Reference	Description of risk to achieving objective	Key controls	Assurance on controls	Gaps in controls	Risk rating	Gap in assurance (RAG)	Lead	Action plan reference
Objective 1 Continue delivering high standards of patient safety by reducing MRSA and C. difficile infection rates even further, working closely with the NHS Institute for Innovati and Improvement and achieving 'Excellent' in the 2008/09 Annual Health Check for Quality of Services.								
BAF 1	Failure to implement infection control programme and associated policies leading to static or increasing rates of infection, with impact on patient safety, reputation and the FT application.	All staff trained and assessed in infection control procedures appropriate to level of patient contact. IV line training. Root cause analysis of all MRSA bacteraemias. Bed management team in place. Antimicrobial prescribing policy in place. Hand hygiene. Screening of patients.	Hygiene Code Assessment (HCC) 2008. (P) HCC closure of investigation and action plan in 08. (P) BHT given as example of most improved for infection control in 'Raising the Standard'. (P Infection Control Report Jan 09 shows MRSA and C-diff both below trajectory. (P)	None identified			Chief Nurse	
BAF 2	Failure to engage staff at all levels in achieving a well coordinated, consistent approach to processes supporting patient safety.	Risk Management Strategy and Policy. Healthcare Governance Committee. Global Trigger Tool. Leadership walkabouts Divisional Governance Boards	Minutes of Healthcare Governance Committee Jan 09 show detailed review of Central Services risk register, part of rolling review of divisional risk registers. (P) Quarterly clinical governance report for Q3. (P) External Audit are reviewing governance arrangements - report expected by year end. (PENDING) NPSA organisation level incident data for 04/08 - 09/08 (P) Paper to Trust Board Seminar Dec 08 on implementation of Governance Review recommendations. (P)	None identified			Chief Nurse	
BAF 3	Failure to achieve compliance with the 43 core healthcare standards.	Healthcare Standards all owned by an executive lead with operational management lead to support. Central collection of evidence to support compliance. Quality Standards Committee monitors progress. Feedback to divisional leads	Internal Audit review of process. (P) Quality Standards Committee minutes. (P) Gap analysis report to Healthcare Governance Committee (Mar09) shows C11b gap (mandatory training). Gap associated with complaints shown as closed. (LIMITED)	Internal mandatory training target of 85%			Chief Nurse	
BAF4	Failure to achieve an existing or new national target	Performance monitoring framework. Escalation plans in place to manage pressures on targets. Monitoring by Access Committee.	Performance scorecard - Jan 09 shows emergency access target not met. (N) Feb 09 - in month emergency access target met (P)	Emergency access target	 RR16		Chief Operating Officer	BAFap1 - BAFap6

Reference	Description of risk to achieving objective	Key controls	Assurance on controls	Gaps in controls	Risk rating	Gap in assurance (RAG)	Lead	Action plan reference
Objective 2 Introduce a programme of service standards to ensure our teams always treat patients with a helpful and respectful attituede that acknowledges the diversity of our society and its values. Make it easy for patients to let us know if we do not deliver this level of service.								
BAF 5	Failure to design and implement the customer service standards programme. Failure to engage staff, getting full support for the programme.	Staff and patients engaged in the development of the standards. Funding identified for 08/09 - non-recurrent. Identified as cost pressure for 09/10. Implementation plan in place to deliver training over 12 months from launch. Project plan with key milestones in place.	Project reports: Jan 09 workforce report to Board shows project meeting targets, decision to launch training programme in early 09/10 due to current pressures on staffing. (P)	Non recurrent funding in 08/09 Funding not identified for 09/10.	RR6		Director of Human Resources	BAFap7
Objective 3 Ensure patients receive timely care by efficiently delivering against national access targets and focusing on theatre utilisation, length of stay , effective discharge								
BAF 6	Failure to meet a national access target.	Weekly review of current position against targets. Monitoring of performance by Access Committee.	Access Committee minutes. Performance scorecard at divisional level. Board performance report Jan 09 shows emergency access target not met (N) all other access targets met (P) Feb 09 - in month emergency access target met (P)	xref to BAF 4	RR16 xref BAF 4		Chief Operating Officer	BAFap1 - BAFap6
BAF 7	Failure to improve theatre utilisation with impact on efficiency.	Theatre utilisation group Feedback from Galaxy information system to divisions and SDUs on theatre utilisation at speciality level.	Information from Galaxy system for Wycombe. Minutes of Theatre Utilisation group. Board performance report - Jan 09 shows 80% target not being met,(N)		RR8		Chief Operating Officer	BAFap8
BAF 8	Not implementing processes to improve discharges.	Bed management and discharge policies. PACE Weekly length of stay meetings monitor performance. Fortnightly whole systems recovery board monitors delivery of projects.	Minutes of whole system recovery meetings. Board perfomance report - Jan 09 shows elective and non-elective ALOS targets not achieved. (NEGATIVE)		RR8		Chief Operating Officer	BAFap9
BAF10	Efficiency of outpatient and diagnostic services impacting on access targets and patient experience.	Weekly monitoring of 15 top diagnostic waits. Monitoring of 'new to follow up' ratios. Review of outpatient services and associated plan to ensure effective use of resources.	Board performance report - Jan 09 shows DNA rates on target (P), new to follow up ratio target not met (N). Diagnostic waits 13 weeks met (P) Diagnostic waits 6 weeks not met (N).		RR8		Chief Operating Officer	BAFap10

