Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-17 L...C	Risk Rating Mar-17 L..C	Trend	Last Review	Target
Home Sweet Home										
1.1	AS	IBP	**Risk:** Lack of robust plans across healthcare systems. / Failure to reduce activity through robust demand management plans. **Cause:** • Lack of clear leadership. •Insufficient collaboration 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. • Full involvement in commissioner led reconfiguration initiatives. • System leadership structure in place changes being considered and implemented • 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 transformation programme being progressed – first phase of consultation began in January 2017 and ended on 9 April 2017. • Options for second phase of consultation being worked up for consultation later in the year. • BOB-wide STP process in place including establishment of Acute Group. •Letter of intent signed with OH and GP Federations to develop need integrated organisational and contracting model •Discussions with specialised commissioner on new commissioning models •Regular reports to the Trust Board and Board Seminars	3-12 mths	4 4 16	4 4 16	↔	13/4/17	2 3 6
1.2	Tbc CS	Esc	**Risk:** Major ~~Business Plans~~ *capital developments* may not be delivered as expected. **Cause:** *• Limited availability of capital funding* *• Site infrastructure requires investment, limiting availability of capital funding for service developments* *• Scale of required investment in IT and replacement medical equipment limits availability of capital funding for service*	**Controls:** *• Agreement of plan for use of sites and capital funding, including investment in infrastructure, IT and medical equipment* *• Development of non-capital solutions for service developments* *• Review of management of capital projects from business case to delivery, including:* *- Accountability for each stage of the process* *- Structure and interaction of teams* *- Whether teams have expertise required*	3-12 mths	New	4 4	n/a	13/4/17	4 3

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-17 L...C	Risk Rating Mar-17 L..C	Trend	Last Review	Target
			developments *• Lack of clarity over strategy for use of sites and capital funding* **Effect:** • Poor accommodation and / or services *• Delays in business case approval and project delivery* *• Reduced efficiency* *• Risk to service continuity* **Impact:** • Negative impact on patient experience *• CQC rating* *• increased running costs* *• abortive design fees*	- *Approvals process* - *Processes for management of capital projects, including sign off of each stage of the design process*			16			12
1.3	PB	Exc	**Risk:** Failure to meet HART Team capacity *due to workforce constraints*. **Cause:** *• Staff appointed may fail selection procedure and security checks* **Effect::** **Impact:** Quality and patient experience	**Controls:** • Recruitment is up at 85% and expected to be fully established by *May 2017* *• Recruitment day held 25th February 2017* *• Advertising campaign live and on Oxfordshire Bus Companies* *• 36 staff to be appointed following references and checks* *• Bespoke training programme every 7 weeks commencing 8th May 17 for new starters* • HART Team development, expansion and further embedding of processes to ensure the team are up to full capacity and running to high quality standards.		New	2 3 6	*n/a*	13/4/17	*1 3* 3
Focus on Excellence										
2.1			**** Risks currently under development**							
Go Digital										
3.1	PK	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.	**Controls:** • Tracking system in place • EPR Roll-out continues, risks reviewed and included on EPR risk register as identified *This will be absorbed by the Trust 'Go Digital' Programme and ''OUH Global Digital Exemplar'* • 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):	3-12 mths	2 3 6	2 3 6	↔	13/4/17	2 2 4

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-17 L...C	Risk Rating Mar-17 L..C	Trend	Last Review	Target
			• Nursing and Medical document incomplete across paper and digital forms **Impact:** • Quality and safety may be effected	• E Learning Training Package in place • E prescribing *inpatient* 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 • ePrescribing is now rolled out at JR maternity • OUH is completing due diligence on a bid for NHSE £10m Global Digital Exemplar funding which will accelerate EPR Rollout as part of 'Go Digital' over the next 2 years • *OUH has been awarded £10m for GDE and awaits confirmation of dates for receipt* • *Actions are to be agreed to improve clinical induction and local device and hardware reporting and maintenance and support*						
3.2	PK	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 • 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.	**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. *This will be absorbed by the Trust 'Go Digital' Programme and ''OUH Global Digital Exemplar' Programme* • 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	3-12 mths	2 3 6	2 3 6	↔	13/4/17	2 2 4

