Brighton and Sussex University Hospitals NHS Trust

Brighton and Sussex University Hospitals

Risk Management Strategy

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With our partner:

brighton and sussex medical school

Contents

1 Introduction

1.1 Brighton and Sussex University Hospitals NHS Trust Board of Directors is committed to ensuring that the needs of patients, staff, volunteers, contractors and visitors are taken seriously at every level of the organisation, and to providing open and transparent risk management systems that ensure that the Trust meets its principal objectives for safe, sustainable, high quality care.

1.2 The Trust supports a dynamic and proactive approach to risk management, identifying and managing potential threats and hazards before adverse events occur. Every risk identified and associated assessment carried out is seen as a care quality improvement opportunity.

1.3 Risks arising are inherent in all Trust activities, for example, treating patients, determining service priority, project management, record keeping, communication, staffing, service design, and setting strategies. Risk is also associated with not taking any action at all. Robust systems are necessary to ensure the management of risk to patients, visitors, staff, and other internal and external stakeholders, and to enable the Trust to meet its principal objectives.

1.4 Risk management involves the identification, assessment, and control of risk. It is the responsibility of all staff to identify and reduce risks. We are all responsible for the health, safety, and wellbeing of patients, visitors, staff and others accessing and using our facilities and services, the delivery of services in line with the NHS Constitution, and for contributing to the delivery of Trust objectives.

1.5 Risks identified can be managed in the following ways:

- Transferred – e.g. moved to another organisation or service;
- Treated – e.g. controlled or reduced by taking action;
- Terminated – e.g. removed altogether by stopping practices; or
- Tolerated – e.g. accepted where appropriate.

2 Purpose of this Strategy

This Strategy describes the Trust's integrated approach to the assessment, reporting and management of risk. It sets out responsibilities, strategic systems, and processes for risk management, to promote the delivery of high quality, safe, accountable healthcare, minimise risks to patients, staff and the organisation, and maximise available resources. The strategy will:

- ensure that risk management is an integral part of organisational culture;
- improve safety by addressing and effectively prioritising risk treatment plans;
- identify risks to achieving the Trust's objectives requiring intervention; and
- drive a standardised, strategic, and accessible approach to risk management.

3 Definitions

Risk Register (RR)	A register of unresolved risks used within business planning to enable the allocation of resources to the highest risks, managed via a web based tool known as Datix (see section 5.1 below).
Board Assurance Framework (BAF)	A framework for the Board of Directors to review risks to meeting Trust objectives, providing opportunities to analyse assurance that those risks are being managed (see section 5.2 below).

4 Responsibilities, Accountabilities and Duties

4.1 All Staff

All staff must utilise Trust risk management systems to highlight risks arising and drive required improvements. Where staff feel that raising issues may not be effective they should follow the Trust's Raising Concerns (Whistleblowing) Policy, which sets out how concerns may be raised in accordance with the requirements of the Public Interest Disclosure Act 1998.

4.2 Directorate, Service/Specialty, and Ward/Locality Leads

Directorate, Service/Specialty, and Ward/Locality Leads are accountable for ensuring that risk is managed in line with this Strategy within their areas of responsibility. They are required to:

- maintain a suitable local forum for the discussion of risks arising, at which the local RR is reviewed at least monthly;
- ensure that risks raised by staff are fully considered, captured on local RRs, kept up to date, re-assessed, and re-graded as necessary;
- develop and implement action plans to ensure risks identified are appropriately treated;
- ensure immediate escalation of risks graded 15 or above;
- ensure that appropriate and effective risk management processes are in place within their designated area and scope of responsibility and that all staff are made aware of the risks within their work environment and of their personal responsibilities to minimise risk; and
- monitor any risk management control measures implemented within their designated area and scope of responsibility, ensuring that they are appropriate and adequate.

4.3 Board of Directors

With over-arching accountability for the management of all risk within the Trust, the Board of Directors is also responsible for:

- identifying, evaluating, and managing strategic risk; and
- reviewing the RR and BAF, to:

    - examine and challenge the risks identified therein;
    - consider wider strategic implications of risks and themes arising, and opportunities to improve management of risk by taking a corporate approach;
    - examine and challenge action plans developed to control risks, and assess their wider impact;
    - scrutinise completed action plans, and associated metrics, accounts, and reports provided as evidence of assurance of the control of risks; and
    - ensure the Trust meets its principal objectives.

Executive Directors of the Board are accountable and responsible for ensuring that all staff implement this Risk Management Strategy. They also have specific responsibility for managing risks which relate to their Directorates, including the following specific responsibilities:

- the Medical Director is responsible for managing risks associated with medical workforce planning;
- the Chief Nurse is responsible for infection prevention and control, as Director of Infection Prevention and Control;
- the Director of Human Resources is responsible for managing risks associated with workforce planning;
- the Chief Information Officer and Senior Information Risk Officer are responsible for managing risks associated with information governance; and
- the Chief Financial Officer is responsible for managing risks to ensure the delivery of the financial plans agreed by the Board.

4.4 Chief Executive

The Chief Executive has overall individual accountability and responsibility for the management of risks to the safe and effective, sustainable delivery of the business of the Trust.

4.5 Director of Clinical Governance

The Director of Clinical Governance has responsibility for the implementation of the Risk Management Strategy, systems, and processes, and for the ongoing evaluation of these.

