

Board of Directors Meeting: Thursday 29 January 2009

BD2009.12

Subject	Board Assurance Framework
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Purpose of paper	<p>This paper updates the Board on changes to the BAF following review by the Governance Committee in September and December 2008. [The Governance Committee is charged with monitoring the progress of the Board Assurance Framework throughout the year and with its presentation to the Board of Directors at least twice a year.]</p> <p>In particular, risks have been updated and where possible gaps in controls and assurances have been addressed. Reference has been made to the Combined Action Plan, which brings together all actions arising from historical due diligence and other current reviews for monitoring by the Trust Board, Executive Board and other groups.</p> <p>The Governance Committee will review the BAF once more before the year end and present the document to the Board in March 2009 prior to its audit by the Trust's internal auditors, CEAC; and prior to its review by the Strategic Health Authority.</p>
Board Lead(s)	Mrs Elaine Strachan-Hall, Director of Nursing and Clinical Leadership
Background papers (if any)	Trust Risk Register and Trust Key Risks Combined Action Plan

Action/decision required	The Board is asked to review and agree the BAF, noting changes since its review by the Governance Committee. The Board is asked to request a further review by the Governance Committee in March 2009 so that it can be assured that it is fit for purpose at the year end.			
Key purpose	Strategy	<u>Assurance</u>	Policy	Performance
Strategic Goal(s)	All			
Strategic Objective(s)	All			
Links to Board Assurance Framework/ Trust Key Risks/Annual Health Check element(s)	The Trust Risk Register, core standards and indicators are referenced within the Board Assurance Framework. In addition the Trust Risk Register is referenced in the			

	summary document, the Trust Key Risks.
Also considered by	The Governance Committee at its meeting on Tuesday 23 December 2008. Members of the Executive team have reviewed individual areas of responsibility
Resource and financial impact	Not applicable
Consideration of legal/equality/diversity/engagement issues	Not applicable
Acronyms and abbreviations used	BAF - Board Assurance Framework; CS - Core Standards; HCC- Healthcare Commission; CQC - Care Quality Commission; CAP - Combined Action Plan; CEAC - Central England Audit Consortium; AFT - Academic Foundation Trust; AHSC - Academic Health Science Centre; LTFM - Long Term Financial Model; IBP - Integrated Business Plan; (see also key to BAF)
Author	Mrs Megan Turmezei, Assistant Director of Governance

Board Assurance Framework (BAF)

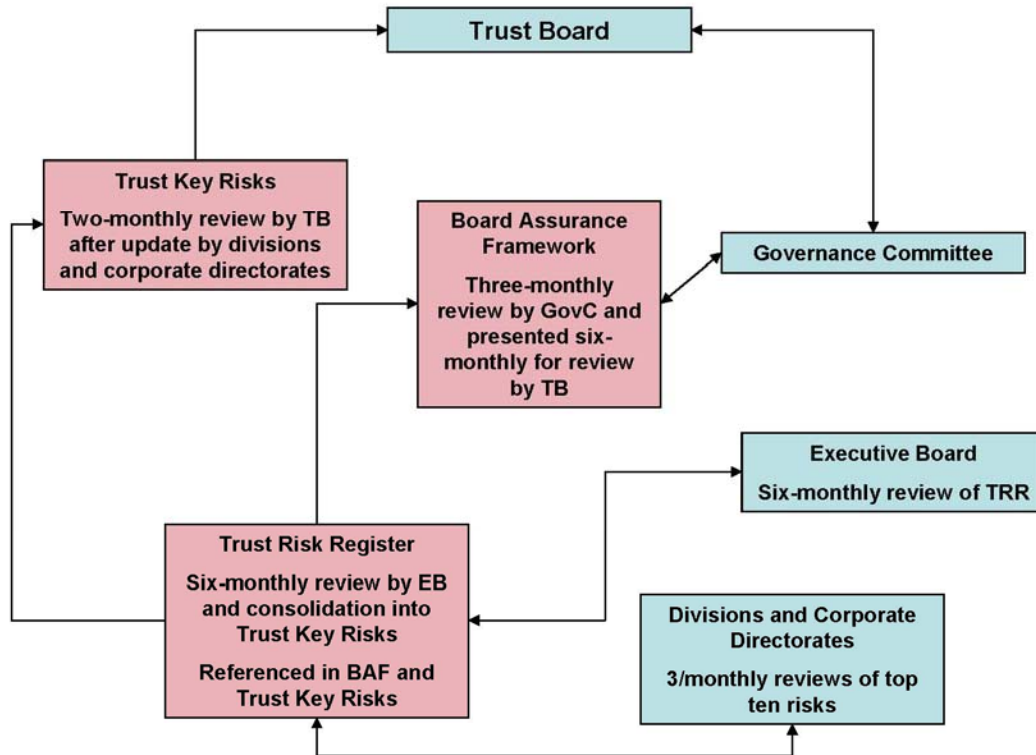
1. The BAF was last reviewed by the Trust Board at its meeting in July 2008. Since that meeting, the BAF has been updated following review by the Governance Committee in September and December 2008, and individual executive leads and by the SHA as part of its monitoring arrangements. Particular attention has been paid to ensuring that the risks to objectives clearly state the potential outcomes and that the progress with both the AFT and AHSC applications is reflected.
2. Updates include the following:
 - 2.1. Inclusion of references to the Combined Action Plan (CAP) that brings together actions arising from the Historical Due Diligence report prepared by PWC, the review by the Audit Commission on governance arrangements, the ALE Action plan, the AFT action plan prepared by the AFT Steering Group, the action plan prepared following the SHA's review and report on public board meetings and the actions arising from the work done by Ernst and Young as a preparation for the HDD process in September.
 - 2.2. The CAP continues to be monitored by the AFT Steering Group, the Executive Board and, through regular updates on AHSC/AFT progress by the Trust Board. In addition, other groups, including the Audit Committee, will review individual areas within the CAP as required.
 - 2.3. Assurances have been updated to include the most recent reports to, for example, the Trust Board, and to include any specific assurance reports that have been received. For example, a number of relevant CEAC reviews have now been completed and the levels of assurance provided have been included together with reference to agreed action plans.
 - 2.4. The action plan column has been updated to show the current position and work planned over the coming weeks.
3. A number of risks have now been removed from the BAF as follows. BAF refs 2.2 and 7.1b have been removed. The actions taken to mitigate the risks are complete and the objectives have been delivered. Both refer to the opening of the refurbished geratology wards on level 4 in August 2008. BAF ref 3.1. has been removed as it is covered in BAF 1.2. BAF 3.4 has been removed as the intestinal transplant service is now in place. BAF 5.3 has been removed and the risk re funding to pump prime emerging services has been included within BAF 5.2. BAF ref 9.1 has been removed as it was duplicated in BAF 7.4.
4. The BAF has been fully referenced to the Trust Risk Register which contains all risks with a rating of 16 or over; i.e. all red risks. Risks within the BAF are significant risks to the ORH's objectives and it could be argued that further definition is not necessary. In addition, the Board considers the updated Trust Key Risks, based on the Trust Risk Register, at each meeting and hence it is aware of the key risk areas and how these link between the various documents. (These links are shown diagrammatically overleaf).