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-17 L...C	Risk Rating Mar-17 L..C	Trend	Last Review	Target
				• 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 • OUH is partnering with Cerner to improve Outpatient PAS to address active encounter clean up and reduce the opportunity for data entry error. • Due to be delivered Jan to Mar17, with a 6 month rollout *This will be live on 22.4.17* • 'Merge' of NOC and ORH System organisations planned to be delivered during rollout						
3.3	PK	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	**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-with HSCIC *now complete and published* • New benefits realisation infrastructure being set up. Additional control added (TME 28 8/14): • Action Plans in place • Roll-out of *inpatient* electronic prescribing and medicines management commenced on 6 October 2014. This will help to drive improvements in	3-12 mths	2 4 8	2 4 8	↔	13/4/17	2 3 6

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-17 L...C	Risk Rating Mar-17 L..C	Trend	Last Review	Target
			• Heightened clinical risk • Reputational damage	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. • OUH is completing due diligence on a bid for NHSE £10m Global Digital Exemplar funding which will accelerate EPR Rollout as part of 'Go Digital' over the next 2 years. *awarded £10m for GDE and awaits confirmation of dates for receipt* • ePrescribing inpatient rollout has completed and has increased clinical engagement • New Exec CIDO appointed, strengthening governance, and implementing a clinically led model with funding for divisions • *Actions are being agreed to improve clinical induction and local device and hardware reporting and maintenance and support* • *A cross divisional exercise to prioritise service need and benefits will be scheduled in May 2017 to re-focus leadership, engagement and delivery in alignment with the 4 other trust strategic programmes and routine quality and financial reporting. This process will evidence clinical advantages of going digital*						
Master Plan										
4.1	CS	Esc	**Risk:** Unsuitable outpatient accommodation in Clinical Genetics Department at the Churchill	**Controls:** ***all works are now complete – recommend to be archived from CRR***	3-12 mths	2 3 6	3 1 3	↓		3 1 3
4.2	JD	IBP	**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 • Greater central controls over use of capital **Effect/Impact** • Trust plans have to be revised and / or deferred • Trust unable to develop services as quickly as envisaged	**Controls:** • Robust business planning approval processes • Strong financial case to justify investments • Board review of investments to ensure affordability over time • Investment Policy	3-12 mths	3 3 9	3 3 9	↔	13/4/17	2 3 6
4.3	MP	Esc	**Risk:**	**Controls:**	Within	3 3	3 3	↓	03/04/17	2 3

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-17 L...C	Risk Rating Mar-17 L..C	Trend	Last Review	Target
			Access to hospital site and current car parking constraints across the trust have an impact on operational performance. **Cause:** • Poor access to hospitals sites **Effect:** • Patient experience delays in getting on site **Impact:** • Poor patient experience, complains and late running of appointments	• Interim arrangements being put in place to address short term road / building works • Longer term negotiations with council re potential solutions. • Trust Management Executive approved introduction of barriers, other recruitment and retention initiatives in relation to access to site for staff. • Consideration should be given to the re-profiling of outpatient clinics to better balance demand over the course of the week • Revised travel and transport policy is completed • Staff consultation has completed	3 mths	9	9			6
4.4	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. • 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 approved support the funding required to open the remaining five unfunded beds on AICU/CICU • Increase in 5 beds across both sites in Oxford (1 bed opened Nov 2015 and another June 16, with plans to open 3 every 6 months) • 18 month period of implementation • Recruitment has started • Staff successfully recruited to open 2 level 3 beds. Others opening at approximate 6-8 month intervals Variation to contract submitted to PFI partners to build another 4 beds at the 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` • The critical care (AICU) development SOC plans are in the process of being expedited moving towards the OBC development in parallel with the Theatres OBC as there are synergies between the two.	Within 3 mths	3 4 12	3 4 12	↔	13/4/17	2 3 6
4.5	CS	ESC CSS	ITU Drainage: Poor estate with risk of ventilation failure, insufficient electrical back up and effluent ingress into clinical area due to age of soil pipes **Cause:** • Aged pipes and surveys have shown the drainage system is heavily scaled and corroded. This is compounded by improper	**Controls:** • Immediate actions in the face of effluent leakage - move patients, call estates - agree rapid response, isolate area, cleaned up, notify duty manager and executives.: In place *• The soil stack in Endoscopy that caused the water seepage into ITU has now been replaced*	Now to 3 mths	5 3 15	3 3 9	↓	13/4/17	5 1 5

