meeting with PCT • Weekly teleconference calls •cancer improvement plan in place DCC / SRG	3-12 mths	3 3 9	3 3 9	↔	01/04/16	2 3 6
3.7	MM	Esc	**Risk:** 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 • Investment Policy (for post FT authorisation) • Approval of Littlemore planning application • a new prioritisation methodology is being discussed at the board seminar on 23 Sep for a subsequent prioritisation debate in October, and will go to the Board for approval in November	3-12 mths	4 3 12	3 3 9	↓	31/03/16	2 3 6

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-16 L..C	Risk Rating Mar-16 L..C	Trend	Last Review	Target L..C
			• Greater central controls over use of capital							
3.9	MM	Esc	**Risk:** 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	**Controls:** • 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 • Revised travel and transport policy is being developed. Staff consultation has completed Final draft of the policy is imminent with improved parking controls to be operational summer 2016	within 3 mths	3 3 9	3 3 9	↔	23/03/16	2 3 6
3.10	PB	Esc	**Risk:** 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% 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	**Controls:** • 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 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	within 3 mths	3 4 12	3 4 12	↔	23/03/16	2 3 6
3.11	TB	OCCG Risk	**Risk:** Potential risk of failing to respond to the results of diagnostic tests **Cause:** • Inconsistencies in the endorsement of results process at the OUHT	**Controls:** • Endorsement of results in quality Account • Result are reported to clinical governance monthly by divisions	within 3 mths	4 2 8	4 2 8	↔	22/03/16	2 2 4
3.12	PB	OCCG Risk	**Risk:** Potential risks to handover of treatment through poor communication of discharge summaries **Cause:** • Delays in the discharge summary process and a lack	**Controls:** • Results of discharge summaries reported monthly to Clinical governance committee • ERP support and training to staff • Medical Director follow-up of poor performers	within 3 mths	5 3 15	5 3 15	↔	01/04/16	2 2 4

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-16 L..C	Risk Rating Mar-16 L..C	Trend	Last Review	Target L..C
			of a comprehensive system to manage test results at the OUHT							
Principal Risk 4: Failure to achieve sustainable contracts with Commissioners										
4.2	AS	IBP	**Risk:** 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 • Specialist commissioners have significant overspend **Effect:** • Unaffordable levels of care demanded • Loss of income from CQUIN targets • Over-performance on contract **Impact:** • Financial deficits for commissioners and OUH • Adverse impact on quality and service performance.	**Controls:** • 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. • Full involvement in commissioner led reconfiguration initiatives. • System leadership structure in place • System-wide Transformation Board in place. • 2016/17 Planning Guidance requires production of system-wide Sustainability and Transformation Plan – to be led by Transformation Board • System-wide transformative DTOC plan initiated (as example of effective execution of a significant system-wide plan) • Strategy refresh being undertaken • Development of system-wide strategy initiated • System-wide contracting principle agreed for 2016/17 • System-wide infrastructure implemented to support development of Sustainability and Transformation Plan	3-12 mths	3 4 12	4 4 16	↑	22/03/16	2 3 6
Principal Risk 6: Failure to sustain an engaged and effective workforce										
6.1	MP	IBP	**Risk:** 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	**Controls:** Targeted interventions focused in the following key areas: • Increasing the substantive workforce through sustained UK and EU/overseas recruitment • Mitigating high cost of living where appropriate, through: targeted recruitment and retention incentives; implementation of the national living wage • Improving professional development and career opportunities • Creating and sustaining the right environment (staff engagement and involvement) • Active Workforce Cost Improvement Group to oversee the implementation of agency staff rate caps and other initiatives to reduce expenditure on contingent workforce	within 3 mths	3 4 12	3 4 12	↔	25/03/16	2 4 8

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-16 L..C	Risk Rating Mar-16 L..C	Trend	Last Review	Target L..C
			• 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 .							
6.2	MP	IBP	**Risk:** Low levels of staff satisfaction **Cause:** • Poor local leadership and management practices • Poor staff engagement • Insufficient recognition • Pressures of work • 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.	**Controls:** • Substantive staffing levels increased and vacancy gaps reduced • Staff Recognition Awards scheme expanded • Range of retention initiatives being implemented • Partnership working via JSCNC and LNC • Established Staff Health and Wellbeing Strategy and Committee • Comprehensive Occupational Health and Wellbeing Service • Exit interview process • Regular local staff engagement feedback Implementation of Employee Assistance Programme(EAP) • Annual Staff Survey and responses	3-12 mths	2 3 6	2 *3* *6*	↔	25/03/16	1 3 3
6.3	CS	IBP	**Risk:** 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	**Controls:** • CPD and access to national development programmes • Access to national leadership development programmes • Active Education and Training Committee • Nurse Foundation Programme implemented • High quality Education and Clinical Supervision • Introduction of Care Support Worker 'Care Certificate' • Multi-professional Education and Learning Strategy approved and being implemented	3-12 mths	2 3 6	2 3 6	↔	03/04/16	1 3 3