5. The necessary assurances continue to be identified for inclusion within the BAF. Particular attention is paid to reports from CEAC, the ORH's internal auditors, and from the Audit Commission, who provide external audit services and report on ALE, a key element within the overall annual health check rating. Current CEAC reports cover areas including physical security, HR, project governance, financial management, various aspects of capital and information technology, and a report on SUIs, incidents, comments and claims.
6. The January Leaders' briefings (held on each site) have covered governance and assurance this month and the importance of verifiable evidence to support assurance was stressed. The BAF provides this at the Board level but the briefings have also made it clear that the principles within the BAF do need to be applied at all levels of the organisation. The programme for developing governance and assurance will be developed in the coming months and will involve a development session for the Board focusing on risks and risk mitigation and controls.
7. There will be a particular focus on providing assurance to the Board that objectives that could impact on the achievement of AFT or AHSC status, relevant across a number of areas, are being managed appropriately. The BAF will summarise those assurances but the Board will receive those documents directly, including, as an example, regular reports on progress with the AFT application and the management of the Combined Action Plan.
8. In addition, as part of the continuing governance work associated with the AFT application, the design and contents of the BAF will be kept under review to make sure that it meets both the national requirements and, more importantly, the assurance requirements of the Board.

Conclusions

9. The Trust Board has considered and agreed its strategic framework and goals and objectives for 2009/2010. This will allow the BAF for 2009/2010 to develop seamlessly from the current year's through the review of risks to those objectives that will take place as the business plan for the coming year develops.
10. The Trust Board is asked
 - 10.1. to review and agree the updated BAF;
 - 10.2. to suggest any amendments or change; and
 - 10.3. to ask that the Governance Committee undertake a final review at its meeting in March 2009 prior to the audit of the BAF by CEAC as part of the year-end review process and the production of the Head of Internal Audit Opinion.

Megan Turmezei
Assistant Director of Governance
January 2009



Operational risks	Strategic risks
Risks emerging from ORH activities and operations are included within the Trust Risk Register, drawn from divisional and corporate risk registers	The risks to what ORH is trying to achieve - the strategic objectives determined each year within the Business Plan - are included within the Board Assurance Framework