Reference	Description of risk to achieving objective	Key controls	Assurance on controls	Gaps in controls	Risk rating	Gap in assurance (RAG)	Lead	Action plan reference
Objective 4: Provide a clean, modern and welcoming environment through improving car parking, outpatient and emergency facilities, a new inpatient women and children's unit at Stoke Mandeville Hospital and improved use of Amersham Hospital.								
BAF12	Failing to improve how we manage car parking with an impact on reputation and patient experience.	Plans in place to increase parking capacity at Stoke. Plans in place to actively manage parking at Wycombe through barriers and monitoring patrols. Working with users to develop other solutions.	Director of Property Services reporting directly to Board. Feb 09 report (N)	Loss of 300+ spaces on completion of sale of land at Stoke on 13 March. Planning application for double deck car park delayed due to need for full tree survey. Significant impact on the reputation of the Trust, patient experience and staff.	RR16		Director of Property Services	BAFap11
BAF 13	Improvement schemes not implemented for outpatients at SMH and WH	Approved business case for retail unit at SMH. Refurbishment and new catering facilities in main reception area at WH.	Delivery monitored through Capital Review Group and reported to Trust Management Committee. (P)	None identified			Director of Property Services	
BAF 14	Challenges presented by the 1960s tower block at WH .	Estates strategy Bid for central funding to address mixed sex issues. Risk profiling of estate.	Delivery monitored through Capital Review Group and reported to Trust Management Committee. (P) Presentation to Board on proposed revision of Estate Strategy (P)	Formal Board approval of revised Estate Strategy.			Director of Property Services	BAFap12
BAF 15	Delays in full implementation of women and children elements of Shaping Health Services	Project Board reporting to Obstetrics Divisional Board	Minutes of W&C Divisional Board.		RR8		Director of Property Services	

Reference	Description of risk to achieving objective	Key controls	Assurance on controls	Gaps in controls	Risk rating	Gap in assurance (RAG)	Lead	Action plan reference
Objective 5 Ensure we always provide patients with the best clinical care possible by targeted re-modelling of pathways of care in: rehabilitation, discharge planning and the interfce with community services, anaesthetics, critical care, emergency care, gastroenterology, orthopaedics, pain managment and spinal services.								
BAF 16	Failure to develop and implement redesign of pathways as detailed in the divisional business plans for 08/09	Project management training for staff. Patient Services Institute PACE project Partnership projects with BPCT April Strategy working with NCIS Performance management of divisional business plans.	Patient Services Institute steering group reports to Board. Jan 09 report (P) Divisional Board minutes				Chief Operating Officer	
Objective 6 Ensure the residents and GPs of Buckinghamshire and beyond are aware of our range and quality of services								
BAF17	Ineffective communication about our services to GPs and population with impact on BHT as hospital of choice.	Web site development contract Marketing Strategy	Medix GP survey (Limited)	Barriers to referral largely from administrative issues			Director of Strategy and	BAFap13
Objective 7 Establish our corporate services departments as internal customer services to support our clinical teams								
BAF18	Failure to commission and act on departmental fitness for purpose reviews with impact on delivery of clinical services.	Fitness for purpose reviews in estates, human resources and finance.	Service review reports available for each area. Action plans in place.					BAFap14

