

Board of Directors meeting: Thursday 16 July 2009

BD2009.59

Subject	Board Assurance Framework			
Purpose of paper	<p>The Board Assurance Framework (BAF) highlights risks to the Trust's strategic objectives, and sets down the controls required to manage and mitigate those risks. The risks have been drawn largely from the Trust Risk Register (also reviewed by the Board), with additional reference to the Trust Business Plan.</p> <p>The BAF also sets out the sources of assurance that those risks are being managed, and highlights gaps in both controls and assurances. It describes the actions being taken in relation to each risk, and defines the status at the point of review.</p> <p>As the year progresses, the gaps in controls and assurances will be met. Accordingly, the BAF is dynamic, requiring regular review and updating throughout the year. Risks that are mitigated during the year will be removed from the BAF. New risks that arise to impact on the strategic objectives will be included in the BAF with appropriate controls.</p> <p>The Governance Committee has reviewed the BAF for 2009/10 before its presentation to the Board, and will continue to do so quarterly. The Board of Directors will review the BAF again in January 2010.</p>			
Board Lead	Mrs Elaine Strachan-Hall, Director of Nursing and Clinical Leadership			
Background papers (if any)	Trust Risk Register and the Trust Business Plan			
Action/decision required	<p>To review and agree the content of the BAF for 2009/10, paying particular attention to identification of the risks to the strategic objectives and the controls in place to mitigate them.</p> <p>To agree to quarterly review of the BAF by the Governance Committee, and at least bi-annual review by the Board each July and January.</p>			
Key purpose	Strategy	<u>Assurance</u>	Policy	Performance
Strategic Goals	All			
Strategic Objectives	All strategic objectives (referenced to the Strategic Goals) are included in the BAF			

Links to Board Assurance Framework/ Trust Key Risks/Annual Health Check element(s)	<p>The Trust Risk Register is one of the key documents used to develop the BAF. In addition, the risks included in the BAF are referenced to the Trust Business Plan, the core standards and, where appropriate, to specific domains and key lines of enquiry used in the Auditor's Local Evaluation.</p> <p>The Care Quality Commission is currently consulting on its proposals for regulation to come into effect from 1 April 2010. Due attention will be paid to this as the BAF is developed over the coming months.</p>
Also considered by	Executive Directors and Divisional Directors

Resource and financial impact	Not applicable		
Consideration of legal/ equality /diversity/engagement/risk issues	Covered within the BAF		
Acronyms and abbreviations used	See key to Board Assurance Framework below		
Author	Mrs Megan Turmezei, Associate Director of Governance		
Key		GovC	Governance Committee
AC	Audit Committee	H&S	Health and Safety Committee
AHC	Annual Health Check	HICC	Hospital Infection Control Committee
AHSC	Academic Health Science Centre	HIEC	Health Innovation and Education Cluster
BHPB	Better Healthcare Programme Board	HRC	Human Resources Committee
BoD	Board of Directors	IGG	Information Governance Group
BRC	Biomedical Research Centre	LB	Leaders Briefings
CC	Commercial Committee	LTFM	Long Term Financial Model
CRPB	Cost Improvement Board	MAC	Medicines Advisory Committee
CQB	Care Quality Board	OPB	Operational Performance Board
CQC	Care Quality Commission	PIT	Performance Improvement Team
CRMC	Clinical Risk Management Committee	SPB	Strategic partnership Board
CS Inds	Core Standard and Indicators	TBP	Trust Business Plan
CSS(G)	Clinical Services Strategy (Group)	TRR	Trust Risk Register
DG	Decontamination Group		
F&PC	Finance and Performance Committee		Risk to achievement of objective remains
FT SG	Foundation Trust Steering Group		Plans in place to mitigate risk(s)
			Risk to objective at reasonable/acceptable level