Oxford Radcliffe Hospitals

Ref & HCC CS	TRR ref	Lead	Principal risks to strategic objective	Risk controls in place	Risk control and monitoring	Control gaps	Assurances on controls	Gaps	Action plans for gaps	Status
SO1 - To consolidate and advance the international status of the Trust's defining services. (SA1, SA2, SA3)										
Principal risks										
1.1 C13a C20b	054 057 070 071	KS	Cancer centre fails to open on time and compromises plans for extending cancer services and improving the environment for patients	Project management in place with appropriate governance arrangements to ensure delivery. Commissioning plan for transfer and operation of services in place and monitored. Risk register in place and updated regularly Recruitment plans in place for all services and regularly reviewed	Relocation team in place and project structure monitors progress Updates to EB on progress to handover		Relocation team in place with Project structure Updates to both Executive Board and Trust Board Project evaluation document		Handover date now agreed with contractor and plans in place to achieve move of services by the year end	Plans in place to achieve opening of the cancer centre
1.2	021 025 024	ASt	Marketing arrangements are not in place to deliver service and financial plans for cancer centre and other clinical services compromising financial position	Marketing strategy framework and action plan agreed by Executive Board and monitored regularly. Agreements for 08/09 in place with PCTs and specialist commissioners. Detailed cancer marketing plan agreed	Marketing plan agreed and in place. Income Board established to monitor achievement of income targets. Monthly		TB approved Marketing framework Sept 08 Audit Committee review on private patients October 08		Work underway to implement marketing plan	Work in hand

Oxford Radcliffe Hospitals

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				and being implemented Plans for private patient facilities regularly reviewed, monitored and approved. Appropriate marketing material	meetings.		with update in Dec 08			
1.3 C7ac	001 062	ESH	HCC Cardiac Action Plan not delivered to agreed timetable with potential for reputational damage for the Trust	Agreed and robust process in place to ensure delivery and monitoring of action plans and associated assurance across trust as a whole Sign off by all parties Embedding of practice - e.g. coding practice and outcome consideration.	Division and Directorate performance monitoring on cardiac issues Internal monitoring and review through GovC and Trust Board. HCC follow up visit May 2008		HCC Progress report October 08 Monitoring by SHA Sign off from SHA and HCC		Actions now delivered and TB to sign off January 2009 Outcomes to Jan 09 TB SHA sign off planned for March 2009	Programme for sign off agreed with SHA
1.4	n/a	KS	Lack of ITU and HDU capacity compromises development of defining services networks, particularly neurosciences and gastroenterology	Plans in place to ensure HDU capacity for cancer centre Recruitment plans in place and monitored on a regular basis Strong network links in	As above (1.1)	As above			Plans in place for additional facilities on Churchill	Plan in place for opening of ITU/HDU services at Churchill

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			services	place						
SO2 - To provide high quality, efficient and innovative core services that meet the needs of local patients and the challenges of the local health community. (SA1, SA4)										
Principal risks										
2.1a Inds C18	028 033 035 036 062 066	AMu	Failure to meet key performance indicators (4 hour wait, delayed transfers of care, cancelled operations) compromises rating for quality and compromises services for local patients AFT application could be compromised	Performance improvement team in place with documented plans for improvement which are reviewed and monitored. Focus maintained from 1 April 2008 to ensure delivery Robust assurance system in place for Annual Health Check and subject to regular monitoring Included in CAP (standards)	Revised arrangements for managem't of elective and emergency access Divisional and Directorate performance and governance monitoring EB agreed trust wide capacity plan Div A capacity plan in place for key seasonal pressure periods .	Trust wide capacity plan to be tested and agreed	Weekly reports EB, monthly to F&PC and TB Reports on compliance across all indicators and standards to GovC, TB and F&PC Board reports on compliance with standards and indicators	Resilience of trust wide capacity plan	Systematic monitoring in place (daily, weekly and monthly) Frequency of reporting intended to pick up variances quickly	Monitoring underway wef 1.4.08 Current position indicates year end compliance for relevant targets

Oxford Radcliffe Hospitals

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2.3 C17 ALE	002	ASt Div C	Changes arising from IRP compromise service delivery, patient safety and recruitment at the Horton Hospital	Horton steering group in place to support work by PCT. Interim plans agreed by TB and Better Healthcare Programme Board (BHPB) Finalised Implementation Plan. Communications plans (internal and external) in place and reviewed	EB and TB review Divisional and Directorate performance and governance monitoring for children's and women's services	BHPB in place	Engagem't with Oxon PCT and, e.g., HOSC and other stakeh'rs Updates to TB		Ongoing participat'n in work led by PCT	ORH working in support of PCT plans
2.4 C7e C8b C10a, 10b C11a, 11b, 11c	005 006 044 045 069 072 079	SD	Recruitment and retention does not improve and continued performance improvements in service quality and delivery is compromised	Overall workforce strategy in place and monitored. Specific service workforce plans reflecting activity and performance targets in place and monitored Policies and procedures in place across all areas of recruitment and retention	EB and HR Committee GovC CEAC Audits		HR Director appointed HR assurances to be provided through GovC		Workforce Committee established Jan 09	Work in hand
2.5 Inds	027	AMu	Transformational and performance projects do not realise expected benefits; financial standing and	Governance for CIP/PIPs in place and followed with documented plans for improvement which are reviewed and monitored.	TB EB Accountability Reviews F&PC		Weekly review meetings EB review F&PC		Ongoing work to achieve completion to plan	Work in progress to achieve plan prior to further