4.6 Head of Risk Management

The Head of Risk Management is responsible for:

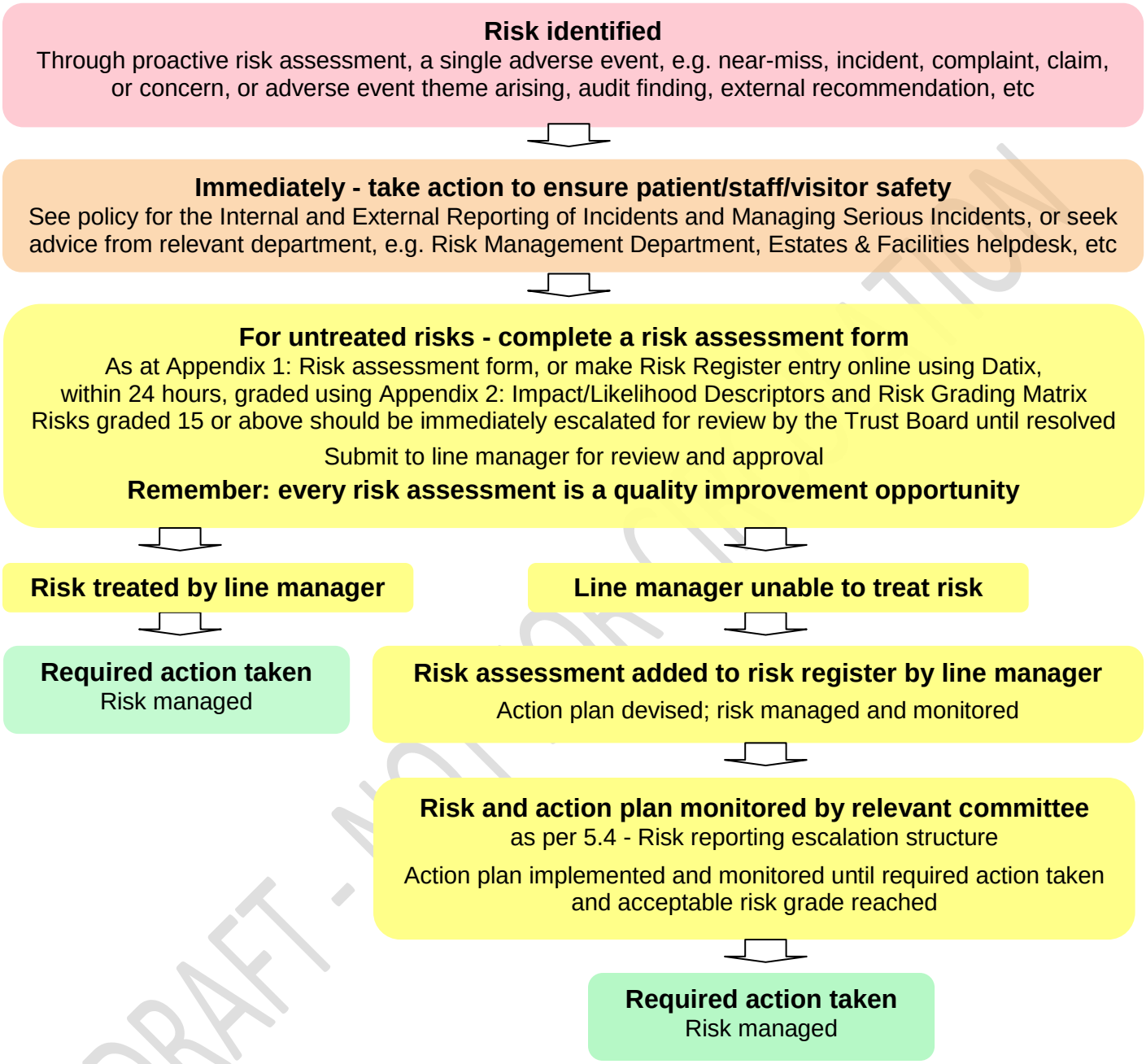
- maintaining an effective Risk Management Strategy, systems, and associated processes, compliant with legal and regulatory requirements;
- co-ordinating, reviewing, and updating the RR and BAF and presenting the documents at Assurance Committees;
- ensuring the RR and BAF are dynamic, and for working with all staff at all levels to ensure that they understand their accountability and responsibilities for managing risks within their areas;
- reviewing reported risks, identifying themes across the Trust, and making recommendations to the Board of Directors and Assurance Committees;
- producing and coordinating risk management training programmes;
- collaborating with external stakeholders key to risk management, for example, the Care Quality Commission, NHS Improvement, and the Health and Safety Executive; and
- overseeing the Risk Management Department, which:
  - maintains risk management processes, and develops the Trust-wide risk management system;
  - oversees health and safety (see Health and Safety Policy);
  - oversees Fire Safety Training, whilst the Estates & Facilities Department oversee practice (see Fire Safety Policy);
  - seeks additional specialist support from other departments, e.g. infection prevention and control, manual handling, security, etc.;
  - receives and collate information on risks within the Trust;
  - provides monthly divisional/directorate RR reports covering all risks;
  - monitors new developments in risk management;
  - develops Trust risk management expertise through the provision of training; and
  - acts as a liaison point for risk management issues both within the Trust and with external bodies.

5 Risk Management Policy

5.1 Risk Register (RR)

The Risk Register (RR) is the means by which staff of all levels may raise risks arising through the course of their work. Risks could relate to anything of concern requiring improvement, including: service design problems; patient flow difficulties; project or change management issues; identification of significant losses through inefficient systems and pathways; lack of allocation of resources; failure to meet targets, failure to comply with legal, national, or regulatory requirements; staffing issues; unsafe systems, etc. Risks identified are managed in line with the process set out below.

5.1.1 Risk Register (RR) process overview



5.2 Board Assurance Framework (BAF)

The Board Assurance Framework (BAF) provides a range of sources of assurance that the risks to the Trust achieving its principal strategic objectives are being managed. All NHS bodies are required to sign a full Annual Statement of Internal Control, and must have the evidence to support this; the BAF brings together a significant part of this evidence. Risks

to the Trust achieving its principal objectives are managed in line with the process set out below.

5.2.1 Board Assurance Framework (BAF) process overview

Trust principal objectives agreed by Board of Directors and reviewed annually

The Trust's objectives will reflect strategic ambitions, national and local commissioning intentions, and locally defined priorities. They should also take account of patient feedback, identified risks, themes relating to reported adverse events, near-misses, incidents, complaints, claims or concerns, audit findings, external recommendations, national initiatives and directives, etc.