Board Assurance Framework

1. Work has continued to mitigate the risks contained within the BAF (and the Trust Risk Register) so that the Trust's strategic objectives can be achieved. For example, the executive-led Boards – Operational Performance, Cost Reduction Programme Board and the Care Quality Board – are focused on the mitigation of key risks and the delivery of the ORH's objectives.
2. However, several risk areas remain, although it is expected that the position with regard to gaps in controls and assurance will change throughout the year:
 - 2.1 achievement of cost reduction programme for 2009/10
 - 2.2 safety and sustainability of services at the Horton General Hospital
 - 2.5 availability of income to cover activity
 - 10.1 Tensions between access targets and quality and safety requirements
 - 10.2 Long term financial position for the Trust and the local health economy
 - 10.5 Financial impact of Cancer centre PFI
3. The Board is asked to note the key areas of concern and also to note the work being done to address the risks and deliver performance and objectives. This work will include work with the Trust's internal and external auditors to review areas of concern; for example the management of medical devices, a key element in patient safety, will be reviewed by CEAC later on this year as part of its review of compliance with core standards. In addition, CEAC will be undertaking audits in relation to information governance (ref 7.10), controlled drugs (ref 7.3), financial management and financial services (10.4) and cost improvement and performance management (ref 2.1, 7.5 and 8.3).
4. If additional risk areas are identified, external sources of assurance will be sought to ensure that plans put in place in the Trust are sufficient and appropriate.

Conclusion

5. The Governance Committee will review the BAF at each of its meetings, and it is proposed that the Board of Directors review the BAF again in January 2010 in advance of the year-end declaration to the Strategic Health Authority.

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Ref & CS	TRR ref	Lead	Principal risks to strategic objective	Risk mitigation/control plans	Risk control & monitoring	Control gaps	Assurances on controls	Gaps	Action plans for gaps ¹	Status
SO1 - To consolidate and advance the international status of the Trust's defining services. (SA1, SA2, SA3) (cardiac, cancer, neurosciences, transplantation and gastroenterology): Principal risks										
1.1 and 2.6	040 041 042 1.1 1.2	COO	Cancer Services Capacity issues in Cancer Intensive Care Unit (CICU) and Day Surgery and theatres (all sites) insufficient for workload, especially once Head & Neck move. High risk of patients requiring HDU being placed on wards and hence safety compromised	Agreed plan to manage capacity across three sites with specific reference to intensive care/HDU capacity and theatres Risk assessment procedure in place across the ORH Clinical Services Strategy (CSS) updated and agreed by Board of Directors CSSG in place	Division review on regular basis OPB COB CSSG	Agreed CSS not in place	BoD approved CSS PCT Cancer Network		Current position shows activity levels being delivered CSS now being developed for agreement with the Board - target for first review October 2009	Plans in place to mitigate risk
1.2	033 1.1 1.2	COO	The move of clinical services to be completed: split services/staff impact on quality and safety of care. Haematology move delayed pending building work.	Agreed plan to complete transfer of services to Churchill site	Division review on regular basis OPB COB	Move to be completed	BoD		Plan being monitored through Commissioning Board, Cancer Directorate and Division B - update August 2009	Plans in place to mitigate risk
1.3	025 043 1.4	COO	Gastroenterology Failure to expand endoscopy facility puts ability of Trust to become Bowel Cancer screening centre at risk with impact on income	Agreed programme for expansion of endoscopy Regular review of capital programme by executive	Bowel Cancer Screening Group		BoD approved CSS PCT		Capital secured for endoscopy scheme	Plans in place to mitigate risk

¹ Reference only with key points - action plans responsibility of lead

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			and reputation Bed pressures mean that GI patients may be in unfunded beds. Additional risk for endocrine patients who have no home ward till H&N move GI wards not staffed to take these patients.	and Board of Directors Agreed plan for development of gastroenterology services CSS updated and agreed by BoD	CSSG in place with appropriate membership and meeting regularly	CSS not in place		CSS to be agreed	CSS now being developed for agreement with the Board - target for first review October 2009	
1.4	017 020 037 1.3	COO	Transplantation - no emergency theatre capacity for patients undergoing transplants compromises patient safety Insufficient ITU capacity - risk of loss of the NCG contract due to inability to maintain activity levels for SPK/Intestinal transplants and risk of loss of >£5m Trust income. Impact on patient safety with patient returning to the ward following major surgery. Lack of beds on transplant ward to cope with patient demand results in transplant outliers being admitted to other wards with consequent	See also 1.1 above Agreed plan for theatre capacity and emergency theatre operating to support all services Proper activity monitoring process in place through OPB and COB and with commissioners Risk assessment procedure in place across the ORH Agreed plan for transplant services at the Churchill to cover all aspects of capacity CSS updated and agreed by BoD	Divisional review OPB COB CSSG	CSS not in place Agreed capacity plan	BoD approved CSS PCT	CSS to be agreed	Agreed activity levels currently being delivered but monitored closely Clinical Services strategy now being developed for agreement with the Board - target for first review October 2009	Plans in place to mitigate risk

