

**Risk Management Strategy**

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| **Document No** | Corp - 00003 | | | | **Version No** | 1.0 |
| **Approved by** | Policy Governance Group | | | | **Date Approved** | 02/11/16 |
| **Ratified by** | Trust Board | | | | **Date Ratified** | 03/11/16 |
| **Date implemented ( made live for use)** | | | 23/11/16 | | **Next Review Date** | 03/11/19 |
| **Status** | | LIVE | | | | |
| **Target Audience-** who does the document apply to and who should be using it. | | All employees directly employed by the Trust, whether permanent, part-time or temporary (including fixed-term contract). It applies equally to all others working for the Trust, including private-sector, voluntary-sector, bank, agency, locum, and secondees. For simplicity, they are referred to as ‘employees’ throughout this policy | | | | |
| **Accountable Director** | | | | Chief Executive | | |
| **Author/originator** – Any Comments on this document should be addressed to the author | | | | Director of Governance and Assurance | | |
| **Division and Department** | | | | Corporate. Corporate Governance | | |
| **Implementation Lead** | | | | Director of Governance and Assurance | | |
| **If developed in partnership with another agency ratification details of the relevant agency** | | | | NA | | |

**Equality Impact**

Great Western Hospitals NHS Foundation Trust strives to ensure equality of opportunity for all service users, local people and the workforce. As an employer and a provider of health care, the Trust aims to ensure that none are placed at a disadvantage as a result of its policies and procedures. This document has therefore been equality impact assessed in line with current legislation to ensure fairness and consistency for all those covered by it regardless of their individuality. This means all our services are accessible, appropriate and sensitive to the needs of the individual.



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# Document Definition

## Introduction

Great Western Hospitals NHS Foundation Trust (the Trust) is committed to implementing the principles of good governance, defined as the system by which the organisation is directed and controlled, at its most senior levels, to achieve its objectives and meet best practice standards in accountability, probity and openness. The Trust recognises that the principles of governance must be supported by an effective risk management system.

Failure to implement a strategy for managing risk could have a severe impact on patient health, the Trust’s reputation and the health and safety of staff and visitors; it would also be a breach of the Trusts statutory obligations. It could also have serious financial consequences. The Trust’s Risk Management Strategy is integral to delivering the Trust’s objectives and Annual Plan.

## References, Further Reading and Links to Other Policies

The following is a list of other policies, procedural documents or guidance documents (internal or external) which staff should refer to for further details:

| **Ref. No.** | **Document Title** | **Document Location** |
| --- | --- | --- |
| 1 | Claims Management Policy | T:\Trust-wide Documents |
| 2 | Complaints Policy | T:\Trust-wide Documents |
| 3 | Health and Safety Policy | T:\Trust-wide Documents |
| 4 | Incident Management Policy | T:\Trust-wide Documents |
| 5 | Information Governance Strategy and Policy | T:\Trust-wide Documents |
| 6 | How To Assess Risk Procedural Document | T:\Trust-wide Documents |
| 7 | Terms of Reference for committees of the Trust Board | Director of Governance & Assurance |
| 8 | Whistleblowing & Freedom to Speak up Policy | T:\Trust-wide Documents |
| 9 | Maternity Service Risk Management Strategy | T:\Trust-wide Documents |
| 10 | NHS Improvement – Independent Regulator of Foundation Trusts | https://improvement.nhs.uk |
| 11 | National Audit Office Financial Governance and Audit Practice | [www.nao](http://www.nao).org.uk |
| 12 | Board Assurance Framework | Director of Governance & Assurance |
| 13 | Safeguard Risk Register | T:\Trust-wide Documents |
| 14 | Mandatory Training Needs Analysis | T:\Trust-wide Documents |
| 15 | Inquests (guidance for staff) Policy | T:\Trust-wide Documents |
| 16 | Scheme of Delegation | T:\Trust-wide Documents |
| 17 | The Great Western Hospitals NHS Foundation Trust Strategy for 2014-2019 | T:\Trust-wide Documents |
| 18 | Risk Escalation Framework | T:\Trust-wide Documents |

## Glossary/Definitions

The following terms and acronyms are used within the document:

|  |  |
| --- | --- |
| **15+ Risk Register** | An extract of the Safeguard Risk Register containing those risks which scored a 15 or above in accordance with the Trust How To Assess Risk Procedural Document (Ref. 8) |
| **ARAC** | Audit, Risk and Assurance Committee |
| **Board Members** | Executive and non-executive directors on the Trust Board |
| **CNST** | Clinical Negligence Scheme for Trusts |
| **Control** | A measure put in place in order to mitigate risk |
| **CoSHH** | Control of Substances Hazardous to Health Regulations 2002 |
| **CQC** | Care Quality Commission |
| **DoH** | Department of Health |
| **H&S** | Health and Safety |
| **Hazard** | The potential for harm, misfortune, damage or loss. |
| **HSE** | Health and Safety Executive |
| **HSMR** | Hospital Standardised Mortality Ratio |
| **Local** | A subdivision of the organisation such as division or specialty |
| **LTPS** | Liabilities to Third Parties Scheme |
| **NHSLA** | National Health Service Litigation Authority |
| **NPSA** | National Patient Safety Agency |
| **PHSO** | Parliamentary and Health Service Ombudsman |
| **PQC** | Patient Quality Committee |
| **Residual risk** | The level of risk which remains when all practicable control measures have been implemented |
| **RIDDOR** | Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 |
| **Risk** | The likelihood of harm, misfortune, damage or loss due to realisation of a hazard. |
| **Rule 28** | A recommendation from the Coroner ` |
| **Safeguard Risk Register** | Electronic repository for risks raised in the Trust, and a risk management tool |
| **Senior Managers** | For the purposes of the Risk Management Strategy, senior managers are defined as Associate Medical Directors and Divisional Directors |
| **SI** | Serious Incident |
| **SIRO** | Senior Information Risk Owner |
| **Specific Area** | A term used to describe specific areas in the Trust that, although not divisions, have their own division-style Risk Register, e.g. Mental Health |
| **Staff** | Used to refer to anyone working for the Trust, including NHS staff employed by the Trust, private-sector, voluntary-sector, agency, locum, contract, seconded and volunteer staff |

## Document Description

This is a strategy. A strategy document is defined as a plan of action intended to accomplish a specific goal. All strategies are agreed by the Trust Board unless otherwise specified in the Scheme of Delegation (Ref. 18).

## Purpose of the Document

The purpose of the Risk Management Strategy is to provide a clearly defined and documented framework to ensure that risks to the achievement of the Trust’s objectives are identified and managed in a consistent manner, appropriate to the level of risk in order to reduce the risk.

## Scope

This document applies to all Trust employees and those that work at the Trust but are not directly employed by the Trust such as agency, locum, volunteer and student.

This is the predominant risk management strategy in the Trust. The Maternity Services Risk Management Strategy (Ref 11) has been developed to supplement the Trust Risk Management Strategy; however this remains subservient to the Trust-wide Risk Management Strategy.

## Regulatory Position

This strategy provides a structured approach to the management of risk as required by the NHS Litigation Authority (NHSLA) and NHS Improvement, the Independent Regulator of NHS Foundation Trusts (Ref. 10).

This strategy has been checked for compliance with NHS Improvement’s governance arrangements and financial risk management assessment.

In creating this strategy, consideration has been given to the National Audit Office Financial Governance and Audit Practice document (Ref. 13) relating to the role of the Audit Committee.

## Special Cases

None identified.

## Consultation Process

The following is a list of consultees in formulating this document:

| **Job Title / Department** |
| --- |
| Associate Medical Directors |
| Audit, Risk and Assurance Committee members |
| Director of Governance & Assurance |
| Executive Directors |
| Divisional Directors |
| Health and Safety Manager |
| Legal & Inquest Manager |

## Comments

Any comments on this strategy should, in the first instance, be addressed to the author.

# General Principles

## Key Principles of this Strategy

* All staff are responsible for identifying and managing risks;
* Trust resources will be allocated in a manner commensurate with level of risk;
* Accountability for managing risk will be determined by the risk score;
* Risks will be assessed in a consistent manner, by adopting the NPSA National Patient Safety Agency risk assessment matrix in the How To Assess Risk Procedural Document (Ref. 8);
* Training will be provided to staff to support the identification and management of risks;
* The Trust will operate a Board Assurance Framework and a Risk Register that will enable systematic oversight and scrutiny of risk.
* The Trust will share learning on risk management success and controls throughout the organisation.

