Agenda item: 21
Enclosure no: TB2018/108

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

BOARD MEETING IN PUBLIC
26 September 2018

Details of the Paper

Title	Organisational Risk Profile
Responsible Director	Director for Governance
Purpose of the paper	To inform the Board of the organisation's top risks and how they are being managed.
Action / decision required	Confirm top risks.

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)

Patient Quality	***Financial Performance***	***Operational Performance***	***Strategy***	***Workforce performance***	*New or elevated risk*
Legal	***Regulatory/ Compliance***	***Public Engagement /Reputation***	*Equality & Diversity*	***Partnership Working***	***Information Technology / Property Services***

ANNUAL OBJECTIVE

Which Strategic Objective/s does this paper link to?
This links to all the strategic objectives.

Please summarise the potential benefit or value arising from this paper:
A sound knowledge of strategic risk enables the Board to make informed decisions.

RISK

Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*: All risks on Board Assurance Framework *Financial Risk*: All risks on Board Assurance Framework

LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY

Which CQC standard/s does this paper relate to?	Well Led Domain; Outcome 17 Good Governance

Author of paper: Liz Hollman

Presenter of Paper: Liz Hollman

Other committees / groups where this paper / item has been considered:
Executive Management Committee; Audit Committee

Date of Paper: 18 September 2018

RISK PROFILE

1. PURPOSE

The purpose of this paper is to inform the Board of the top organisational risks and how they are being managed.

2. BACKGROUND

The Board Assurance Framework is the key document detailing the strategic risk and how it is managed and this is reviewed four times a year.

The Corporate Risk Register shows risks emerging from clinical divisions and corporate services.

These risks are reviewed throughout the organisation from Service Delivery Unit through to Board Committees and the risk level, controls and actions are reviewed.

3. BOARD ASSURANCE FRAMEWORK

The Board Assurance Framework sets out the risk and assurance against delivery of the corporate objectives agreed for 2018/19.

Each Executive Director has reviewed the risks against the delivery of the corporate objectives for which they are the lead and these risks are set out in the BAF appended to this paper.

4. TOP RISKS

The top strategic and operational risks are linked and are as follows:

- Risk around the delivery of the financial plan.

  Key actions are in place to promote efficiency and effectiveness; to closely monitor financial delivery at all levels of the organisation; and a framework of controls is in place. The identification of transformation (cost improvement) programmes and the delivery of these schemes is a risk for 18/19.

  The limited availability of capital resource is creating risk around medical equipment replacement, maintenance of the environment, and ability to move forward with improvements in information technology.

  The Finance and Business Performance Committee monitors the assurance relating to this risk.

- Risk to delivery of organisational objectives if we do not have the right number of staff with the right skills and talent.

  To address this risk there is a comprehensive recruitment and retention plan in place to attract new staff and keep existing staff.

  Safe staffing is managed on a day to day basis and it is necessary to use temporary staff from bank and agency. Over-reliance on temporary staff has a quality and cost implication for the Trust.

  The Strategic Workforce Committee and the Quality and Clinical Governance Committee monitor the assurance relating to this risk.

- Risk to patient experience due to pressures on the urgent care pathway.

  The mitigations to this risk and other risks around delivery of NHS Constitution standard are set out in the exception reports for the Integrated Performance Report.

  The Quality and Clinical Governance Committee monitors the assurance relating to this risk.

5. RECOMMENDATION

The risks are recommended to the Board for discussion and action as necessary.

Liz Hollman
Director for Governance
18 September 2018

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
Includes Reference to Corporate Risk Register where relevant	*Focused on strategic risk.*	*The score if there were no controls in place*	*IC = internal control* *EC = external control* *Controls recorded on separate lines*	*IA = internal assurance* *EA = external assurance* *Assurances map to individual controls.*	*No assurance = red* *No external assurance = amber* *Internal and external and timely assurance = Green*	*Areas which will require action if risk score or assurance RAG are to improve.*	*This indicates the level of concern i.e. are the assurances giving us negative or positive indications.*	*This will include timescales for tracking and show where timescales have not been met.*	*Executive director lead*
1. Quality (Medical Director and Chief Nurse) **We will offer high quality, safe and compassionate care in patients' homes, the community or one of our hospitals**									
1.1 Enhance our culture of safety **Key Focus:** **Implement a clinical accreditation scheme to improve quality of care, reduce variation and share best practice** **Quality peer review established in each ward and community area June 2018** **Launch Clinical Accreditation Programme September 2018** **75% of areas will be independently assessed by December 2018** **Minimum 3 areas will be accredited excellence in all categories March 2019**									
BAF 1.1a	There is a risk that the Quality Peer Review process established in June 2018 do not reduce variation in quality. *Board Committee with oversight: Quality and Clinical Governance*	16	Systematic self-review programme co-ordinated by the Associate Chief Nurse – patient experience and professional standards, led and driven by senior nurses, matrons and ward managers. 5 domains are completed each month linked to Care Quality Commission Key Lines of Enquiry. Perfect Ward App scores the reviews and provides immediate feedback to nursing staff in hospital and community locations. (IC)	Outputs from the Perfect Ward App (IA) Monthly reports to the Quality and Patient Safety Group and minutes from that meeting. (IA) Quarterly reports to the Quality and Clinical Governance Committee and minutes from that meeting. (IA)	Amber	There is an assurance gap in that we are not yet confident that all the self reviews are done in a consistent way.	**8 (4x2)**	Established baseline from the monthly reviews by September 2018 and then commence a process of clinical accreditation.	Chief Nurse
			Escalation process where trends are reported to Divisional Quality Boards for action. (IC)	Trend reports for Divisional Boards. (IA) Minutes from Divisional Board meetings where this has been discussed. (IA)					
			Programme of peer review within the organisation using an independent peer review team including external reviewers. (IC)	Peer review reports. (IA)					
			Learning and real time feedback on excellence and areas for improvement. (IC)	Outputs from the Perfect Ward App (IA) Monthly reports to the Quality and Patient Safety Group and minutes from that meeting. (IA) Quarterly reports to the Quality and Clinical Governance Committee and minutes from that meeting. (IA)					

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1.2 Listen to our Patient Voice **Key Focus:** **Work in partnership with patients to improve their experience of discharge from our care, outpatients and A&E** **Reduce number of patients waiting longer than 4 hours in A&E – monthly review** **10% reduction in outpatients cancellations (11,651 appointments) by March 2019** **95% of patients will have their discharge medication provided within our standard by March 2019** **A&E Friends and Family response rate improved by 75% and 'would recommend' rates exceed 95% by March 2019**									
BAF 1.2a	There is a risk that if we do not listen to our patients and take appropriate action that this will negatively impact on patient experience and care outcome. Board Committee with oversight: Quality and Clinical Governance	16	Systematic collection of Friends and Family Test information. All our services within a hospital setting are asked to provide this feedback. Systematic Quality Rounds on a monthly basis in all clinical areas and in the community. There is real time patient feedback through this mechanism. 'You said, we did' boards in hospital wards and clinical departments. Non-Executive director review of a sample of complaints each month. Chief Executive Officer and Chief Nurse see every complaint that comes to the organisation. Themes from FFT and accolades fed back at local level. Patient story at each public board meeting. Patient representative on the Quality and Clinical Governance Committee. Patient Experience Strategy and Implementation Plan.	FFT data is reported in the Integrated Performance Report to the Board. Information including the narrative is sent to wards on a monthly basis. Patient Safety and Quality Group receives progress reports on a bi-monthly basis on the implementation plan. Summary report from Quality Rounds reported to Patient Safety and Quality Group, Executive Management Committee and Quality and Clinical Governance Committee. Healthwatch oversight of quality.	**Green**	There is no national tool for FFT for care within patients' own home.	**8 (4x2)**	Link with the work on being a 'learning organisation' to facilitate our learning from patient feedback and find a mechanism to report the assurance from this learning and action. December 2018. Commence Clinical Accreditation programme by March 2019 based on the outputs from Quality rounds. Work to improve mechanisms for capturing the feedback from patients cared for in their own homes. December 2018.	Chief Nurse
1.3 Develop as a learning organisation **Key Focus:** **Learn and share best practice to improve safety of medications and recognition of sepsis and clinical deterioration** **Implement Go Engage initiative to improve staff engagement. September 2018** **Approve a Trust –wide learning organisation framework. December 2018** **Review and revitalise the processes for learning from good practice through BHT Way. December 2018** **Implement an quality improvement skills programme for all staff March 2019**									
BAF 1.3a	There is risk that without a framework in place setting out how we will develop as a learning organisation that the quality of care and staff engagement will be impacted negatively. *Board Committee with oversight: Strategic Workforce Committee*	16	Overarching framework in place setting out a systematic set of interventions (IC) Go Engage programme introduced across the Trust (IC) Quality improvement training rolled out across the Trust (IC) BHT way programme in place for the year (IC)	Minutes from Executive Management Committee. (IA) Reporting of results to EMC and Strategic Workforce Committee. (IA) No. of staff enrolled in Quality Improvement training, internal and external (IA) Records of content and numbers of staff attending BHT Way (IA)	**Amber**	None currently	**9 (3x3)**	No gaps to address.	Director of Workforce and Organisational Development

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2. People (Director of Organisational Development and Workforce Transformation) **We will be a great place to work where our people have the right skills and values to deliver excellence in care:**									
2.1 Inspirational leaders developing strong teams **Key Focus:** **Our leaders and teams are enabled to innovate and develop their services** **Each leader has a transformation project as part of their annual objective June 2018** **15 teams enrolled in Go Engage June 2018,** **15 further teams enrolled December 2018** **50 leaders complete Trust Development Programme March 2019**									
BAF 2.1a	There is a risk that if our leaders do not have the right skills to develop strong teams that teams will not innovate and develop their services, thus negatively impacting on patient care and staff engagement *Board Committee with oversight: Strategic Workforce Committee*	9	15 teams engaged in the Go Engage programme in both June and December (IC) Survey results as part of Go Engage programme (IC)	Outputs from Go Engage programme reported to Strategic Workforce Committee on a quarterly basis	Green	None currently	**6 (2x3)**	No gaps to address	Director of workforce & OD
			50 Leaders (in 3 cohorts) enrolled in Trust leadership programme during the year	Cohort numbers reported to SWC Feedback from cohorts reported to SWC					

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2.2 Attracting and retaining high calibre and engaged people **Key Focus:** **Transform our nursing workforce for the future** **Recruitment of 70% of University of Bedfordshire students in September 2018** **Recruit 25 individuals from Portugal by March 2019** **Increase internal appointments from 179 to 230 by March 2019**									
BAF 2.2a	There is a risk to us delivering all corporate objectives if we don't attract and retain high calibre and engaged people *Board Committee with oversight: Strategic Workforce Committee*	20	Trust-wide programme to transform the clinical workforce, comprising 6 elements Transform our nursing workforce for the future (IC) - Recruitment including career pathways (IC) - Education and training (IC) - Promoting excellence (including health & wellbeing) (IC) - Smart working (IC) - Temporary staffing (IC)	Outcomes of actions from the programme, reported to Executive Management Committee and Strategic Workforce Committee (IA) Nurse turnover rate (IA) Nurse vacancy rate (IA) Sickness absence rate (IA)	Green	Individuals may choose to apply to other employers	16 (4x4)	Separate recruitment plan in place. Actions include: Students final placements to areas that they have expressed an interest in working in Offer letters sent in year 2 Close support for students and line managers by recruitment and education teams	Director of workforce & OD
			Recruitment of 70% of the cohorts graduating from the University of Bedfordshire - fast track recruitment process in place (IC)	Numbers of individuals recruited (IA)					
			Recruit 25 individuals direct from Portugal Erasmus programme in place (EC)	Numbers of individuals recruited (IA) Numbers of individuals on Erasmus programme (EA)					
			Increase internal appointments to 230 during f/y 18-19 (IC)	Numbers of individuals appointed (IA)					
2.3 Pioneering new ways of working across sites, services and organisations **Key Focus:** **Use apprentices to provide skilled workers for the future** **60 Level 3 by March 2019** **60 Level 5 by March 2019** **20 Level 6 by March 2019**									
BAF 2.3a	There is a risk that without us pioneering new ways of working, the numbers and calibre of staff would be impacted and therefore the quality of patient care would be impacted. *Board Committee with oversight: Strategic Workforce Committee*	12	Recruiting to >100 apprenticeship posts during 2018-19 (IC) 70 Level 3 HCA apprentices - 3 x cohorts of 23 by July, November 2018, March 2019 15 nurse degree apprentices – February 19 10 young nurse degree apprentices – March 19 Nurse associate trainees – 10 recruited by August 18	Numbers of individuals recruited onto each course reported on a quarterly basis to SWC (IA)	Amber	Until apprenticeships are registered there is a risk to achieving these numbers Until new posts are budgeted for and recruited to there is a risk to achieving these numbers	9 (3x3)	Pro-active recruitment to these pathways Education team supporting senior managers	Director of workforce and OD
			Creating new roles (IC) By the end of 2018-19 20 doctors' assistants in post by the end of 2018-19 5 physicians associates in post by the end of 2018-19	Numbers of individuals recruited into each of these roles reported on a quarterly basis to SWC (IA)					