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-17 L...C	Risk Rating Mar-17 L..C	Trend	Last Review	Target
			disposable of non-biodegradable items in the drainage system, causing temporary blockages and hence the outflow of effluent. **Effect:** • The major concern is an increased risk of nosocomial (hospital acquired) infection; which may include multi-drug resistant organisms. **Impact:** • Service provision, reputational, quality of care, staff/patient/relative experience.	• Review and revise business continuity plans to include relocation of patients from affected /adjacent areas or total AICU closure. Update Nov 16: In progress • Undertake repeat camera survey of pipes. Update Nov 16: Survey undertaken Nov. Narrowing of pipes, and evidence of dialysis bags • Service moves into a new/refurbished ICU meeting current standards. Update Dec 16: Plan to take outline business case to TME in March 17 for ICU and theatres. • Structural work to improve drainage from Endoscopy/AICU. Update dec 16: Section of piping replaced, awaiting performance assessment.						
High Quality Costs Less										
5.1	CS	IBP	**Risk:** Patients experience indicators may show a decline in satisfaction with quality.	***Recommend to be removed from CRR as it is no longer considered a risk***	Over 12 mths	2 2 4	1 2 2	↓		1 2 2
5.2	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:** • Potential loss of reputation • Goals are not achieved	**Controls:** • Quality Priorities in place for 2016/17 • Quality Report completed for 2015/16 • 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 • 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 • Annual Quality Report monitored at Board and Committee • Strategic review with development of improvement champions • CQC Assurance	Over 12 mths	2 3 6	2 3 6	↔	13/4/17	2 2 4
5.3	MP	IBP	**Risk:** Low retention of non-medical workforce in some clinical areas	**Controls:** Targeted interventions focused in the following key areas:	Within 3	3 4 12	3 4 12	↔	4/	2 4 8

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-17 L...C	Risk Rating Mar-17 L..C	Trend	Last Review	Target
			and disciplines, leading to ongoing recruitment challenges **Cause:** • National shortages in some staff categories • Economic challenges associated with Oxfordshire • Limited numbers of staff with the requisite skills and experience applying for posts • Limited provision of sufficient personal and professional development opportunities • Reduced numbers of Registered Nurses applying or posts exacerbated by non UK trained Registered Nurses required to undertake IELTS test. **Effect:** • Higher vacancy rates and increased requirement to use temporary workforce agencies. • 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 decrease in staff satisfaction leading to increased absence • Potential impact on ability to deliver aspects of the Annual Plan	• Increasing the substantive workforce through ongoing 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 the promotion of and access to professional development and career opportunities • Engage staff in identifying retention ideas • Active Workforce Cost Improvement Group to oversee the implementation of agency staff rate caps and other initiatives to reduce expenditure on contingent workforce • Retention strategy to be actively implemented to mitigate reliance on recruitment initiatives Plan and pilot the recruitment of RNs internationally for hard to recruit areas such as operating theatres	mths					
5.4	TB	Esc	**Risk:** The implementation of the Horton contingency plan results in potential adverse outcomes and patient outcomes for parents and children	**Controls** • A separate risk register has been developed to address these concerns and is regularly reviewed by TME	1	2 5 10	2 5 10	↔	13/4/17	2 1 2
5.5	TB	IBP	**Risk:** Inability to continue to supply stock medicines to wards and medicines to all the Trust's dispensaries **Cause:** • Age and condition of the buildings (~1950s), not designed as a pharmacy store, inadequate space, uncontrolled temperature fluctuations, poor security, inadequate space to unpack and pack boxes.	**Controls:** • Move to electronic ordering and invoicing underway • Move low risk and high bulk items to NHS Supply chain • Re-organise storage • Build new pharmacy Procurement and Distribution Unity • Build a new Pharmacy Procurement and Distribution unit within OUH sites. CP in discussion with Estates project office to progress previous bids. Update Jan 16: CP has met with estates to discuss options. Update	3 to 12 mths	3 4 12	3 4 12	↔	13/4/17	1 2 2

