Sussex Community NHS
NHS Foundation Trust

Risk Management Strategy & Policy

2016-2017

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Document Approval.

Date	Approval committee	Chair	Role
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1.0 INTRODUCTION

1.1 An understanding of the risks that face NHS Foundation Trusts is crucial to the delivery of healthcare services moving forward. The business of healthcare is by its nature, a high-risk activity and the process of risk management is an essential control mechanism. Effective risk management processes are central to providing Sussex Community NHS Foundation Trust (SCFT) Board with assurance on the framework for clinical quality and corporate governance.

1.2 The stated vision for Sussex Community NHS Foundation Trust is to provide excellent care at the heart of the community. To ensure that the care provided at SCFT is safe, effective, caring and responsive for patients, the board must be founded on and supported by a strong governance structure.

1.3 SCFT is committed to developing and implementing a risk management strategy that will identify, analyse, evaluate and control the risks that threaten the delivery of its critical success factors. By definition, the risk management strategy is also a policy on the management of risk that every member of staff must support. The board assurance framework (BAF) will be used by the Board to identify, monitor and evaluate risks to the achievement of the strategic objectives. It will be used alongside other key management tools, such as performance and quality dashboards, and financial reports, to give the Board a comprehensive picture of the organisational risk profile.

1.4 The management of risk underpins the achievement of the Trust's objectives. SCFT believes that effective risk management is imperative to not only provide a safe environment and improved quality of care for service users and staff, it is also significant in the financial and business planning process where a successful and competitive edge and public accountability in delivering health services is required. This illustrates that risk management is the responsibility of all staff.

1.5 The risk management process involves the identification, evaluation and treatment of risk as part of a continuous process aimed at helping the Trust and individuals reduce the incidence and impacts of risks that they face. Risk management is therefore a fundamental part of both the operational and strategic thinking of every part of the service delivery within the organisation. This includes clinical, corporate, business and financial risks.

1.6 The Trust is committed to working in partnership with staff to make risk management a core organisational process and to ensure that it becomes an integral part of the Trust philosophy and activities. The risk management strategy and policy represents a developing and improving approach to risk management which will be achieved by building and sustaining an organisational culture, which encourages appropriate risk taking, effective performance management and accountability for organisational learning in order to continuously improve the quality of services.

1.7 The Trust Board recognises that complete risk control and/or avoidance is impossible, but that risks can be minimised by making sound judgments from a range of fully identified options and having a common understanding at Board level on risk appetite.

1.8 As part of the Annual Governance Statement, SCFT will make a public declaration of compliance against meeting risk management standards. The Trust currently has good

systems and process for risk management in place as evidenced by internal and external audit opinion.

1.9 The risk management strategy and policy is subject to annual review and approval by the Trust Board.

2.0 PURPOSE OF THE RISK MANAGEMENT STRATEGY AND POLICY

2.1 The purpose of the risk management strategy and policy is to detail the Trust's framework within which the Trust leads, directs and controls the risks to its key functions in order to comply with Health and Safety legislation, Monitor/NHS Improvement (NHS I) Terms of Authorisation, key regulatory requirements such as Care Quality Commission, and its strategic objectives. In March 2016, SCFT was successful in achieving 'Foundation Trust' status. This strategy and policy incorporates systems to maintain compliance with the provider licence standards and NHS I risk assessment framework.

2.2 The risk management strategy and policy underpins the Trust's performance and reputation, and is fully endorsed by the Trust Board.

3.0 RESPONSIBILITY FOR RISK MANAGEMENT

3.1 The success of the risk management strategy and policy is dependent on the defined and demonstrated support and leadership offered by the Trust Board as a whole.

3.2 The day-to-day management of risk is the responsibility of everyone in the organisation. The identification and management of risks requires the active engagement and involvement of staff at all levels. The staff are best placed to understand the risks relevant to their areas of work and must be enabled to manage these risks, within a structured risk management framework.

4.0 PROMOTING A FAIR AND OPEN CULTURE

4.1 All members of staff have an important role to play in identifying, assessing and managing risk. To support staff the Trust provides a fair, open and consistent environment which does not seek to apportion blame. In turn, this will encourage a culture and willingness to be open and honest to report any situation where things have, or could go wrong. Exceptional cases may arise where this is clear evidence of wilful or gross neglect contravening the Trust's policies and procedures and/or gross breaches of professional codes of conduct which will be managed and referred accordingly.