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1.5	039 1.1 1.5	COO	Cardiac services: Lack of capacity for cardiac services with insufficient resources in most areas results in pressure to deliver demand and targets.	CSS updated and agreed by BoD Robust performance and activity monitoring in place supported by scheduling NSF Task Force Group in place	OPB CSSG	CSS not in place	BoD approved CSS	CSS to be agreed	CSS now being developed for agreement with the Board - target for first review October 2009	Plans in place to mitigate risks
S02 - To provide high quality, efficient and innovative core services that meet the needs of local patients and the challenges of the local health community (SAT):										
Principal risks										
2.1 ALE	044 2.1	COO DF&P	Failure to deliver performance improvement and cost reduction programme compromises financial performance, standing, reputation, services (particularly core services) and FT application Reductions in management capacity will impact on performance NB Links to longer-term financial position see 10.2	Robust arrangements in place to monitor service performance, financial performance and cost improvement plans at all levels. PIT in place Agreed and deliverable CIP in place Mechanism in place to monitor knock-on effects on service quality and safety	Executive-led monitoring structure in place covering operational, financial and quality performance CRPB OPB COB	CIP plans not finalised but new monitoring arrangements in place	F&PC - monthly review BoD - review in July 2009		Regular review through Executive and BoD structure Impact of long term position being factored in F&PC and BoD Review July 2009	Risk remains

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2.2 C2 C17	004 005 2.2 9.5	COO DP&I	Horton General Hospital: Sustainability of safe services for maternity, paediatrics, gynae and anaesthetics post IRP decision for at least the next two years while PCT develops long term vision for services. Particular pressured on paediatric staffing levels Sustainability of emergency general surgery challenging. The general surgical and trauma junior medical on-call rota is combined overnight and this could impact on quality and safety of services.	Agreed plan in place with ORH supporting PCT led Better Healthcare Programme Contingency plan to meet staffing issues (particularly in paediatrics) Agreed plan for management of emergency surgery	Active engagement with clinicians on contingency plans Regular review within relevant services, e.g. Children's and Women's.	Problems in maintaining interim plans in paedics addressed Implementation of plan for emergency surgery	Weekly meetings of Horton Group BHPB - PCT led BoD review July 2009	Agreed long term solution from BHPB	Weekly meetings continue to ensure sustainability of safe services Next phase begins July 2009 – evaluation of Invitation to Innovate and developments of sustainable models of care. Contingency plans developed for implementation if required.	Plans in place but risks to services remain high
2.3 C6 C17 C18	054 2.3	DP&I	Failure to develop partnerships, e.g. with PCT and GPs, compromises improvements to emergency care pathways and care of patients with long term conditions	Active programme of collaboration in place with specific initiatives agreed between ORH and PCT Robust performance monitoring arrangements	Key comm. meetings OPB	Funding impacts on delivery of initiatives	Key Commiss'r meetings BoD		Clarification on joint PCT/ORH approach to deliver initiatives Potential to compromise activity/finances and reputation through lack of collaborative demand management	Plans in place to mitigate risks
2.4 Inds	028 2.1	COO	Failure to meet emergency access target compromises patient care and overall	Agreed plan to manage emergency access targets and to ensure links with	Daily monitoring in place	Continued pressure on	BoD review July 2009 Emergency		Five workstreams being taken forward - role and purpose of	Plans in place to mitigate

