




Hazard	Impacts	Residual Severity	Residual Likelihood	Target Risk Value	Existing Control Measures	Assurances of Controls	Improvements	Progr
HIGH QUALITY ACUTE	HOSPITAL	AND	SPECIALIST	CARE	FOR PATIENTS	MEDICAL & NURSING	DIRECTORS, COO	+
Key patient safety indicators do not improve	1. Loss of income 2. Reputational issue	Major (4)	Possible (3)	8	<ol style="list-style-type: none"> Membership of Patient Safety First campaign and adoption of its recommendations including WHO checklist, patient stories, Leadership Patient Safety Walkabout Agreed major pandemic / major incidents / business continuity plans in place Root cause Analysis of Serious Incidents All hospital-acquired pressure ulcers grade 3 and above being reported as serious incidents Medicines management process - policy, ward pharmacy service, storage administration clinical risk manager in post to coordinate/ monitor Ward pharmacist review of prescriptions Safer medication group review of issues, inc threshold of reporting and guidelines Matrons' rounds to monitor activity Audit of VTE prophylaxis given. 	<p>CQC registration unconditional</p> <p>NHS LA accreditation 2009 Level 1 full score both general and maternity</p> <p>CQC Quality Risk profile mostly green, 4 areas only highlighted for improvement</p> <p>Annual clinical audit programme linked top national imperatives.</p>	<ol style="list-style-type: none"> Electronic link to GP prescribing history to improve medicines management VTE assessment introduced and monitored to improve completion Revalidation process with new appraisal system introduced for doctors 	

Hazard	Impacts	Residual Severity	Residual Likelihood	Target Risk Value	Existing Control Measures	Assurances of Controls	Improvements	Progress
					Participation in national audit 11. Responsible officer for revalidation of medical staff appointed			
Target for reducing mortality not achieved	1. Reputational issue	Major (4)	Possible (3)	8	1. Quarterly RAG monitoring of mortality 2. Global trigger tool review of notes 3. PAR team statistics	Benchmarking via CHKS reports and Quality Intelligence East data (although latter not current). CHKS Top 40 hospital 2010 and Dr Foster Band 4 (5 Best) 2009.	1. Adoption of single mortality measure (DH dependent)	
COQIN / QA objectives not achieved	1. Loss of Income to the Trust	Major (4)	Likely (4)	8	1. COQIN indicator monitoring framework 2. VTE risk assessment figures reported to Board	Reports to EMG and Finance Cmte	1. Home for lunch action plan [31/12/2010] 2. Action plan to increase VTE risk assessments [31/12/2010]	
Infection levels do not reduce	1. damage to Trust reputation 2. Impact on patients	Major (4)	Unlikely (2)	4	1. Monthly reporting to PSC/Board 2. RCA of MRSA and c diff cases 3. Awareness campaigns 4. Appropriate environmental cleaning	Weekly hand hygiene audit and monthly board report on hand hygiene. PEAT score	1. Closer working with PCT over clostridium difficile prevention. 2. Increase MRSA screening performance 3. Work to reduce delay in time to isolate	
Delay in service improvements identified in IBP	1. Loss of potential income	Major (4)	Unlikely (2)	4	1. Monitored action plan in place for each development	Strategic scorecard report to Board		