## Definition of Risk Management

Risk management is a systematic and cyclical process, in which potential risks are identified, assessed, managed, monitored and reviewed. It is applicable at all levels – corporate, divisional, department, team and individual.

Risk Management is a proactive approach which:

* Identifies the various activities of the organisation;
* Identifies the hazards that exist within those activities and the risks associated with those hazards;
* Assesses those risks for likelihood and potential severity;
* Eliminates the risks that can be eliminated;
* Reduces the effect of those risks that cannot be eliminated;
* Acknowledges those risks that can be accepted;
* Seeks to engage with staff to understand risks and explain tolerated risks; and
* Regularly monitors and reviews all risks.

## Categorisation of Risks

Risks come in many forms. The Trust has adopted the Care Quality Commission (CQC) domains to categorise its risks and included finance as an additional category. The full list can be found in Appendix F. They are as follows:

|  |
| --- |
| **CQC Domains** |
| Safety |
| Effectiveness |
| Caring |
| Responsiveness |
| Well Led |
| + Finance\* |

\*The Trust recognised the need to retain the category of Finance from its previous risk Group categories.

Risk Group is a mandatory field on the Safeguard Risk Register (see Section 5.7 of this document) to ensure that all risks added to the system are categorised.

## Acceptable Risk

The Trust recognises that it is not possible to eliminate all risks and systems and controls should not be so rigid that they stifle innovation and imaginative use of limited resources in order to achieve health benefits. The high costs of eliminating a risk in comparison with the potential severity of the risk being realised mean that risks will not always be eliminated.

When all reasonable control measures have been put in place some residual risk will remain in many Trust processes and this level of risk will be accepted if the risk :

1. Is minor in nature, with minimal potential for financial loss or damage to structure, persons, equipment or property;
2. Will occur rarely and might cause serious harm, damage or loss but which would take disproportionate resources to eliminate or reduce.

Where risks are deemed ‘accepted’, with no further action to be taken, they should be reviewed to ensure that no further action could be taken to mitigate them. The frequency of the review will depend on the level of risk. The minimum review frequency for accepted risks is set out below.

|  |  |  |
| --- | --- | --- |
| **Risk score** | **Level of risk** | **Review frequency** |
| 1-3 | Low risk | Yearly |
| 4-6 | Moderate risk | Yearly |
| 8-12 | High risk | Quarterly |
| 15+ | Extreme risk | Monthly† |

**†All risks that score 15 or above can only be deemed ‘accepted’ by Trust Board. All risks which score 15 or above must be reviewed at least monthly, irrespective of whether they are deemed ‘accepted’.**

# Objectives

## Strategic Objectives

The Trust set out its strategic objectives in the Great Western Hospitals NHS Foundation Trust 5 Year Plan for 2014-2019 (Ref 19).

They are:

1. To deliver consistently high quality, safe services which deliver desired patient outcomes.
2. To improve the patient and carer experience for every aspect of the care that we deliver.
3. To ensure that staff are proud to work for the Trust and would recommend the Trust as a place to work or receive treatment.
4. To secure the long term financial health of the Trust.
5. To adopt new approaches and innovation so that we improve services as healthcare changes whilst continuing to become even more efficient.
6. To work in partnership with others so that we provide seamless care for patients.

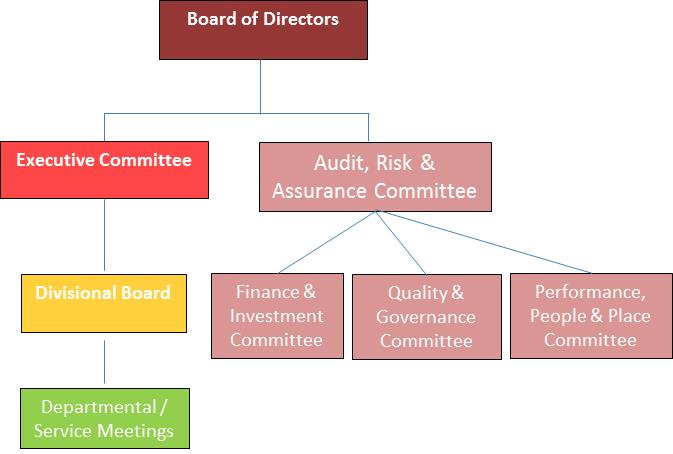
In addition the Trust will set out its objectives annually in an annual plan which is published on NHS Improvement’s website (Ref. 12).

# Risk Management Organisational Structure

**Note - Please refer to terms of reference (Ref 9) for Committees in conjunction with this strategy for more information on the role of these committees. These are available from the Director of Governance & Assurance.**

## Risk Management Organisational Chart

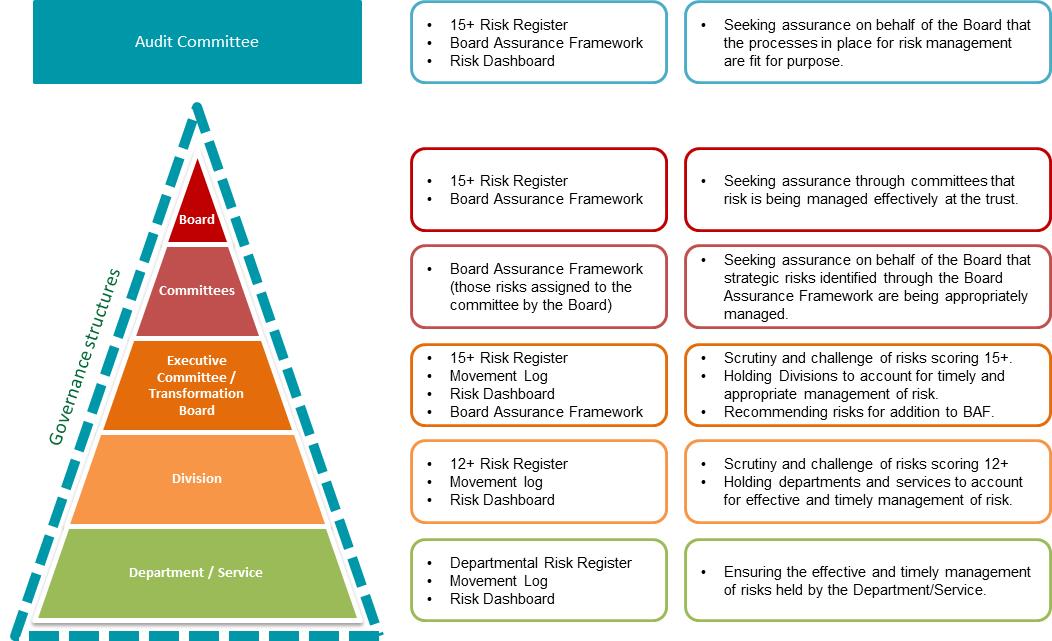
|  |
| --- |
| Trust Board  Overarching responsibility for risk.  Ratify the Risk Management Strategy.  Review the Board Assurance Framework twice a year.  Review 15+ Risk Register twice a year. |
| Executive Committee (operational responsibility)  Review the Board Assurance Framework quarterly times a year.  Assure ARAC that risks are being managed.  Reviews each divisional risk register once a year.  Scrutinises the 15+ Risk Register monthly. |
| Audit, Risk and Assurance Committee (ARAC) (process assurance)  Assures Trust Board of the effectiveness of the risk management processes.  Review 15+ Risk Register twice a year.  Review Board Assurance Framework twice a year.  Review the Risk Dashboard twice a year  Board Committees  Receives assurances in relation to those BAF risks which have been delegated to the committee by the Board. |
| Divisional meetings (operational responsibility)  Review divisional risk registers monthly.  Direct action to mitigate high-scoring risks (12+) within Division |
|  |



Of those committees with responsibility for risk Departmental meetings, Division meetings, and the Executive Committee have an operational responsibility for managing risk, whereas the Audit, Risk and Assurance Committee is responsible for providing assurances to Trust Board that the processes for managing risk, as set out in this strategy, are effective. The Audit, Risk and Assurance Committee will consider any oversight of risk management by the Board Committees which may consider risk management within their areas of

responsibility.