5.0 OBJECTIVES OF THE STRATEGY (2016 – 2017)

5.1 The risk management strategy has the aim of achieving well managed risks so that the SCFT vision of excellent care in the heart of the community can be realised. To achieve this aim SCFT has a series of objectives to be achieved in 2016-2017:-

- To ensure all risks, including clinical risks, service development risks, corporate risks and project risks are being identified through a comprehensive and informed risk register and risk assessment process.
- To ensure the open reporting of adverse events (incidents) is encouraged and learning is shared throughout the organisation.
- To monitor the effectiveness of the risk management strategy and policy via the monitoring of agreed key performance indicators (e.g. incidents, complaints etc) and key risk indicators specific to the effectiveness of a control.
- To further develop the organisational safety culture and its effectiveness through implementation of Sign up to Safety and Patient Safety Collaborative interventions.
- To continue to develop and implement the annual risk management plan.
- To ensure that all individuals within the organisation are aware of their role, responsibilities and accountability with regard to risk management (e.g. through training and direct support from the risk management team).
- To ensure that the structure and process for managing risk across the organisation is reviewed and monitored annually.
- To ensure compliance with NHS I, Care Quality Commission registration requirements, and Health and Safety Standards.
- To develop a culture where risk management is integrated into all Trust business;
- To reduce risks to patients, carers, staff, sub-contractors, members of the public, visitors etc to an acceptable level.
- To minimise financial liability.
- To provide a system, which integrates into the planning and performance management frameworks to minimise duplication whilst adding value.
- To successfully introduce the new risk management reporting system, 'Datix' to every service in the Trust.

6.0 COMPLIANCE AND ASSURANCE

6.1 NHS I has a very clear compliance framework which ensures that all NHSFTs are able to demonstrate that they are remaining within their agreed provider licence. It is therefore imperative that the Trust is aware of any risks (e.g. associated with new business or service changes) which may impact on its ability to adhere to this framework.

6.2 The Board Assurance Framework (BAF) provides the Trust Board with a vehicle for satisfying itself that its responsibilities are being discharged effectively. It will inform the Board where the delivery of strategic goals is at risk due to a gap in control and/or assurance. This allows the organisation to respond rapidly.

6.3 All NHS bodies are required to sign a full Annual Governance Statement (AGS) and must have the evidence to support this Statement. The BAF brings together this evidence.

6.4 In order to identify the risks against delivery of strategic goals and gaps in control/assurance the Trust Board must have a comprehensive Performance Management Reporting framework. The Trust Board must agree its own indicators for Performance Reports which will act as assurance on service delivery and quality. Any

significant gaps in assurance or control within the performance reports must be identified and translated onto the BAF and remedial action agreed.

6.5 The Trust board undertake a high level review of the BAF on a quarterly basis. The BAF identifies the principal risks facing the Trust and informs the Trust Board how each of these risks is being managed and monitored effectively. Each principal risk has an identified local risk manager, normally an Executive Director, who is responsible for managing and reporting on the overall risk. The Audit Committee carries out a detailed review of the BAF quarterly to assure the Trust Board that it is being monitored, gaps in controls identified, and processes put into place to minimise the risk to the organisation.

6.6 The designated Assurance Committees of the Trust Board are the Quality Committee (Quality Risk), the Finance and Investment Committee (Financial Risk), and the Audit Committee (internal audit)

6.7 It is the responsibility of the Assurance Committees to report to the Trust Board any new risks identified, gaps in assurance/control, as well as positive assurance on an exception basis. If a significant risk to the Trust's service delivery or gap in control/assurance is identified then this should be reported immediately via the Executive Directors.

6.8 It is important for the Trust Board to be able to evaluate the quality and robustness of the BAF and to have arrangements in place to keep it updated in light of evidence from reviews and actual achievements. For consistency, the Patient Safety and Risk Manager attends the Executive Leadership Team (ELT) quarterly to review and update the BAF along with the high level Risk Register consisting of those risks scoring 15 and above.

6.9 The Patient Safety and Risk Manager shall continue to work closely with the Medical Director (Executive lead for risk), Company Secretary and other Directors to ensure that the document remains dynamic and is integral to the Business Planning cycle.

6.10 If at any time performance reporting and risk management processes indicate that the Trust will not meet a current or future regulatory requirement/target then the Board must notify NHS I via an exception report.