Hazard	Impacts	Residual Severity	Residual Likelihood	Target Risk Value	Existing Control Measures	Assurances of Controls	Improvements	Progr
Failure to deliver national and local targets.	<ol style="list-style-type: none"> 1. Failure to maintain unconditional CQC registration 2. Failure to meet terms of authorization for Monitor 3. Reputational issue 	Major (4)	Unlikely (2)	8	<ol style="list-style-type: none"> 1. Reports to the Trust Board and Patient Safety Committee monthly from which weaknesses identified 2. Performance and Planning Framework 3. Contract monitoring framework for PCT and escalation process 4. 18 week action plan 5. SHA quarterly review of performance (on exception basis) 	<p>PCT quarterly monitoring</p> <p>Internal Audit reports on performance management Sept 09 / Data quality March 2010</p> <p>Performance monitoring of Stroke and PCI developments by networks</p> <p>Peer review of cancer and cardiac service by network</p> <p>Monthly governance report to SHA- currently green</p>	<ol style="list-style-type: none"> 1. Implement action plans : Colposcopy; PMETB anaesthetics; PMETB paediatrics 2. Continue to develop monthly scorecard 3. Good to Great Action Plan 	
TRANSFORMING THE	WAY WE WORK	CE	COO	DOD				
Failure to achieve productivity improvements	<ol style="list-style-type: none"> 1. Failure to Achieve Efficiency Savings and to Drive the Quality Agenda Forward 2. failure to achieve CIP's 	Moderate (3)	Possible (3)	6	<ol style="list-style-type: none"> 1. Continuous improvement strategy and transformation board and trained staff champions in place. Each project has programme. Overall position reported to Trust Board monthly 2. productive ward 3. Review of pay management to improve controls 	<p>EMG Reports by Division</p> <p>Performance Board Reports</p> <p>Performance and Planning group</p>	<ol style="list-style-type: none"> 1. 2. Workforce Plan Developed and Monitored to Ensure Costs Kept Within Budget [31/03/2011] 2. 3. Nursing Workforce Review [30/09/2011] 3. 4. Introduction of Further Productive Projects[31/03/2011] 4. 5. Revised Contract Monitoring Arrangements with Quarterly Sign Off [31/03/2011] 5. Review of consultant job plans 	


Hazard	Impacts	Residual Severity	Residual Likelihood	Target Risk Value	Existing Control Measures	Assurances of Controls	Improvements	Progress
							linked to activity appraisal and revalidation [31/03/2011]	
Staff satisfaction survey results show no improvements	1. CQC risk profile	Moderate (3)	Possible (3)	6	1. Divisional Staff survey action plans 2. Participation in local health economy healthier workforce group 3. Vacancy review 4. Stress management programme	Staff survey outcomes	1. Review of appraisal system 2. Plan to improve recruitment timescale to reduce vacancies	
Insufficiently responsive to changing political / consumer expectations	1. Decline and loss of our market share and income	Major (4)	Possible (3)	8	1. performance targets monitored by Board 2. Waiting times actively managed 3. Patient satisfaction survey undertaken		1. Develop business support office and introduce service line management	
NHS Constitution not embedded in communications and activities		Moderate (3)	Possible (3)	6	1. NHS constitution reference on all Board papers 2. Performance target monitoring			
Improved relationship with NHS Bedfordshire not evident	1. Plans not aligned 2. Financial risk	Major (4)	Possible (3)	8	1. Contract monitoring arrangements with PCT 2. Board to Board meetings with PCT 3. Signed SLA with NHS Bedfordshire 4. Regular dialogue Chair/ Chair, CE/CE		1. QIPP planning process	
Commercial skills not developed		Major (4)	Possible (3)	8	Interim appointment of business Director		1. Co-locate unit with LEAN team	


Hazard	Impacts	Residual Severity	Residual Likelihood	Target Risk Value	Existing Control Measures	Assurances of Controls	Improvements	Progr
Delay on implementing business unit structure	1. Lack of financial awareness at operational level	Moderate (3)	Possible (3)	8	SLM structure agreed. Consultation on filling posts in progress		1. Devolve responsibility to CBU's on earned basis	
BECOMING A LEADING	HOSPITAL/CARE	NET	WORK	AND	CAMPUS	CHIEF EXECUTIVE		
Foundation Trust status not achieved	1. Trust ceases to exist as separate organisation if not achieved by 2014	Major (4)	Unlikely (2)	4	1. FT project / staff engagement plans in place	SHA sign off Foundation Trust application Pricewaterhousecoopers due diligence report for FT bid Application supported by DH applications committee	1. Foundation Governor elections 2. Revised integrated Business Plan for monitor assessment [31/03/2011]	
Failure to win tender for PCT provider arm	1. Additional local competitor 2. Opportunity to increase scale of organisation not available 3. Potential impact on development of integrated care pathways	Moderate (3)	Almost Certain (5)	15	1. Partnership arrangements agreed to strengthen bid for provider arm	Selection for second stage of provider arm tender	1. Develop integrated pathways via QIPP process	
No progress with MK/SEM cluster		Moderate (3)	Possible (3)	6	1. Steering group established, programme director in post, case for change being developed for MK SEM cluster	Progress monitored by Chairs group	1. Work streams established to report on vascular, stroke, cardiac 2. Further work streams to be developed 3. opportunities for pathology to	