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3. Money (Director of Finance) **We will be financially sustainable, will make the best use of our buildings and be at the forefront of innovation and technology:**									
3.1 Deliver our system control total **Key Focus:** **Manage within agreed budget and agency cap** **Improvement on prior year underlying position and meeting control surplus of £9.9m including STF.** **Staff costs not exceeding 2018/19 budget of £250m** **Meet our total agency spend annual cap of £10.5m**									
BAF 3.1a (link to CRR 32)	The failure to deliver the annual financial plan has the potential to jeopardise the future of the organisation. It is also a breach of the statutory duty to break even. Receipt of the Provider Sustainability Funding is dependent on achieving the financial plan trajectory on a quarterly basis. (Monitored through Finance and Business Performance Committee, F&BP)	20	Compliance with Standing Orders and Standing Financial Instructions. (IC)	Financial report to Board. (IA) Monthly FIMS forms for NHSI. (EA) External audit programme. (EA) Internal audit programme (EA) Minutes of NHS I Integrated Delivery Meeting. (EA) Audit Committee review of compliance with Standing Financial Instructions (waivers, losses etc.)	Green	Cost improvement programme not yet delivering to target. (C) Nursing and medical agency staffing still running above internal targets. (C) Delivery against Accident and Emergency trajectory. Bank and agency run rate exceeding cap	**20** **(5x4)**	Continued focus on financial control and accountability at all levels of the organisation. Accident and Emergency delivery plan. Cost Improvement Programme Oversight groups established and CEO FRP group (August 2018).	Director of Finance
			Signed Service Level Agreements (EC)	Performance management process against service / contractual specifications both internal and external with Buckinghamshire Clinical Commissioning Group. (IA & EA)					
			Divisional Performance Management process including monitoring, review and actions to address variances on Key Performance Indicators. (IC)	Deep Dive process each month for Divisions. (IA) Internal Audit of Divisional performance in 17/18 EIA) Income deep dive. (IA) Workforce deep dive. (IA) Run rate analysis and actions.					
			Delivery of action plan for Bank and Agency reduction.	Performance against NHS Improvement cap reviewed monthly (IA)					

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
BAF 3.1b (Links to CRR 38)	There is a risk that if we do not deliver the financial plan we will not have sufficient cash to make repayments to facilities and loans and fund capital requirements. (Monitored through Finance and Business Performance Committee, F&BP)	20	Compliance with Standing Orders and Standing Financial Instructions. (IC)	Financial report to Board. (IA) Monthly FIMS forms for NHSI. (EA) External audit programme. (EA) Internal audit programme (EA) Minutes of NHSI Integrated Delivery Meeting. (EA)	Green	Cost improvement programme not delivering to target. (C) Nursing and medical agency staffing still running above internal targets. (C)	**20** **(5x4)**	Debtor review and focus on collection. Cash forecast and ongoing discussions with NHSI Capital and Cash re loan drawdown. FRP to improve financial position and reduce cash requirements	Director of Finance
			Signed Service Level Agreements (EC)	Performance management versus contractual specification. (IA)					
			Divisional Performance Management process (IC)	Deep Dive process each month for Divisions. (IA) Internal Audit of Divisional performance in 17/18 (IA) Divisional performance monthly reviews by exception and quarterly reviews. (IA)					
			Prioritisation of cash payments and cash forecast. (IC)	Finance report which includes a section on cash forecast, debt and liquidity to Finance and Business Performance Committee and Board. (IA)					
BAF 3.1c	There is a risk that if we spend more than £10.5m on agency costs that this will impact on financial targets and could impact on NHSI segmentation *Board Committee with oversight: Finance and Business Performance Committee*	20	Escalated sign off by Senior Managers for all agency spend. (IC) Week-end agency signed off by Gold command. (IC) Monthly meetings reviewing agency usage for specific staff groups against agreed targets for the year. Remedial action taken as necessary. (IC)	Weekly reported nurse / doctor agency spend. (IA) Divisional targets monitored through deep dives. (IA) Performance trajectory and monthly targets in place for specific staff groups. (IA) Exception report on agency spend to Improving Performance Group monthly (IA)	Green	No interface between rostering systems and temporary staffing systems, which would allow triangulation of demand	**16** **(4x4)**	Allocate system includes interface	Director of Workforce and Organisational Development
			All requests for admin/ clerical agency is signed off by the Director of Finance or the Director of Human Resources as part of the vacancy control panel (IC)	Reconciliation of agency ledger to request process confirmed monthly. (IA) Weekly review by vacancy panel. (IA)					
			Process for booking and managing locum doctors is in-house, with senior sign off. (IC)	Monthly reporting of agency spend provides an indication of how effective this change has been. (IA) Medical agency spend reviewed by Medical Director and Director of workforce & OD on a weekly basis. (IA)					
			National Guidelines on bank and agency usage (EC)	Weekly report on non-compliance to NHS Improvement. (EA)					
			Clear process for booking agency and agency usage policy. (IC)	Weekly reporting internally and to NHS Improvement. (IA)					
			Roll-out of Allocate rostering system (led by Chief Nurse)	Monthly reporting of allocate project to EMC (IA)					

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3.2 Improve our operational productivity Key Focus: Use model hospital data to highlight areas for improvement and take actions Reduction in cost per Weighted Unit of Activity ("WAU") across all specialties. Deliver £20m transformational programme									
BAF 3.2a	There is a risk to delivery of the financial plan if the Cost Improvement Plan is not achieved. This could affect future sustainability of the organisation. (Monitored through Finance and Business Performance Committee, F&BP)	**20**	Programme Management Office (PMO) Lead and PMO function in place (IC).	Monthly financial reporting to Board, divisions, EMC, corporate services and NHSI (IA). Transformation Board minutes. (IA) Project Initiation Documents (IA) Quality Impact Assessment process (IA) Planning and documentary evidence of CIPS. (IA) Monitoring of delivery. (IA)	**Green**	Further schemes required. All schemes not rated Green or Amber.	**16** **(4x4)**	Continued focus on financial control and accountability at all levels of the organisation. Specific actions to manage risks and deliver mitigating actions.	Director of Finance
			Full governance methodology and process in place for cost improvement plans (IC).	Reports of internal and external audit (EA).					
			Performance management framework for divisions and corporate services (IC).	Financial control totals agreed for divisions and corporate services. Monthly performance meetings by exception and quarterly monitoring review process and action plans.					

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
3.3 Deliver our capital plan Key Focus: Manage and mitigate risks in capital backlog Keep within the Trust's Capital Resource Limit Phased disposal plan June 2018 STP Estates bid submission June 2018 Monthly capital risk assessment and escalation Maximise opportunities for external funding and replacement of medical equipment									
BAF 3.3a (Link to CRR 27, CRR 60, 73 and 79)	There is a risk that we will not deliver the capital programme in the most effective way, or deliver the Capital Resource Limit if the programme is not managed effectively. (Monitored through Finance and Business Performance Committee, F&BP)	20	Governance structures: Estates CMG; IT CMG; Medical Equipment CMG; CMG. (IC) Risk assessed prioritisation of schemes. (IC) Prioritised IT and medical equipment replacement strategy developed to inform 5 year capital plan. (IC)	Meeting minutes for CMG (IA) Monthly monitoring of capital programme through Capital Management Group and F&BP (IA) Deferral risk assessment and reported to Capital Management Group, Executive Management Committee and Finance and Business Performance Committee. (IA)	Amber	The monitoring of tendering, procurement and contracts needs to be strengthened to provide greater assurance. Assurance around post project reviews to be developed. Finalisation of Estates Strategy and management of implementation.	20 (5x4)	5 year Estates Strategy in development. Draft to be reviewed by Trust Board in March 2018. Prioritised IT and medical equipment replacement strategy in development to inform 5 year capital plan. Potential risk of breaching Capital Resource Limit is still being worked on. Steering group set up with Non-Executive Director involvement to manage process prior to Board approval. Review process, training, support from interim Transformation Director.	Director of Finance
			Business cases and tendering and procurement process. (IC)	Business cases (IA) Cycle of internal audit of procurement (EA)					
			Project management of implementation using Prince 2 type methodology. (IC)	Property Services PMO . (IA) Resourcing plan for implementation. (IA)					
BAF 3.3b	There is a risk that the available capital budget that we will not achieve all the high priority requirements relating to the estates backlog, medical equipment backlog, and the Information Technology national, statutory and local requirements. (Monitored through Finance and Business Performance Committee for business risk and Quality Committee for clinical risk)	20	Prioritisation of capital projects based on risk for 18/19 financial year. This is carried out at Capital Management Group and reviewed by Executive Management Committee and Finance and Business Performance Committee.. (IC) Monitoring of risk impact through the incident reporting process and updates to Capital Management Group, Executive Management Committee, Finance and Business Performance Committee and Board.. (IC) Preparation of business cases for potential external funding. (IC)	Capital Management Group minutes. (IA) Risk profiled capital bids. (IA) Incident reporting trends reports to Quality Committee. (IA) 18/19 prioritisation reviewed by Capital Management Group in February. (IA) Ongoing monthly review. (IA) Business case review process through Trust governance structure.	Amber	Capital allocation less than amount required.	20 (5x4)	Development of initiatives to increase Capital Resource Limit in 18/19 and 19/20.	Director of Finance

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4. Reducing Variation in Quality and Efficiency (Chief Operating Officer and Medical Director)									
4.1 Ensure we are meeting NHS Constitutional standards (Chief Operating Officer) **Key Focus:** **Meeting A&E, Referral to Treatment and Cancer Access targets** **4.2 Adopt best practice to reduce clinical variation to improve quality and efficiency of service (Medical Director)** **Key focus:** **Implement top two 'Getting It Right First Time' recommendations in each specialty specialties**									
BAF 4.1a	There is a risk that we will not deliver the NHS Constitution Standards which directly impacts on patient experience. Specifically: 4 hour A&E performance, Referral to Treatment Times, Access to Diagnostics & Cancer 62 day waits. Risks: Quality - impact on patient experience Financial - link to STF Regulatory (Monitored through Finance and Business Performance Committee, F&BP)	16	Weekly demand and capacity group managing access for RTT, Cancer and diagnostics. (IC) Demand Management Programme to commence with the Buckinghamshire Clinical Commissioning Group Plan for reducing non-elective and elective admissions. (EC) Escalation of all patients within 10 days of a breach to Divisional Directors and Divisional Chairs for cancer pathways. (IC)	Demand and Capacity Group minutes (IA) Weekly escalation meeting chaired by the Chief Operating Officer. (IA) Operational performance dashboard reported at Divisional, Board and Committee level (IA) Internal audit of performance reporting Service Strategies (IA) Deep dives and performance reviews (IA) Deep dive presentations to Finance and Business Performance Committee (IA)	**Green**	Operational Capacity to deliver required standards in particular specialities. Staffing challenges in some areas. Patient flow and length of stay.	**20 (5x4)**	Reduction in numbers of patients staying over 21 days, by December 2018. Detailed work programme through the Urgent Care Recovery Board & A&E delivery board. Unplanned care forecasting tool launched as planned. Additional RAT space to be added by Winter 2018. RTT recovery plan for specific specialities, including outsourcing. Demand management and scheduling between winter and summer and reduce cancer wait time. New Director of Planning and Performance in post. Build capacity in Accident and Emergency. Outline business case approved at Board in May 2018, progressing to full business case. Work on improved bed modelling. Implementation of improvement plan for cancer and urgent care.	Chief Operating Officer
			Planned Care Board (CCG led, launched Sept 2016) (EC)	Meeting minutes (EA)					
			Urgent Care Recovery Programme Board chaired by Chief Operating Officer and attended by the Chief Nurse and Medical Director (IC). Support from NHS Improvement on our urgent care pathway and cancer pathways. (EC)	Programme Board actions and minutes. (IA) Daily national reporting on performance. (EA)					
			Local A&E Delivery Board (health and social care system). The latter is an action focused meeting. (IC & EC)	Programme Boards action plans and minutes (EA)					
4.2	There is a risk that we will not implement the top two 'Getting it Right First Time' recommendations in each speciality which will impact on quality and efficiency.		GIRFT and Clinical Variation Board chaired by Deputy Medical Director who is the lead for GIRFT. Meets on a monthly basis and reports into Quality and Patient Safety Group. National guidance in place to implement this work.	Minutes of the GIRFT and Clinical Variation Board showing progress reports from each speciality lead and that we are working to national guidance. Review of Trust data in specific GIRFT specialities resulting in a report back to the Trust from NHS Improvement GIRFT team and from this an action plan is developed and returned to NHS improvement GIRFT team.	**Green**	Process for GIRFT at a national level are continuing to develop.	**8 (4x2)**	Workplan with speciality identified areas of focus for a rolled out approach dependent on the national GIRFT programme.	Medical Director