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			performance (4 hour) Impacts across both JR and HGH ED departments and inpatient specialities	inpatient specialities Internal arrangements robust to support service models System-wide structure to support delivery Executive level leadership in place	OPB	performance	access development plan agreed with PCT & SHA CQC AHC Nov 2009		ED, relationship with inpatient specialities, clinical decision unit, management of minors side (which continues to perform above target), and teaching and training.	risks
2.5 ALE	045 3.4	DP&I	Commissioners will be unable/unwilling to fund current levels of activity and activity in 2009/10. Impact on all services	SLA in place with robust monitoring in place Demand management plan in place and agreed with commissioners	OPB Key Commissioners' meetings	Oxon position unclear	F&PC review BoD - review in July 2009 PCT/SHA		Work continuing to plan for financial position and monthly F&PC meetings Impact of long term ££ position being factored in	Risks remain high
2.7 Inds	038 2.1	COO	Stroke unit admission not available to all stroke patients with impact on service, performance and reputation of Trust. Additional risks to quality of care and to staff morale and sickness rates.	Agreed capacity for stroke patients in place and maintained (link to demand management and emergency access) Robust audit and performance monitoring arrangements in place	OPB COB	Performance for 08/09 shows performance not met because of capacity issues Highlighted as a priority for ORH in	BoD July 2009 CQC AHC Nov 2009		Implemented ring fenced capacity at JR and HGH April 09 Implemented step down capacity in Witney CH May 09 Plans to open step down in Abingdon Sept 09 Successfully bid and won money from SHA	Plans in place to mitigate risks

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	TBP ref					Quality Strategy to BoD July 2009			to implement early supported discharge in Oxford City Autumn 09 TIA service plans in place. Appointed national consultant to support service July 09	
<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): Principal risks</p>										
3.1 C9 ALE	046 047 3.4 10. 3	DP&I	Problems with the coding, recording and reporting of information will lead to a loss of income and misreporting of income within the Trust. Risk heightened by introduction of HRG4 and has impact on specialist services. Coding issues impact on acute core services and front line services.	Data Quality Board in place Robust training on data quality/coding etc Clarity re impact of HRG4	Data Quality Board IGG Income Board Divisional reviews		Reports to GC - June/Sept 2009 F&PC monthly review re income BoD - review in July 2009			Plans in place to mitigate risk
3.2 C7ac C20a	031 10. 5	DF&P	Risks arising from imbalance between funding and standards of service required and capital/revenue funds to support all Trust strategies	Agreed capital programme in place that meets requirements Sources of additional	Physical Resource Group CC	Funding gap remains	F&PC monthly review BoD - review	External benchmarking underway	Capital programme reviewed regularly	Lack of funds remains an issue

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ALE	TBP ref		and business cases (capacity, environment, performance) Specific issues for ITU/HDU, transplantation, renal and endoscopy (and Churchill site)	funding identified			July 2009			
SO4 - To identify, evaluate, prioritise and nurture emerging services (SA1, SA2): Principal risks										
4.1	052	MD	Failure to build on opportunities afforded by the BRC for translational research compromises agreement on strategies for: new and emerging services; new technologies in the gene & pathology services; and specific service developments	Agreed programme for BRC covers agreed areas within emerging services Annual R&D Report to the Board of Directors CSS in place covering emerging services	BRC Steering Group CSSG	Link to AHSC planned work	GC - review of research governance June 2009 BoD SPB		Work underway to identify future plans through BRC and CSS and AHSC work Translational research and innovation key priority for DH	Plans in place to mitigate risk
4.1a	1.6									
4.1b										
4.1c										
SO5 - 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): Principal risks										
5.1 Inds	026 2.1	COO	Achievement of diagnostic access targets - From March 2008 all radiology examinations are to be undertaken within 4 weeks of referral The primary risk to achieving the target is MRI imaging Neuroradiology	Robust local and corporate monitoring arrangements in place Divisional accountability reviews	OPB COB Divisional/ service groups		BoD - review in July 2009 CQC AHC Nov 2009		Weekly & monthly monitoring to manage activity and achieve targets	Plans in place to mitigate risk