Risks to the achievement of the objectives identified by Trust Board

Risks graded using Appendix 2: Impact/Likelihood Descriptors and Risk Grading Matrix

Every risk identified is a quality improvement opportunity

Executive Directors identified as leads manage risks to principal objectives

Leads must:

- devise action plans, to include details of current and planned control mechanisms;
- identify actual and potential sources of assurance on the effectiveness of the controls (e.g. key performance indicators, internal and external audits, third party reviews); and
- report progress on delivery of action plans via the BAF.

Trust Board monitors action plans until risks resolved

Action plans devised; risks managed and monitored

Risks and action plans monitored by relevant committee

as per 5.4 - Risk reporting escalation structure
Action plans implemented and monitored until required action taken and acceptable risk grade reached

Required actions taken

Risks managed

5.3 Key responsibilities and accountability for risk management

The tables below show key responsibilities and accountability for risk management:

		Accountable Officer (s):	Risk Register (RR) Review & Frequency:	Board Assurance Framework (BAF) Review & Frequency:
Overarching Accountability	**Trust Board** **Key Risk Management Responsibilities:** • provide effective and proactive leadership of the Trust within a framework of processes, procedures and controls which enable risk to be assessed and managed, directly and through delegated powers; • identify, evaluate, and manage strategic risk; • review the Risk Register (RR) and Board Assurance Framework (BAF); • ensure an Executive Director is allocated responsibility for each risk arising on the RR and BAF; • ensure an appropriate Assurance Committee is allocated oversight of each risk arising on the RR and BAF; • agree a performance management reporting framework with indicators to act as assurance on service delivery and quality within the BAF; • ensure significant gaps in assurance or control found within performance reports are identified on the BAF, and remedial action is agreed, described therein, and implemented; • ensure risks arising are described on the RR and BAF clearly and accurately, graded consistently, and managed appropriately to reduce risks to the desired level; • challenge the risk controls and sources of assurance described within the RR and BAF; • consider wider strategic implications of the risks identified, and make recommendations to improve management of risk by taking a corporate approach; • examine and challenge action plans developed to control their impact; • scrutinise metrics, accounts, and reports provided as evidence of action plan completion; • ensure the Trust meets its agreed annual principal objectives; and • before close of each meeting, minute new risks arising through discussions to be added to the RR.	Chief Executive Officer	RR - risks graded 15 & above every third meeting, alternating with BAF and Board confirm and challenge meetings	BAF every third meeting, alternating with RR and Board confirm and challenge meetings

		Accountable Officer (s):	RR Review & Frequency:	BAF Review & Frequency:

Assurance Committees	**Audit Committee**
	Key Risk Management Responsibilities:
	• review systems of:
	  ○ operational and strategic risk management via RR and BAF; and
	  ○ internal control;
	annually, and ad hoc as necessary, to ensure these are effective across the whole of the Trust's activities to manage any risks arising and support the achievement of the Trust's corporate objectives;
	• ensure risks identified through Audit Committee business are entered onto the RR and BAF as necessary, clearly and accurately described, graded consistently, and managed appropriately to reduce risks to the lowest possible level;
	• challenge the risk controls, and sources of assurance described within the RR and BAF;
	• independent scrutiny supported by the work programmes of internal and external audit;
	• recommendations to the Trust Board on the development and implementation of the Risk Management Strategy as it considers necessary; and
	• before close of each meeting, minute new risks arising through discussions to be added to the RR.
		Director of Clinical Governance as Executive Lead for risk management	RR - risks graded 15 & above bi-annually	BAF bi-annually

	Trust Programmes Board
	Key Risk Management Responsibilities:
	• oversee, scrutinise, and challenge risk management relating to the:
	  ○ Clinical Service Transformation Programmes Board;
	  ○ Leadership & Workforce Development Programme Board;
	  ○ Safety & Quality Programmes Board; and the
	  ○ Financial Transformation Programmes Board;
	• ensure risks identified through Trust Programme Board business are entered onto the RR and BAF as necessary, clearly and accurately described, graded consistently, and managed appropriately to reduce risks to the lowest possible level;
	• ensure appropriate action is taken to manage all risks within Trust Programmes overseen;
	• provide the Audit Committee and Trust Board with assurance that appropriate arrangements are in place to manage risk; and
	• before close of each meeting, minute new risks arising through discussions to be added to the RR.
		Director of Strategy & Commercial Development	RR – Trust Programme risks graded 15 & above quarterly	BAF bi-annually to review Trust Programme risks

		Accountable Officer (s):	RR Review & Frequency:	BAF Review & Frequency:

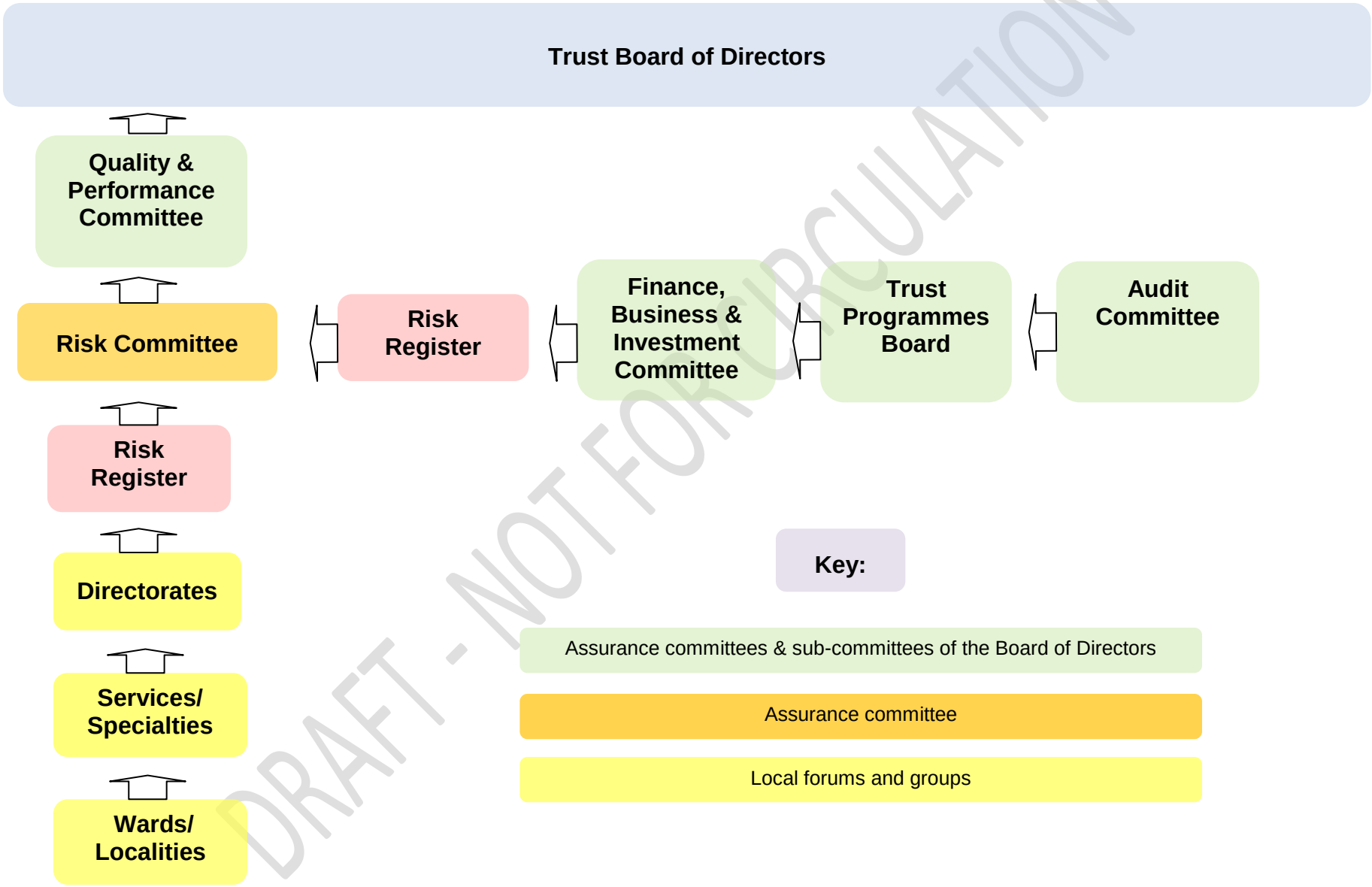
Assurance Committees	**Quality & Performance Committee**
	Key Risk Management Responsibilities:
	• ensure:
	  ○ effective management of risk and safety;
	  ○ quality assurance;
	  ○ optimal performance; and
	  ○ compliance with law, best practice, and regulatory standards;
	• review risk management systems for completeness and accuracy, ensuring that risks to quality, safety, performance, and compliance have been appropriately identified and managed;
	• determine whether quality, safety, performance, and compliance risks identified through review of risk assessments, incidents, concerns, complaints, claims, clinical audit reports, external audit reports, regulatory reports, national initiatives, and horizon-scanning, etc. should be added to the RR and BAF;
	• ensure risks identified through Quality & Performance Committee business are entered onto the RR and BAF as necessary, accurately described, graded consistently, and managed appropriately to reduce risks to the lowest possible level;
	• receive recommendations from Risk Committee;
	• provide the Audit Committee and Trust Board with assurance on the effective implementation of the RR and BAF, including reports to the Board highlighting any new risks identified, gaps in assurance/control, recommendations, and positive assurance; and
	• before close of each meeting, minute new risks arising through discussions to be added to the RR.
		Director of Clinical Governance	RR every other meeting - risks graded 15 & above, & any poorly controlled risks graded 10 - 15, alternating with BAF	BAF every other meeting, alternating with RR

	Finance, Business & Investment Committee **Key Risk Management Responsibilities:** • oversee financial risks across the Trust; • ensure the identification of, and planning to control, financial risks; • ensure risks identified through Finance, Business & Investment Committee business are entered onto the RR and BAF as appropriate, accurately described, graded consistently, and managed appropriately to reduce risks to the lowest possible level; • provide the Audit Committee and Trust Board with assurance that appropriate arrangements are in place to deliver in-year financial plans; and • before close of each meeting, minute new risks arising through discussions to be added to the RR.	Chief Financial Officer	RR – Finance, Business & Investment risks graded 15 & above quarterly	BAF bi-annually to review Finance, Business & Investment risks

		Accountable Officer (s):	RR Review & Frequency:	BAF Review & Frequency:
Assurance Committee	**Risk Committee** **Key Risk Management Responsibilities:** • produce and oversee the implementation of the Trust's Risk Management Strategy; • ensure the maintenance of an effective system of risk management across the whole of the organisation; • develop and maintain a comprehensive and current RR and BAF; • review existing risks and agree new risks on the RR; • propose the corporate RR to be presented to the Quality & Performance Committee, reviewing themes arising across the Trust, and ensuring that risks graded 15 and above, and where appropriate other low graded risks reported across the Trust, are escalated to the Trust Board of Directors; • propose the BAF to be presented to the Quality & Performance Committee; • provide risk management analysis and advice to the Quality & Performance Committee; • provide advice on the quality of the RR, BAF and risk processes to the Quality and Performance Committee, Audit Committee and Board of Directors; • ensure implementation of effective risk management processes at all levels of the Trust; • ensure risks identified are entered onto Datix, accurately described, graded consistently, and managed appropriately to reduce risks to the appropriate level; • approve new risks, suggest modification of existing risks, or approve closure of resolved risks; • determine whether quality, safety, or performance risks identified through review of risk assessments, incidents, concerns, complaints, claims, clinical audit reports, external audit reports, regulatory reports, national initiatives, and horizon-scanning, etc., should be added to the RR; and • before close of each meeting, minute new risks arising through discussions to be added to the RR.	Director of Clinical Governance	RR every other meeting - risks graded 15 & above, & any poorly controlled risks graded 10 - 15, alternating with BAF	BAF every other meeting, alternating with RR