Oxford Radcliffe Hospitals

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			AFT compromised	Performance improvement team in place. Robust plans with clear accountabilities for specific projects and monitoring process in place. CAP (Finance)	Directorate workshop Nov 08 CAP monitoring in place by agreed groups including AFTSG, EB and TB		review TB review CAP updates KPMG Review			HDD review
<p>S03 - To continue to strengthen the Trust's portfolio of specialist services and to consolidate and extend the catchment area from which patients for specialist services are drawn. (SA1, SA2, SA3)</p> <p>Principal risks</p>										
3.2 C16 C17 C13a, 13b, 13c C15a, 15b C20b, C21 Inds	001 002 033 035	ESH	Anticipated customer care improvements not delivered and hence referral base is not extended and improvements for patients are not delivered	Customer care strategy and plan agreed by Board, regularly monitored, and covers patients, their families, the public and clinical partners including GPs and consultants in referring hospitals Action plan for 2008/09 agreed and monitored Resources in place to deliver improvements, particular for 'customer	Divisional and Directorate performance and governance monitoring with focus on customer care Patient survey ORH Patient Panel and membership recruitment and	Action plan for 08/09 activity - also in ALE action plan Agreed action plans on outcomes from patient surveys Update ToR for Patient Partnership	TB annual review of customer care strategy and plan and patient engagement strategy and plan GovC quarterly review	Role of PPC in light of changes for AFT TB updates on patient stories	Plan for 08/09 activity in place Leaders' briefings in Jan update on customer care standards Participat'n in membership recruitment	Work in hand to achieve plan for 08/09 by year end

Oxford Radcliffe Hospitals

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				services' Customer/patient care surveys undertaken and required actions planned for and implemented PROMS with supporting process	engagement HOSC ORH staff	Committee			activities Additional one-off and real time surveys to be explored and costed PROMS to be put in place	
3.3	037 038	ML	Business cases for extension of renal transplantation and renal dialysis are not successful	Robust business cases approved following detailed discussions with commissioners Internal sign up to plans and inclusion in plans for 2008/09 Strong and explicit engagement through BMRC and Oxford University	Project management process in place Divisional and Directorate performance and governance monitoring linking with estates strategy work	TB Review of Estates Strategy	EB and TB sign off of business plans	TB review of Estates Strategy March 09	Dialysis capacity expansion on track for finish in year Estates Strategy to March 2009	Work on track for dialysis Interim transplant plan delayed by CC move
<p>SO4 - To ensure that the development of platform services parallels and advances the strategy for clinical services, ensuring that platform services contribute to optimising the efficiency and customer care focus of the Trust. (SA1, SA2)</p> <p>Principal risks</p>										

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4.1 C16 C17 C18 Inds	003 015 033 034 062	AMu/ AM	Planned improvements in diagnostic services (improvements in equipment and the patient pathways) are not delivered and hence indicators are not achieved and improvements in customer care are not delivered	Performance improvement projects in place to address specific diagnostic service issues and outcomes reviewed Engagement with users in place and monitored CAP (Standards) Annual health check compliance reports	Activity Divisional and Directorate performance and governance monitoring	Tbc	F&PC and TB performance reports Regular compliance reports to TB CAP monitoring			Perf Imp projects are on going. Action plan following LEAN review of CT services being implem'd. All targets are being met.
4.2	015	AM	Business case for IT improvements in laboratories not approved and opportunities for improvements (e.g. better communications with GPs and other customers) are missed.	Robust case prepared for sign off with commissioners and internal customers. NB Note crucial involvement of GPs Full roll out of electronic discharge system (EDS)	Divisional and Directorate performance and governance monitoring CEAC Audits commissioned		Annual assessment by DH CEAC Audit (07/ORH/IT/05) on discharge - action plan agreed		Action plan for EDS updates and improvements in place Jan 09 OBC approved GP remote requesting being rolled out to 2 more 'test' surgeries. Programme manager to	Work in hand on EDS GP roll out underway

Oxford Radcliffe Hospitals

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									be appointed to implement in all 86 GP surgeries	
4.3	008 009	CH	<p>Risk that the standard of the content of the health record and its availability will not be high enough to support safe quality clinical care or NHSLA for level 2.</p> <p>Multiple Health records - information could be missed - remain a risk.</p>	<p>Full risk mitigation plans in place including electronic scanning</p> <p>Link to CRS programme (see below)</p> <p>CAP (Risk)</p> <p>Divisional engagement in information governance issues through membership of IGG</p> <p>Senior Information Risk Officer (Director of Nursing) in place</p>	<p>EB review</p> <p>Health Records Group</p> <p>Data Quality Group</p> <p>IGG</p>		<p>GovC</p> <p>CC review</p>	<p>Work continuing to implement electronic record scanning and ensure proper arrangements for information governance</p> <p>Staff leaflet on confidentiality of patient and personal data to be circulated Feb 09</p>	Work in hand	
SO5 - To identify, evaluate, prioritise and nurture emerging services (SA1, SA2)										