6.11 The Trusts processes align to the International Standard for Risk Management (Principles and Guidelines) ISO31000 and enable compliance with legislation, NHS Improvement and Care Quality Commission requirements. This includes the Health and Social Care Act 2012, Care Quality Commission (CQC) standards, NHS Foundation Trusts: Code of Governance 2014, Section C2: Risk Management and Internal Control; and Section 3 Risk Assessment, NHS Improvements - Risk Assessment Framework and Provider Licence Conditions.

6.12 The Trust also has statutory responsibilities for assessing and reducing risks under Health and Safety at Work Act 1973; and Management of Health and Safety at Work Regulations 1992 (amended 1999);

6.13 All leads with responsibility for elements of risk will ensure appropriate assurance systems are applied. Examples of internal assurance include committee monitoring reports, self-assessment processes, internal audit reports and the Trust's quarterly and annual risk reports. External assurance examples include CQC assessment outcomes, reports from NHS Improvement and external audit outcomes.

7.0 THE TRUST RISK REGISTER

7.1 Each service will continue to carry out risk assessments which feed into the service Risk Registers. A single framework for the assessment, rating, and management of risk is used throughout the Trust; this process is described in detail within the Risk Management Policy section of this document. The service risk register is reviewed at the monthly service management team meetings.

7.2 Each division will continue to maintain a comprehensive risk register, which will be formally reviewed at monthly divisional management team meetings. At these meetings the division will be expected to report on their risk register (risks scoring 8 or above), highlight any new or emerging risks to service delivery and present action plans for minimising and managing these risks. The divisional management team meeting should identify those departmental risks which also pose a corporate threat and so require escalation to the Trust Wide Clinical Governance Group and if appropriate to the Executive Leadership Team. The risk register should be seen as a dynamic process as ranking/prioritisation of risks will change as risk reduction practices take place. The DMT has responsibility for ensuring that all risks within the division are appropriately graded and have sufficient actions in plan to mitigate/reduce the risk.

7.3 All risks scoring 12 or more will be reviewed monthly by the DMT with any risks requiring escalation reviewed monthly at the Trust Wide Clinical Governance Group meeting.

7.4 All risks scoring 15 or more will be reviewed monthly at the Executive Leadership Team Performance and Governance meeting.

7.5 The service and division risks identified at the service and divisional management team meetings which impact on the corporate objectives are combined with the corporate risks on the Trust Risk Register, thus allowing for a bottom up top down approach to identifying the Trust's principal risks and informing the BAF. This proactive approach to risk management should be holistic and identify all risks to the organisation, including clinical, organisational, health and safety, business, marketing and financial.

7.6 The Audit Committee shall receive the entire Risk Register annually along with the BAF quarterly.

8.0 RISK MANAGEMENT POLICY

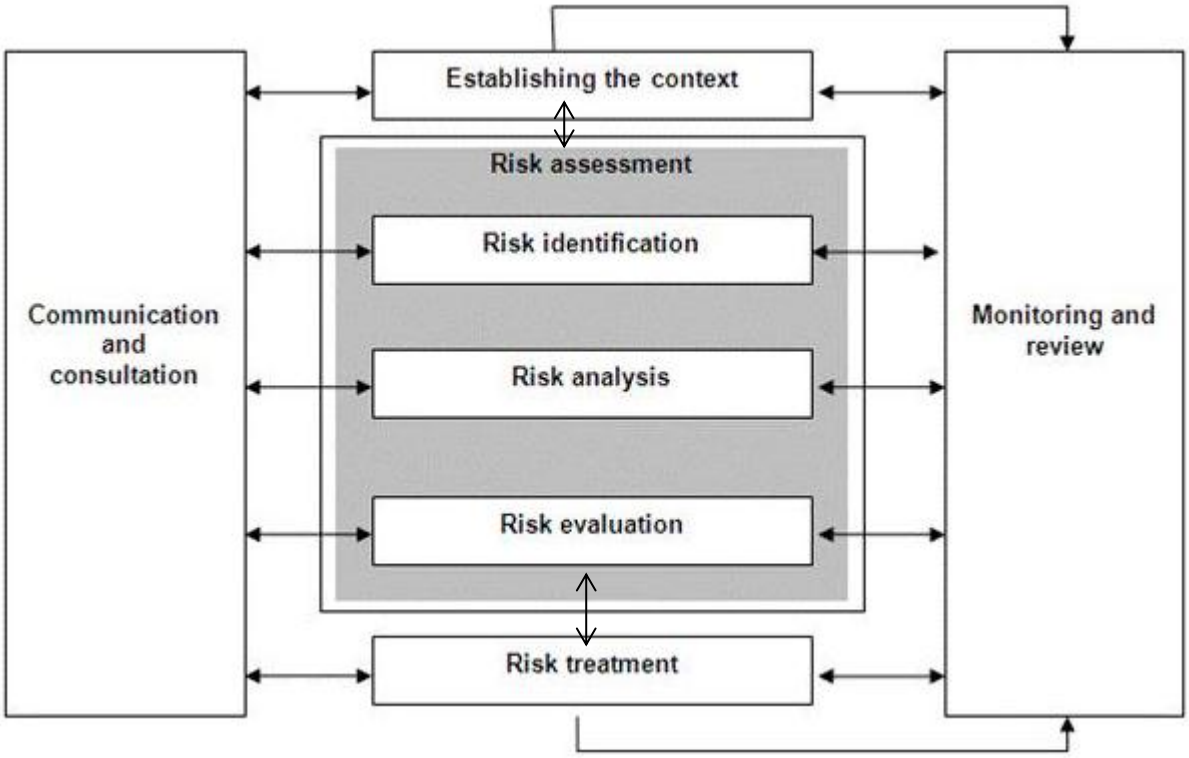
8.1 Risk assessments carried out across the Trust must utilise the format as set out in the Risk Management Policy. This process for submission and review must be adhered to.