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5. Integration, Care Pathways and Models of Care (Chief Operating Officer)									
5.1 Deliver Urgent and Emergency Care Transformation **Key Focus:** **Transform services to reduce demand for Urgent and Emergency care** **Reduce demand for A&E attendances and emergency admissions in line with contract agreements** **5.2 Deliver Primary and Community Care Transformation** **Key Focus:** **Implement integrated care teams and community hubs in Buckinghamshire Communities** **Reduce demand for A&E attendances and emergency admissions in line with contract agreements** **Increase in the use of the Community Assessment and Treatment Services(CATS)**									
BAF 5.1a (links to CRR 49)	There is a risk to the quality of patient experience and outcomes if we do not rapidly reform our urgent care pathways *Board Committee with oversight: Finance and Business Performance Committee*	25	Urgent Care Programme Board chaired by Chief Operating Officer (IC) Buckinghamshire Integrated Care Board (IC) SAFER delivery plan (IC) Support from NHS Improvement on the urgent care pathway. (EC)	Urgent Care Recovery Board minutes (IA) Care Closer to Home Programme plan (IA) Improving Flow from Wards programme (IA) Transformation Board minutes (EA)	Green	Workforce vacancies for nursing (c) Bed capacity and ability to deploy flexibly across 2 hospital sites (c) Variability in external supporting capacity (social care) (c)	20 (5x4)	Detailed 'Care-Fully' Urgent Care Programme being initiated with six key modules (Pre--Hospital, Emergency Department, Acute Medicine, Bed/Site, Inpatient Specialities, and Post-Hospital). Improvement plan development with NHS Improvement. Implement over 6 week period (Improvement plan development with NHS Improvement. Implement over 6 week period August - Sept 2018.	Chief Operating Officer
			STP Urgent Care Programme Board (EC) Operational delivery through clinical leads at project level for each workstream. These are: Medical Take and Maximising the use of Ambulatory Care; Frailty Pathway; Minors Recovery Plan; Speciality response to A&E (Plastics, Surgery and Trauma and Orthopaedics); Continuation of Discharge to Assess; To Take Out medicines; Site Management; Patients with a length of stay greater than 7 days. (IC) Transformation Delivery Group (EC)	Programme board annual plan / meeting minutes (EA) Metrics for each workstream. (IA)					
			Performance Management framework and Divisional Governance Structures (IC)	Performance dashboards - SDU / Division / Board (IA)					
			Support from the NHS Improving Quality 7 day working team (EC) Forward planning using data from Almanac to prepare better across all services. (IC)	7 day audit results (EA)					
			Local A&E Delivery Board (health and social care system) (EC)	Work programme from delivery board (EA)					

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
BAF 5.1b (links to CRR 49)	There is a risk that we will not transform urgent care services in Buckinghamshire to reduce demand for A&E and emergency admissions by April 2019 *Board Committee with oversight: Finance and Business Performance Committee*	15	Bucks Urgent Care redesign and co-production framework (EC) A&E Delivery Board. (EC) Buckinghamshire Provider Collaborative Board (EC) Urgent Care Programme Board (IC) Contract monitoring process. (EC) Co-design workshops completed (CCG, FedBucks, SCAS, BHT).	Board and FBP Committee papers on Urgent Care (IA) Service specification for newly designed urgent care service (IA) Implementation Plans for changed model of care (IA) Meeting of A&E Delivery Board and mobilisation plan for April 2019 (EA) Performance dashboards for Bucks ICS (EA) Outputs discussed at Provider Collaborative Board in August.	Green	Implementation new model of care September to April 2019	12 (4x3)	Implementation plan including urgent treatment centre designation at Wycombe, swift access for mental health patients from Wycombe, combining GP streaming and out-of-hours services at Stoke Mandeville Hospital, transferring GP practice on to Wycombe site, extending GP out-of-hours to practices in South Chiltern. Actions delivered by end of October 2018. Commissioned a system wide urgent care capacity and demand model to be in place by November	Director of Strategy
BAF 5.2a	There is a risk that we will not deliver the level of transformation in primary and community care that will most benefit our population with care closer to home. If we do not deliver this transformation it may have a negative impact on the urgent care pathway.	20	Local Operational Meetings – Feeding into a Governance Meeting (Partnership meeting with social services & GPS.) (EC) Stakeholder group - Community Stakeholders (EC) New Community Transformation group to be set up across the county where the HUBS and Buckinghamshire Integrated Teams (BITS) will report into – This will report into the NEL FRP (non-elective financial recovery plan) group and ultimately the Integrated Care System Board. This is the same process for BITS BITS x 4 at the moment have local groups that meet fortnightly that integrated meeting with the different organisations. This feeds into a mobilisation group that meets monthly. This will feed into the New Community Transformation group.	6 monthly reporting to HASC (EA) Minutes of the NEL FRP group and Integrated Care System Partnership Board. (EA)	Green	This is early stages of transformation and will take time to develop. (A) System wide leadership capacity. (C)	12 (4x3)	• Develop the hubs model, and consider what would work for each locality • Raise awareness of hubs with public and GPs • Increase the service to at least five days per week • Consider expanding the process to self-referral • Wider range of outpatient clinics and voluntary sector • Better co-ordination of services within the hubs & signposting • Change the environment – to be less clinic-like, – better facilities for partner organisations – to be dementia, mental health a learning disabilities Phase 1 April 2018 Continue community hubs in Thame and Marlow for a further two years Phase 2 April – June 2018 Review out of hospital care model to understand scalability of services between Hubs and Integrated teams Phase 3 June 2018 - March 2019 Increase the scale of delivery of the hubs and integrated teams across the county Phase 4 April 2019 - March 2020 Integrate the out of hospital elements into the full care model	Chief Operating Officer

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
6. Sustainable Service Growth (Director of Strategy)									
6.1 Repatriate patients into the Trust from Buckinghamshire and surrounding areas Key Focus: Work with ICS to treat more Buckinghamshire patients and seek opportunities to expand services into new markets Increase number of patients choosing to be treated at the Trust in the following specialities: musculo-skeletal, cardiology, obstetrics, plastics, and general surgery Increase number of women choosing the Trust as a preferred place of birth 6.2 Increase non-NHS income Key Focus: Increase private patient income Expand provision in cardiology, dermatology, ophthalmology and orthopaedics in line with Commercial Strategy March 2019									
BAF 6.1a	There is a risk to the future sustainability of the service unless the Trust can attract more patients from Buckinghamshire and surrounding counties . (Monitored through Finance and Business Performance Committee, F&BP)	15	Bucks ICS Elective Programme Board (EC) Bucks ICS Executive Group (EC) ,	Transformation Action Plan (IC), Repatriation Action Plan (IA), Outpatients Action Plan (IA), Minutes of ICS Executive group. CCG Contract Agreements on Repatriation (EA), Monthly Finance reports on Activity by Specialty (IA)	Green	Further development of Elective Programme Plan with CCG , Implementation of Transformation Action Plan, GP and patient Choice of Provider, Block contract restrictions, specialty targets agreed with SDUs	12 (4x3)	Agree clear contract variations linked to repatriation with the CCG in key specialties such as cardiology, plastics and orthopaedics, Ensure specialty targets for repatriation agreed with SDUs	Director of Strategy
			Transformation Programme (IC) , Finance and Business Performance Committee (IC) , Commercial Development Committee (IC)	Bucks ICS Operating Plan (ERA), Bucks ICS Financial Recovery Plan and Monitoring (EA), Quarterly Updates on Corporate Objectives (IA), Quarterly updates on market share analysis to FBPC (IA)					
BAF 6.2a	There is a risk that the Trust will not increase non NHS income in line with the Commercial Strategy and transformation programme target	15	Commercial Development Committee (IC), Finance and Business Performance Committee (IC), Transformation Programme (IC) Appointment of Commercial Director in September 2018. (IC)	Minutes and monthly reports to the Commercial Development Committee (IA), Contract agreements with external partners (EA), Minutes and quarterly reports to the Finance and Business Performance Committee (IA), Transformation Programme Monitoring (IA), Capital Programme (IA), Communication and Engagement Implementation Plan (IA), Communication and Marketing Material (IA)	Green	Capital resources to support any estates changes	12 (4x3)	Seek external joint ventures and partnerships where appropriate to lever additional capital	Director of Strategy

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
7. Health and Wellbeing (Director of Organisational Development and Workforce Transformation / Chief Nurse)									
7.1 Support health and wellbeing for all staff **Key Focus:** **Programmes to combat stress and increase resilience; MSK care and targeted approaches to the flu vaccine uptake** **Reduction in number of sickness episodes due to stress and MSK episodes by 10%** **Improvement in flu vaccination uptake** **7.2 Ensure the best start in life for Buckinghamshire Children.** **Key Focus:** **Ensure children are safeguarded from harm by working with agencies such as police, social care, education and other health providers** **Safeguarding Level 1 & 2 –over 90% of the relevant staff have received training** **Timely Health Assessments for Looked After Children**									
BAF 7.1a	There is a risk that the programmes to support staff health and wellbeing will not deliver resulting in a negative impact on staff sickness levels with the potential to adversely impact on patient care. *Board Committee with oversight: Strategic Workforce Committee*	20	• Muscular Skeletal issues (MSK) - triage approach to staff MSK referrals, which helps prioritize actions that reflect the severity of the referral and offer immediate self-help advice where appropriate. Appointment of a MSK specialist within the Occupational Health and Wellbeing team to enable more proactive prevention of MSK and be more responsive when intervention required.	increase in staff responding "no" to the question "in the last 12 months have you experienced MSK problems as a result of work activities	Amber	Historical take up of flu vaccination is lower than 75%	16	Robust action plan for flu vaccination including early implementation of plan	Director of workforce & OD
			Robust staff flu vaccination programme informed by lessons learnt meeting in June for implementation from September 2018	% of staff who have taken up the flu vaccine (IA)					

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
8. Innovate and Improve (Director of Strategy)									
8.1 Develop an improvement and innovation culture **Key Focus:** **Implement a single improvement methodology that supports the adoption and spread of best practices.** **Launch service improvement methodology throughout the Trust by September 2018** **200 additional staff trained in service improvement methodology by March 2019** **8.2 Launch Buckinghamshire Life sciences Innovation Centre (BLIC)** **Key Focus:** **Establish innovation hub to support SMEs develop new products with patients and clinicians.** **Innovation centre at Stoke Mandeville Opened December 2018**									
BAF 8.1a	There is a risk that if we do not engage and develop all colleagues in service improvement we will not improve the quality of patient care	20	Minutes of the Workforce Development Committee, Minutes of EMC (IC), Minutes of the Quality Committee (IC)	Service Improvement Training and Development Plan (IA), Communications and Engagement Plan (IA), Action Notes of Service Improvement Taskforce (IA), Monthly Team brief (IA)	Amber	Service Improvement Taskforce to meet, single improvement methodology to be agreed, training and development plans to be implemented, communications and marketing plan	**12 (3x4)**	Taskforce meeting in July 2018 to provide framework and action plan for service improvement launch across the Trust at BHT Way in October 2018	Director of Strategy/Chief Nurse
BAF 8.2a	There is a risk that if we do not launch a Buckinghamshire Lifesciences Innovation Hub supporting businesses we will not be able to develop their healthcare products and services in conjunction with our patients and clinicians.	16	Buckinghamshire Lifesciences Partnership Board (EC), LEP Capital Investment (EC), 20178/19 Capital Plan (IC), Business case for Innovation Hub (IC), European funding confirmed (EC) Health and Social Care Ventures launched 10 September 2018. (IC)	Minutes Buckinghamshire Lifesciences Partnership Board (EA), Business case for capital changes at SMH (IA), Memorandum of Understanding and Partnership Agreements (IA), LEP Grant Letter (EA), European Funding grant letter (EA)	Green	Full Business case yet to be agreed, Robust capital estimate.	**4 (4x1)**	Robust business case for redesign	Director of Strategy
HORIZON SCANNING									
BAF 9.1a	There is uncertainty about the potential impact of Brexit on the Trust's ability to deliver objectives in the coming year.	25	Close attention to direction from the Department of Health and Social Care with regard to any actions to minimise risk. (IC)	Supportive advice around the status of employees from the European Union in 2019/20. (EA)	Red	The situation is uncertain.	**10 (5x2)**	Acknowledgement of the risk. No specific actions at present.	Chief Executive Officer

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TRUST BOARD MEETING
26 September 2018

Title	Risk Management Strategy and Risk Management Policy revision
Responsible Director	Director for Governance
Purpose of the paper	The purpose of the paper is to ratify the revised Risk Management Strategy and Risk Management Policy. These documents have been reviewed by the Audit Committee on the 13 September and the Committee has supported the changes.
Action / decision required	For ratification.

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	*Financial Performance*	*Operational Performance*	*Strategy*	*Workforce performance*	***New or elevated risk***
Legal	***Regulatory/ Compliance***	*Public Engagement /Reputation*	*Equality & Diversity*	*Partnership Working*	*Information Technology / Property Services*

ANNUAL OBJECTIVE	
Which Strategic Objective/s does this paper link to? This links to all strategic objectives.	
Please summarise the potential benefit or value arising from this paper: This paper provides a framework for risk management.	
RISK	
Are there any specific risks associated with this paper? If so, please summarise here	*Non-Financial Risk*: None *Financial Risk*: None
LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY	
Which CQC standard/s does this paper relate to?	All standards.
Author of paper: Liz Hollman	
Presenter of Paper: Liz Hollman	
Other committees / groups where this paper / item has been considered: Circulated to the executive team; Audit Committee	
Date of Paper: 7 September 2018	

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RISK MANAGEMENT STRATEGY AND RISK MANAGEMENT POLICY REVISION

1. PURPOSE

The purpose of the paper is to ask the Board to ratify the revised Risk Management Strategy and Risk Management Policy. These documents are appended to the paper.