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5.2 Inds	008 2.1	COO	Maintenance of plain film reporting and introducing 'hot reporting' for urgent inpatient & ED referrals Insufficient medical staff hours to maintain timely reporting service. Films not being reported and patient safety/treatment/performance compromised	Adequate staffing levels to deliver service Protocols in place for radiographer reporting Robust risk assessment procedure in place	OPB COB Divisional accountability reviews	Agreement re additional staff	BoD - review CEAC review awaited		Job planning Reinstatement of radiographer reported at HGH to reduce delays	Plans in place to manage risk
5.3	027 5.2	COO	Laboratory IT system - Labs currently use multiple IT systems. Systems reviewed; a single IT system recommended to support all areas. Severe governance implications if system fails IT investment requirement for HCAI reporting and monitoring	Agreed business case and plan for procurement and implementation of IT system	CC Divisional (C) accountability review	Linked to CRS Business plan to be agreed			Agreement on business case pending Timescale for CRS to be confirmed	Plans in place to manage risk
SO6 - To develop the Trust's role as an academic health science centre of international standing working in partnership with the University of Oxford and the Nuffield Orthopaedic Centre and other partner organisations. (SA2): Principal risks										
6.1	052 6.1 6.2	DP&I	Failure to obtain AHSC designation will adversely impact on reputation and finance and could compromise BRC and organisational development Failure will impact on progress	Timetable and process for next stages of AHSC agreed in local healthcare system by all partners Agreed approach for HIEC within northern SHA	AHSC Steering Group meetings	Final agreement on way forward outstanding with all	BoD review July 2009 SPB SHA DH		BoD to agree way forward for AHSC so that implementation plans can be drawn up HIEC meetings 18 & 22 June 2009 but letter	Plans in place to mitigate risks

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			with integration of patient care, teaching and research			partners Clarity on HIEC needed			due from SHA CEO Group to be established following meeting 25 June 2009	
6.2	057 6.1 6.2 6.3 6.4 9.4	DP&I	Failure to agree timetable and process for FT application compromises ORH reputation and standing particularly with key partners including Oxford University Failure to deliver credible LTFM in current and long term financial situation compromises success	Timetable and process agreed by BoD with SHA and Monitor Agreed LTFM	AFT SG Executive Directors	Executive to Executive discussions with SHA LTFM pending	BoD Away Day F&PC and BoD Review July 2009 SHA Monitor	Plans to be agreed with SHA and DH	Discussions to agree timetable with BoD and SHA	Plans in place to mitigate risks
6.3	051 6.1 6.2 6.3	DP&I	Failure to gain PCT support will jeopardise Foundation Trust application and AHSC process	Agreed LTFM (see also above)	AFT SG ORH/PCT meetings Clinical liaison meetings	Agreement on LTFM and FT timetable	As above		As above	As above
S07 - To provide demonstrably excellent clinical outcomes and indicators of patient safety. (SA1): Principal risks										
7.1 C1a C1b	001 7.1 7.3	DNCL	Improvements in patient safety not delivered and safety compromised. Financial situation could	Staff and patient safety strategy in place with supporting actions and assurance processes	Divisional governance arrangements	Ongoing work throughout year	GC review June and Sept 2009 BoD Review	ongoing	Actions include Safety Action Groups, preparation for NHSLA review (Sept 2009),	Plans in place to mitigate risks

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C2 C7ac	7.4 7.5 7.6		divert attention from the safety agenda Registration with CQC may be compromised Failure to address actions in external reports (e.g. Mid Staffs, Children's Services) compromises safety and quality in all areas	Safeguarding arrangements in place NHSLA level 1 and 2	H&S, CRMC etc. COB	Process for CQC not yet clear	July 2009 CEAC Audit core standards (Nov 2009) CQC AHC Nov 2009		safeguarding reports, update paper on Mid Staffs (July 2009), review of compliance with HCAI registration	
7.2 C4a C4c Inds	020 003 7.2	MD	Failure to manage all aspects of HCAI to meet 09/10 targets, MRSA screening, environmental concerns, CQC registration, decontamination and storage, cleaning etc Environmental issues in theatres and OT Specific issues within Neonatal Unit	Compliance with CQC HCAI registration with associated policies and procedures in place HICC and DG in place Agreed plan for refurbishment of Neonatal Unit	OPB COB HICC DG	Ongoing work in all areas to deliver improv'ts	F&PC review BoD review of work programme July 2009 CQC - AHC Nov 2009 PCT SHA		Continued regular reporting and review of compliance Action plans in place to meet shortfalls NNU Business plan being developed for BoD Review Sept/Oct 2009	Plans in place to mitigate risks
7.3 C4d	006 7.1	DNCL MD	Medicines Management risks across a number of areas including controlled drugs	MAC in place with agreed policies and procedures Divisional and directorate monitoring arrangements in place Annual Medicines Management Report	Divisional governance arrangements MAC COB		GC - review of Annual Medicines Management Report BoD		Plans in place to mitigate risks and to deliver in all areas including those dealing with specific NPSA alerts	Plans in place to mitigate risks