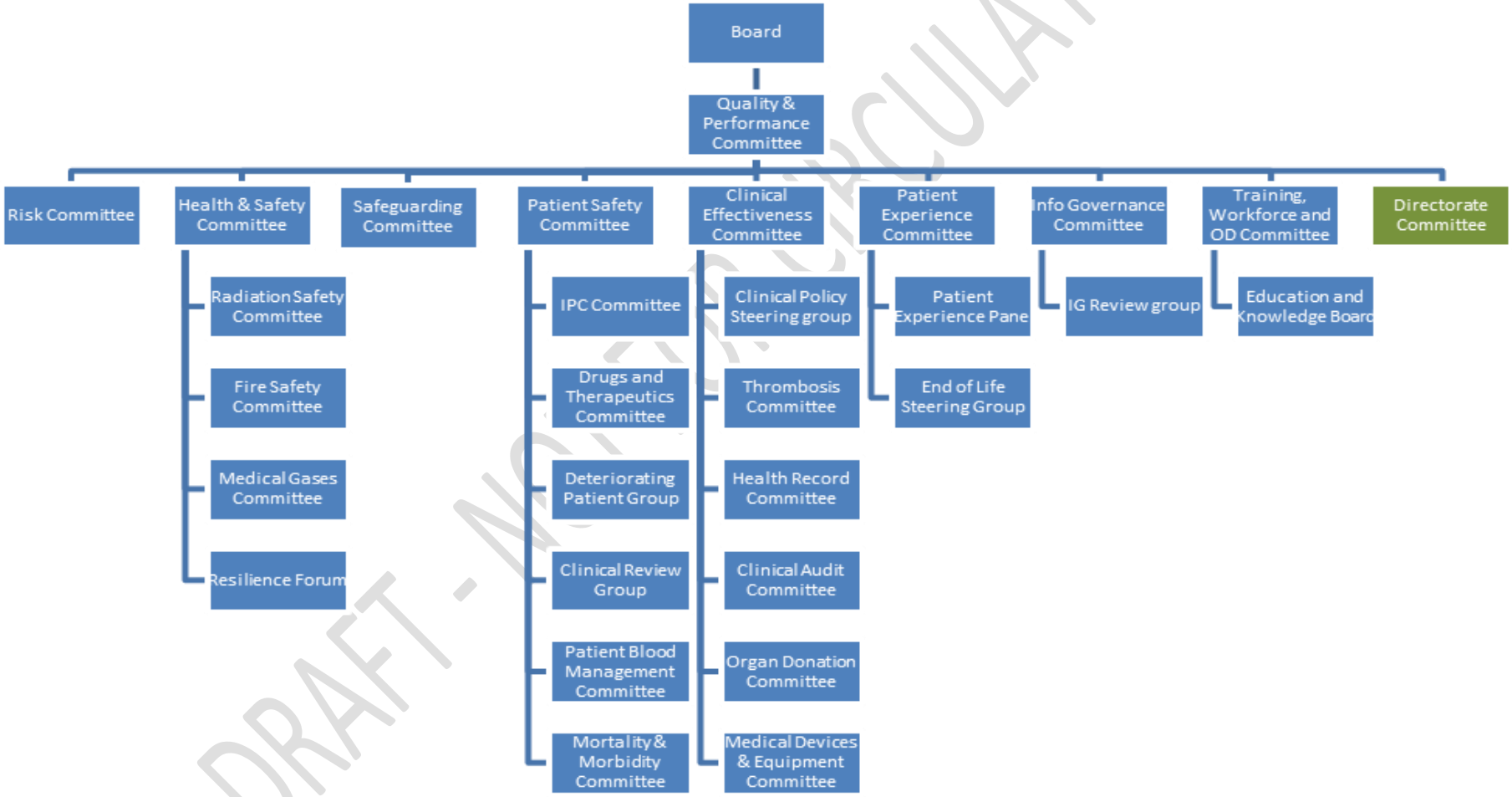
		Accountable Officer (s):	RR Review & Frequency:	BAF Review & Frequency:
Local RR Review Forums	**Directorates** **Key Risk Management Responsibilities:** • ensure risks identified are entered onto Datix, accurately described, graded consistently, and managed appropriately by Services/Specialties to reduce risks to the appropriate level; • approve new risks, suggest modification of existing risks, or approve closure of resolved risks; • determine whether quality, safety, or performance risks identified through review of risk assessments, incidents, concerns, complaints, claims, clinical audit reports, external audit reports, regulatory reports, national initiatives, and horizon-scanning, etc., should be added to local registers; • monitor themes across Services/Specialties and ensure actions are taken as required; • ensure RR review and discussion at Directorate meetings; and • before close of each meeting, minute new risks arising through discussions to be added to the RR.	Directorate Risk Lead	RR as standing agenda item at monthly Directorate meetings	-
	Services/Specialties **Key Risk Management Responsibilities:** • ensure risks identified are entered onto Datix, accurately described, and managed appropriately within Wards/Localities to reduce risks to the appropriate level; • determine whether quality, safety, or performance risks identified through review of risk assessments, incidents, concerns, complaints, claims, clinical audit reports, external audit reports, regulatory reports, national initiatives, and horizon-scanning, etc., should be added to local registers; • monitor themes across Wards/Localities and ensure actions are taken as required; • identify appropriate Risk Leads within all Wards/Localities, e.g. Ward/Locality Manager; • ensure RR review and discussion at Service/Specialty meetings; and • before close of each meeting, minute new risks arising through discussions to be added to the RR.	Service/ Specialty Managers (supported by the Service/ Specialty Management Team)	RR as standing agenda item at monthly Service/ Specialty meetings	-
	Wards/Localities **Key Risk Management Responsibilities:** • allocate responsible individuals to manage risks; • ensure risks identified are entered onto Datix, accurately described, and managed appropriately within Wards/Localities to reduce risks to the appropriate level; • determine whether quality, safety, or performance risks identified through review of risk assessments, incidents, concerns, complaints, claims, clinical audit reports, external audit reports, regulatory reports, national initiatives, and horizon-scanning, etc., should be added to local registers; • monitor themes across Wards/Localities and ensure actions are taken as required; and • before close of each meeting, minute new risks arising through discussions to be added to the RR.	Ward/Locality Managers	RR as standing agenda item at monthly Ward/ Locality Meetings - all risks	-