## Accountability for Risk / Risk Escalation Framework



## Trust Board

The Trust Board is responsible for risk management throughout the Trust. It delegates some responsibility to the Executive Committee and the Audit, Risk and Assurance Committee and receives assurance from those committees on the effectiveness of the risk management strategy. To discharge its responsibilities it will:

* Ratify the Trust’s Risk Management Strategy every two years;
* Review the 15+ Risk Register twice a year;
* Review the Board Assurance Framework twice a year;
* Delegate responsibility for taking assurance on the risk management processes to the Audit, Risk and Assurance Committee.

## Audit, Risk and Assurance Committee

The role of the Audit, Risk and Assurance Committee is to oversee the implementation of the Risk Management Strategy and to take assurances that the processes supporting the Risk Management Strategy are effective in mitigating risk. It does not have operational responsibility for individual risks, but will take assurances from the Executive Committee that risks are being managed. Its specific responsibilities are:

* To review the 15+ Risk Register at least twice a year;
* To review the Board Assurance Framework twice a year.
* To review the Risk Dashboard at least twice a year,
* To gain an understanding of any significantly increasing risks below 15+ or of material future concern, where possible.

The Audit, Risk and Assurance Committee will also receive assurances from the Board Committee to supplement the overall assessment of risk and the effectiveness of the risk management process within the Trust. Each Board Committee is responsible for the governance in their area and the Audit, Risk and Assurance Committee take assurance from their work. The Terms of Reference for the Audit, Risk and Assurance Committee support this. The Committee gets specific assurance from each committee's work and then has a view itself of the whole integrated processes and assurances.

Where the Audit, Risk and Assurance Committee identifies significant gaps in the Trust’s risk management strategy or processes for managing risk, the Chair of the Committee will make a verbal report to Trust Board and if deemed necessary to the Council of Governors.

## Board Committees

There are three Board Committee with responsibility for seeking assurance relating to work within their remit. The Quality & Governance Committee is particularly concerned with reviewing both clinical and regulatory compliance matters and ensuring risk mitigation in these areas, whereas the Finance and Investment Committee is engaged in regular reviews of risk outcomes of financial performance and both short and longer term financial planning with actions to mitigate risk being identified. The Performance, People and Place Committee is concerned with operational performance, workforce, estates, IT and business continuity. All Board Committees will provide assurance to the Audit, Risk and Assurance Committee to supplement the overall assessment of the effectiveness of the risk management process. This is done via an overlap of committee membership and specific reports to the Audit, Risk and Assurance Committee as necessary.

Each of these committees has delegated oversight of those relevant strategic risks from the Board Assurance Framework which have been assigned to them by the Board. The committees will undertake the following roles in relation to the Board Assurance Framework;

* Receive and review those BAF risks delegated to them by the Board in order to seek assurance that they are effectively managed and mitigated, on a quarterly basis.
* Agree the scoring of the strategic risks delegated to them by the board based upon the assurance received.
* Report any gaps in assurance or deterioration on strategic risks scores to the Board by exception.
* Receive and consider recommendations from the Executive Committee for the addition of new risks to the Board Assurance Framework.

## Executive Committee / Transformation Board

The Executive Committee consists of the Executive Directors, Associate Medical Directors and Divisional Directors. The Executive Committee has operational responsibility to ensure risks are being managed. It has specific responsibility to:

* Scrutinise and challenge the 15+ Risk Register on a monthly basis;
* Consider risks for escalation to the Board Assurance Framework and where identified recommend these for inclusion to the appropriate Board committee;
* Scrutinise and challenge the Board Assurance Framework quarterly;
* Scrutinise and challenge each Division Risk Register once a year;
* Hold Associate Medical Directors and Divisional Directors to account using the Risk Dashboard on how risks are managed within their Division, directing action where appropriate; Scrutinising and challenging may involve:
* Identifying any gaps in the 15+ Risk Register and Board Assurance Framework;
* Checking that risks are scored appropriately and consistently in accordance with the How To Assess Risk Procedural Document (Ref. 8);
* Asking Associate Medical Directors and Divisional Directors to take account of risks identified in other Divisions that may be relevant to their own Division.

Where a risk has been added to the 15+ Risk Register and Executive Committee considers the risk accepted, this should be reported to the next Trust Board by the Chair of Executive Committee, for formal agreement that the 15+ can be accepted with no further action to be taken.

Where issues are identified, the Executive Director, Associate Medical Director or Divisional Director for the Division in which the risk was raised are responsible for addressing the issue within the timeframe set by the Committee. The Executive Committee can ask for amendments to the wording or scoring of risks raised by the Divisions. The action should be minuted and the Executive Director, Associate Medical Director or Divisional Director should liaise directly with the risk owner to effect the change before reporting back to the Committee.

## Division Meetings

For the purposes of the Risk Management Strategy, the Divisions are defined as follows:

* Corporate;
* Diagnostics and Outpatients;
* Planned Care;
* Unscheduled Care;
* Women’s and Children’s;

Division meetings will:

* Scrutinise risks scoring 12 or above within their Division;
* Holds departmental managers to account for managing their risks;
* Reports areas of concern to the Executive Committee.

Divisional meetings will review their Divisional risk registers on a monthly basis. The review, together with any action taken, should be minuted.

The Executive Director, Associate Medical Director and Divisional Director for a Division will be asked to complete the checklist at Appendix D at least once a year to provide assurance that the processes for managing risk within their Division remain effective.

## Specific-area Meetings

For the purposes of the Risk Management Strategy the following area has been designated a ‘specific area’ requiring a Risk Register:

* Mental Health

Although not a formal Division in the Trust, Mental Health has been designated a division in the Safeguard Risk Register to enable a Mental Health Risk Register to be compiled. The Mental Health Risk Register is further subdivided into the areas of Mental Health and Mental Capacity.

The Mental Health Risk Register will be reviewed by the Mental Health Committee at least three times a year.

## Departmental Meetings

Wards and departments will review their risk registers on a monthly basis. Departmental meetings will:

* Scrutinise risks identified for their department;
* Hold individuals to account for managing risks assigned to them;
* Report areas of concern to the Division meeting

## Individual Management

Individuals are responsible for management of risks where they are the risk owner/manager. Actions should be identified to mitigate risk and recorded on the Safeguard Risk Register. In addition, progress against these actions must be recorded on the Safeguard Risk Register and actions closed once they have been completed. Risks should be reviewed in a timely manner as specified in accordance with the frequency of review.

# Risk Management Process

## How all Risks are Assessed

All risks are assessed in accordance with the 5x5 NPSA risk management matrix (Appendix C - Risk Assessment Matrix). For more information, refer to the Trust’s How to Assess Risk Procedural Document (Ref. 8).

## How Risk Assessments are Conducted Consistently

The Trust will ensure that risk assessments are conducted in a consistent manner by:

* Adopting the NPSA Risk Assessment Matrix for the assessment of all risks (Appendix C- Risk Assessment Matrix);
* Providing training to staff on risk assessment at corporate induction (Section 9);
* Making a How to Assess Risk Procedural Document (Ref. 8) available to all staff through the intranet;
* Employing an electronic risk register system with mandatory fields (Section 5.7);
* Employing a standardised paper-based risk assessment form which is part of the How to Assess Risk Procedural Document (Ref. 8);
* Ensuring challenge and scrutiny of risks at all levels – committees, divisions, teams (Section 4).

## How Risk is Managed Locally

For the purposes of the Risk Management Strategy the Trust has adopted the NHSLA definition of ‘local’, that is:

*A subdivision of the organisation, for example division, department, speciality or business unit.*

This section will therefore focus on the processes for managing risk at a Division level. Further guidance on managing risks within wards and departments is available from the Health and Safety Policy (Ref. 3).

Risk is managed locally by using a combination of proactive and reactive risk assessment and escalating risk using the Safeguard Risk Register and paper risk assessment form (only where use of an electronic system is not available, i.e. some community locations).

### Immediate Action

All staff are responsible for identify and managing risk.

Where a risk can be immediately mitigated, e.g. removing a cable from the floor, this should be done without delay. Where the risk cannot be immediately mitigated, staff should conduct a risk assessment in accordance with the How to Assess Risk Procedural Document (Ref. 8).

Requirements for escalating risks are set out in 5.4.

Responsibilities for managing risk are set out in section 5.5.

### Risk Assessment

All staff are accountable for identifying and managing risk and are trained at Corporate Induction to complete risk assessments. Staff will also have access to the How to Assess Risk Procedural Document which is available by searching for ‘How to Assess Risk’ on the Policies and Procedures page of the Trust intranet. If the staff member still feels they are not able to adequately assess the risk themselves, they should report the risk to their line manager. The line manager will then conduct the risk assessment and consider if further training is required.