2. BACKGROUND

Each year the Risk Management Strategy and Risk Management Policy undergo a review to confirm that they are fit for purpose. These are core documents underpinning governance processes across the organisation, from Board to ward and from ward to Board.

The strategy sets out the organisation's intentions in relation to risk management while the policy sets out how this will be accomplished in practice.

The Board and committees see the evidence of these documents in action at every meeting.

3. KEY ELEMENTS

The documents have been written with the goal of making them accessible to the reader and to explain a very complex process in a straightforward way.

The revision also ensures that the documents are in line with best practice, and with changes and developments in the organisation.

4. RECOMMENDATION

The Trust Board is asked to ratify the revisions to the Risk Management Strategy and Risk Management Policy.

Liz Hollman
Director for Governance
13 September 2018

Buckinghamshire Healthcare NHS
NHS Trust

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RISK MANAGEMENT STRATEGY

Version 7.0

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BHT Strategy No:	**S012**
Version:	**7**
Issue:	**1**
Author:	Elizabeth Hollman, Director for Governance
Lead Executive Director:	Neil Macdonald, Chief Executive Officer

Consultation:	**Executive Management Committee** **Audit Committee**

Approved by:	**Trust Board**
Date Approved:	
Review date:	September 2018
EQIA:	March 2009 Reviewed July 2011. Reviewed October 2014.
Location:	Swan Live Intranet/ Policies and Guidelines/ Policies and Strategies/ Corporate/Quality & Safety/ Healthcare Governance

Document History

Risk Management Strategy- BHT S012

Version	Issue	Reason for change	Authorising body	Date
1		Author: Jill Henderson, Clinical Governance	Trust Board	06.04.04
2		Author: Dorothea Reid, Associate Director Governance & Elizabeth Hollman, Patient Safety Manager	Trust Board	26.05.05
3		Author: Dorothea Reid, Associate Director Governance & Elizabeth Hollman, Patient Safety Manager	Governance Committee *Accepted by Trust Board*	23.02.07 *March 2007*
3	**1**	Author: Elizabeth Hollman, Patient Safety Manager Strategy updated to reflect changes in the organisation	Governance Committee	October 2007
4		Author: Elizabeth Hollman, Associate Director Healthcare Governance & Elizabeth Palmer, Company Secretary	Healthcare Governance Committee Ratified : Trust Board	May 2009 27.05.09
4	**1**	Amended compliance monitoring and merger with Community Health Bucks in April 2010.	Approved	26.07.10
4	**2**	Minor amendments to Trust Name & Logo.		18.03.11
5		Author: Elizabeth Hollman, Director Healthcare Governance. Formal review-June 2011 EIA review-July 2011	Risk Monitoring Group Healthcare Governance Ratified: Trust Board	22.06.11 12.07.11 05.10.11
5	**1**	Version 5 updated to reflect changes agreed by the Audit Committee in March 2012, and in the light of feedback from the NHS Litigation Authority. The changes constitute amendments rather than entirely	**Trust Board**	**May 2012**
5	**2**	Annual review of strategy	**Trust Board**	**May 2013**
6	**0**	Full Review of Strategy undertaken	**Trust Board**	**October 2014**
6	**1**	Annual Review of Strategy (informed by Trust Board Seminar November 2015)	**Trust Board**	**January 2016**
6	**2**	Annual Review of Strategy	**Trust Board**	
7	**0**	Annual Review of Strategy	**Trust Board**	**May 2017**
7	**1**	Annual Review of Strategy	**Trust Board**	**Septembe r 2018**

Associated documents

BHT Ref	Title	Location/Link
BHT Pol 079	**Risk Management Policy**	BHT Intranet/Trust Policies/ Corporate Policies, & CHB Intranet/Policies, Guidance & Procedures
		Swan Live Intranet/ Policies and Guidelines/ Policies and Strategies/ Corporate/Quality & Safety
	Incident Reporting Policy	
BHT Pol 135	Compliance with legislation policy	

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1. EXECUTIVE SUMMARY

In healthcare delivery risks are taken on a daily basis in order to deliver high quality outcomes for patients. This includes clinical risks such as undergoing surgery, and business risks such as investing in innovation in order to deliver long term efficiency.

It is important in a safe, efficient and effective healthcare system that any decision to take a risk is accompanied by clear mitigation through effective controls, a transparent decision making process, and a process for monitoring the impact of any risk.

Some risks are predictable and managed through established systems of control. Other risks are unpredictable and a culture of risk awareness and ongoing vigilance is necessary to identify risks early and to take mitigating action to address.

The complexity of risk in a healthcare organisation can be challenging to identify, communicate, manage and monitor and no system will be perfect. This strategy sets out the framework for risk management and includes a risk appetite statement which acknowledges the balance between taking risk in order to achieve benefit, and not taking unnecessary risk.

Each member of staff has a responsibility to identify and report risks in their work environment and their practice in order to reduce the impact of such risks on patients, staff, visitors and themselves.

The Trust Board has overall responsibility for ensuring that everything possible is being done throughout the Trust to mitigate and manage risks as far as possible and to deliver high quality, safe and effective patient care.

Corporate and individual accountability for managing risk is set out in this strategy as follows:

- The Trust Board's role in reviewing the management of extreme risks
- The Audit Committee's role in monitoring the effectiveness of the system for managing risks
- The Quality and Clinical Governance Committee and Finance and Business Performance Committee role in monitoring the content of the Corporate Risk Register
- The Executive Management Committee role in moderating the risk scores
- The Risk and Compliance Monitoring Group role in the review of risk registers and making recommendations to the Executive Management Committee
- The Trust Chief Executive Officer's role as the person with overall responsibility for managing risk.
- The responsibilities of each executive director in relation to specific areas of risk in the Trust
- The requirement for Divisional and Service Delivery Unit leads, senior nurses and senior managers to carry out risk assessments, ensure that divisional staff are trained and competent to do the jobs asked, and to maintain essential services in times of emergency.
- The responsibility for all staff to take reasonable care for their own safety and the safety of all others that may be affected by the Trust's business.
- The scope and range of advice the Board and Trust staff can call upon.

A separate document – the Risk Management Policy – describes the process of risk

identification and management which all staff are expected to follow.

2. INTRODUCTION

Buckinghamshire Healthcare NHS Trust is exposed to a wide range of potential risks,

including

- Clinical risks e.g. unavoidable and avoidable risks in treatment.
- Health and safety risks e.g. accidents involving patients, staff or visitors.
- Workforce and recruitment risks e.g. insufficient staff, or skill shortages.
- Financial and business risks e.g. non delivery of the financial plan, cash management, capital management
- Estate and environmental risks e.g. poor maintenance or faulty equipment, backlog maintenance
- Information Governance risks e.g. breaches of confidentiality.

Risk assessment is a critical element in every activity in the Trust, and the Trust Board must manage its risks in such a way that people are not harmed, losses are minimised to the lowest acceptable levels, and organisational objectives are delivered.

Building the Assurance Framework: A Practical Guide for NHS Boards details the requirement for Trust Boards to be confident that the systems, policies and people they have in place are operating in a way that is:

- Effective
- Focused on key risks
- Driving the delivery of the Trust's objectives and meeting the national healthcare standards.

To meet the requirements of the Annual Governance Statement (AGS) Trust Boards are required to have in place:

- Clear objectives, which provide the framework for all the Trust's activity.
- Structured risk identification systems covering all possible risks to the Trust.
- Robust controls for the management of risk.
- Appropriate monitoring and review mechanisms that provide information (assurance) to the Board that the system of risk management across the Trust is effective.

3. OBJECTIVE AND SCOPE OF THE STRATEGY

The objective of the Risk Management Strategy is to promote a consistent and integrated approach across all parts of the organisation embracing clinical, organisational and financial risks. It aims to do this through a robust governance structure, sound processes and systems of working, and an open and fair, blame-free culture that is focused on patient and staff safety and high quality care.

The strategy applies to every employee of the Trust and contractors or other third parties working within the Trust. Managers at all levels are expected to make risk management a fundamental part of their approach to clinical and corporate governance.

4. DEFINITION OF RISK AND RISK MANAGEMENT

A risk is the chance of something happening that will have an adverse impact whether it be on the achievement of the Trust's development objectives, including the delivery of high quality patient care, or the safety of staff.

Risk management is the proactive identification, classification, communication and control of events and activities to which the Trust is exposed.

5. RISK APPETITE STATEMENT

The Board of Buckinghamshire Healthcare NHS Trust acknowledges that there are two important elements to risk appetite, namely risk avoidance and risk tolerance. Both are necessary to ensure that the organisation takes enough risk to develop the business, foster innovation and transformation whilst at the same time delivering a safe, efficient and effective service.

The extent of risk tolerance for each decision will vary based on potential benefit against possible adverse consequence based on best current intelligence. Any decision will take into account the importance of risk control and risk management i.e. a choice may be made to take risk, but controls must be in place to minimise the possible adverse impact of the risk. Consideration will also be given to potential exit strategies should an adverse consequence materialise.

This approach applies to all aspects of the business including quality, people and money.

Risk will not be considered in isolation but in aggregate.

There will be an accompanying template for any paper requiring the Board to make a significant decision which sets out the risk profile of the decision. This will form the foundation of risk for the 'project' as it moves forwards through due diligence and implementation and thereafter, when it has gone live. Risk mitigation actions will be regularly reviewed within project reviews and exit strategies updated and in place at every phase. Escalation to the Board through this process will occur when appropriate.

6. PRINCIPLES OF EFFECTIVE RISK MANAGEMENT

Effective risk management relies on the following principles:

- An open, objective, supportive and learning culture that encourages staff to report potential risk issues.
- A systematic process for identifying, reporting, managing and monitoring risk.
- Leadership by the Board
- Clear understanding by managers of their responsibilities in following risk process through clarity of job role, training and development, and ongoing support
- Clear understanding by each member of staff of their role in minimising any risk associated with their area of work

7. CORPORATE AND INDIVIDUAL ACCOUNTABILITY FOR MANAGING RISK

7.1. The Trust Board

The Trust Board is responsible for setting the 'risk appetite' for the organisation. Risk appetite can be defined as 'the amount and type of risk that an organisation is willing to take in order to meet their strategic objectives.'

The Trust Board is responsible for reviewing the effectiveness of its internal control systems through its Board Assurance Framework (BAF), performance monitoring, and the Corporate Risk Register. The Board is required to seek assurance that it is doing its reasonable best to ensure the Trust meets its objectives and protects patients, staff, the public, and other stakeholders against risks of all kinds.

The Annual Governance Statement (AGS) made by the Trust Chief Executive Officer in the annual accounts must demonstrate that the Trust Board has been informed through the Board Assurance Framework about all risks, not just financial ones and has arrived at its conclusions on the totality of risk based on all the evidence presented to it.

7.2. Chair and Non-Executive Directors

The Trust Chair and Non-Executive Directors responsibility for monitoring risk is effected through review of assurance at Board and Board Committee meetings, challenging as necessary, and triangulating through walkabout observations.

In addition there is a non-executive director champion for each of the following areas in the Trust:

- Whistleblowing
- Security
- Counter Fraud
- Health and Safety
- Organ and Tissue Donation Committee
- Equality and Diversity

7.3. Executive Directors

The Compliance with Legislation Policy (BHT Pol 135) sets out each Executive Director's areas of responsibility in relation to compliance, and from this provides a basis for the risk accountabilities for each Director.

In addition each year the Board agrees the Corporate Objectives and each of these is allocated an executive lead who is responsible for communicating risks to delivery of these objectives.

There is a shared accountabililty across the Executive Directors for delivery of high quality services, delivery of the financial plan and delivery of people objectives. However, there are some specific accountabilities for individual directors which are set out below.

7.3.1. The Trust Chief Executive Officer

As Accountable Officer, the Chief Executive has overall responsibility for ensuring that governance and risk management systems are adequate within the Trust to cover all its

activities. The Chief Executive Officer is required to sign an Annual Governance Statement on behalf of the Board to provide stakeholders with an assurance that the Trust has met its governance responsibilities.

7.3.2.Chief Operating Officer

The Chief Operating Officer has overall responsibility for the delivery of all operational clinical and clinical support services.

7.3.3. The Medical Director

The Medical Director has joint lead responsibility for clinical governance with the Chief Nurse. This includes lead responsibility for clinical performance of the medical workforce, medical innovation, research governance, Caldicott Guardian issues, Licence Holder for the Human Tissue Act, medicines management and medical education.

7.3.4. The Chief Nurse

The Chief Nurse has joint lead responsibility for clinical governance with the Medical Director. This includes lead responsibility for Patient Safety, Claims & Litigation, Complaints and Safeguarding, and clinical audit. The Chief Nurse also coordinates the Care Quality Commission Registration and the maintenance of compliance with the regulations and outcomes that apply to the Trust.