Oxford Radcliffe Hospitals

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Principal risks										
5.1	036	ML/ KS/ AM	Operational pressures divert from management focus on emerging services e.g. clinical and laboratory genetics	Clarity of objectives to support service development Strong and explicit engagement through BMRC and Oxford University and through AHSC process Business plan framework	Divisional and Directorate performance and governance monitoring BRC Steering Group		TB agreed strategic framework for business plan Nov 08	TB to agree Business Plan in March 09	Work in hand through directorate and Trust Business plan process	All in hand Examples such as organ retrieval bid & intro of TAVI
5.2	020	ASt CH	Failure to engage commissioners in development of service strategy compromises plans and could impact on AFT Inability to identify the funding necessary to nurture/pump-prime compromises services	Strong commissioning team in place Specific service strategies in place and reviewed regularly Strategies refreshed as part of development of AFT IBP, LTFM and AHSC Business Planning strategic framework and business plan with clarity of objectives for these services Publication of The Way Ahead (3 rd Strategic	Divisional and Directorate performance and governance monitoring Service development within divisions and directorates - link to AFT IBP update	Financial position of commissioners Strategic Review document to be published	AFTSG - IBP and LTFM update TB updates on AFT TB agreed strategic framework for business plan		Work continues as above Specific engagement with PCT on service strategy and plans	In hand and on target

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				Review document) CAP (Finance)						
SO6 - To provide demonstrably excellent clinical outcomes and indicators of patient safety. (SA1)										
Principal risks										
6.1 All CS & hygiene code All indicators	001 062	ESH	Operational and performance pressures result in failure to improve rating for quality (and quality of financial management) and impact on patient safety	<p>Patient and Staff Safety Strategies agreed and in place and regularly reviewed through Safety Action Groups and clinical champions</p> <p>Annual reports on safeguarding to TB</p> <p>Robust system to monitor delivery of core standards and ALE (CAP)</p> <p>Agreed plan to implement NPSA medicines alerts</p> <p>Plans in place and monitored to deliver patient safety activity agreed with SHA (e.g. audit on information flows for pressure sores and falls)</p> <p>Trust-wide Risk</p>	<p>Divisional and Directorate performance and governance monitoring</p> <p>TB and GovC review</p>		<p>TB approved patient and staff safety strategies and patient stories</p> <p>CEAC reviews on governance and risk</p> <p>ALE</p> <p>Update on Children's safeguarding to GovC Sept 08</p> <p>F&PC Review on safeguarding</p> <p>HCC review</p>		<p>Weekly, monthly and quarterly monitoring through Divisions, EB and TB</p> <p>Safety Action Groups (SAGs) being established</p> <p>Review of Report on Baby P to ensure ORH's measures in place to TB Jan 09</p>	<p>Work continuing to deliver patient safety objectives with specific focus on</p> <p>a) SAGs (reflecting SHA and TB priorities)</p> <p>b) Safeguarding</p>

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				<p>registers in place supported by regular assessments and reviews - Trust Risk Register in place and reviewed - consolidated into Trust Key Risk document</p> <p>Regular reports on compliance to Trust Board</p> <p>CAP (governance)</p>			<p>and Patient Surveys</p> <p>SHA and DH</p> <p>CEAC</p> <p>Review of physical security (08/ORH/16) - SA</p> <p>OSCB's comment on ORH Declaration of Compliance</p>			
6.2 C4a, 4b, 4c, 4e C21 indicators for MRSA and Cdiff Hygie	010 011 077	JM/ ESH	<p>Failure to deliver consistent good practice in relation to HCAI and other related aspects of patient safety (e.g. decontamination, cleaning standards)</p>	<p>Ward to Board reporting and accountability in place for all aspects and work plan agreed by TB.</p> <p>Outcomes from HCC inspections delivered</p> <p>Updated and implemented policies and procedures are monitored across all areas including those for decontamination</p>	<p>Divisions and Executive Board</p> <p>Divisional and Directorate performance and governance monitoring, including Matron's reports</p> <p>Divisional</p>	<p>Registration process to be completed</p>	<p>SHA review of Hygiene Code action plan</p> <p>Annual report approved by TB</p> <p>NPSA</p> <p>DH audits</p> <p>Hygiene Code</p>		<p>Preparation for registration with CQC and Hygiene Code inspection in Q1 2009</p> <p>Briefing paper to TB Jan 09 to registration deadline of</p>	<p>Work in hand to register with CQC by required date</p>

Oxford Radcliffe Hospitals

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ne Code				<p>Joint working across all areas of the hospitals to include clinical staff, control of infection staff, facilities and estates staff</p> <p>TEAR/PEAT audits in place with supporting action plans that are regularly reviewed</p> <p>Registration for HCAI with CQC</p>	<p>Quality reports</p> <p>Compliance audits</p> <p>F&PC</p> <p>Plan for registration in place</p> <p>Decontamination policy updated by end Dec 08</p>		<p>Inspection</p> <p>Patient Surveys</p> <p>PEAT etc</p>		6 Feb 09	
6.3 C1a, 1b C2, C3 C4b, 4c, 4d, 4e	016 017 018	ESH/ JM & ML KS, AM	<p>Failure to improve performance on, for example, fractured neck of femurs, readmission rates, medicines management, etc compromises patient safety and AFT application</p>	<p>Governance arrangements in place to ensure delivery of agreed targets and that plans are regularly reviewed</p> <p>Annual Medicines Management Report and Medicines Advisory Committee</p> <p>Development of Dr Foster - use of tool to identify areas of risk - esp. mortality and unexpected readmission</p>	<p>Divisional and Directorate performance and governance monitoring</p> <p>Divisional Quality reports covering Dr Foster</p> <p>EB agreed business case to meet NPSA medicines</p>		<p>GovC review and updates</p> <p>TB reports and minutes</p> <p>Patient surveys</p> <p>HCC and other reports</p>		<p>Work in hand with routine reports and monitoring underway</p> <p>Monthly meetings with Dr Foster</p> <p>Dr Foster being used within clinical services e.g. clinical</p>	<p>Work in hand to ensure delivery & compliance throughout year</p>