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-17 L...C	Risk Rating Mar-17 L..C	Trend	Last Review	Target
			Effect: • Poor efficiency, poor working conditions, inappropriate temperatures for medicines storage, stock losses, lack of stock rotation. **Impact:** • Breaches in fire regulations, WDL at risk from MHRA, Non-implementation of national guidelines for Purchasing for Safety, high staff turnover, low staff morale and delays in timely supply of medicines, delay in discharges	Mar 16: Exploring options for offsite premises. Update Jul 16: Offsite option not feasible, being considered as part of wider estates review. • Plan to improve staff accommodation is in progress and the space created will need to be converted to medicines storage, but awaiting estates for review and small works funding.						
Sustainable Compliance										
6.1	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 **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 of ED Monitor standard – Red Flag • Increased costs of temporary staff & in additional capacity. • Financial impact through increased penalties	**Controls:** Internal ` •ED escalation process & divisional/executive rota in place Hourly monitoring of patient flow through ED/EAU on both sites, •Daily Executive teleconference calls with l DCS ^ CN • Urgent Care Improvement plan in place and revised monthly •Weekly internal DCS *if required* • Daily whole system teleconference calls • Contingency & Recovery plans in place • *Weekly Urgent Care Dashboard* • *Urgent & Emergency fortnightly MRC meetings* • Fortnightly performance meetings • Monthly Divisional performance meetings; Monthly reporting & monitoring access targets through Trust Management executive & Trust Board • Reviewed complaints/Patient experience at Board • Review of Incidents at Board • Board walk rounds External • *Monthly* A&E Delivery Board with whole system plan to reduce demand – Urgent care Improvement Plan • Monthly Contract meeting with CCGs *and Quality* • OPEL Escalation triggers in place in ED, EAU and SEU • Weekly CEO / COOs and DTOC meeting • five point plan has been developed to recover performance and deliver sustainable compliance.	3-12 mths	5 4 = 20	5 4 = 20	↔	13/4/17	2 3 = 6
6.2	JD	IBP	**Risk**	**Controls**		4 3 = 12	4 3 = 12	↔	4	2 2 = 4

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-17 L...C	Risk Rating Mar-17 L..C	Trend	Last Review	Target
			Contractual targets for CQUIN not met and CQUIN funding not available **Cause**: • Failure to meet contractual targets for CQUIN and therefore being ineligible for CQUIN funds **Effect**: • adversely impacts on financial plan • Increased regulatory scrutiny **Impact**: • Implementation of mitigating actions • loss of financial resources • potential loss of reputation	• Monthly contract review meeting held between the Trust & Commissioners • Internal weekly Business Planning meetings • Detailed Financial Monitoring suite via SLAM		12	12			4
6.3	JD	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. • Failure to deliver control total • Failure to gain STF funding	**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	3-12 mths	4 4 16	4 4 16	↔	13/4/17	3 3 9
6.4	JD	IBP	**Risk** Risk of not hitting financial targets or operational trajectories to access Sustainability and Transformation Funding **Cause:** • Failure in performance leads to Trust missing agreed targets and therefore being in-eligible for Sustainability & Transformation funds. • *Failure to deliver financial target due to anticipated income*	**Controls** • Monthly contract review meeting held between the Trust & commissioners • Internal weekly Business Planning Meetings • Detailed financial monitoring suite via SLAM	3-12 mths	4 4 16	4 4 16	↔	13/4/17	3 3 9