7.3.5. The Director of Workforce and Organisational Development

The Director of Workforce is the lead director for strategic risks related to employment law, organisational and personal development, and training.

The Director of Workforce is the Board lead for Equality and Diversity.

7.3.6. The Director of Finance

The Director of Finance is the lead director for financial risks, risks related to procurement and risks related to information governance. (This is in the office of Senior Information Risk Owner [SIRO]).

He is professionally accountable for financial practice and development and the coordination of the internal audit function which provides the Trust with independent assurance.

7.3.7. The Director of Strategy and Business Development

The Director of Strategy and Business Development is the lead director for risks to marketing, commercial development and development of new models of care.

Through line management of the Director of Property Services he has responsibility for providing a safe and secure environment for patients, staff and visitors including environmental controls, fire, security, food safety, hospital transport, decontamination, and

cleanliness. This director is responsible for risks to the delivery of the capital programme.

The Director of Strategy is the lead director on the Board for health and safety.

7.3.8. Director for Governance

The Director for Governance is responsible for ensuring that there is a process in place for risk to be identified in the organisation, escalated through the risk register and Board Assurance Framework and top risks reported to the Board.

The Director for Governance is responsible for having a system in place for reporting on compliance with statute and regulation.

The Director for Governance is responsible for ensuring that the Directors on the Board receive risk training on an annual basis and that there is training available for organisational clinical leads and managers to receive risk training.

7.4. Divisional Leads

Divisional Directors, Chairs and Chief Nurses have specific responsibility for identifying significant risks within their services and taking action to manage and reduce them to an acceptable level. Risks assessed as medium to extreme and the actions being taken to reduce them should be recorded on divisional risk registers.

In addition the Head of Midwifery leads on risks associated with maternity services.

Each Service Delivery Unit clinical lead is responsible for ensuring that risks are identified and reported to the Division through the risk assessment and risk register process.

7.5.Trust Risk Advisers

The Trust receives advice on a comprehensive range of risks from a number of advisers which include (list not exhaustive):

- The Director of Infection Prevention and Control, and the Control of Infection Team
- The Head of Occupational Health
- The Health and Safety Manager
- The Fire Safety Advisers
- The Radiation Protection Adviser
- The Chief Pharmacist
- The Child Protection Designated Nurse and Designated Doctor
- The Human Tissue Act Designated Individuals
- The Trust Security Adviser – Local Security Management Specialist
- The Data Protection Officer
- Emergency Planning Officer
- Local Counter Fraud Service

7.6. Trust Senior Managers

Trust senior managers must ensure that:

- Patient and staff safety is given the highest priority.
- Staff are working within their level of competence.
- Staff are enabled to attend training appropriate to their role particularly statutory and mandatory training.
- Sufficient staff are available in the Division to carry out formal risk assessments and to determine adequate control measures within the working environment.
- Formal risk assessments are incorporated into a Departmental or Divisional Risk Register that informs the Trust Corporate Risk Register.
- Fire and other emergencies are appropriately dealt with
- There are contingency plans in each division to maintain an acceptable level of service following any unplanned interruption of essential services.

7.7. All employees

It is essential that if a member of staff considers that a serious concern which they have raised through the line management route has not been resolved, they should report this to a more senior level of management.

All staff must:

- Co-operate fully with departmental and Trust guidelines, protocols and policies in the interests of health and safety and risk management.
- Report any incident, defect or other concern directly to their manager and complete an incident reporting form promptly.
- Follow prescribed working practices and all information and training provided.
- Attend training as identified by their manager or by the Trust (e.g. induction and new procedures, statutory and mandatory training: induction, fire safety, moving and handling and personal safety).
- Participate actively in the process of risk assessment and risk escalation. Comply with, and implement control plans that arise from assessments.
- Promptly report to their manager or local risk assessor, any changes that might affect assessments / working conditions.

8. GOVERNANCE STRUCTURE

The Trust is committed to delivering excellent services for its patients. To ensure this is managed in a fair and transparent way, the Trust has implemented a governance structure that ensures quality is the responsibility of all staff and risks are minimised as much as possible. The Trust's governance structure which identifies all the Trust's committees and their relationship to the Board is appended. (**Appendix 1)** The purpose of each Board Committee and the Executive Management Committee in relation to this strategy is set out below:

8.1. Trust Board

The Trust Board is responsible for reviewing the effectiveness of its internal control systems – clinical and non-clinical. The Board is required to receive and analyse statements of assurance to confirm that it is doing its reasonable best to ensure the Trust meets its objectives and protects patients, staff, the public and other stakeholders against risks of all

kinds. The Board reviews the Board Assurance Framework at least three times a year. The Board discharges some of these responsibilities through its committees (the Audit, Finance and Business Performance, Quality and Strategic Workforce Committees. (See below). It receives reports from each Committee through the Committee Chairs at Board meetings.

The Trust Board receives routine reports throughout the year which identify how risks are being managed and quality maintained. Considerable importance is placed on the quality of the information the Board receives. The Trust Executive directors have the ultimate responsibility for ensuring the information that that Board receives is accurate, appropriate and comprehensive. Examples include regular financial reports, complaints and incident reports, reports on performance, reviews of the corporate risk register, updates on national guidance and minutes of all the Board Committees.

At the end of each Board meeting the Director for Governance identifies the risks which have arisen through information presented to the Board and ensuring discussions and this is recorded in the minutes. This summary is then used to check that the Board Assurance Framework and Corporate Risk Register are accurately reflecting the emerging risks.

The Annual Governance Statement (published with the Annual Accounts) summarises the Board's review of its system of risk management.

8.2. Executive Management Committee

The Executive Management Committee is the operational management group that ensures that all management processes and systems are in place and are fit for purpose. It is the committee with the responsibility for moderating the Board Assurance Framework and the Corporate Risk Register to ensure consistency in the way risk is communicated in the organisation.

All executive directors are members of this committee. The Chief Executive Officer reports to the Board.

The Risk and Compliance Group comprising Divisional representation and risk specialists provides information to the Executive Management Committee to support the moderation process. The terms of reference for this Group are appended to the strategy in Appendix 2.

8.3. Audit Committee

The purpose of the Audit Committee is to

- Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across all the Trust's activities
- Ensure this system supports the achievement of the Trust's objectives, through its three times a year scrutiny of the Board Assurance Framework and raise any specific concerns to the Board as necessary.

The Audit Committee seeks assurance from internal and external auditors, including external bodies that inspect the Trust.

The Audit Committee receives assurance reports from the Quality and Clinical Governance Committee, the Strategic Workforce Committee and the Finance and Business Performance Committee.

8.4. Quality and Clinical Governance Committee

The purpose of the Quality and Clinical Governance Committee is to review assurance relating to the quality of the care provided by the trust by reviewing the delivery of the Quality Improvement Strategy and other quality measures, including the Corporate Risk Register. The Quality and Clinical Governance Committee reviews the quality related risks on the Corporate Risk Register at least four times a year and escalates any concerns both to Audit Committee and Trust Board.

The Quality and Clinical Governance Committee receives presentations from the five Divisional Risk Registers on an annual basis including a review of top risks.

8.4.1. Organ and Tissue Donation Committee

The Organ and Tissue Donation Committee is set up as a sub-committee of the Quality and Clinical Governance Committee. It's role is to champion and oversee the work of organ and tissue donation at the Trust.

8.5. Finance and Business Performance Committee

The purpose of the Finance and Business Performance Committee is to review assurance from the executive team around financial, operational and workforce performance.

The Finance and Business Performance Committee reviews risks relating to finance, operational delivery and workforce and escalates any concerns to Audit Committee and Trust Board.

Each Division is invited on an annual basis to present to the Committee their risks and controls relating to finance, operational delivery and workforce. This is both to provide assurance to the Committee and to give an opportunity for the Committee to provide feedback on the management and presentation of risk.

This Committee has oversight of the wholly owned subsidiary Outpatient Pharmacy.

This Committee also has oversight of the performance of the sub-contract with FedBucks, the GP (General Practitioner) Federation providing a primary care out-of-hours service, and a Minor Injuries and Illness Unit at Wycombe Hospital.

8.5.1. Commercial Development Committee

The Commercial Development Committee is established as a sub-committee of the Finance and Business Performance Committee to provide assurance and strategic direction to innovative commercial thought leaders from within the organization.

The committee receives assurance that commercial opportunities are being maximised; provides advice and guidance for commercialisation and innovation initiatives; and receives assurance that Commercial Initiatives in workstreams are in alignment with Trust Strategy and Values.

The ethos of the group is positive, fast paced and focussed and is intended to build an entrepreneurial culture within the organisation.

8.6. Strategic Workforce Committee

The purpose of the Strategic Workforce Committee is to review assurance in relation to workforce planning, organisational development, health and safety and equality and diversity.

Risks are escalated to the Audit Committee and Board as necessary.

8.7. Nominations and Remuneration Committee

The purpose of the Nominations and Remuneration Committee is to ensure that senior managers are fairly remunerated for their individual contribution to the organisation, with consideration of affordability and public accountability.

8.8. Charitable Funds Committee

The purpose of the Charitable Funds Committee is the governance and management of the Trust's Charitable Funds on behalf of the Trust Board.

9. RISK MANAGEMENT PROCESS

9.1. The Approach

Buckinghamshire Healthcare NHS Trust has a structured approach to risk management. This process is described in detail in the Risk Management Policy and involves

- A pro-active approach to the identification and management of principal risks that may threaten the achievement of strategic and divisional objectives.
- A reactive approach to the identification and management of risks that may threaten the achievement of the Trust's risk management systems and processes.
- Progress reports to the Board.