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7.4 C6	015 7.1	COO	Absence of clear pathway for intra-hospital escort compromises acutely ill patients. High risk patients within Horton ED, CCU & Maternity compromised when ED / anaesthetic staff act as escorts out of hours.	Plan agreed between clinical services covering all aspects Agreed audit/review process in place	Clinical Risk Management Committee COB	Review process to be agreed post agreement of the plan	GC to review delivery of action plan	Tbc by end Dec 2009	Work underway for completion by end Sept 2009 Review process to be in place by end Sept 2009	Plans in place to mitigate risks
7.5 & 8.3 All CS and inds	021 7.1 7.2 7.3 7.4 7.5 7.6	DNCL	Failure to meet core standards, existing and new national targets for half year 09/10 and failure to meet criteria for registration with COC Failure to agree metrics and their delivery compromises performance management and governance and assurances	Robust plan in place to monitor all aspects of performance and compliance Governance arrangements in place	OPB COB monthly update Divisional governance arrangements	Lack of clarity on registrat'n from 1 April 2010	GC BoD review July 2009 COB - AHC Nov 2009		Stronger assurance mechanisms to support compliance statements within directorates and divisions through COB Briefing Paper to BoD July 2009 on registration	Plans in place to mitigate risks
7.6 C1a C1b C4b	010 7.1	COO	Risk of exposure to staff and patients from radio-pharmaceuticals within Nuclear Cardiology External inspection by the Environment Agency 24.2.09 may impact integrity of unit.	Facility inspected and approved by Environment Agency	Directorate Board and Radiation Protection Committee		Environment agency			Plans in place to mitigate risk
7.7 C9	013 7.1	DF&P	Risks associated with the filing into, the access to health records in a number of areas,	Programme for microfilming/scanning of case notes and for	CRS project arrangements	Trust-wide prog. not	GC		Roll out of culling, scanning and digitization	Plans in place to mitigate

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	7.4 10.2		including AGM, outpatients and renal clinical at Horton Duplicate records remain a risk to treatment and patient safety Impact across the ORH	reduction in duplicate records in place CRS timetable agreed	IGG	complete			programme underway	risks
7.8 C1a C1b C4b	009 7.1 7.4	COO	Point of care testing is performed with inadequate staff training, patient identification, result recording, and limited ability to audit testing, incomplete link nursing support structure and no external quality assessment scheme in several cases. ACT Calibration not in place	Appropriate equipment and staffing resources in place with training programme	Division C governance accountability reviews	Additional resource required	GC		Plans in place – new electronic equipment, and machine testing pads etc.	Plans in place to mitigate risks
7.9 C4a C4c C7ac C13a C20a C20b	014 10.5	DF&P	Health, safety and security risks exist because of lack of capital funding for statutory legislation, enhanced patient environment, control of infection and carbon reduction strategy. New "central" directives require a speedy resolution e.g. Privacy & Dignity, Control of Infection and Disability Discrimination Act to be	Agreed capital programme in place with sufficient resource to meet all requirements	Physical Resource Group Commercial Committee COB	Gaps remain in funding	GC F&PC BoD CQC AHC Nov 2009		Additional funds allocated for single gender accommodation (see also 8.5) Joint programme with Infection Control	Plans in place but risks remain high