Once the risk has been assessed, the process for onward reporting of risks is dependent on risk score (see Section 5.4 for more information).

Where applicable, individual departments will be expected to have risks assessment in place for the following:

* Lone worker activities;
* Young persons at work;
* Violence and aggression;
* Work equipment, e.g. shredder, lasers, sluices, macerators;
* Display screen equipment;
* Latex management (for latex allergic staff or for continued individual use of latex gloves);
* Patient Manual Handling, e.g. hoists;
* General Manual Handling, e.g. lifting boxes, files;
* New and expectant mothers;
* Sharps;
* Falls Assessment (patients-only) (NHSLA requirement);
* CoSHH.

These can be recorded on a paper-based risk assessment form (where access to the safeguard system is not available only, i.e. community locations) (see How to Assess Risk Procedural Document – Ref. 8) or on the Safeguard Risk Register. There is no requirement to complete a separate paper-based risk assessment form in addition to the completed risk assessment on the Safeguard Risk Register.

The Occupational Health and Safety Department will also undertake spot checks audits on departments to demonstrate compliance with this process.

### Action Plans

All risk assessments should include actions where the risk is to be mitigated or eliminated. Actions to be taken to mitigate/eliminate a risk will be documented either on the paper-based risk assessment form (where access to the electronic system is not available only) or the Safeguard Risk Register.

Division management will take a risk-based approach to resource allocation, and resource will be allocated first to risks with a higher score according to the How to Assess Risk Procedural Document (Ref. 8).

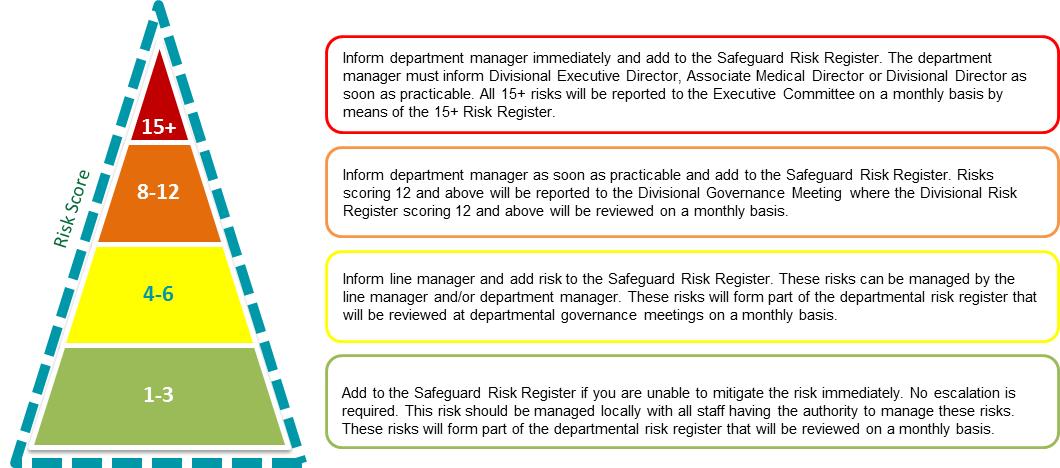
### Monitoring the Local Process for Managing Risk

The process for monitoring how risk is managed locally (at Division-level) is that risks that are scored as 12 or above are followed up by Division management by reviewing the division risk register on a monthly basis (see Section 5.8).

In addition, each Division’s Safeguard Risk Register will be scrutinised by Executive Committee at least once a year to ensure risks are appropriately scored, reflective of the risk profile of the Division and that actions to mitigate the risk are in place and effective.

## How Risks are escalated through the Organisation

Risk escalation will be determined by risk score.



Where risk assessments concern specific patients or staff and contain confidential information they should not be added to the Safeguard system in order to avoid breaching patient or staff confidentiality. Such risk assessments should be stored in the patient’s health record, or staff personnel folder.

**Where there is an immediate risk to the health and wellbeing of patients, staff or visitors, this should be escalated immediately. If outside of normal working hours, the risk should be reported to the on-call manager for assistance.**

## Authority to Manage Risk

The authority to manage risk is determined by the risk category. Risk categories are based on the NPSA risk management matrix (Appendix C).

### 15+ ‘Extreme risk’ (Red)

Individuals must inform department manager immediately and add to the Safeguard Risk Register. The department manager must inform Divisional Executive Director, Associate Medical Director or Divisional Director as soon as practicable. All 15+ risks will be reported to the Executive Committee on a monthly basis by means of the 15+ Risk Register.

### 8-12 ‘High Risk’ (Amber)

Individuals must inform department manager as soon as practicable and add to the Safeguard Risk Register.

All open risks that have been added to the risk register from a Division, will populate that Division’s risk register that will be reviewed by the Executive Committee at least once a year. It is expected that the Divisions’ 12+ risks be discussed monthly, at a Division management or governance meeting.

### 4-6 ‘Moderate Risk’ (Yellow)

The individual must inform line manager and add risk to the Safeguard Risk Register. These risks can be managed by the line manager and/or department manager. These risks will form part of the departmental risk register that will be reviewed at departmental governance meetings on a monthly basis.

### 1-3 ‘Low Risk’ (Green)

The individual must add these to the Safeguard Risk Register if they are unable to mitigate the risk immediately. No escalation is required. This risk should be managed locally with all staff having the authority to manage these risks. These risks will form part of the departmental risk register that will be reviewed on a monthly basis.

## Board Assurance Framework

The Board Assurance Framework is a document which identifies which of the Trusts objectives are at risk because of inadequacies in the operation of controls or where the Trust has inadequate assurances. It also provides structured assurances about where risk is being managed effectively and objectives are being delivered.

### Purpose of the Board Assurance Framework

To ensure that risks to the Trust achieving its strategic objectives are identified promptly; that control measures are put in place to mitigate those risks; to ensure that assurances are taken throughout the year; and to ensure that those control measures are effective in mitigating the risk.

### Content of the Board Assurance Framework

The Board Assurance Framework will reflect the Trust annual objectives for the year in which it operates. Risks will be identified against those objectives as set out in the Annual Plan. New risks to the strategic objectives of the Trust identified through the year will be added to the Board Assurance Framework by the Executive Committee. Each risk identified will have the following minimum data set:

* A sequential reference number;
* Description;
* Initial risk rating;
* Key control(s);
* Source of assurance on those controls (internal and external)
* Responsible Executive Director

At least three times a year the Board Assurance Framework will be reviewed by the Director of Governance & Assurance who will add details of:

* Positive assurances received since the last review;
* Any negative assurances received;
* Gaps in control (where identified);
* Gaps in assurances.

Based on the assurances received in the preceding quarter the Executive Committee will review the risk score, requesting amendments where necessary.

Risks that are identified on the Board Assurance Framework that score above a 15 in accordance with the Trust’s How to Assess Risk Procedural Document (Ref. 8) will be included to the 15+ Risk Register.

### Process for Compiling the Board Assurance Framework

Each financial year, after publication of the Trust Annual / Operational Plan, the Director of Governance & Assurance will revise the Board Assurance Framework based on the risks identified in the Annual Plan for the year ahead. Where possible, the Director of Governance & Assurance will identify the controls measures, sources of assurance and any gaps in the control framework, before meeting with each of the Executive Directors to review the Board Assurance Framework.

### Scrutiny and Challenge Including Frequency

The Board Assurance Framework is subjected to scrutiny and challenge quarterly by the Executive Committee and at least twice a year by the Audit, Risk and Assurance Committee. The Audit, Risk and Assurance Committee will take assurances from the Executive Committee that the Board Assurance Framework accurately reflects the risk profile of the Trust and that risks are being appropriately managed. Trust Board will then review the Assurance Framework twice a year.

The Board Committees will oversee scrutiny and assurance on behalf of the Board for those strategic risks captured on the Board Assurance Framework which are delegated to them for review. Committees will review their sections of the Board Assurance Framework on a quarterly basis and draw to the attention of the Board any issues or concerns or the need for action plans.

## Safeguard Risk Register

### Purpose of the Safeguard Risk Register

From the 1 April 2012, the Trust has used the Safeguard Risk Register as its risk register. The purpose of the risk register is to enable oversight and scrutiny of risks identified in the Trust and to ensure mitigating action is taken to reduce the risk. The additional purpose of the Safeguard Risk Register is a centralised system to manage all aspects of an individual risk.