Diagram 1 Risk Communication Process for Board Assurance Framework

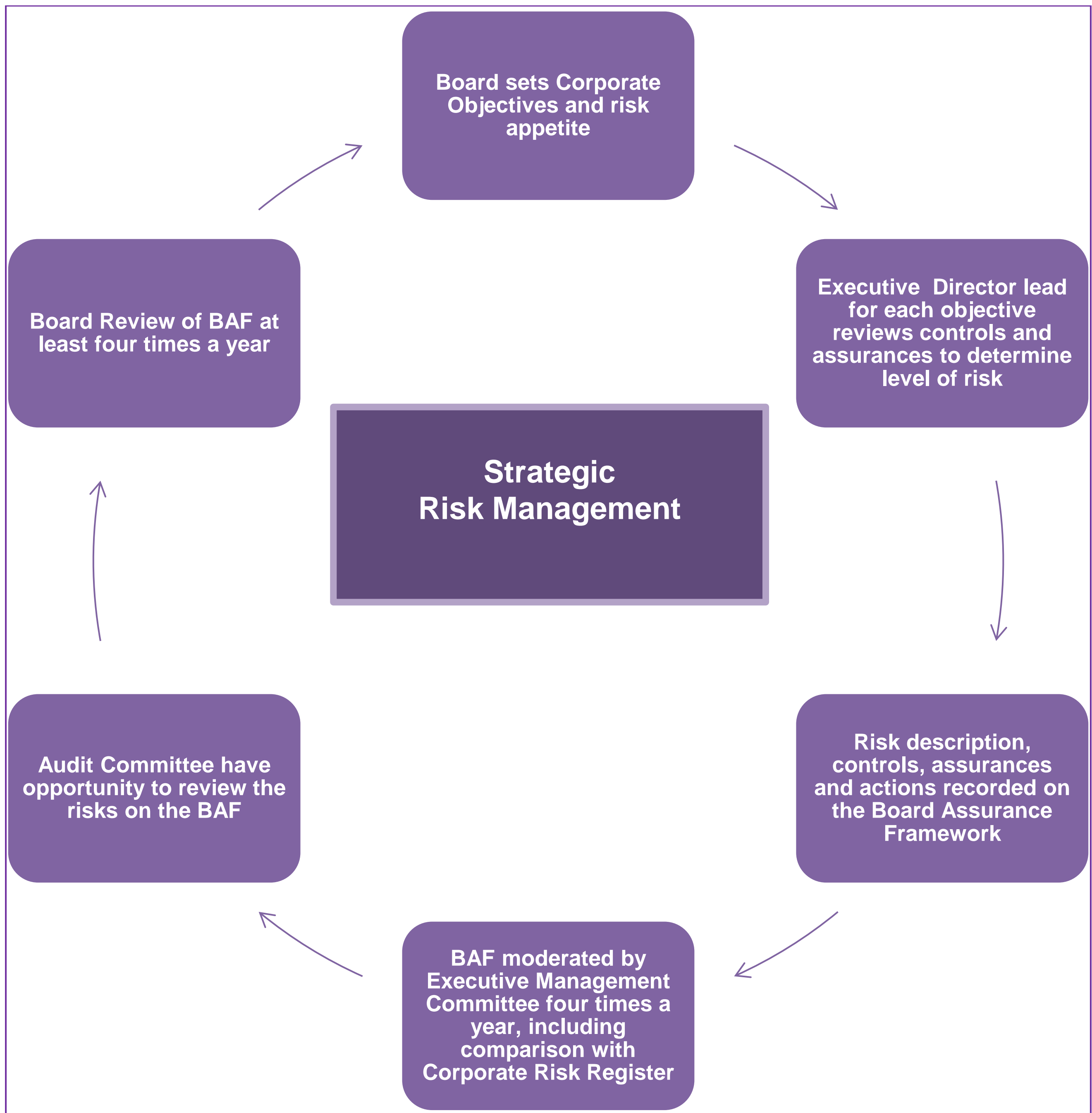
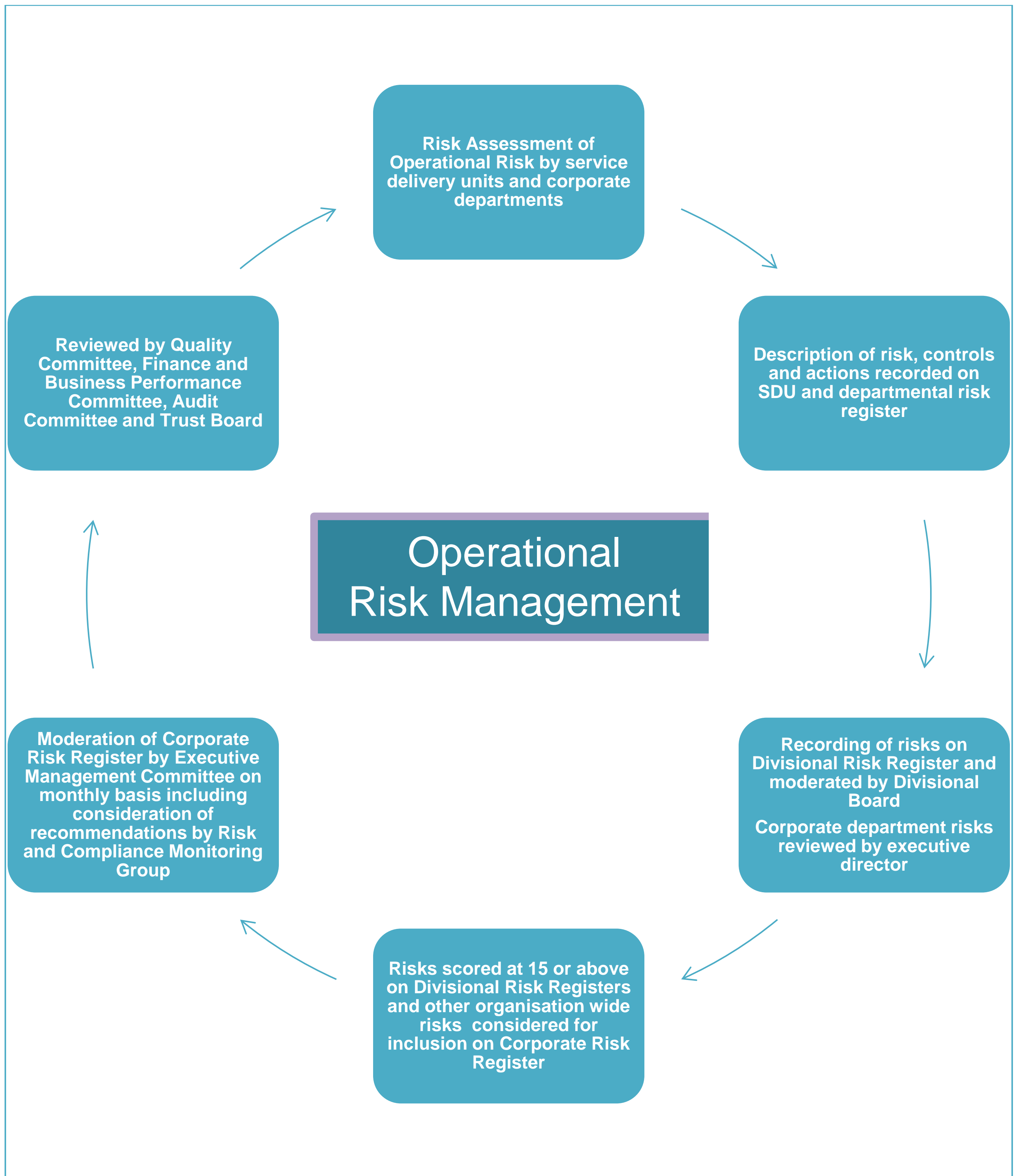


Diagram 2 Risk Communication Process for Corporate Risk Register



9.2. Board Assurance Framework

The Board Assurance Framework is the key document enabling the Board to understand the strategic risks facing the organisation, i.e. the risk against the delivery of the organisational objectives year on year.

The risks identified from the Board Assurance Framework cover the full range of corporate objectives and include consideration of present risks, future risks, risks arising from within the organisation and risks occurring as a result of external pressures and changes.

The Board Assurance Framework is a live document updated by the Executive leads for each of the corporate objectives at least quarterly and more often if appropriate. It provides the basis for both the assurances and gaps in control reported in the Annual Governance Statement.

9.3. Corporate Risk Register

The Trust's Corporate Risk Register is at the centre of the operational risk management process and is a living document. It changes continually to reflect the dynamic nature of risk and the Trust's management of it.

The Corporate Risk Register captures top risks identified from Divisional risk registers and risk registers associated with some corporate services such as Property Services. All risks scored at 15 or above showing on divisional and corporate service risk registers are considered by the Executive Management Committee for inclusion on the Corporate Risk Register. In addition, risks which emerge from within Divisions at a lower score but clearly having an organisation wide impact are considered by the Executive Management Committee for inclusion on the Corporate Risk Register.

Each division has its own risk register which captures in one place how divisional risks are being managed. The Divisional Boards are accountable for the assessment, communication and management of risks within their area of responsibility.

In addition there are corporate service risk registers covering risks from Finance, Information Technology, Property Services, Human Resources, Safeguarding and Emergency planning. Each register is managed by the Executive Director responsible for these areas of risk.

Any other risks within the portfolio of individual Executive Directors are communicated through the Divisional Risk Registers where appropriate, and the Board Assurance Framework.

10. RISK MANAGEMENT TRAINING AND INFORMATION

Training and information are key elements in the development of a positive risk management culture. They provide staff with the necessary awareness, knowledge and skills to work safely and to minimise risks at all levels. The Trust's Education Training and Development Strategy sets out a framework that enables all staff to access education, training and development so that they achieve the level of competence required to deliver service needs and provide safe and high quality patient care.

The Risk Management Strategy is made available to staff via the intranet, and risk management training is available to all divisions through the training department and where request is made to the Director for Governance to provide such training.

General awareness-raising for staff is also undertaken through staff briefings, induction programmes and various newsletters.

11. STAKEHOLDER INVOLVEMENT

It is good practice to involve stakeholders, as appropriate, in all areas of the Trust's activity, including the Risk Management Strategy and any significant risks. The Trust must ensure that it has and maintains a range of communication and consultation mechanisms with relevant stakeholders, both internal and external.

It is the role of the Trust Board to ensure that the Trust is working in partnership with the following stakeholders.

- Patients and the general public
- Members of staff and the Joint Management and Staff Committee
- Healthwatch England
- Buckinghamshire Health and Adult Social Care Select Committee
- Buckinghamshire Safeguarding Children Board
- Buckinghamshire Safeguarding Vulnerable Adults Board
- Voluntary Organisations and public interest groups
- Local Councillors, MPs and the Secretary of State
- Neighbouring healthcare organisations
- NHS Improvement
- Clinical Commissioning Groups
- Local and national media

(this list is not exhaustive)

The Trust also keeps the Care Quality Commission informed of risks and concerns.

12. PERFORMANCE FRAMEWORK AND MONITORING

12.1. Risk Management Strategy

The Trust Board has overall responsibility for overseeing the implementation of this strategy, and of taking actions associated with risk management.

The Audit Committee has responsibility for monitoring the risk management system, and providing appropriate verification to the Chief Executive and the Trust Board. The Trust is required to develop an Annual Governance Statement that confirms that action has been taken to manage risk, and to publish this statement in its annual report. The work of internal audit provides assurance to the Audit Committee of compliance with the risk strategy.

The Quality and Clinical Governance Committee monitors the risks emerging through the corporate risk register in the context of quality assurance. The Chair of the Quality and Clinical Governance Committee highlights any concerns about particular risks to the Audit Committee and Trust Board.

12.2. Indicators

Success with managing risk will be assessed by using the following standards as benchmarks, combining internal self-assessment against external assessment where appropriate to do so.

12.2.1. An annual internal audit of the Board Assurance Framework to provide assurance.

12.2.2. A review of governance processes including risk to be included in the rolling Internal Audit programme

12.2.3 Annual review of the Annual Governance Statement by the Trust's external auditors to confirm that it accurately reflects the risk position of the organisation.

13. APPROVAL AND REVIEW OF THE RISK MANAGEMENT STRATEGY

The Risk Management Strategy has been developed in the light of currently available information, guidance and legislation that may be subject to review.

Any revisions to the Strategy will be considered at the Audit Committee and require the approval of the Trust Board.

The Director for Governance will ensure that the strategy is communicated to Trust staff.

References

Building the Assurance Framework: A Practical Guide for NHS Boards (*DOH March 2003*)

Assurance – The Board Agenda *(DOH July 2002*) Building the Assurance Framework: A Practical Guide for NHS Boards *(DOH March 2003*)

Health and Social Care Standards and Planning Framework 2005/06-2007/08 *(DOH July 2004).*

Linked Policy: Risk Management Policy**- BHT Pol 079**

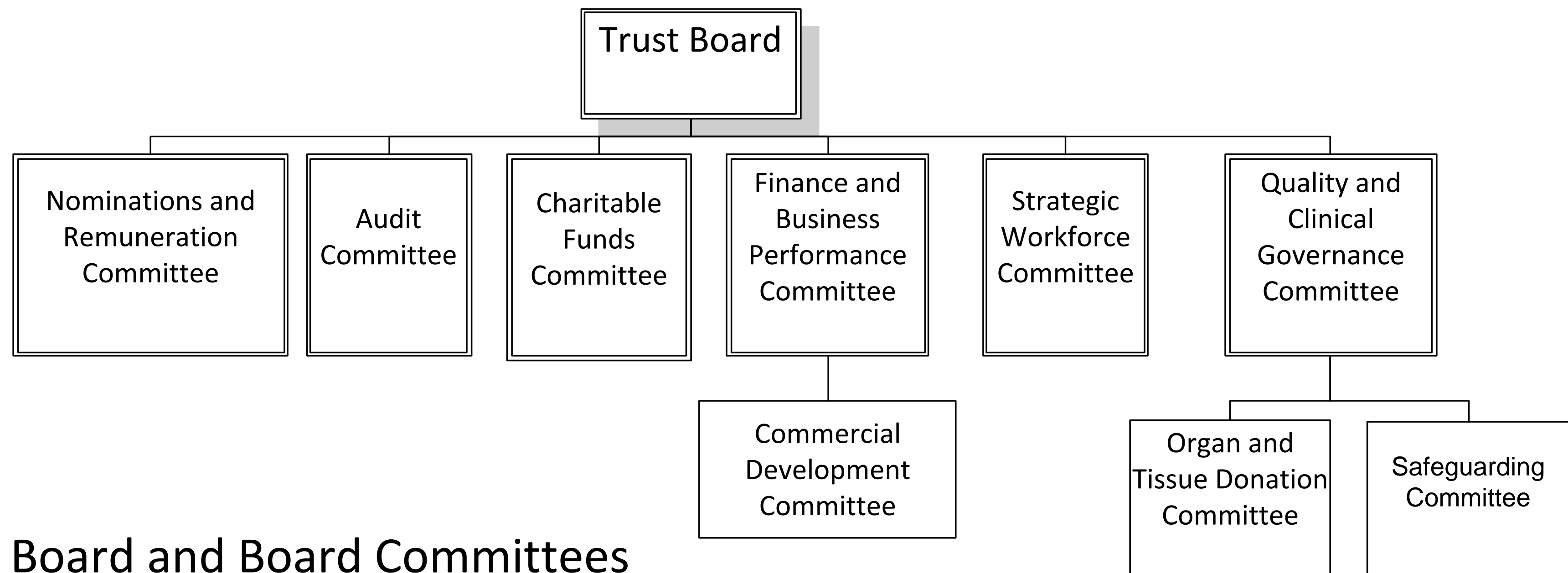
Linked Policy: Being Open Policy BHT Pol 007