Oxford Radcliffe Hospitals

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				- with tailored audits AHC update reports CAP (Standards)	alerts Regular meetings with Dr Foster to develop use				haem.	
6.4 C5a, 5b, 5c, 5d C11b C7ac	tbc	ML KS, AM	Lack of engagement in clinical governance within the directorates compromises governance arrangements and so could impact on AFT application (see also 1.4)	Delivery of HCC action plan that covers trust-wide governance Accountability reviews test embedding within divisions and directorates Review of governance, quality and risk framework Sufficient resource in place CAP (governance)	Divisional and Directorate performance and governance monitoring	Lack of robust scheduling of quarterly divisional account'ity reviews	GovC TB SHA - HCC action plan TB and GovC External review on governance		Updated reports for Dec 08 to GovC and work continuing External review in hand to support governance, safety, quality and risk arrangements	Work underway and TB to review in March 2009
6.5 C7ac	008 009	ESH	Failure to agree plan for NHSLA level 2 during 2009/10 compromises AFT application and patient safety	Business case agreed for resourcing plan to achieve level 2 Governance arrangements in place to support delivery of plan and reviewed	Progress on plan to be reported to CRMC Staff to be in place (Jan/Feb 09)		CRMC GovC		Resources in place Jan 09 and project plan to be finalised	Work well in hand

Oxford Radcliffe Hospitals

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				regularly						
6.6 C9		ESH	<p>Failure to meet national requirements for information governance could impact on patient safety</p> <p>Failure to meet requirements under FOI could impact on reputation</p> <p>Failures in data quality could impact on patient care and hence patient safety (e.g. alterations to patient and GP details to be recorded, smoking and weight to be recorded etc)</p>	<p>Information Governance Group in place</p> <p>Agreed IG work programme and robust and regularly updated policies</p> <p>Executive Director with Board level responsibility</p> <p>Identified SIRO with understood role</p> <p>FOI publication scheme</p> <p>Policies and procedures updated and approved through agreed work programme</p>	<p>Regular reports to assure GovC on programme, systems and processes in place</p> <p>Review by IGG on information governance Incidents/SUIs</p>		<p>GovC</p> <p>CEAC audit on 07/08 - limited assurance in relation of collated evidence (08/ORH/2 0-2)</p> <p>CEAC Audit on data integrity (08/ORH/2 0-1) - LA</p> <p>AC review</p>		<p>CEAC Action plans to be finalised and delivered to timescales agreed</p> <p>IGG regular review of progress for Information Governance Assessment</p>	<p>Work in hand on a number of fronts with regular reporting to GovC and through it to the Trust Board</p> <p>Agreed policies in place</p>
<p>S07 - to improve the overall patient experience by offering excellent customer care. (SA1)</p> <p>Principal risks</p>										

Oxford Radcliffe Hospitals

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7.1 C13a C20b	031 032	ML KS ESH IH	Cardiac and cancer centre projects do not open to time and delays in providing improved accommodation for significant number of patients compromises privacy and dignity	Robust commissioning plans in place and reviewed regularly Monitoring of standards (e.g. placements of patients) during transfer of services NOTE: Cardiac Centre also to provide additional single gender accommodation Reports on separate gender accommodation	Matrons' reports Divisional and Directorate performance and governance monitoring Divisional Quality Reports to GovC		Commissioning Board for Cancer Cardiac Implementation Board GovC TB reports Nov 08 PCT and SHA monitoring		AHC compliance updates to each Board meeting	Cancer Centre opening dates now agreed Cardiac Phase 1 during 08/09
7.2 Indicators	028 033 035 036 062	ESH/ AMu	Access targets are not met and hence performance rating worsens and compromises reputation, AFT application and customer care	Strong monitoring arrangements in place wef 1 April 2008 (see also above) Annual health check reports to TB every two months CAP (standards)	Divisional and Directorate performance and governance monitoring EB weekly updates	NOTE: data for DTOC not clear - indicator dropped from 07/08 assessment	TB reports and F&PC GovC review Position in November shows compliance across areas		AHC compliance updated Weekly updates to Executive Board TB report Jan 09	Work in hand to ensure compliance
7.3 C13a,	031 032	ESH See also	Required customer focus initiatives are not put in place	Approved customer care strategy and plan and regularly reviewed	Divisional and Directorate performance	Monitoring system to be finalised	TB and assurance committees	Updated complaints report	Detailed action plans worked up	Work in hand