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-17 L...C	Risk Rating Mar-17 L..C	Trend	Last Review	Target
			not being as great as predicted and /or costs being higher than anticipated. **Effect:** • Adversely impacts on financial plan **Impact** • Uncertainty in financial position, further cost pressures lead to increase CIP Schemes							
6.5	PB	IBP	**Risk:** Failure to deliver national access target 18 weeks incompletes target and failure to deliver 1% or less for diagnostic waits within 6 weeks' **Cause:** • Lack of sufficient capacity/workforce • Implementation of Electronic Patient Record (EPR) disrupted data • Increase in demand or failure of health system to divert patients. • Poor bed availability due to delayed transfers of care. • Failure to deliver efficient patient pathways. Poor Productivity • 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 **Impact:** • Failure to meet contractual requirements, increased costs • Increased costs of temporary staff & in additional capacity.	**Controls:** Internal • Fortnightly performance meetings with OSMs & DGMs RTT improvement Plan in place and ~~revised monthly~~ *updated every two weeks* • Monthly Divisional performance meetings; Monthly reporting & monitoring access targets through Trust Management executive & Trust Board; *• Reviewing trust-wide demand and capacity plans in order to sustainably achieve RTT and Cancer standards. Reviewed at TME; Trust Board* External • Monthly OCCG/OUH RTT/Cancer meeting. • Monthly contract *and Quality* meeting with CCG • Weekly NHS conference calls with DCS • Weekly external reporting and monitoring of RTT to NHSi and NHSE	3-12 mths	3 3 9	3 3 9	↔	13/4/17	1 3 3
6.6	PB	Esc	**Risk:** Failure to deliver National Access targets Cancer – 62 day Cancer Standard **Cause:** • Lack of sufficient capacity/workforce • Implementation of Electronic Patient Record (EPR) disrupted	**Controls:** Internal • Weekly Tumour site *MDT* meetings Daily tracking meetings for high volume tumour sites in place. • Fortnightly performance meetings with OSMs & *DGMs Cancer* Improvement Plan in place		3 3 9	3 3 9	↔	13/4/17	2 3 6

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-17 L...C	Risk Rating Mar-17 L..C	Trend	Last Review	Target
			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.	• Escalation process in place across all divisions with escalation to Executives • Monthly Divisional performance meetings; Monthly reporting & monitoring access targets through Trust Management executive & Trust Board; • Cancer Improvement Plan in place and revised monthly •*104 Clinical Harm Review in place* External • Monthly OCCG/OUH RTT Cancer meeting • Monthly Cancer Leads meeting • Monthly Contract *& Quality* meeting with OCCG						
6.7	JD	IBP	**Risk:** Services display poor cost-effectiveness. **Cause:** • Ineffective and insufficiently granular planning • Poor recording of activity **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): • Additional financial controls around budget management and review of financial position • Strategy over use of financial contingency • Implementation of monthly SLR reporting from April 2017	3-12 mths	2 3 / 6	3 3 / 9	↑	13/4/17	2 2 / 4
6.8	JD	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 • Lack of knowledge re safe staffing levels. • Increased demand for services above planned level **Effect:** • Poor financial controls destabilise the financial position.	**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 • Additional financial controls around tighter signoff of agency usage at a higher level.	3-12 mths	3 3 / 9	3 3 / 9	↔	13/4/17	3 3 / 9