Hazard	Impacts	Residual Severity	Residual Likelihood	Target Risk Value	Existing Control Measures	Assurances of Controls	Improvements	Progr
							be explored with all	
Renal services not developed locally		Moderate (3)	Unlikely (2)	3	1. Partnership arrangements proposed to strengthen bid for renal development 2. Commissioning plan confirms 8 beds to be located in Bedford in 2011		1. Confirm arrangements with proposed renal partner	
Plans not in line with strategic direction		Moderate (3)	Possible (3)	6	1. Agreed strategy, refreshed May/June 2010 2. Integrated Business Plan based on strategy 3. Approved capital programme includes agreed service developments e.g. theatre 4. QIPP programme board established 5. Membership of QIPP programme board		1. Pursue QIPP plans, including integrated pathways	
Reliance on single commissioner for 95% of business		Major (4)	Almost Certain (5)	16	1. Developing relationship and joint planning with commissioner		1. Implement marketing strategy	
DELIVERING	PATIENT FOCUSED	CARE	COO	DNPS				
Patients dissatisfied with care		Major (4)	Unlikely (2)	4	1. Complaints and compliments reported and monitored 2. Productive ward project 3. Patient involvement in focus groups for <EAN reviews, plans for service	No of complaints referred to Ombudsman Patient survey responses	1. Patient Survey Action Plan [30/09/2011] 2. Personal Best training programme roll out [31/03/2011]	

Hazard	Impacts	Residual Severity	Residual Likelihood	Target Risk Value	Existing Control Measures	Assurances of Controls	Improvements	Progress
					development		3. Completion of Productive ward project [31/03/2011] 4. Extend use of internal patient survey and action planning on outcomes [01/04/2011] 5. Whole health system approach to care of the dying patient to be developed - implement End of life care action plan [31/03/2011] 6. Vulnerable adult / Learning disabled persons service improvement framework developed [31/03/2011]	
Patient survey scores not improved in 3 areas	1. CQC indicator 2. Bad press / loss of reputation	Major (4)	Likely (4)	8	1. Improving Patient experience Strategy and committee in place	National benchmarking	1. Action plan	
Waiting times in outpatient department not reduced	1. Poor Patient Survey 2. Delays in accessing services 3. Loss of Business	Moderate (3)	Possible (3)	3	1. Outpatient department waiting times reported daily 2. Action Plan in Place 3. Links with divisions and Clinical Teams established	Performance and Planning group	1. LEAN on outpatient department - short / medium / long term [31/10/2013] 2. Outpatient Booking Review	

Hazard	Impacts	Residual Severity	Residual Likelihood	Target Risk Value	Existing Control Measures	Assurances of Controls	Improvements	Progress
							[31/10/2013]	
Aim of morning discharges with TTO drugs	1. Delays in transfer of care 2. Poor Patient Survey 3. Breach of 4 hour A&E Target	Moderate (3)	Likely (4)	6	1. Weekly report on morning discharges to general managers 2. Multi-agency workstreams to improve pathways	Monitoring by planning and performance group EMG review	1. Part of the roll-out for the QUIPP Agenda 2. Home for lunch action plan	
Cancelled operation target met	1. Reputational impact	Moderate (3)	Possible (3)	6	1. Review of each cancelled operation 2. Capacity planning tool and escalation process in place	Board reporting	1. Cancelled operations action plan 2. Review of equipment servicing/ resilience 3. Scheduling of temporary theatre activity	
Discharge letter not completed and sent to the correct GP according to terms of PCT contract.	1. Financial penalties 2. risk to patient safety	Major (4)	Likely (4)	4	1. Project Group in place 2. Reporting of performance 3. Reports to EMG, QPC, Audit and Finance Committees 4. Internal Audit report actioned 5 Ward clerk training 6 IT improvements introduced	Internal audit report on discharge summaries- weak	3. Contract variations agreed, subject to pilot running through March [31/03/2011]	
Delay in establishing business support function	1. Unable to sustain and continuously improve quality of services	Moderate (3)	Possible (3)	3	SLM project plan/ implementation group in place			