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			adopted.							
7.10	012	DNCL	Loss of portable media containing patient identifiable data : (USB sticks, Blackberries/mobile phones and Laptops) could compromise patient confidentiality and reputation	Serious Information Risk Owner identified - DNCL Information Governance arrangements in place	IGG COB		GC - June 2009 DH CEAC Audit of self assessment CQC AHC Nov 2009			Plans in place to mitigate risks
C13b	029		Ward pcs located in public spaces on wards risk: and risk of breach of patient confidentiality	Policies and procedures maintained and annual work programme Improvement in IG Self Assessment						
C13c	7.4									
S08 - To improve the overall patient experience by offering excellent customer care. (SA1): Principal risks										
8.1	030	DNCL	Failure to implement an appropriate End of life pathway for all appropriate patients could impact on quality of care as measured through, for example, patient survey, comments and complaints: performance and reputation could be compromised and rating could be reduced	Agreed process for end of life care pathway in place Monitoring process in place for comments and complaints Action plans agreed following patient surveys Robust organisation learning in place	Divisions and directorates Incidents, comments and complaints Comm COB	Further work on organisational learning in hand through CQB	GC - review June 2009 BoD - review July 2009 CQC AHC Nov 2009		Ongoing work to deliver pathways and service improvements and compliance with core standards	Plans in place to deliver service improvements
C13a	7.1									
C20b	8.2									
8.2	050	DNCL	Privacy and dignity of patients is compromised	Improvements in single gender accommodation	Divisional arrangements	Action plan on same-	GC BoD - review		Detailed work being done to deliver same-	Plans in place to
	7.1									

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C13a C20b	8.2		across ORH as a whole with an impact on perception and reputation with patients	delivered across the ORH Matrons' reports to Board of Directors	CQB	sex accommodation not yet complete	July 2009 PCT and SHA DH		sex accommodation - working with both PCT and SHA	mitigate risks
8.3 & 7.5 C7ac COC	021	DNCL	Failure to meet core standards, existing and new national targets for half year 09/10 and failure to meet criteria for registration with CQC Failure to agree metrics and their delivery compromises performance management and governance and assurances	See 7.5 above	See 7.5 above	See 7.5 above	See 7.5 above	See 7.5 above	See 7.5 above	See 7.5 above
8.4 C16 C17	055 8.3	DP&I	Failure to develop and maintain public membership through delays in AFT application compromises wider challenge to support patient and public engagement particularly in relation to election process	Communication strategy in place for FT public and staff members Timetable agreed for FT elections and processes	AFT SG	Clarity re timetable for FT process required	BoD SHA Monitor		Further discussion at BoD on AFT work Communications plan in place and events being planned for FT members	Plans in place to mitigate risk
S09 - To maximise the Trust's contribution to the health and wellbeing of the local community. (SA1, SA4)										
Principal risks										
9.1	054	COO	Failure to develop	Clinical liaison structure in	System-wide	Greater	BoD		Work underway across	Plans in

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Ref & CS	TRR ref	Lead	Principal risks to strategic objective	Risk mitigation/control plans	Risk control & monitoring	Control gaps	Assurances on controls	Gaps	Action plans for gaps ¹	Status
C22a &c	2.3 9.1 9.2 9.3	DP&I	partnerships, e.g. with PCT and GPs, compromises improvements to emergency care pathways and care of patients with long term conditions Potential to compromise activity/finances and reputation through lack of collaborative demand management	place with PCT and GPs (e.g. urgent care, public health initiatives) System-wide engagement in demand management etc.	meetings structure OPB	engagement required across all partners	PCT Whole system structures		the system with partners to deliver agreed initiatives Linked to potential work to deliver innovative and change in the delivery of healthcare in certain areas, e.g. chronic disease, diabetes, dementia (AHSC)	place to mitigate risks
9.2 C24	059	COO	Trust is not prepared for the impact of flu/swine flu outbreak and all aspects of performance (including financial because additional costs) are compromised Impact on staff and hence capacity in all areas at greatest risk of compromise - e.g. ITU	Full risk assessment in place across all aspects System-wide procedure for management with agreed reporting systems	ORH takes part in PCT/SHA-wide system		BoD review July 2009 ORH plan has been externally reviewed PCT, SHA CQC - AHC Nov 2009		Ongoing work in collaboration with PCT and other parties	Plans in place to mitigate risks
9.3 C11b	007	COO	Over activity/ insufficient staffing/RSI in specimen reception, leading to WRULDS (Work related upper limb disorders) in staff, increased staff sickness/absence. HSE may take action if	Health and Safety policies and procedures in place Staff Safety Strategy in place	Divisional risk and governance meetings H&SC COB	Resource required	COB GC		Plans in place to manage workload for affected staff	Plans in place to mitigate risks