8.2 The following section outlines the processes by which the Trust will implement its Risk Management Strategy. Please refer to Appendix 2 for process flowchart. The Trust's risk management processes include six stages:

a) Establish the context
b) Identify risks/issues (including classification)
c) Analysis (Risks - likelihood x severity / Issues – assess severity)
d) Evaluation (Identify the risk rating)

e) Treatment - Control the residual risk / Actions to address issues
f) Monitor and review

The above steps are based upon the risk management process as outlined by ISO31000 demonstrated in the diagram below:



8.3 Establishing context

Assessing all risks and issues should occur within the context of strategic and local objectives.

8.4 Identification

It is important that all staff are aware of the difference between a risk and an issue. All staff, with the support of their manager must determine if the situation is an:

(a) **Issue:** An actual event that has already occurred or is still occurring that may affect achievement of strategic or local objectives or generate other risks.
(b) **Risk:** The potential of an event occurring with the combined likelihood and consequence of harm, injury, damage or loss occurring or impacting the achievement of the Trust's objectives or strategic goals.

Identification of risks occurs via a number of mechanisms and may be both proactive and reactive from a number of sources, including but not limited to;

- Analysis of key performance indicators;
- Capital and service development projects;
- Change control processes.
- Claims, incidents, serious incidents and complaints;
- Clinical Risk Assessments;

- Contingency/Disaster recovery planning and exercising;
- Coroners reports;
- Environmental and workplace risk assessments;
- Equipment and system malfunction or failure;
- Equipment purchase/modification;
- Information Governance Toolkit;
- Internal and External reviews, visits, inspections, audits and accreditation;
- National recommendations;
- New legislation and guidance;
- Preventative maintenance issues;
- Risk assessment of everyday operational activities, especially when there is a change in working practice or environment;
- Safety alerts (e.g. Central Alerting System and NSH protect)
- Staff and patient surveys; and
- Raising Concerns Policy;

Staff should discuss all risks or issues identified with line managers and together objectively define it using simple and unambiguous language, ideally, using no more than one or two sentences.

8.5 Classification:

The manager should determine the primary risk sub-type (area of impact)

Sub Type	Definition
Strategic	These relate to risks or issues which could impact the strategic objectives of the trust
Financial	These relate to risks or issues which could impact income, expenditure fulfilment of contracts, commercial application of procurement and financial instructions
Operational	These relate to risks or issues regarding meeting terms of contract, service continuity etc
Quality	These relate to risks which could impact patient safety, patient experience, clinical outcomes
Regulatory	These relate to risk that could impact on-going compliance with regulation including Health and Safety, medicines management, medical devices
Reputational	These relate to risks which may cause significant repercussion for the organisation

Classification of a risk can vary depending on context with some risks falling into more than one category. To ensure a consistent approach the risk team provide advice and support in determining risk sub type and any cross reference to related risks if required.