All risks which cannot be mitigated or resolved immediately should be added to the Safeguard Risk Register (or paper register where access to Safeguard is not available in some community sites only).

### Content

The Trust prescribes the following minimum content of the Safeguard Risk Register:

* Reference number;
* Risk description;
* Source of the risk;
* Nature of risk;
* Current status (accepted, action required, closed)
* Original risk score, current risk score, residual risk score;
* Action to mitigate risks, with due dates, progress reports and action leads;
* Operational and Executive leads.

Where staff wish to see risks pertinent to their area, they can filter the Safeguard Risk Register according to Department or Division, (Including Risk Score and Risk Group and Type.)

### Source of the Risk

Risks are identified through the following process and are added to the Safeguard Risk Register:

* Incident reports;
* Risk assessments;
* Local risk registers;
* External recommendations.
* National Risk Register

In areas where paper risk assessments are in use because there is no access to the electronic system, these must inform the Safeguard Risk Register at the earliest opportunity. Support from the Risk Team can be sought for this. .

Risks added first to the Safeguard Risk Register do not need a duplicate paper risk assessment, but should a staff member wish to have a copy of the assessment to make it available to staff in their area, they are can print a single risk report from the Safeguard Risk Register.

The Trust does not operate local risk registers separate to the Safeguard Risk Register; however, the Safeguard Risk Register can be filtered by Department and Division, to create Department and Division risk registers.

For the purposes of this strategy, the Trust has defined ‘external recommendations’ as recommendations from independent inspection, accreditation or regulatory bodies such as the following:

* Care Quality Commission;
* Health and Safety Executive;
* NHS Improvement;
* NHS Litigation Authority.

It is not intended to include recommendations from external auditors, the Trust’s commissioners or other bodies not independent or organisations which are not designated inspection, accreditation or regulatory bodies.

Recommendations from the Coroner will be addressed in accordance with the Trust Inquest Policy (Ref. 17).

### Acceptable Risk

See Section 2.4.

### Review

15+ Risk Register

The 15+ Risk Register is an extract of the Safeguard Risk Register containing only those risks which score 15 or above.

The 15+ Risk Register is scrutinised and challenged by the Executive Committee on a monthly basis and by the Audit, Risk and Assurance Committee at least three times per year.

The Executive Committee will scrutinise individual risks scoring 15 or greater to ensure they are accurately described and scored, that they appropriately reflect the level of risk, and that appropriate actions are in place to mitigate the risk. If there are any concerns the Executive Committee can require that the Executive Director, Associate Medical Director or Divisional Director for the Division in which the risk was raised take action. Actions will be minuted and followed up in future meetings to ensure compliance.

The Audit, Risk and Assurance Committee seeks assurance that the process for identifying risks is in place and that risks are being managed.

Other risks

All other risks that are added to the Safeguard Risk Register will be subject to review via division or specific-area risk registers see Section 5.8.

The format of the reports from the Safeguard Risk Register is kept under constant review by the Risk & Governance Facilitator to ensure effectiveness and continued compliance with the NHSLA standards and wider regulatory framework.

### Adding Risks to Safeguard

Only staff that have received training on the Safeguard Risk Register are provided with access. Where a staff member who is not trained identifies a risk that scores eight or above, he or she should report the risk to their department manager so that the risk can be added. If in doubt, the department manager can contact the Risk and Governance Facilitator on 01793 605426 to find out who is trained within their Division.

## Division and Specific-area Risk Registers

### Purpose of Division and Specific-area Risk Registers

Divisions and specific areas are required to review their risks on a regular basis to ensure that there is oversight and management of those risks at a Division/specific area level.

Divisional Governance meetings should review their risk register (which captures risks scoring 12 and above) on a monthly basis as per the risk escalation framework. Similarly Service/Departments should review their risk registers on a monthly basis with a focus on ensuring timely review, action and accuracy of rating.

### Content of Division and Specific-area Risk Registers

When risks are added to the Safeguard Risk Register, they must be allocated to a Division or specific area (this is a mandatory field and risks cannot be saved without completing it). As of 1 October 2013 the divisions/specific areas are as follows:

* Corporate;
* Diagnostics and Outpatients;
* Finance;
* Mental Health (there is no mental health division in the Trust, however this is treated as a specific area for the purposes of the Trust Risk Management Strategy in order to ensure oversight of this important area of risk);
* Planned Care;
* Unscheduled Care;
* Women and Children’s;
* Workforce and Education.

In order to compile a Division/specific area risk registers, the Safeguard Risk Register is filtered to provide a report relevant to the area.

### Sources of Risk (Division and Specific-area Risk Registers)

See ‘Source of the risk’, Section 5.7.3.

### Review of Division and Specific-area Risk Registers

Divisions and specific areas are required to review their risks monthly. This will normally be at a Division-level meeting. Should any issues arise from this review, they will be reported to Executive Committee.

At least once per year, there should be an overview of the division/specific-risk registers by the Executive Committee. A schedule of dates when division/specific-area risk registers are due to be reviewed by these committees is available from the Risk & Governance Facilitator.

# Risk Management Tools

## How to Assess Risk Procedural Document

The How to Assess Risk Procedural Document (Ref. 8) is based on the NPSA Risk Matrix for Managers and should be the basis for all risk assessments conducted in the Trust. This procedure can be located by searching for ‘How to Assess Risk’ on the ‘Polices and Procedures’ page of the Trust intranet.

## Paper-based Risk Assessment Form

This can be found as an appendix in the How to Assess Risk Procedural Document (Ref. 8). This should be used in areas where there is no access to the electronic system only. However, all risks must be added to the Safeguard Risk Register regardless of their score.

## Safeguard Risk Register

See Section 5.7. For details on who is trained in a division, or to enquire about the next training session, contact the Risk & Governance Facilitator on 01793 605426.

## 15+ Risk Register

This is an extract of the Safeguard Risk Register containing only risks which score 15 or above. These risks are considered extreme risks in accordance with the NPSA Risk Management Matrix and therefore require the highest level of scrutiny and resources to mitigate. The 15+ Risk Register is reviewed by Executive Committee, the Audit, Risk and Assurance Committee and Trust Board.

## Risk Dashboard

A presentation of analysis of the Trust’s risk management environment. This dashboard presents the profile of risks held by the Trust, Division or Department along with details of the number, and nature of, those risks which are beyond their stated review date.

## Division Risk Registers

See Section 5.8.

## Board Assurance Framework

See Section 5.6. A copy of the Board Assurance Framework is available from the Director of Governance & Assurance.

# Analysis and Improvement

The Trust will analyse data on incidents, complaints and claims in order to learn lessons and provide a risk profile for the organisation.

The Trust will produce monthly or quarterly reports which analyse incidents, complaints and claims. These reports will contain both quantitative and qualitative analysis.

This will be in addition to learning from individual incidents, complaints and claims.

Reporting templates can be found at Appendix E. Report templates may be amended from time-to-time and they are a guide for writing reports. The author of the report is responsible for keeping the latest version of the template.

## Incidents (clinical)

Every month, the Clinical Risk Manager will analyse clinical incident data by compiling a report using the template found in Appendix E as a guide, which will form part of the Patient Safety and Quality Report. The report will be received by Executive Committee. The report is shared with Trust Board and, where relevant issues are identified, these will be cascaded to Division staff by the Associate Medical Director and Divisional Director.

If actions arising from the report are identified by the Committee these will be minuted and added to the ‘actions tracker’, which is followed up at each meeting to ensure compliance. If a risk is identified from the analysis, this risk will be added to the Safeguard Risk Register within one week of the report being received by the Committee.

See also the Incident Management Policy (Ref. 4).

## Incidents (non-clinical)

Each month, the Health and Safety team will compile an analysis of non-clinical incident data for presentation at the H&S Committee using the template at Appendix E. The data will include a quantitative analysis of fire, manual handling, slips, trips and falls, and sharps incidents. The H&S Committee will provide qualitative analysis of the data which will be minuted.

The incident data, together with the minutes from the Committee are shared with all members of the H&S Committee.

Where actions are identified following discussion of the data at the H&S Committee, these actions will be minuted and followed up at a future meeting (depending on the set timeframe) under the ‘Matters arising’ agenda item. Where risks are identified from the analysis, they will be added to the Safeguard Risk Register by the Health and Safety Manager within one week of the Committee receiving the report.