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Objective 8 Ensure a financially sound organisation that is rated as 'excellent' for use of resources in the 2008/09 Annual Health Check								
BAF19	Failing to achieve statutory duty to breakeven	Whole System Recovery programme Resolve outstanding amounts in dispute for 08/09 with South Central SHA Cost improvement programme	Finance reporting to Board. Jan 09 (P)	Amounts in dispute for 08/09.	RR9		Director of Finance	BAFap15
BAF20	Failing to achieve a surplus for 08/09	Whole System Recovery programme Cost improvement programme	Finance reporting to Board. Jan 09 (N)	Reductions in demand have not been achieved. Income from Bucks PCT for 2008/2009 has been capped at £168.8m.			Director of Finance	
BAF21	Change of Local Service Provider for our Care Records System (CRS)	Live Site Exec meetings ensure the Trust is aware of current developments and tha the Trusts CRS priorities are heard at the highest level.	CRS group. Reports to TMC. Nov 08 report (P)	Delays mean the Trust will need to continue using legacy systems and processes, increasing risks around data quality and reporting, with an impact on recoverable income.	RR9		Director of Finance	BAFap16
BAF22	Governance arrangements not sufficiently integrated.	Governance Review commissioned. Impementation group (GRIT) Board review of need for Finance & Investment Committee	Governance review report. Minutes of GRIT meetings (P) Reports to Healthcare Governance Committee and Audit Committee (P) External Audit reviewing governance arrangements (pending) Historic Due Diligence Report (P)	Trust to consider Estates Committee of Board.			Medical Director	
BAF24	Changes to requirements of ALE assessment	Self assessment Close working with auditors to confirm evidence required.	Reporting to TMC. Reporting to Audit Committee Feedback from auditors during process.				Director of Finance	
BAF25	Buckinghamshire Primary Care Trust does not deliver its financial recovery and shifts additional cost pressures and financial risk to BHT	Whole System Recovery Board - workstreams address key areas for improving efficiency and managing demand. Business strategy based on accommodating the planned reductions in demand. Developed together with BPCT.	Finance reporting to Board. Performance report to Board. Recovery meetings with BPCT.	Contract for 09/10 to be agreed.	RR16		Director of Financne	BAFap17
BAF27	The Protection, Repatriation and Growth Strategy is not realised with a resulting impact on income	Marketing Strategy 5yr Business Plan	Marketing reports to Board. Jan 09 (P) Performance management of business plan		RR12		Director of Strategand System Reform	BAFap18

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Objective 9 Achieve foundation trust status								
BAF28	Failing to achieve alignment between commissioning intentions of BPCT and the activity in the IBP and LTFM.	xRef BAF 25	xRef BAF25	xRef BAF 25			Director of Finance	BAFap17
BAF29	Not meeting the requirements of the Compliance Framework for authorisation	xRef. BAF 4 & 19	Finance and Performance report to Board Historic Due Diligence report.	Emergency access target.			Director of Finance	BAFap18
BAF30	Failing to meet the MRSA trajectory	xRef BAF1	Board Infection Control reports. Jan 09 report (P)	None identified			Chief Nurse	
BAF31	Failing to build and maintain a representative membership	Membership Strategy	Membership reports from database (P)	Membership in South Bucks <1%			Chief Executive	BAFap19
Objective 10 Embed leadership in our new clinical management structures with training and development support								
BAF32	Not delivering appropriate developmen programme.	Perfomance review meetings Accountability framework	Reports to TMC. Programme of development for divisional boards delivered				Director of Human Resources	