5.4 Risk Reporting Escalation Structure



5.5 Quality, Patient Safety, and Clinical Effectiveness Governance Reporting Structure

The following specialist committees report to the Quality & Performance Committee, and are responsible for the identification and reporting of risks identified throughout their business, and the provision of specialist advice:



5.6 Other proactive risk management processes

5.6.1 Policies and supporting documentation

In addition to this Risk Management Strategy there is a range of other policies that support the management of risk within the Trust, some of which are listed at section 10 of this Strategy. These are available on the Trust's intranet site: http://nww.bsuh.nhs.uk/policies/

5.6.2 Resilience management

The Trust has in place a comprehensive Major Incident Plan, as well as a range of associated plans and documents, designed to ensure the resilience of the Trust in a range of scenarios that would limit the operating capacity of the Trust. These plans are tested on a regular basis, and learning from these tests is communicated to relevant staff groups and Committees to ensure that processes are refined.

5.6.3 Implementation of clinical guidance

The Trust has mechanisms in place to implement the latest guidance and recommendations from National Service Frameworks, the National Institute for Health and Care Excellence (NICE) and so on. These are covered by the Trust's Policy for the Management of External Agency Visits, Inspections and Accreditations.

5.6.4 Standards and accreditation

The Trust ensures that it meets (and aims to exceed) a range of standards and accreditations. Many of these are covered by the Trust's Policy for the Management of External Agency Visits, Inspections and Accreditations.

5.6.5 Audit activity (clinical, internal and external)

There is extensive audit activity within the Trust covering a range of issues. Findings from these reviews are fed back as appropriate to staff, and reports made to the Quality and Performance Committee, the Board of Directors (clinical audit), the Audit Committee (internal and external audit), and a range of local forums.

5.6.6 Reports to Board of Directors on Trust priorities

Regular reports are made identifying potential risks to the Trust's strategic priorities and the actions being taken to minimise these risks. The Board Performance Dashboard covers a number of key trust targets, aligned to strategic priorities. Triggers linked to these targets result in remedial action when performance is below acceptable levels.

5.6.6 Horizon scanning

The Trust routinely scans its horizons to identify potential risks to service delivery.

5.6.7 Organisational learning

The Trust seeks to learn from the experiences of other organisations. For example, published reports from key regulators are reviewed, with findings compared to existing Trust practice.

5.6.8 Training (incorporating statutory and mandatory training)

Extensive training activity takes place within the Trust on a range of subjects. Much of this is regulated by professional bodies such as the General Medical Council and the Royal College of Nursing, but may be linked to individual personal development plans, or to the implementation of Trust policies. As a minimum, all staff receive appropriate statutory/mandatory training as described in the Trust's Statutory and Mandatory Training Policy.

5.7 Reactive risk processes

The Trust also identifies potential risks from events that have already occurred in the Trust and beyond, and uses risk management techniques to address. Such reactive risk identification sources include:

5.7.1 Complaints

The Trust has a well-established process for the handling of complaints, ensuring that all concerns are responded to within the approved timescales, as described in detail within the Trust's Management of Formal Complaints from Patients and their Representatives Policy, and the Investigation of Incidents, Complaints and Claims using Root Cause Analysis Policy.

5.7.2 Incidents

The Trust has a system for reporting adverse incidents, described within the Trust's Policy for the Internal and External Reporting of Incidents and Managing Serious Incidents. All notified incidents are graded using a matrix consistent with that used for risk assessment.

5.7.3 Claims, Litigation, and Inquests

The Trust's Medico-Legal Department works closely with the Complaints and Risk Departments to enable the early identification of potential legal claims against the Trust. The Medico-Legal Department liaises with HM Coroner and clinicians in respect of the inquest process. Any concerns or recommendations raised by the Coroner are communicated appropriately to ensure that remedial action is taken. The

processes associated with claims, litigation, and inquests are set out in the Trust's Claims Management Policy.

5.7.4 Specific Clinical Risks

Clinical risks are identified through a vast range of assessments carried out at the patient/clinician interface, for example, for the prevention and management of:

- venous thrombo-embolism;
- patient falls; and
- sepsis.

5.7.5 After Action Review

After Action Review (AAR) is a discussion of an event that enables individuals involved to learn for themselves what happened, why it happened, what went well, and what could be improved. AAR is a timely intervention that seeks to understand the expectations and perspectives of all those involved. It generates insight, lessons learned, and leads to greater awareness, changed behaviours and agreed actions. It may be initiated by any of the Executive Directors, and can be separate from or complementary to the processes described within this Strategy.

5.7.6 Central Alert System

The Trust has robust processes in place to respond to alerts issued through national frameworks, and supplements this with its own internal alert system. These are set out in the Trust's Safety Alerts and the Reporting of Medical and Non-Medical Device Incidents Policy.