See also the Health and Safety Policy (Ref. 3).

## Complaints

Each calendar month, Patient Advice Liaison Service (PALS) will produce a patient experience report that analyses complaints data by identifying themes across acute, community and maternity complaints using the template at Appendix E as a guide. The report will be received by Executive Committee and where actions are identified each month, these will be minuted by the Committee and followed up in future meetings (depending on the set timeframe) using an ‘actions tracker’. Where risks are identified, the Head of Marketing and Communications will add the risk to the Safeguard Risk Register within one week of the report being received by the Committee.

See also the Complaints Policy (Ref. 2).

## Claims

The Legal & Inquest Manager analyse claims data each quarter using the report template in Appendix E as a guide. Data will be analysed both in terms of numbers and categories, but also in terms of themes, with qualitative analysis of the data. The report will be received by the Trust Patient Quality Committee each quarter. Where issues are relevant to a Division, Associate Medical Directors and Divisional Directors will cascade the information from the Committee to their teams.

On review of the report at the Committee, if there are any actions to be taken, these will be minuted by the Committee with followed up at a future meeting (depending on the set timeframe) through an actions tracker. Where a risk is identified following the analysis of data, this will be added to the Safeguard Risk Register by the Legal & Inquest Manager within one week of the report being received by the Committee.

See also the Claims Management Policy (Ref. 1).

## Trust Risk Profile

Risks identified through from the incidents, complaints and claims reports will be combined via the Safeguard Risk Register which is the Trust’s risk profile. Where risks are identified from the analysis of incidents, complaints and claims data the report author will add these risks (with relevant controls, actions, deadlines) to the Safeguard Risk Register, within one week of the report being received by the relevant committee.

The Safeguard Risk Register will be reported on and shared in accordance with this strategy.

# Duties of Individuals

For the duties of committees regarding risk management, see Section 4.

## All Staff

All employees are required to comply with all relevant legislation and regulation, attend training where appropriate and maintain their own professional competencies, ensuring they are familiar with, and comply with, Trust policies, procedures and other documents.

All employees have a responsibility to ensure any risks that they identify are flagged to their line manager in the first instance. Staff should be aware of risk management procedures and be willing to report incidents and risk management issues.

## Board of Directors

The Board is responsible for ensuring that the Trust has effective systems for identifying and managing all risk; clinical, financial and organisational. Responsibility for monitoring the effectiveness of these systems is delegated to the Audit, Risk and Assurance Committee. The Executive Committee is delegated authority to oversee the management of the Risk Management system and together with the Board Committees provide assurance to inform the Audit, Risk and Assurance Committee that processes are being maintained and risks are managed.

The Board has established a risk management structure to help deliver its responsibility for implementing risk management systems within the Trust which is explained below. Trust Board will review the 15+ Risk Register and Board Assurance Framework twice a year. Only Trust Board may determine that a risk where the residual score is 15 or above following implementation of all mitigating actions and controls is ‘accepted’.

## Chief Executive

The Chief Executive has overall accountability to the Board for ensuring that an effective risk management system is in place within the Trust and for meeting all statutory requirements. The Chief Executive is responsible for implementation of risk management and is the Executive Lead on maintaining the Board Assurance Framework. The Chief Executive is the Accounting Officer.

## Executive Directors

Executive Directors are directly accountable to the Board for effective risk management within their areas of responsibility. They are required to ensure that risks are identified promptly and managed effectively in accordance with this Strategy and any associated documents, policies and procedures. Executive Directors are responsible for ensuring that Associate Medical Directors are aware of their responsibilities under this Strategy and for compliance.

## Associate Medical Directors

Associated Medical Directors are responsible for the management of both strategic and operational risk within their Divisions. This includes the implementation of risk management procedures and for escalating risks that cannot be managed at a local level. They are responsible for the Division and specific-area risk registers and accountable to the Executive Committee on risk management. They are responsible for:

* Promoting a risk management culture within the Trust by actively encouraging the identification of risks;
* Identifying a suitable local forum (usually monthly division meetings) for the discussion of risk management issues;
* Consideration and discussion of risk management issues at that forum;
* Development and implementation of work plans to ensure risks are identified and treated;
* Ensuring Division risk registers are maintained and reviewed at least four times a year to ensure timely and systematic risk management and communication of risk;
* Ensuring escalation of risks from divisions for inclusion in the 15+ Risk Register/attention of the Board.
* Confirming to the Executive Committee on an annual basis that risk is being managed effectively by completing the risk management check list. **Appendix D sets out the check list in respect of risk management for divisions / specific areas.**

## Divisional Directors

Divisional Directors are responsible for supporting the Associate Medical Directors in managing risk within their divisions/specific areas. They are responsible for:

* Ensuring that appropriate and effective risk management processes are in place within designated areas and scope of responsibility and that all staff are made aware of the risks within their work environment and of their personal responsibilities;
* Implementing and monitoring any identified risk management control measures within their designated area and scope of responsibility ensuring that they are appropriate and adequate;
* Ensuring that risks are captured onto division/specific-area risk registers; and
* Ensuring that a local group (usually the monthly division/specific-area meetings) review the Division/specific-area risk register at least four times a year.

## Director of Governance & Assurance

* The Director of Governance & Assurance is the author of the Risk Management Strategy and has responsibility for:
* Supporting the Chief Executive in developing and implementing integrated governance and risk management strategies.
* Supporting Executive Directors in maintaining an effective Board Assurance Framework;
* Implementation of the Risk Management Strategy
* Compiling a 15+ Risk Register in accordance with this strategy;

## Risk Governance Facilitator

The Risk and Governance Facilitator is responsible for:

* Supporting Divisions in compiling division risk registers;
* Providing support and training on the Safeguard Risk Register;
* Producing Divisional Risk Registers using data from the Safeguard system on a monthly basis to support the review of risk at Divisional Governance Meetings.
* Supporting the Director of Governance & Assurance with compiling a 15+ Risk Register; and
* Providing administrative support and training on the Safeguard Risk Register.
* Provide support to department in the monthly production of the template which enables them to produce and report on their area risk registers.

## Line Managers

All staff with managerial responsibility must understand and implement the Trust’s risk management strategy and underlying policies. They are responsible for the following:

* Ensuring they have adequate knowledge of relevant legislation, seeking advice from appropriate experts where necessary and ensuring that compliance with legislation is maintained.
* Ensuring that this strategy is implemented in their areas and that staff are made aware of their individual responsibilities.
* Ensuring that staff have access to the necessary information and training to enable them to work safely. These responsibilities extend to anyone affected by the Trust’s operations including bank and agency staff, contractors, members of the public and visitors.
* Ensuring appropriate resources are available and procedures are in place to implement this strategy.
* Promoting greater risk management and health and safety awareness amongst all staff.
* Ensuring that risks are identified, evaluated, recorded and reviewed.
* Ensuring that staff comply with relevant policies including health and safety, fire, occupational health, CoSHH, and first aid.

This list is not exhaustive.

# Education and Training Requirements

It is important that there is a mechanism to ensure relevant staff are educated and trained in respect of the requirements of any documents, policies and associated procedures that affect them in their work.

## Education and Training Plan

| **Education and training plan** | **Resources** | **Responsibility** | **Date / Frequency** |
| --- | --- | --- | --- |
| All staff receive training on completing risk assessments as part of the Health and Safety session at Corporate Induction. | Time, slides. | Occupational Health and Safety Team. | One off, on joining the Trust. |
| All Managers receive additional training in their responsibilities for managing their risks in the ‘Managers Responsibilities for H&S’ training. | Time, slides | Occupational Health and Safety Team. | Ad hoc |
| Risk awareness training for Board members and senior managers. See Section 8.2. | Time, slides | Director of Governance & Assurance | One off, on joining the Trust. |
| One-off training on the Safeguard Risk Register. Only staff approved by an Associate Medical Director, Divisional Director or an executive director can attend. | Time, slides. | Legal Services Team | One off. At least six sessions will be made available per year. |

## Risk Awareness Training for Board Members and Senior Managers

### Content

A one-off training session for Board Members and senior managers covering the principles of, and the Trust’s approach to, risk management. As a minimum the session will cover:

* Principles of risk management;
* Board Assurance Framework;
* Risk assessment;
* Risk Registers.