Linked Strategy: Maternity Risk Management Strategy

APPENDIX 1 GOVERNANCE STRUCTURE FLOWCHARTS

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS
NHS Trust

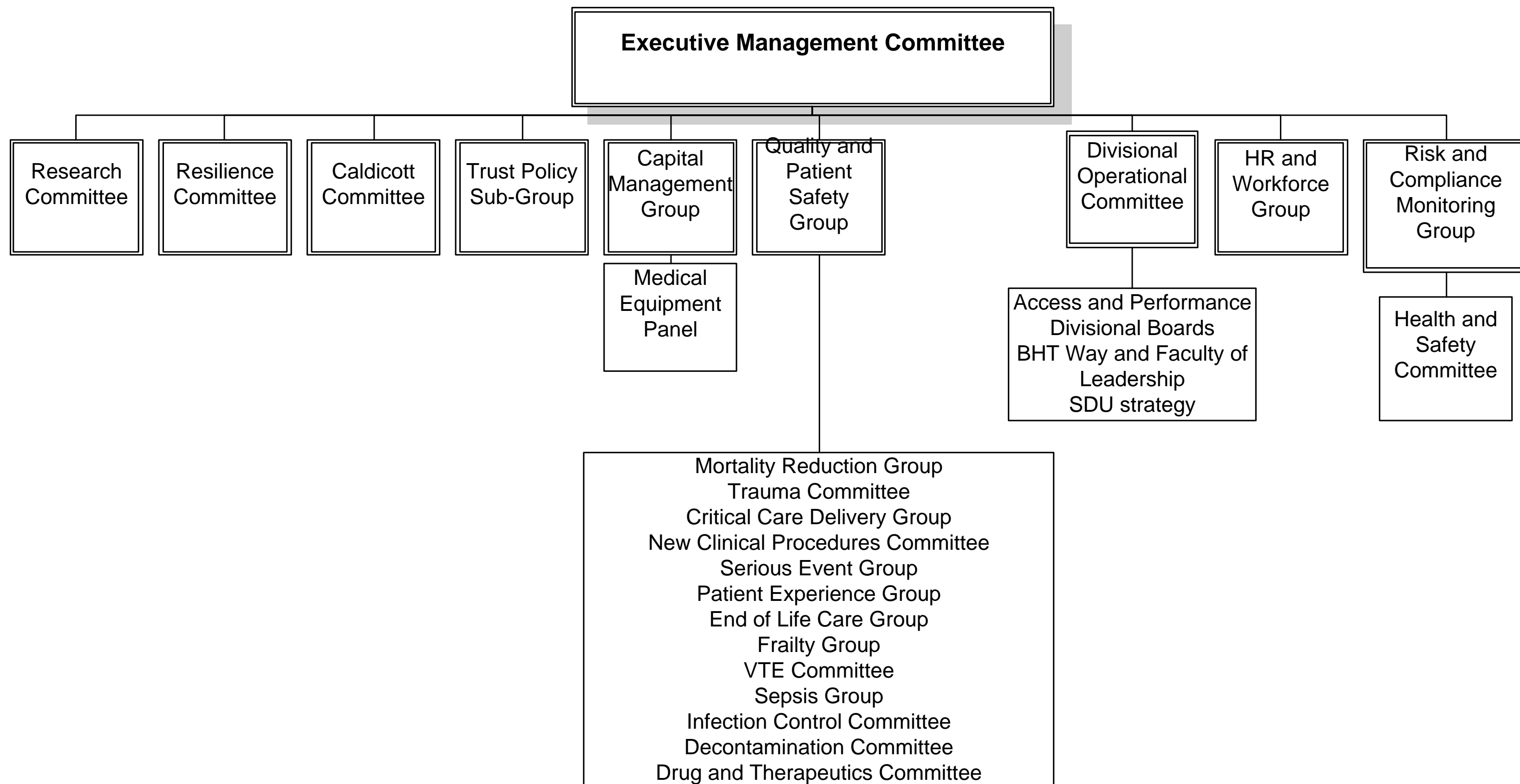


Board and Board Committees

Operational Committees

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust



RISK AND COMPLIANCE MONITORING GROUP TERMS OF REFERENCE v1 November 2017

Reports to: Executive Management Committee **Chaired by: Director for Governance**

Meetings: Every calendar month 2 hours long Monitor information, make recommendations to EMC, take action	**Purpose:** The overarching purpose of this group is to provide a forum where executive directors, divisional and departmental representatives can review compliance with legislation including CQC standards, review the outputs of risk processes, and take actions to improve or make recommendations to the Executive Management Committee.
Members: Director for Governance (Chair) Chief Operating Officer (Deputy Chair) Chief Nurse (or representative) Divisional lead from each Division (either Chair, Director or Chief Nurse, or a deputy) Property Services Risk Manager Head of Medical Records Head of Midwifery Head of Patient Safety and Litigation Chief Pharmacist Head of Allied Health Professionals Emergency Planning Officer Others by invitation depending on agenda **Quorum:** one executive director, two reps from clinical divisions and one departmental rep from the corporate division	**Duties:** **Compliance** Monitor compliance against self-assessments Prepare for information request for the CQC Prepare for external reviews Oversight of compliance against statutory requirements, including CQC regulatory standards Oversight of Health and Safety compliance Support co-ordination of inspection preparation Annual review of minutes **Risk** Challenge around length of time to resolve risks Recommendations to Executive Management Committee on moderating the Corporate Risk Register Understand organisational risk gaps Voice of clinical services in informing the Corporate Risk Register

Success Criteria: Improved assurance of compliance with legislation Better quality risk registers – division, department, corporate Evidence of effective risk management	**Outputs:** Record of actions Record of decisions Notes to EMC through the Chair
Inputs: Minutes of Health and Safety Committee Corporate Risk Register Divisional Risk Registers External review register	**Method of working** Culture of openness and frank discussion and challenge with a solution focus Trust values will be adhered to and the group will be mutually supportive Paper at each meeting containing Corporate Risk Register and highlighting risks scored at 15 or above on Divisional and Corporate Service Risk Registers (EH) Rotation of review of each Division's risk register

Buckinghamshire Healthcare NHS
NHS Trust

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RISK MANAGEMENT POLICY

Version 5.2

Version:	**5**
Issue:	**3** *Comprehensive review of version of 4.2 to update to V5.0*
Consultation:	Executive Management Committee; Audit Committee
Date:	
Approval by:	Trust Board
Date approved:	
Author:	Elizabeth Hollman, Director for Governance
Lead Director:	Neil Macdonald, Chief Executive Officer
Name of responsible committee/individual:	Trust Board
Document reference:	**BHT Pol 079**
Date issued:	
Review date:	May 2018
Target audience:	All Trust staff
Equality Impact Assessment	Consistency Panel approved 24/03/09 Review July 11 Review October 2014
Location:	BHT Intranet Trust Policies/Corporate Policies CHB folder of the PCT Intranet/Policies Swan Live Intranet/ Policies and Guidelines/Policies and Strategies/ Corporate/Quality & Safety

Document History

Risk Management Policy- BHT Pol 079

Version	Issue	Reason for change	Authorising body	Date
1		Author: John Hilton New Policy		
2		Authors: Elizabeth Hollman, Patient Safety Manager, Dorothea Reid, Associate Director of Governance, Mary Klaus & Sarah Langan-Hart		
2	**1**	Amendment to Version 2 to update the policy to reflect the changes in the organisation.	Governance Committee	October 2007
3		Authors: Elizabeth Hollman, Associate Director Healthcare Governance, Mary Klaus & Sarah Langan-Hart	Executive Management Healthcare Governance Committee	17.04.09 12.05.09
3	**1**	Authors: Elizabeth Hollman, Associate Director Healthcare Governance & Catherine Brown, Board Assurance Facilitator	Re-issued	30.07.10
3	**2**	Minor amendments to Trust name and Logo. Board Assurance Administrator	Re-issued	18.03.11
4		Full review. Elizabeth Hollman, Associate Director Healthcare Governance & Catherine Brown, Board Assurance Facilitator	Risk Monitoring Group	26.06.11
			Healthcare Governance Committee	12.07.11
			Trust Board	05.10.11
			Issued	24.05.11
4	**1**	Version 4 updated to reflect changes agreed by the Audit Committee in March 2012, and in the light of feedback from the NHS Litigation Authority. These changes constitute amendments to these versions rather than entirely new versions.	**Trust Board**	**30.05.12**
4	**2**	Formal Review	Audit Committee	**16.05.13**
			Risk Monitoring Group	**17.03.13**
			Healthcare Governance Committee	**07.05.13**
			Trust Board	**29.05.13**
5	0	Full Review	Trust Board	**November 2014**
5	1	Update to reflect organisational changes	Trust Board	

5	2	Annual Review	Trust Board	**May 2017**
5	3	Annual Review	Trust Board	**September 2018**

Associated documents

BHT Ref	Title	Location/Link
BHT S012	**Risk Management Strategy**	BHT Intranet/Trust Policies/ Corporate Policies, & CHB Intranet/Policies, Guidance & Procedures
		Swan Live Intranet/ Policies and Guidelines/ Policies and Strategies/ Corporate/Quality & Safety

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INTRODUCTION

The Trust is required (by statute and Department of Health and Social Care guidance) to systematically identify and control all significant strategic and operational risks. These arise across the organisation and include clinical services and corporate services. The Board is required to ensure that robust systems exist and be assured that there are systems in place to control and reduce risk.

This involves both the proactive identification and management of principal risks that may threaten the achievement of Trust objectives and the response to adverse events or learning from audits.

The purpose of the Risk Management Policy is to set out the process for achieving the Risk Management Strategy. The Risk Management Strategy sets out the overall plan and direction for Risk Management in the Trust.

This policy describes the mechanisms and responsibilities for:

- Identifying risk
- Assessing and evaluating risk in a consistent manner using the Trust's Risk Assessment Tool (RAT)
- Controlling risk
- Recording risk within the Trust's risk documents – namely the Board Assurance Framework, Corporate Risk Register and Divisional Risk Registers.

Definitions

Acceptable / Tolerable Risk	Tolerability is a willingness to live with risk to secure certain benefits but with the confidence that it is being properly controlled. To tolerate risk does not mean to disregard it, but rather that it is reviewed with the aim of reducing further risk. This may also be referred to as 'risk appetite'. It is a fundamental principle that no person should be exposed to serious risk unless they agree to accept the risk. It is reasonable to accept a risk that under normal circumstances would be unacceptable if the risk of all other alternatives, including doing nothing, is even greater.
Adverse Event	Any event or circumstance leading to unintentional harm or suffering.
Co-employer	Another employing organisation which has links with the Trust (e.g. Sodexo, Medirest, Clinical Commissioning Groups, South Central Ambulance Foundation Trust, Oxford Health NHS Foundation Trust etc.)
Control	A procedure or arrangement that is implemented to prevent a risk, reduce the potential impact of such a risk, or detect a failure of internal or external control when it happens.
External	Refers to activities or documents which do not originate in the Trust
Internal	Refers to activities or documents within the Trust.
Patient Safety Incident	Any unintended or unexpected incident which could have harmed or did lead to harm for one or more patients receiving healthcare. It is a specific type of adverse event.
Residual Risk	The lowest possible level of risk remaining after reasonable control measures / actions have been implemented.
Risk	A risk is the chance of something happening that will have an adverse impact on the achievement of the Trust's objectives and the delivery of high quality patient care. It comprises a combination of adverse consequence and likelihood.
Risk Assessment	Identification of significant hazards which arise out of Trust activities and a judgement of the likelihood and severity of harm which might occur as a result of exposure to the hazard.
Risk Assessment Training	Training delivered either by the Healthcare Governance Team or by the Director for Governance.

Risk Assessor	Member of staff (manager or other) who has received risk assessment training.
Risk Management	Risk Management is the proactive identification, classification, communication and control of risks to which the Trust is exposed through its day to day activities and through pressures from external sources.
Risk Moderation	This is a mechanism whereby a designated group reviews risks recorded on a risk register and takes a view as to whether the risk has been scored at the right level and scored consistently when compared with other risks. The group can make the decision to adjust the risk score on the basis of the review.
Senior Manager	Someone who plays a significant role in making decisions regarding the management of the whole or a significant part of the organisation's activities and those who carry out those activities. This includes, but is not limited to, all managers who report to a Director.
Trust	Buckinghamshire Healthcare NHS Trust

SECTION ONE: OPERATIONAL RISK MANAGEMENT

THE CORPORATE RISK REGISTER

1. Identification and Control of Operational Risks

1.1. Identifying Potential Risks

Potential risks can be identified from a variety of sources for example:

- Internally generated information such as departmental meetings, internal audits, external audits, clinical audits, incidents reports, complaints, claims
- Externally generated information such as guidance from the Department of Health, the Care Quality Commission, the Health and Safety Executive and the Royal Colleges
- External inspections

Senior Managers should note that they have a duty within their areas of responsibility to:

- Identify risk
- Assess risk
- Establish risk management processes within their areas of responsibility
- Allocate appropriate staff and resources to manage risk
- Control risks where possible and escalate to Executive Management Committee where risks are not controlled
- Maintain a risk register ensuring that it reflects a full range of risks and is up-to-date
- Communicate risks to staff

1.2. Risk Assessment and Evaluation

Risks must be assessed and graded using a common matrix (the National Patient Safety Agency [NPSA] risk matrix shown in Appendix A). Grading shall take into account **all existing controls** (e.g. fire alarm detection, maintenance, contracts, protocols, training etc) and the effectiveness of these controls (e.g. how up-to-date the training is, when the last fire drill took place).

Grading requires skill and relevant knowledge, and involves the following process:

i) Determine the potential adverse consequence (also known as severity or impact) as objectively as possible and identify the most appropriate consequence score

ii) Determine the likelihood of this adverse consequence taking place, as objectively as possible, and identify the most appropriate likelihood score taking into account the existing controls

iii) Multiply the consequence score by the likelihood score to give the risk score.