Oxford Radcliffe Hospitals

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C14a, 14b, 14c C16, C17, C20a, 20b C21	036 052 053	3.2	consistently and effectively and complaints increase	Complaints handling policy and procedure updated and in place taking account of recent review (Feb/March 2008) Plans to ensure continued learning and 'closing of loop' on complaints, comments and incidents. Regular review to ensure learning delivered	and governance monitoring Performance reports to TB on, e.g. complaints handling	(see also 3.2) Link to AFT members' initiatives	HCC Patient surveys	to TB	for specifics, including updated training plan Leaders' briefed (Jan 09) on customer care standards for ORH	
7.4 C6 C16 C17	061 062	ESH JP	Patient and public engagement does not support successful creation of membership body to support AFT application	AFT Membership strategy and patient and public engagement strategy in place Action plans implemented for 2008/09 and followed up by regular review (to include detailed plans for elections) Robust membership strategy for AFT and supporting plans for governance of AFT Plans in place to ensure engagement of	TB agreed plan March 2008 Meetings with HOSC Patient Panel and other bodies University events for January 2009	Final plans for Patient Panel and Patient Partnership Committee	SHA re AFT application Feedback from Members' events in October, Dec and Jan 09 Increasing member numbers	TB review of AFT consult'n	Continued Members events and Jan 09 Elections planning underway TB to consider full report in March 2009	Work in hand

Oxford Radcliffe Hospitals

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				<p>university staff esp. through AHSC plans</p> <p>Strong consultation and communication plan in place and reviewed regularly</p>						
7.5 C9		ESH	Failures in aspects of information governance will result in poor customer care - poor discharge communications for patients and GPs	<p>Appropriate paper and electronic discharge arrangements in place</p> <p>Information Governance Group with agreed work plan in place and reviewed</p> <p>(see also 4.2)</p> <p>SIRO in place - Director of Nursing and Clinical Leadership</p>	IGG review and work plan in place		CEAC Audit (07/ORH/IT/05) on both paper and electronic systems - limited assurance for paper but significant assurance for electronic system		<p>Formal recommendations contained in CEAC report to be delivered in accordance with agreed timetable</p> <p>Regular review by IGG on progress</p>	Work in progress
<p>SO8 - To develop the Trust's role as an academic health sciences centre of international standing. (SA2)</p> <p>Principal risks</p>										
8.1 C7ac	074	ASt	Failure to establish governance arrangements in partnership with	AHSC/AFT programme structure and plan Strategic Partnership	SHA, DH and Monitor Oxford	Final timetable for AFT	Strategic Partnership Board		Refreshed programme for AHSC/AFT	Work in hand with University and others

Oxford Radcliffe Hospitals

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C12			University could compromise success of AHSC accreditation and impact on AFT application	<p>Board</p> <p>Joint Estates Strategy Group established.</p> <p>Executive Director lead in place with dedicated project support</p> <p>Process for MSD staff to become AFT members</p> <p>CAP (Governance)</p>	University Medical Sciences Division Board and Council	process	<p>minutes</p> <p>TB minutes</p> <p>AFT sessions for TB and others</p> <p>AFTSG (CAP monitoring)</p> <p>Leaders briefings (LB) and sessions for MSD staff</p>		<p>application</p> <p>AHSC Part 1 application submitted</p> <p>Part 2 application work underway</p> <p>Meeting with SHA on AFT 30 Jan 09</p> <p>HDD review</p>	with agreed timetable for AHSC/AFT programme
8.2 C7ac ALE	074	ASt	Lack of engagement and understanding within the ORH compromises success of application	<p>CAP in place covering all areas</p> <p>Communications plan regularly reviewed by AFTSG</p> <p>Full consultation record</p> <p>Targeted activities with clinical staff and university</p>	<p>AFT Steering Group</p> <p>TB updates</p> <p>AFT Development sessions</p> <p>SHA, DH and Monitor</p>		<p>F&PC</p> <p>TB update reports</p> <p>Leaders Briefings</p>		<p>TB Update on AHSC/AFT progress Jan 09</p> <p>Staff engagement initiative for ORH and MSD from Jan 09</p>	Work well underway
SO9 - To maximise the Trust's contribution to the health and wellbeing of the local community. (SA1, SA4)										

Oxford Radcliffe Hospitals

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Principal risks										
9.2 ALE VFM	As above	ASt	Failure to achieve membership targets and to develop appropriate programme of engagement	AFTSG in place to oversee all aspects through CAP Agreed membership strategy as part of IBP Membership milestones in place and being met CAP (External)	AFTSG CAP		TB and EB SHA re AFT application Members events and letters Monitor		Continue review through AFTSG with focus on timetable for events post meeting with SHA 30 Jan 09	November target exceeded Election provider agreed Work underway to maximise engagement
9.3 ALE VFM	As above	ASt	Partnerships with local PCTs and councils are not taken forward sufficiently and PCT does not support AFT application	Patient and public engagement to ensure work with PCTs and HOSC through agreed means reviewed regularly CAP (various)	AFTSG EB		AFT SG HOSC Monitor		Specific work with PCT and GPs to address points raised on AFT	Work in hand
SO10 - To become a strategic, high performing and agile organisation supported by efficient and patient focused clinical processes, modern systems and business processes. (SA1, SA3, SA4)										
Principal risks										
10.1 ALE	028 036	All	Financial and operational pressures are too great and divert from long-term	Financial and activity monitoring systems in place	ALE project group EB, TB		TB F&PC		AC review Dec 08 ALE meeting	Work in hand to achieve agreed