### Who is Covered?

All Board Members (executive and non-executive directors), together with Associate Medical Directors and Divisional Directors, must attend risk awareness training for senior managers.

Senior staff who have attended the Safeguard Risk Register training (which covers the minimum content listed at 9.2.1) will be exempt from attending risk awareness training for senior managers.

# Monitoring Compliance and Effectiveness of Implementation

The arrangements for monitoring compliance are outlined in the table below: -

| **Measurable strategy objectives** | **Monitoring / audit method** | **Monitoring responsibility** (individual / group / committee) | **Frequency of Monitoring** | **Reporting arrangements** (Committee / groups the monitoring results are presented to) | **What action will be taken if gaps are identified?** |
| --- | --- | --- | --- | --- | --- |
| Adequacy of Terms of Reference of Committees with overarching responsibility for risk (Executive & Audit Risk and Assurance Committees) | Review of terms of reference – consideration by respective committees | Trust Board | At least once per year | Trust Board | ToR will be amended by the Director of Governance & Assurance. |
| Compliance with Terms of Reference of Committees with overarching responsibility for risk | Review of compliance – report to Committee  Reporting arrangements through the Committees to the Board | Director of Governance & Assurance | At least once per year | Trust Board | ToR will be amended by the Director of Governance & Assurance. |
| Development and maintenance of a Board Assurance Framework | Audit conducted by Trust internal auditors | Director of Governance & Assurance | Yearly | Audit, Risk and Assurance Committee | Director of Governance & Assurance will be responsible for ensuring actions from the audit report are completed and providing assurance to ARAC. |
| 15+ Risk Register review and scrutiny | Scrutinised and challenged at committee | Executive Committee  Audit, Risk and Assurance Committee | Monthly  At least 3 times a year | Trust Board | The Director of Governance & Assurance will be responsible for acting on recommendations and reporting back to the auditors. |
| Duties of key individuals | Risks are identified, recorded on the division risk registers, action plans in place and registers reviewed | Executive Committee | At least once per year | Audit, Risk and Assurance Committee | Actions minuted, followed-up at future Executive Committee meetings. |
| Division risk registers review and scrutiny | Scrutinised and challenged by meetings / Committee | Division meetings  Executive Committee | Monthly  At least once per year | Executive Committee | Actions minuted, followed-up at future Executive Committee meetings. |
| 95% compliance with risk management training for Board Members and senior managers. | Training records  Training material  Attendance sheet | Director of Governance & Assurance | Ad hoc. Following group training session or following commencement of employment. | Audit, Risk and Assurance Committee | Slides and signature sheet sent out for completion. Followed up with line manager if non-compliance. |

# Review Date and Arrangements

This Strategy will be reviewed once every three years, or sooner if procedural, legislative or best practice changes occur.

# Appendix A – Equality Impact Assessment

**Equality Impact Assessment**

**Our Vision**

Great Western Hospitals NHS Foundation Trust wants its services and opportunities to be as accessible as possible, to as many people as possible, at the first attempt.

**Are we Treating Everyone Equally?**

Define the document. What is the document about? What outcomes are expected?

Consider if your document/proposal affects any persons (Patients, Employees, Carers, Visitors, Volunteers and Members) with protected characteristics? Back up your considerations by local or national data, service information, audits, complaints and compliments, Friends & Family Test results, Staff Survey, etc.

If an adverse impact is identified what can be done to change this? Are there any barriers? Focus on outcomes and improvements. Plan and create actions that will mitigate against any identified inequalities.

If the document upon assessment is identified as having a positive impact, how can this be shared to maximise the benefits universally?

# Appendix B – Quality Impact Assessment Tool

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Purpose** To assess the impact of individual policies and procedural documents on the quality of care provided to patients by the Trust both in acute settings and in the community. | | | | | | | |
| **Process** The impact assessment is to be completed by the document author. In the case of clinical policies and documents, this should be in consultation with Clinical Leads and other relevant clinician representatives.  Risks identified from the quality impact assessment must be specified on this form and the reasons for acceptance of those risks or mitigation measures explained. | | | | | | | |
| **Monitoring the Level of Risk**  The mitigating actions and level of risk should be monitored by the author of the strategy or procedural document or such other specified person.  High Risks must be reported to the relevant Executive Lead. | | | | | | | |
| **Impact Assessment** Please explain or describe as applicable. | | | | | | | |
| 1. | Consider the impact that your strategy or procedural document will have on our ability to deliver high quality care. | The aim of the Risk Management Strategy is to have a positive impact on our ability to deliver high quality care by providing a framework for identify and managing risks before they materialise. | | | | | |
| 2. | The impact might be positive (an improvement) or negative (a risk to our ability to deliver high quality care). | | | | | | As above. |
| 3. | Consider the overall service - for example: compromise in one area may be mitigated by higher standard of care overall. | | | | The Risk Management Strategy applies trust-wide. | | |
| 4. | Where you identify a risk, include in the Risk Register section and identify the mitigating actions you will put in place. Specify who the lead for this risk is. | | | No specific risks associated with implementing this strategy have been identified. | | | |
| **Impact on Clinical Effectiveness & Patient Safety** | | | | | | | |
| 5. | Describe the impact of the strategy or procedure on clinical effectiveness. Consider issues such as our ability to deliver safe care; our ability to deliver effective care; and our ability to prevent avoidable harm. | | The implementation of the Risk Management Strategy will improve the Trust’s resilience and ability to proactively identify and manage risk before harm is caused. | | | | |
| **Impact on Patient & Carer Experience** | | | | | | | |
| 6. | Describe the impact of the strategy on patient / carer experience. Consider issues such as our ability to treat patients with dignity and respect; our ability to deliver an efficient service; our ability to deliver personalised care; and our ability to care for patients in an appropriate physical environment. | | | | | Implementation of the Risk Management Strategy will help us manage risks involving patients and carers. | |
| **Impact on Inequalities** | | | | | | | |
| 7. | Describe the impact of the document on inequalities in our community. Consider whether the document will have a differential impact on certain groups of patients (such as those with a hearing impairment or those where English is not their first language). | | | | | The Risk Management Strategy does not discriminate against any section of the community*.* | |

# Appendix C – Risk Assessment Matrix

See also the separate How to Assess Risk Procedural Document (Ref. 8)

The overall risk rating reflects both the likelihood that harm or loss will occur and the severity of its outcome: **(i.e. risk = likelihood x consequence).**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | | (1) | (2) | (3) | | (4) | (5) |  |
| Consequence | Catastrophic (5) | | 5 | 10 | 15 | | 20 | 25 | (5) |
| Major (4) | | 4 | 8 | 12 | | 16 | 20 | (4) |
| Moderate (3) | | 3 | 6 | 9 | | 12 | 15 | (3) |
| Minor (2) | | 2 | 4 | 6 | | 8 | 10 | (2) |
| Negligible (1) | | 1 | 2 | 3 | | 4 | 5 | (1) |
|  | | Rare  (1) | Unlikely (2) | Possible (3) | | Likely  (4) | Almost certain (5) |  |
|  |  | | Likelihood | | | | | |  |
|  | \*based on an NPSA template | | | |  | |  |  |  |
| **THE OVERALL RESIDUAL RISK RATING** | | | | | | | | | | | | |
| **Low Risk (1-3)**  Quick easy measures implemented immediately and further action planned for when resources permit | | | **Moderate Risk (4-6)**  Actions implemented as soon as possible, but not later than a year | | | | **High Risk (8-12)**  Actions implemented as soon as possible and no later than six months | | | | | **Extreme Risk (15+)**  Requires urgent action. Trust Board is made aware and implements corrective action |

# Appendix D – Division or Specific-Area Risk Management Checklist

The Trust’s Risk Management Strategy requires that each division or specific area risk register is reviewed by the Executive Committee at least once per year in order to provide assurance that risks are identified and managed in accordance with the Strategy.

In order to facilitate that review process, the Associate Medical Director or the executive director for the area are kindly asked to complete the following questionnaire (which is designed to be completed electronically) for monitoring purposes.

1. What active steps do you take to promote a risk management culture?

Click here to enter text.

1. Are you satisfied that risks are being identified in your division/specific area?

Choose an item.

If ‘other’, please explain: Click here to enter text.

1. From which of the following sources of information have you identified risks?
   1. Incident reports Choose an item.
   2. Risk assessments Choose an item.
   3. Complaints Choose an item.
   4. External assessments Choose an item.