8.6 Risk Analysis and Evaluation

Risk analysis and evaluation involves developing a further understanding of the risk to enable an evaluation of how the risk should be treated. As such, risk analysis involves the consideration of the causes and sources of the risk, their positive and negative consequences and the likelihood that those consequences may occur.

Ideally, risk analysis should be an objective process and wherever possible should draw on independent evidence and valid quantitative data. However, it is recognised that such evidence and data may not be available to the assessor(s), who will be required to make a subjective judgement. When facing uncertainty, the assessor(s) should take a conservative approach.

8.7 Risk scoring

In order to ensure consistency of risk quantification across the Trust a standardised set of descriptors and scoring matrices (based upon the Australian/New Zealand Standard AS/NZS 4360:2004) will be used for risk analysis.

The risk score is based upon the consequence of a risk and the likelihood of it being realised;

Consequence x Likelihood = Risk Score

The Trust uses three risk scores during the management of risks;

Initial Risk Score
The score when the risk was first identified and is assessed with existing controls in place. This score will remain unchanged for the lifetime of the risk and is used as a benchmark against which the effect of risk mitigation can be measured

Current Risk Score
This is the score at the time the risk was last reviewed in line with the set review dates. It is expected that the current risk score will reduce and move toward the Target Risk Score as action plans and mitigating actions are developed and implemented.

Target Risk Score
The score that is expected to be reached after the action plan and mitigating actions have been fully implemented to enable the risk to be reduced to a level, which is tolerable.

Scoring the Consequence
Consequence must be scored using the Table of Consequences, with existing controls in place. The Trust provides a number of domains for consideration; where there are multiple domains to be considered the highest consequence should be used.

	Consequence Score and Descriptor				
	1	**2**	**3**	**4**	**5**
Domain:	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Injury or harm Physical or Psychological	No/ minimal injury requiring no / minimal intervention or treatment No Time off work required	Minor injury or illness requiring intervention Requiring time off work < 4 days Increase in length of care by 1-3	Moderate injury requiring intervention Requiring time off work of 4-14 days Increase in length of care by 4-14 days RIDDOR / agency reportable incident	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days	Incident leading to fatality Multiple permanent injuries or irreversible health effects
Quality of Patient Experience / Outcome	Unsatisfactory patient experience not directly related to the delivery of clinical care	Readily resolvable unsatisfactory patient experience directly related to clinical care.	Mismanagement of patient care with short term affects <7 days	Mismanagement of care with long term affects >7 days	Totally unsatisfactory patient outcome or experience including never events.
Statutory	Coroners verdict	Coroners verdict of	Police investigation	Coroners verdict of	Coroners verdict of

Domain:	Consequence Score and Descriptor				
	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
	of natural causes, accidental death or open No or minimal impact of statutory guidance	misadventure Breech of statutory legislation	Prosecution resulting in fine >£50K Issue of statutory notice	neglect/system neglect Prosecution resulting in a fine >£500K	unlawful killing Criminal prosecution or imprisonment of a Director/Executive (Inc. Corporate Manslaughter)
Business / Finance & Service Continuity	Minor loss of non-critical service Financial loss of <£10K	Service loss in a number of non-critical areas <6 hours Financial loss £10-50K	Service loss of any critical area Service loss of non-critical areas >6 hours Financial loss £50-500K	Extended loss of essential service in more than one critical area Financial loss of £500k to £1m	Loss of multiple essential services in critical areas Financial loss of >£1m
Potential for patient complaint or Litigation / Claim	Unlikely to cause complaint, litigation or claim	Complaint possible Litigation unlikely Claim(s) <£10k	Complaint expected Litigation possible but not certain Claim(s) £10-100k	Multiple complaints / Ombudsmen inquiry Litigation expected Claim(s) £100-£1m	High profile complaint(s) with national interest Multiple claims or high value single claim .£1m
Staffing and Competence	Short-term low staffing level that temporarily reduces patient care/service quality <1day Concerns about skill mix / competency	On-going low staffing level that reduces patient care/service quality Minor error(s) due to levels of competency (individual or team)	On-going problems with levels of staffing that result in late delivery of key objective/service Moderate error(s) due to levels of competency (individual or team)	Uncertain delivery of key objectives / service due to lack of staff Major error(s) due to levels of competency (individual or team)	Non-delivery of key objectives / service due to lack/loss of staff Critical error(s) due to levels of competency (individual or team)
Reputation or Adverse publicity	Rumours/loss of morale within the Trust Local media 1 day e.g. inside pages or limited report	Local media <7 days coverage e.g. front page, headline Regulator concern	National Media <3 days coverage Regulator action	National media >3 days coverage Local MP concern Questions in the House	Full public enquiry Public investigation by regulator
Compliance Inspection / Audit	Non-significant / temporary lapses in compliance / targets	Minor non-compliance with standards / targets Minor recommendations from report	Significant non-compliance with standards/targets Challenging report	Low rating Enforcement action Critical report	Loss of accreditation / registration Prosecution Severely critical report

Scoring the Likelihood

Likelihood must be scored using the Table of Likelihood, with existing controls in place.