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-17 L...C	Risk Rating Mar-17 L..C	Trend	Last Review	Target
			Impact: • Employee engagement and perceptions of safety	• Strategy over use of financial contingency • Full range of policies improved to help with the management of agency spend. • Monitoring system in place to measure compliance with price caps and agency rates • Management of Vacancies • Establishment Controls • Agency Controls • Actions and reviews						
Building Capabilities										
7.1	CS	IBP	**Risk:** Insufficient provision of appropriate education and learning development opportunities **Cause:** • Insufficient funding causes inability to support training and development • Current insufficient access to appropriate room facilities for training programmes • *Delay in notification of CPD funding for 2017/18.* • Notification received from HETV of a delay in notification of CPD funding for 2017/18. **Effect:** • Reduced staff motivation and morale • Increased staff turnover **Impact:** • Potential impact on ability to attract, recruit and retain high quality staff • Potential impact on quality of care and patient experience • Loss of reputation	**Controls:** • Access to appropriate leadership development programmes • Monitoring through Education and Training Committee • Monitoring through Nursing and Midwifery Board • Monitoring through Cross Divisional Education and Practice Development Forum • Increasing provision of high Quality Education and Clinical Supervision • Ongoing implementation of the Care Certificate • Trust Apprenticeship Committee established to run monthly from April, currently running every two months. • To achieve Employer Provider Status to support investment of Apprenticeship Levy May 2017 • Trust training needs analysis completed to maximise use of funding and targeted against need and priorities. • Multi-professional Education and Learning Strategy approved and being implemented • Adoption of Magnet Accreditation Programme • Development of in-house academic accredited programmes • Ensure education commissioning focuses on both quality and value for money. • Education programmes and associated provision approved by Divisional Education leads • Provisional funding agreed to relocate Practice Development and Education, Back Care, and Learning and Development Teams to the Churchill Hospital site and establish an Education Centre in what was Geoffrey Harris Ward. Will significantly increase teaching accommodation.	3-12 Mths	2 3 6	2 3 6	↔	13/4/17	1 3 3

Risk ID	Risk Owner	Source	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Proximity	Risk Rating Jan-17 L...C	Risk Rating Mar-17 L..C	Trend	Last Review	Target
				• To develop a second year Foundation programme to build upon current year one programme. To commence September 2017						
Operational Risks										
8.1	CS	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. • Posters on display to remind women and staff what is acceptable to flush	Within 3 mths	3 4 12	3 4 12	↔	13/4/17	1 3 3
8.2	CS	Esc	**Risk:** Potential of reduced staffing levels within the Maternity Service **Cause:** • Midwifery vacancies and high numbers of staff on maternity leave. • 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 • One obstetric hospital covered by a senior member of staff on-call out of hours. • Community hospitals are covered by the community on call service • 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 • Maternity Bleep holder in post to cover day shifts • Out of area late bookings will not be accepted. • Measures are being put in place to decrease the Length of stay. • Level 5 increase in capacity to accommodate increased numbers of women • Use of CS bay on level 5 • ELCS now undertaken in Gynae theatres	3-12 mths	4 3 12	4 3 12	↓	13/4/17	2 2 4
8.3	TB	Esc	**Risk:**	**Controls:**	12-24	4 4	4 4	↔	03/0	2 3

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			CAS Alert NPSA 2011/PSA001: Safer spinal (intrathecal), epidural and regional devices Part B (applies to spinal infusions, all epidural and regional blocks) **Cause:** Risk of wrong route of administration due to compatibility of epidural, spinal and regional infusion devices with intravenous Luer connectors. There is a national supply issue affecting all hospitals; at this time the Trust is unable to fully implement NPSA recommendations re introduction of safe connectors as some components are not commercially available. 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	Complete implementation of part A before starting on this section. Focus on epidurals, then other regional anaesthesia. Specialist neuroscience area will have separate action plan as compliant devices not comprehensively available · 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 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' Medical Directors Office agreed to send communication to medical staff highlighting the safeguards to protect patients.	mths Suspected, longer for neuroscience	12	12			6
8.4	TB	OCG 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 EPR • Result are reported to clinical governance monthly by divisions • Performance managed in exec performance reviews quarterly Continues within maternity, we are working on improving and escalating the need for this to be completed	within 3 mths	4 2 8	4 2 8	↔	13/4/17	2 2 4
8.5	TB	OCG Risk	**Risk:** Potential risks to handover of treatment through poor communication of discharge summaries **Cause:** • Delays in the discharge summary process and a lack of a comprehensive system to manage test results at the OUHT	**Controls:** • Results of discharge summaries reported monthly to Clinical governance committee • ERP support and training to staff **improvement from 40-75%** • Working towards improving discharge summaries. All women in	within 3 mths	4 2 8	4 2 8	↔	13/4/17	2 2 4