5.7.7 Specific health and safety risk assessments

The assessment of certain specific health and safety risks is required to be undertaken by a trained assessor. Guidance, training and support are available from specific departments regarding the following assessments:

- Risk Management Department:
  - Health and safety;
  - Expectant and post-natal mothers;
  - Young persons at work;
  - Control of substances hazardous to health;
  - Slip, trips and falls;
  - Transport of dangerous goods;
  - Noise;
- Occupational Health Department:
  - Manual handling of patients and other loads;
  - Display screen equipment;
- Estates and Facilities Department:

- Fire safety;
- Waste;
- Medical gas;
- Physical security;
- Water Safety;
- Risk assessment such as aspergillus;
- Infection prevention in conjunction with the Infection, Prevention and Control Team;

- Human Resources Department:
  - Management of work related stress;
- Security Department:
  - Lone working.

Please access the associated Trust policies for further guidance and information.

6 Training Needs

Knowledge of risk identification, assessment, and control is essential to effective organisational risk management. Employees must be provided with all necessary information, instruction, training and supervision to enable them to recognise hazards to themselves and to others, and to appreciate and manage risks.

Statutory and mandatory risk management training is provided as follows:

- generic risk management training at:
  - Trust induction;
  - Local induction carried out by line management, including:
    - general awareness of the risk management process, RR, any significant uncontrolled risks; and
    - completion of any specific risk assessments, e.g. lone working, young persons, display screen equipment, etc.;
  - annual Clinical and Non-Clinical Mandatory Training Day/e-Learning, to ensure all staff are competent at risk identification, assessment and management;
- three-yearly high level risk management awareness training in wider risk management techniques for all Non-Executive Directors, Board Members, and Ward/Locality Managers; and
- one-off Datix RR training for staff with responsibility for recording risks on the RR.

For details of training requirements and frequency of updates, please refer to the Trust's training needs analysis (TNA) which is available within the Trust's Statutory and Mandatory Training Policy.

7 Monitoring Arrangements

Implementation of this Strategy will be monitored as follows:

Measurable Strategy Objective:	Monitoring/Audit Method:	Frequency:	Responsibility for performing monitoring:	Where is monitoring reported and which groups/ committees will be responsible for progressing and reviewing action plans:
Review of RR & BAF in line with: • table 5.3 Key responsibilities and accountability for risk management; and • chart 5.4 Risk Reporting Structure, of this Strategy.	Audit of Board/ Committee/local forum meeting minutes.	Annually.	Head of Risk Management.	• Quality & Performance Committee; • Audit Committee; and • Trust Board.

7.2 Compliance with terms of reference of trust assurance committees

Trust assurance Committees are required to undertake an annual review of their effectiveness, to include monitoring attendance of members and compliance with their Terms of reference, the outcome of which will be reported to the Board of Directors and Audit Committee.

7.3 Review of the BSUH Risk Management Strategy

This Strategy will be reviewed at least on a three-yearly basis, and updated before review is due, as required. This will be the responsibility of the Director of Clinical Governance.

8 Due Regard Assessment Screening

As an NHS organisation, BSUH is under a statutory duty to set out arrangements to assess and consult on whether this Strategy and function impacts on equality. This Strategy does not discriminate against any groups on the basis of race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation, age, disability, gender identity, marriage/civil partnership status, pregnancy or maternity.

9 Associated Trust Documents

- Safety and Quality Strategy;
- Duty of Candour - Policy for communicating with patients and their carers following a patient safety incident, complaint or claim;
- Claims Management Policy;
- Fire Safety Policy;
- Safety Alerts and the Reporting of Medical and Non-Medical Device Incidents Policy;
- Health and Safety Policy and Statement of Intent Including Health and Safety Committee Constitution;
- Investigation of Incidents, Complaints and Claims using Root Cause Analysis;
- Management of Formal Complaints from Patients and their Representatives;
- Statutory and Mandatory Training Policy;
- Internal and External Reporting of Incidents and Managing Serious Incidents;
- Management of External Agency Visits, Inspections and Accreditations;
- Safe and Secure Handling of Medicines; and
- Raising Concerns (Whistleblowing) Policy.

All of the above policies are available on the BSUH intranet at the following link: http://nww.bsuh.nhs.uk/policies/

10 References

- Care Quality Commission Fundamental Standards;
- NHS Improvement Guidance;
- Monitor Quality Governance Guidance;
- The Healthy NHS Board: Principles for Good Governance - NHS leadership Academy;
- Taking it on Trust: Questions for Boards - Health and Safety Executive - National Clinical Programmes Model of Care Development - Checklist - Governance for Quality and Safety;
- Health and Safety at Work etc Act 1974;
- The Management of Health and Safety at Work Regulations; and
- Health and Safety Executive (HSE).

Appendix 1: Risk Assessment Form for Risk Register Entry

(See Appendix 2 for Impact/Likelihood descriptors and risk grading matrix)

Risk I.D.	Date Assessed	Risk Description	Risk Source (e.g. incident, near-miss, complaint, claim, audit, external report, etc.)	Initial Risk Grade (Impact x Likelihood = Risk Grade)	Risk Controls Currently in Place	Target Risk Grade (Impact x Likelihood = Risk Grade)	Risk Treatment Action Plan	Current Risk Grade (Impact x Likelihood = Risk Grade)	Date Reviewed by Line Manager
		Risk of: **Due to:** **Who might be harmed and how?**							
Name of Person Completing Form:						**Job Title:**			
Name of Line Manager:						**Job Title:**			
Department:									

Please submit to your line manager for review and approval

NB: Risks graded 15 or above should be immediately escalated for review by the Trust Board until resolved, as per the flowcharts at 5.1.1 and 5.4 of the Risk Management Strategy

Appendix 2: Impact/Likelihood Descriptors:

Descriptor	Insignificant	Minor	Moderate	Major	Extreme
Score	1	2	3	4	5
Impact on individual Patient /Employee/ Visitor Safety	Minor injury not requiring first aid.	No permanent injury (psychological, emotional, physical) Minor injury or illness, first aid treatment required.	Semi-permanent injury (psychological, emotional, physical). increase in treatment for a patient i.e. return to surgery, an unplanned readmission RIDDOR/Agency reportable.	Permanent injury, serious disability, reduced life expectancy (psychological, emotional, physical).	Unexpected death.
Patient Experience	Unsatisfactory patient experience not directly related to patient care.	Unsatisfactory patient experience readily resolvable.	Mismanagement of patient care.	Serious mismanagement of patient care.	Totally unsatisfactory patient outcome or experience.
Complaints/ Claims	Locally resolved complaint.	Justified complaint peripheral to clinical care.	Below excess claim. Justified complaint involving lack of appropriate care.	Claim above excess level. Multiple justified complaints.	Multiple claims or single major claim.
Objectives/ Projects	Insignificant cost increase/schedule slippage. Barely noticeable reduction in scope or quality.	<5% over budget/schedule slippage. Minor reduction in quality/scope.	5-10% over budget/schedule slippage. Reduction in scope or quality.	10-25% over budget/schedule slippage. Doesn't meet secondary objectives.	>25% over budget/schedule slippage. Doesn't meet primary objectives.
Clinical Service/ Business Interruption	Local interruption with back up.	Local interruption.	Loss/interruption > 1hour.	Loss/interruption > 8 hours.	Loss/interruption > 24 hours.
Staffing & Competence	Short term low staff level temporarily reduces service quality (<1day).	On-going low staffing level reduces service quality.	Late delivery of key objective/ service due to lack of staff. Minor error due to poor training. On-going unsafe staffing level.	Uncertain delivery of key objective /service due to lack of staff. Serious error due to poor training.	Non-delivery of key objective/ service due to lack of staff. Loss of key staff. Critical error due to insufficient training.
Financial	Less than £100.	<£1000 but >£100.	<£10,000 but >£1000.	<£100,000 but >£10,000.	<£100,000 to reduce the risk.
Inspection/Audit	Minor recommendations. Minor non-compliance with standards.	Recommendations given. Non-compliance with standards.	Reduced rating. Challenging recommendations. Non-compliance with core standards.	Enforcement Action. Low rating. Critical report. Major non-compliance with core standards.	Prosecution. Zero rating. Severely critical report.
Adverse Publicity /Reputation	Rumours.	Local media – short term. Minor effect on staff morale.	Local media – long term. Significant effect on staff morale.	National media < 3 days.	National media >3 day. MP concern (Questions in the House).
Counter Fraud	Interception of non-recurring fraud with no losses.	Small losses incurred from fraud/error but no evidence to support sanctions.	Investigation leading to minor disciplinary sanction only.	Criminal investigation and possible dismissal. Local press coverage.	Criminal investigation. National press coverage. Poor systems exposed.

RISK GRADING MATRIX	IMPACT				
LIKELIHOOD	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Extreme
1 Rare: This will probably never happen	1	2	3	4	5
2 Unlikely: Do not expect it to happen	2	4	6	8	10
3 Possible: Might happen occasionally	3	6	9	12	15
4 Likely: Will probably happen	4	8	12	16	20
5 Almost certain: Will undoubtedly happen	5	10	15	20	25

KEY
- High risks
- Significant risks
- Moderate risks
- Low risks

Appendix 3: Version Control Sheet

Version	Date	Author	Status	Comment
2	15/04/2012	Head of Risk Management	Draft	Policy updated and combines the previous RM17 Risk Assessment Policy and RM21 Board Assurance Framework
3	30/09/2012	Director of Corporate Affairs	Final	Review prior to circulation to Board of Directors
4	31/08/2013	Head of Risk Management	Final	Policy updated
5	31/09/2016	Director of Clinical Governance	Draft	Rationalised for accessibility

Appendix 4: Plan for Dissemination

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Title of document:	**BSUH Risk Management Strategy**		
Date finalised:	**30 Sept 2016**	**Dissemination lead:**	**Lyn Allinson, Head of Risk Management Exnt 8073**
Previous document already being used?	**Yes**		
If yes, in what format and where?	**Trust Infonet in policies section**		
Proposed action to retrieve out of date copies of the document:	**Request policies TW/017 Version 4.0 to be electronically archived**		

To be disseminated to:	**How will it be disseminated, who will do it and when?**	**Format (i.e. paper or electronic)**	**Comments:**
Strategic Management Team	**Strategic Management Team**	**Electronic**	**For Consultation**
Board of Directors	**Trust Board**	**Electronic**	**For Approval**
Health and Safety Committee members	**Health and Safety Committee meeting**	**Electronic**	**For Information**
Quality, Risk & Performance Committee members	**Quality & Performance Committee meeting**	**Electronic**	**For Information**
Risk Committee members	**Risk Committee**	**Electronic**	**For Information**
All Trust Staff	**Weekly all staff e-mail**	**Electronic**	**For information**
All Trust Staff	**Whats new section of Trusts extranet**	**Electronic**	**For information**

Dissemination Record - to be used once document is approved

Date put on register / library of policies:		**Date due to be reviewed:**	

Disseminated to: (either directly or via meetings, etc.)	**Format (i.e. paper or electronic)**	**Date disseminated:**	**No. of copies sent:**	**Contact details / comments:**

Appendix 5: Due Regard Assessment

		Yes/No	Comments
1.	**Does the document/guidance affect one group less or more favourably than another on the basis of:**	No	
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
2.	**Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?**	No	
3.	**If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the document/guidance likely to be negative?**	No	
5.	**If so, can the impact be avoided?**	NA	
6.	**What alternative is there to achieving the document/guidance without the impact?**	NA	
7.	**Can we reduce the impact by taking different action and, if not, what, if any, are the reasons why the policy should continue in its current form?**	NA	

If you have identified a potential discriminatory impact of this Strategy, please refer it to Lyn Allinson, Head of Risk Management, x8073, together with any suggestions for improvement.