Table of Likelihood			
Descriptor	Score	Frequency	Probability
Rare	1	This will probably never happen / recur	> 1 in 100,000
Unlikely	2	Do not expect it to happen / recur but it may	> 1 in 10,000
Possible	3	Might happen / recur occasionally	> 1 in 1,000
Likely	4	Will probably happen / recur but it is not a persistent issue	> 1 in 100
Almost Certain	5	Will undoubtedly happen / recur, possibly frequently	> 1 in 10

8.8 Risk rating

Once the Consequence and Likelihood have been determined, the over-all risk score can be measured using the Risk Score Matrix:

Risk Score Matrix					
	Likelihood:				
Consequence:	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost Certain (5)
Insignificant (1)	1	2	3	4	5
Minor (2)	2	4	6	8	10
Moderate (3)	3	6	9	12	15
Major (4)	4	8	12	16	20
Catastrophic (5)	5	10	15	20	25

Risk rating makes evaluation of the risk easier with reference to the divisional and/or Trust wide risk profile; providing a systemic framework by which to identify the level at which risks will be managed, prioritising remedial action and availability of resources to address risks.

Risk rating also allows the Trust to set its risk appetite, informs escalation processes including the urgency of action to mitigate the risk and clarifies ownership, reporting and oversight.

8.9 Controlling residual risk (Treatment)

Controlling (eliminating or reducing) residual risk involves identifying the target risk score and then identifying the range of options for treating risk, assessing these options, preparing treatment plans and then implementing them. In general, there are four potential responses to address a risk once it has been identified and assessed;

Tolerate
The risk may be considered tolerable without the need for further mitigating actions, for example the risk is rated low or the Trust's ability to mitigate the risk is constrained or if taking action is disproportionately costly.

In general the Trust will tolerate all risks scored 6 or less, which do not require further mitigating actions; however they must be regularly assessed and monitored, (at least annually) to identify any change in circumstances or scoring.

Where the decision to tolerate a risk is taken, consideration should be given to developing contingency arrangements for managing the consequences if the risk is realised.

Treat
This is the most common response to managing risks. It allows the Trust to continue with the activity whilst ensuring that mitigating actions are implemented to reduce the risk to a

tolerable level e.g. as low as reasonably practicable. In general, action plans will reduce the risk over time, but are unlikely to eliminate it.

It is important to ensure that mitigating actions are proportionate to the identified risk and give reasonable assurance that the risk will be reduced to a tolerable level. Once a tolerable level of risk has been reached, it should continue to be reviewed a minimum of annually to ensure that there has not been a change in circumstances or scoring.

It is the responsibility of the Divisional Management Team to ensure that action plans are suitable to reduce the risk with regular monitoring.

Transfer

In some circumstances, the risk may be transferred, for example through conventional insurance policies or by sub-contracting a third party to take the risk. This option is particularly suited to mitigating financial risks or risks to assets.

It is important to note that risks to the Trust's reputation cannot be transferred.

Terminate

In some circumstances, the only way to reasonably prevent the risk is to terminate the activity, which gives rise to the risk or by changing the way in which the activity is undertaken. Within the NHS, this option is limited as there are many activities, which have associated risks that are deemed necessary for the delivery of effective health care services.

8.10 Ownership

All new risks must be discussed with line management to ensure an appropriate risk owner is identified to hold over-arching responsibility for its management. The owner must be involved in the assessment and recording of the risk onto Datix; however, the owner may delegate the management through the implementation of controls and action plans as appropriate.

Identification of risk ownership should be commensurate to the level of assessment severity.