*N.B. It is a mandatory requirement of the NHSLA Standards for Acute Trusts that risks are identified from* ***all*** *of these sources.*

1. Have all risks been assessed and scored in accordance with the Trust’s How to Assess Risk Procedural Document (available on the intranet)?

Choose an item.

If ’other’, please explain: Click here to enter text.

1. Have all risks been added to Safeguard Risk Register?

Choose an item.

If ’other’, please explain: Click here to enter text.

1. Are you satisfied that your risk register accurately reflects the risk profile of your division/specific area?

Choose an item.

If ’other’, please explain: Click here to enter text.

1. Are risks appropriately described, i.e. do they describe the consequence of the risk rather than the source?

Choose an item.

If ’other’, please explain: Click here to enter text.

1. Has the risk register been reviewed on a monthly basis at a division/specific area meeting?

Choose an item.

If ’other’, please explain: Click here to enter text.

1. At those meetings is there a full discussion of risk and its management?

Choose an item.

If ’other’, please explain: Click here to enter text.

1. Are action plans to mitigate risk being implemented?

Choose an item.

If ’other’, please explain: Click here to enter text.

1. Is implementation of action plans to mitigate risk being monitored at the division/specific area meetings?

Choose an item.

If ’other’, please explain: Click here to enter text.

1. Has the division/specific-area risk register been updated each month?

Choose an item.

If ‘no’, explain why and what measures will be put in place to ensure monthly update. Click here to enter text.

1. How have you communicated risk within your division / specific area?

Click here to enter text.

1. Have you made staff in the division/specific area aware of their responsibilities in respect of risk management, namely that all staff are required to comply with all relevant legislation and regulation, attend training where appropriate and maintain their own professional competencies, ensure they are familiar with, and comply with, Trust policies, procedures and other documents.?

Choose an item.

If ’other’, please explain: Click here to enter text.

1. Have you undertaken an annual over view of the division/specific risk register to remove old risks?

Choose an item.

If ’other’, please explain: Click here to enter text.

Please return the questionnaire to the Risk & Governance Facilitator, seven working days before the next Executive Committee.

# Appendix E – Incident, Complaints and Claims Report Templates

**Health and Safety report template**

Incident data is reported to the H&S Committee on a monthly basis in the form of Excel graphs and data. That data will include:

* **Manual handling incidents grouped by month;**
* **Sharps incidents grouped by month;**
* **Slips, trips and falls data, grouped by month;**
* **RIDDORs, number and description;**
* **Fire incidents by month and nature.**

**The H&S Committee will review the data and provide a qualitative analysis that will be documented in the minutes.**

**Patient experience report template**

* **Introduction**
* **Complaint handling performance**
* **Overview (graphical representation and qualitative analysis)**
* **Action being taken**
* **Complaint themes**

The summary of the themes of complaints, split by acute, community and community maternity can be found in an appendix to this report. This information is available broken down to division level identifying wards and departments and is available so that divisions are better able to focus their attention on the areas of main concern.

* **Action taken as a result of patient feedback;**
* **Parliamentary and Health Service Ombudsman (PHSO)**
* **Compliments**
* **Graphical representation**
* **Surveys**
* **Actions taken**

**Clinical Risk report template**

* **Serious Incidents (SIs)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| IR1 | STEIS | Incident Grade | Incident | Ward/ Department |
|  |  |  |  |  |

Relevant immediate actions have been taken where appropriate. Investigation leads have been identified. Root cause analysis and serious investigation reports are being completed for the above stated incidents. The progress against investigations will be monitored by PQC.

* **Key learning and improvements from serious incident investigation presented this month**

|  |  |
| --- | --- |
| Incident | Actions taken |
|  |  |

* **Never events**
* **Thematic Analysis of incident trends**

**Legal SERVICES Template REPORT**

* **Introduction**
* **Summary of activity**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Activity Totals | Q(-3) | Q(-2) | Q(-1) | Quarter (Q) | Rolling Year  Total |
| Legal disclosures |  |  |  |  |  |
| New legal claims |  |  |  |  |  |
| Inquests |  |  |  |  |  |
| All legal matters (inquests, disclosures, new and ongoing claims) handled by the team by quarter. |  |  |  |  |  |
| Legal costs |  |  |  |  |  |

* **Legal disclosures**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Q(-3) | Q(-2) | Q(-1) | Quarter | Rolling Year Total |
| Number of disclosure requests received |  |  |  |  |  |
| Within 21 days (best practice) |  |  |  |  |  |
| More than 21 days |  |  |  |  |  |
| Compliance with statutory requirement - within 40 days |  |  |  |  |  |

* **GRAPH – Number of legal disclosures in 20xx/xx compared to previous years**
* **Legal claims**
* **New Claim****s**
* **GRAPH – Number of legal claims in 20xx/xx compared to previous years**
* **GRAPH – Total number of new legal claims referred to the NHSLA by organisation** **20xx/xx**
* **TABLE - Summary of the new claims against the Trust in Q1 20xx/xx**
* **Learning, themes and trends**
* **CHART – Trust Open Claims by issue**
* **Trust Open Claims**
  + GRAPH –Open Claims by Division

|  |  |  |
| --- | --- | --- |
| Estimated Damages | Clinical Negligence Scheme for Trusts  (CNST) | Liabilities to Third Parties Scheme (LTPS) |
| > £1 Million |  |  |
| £50,000 - £1 Million |  |  |
| < £50,000 |  |  |

* **TABLE - Claims by value**

|  |  |  |  |
| --- | --- | --- | --- |
| Ref | Case Précis | Damages (£) | Speciality |
|  |  |  |  |

**Inquests**

* **GRAPH – Number of inquests in 20xx/xx (year to date) compared to previous years**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Inquest date | Circumstances | Date of death | Verdict | Ruling? |
|  |  |  |  |  |

* **TABLE – Circumstances relating to inquests in Q1**
* **Expenditure**

# Appendix F – Care Quality Commission Quality Domains

|  |  |  |  |
| --- | --- | --- | --- |
| **1 SAFE** •Admission/transfer/discharge •Delayed diagnosis •Environment •Equipment •Falls •Fire  •General incidents •Incident awareness training •Infection control •Mandatory training •Medicine management •Never events •Pressure ulcers •Handovers •Records/information management  •Patient risk •Processes •Safeguarding •Safety thermometer •Security •Serious incidents  •Staff capacity •Staff safety •Staff survey •5 Steps to safer surgery  •Waste Management | **2 EFFECTIVE** •Access to information •Care Bundles Competent staff •Consent, Mental Capacity Act 2005 and DoLS •Evidence-based care and treatment •External Reviews •HSMR •ICNARC •KPI •Management of the deteriorating patient •Mortality alerts •Mortality outliers •Multi-disciplinary working •National clinical audits •National surveys •NCEPOD •NICE •Nutrition and hydration •Pain relief •Pathways of care •Patient outcomes •Seven-day working •SHMI •Staff training •WHO safer surgical checklist | **3 CARING** •Cancer patient survey •Comfort rounds •Compassionate care •Complaints •Friends and family test •Inpatient survey •National bereavement survey •NCDAH •Outpatient survey •Patient experience •Patient needs •Patient stories •Patient understanding and involvement •Response to buzzers/call bells •Staff/patient interaction •Trust values | |
| **4 RESPONSIVE** •Access and flow •Ambulance stays •Analysis of complaints •Bookings •Cancelled operations •Car park •Claims •Comfort factors (TV, seats, parent rooms) •Discharge planning •Educational services •Incidents •Individual needs •Internal audits •Length of stay •Local people’s needs •Patient report •Referral to treatment (RTT) •Transfers •Translation facilities •Violence and aggression •Waiting time standards | **5 WELL-LED** •Agency staff •Board/ward interaction •Business continuity •Contractual arrangements •External reviews •Focus groups •Flu vaccination rates •Governance, risk management and quality measurement •Handling/learning from complaints •Information technology •Innovation, improvement and sustainability •Interview (CEO, MD, DON) •Leadership •Major incident •Mortality reviews •Negative publicity •Performance targets •Public and staff engagement •Reputation •Risk register •Sickness rates •Staff morale •Staff reports •Staff survey •Staffing levels •Stake holders •Trust vision | | **6 FINANCE** •Budget •Capital •CIPS •Expenditure •Financial penalty •Income |