Hazard	Impacts	Residual Severity	Residual Likelihood	Target Risk Value	Existing Control Measures	Assurances of Controls	Improvements	Progr
	2. Failure to demonstrate financial viability							
FINANCIAL STRENGTH	AND ACCOUNTABILITY	DIRECTOR	OF FINANCE					
Integrated QIPP project not delivered	1. Financial	Moderate (3)	Likely (4)	8	1. QIPP programme monitored by SHA		1. Implement step down unit 2. Implement action plan	
Capital programme exceeds budget	Consumption of cash Reduced capital for future years	Major (4)	Unlikely (2)	4	1. Capital expenditure reports to Finance Committee via capital planning group- on track 2. Project management in place for each project		Internal reporting capability	

Hazard	Impacts	Residual Severity	Residual Likelihood	Target Risk Value	Existing Control Measures	Assurances of Controls	Improvements	Pro
Failure to generate sufficient income in a competitive market.	1. 2. Failure to demonstrate financial viability	Moderate (3)	Likely (4)	6	1. EMG / Finance committee review performance monthly including Cost improvement programme 2. reporting to SHA - governance 3. Financial Improvement team 4. Robust contract monitoring in place 5. Monthly Divisional review meetings	Internal audit reports on financial systems (payroll, income and debtors, clinical income, creditors, general ledger) and data quality External auditor opinion on accounts External auditor value for money opinion External audit ALE scores External audit of half year close	1. Discussions with PCT to achieve break-even outturn [31/03/2011] 2. Implement actions from half year audit, inc asset values and capital salaries [31/03/2011] 3. SLM structure being implemented [31/03/2011] 4. Continue implementation of action plan following review of finance function 30/06/2011]	
ACHIEVING EFFECTIVE	STAKEHOLDER	RELATIONS	CE	COO				
FT membership not increased	1. issues with Monitor	Moderate (3)	Possible (3)	6	1 Membership strategy in place 2 Routine analysis of membership numbers and breakdown		Membership invitations sent out with OP appointment letters	
Patient choose to be treated elsewhere	1. Loss of income 2. Possible loss of sustainability	Major (4)	Possible (3)	4	1. CHKS analysis of patient flows reviewed by Board			
Direct engagement of GPs not achieved	1. referrals made elsewhere 2. GP	Moderate (3)	Possible (3)	6	1. GP communication- web site, magazine, open sessions		1. Targeted GP marketing programme	

	requirements not understood and not met				2. MD involvement with PEC		[30/06/2011]	
Corporate relationships with PCT not improved	1. Lack of coordinated approach 2. Immature contract relationship	Major (4)	Unlikely (2)	4	1. Planning and Performance meetings with PCT 2. Board to Board meetings with PCT 3. Joint working with PCT on QIPP, lead for emergency / urgent care, involvement in repatriation.	PCT quality review strategy review	1. NHS Bedfordshire / Bedford Hospital Board development - buddying etc [31/03/2011]	
Community engagement strategy not implemented	1. Services not customer focussed	Moderate (3)	Possible (3)	6	1. Involvement of LINKs / Overview and Scrutiny Committee in formal quality process. 2. CE member of Bedford Borough Strategic Partnership Board 3. Engagement strategy agreed Jan 2010 4. Focus groups , including those for LEAN projects involve users		1. Community Engagement Strategy Action Plan [31/03/2011] 2. Improve relationships with voluntary / pressure groups [31/03/2011] 3. COUIN measures for 2011/12 [30/09/2011]	
Healthier Bedfordshire initiatives not delivered	1. lack of alignment with PCT plans	Moderate (3)	Possible (3)	6	1. Joint working e.g Safeguarding Board, Transport plan, Maternity Services 2. Specialist pathways developed- diabetes, COPD 3. QIPP plans developed for emergency care			
DEVELOPING LEADING	EDGE SUPPORT	SERVICES	DF, DNPS	DOD				