8.11 Escalation

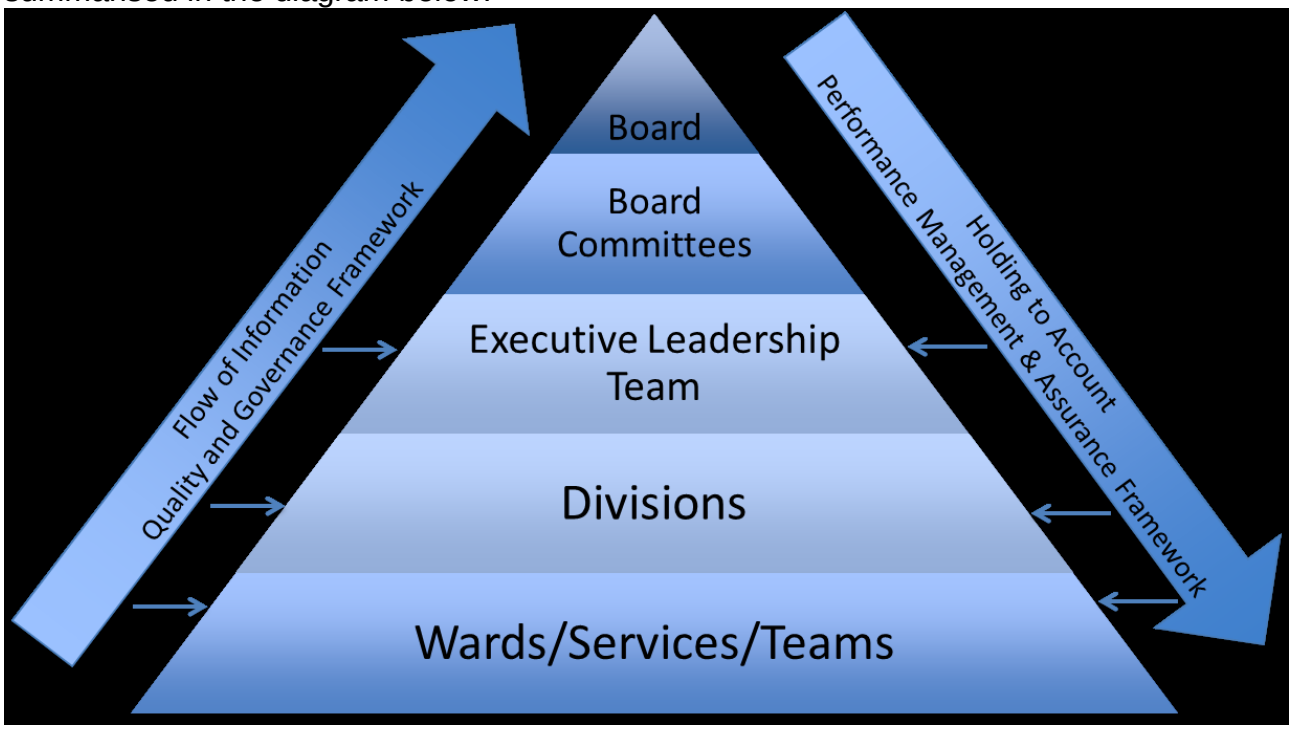
The Board assurance and escalation framework describes the Trust's governance structure enabling risks and issues to be managed at the appropriate level within the Trust, ensuring there is a committee/group or meeting with responsibility for providing assurance that risks have been suitably and effectively identified, assessed and documented.

The responsible group or committee will monitor and review all existing risks and issues This includes processes for the initial and ongoing review of validation of scoring, adequacy of controls, supporting action plans, agreement of target scores and timeframes and confirmation of the correct recording of the risk on the appropriate section of the Datix system. A summary of all new risks, changes in existing risks or risk closures will be included within assurance reports.

The committee/groups are also responsible for ensuring that all controls and actions are proportionate and implemented effectively.

It is the responsibility of the committee/group or meeting with responsibility for governance and monitoring to ensure appropriate escalation this includes escalation of any themes.

The organisational management of risk forms part of the Trust's overall approach to governance in accordance with SCFTs board governance and escalation framework, summarised in the diagram below:



8.12 Documentation (Datix)

The Trust records all risks onto the Trust's risk management system (Datix).

All risks scoring **12 and above** escalate to the Divisional Management Team and are reviewed by the Trust Wide Clinical Governance Group.

All risks scoring **15 and above** are immediately escalated to the corporate risk section and are reviewed by the Executive Leadership Team (performance and governance). These are closely monitored by the Board alongside the on-going review of the Board Assurance Framework.

To enable assessment of aggregated risk impact, where applicable the system allows for the cross reference to any related risks, issues and incident data contained within the system.