Oxford Radcliffe Hospitals

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	062		objectives - rating for quality of financial management is not improved	Project plan to oversee ALE throughout year reporting to AC and TB - Strong IBP linked with in year finances through LTFM CAP (Finance)	SHA - through ALE Action plan DH AFTSG and LTFM Group		AC		Jan 09 Update TB Jan 09	improvements for 2008/9 ALE
10.2 ALE	027	AMu	Performance improvement programme is not achieved in-year and service and performance improvements are lost impacting on financial position and AFT application	Governance for CIP/PIPs in place and followed with documented plans for improvement which are reviewed and monitored. Performance improvement team in place. Robust plans with clear accountabilities for specific projects and monitoring process in place. Business planning process in place	TB EB Accountability Reviews F&PC	Further work to be done on project evaluation	Weekly review meetings EB oversight F&PC & TB monitoring KPMG review		Ongoing work to achieve completion to plan through business planning process and Directorate workshops KPMG review	Work in progress to achieve plan
10.3 C7ac C9	049 050	VH	CRS project cannot be delivered because of national and financial limitations leads to lack of clinical	Strong governance and project management arrangements in place which are subject to review (e.g. CC, IGG)	Project Board and links to other partners within health economy		TB reports on progress with CRS Review through	National programme	Options being considered for way forward	Work in hand to agree plan

Oxford Radcliffe Hospitals

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			engagement within ORH Failure to reach agreement on contract amendments impacts on go live date for ORH	Risk register in place and updated regularly Revised plans being considered - BT solution			IGG		focusing on BT product	
10.4 ALE	027	AMu	Structural changes are not achieved in support of performance improvement - e.g. operations coordination, and hence rating of excellent not sustained	Governance for CIP/PIPs in place and followed with documented plans for improvement which are reviewed and monitored. Performance improvement team in place. Robust plans with clear accountabilities for specific projects and monitoring process in place. Appointment of Chief Operating Officer CAP (finance)	TB EB Accountability Reviews F&PC Date for COO appointment		Weekly review meetings EB oversight F&PC monitoring TB monitoring KPMG review		Ongoing work to achieve completion to plan	Work in progress to achieve plan
10.5 C7e C8b	072	SD	Workforce plan is not in place and recruitment and retention plans are	Workforce plan in place for trust as a whole that is reviewed regularly and to address specific	EB and executive-led Workforce committee	Finalise executive-led HR com	TB GovC - to cover HR		Confirm HR assurance through ToR for GovC	Ongoing

Oxford Radcliffe Hospitals

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C10a, 10b C11a, 11b, 11c			not delivered	areas: e.g. cardiac centre opening, specialist recruitment areas	Divisional Boards		assurances		ToR for Workforce Committee confirmed Jan 09	
10.6 C15a, 15b C20a, 20b C21	052 053	IH	Resources to improve asset base and deliver much needed environmental and physical improvements are not available and compromise performance against core standards and ALE	Updated estates strategy in place for all sites with annual review and updating Backlog maintenance programme agreed, resourced and reviewed regularly CAP (risk)	Reports to TB on estates and capital programme ALE actions included in CAP (finance) EB monitoring of CC activities	Estates Strategy	TB review and agreement of estates strategy F&PC review ALE/Audit Committee CC in place		Estates strategy work in hand for March 09	Work in hand

Oxford Radcliffe Hospitals

Key

	Committee/Group		Document/report		External Body
TB	Trust Board	TRR TKR	Trust Risk Register Trust Key Risks	SHA	South Central Strategic Health Authority
F&PC	Finance and Performance Committee	CAP	Combined Action Plan (HDD, ALE, Audit, AFT, E&Y, SHA etc.)	HCC CS Inds	Healthcare Commission core standard (and hygiene code) Annual health check indicators
GovC	Governance Committee	IBP	Integrated Business Plan	CEAC SA LA	Central England Audit Consortium - internal audit Significant assurance Limited Assurance
AC	Audit Committee	LTFM	Long term financial model	ALE	Auditor's Local Evaluation (carried out by Audit Commission - external audit)
EB	Executive Board			BHPB	Better Healthcare Programme Board - PCT led
CC	Commercial Committee			CQC	Care Quality Commission (successor body to HCC from 1 April 2009)
HRC	HR Committee				
IGG	Information Governance Group				
AFTSG	AFT Steering Group				
LBs	Leaders Briefings				

	Risk to achievement of objective outstanding
	Work well underway on to achieve objective
	Risk to objective at reasonable/acceptable/minimal level