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Ref & CS	TRR ref	Lead	Principal risks to strategic objective	Risk mitigation/control plans	Risk control & monitoring	Control gaps	Assurances on controls	Gaps	Action plans for gaps ¹	Status
			improvements not made							
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)										
10.1 All C7ac	016 022 023 10. 1	All	Tensions between access targets and quality and safety requirements compromise performance in all areas of service - front line, clinical support and support and infrastructure services, particularly at a time of significant financial and capacity pressures.	Robust governance arrangements across the ORH with Board-led review of risks and performance Risk Register in place regularly reviewed	Divisional meetings Accountability reviews OPB CRPB COB	Risks remain high between competing priorities	GC F&PC GC review June 2009 BoD - review July 2009 CQC AHC Nov 2009		Ongoing work in all areas to manage all aspects of risks 'Could it happen here' paper to BoD July 2009 and regular review through CQB	Risks remain high
10.2 ALE	056 10. 1	DF&P	Current and long term financial position for ORH and across the health economy compromises financial stability of the Trust Scale of CIPs required impact on LTFM (and hence FT) Anticipated year on year negative growth	Financial strategy in place agreed by Board and regularly updated Agreed CRP in place and monitored regularly	OPB CRPB	Whole system work to be completed (see also AHSC work)	F&PC AC BoD - review July 2009		Continued work to assess situation and prepare plans in partnership with PCT and others	Risks across whole system remain high
10.3 C7b e C8a b	036 058 10.	DHR COO	Staffing constraints and workload pressures in specific areas and across the ORH impact on service provision and quality Insufficient	Agreed workforce plans in all areas Workforce panels in place	HR Committee OPB		F&PC BoD - review in July 2009 CQC -			Plans in place to mitigate risks

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Ref & CS	TRR ref	Lead	Principal risks to strategic objective	Risk mitigation/control plans	Risk control & monitoring	Control gaps	Assurances on controls	Gaps	Action plans for gaps ¹	Status
C10ab C11ab C11c	4		workforce capability and/or capacity in specific areas and across ORH as a whole compromises delivery of services within agreed budgets	Agreed CIPs Appropriate HR policies and procedures in place	COB CRPB		declaration of compliance Oct 2009			
10.4 ALE	049	DF&P	Cash Management Inability to meet the stringent requirements for cash management demanded by Monitor for a Foundation Trust	Cash Management policy agreed in line with current best practice and DH requirements	Finance Group AFT SG		AC			Plans in place to manage risks
10.5 ALE	033 1.1	COO DF&P	The financial risks associated with the Cancer PFI are the losses that will be incurred in the initial years of operation in the context of the Trust's application to become a Foundation Trust.	Agreed marketing plan for services Agreed LTFM	OPB Cancer Centre Steering Group AFT SG	Linked to 10.2 and financial position of Oxon and other commissioners	F&PC BoD SHA		Regular review through Divisional and Operational Performance and Cost Reduction Programme Boards	Plans in place to manage risks but risk remains high
10.6 ALE	035 10.5	DF&P	Ageing Equipment across the ORH compromise service delivery, performance, quality and safety Particular impact on clinical support and diagnostic services	Agree capital equipment replacement programme supported by capital programme	Physical Resource Group CC		F&PC BoD - review in July 2009			Plans in place to mitigate risks but remains high
10.7	032	DF&P	Insufficient capital for maintenance despite planned	Agreed Estates Strategy	Physical Resource	Open buildings	F&PC		Estates strategy work continues - informs	Work in hand to

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Ref & CS	TRR ref TBP ref	Lead	Principal risks to strategic objective	Risk mitigation/control plans	Risk control & monitoring	Control gaps	Assurances on controls	Gaps	Action plans for gaps ¹	Status
ALE	10.5		closures; buildings kept open to meet demand - funds may be diverted to support major energy efficiency scheme advancement.	with site Master Plans Agreed capital programme Energy scheme agreed	Group	require resources	BoD - review in July 2009		capital programme	mitigate risks Pressures on capital prog continue
10.8 ALE	048 10.3	COO	Failure to achieve private patients income and 'bottom line' compromised by a number of factors including lack of theatre and bed capacity	Marketing plan agreed and implemented Agreements in place with private health insurers Policies for private practice agreed and implemented within ORH	OPB CC CRPB	Additional capacity sought Recruitment process remains an issue	F&PC AC BoD		Performance and income monitored closely - improvements to recruitment sought together with greater engagement across clinical specialities	Plans in place to mitigate risks