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-16 L..C	Risk Rating Mar-16 L..C	Trend	Last Review	Target L..C
			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	• Adoption of Magnet accreditation programme						
6.5	CS	Esc	**Risk:** Potential of reduced 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 • Skill mix due to the high numbers of newly qualified midwives working in all areas of the service **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	**Controls:** • Substantive staff work additional hours on NHSP • 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. • Hospital on call midwives are available at night. • Rotation of midwives into acute from community dependent upon activity levels. Gaps in staffing 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 of midwives • Current ratio of women to midwives 1:30 • Birth Rate + used to monitor acuity of patients against staff levels	3-12 mths	3 3 9	3 3 9	↔		2 2 4
6.7	PB	Esc	**Risk:** 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	**Controls:** • 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. • The Theatre Sister is acting up into Deputy Theatre Manager role.	3-12 mths	3 3 9	3 3 9	↔	01/04/ 16	1 3 3

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-16 L..C	Risk Rating Mar-16 L..C	Trend	Last Review	Target L..C
			potential for cancellations. Impact of patient experience and ability to maintain operational targets.							
Principal Risk 7: Failure to deliver the required transformation of services										
7.5	AS	IBP	**Risk:** 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 • 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	**Controls:** • Clinical roll-out commenced with order communications and admissions, discharges and transfers. • 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-undertaken with HSCIC. • New benefits realisation infrastructure being set up. Additional control added (TME 28 8/14): • Action Plans in place • 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. • Consultation *undertaken* on future priorities and new governance arrangement and paper signed off by Trust Board on 13/01/16 •New clinically-led governance arrangements being implemented.	3-12 mths	2 4 8	2 4 8	↔	22/03/16	2 3 6
7.8	MM	Esc	**Risk:** 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	**Controls:** • Additional education in relation to good practice processes • Regular monitoring of potential issues.	within 3 mths	3 4 12	3 4 12	↔	23/03/16	1 3 3
7.9	MM	Esc	**Risk:** Potential risk posed by the fire detection systems in the JR that require upgrading **Cause:**	**Controls:** • Increase to regular testing of alarm system • Monitoring of all alarms and response when activated, with RCA to evaluate response times etc.	within 3 mths	2 3 6	2 3 6	↔	23/03/16	1 3 3

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-16 L..C	Risk Rating Mar-16 L..C	Trend	Last Review	Target L..C
			• Poor estate infrastructure **Effect:** • Potential for increased risk if fire should break out **Impact:** • Potential impact on patients.	• 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. • Level 0 works have now been implemented in full						
7.12	MM	Esc	**Risk:** 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.	**Controls:** • Main in-patient areas in the retained estate are proposed to be progressively vacated over time . • Carbon project agreed and works ongoing	Over 12 Mths	3 3 9	3 3 9	↔	23/03/16	1 3 3
Principal Risk 8: Failure to deliver the benefits of strategic partnerships										
8.1	PB	IBP	**Risk:** Potential failure to sustain the value of partnership and sustain effective regional networks. **Cause:** • Reduced referrals threaten clinical and financial sustainability. • Insufficient focus on strategic objectives because of operational priorities • systems leadership narrative that engages partner boards to support regional networks and foster integration • Failure to complete joint projects with partners • Failure of partners' boards to engage their clinical workforce and support their participation in networks • Failure of partner boards to invest resources • Failure to rationalise the different groups of networks • Failure to develop a model of distributive leadership that allows the clinical networks to flourish • Poor regional network leadership and poor	**Controls:** • Clinical network meetings. • Development of AHSN • Marketing and market research • Performance review process for regional networks •Enhanced informatics capacity • Development of leadership capacity in clinical workforce Additional control added (TME 28 8/14): • Internal processes developed to maintain partnership links • Systems leadership • Appropriate focus on strategy • Concerted strategy to increase engagement with partners at all board roles • Appropriate support and resource for regional networks • Development of leadership capacity in clinical workforce Formal performance review process for regional networks • Enhanced informatics capacity	Over 12 Mths	2 3 6	2 3 6	↔	23/03/16	1 2 2

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-16 L..C	Risk Rating Mar-16 L..C	Trend	Last Review	Target L..C
			performance and impact • Competing attraction from geographically adjacent regional networks • Failure of the regional networks to reflect the priorities of the providers and population • Poorly developed informatics that prevent interoperability of databases and information sharing **Effect:** • Failure to improve outcomes and increase value of healthcare in the region • Loss of support from network partners • Suppression of collaboration by competition • Disruption and division of an adequate population base to support regional networks **Impact** • Failure to build a sustainable healthcare system based on partnership • Loss of leadership of healthcare economy • Loss of a population base that threatens some tertiary							