Risk Assessments are carried out using the Risk Assessment Tool. A risk assessment may be carried out by any member of staff, preferably with risk assessor training, and must be signed off by a manager. It is the role of the manager to determine whether the current controls are sufficient to manage the risk at to its lowest level, or whether further actions are required to reduce the risk level in which case this should be communicated and escalated through the risk register.

Risks scored at 15 or above (extreme) should be escalated to a senior manager for review and where the level of risk has been confirmed by a senior manager this should be immediately brought to the attention of the appropriate Executive Director at the time of recording the risk on the risk register.

The Trust's Risk Assessment Tool is shown in Appendix A.

Copies of the completed RAT's should be held by the manager responsible for the area where from which the risk has emerged.

1.3. Reducing the Risk

The purpose of identifying and assessing risk is to ensure that measures are put in place to reduce the risk to the **residual risk** level.

Table indicating level of risks and acceptable timescales for commencing action:

Table 1: Timescales for commencing action

Level of Risk	**Target time for commencing action**
Extreme (15-25)	**Immediately or within 48 hours**
High (8-12)	Up to two weeks
Moderate (4-6)	Up to 6 weeks
Low Risk (1-3)	**Up to 12 weeks**

2. Recording Risks on a Risk Register

In the case where following identification, assessment and initial control of a risk, the risk controls are not holding the risk at the lowest level of residual risk this must be included within the relevant risk register and accompanying actions should be recorded. To minimise

administration 'low' risks do not need to be included in the register. There is a hierarchy of risk registers used in the organisation as shown on the diagram below. More detail about the management of these registers is shown in the following sections.

Diagram 1: Hierarchy of risk registers

2.1. Service Delivery Unit Risk Registers

Risks identified at Service Delivery Unit (SDU) or ward level should be recorded by a Senior Manager on a Service Delivery Unit Risk Register. There is a standardised format for this register. Review of the SDU Risk Register should take place on a monthly basis at the SDU clinical governance meeting and therefore is included on the standardised agenda template for these meetings. The SDU lead is accountable for ensuring that there is a process within the SDU for identifying and managing risk.

2.2. Divisional Risk Registers

The Divisional Chair, Divisional Directors and Divisional Chief Nurses should have sight of the SDU risk registers and ensure that risks scored at 12 or above are recorded on the Divisional Risk Register. Other risks may also be recorded if the Divisional Board deems this to be appropriate. The Divisional leads may delegate the function of managing the risk registers to the Divisional Governance Facilitator but remain accountable for ensuring that risks are being identified and managed across the Division.

Divisional Risk Registers should be **moderated** at Divisional Board meetings. The work associated with this may be carried out in Divisional Quality Meetings but the Divisional Board should be aware of the range and scale of risks in the Division.

The Divisional Risk Registers will be included in the Divisional Performance Reviews as one mechanism to ensure the quality of the document.

Divisional Risk Registers are accessible to all senior managers, clinical governance leads, lead clinicians and matrons in a shared drive entitled 'directorate risk registers'. Access and administration of this drive is managed by the Director for Governance.

Each Division will present their Divisional Risk Register to the Quality Committee on an annual basis as part of a rolling programme.

Each Division will present risks relating to finance, operational delivery and workforce to the Finance and Business Performance Committee on an annual basis as part of a rolling programme.

2.3. Corporate Service Risk Registers

Each Executive Director is accountable for assessing and managing risk associated with their corporate service. By nature of their business many of these risks will be strategic and this is covered in Part 2 of the risk policy. However some corporate services have very specific operational risks and these risks will be recorded on the Corporate Service Risk Register.

2.4. Corporate Risk Register

The Director for Governance will on a monthly basis identify all risks scored at 15 or above on the Divisional and Corporate Service risk registers and will bring these to the attention of the Risk and Compliance Monitoring Group on a monthly basis. The Terms of Reference for this group are shown in Appendix B. The Risk and Compliance Monitoring Group will review the Corporate Risk Register and make recommendations to the Executive Management Committee to guide its moderation of the document. The Group has a role in cross organisational challenge at service level with a view to continuous improvement in the way risk is presented and managed in the organisation. The risk discussion will not be limited to risks currently showing on the registers but a wider consideration of whether there are known risks which have not yet been recorded on the risk documentation and should therefore be included.

The Executive Management Committee for consideration as to whether the risk should be included on the Corporate Risk Registers. Other risks not at the extreme level but having a wider organisational impact will also be considered by the Executive Management Committee.

The Corporate Risk Register will be **moderated** on a monthly basis by the Executive Management Committee (EMC) including all risks scored at 15 or above on divisional/corporate service risk registers. The risk discussion will not be limited to risks currently showing on the registers but a wider consideration of whether there are known risks which have not yet been recorded on the risk documentation and should therefore be included.

The moderated version of the Corporate Risk Register (CRR) will be submitted to the Quality and Clinical Governance Committee, Finance and Business Performance Committee and the Audit Committee on a bi-monthly basis.

Top risks from the Corporate Risk Register will also be reported to the Trust Board at least four times a year.

In some cases it is clear that an operational risk showing on the CRR has significant implications for the delivery of a Trust Objective. In these cases consideration will be given by EMC as to whether a related strategic risk should be recorded on the Board Assurance Framework.

SECTION TWO: STRATEGIC RISK MANAGEMENT

THE BOARD ASSURANCE FRAMEWORK

3. Identification and Control of Strategic Risks

3.1. Assessing Strategic Risk

The Board agrees a set of Corporate Objectives on an annual basis as the means by which the overall Vision and Strategy of the organisation will be achieved. Each of these Corporate Objectives is allocated an Executive Director lead.

Working with the Director for Governance each Executive Director will identify the controls in place to ensure delivery of their Corporate Objectives and the sources of assurance that these controls are working effectively. This information should be recorded on the Board Assurance Framework for each Corporate Objective.

In consideration of the relevant controls and assurances the Executive Director will then determine the risk to delivery of the Corporate Objectives for which they are the lead and this shall be recorded on the Board Assurance Framework.

3.2. Moderating the Board Assurance Framework

The Board Assurance Framework will be moderated by the Executive Management Committee at least 4 times a year.

3.3. Communicating Strategic Risk

The Board Assurance Framework (BAF) will be submitted to the Audit Committee at least four times a year for consideration. As part of the review process individual Executive Directors will be invited to the Audit Committee to present a ‘deep dive’ on the assurances recorded against individual Corporate Objectives.

The Trust Board will receive the Board Assurance Framework at least four times a year.

TRAINING

4. Levels of risk training available to staff

4.1. Training for Board members

Risk training for Board members will be provided through the Board Development Programme at least annually and will be reinforced through risk discussions at Board and Committees.

Where individual members of the Board have not attended risk training within a 12 month period the Director for Governance will liaise with the individual Board member to provide training.

The Director for Governance is available to provide training on an individual basis to any member of the Board on request.

4.2. Training for Managers and Clinicians

Training for senior managers will be provided by the Director for Governance at the request of any of the Divisional leads or the Governance Co-ordinator. This training will focus on risk assessment and communication.

The Director for Governance will review the entire divisional risk register with at least one of the Divisional leads on a quarterly basis and provide feedback and support in relation to risk management processes.

4.3. Training for Health and Safety Risk Assessors

Health and Safety risk assessors will be trained through the Risk Assessor Training Course run by the Health and Safety Facilitator with the support of the training department.

Divisional leads will be asked to confirm on an annual basis to the Director for Governance that they have sufficient numbers of trained risk assessors to identify, assess and report risks.

In the case of non compliance with attendance at training the Director for Governance will escalate this to the Chief Operating Officer to deal with through the performance monitoring route.

4.4. Training for All Staff

All staff will receive risk related training as part of induction and annual statutory training. This will be monitored through annual appraisal.

Line managers are responsible for ensuring that their staff have fulfilled all their statutory training requirements each year and for escalating through a disciplinary route where there is persistent non-compliance.

MONITORING THIS POLICY

The Board Assurance Framework will be the subject of an Internal Audit on an annual basis.

Risk management processes are audited on an annual basis by Internal Audit.

The Audit Committee reviews the level of assurance provided by these audits, and through a series of 'deep dives'.

This policy will be reviewed every year.

APPENDICES

APPENDIX A: RISK ASSESSMENT TOOL

(This can also be downloaded from the Intranet in a Word version http://swanlive/policies-guidelines/healthcare-governance-0)

Generic Risk Assessment Tool (April 2017)

Section 1 – Understanding the Risk	
Name of Person Completing the Risk Assessment	
Job role of Person Completing the Risk Assessment	
Date Risk Assessment Completed	
Subject of the Risk Assessment	
Where is the Risk?	
What are the potential negative consequences / impacts from this Risk?	

Using the NPSA Risk Matrix, identify a numerical score for consequence / impact.	
What do you have in place already to prevent the potential negative outcome from this risk? (Controls)	
Taking into account the controls you already have in place, what is the likelihood of the negative consequence that you have identified actually occurring?	
Using the NPSA Risk Matrix, identify a	

numerical score for the likelihood.	
Record the total risk score (Consequence score x Likelihood score)	
Section 2 – Management review of risk	
Name of manager reviewing the risk	
Job role of manager reviewing the risk	
Date manager reviewed risk assessment	
Are there any gaps in control? If yes, please list them. If no, please record that the risk is at its lowest level and does not need to go on the risk register. If no, the rest of this tool does not need to be completed.	

What actions will you initiate to address the gaps in control?	
Who is leading on these actions?	
When will these actions be complete?	
What score do you think this risk could be reduced to once gaps in control are eliminated? (Residual risk score)	
Who is responsible for monitoring delivery of the actions?	
When will the risk next be reviewed?	

Date added to risk register and risk register reference.	
Section 3 – Final risk sign off	
Date risk signed off as reaching residual risk score.	
Name of manager signing off risk for removal from the register.	

	Consequence Score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million

Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur <0.1 %	Do not expect it to happen/recur but it is possible it may do so **<0.1 – 1%**	Might happen or recur occasionally 1 – 10%	Will probably happen/recur but it is not a persisting issue **10 – 50%**	Will undoubtedly happen/recur,possibly frequently >50%

Appendix A continued

Risk Scoring Matrix

	Severity				
Likelihood	**1** **Insignificant**	**2** **Minor**	**3** **Moderate**	**4** **Major**	**5** **Catastrophic**
1 Rare	**1**	**2**	**3**	**4**	**5**
2 Unlikely	**2**	**4**	**6**	**8**	**10**
3 Possible	**3**	**6**	**9**	**12**	**15**
4 Likely	**4**	**8**	**12**	**16**	**20**
5 Almost Certain	**5**	**10**	**15**	**20**	**25**

Target Times for Controls

Level of Risk	**Target Time for Commencing Controls**
Extreme (15-25)	Immediately or within 48 hours
High (8-12)	Up to 2 weeks
Moderate (4-6)	Up to 6 weeks
Low Risk (1-3)	Up to 12 weeks

RISK AND COMPLIANCE MONITORING GROUP TERMS OF REFERENCE v1 November 2017

Reports to: Executive Management Committee Chaired by: Director for Governance

<table>
<tr>
<td><u>Meetings:</u>
Every calendar month
2 hours long
Monitor information, make recommendations to EMC, take action</td>
<td><u>Purpose:</u>
The overarching purpose of this group is to provide a forum where executive directors, divisional and departmental representatives can review compliance with legislation including CQC standards, review the outputs of risk processes, and take actions to improve or make recommendations to the Executive Management Committee.</td>
</tr>
<tr>
<td><u>Members:</u>
Director for Governance (Chair)
Chief Operating Officer (Deputy Chair)
Chief Nurse (or representative)
Divisional lead from each Division
(either Chair, Director or Chief Nurse, or a deputy)
Property Services Risk Manager
Head of Medical Records
Head of Midwifery
Head of Patient Safety and Litigation
Chief Pharmacist
Head of Allied Health Professionals
Emergency Planning Officer
Others by invitation depending on agenda

<u>Quorum:</u> one executive director, two reps from clinical divisions and one departmental rep from the corporate division</td>
<td><u>Duties:</u>
Compliance
Monitor compliance against self-assessments
Prepare for information request for the CQC
Prepare for external reviews
Oversight of compliance against statutory requirements, including CQC regulatory standards
Oversight of Health and Safety compliance
Support co-ordination of inspection preparation
Annual review of minutes

Risk
Challenge around length of time to resolve risks
Recommendations to Executive Management Committee on moderating the Corporate Risk Register
Understand organisational risk gaps
Voice of clinical services in informing the Corporate Risk Register</td>
</tr>
</table>

Success Criteria:	**Outputs:**
Improved assurance of compliance with legislation Better quality risk registers – division, department, corporate Evidence of effective risk management	Record of actions Record of decisions Notes to EMC through the Chair
Inputs: Minutes of Health and Safety Committee Corporate Risk Register Divisional Risk Registers External review register	**Method of working** Culture of openness and frank discussion and challenge with a solution focus Trust values will be adhered to and the group will be mutually supportive Paper at each meeting containing Corporate Risk Register and highlighting risks scored at 15 or above on Divisional and Corporate Service Risk Registers (EH) Rotation of review of each Division's risk register