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				maternity discharged with a summary						
8.6	CS	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	↔	13/4/17	1 3 3
8.8	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:** • Care 24/7 Programme in place monitored via TME on a quarterly basis • The Care 24/ 7 programme is in place and is managing delivery and monitoring against an agreed Action Plan. • Care 24/ 7 has progressed to phase 3 of implementation at the JRH • The national survey against the four priority standards was undertaken in March and published results in June. The OUH met 100% of emergency categories. *Next audit is due in April 2017*	3-12 mths	2 3 6	2 3 6	↔	13/4/17	1 3 3
8.9	PK	Esc	**Risk:** Failure of accurate reporting & poor data quality due to implementation of the Electronic Patient Record (EPR) Tie failure between EPR and CRIS	*Agreed to archive*	3-12 mths	2 3 6	1 3 3	↓		1 3 3
8.10	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. Standard 11:.have their care coordinated and delivered in accordance with their personalised care plan, including rapid	**Controls:** • Guidance sought from Leadership Alliance for care of dying people following withdrawal of the Liverpool Care Pathway •Group led by Medical Director-in • Agreement with Sobell House charity fund for 2 years to support EOLC • EOLC Group meet monthly • EOLC Symposium late 2015 • EOLC • EOLC stats to TME in June and Board in July 16 (note, this is a CQUIN for 16/17)	within 3 mths	2 3 6	2 3 6	↔	13/4/17	1 3 3

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			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.							
8.11	MP	IBP	**Risk:** Low levels of staff satisfaction	**recommend for archive as staff engagement index score increased in 2016 and we are now in the top quartile of all acute trusts.**	3-12 mths	2 3 6	1 3 3	↓		1 **3** 3
8.12	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	**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. • Reported at Quality Committee and Audit Committee and re-audit (IA) KPMG audits, action plan commenced and completed for areas of concern	3-12 mths	5 1 **5**	5 1 **5**	↔	13/4/17	3 1 3
8.13	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:** • Non Leur safety devices implemented across all sites for lumbar puncture and spinal anaesthesia. • Reviewed spinal needles use for non-spinal indications to confirm whether a non-Leur device should be used or provide a suitable alternative device. • Two clinical incidents with failure of non-Leur spinal introducer (in anaesthesia) led to national product withdrawal and need to swap to a separate Leur introducer needle (approved by Medical Director). There remains a risk that in some patients this could penetrate the spine, but the introducer is not intended for medicines administration. Change communicated to clinical areas. NHS Improvement (NHSI) have confirmed that use of this non Leur introducer (needed for Sprotte needles over 90mm) is not complaint with the alert. Awaiting clinical feedback from review of redesigned introducer sample to agree whether	0-3mths	1 4 4	1 4 4	↔	13/4/17	1 3 3