Hazard	Impacts	Residual Severity	Residual Likelihood	Target Risk Value	Existing Control Measures	Assurances of Controls	Improvements	Progress
Untoward events impact on Trust's reputation	1. Damage to the reputation of the Trust	Major (4)	Possible (3)	12	1. Monitoring of never events- none yet recorded 2. Business continuity plans			
Carbon use not reduced	1. Cost 2. Damage to Trust's reputation	Moderate (3)	Possible (3)	6	1. Carbon reduction plan in place 2. Trust ready for carbon reduction commitment funding scheme 3. Energy use/ costs reviewed by Finance Cmte monthly 4. Investment in new boiler plant 5. poster campaign	Monitoring by finance committee	1. Travel plan updated	

Hazard	Impacts	Residual Severity	Residual Likelihood	Target Risk Value	Existing Control Measures	Assurances of Controls	Improvements	Progress
OD plan not delivered with impact on FT application and IHBP	1. Ft application weak	Moderate (3)	Unlikely (2)	3	1. Plan agreed	Investors in people reaccrreditation January 2010 Two ticks may 2010	1. Completion of implementation	
Issues with providing high quality information and information governance	1. Decision making based on inaccurate/ incomplete information 2. Minimum score of 2 in IG toolkit not achieved 3 Loss of confidence by clinicians in ability of IT to support their services	Major (4)	Likely (4)	8	1. Policy framework / strategy for procurement, estates, IM&T, marketing 2. Investment plans for IM&T infrastructure 3. Contract arrangement with GSTS for pathology computer system 4. Improved pathology system included in GSTS contract 5. IG Manager appointed to lead IG toolkit implementation 6. Updated IG strategy under discussion, to overcome weaknesses and improve IM&T strategy being developed to address weaknesses and improve integration	IG toolkit score for 2009/10	1. Achieve No IGT toolkit score under 2 required by 31.03.11 [31/03/2011] 2. Action plans implemented for marketing, IM&T, sustainable development strategies / plans [31/03/2011] 3. Complete installation of pathology computer system [31/03/2011] 4. Implement Action Plan from Internal audit report on IM&T infrastructure [31/03/2011] 5. Agree updated IM&T strategy [31/05/2011]	
ACHIEVE FOUNDATION	TRUST STATUS	CHIEF	EXECUTIVE					

Fragility of LTFM to satisfy Monitor	1. FT bid unsuccessful as unable to demonstrate financially viable organisation	Major (4)	Possible (3)	8	<ol style="list-style-type: none"> 1. Monthly financial reporting Good Control 2. Use of Monitor recommendations Good Control 3. Cash loan taken out to improve cash position 4. Monitoring of CIPs by Finance Cmte, quality assessment by clinical group 	<p>Board approved LTFM</p> <p>SHA satisfied with IBP/LTFM</p> <p>Regular meetings of the FIT group</p> <p>FT Application Committee signed off LTFM</p>	ACHIEVE FOUNDATION	TRUST STATUS	EXE
Performance issues identified by SoS and Monitor	<ol style="list-style-type: none"> 1. FT application deferred 2. Unable to meet the terms of authorisation 				<ol style="list-style-type: none"> 1. Monthly SHA monitoring 2. Loan taken out to improve cash position 3. New chief executive in post 4. Work of FIT team to achieve CIPs 	<p>Monthly SHA monitoring</p> <p>Feedback from DH/EoE on quality & governance.</p> <p>Board/ Finance Committee monitoring of position</p>	<ol style="list-style-type: none"> 1. Implementation of Action Plans to address under performance [31/03/2011 - Ongoing] 2. Improved cash flow monitoring/ reporting [31/03/2011 - Ongoing] 		