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				to consider implementing in practice. • Roll out in Radiology planned following agreement to stop using yellow Leur syringes for local anaesthetic use, revised interventional packs being sourced. • Continue to work with several highly specialist neuroscience practices to understand whether non Leur kit is available and implement.						
8.14	CS	RA	**Risk:** Excessive use of temporary workforce agencies may pose a risk to the quality of service delivered and lead to increased workforce costs **Cause:** • Negative experiences reported through patient feedback (for example, net promoter score) and other externally benchmarked feedback exercises. • Failure to provide adequate staffing trained at an appropriate level. **Effect:** • Failure to meet quality and safety standards • Negative media coverage **Impact:** • Potential loss of Safety and quality of care	**Controls:** • Twice daily monitoring of safe staffing levels on all sites and staff moved to mitigate clinical risk, shift by shift. • Weekly monitoring of all temporary staff including medical locums and nursing • Use of recognised framework agencies including high cost agency according to NHS England's directive. • Local induction of agency staff • Ongoing recruitment drives both nationally and internationally • Vacancy levels monitored monthly by Divisions and recruitment including attrition • Government target of Nursing agency cap to be 8% of current workforce costs (7% Dec 16)	within 3 mths	2 2 4	2 2 4	↔	13/4/17	1 2 2
8.15	TB	CQC	**Risk:** Failure to implement actions following the CQC Improvement Notice which	***To archive. The development and implementation of the Annual Audit Plan is in place to mitigate against future risk**The CQC have re-inspected and removed the improvement*	within 3 mths	2 3 6	1 3 3	↓		3 1 3
8.16	TB	Esc	**Risk:** Risk of lower quality care for patients **Cause**: Some *Trust Wide Clinical* policies and Standard Operating Policies are not updated in accordance with the Trust Policy. **Effect:** • Staff potentially following out of date policies **Impact:** •Potential impact upon the quality of care.	**Controls:** • Policies to be updated *Trust wide clinical policies are now 100%* • SOPs to be updated		4 3 12	4 3 12	↔	13/4/17	1 3 3
8.17	TB	Esc	**Risk:** Potentially unable to sustain Emergency Department (both JR and HGH)middle grade rota due to recruitment difficulties	**Controls:** •Allocate clerical staff to make sure there is an adequate rota for service delivery.		4 3 12	3 3 9	↓		1 2 2

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				•Consultant Lead from 0800-2000. •Active recruitment ongoing •Support from CCG regarding alternative pathway for care i.e. GP out of hours. •Creation of SOP around ad-hoc reallocation of middle grade doctors, when necessary. • Implementation of escalation protocols. • *Gaps in rota addressed at CCC meeting – completed 3 times daily*						
8.18	TB	Esc CSS	**Risk:** Manual handling of the deceased and their dignity when being moved to temporary body store. **Cause:** • Increase in length of storage time due to change in regulations - The Cremation (England and Wales) Regulations 2008 - guidance to medical practitioners for completing Cremation 4 and 5, February 2012. Ministry of Justice. **Effect:** • Insufficient capacity at JR in permanent store **Impact:** • Bodies stored in temporary body stores 365 days of year.	**Controls:** • Build additional body storage • Manual handling risk reduced by not using bottom 8 trays impermanent and top trays in temporary stores • Transfer of deceased to Churchill or Horton body stores • Use of temporary body stores • Use of funeral directors for additional storage		5 3 16	5 3 16	↔	13/4/17	1 0 1
8.20	TB	Esc Lead	**Risk:** Wrong Blood in Tube (WBIT): **Cause:** • Incorrect patient registration at entry to hospital (PPID) / delays to registration Electronic prompt to incorrect patient • Staff choosing the incorrect patient • EPR is able to generate sample labels without requirements to scan wristband, pre-printing wristbands in advance • failure to use wristbands for barcode • Printed wristbands in notes and not on patient, • Ward equipment giving potential for work around that are not working, consistency of actions following incorrect labelling **Effect:** • Patients may receive the wrong treatment based on another patient's results and may be undetected which would be	**Controls:** • CERNER clinical safety officer engaged and looking at how to alter the prompt • Data monitoring increased to daily, allowing immediate correction of errors • Global Emails now being sent fortnightly incorporated into EPR training and data quality meetings • Incorporated into PPID policy increased link nurse training • wrong or broken wristbands investigated as incidents • Revised SOP to standardise laboratory action on incorrect labelling • Update on i-passport • RFC submitted to EPR to produce wristbands with messages "immediately apply to patient" and "do not store in notes" which cover over when wristband sealed • EPR request for new functionality- PPID Powerchart Specimen		new	3 3 9	n/a	13/4/17	1 3 3

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			potentially a serious risk to patients. **Impact:** • Patient safety, Quality and Reputation	Collection. This will enforce barcode scanning to identify patient and will be a key factor in reducing errors wristband alternatives being devised for outpatients (replacing outcome forms)						