8.13 Specific Risk areas

8.13.1 Health and Safety Risks

Due to their specific nature, health and safety related risks must be recorded on the appropriate health and safety risk assessment form. Health and safety related risk

assessments forms will be retained locally and only health and safety risks scoring 8 or more will be added to the Operational section of Risk Register via Datix.

8.13.2 Patient Clinical / Individual Risks

Specific patient risks and those relating to individuals will be held locally (e.g. within patient records) using the appropriate assessment form/documentation and will not be entered into Datix.

8.13.3 Project / Programme Risks

Project / Programme Boards will record all risks and issues using the projects own internal documentation. For each overall project, a summary entry should be entered onto Datix. Any project/programme risks which impact outside the project itself scoring 12 or above will be added to the Operational section of Datix.

8.14 Risk Review

The process and timescales for reviewing risks are below. These should be recorded on the Datix system to ensure a documented audit trail.

8.14.1 Period of Review

Minimum periods for formal review have been set for all risks aligned to the risk score, more frequent review may be undertaken as necessary/required. Where a risk may require less frequent review this may be approved (and included within minutes) of the overseeing committee or group.

Score	Level	Review Period	Recommended action
15-25	High	Monthly Review	Inform Executive lead & Patient Safety and Risk manager. Risk not acceptable Action plan required to eliminate, reduce /control risk Significant resources may be required to reduce risk to a tolerable level
12	Moderate	Monthly Review	Inform Divisional Leader/s & Head of Service & Patient Safety and Risk Manager. Risk not acceptable Action plan required to eliminate, reduce /control risk
8-10	Moderate	Two Monthly Review	These risks must be recorded to agree tolerability Where additional reasonably practicable controls are identified the risk is unacceptable until they have been implemented
1-6	Low	Six Monthly Review	Monitor risk to ensure that controls are maintained and risk are acceptable
Tolerable	Closed	Annual Review	Ensure mitigations remain effective

8.14.2 Process for reviewing a Risk/Issue

When undertaking the risk review the following should be considered;

Consideration	Description/Question	Impact/Outcome
Risk Description	Is the risk still the same or has it changed?	Risk updated to reflect the new nature of the risk or a new risk raised
Realisation of the risk	Has the risk occurred? To what extent?	Move to Issues Log and consider any new risks as a result of the risk occurring
Incidents, Complaints or Claims	Have there been related incidents, complaints or claims? or has the number of incidents, complaints or claims increased/decreased?	May change the Likelihood Score or Consequence Score
Control Effectiveness	Are the controls put in place effective in reducing the risk?	Change of consequence or likelihood score
Completed Actions & Effectiveness	Have mitigating actions been completed? If so how effective are they in reducing the risk?	Change to consequence or likelihood score
Consequence Score	Has the likelihood or consequence changed?	Change to consequence or likelihood score
Tolerable Score	Is the tolerable score still achievable or has it been reached?	Change to tolerable score or closure of risk.

9.0 RISK APPETITE

9.1 Introduction

9.1.1 This Trust's Risk Management Strategy sets out the process for the annual review of the Trust's Risk Appetite Statement. The Risk Appetite Statement was formally approved by the Board in June 2016.

9.1.2 The Board Assurance Framework sets out the risks to achieving the strategic objectives of the board. The Board regularly reviews the risks and the risk scoring on the BAF which helps to inform the risk appetite of the Board. The Board has discussed it's risk appetite at Board Seminar.

9.2 Definition of Risk Appetite

The amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time.
(HM Treasury - 'Orange Book' 2006)

The risk appetite of the Trust is the decision on the appropriate exposure to risk it will accept in order to deliver its strategy over a given timeframe. In practice, an organisation's risk appetite should address several dimensions:

- The nature of the risks to be assumed;
- The amount of risk to be taken on;
- The desired balance of risk versus reward;

On an annual basis the Trust will publish its risk appetite statement as part of this Risk Management Strategy and Policy covering the overarching areas of:

- Risk to patients
- Organisational risk
- Reputational risk
- Opportunistic risk

The statement will also define the Board's appetite for each risk identified to the achievement of strategic objectives for the financial year in question.

Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk.

The following risk appetite levels, developed by the Good Governance Institute, have been included, for information, as they formed the background to the discussion in relation to appetite.

Appetite Level	**Described as:**
None.	The avoidance of risk and uncertainty is a key organisational objective.
Low.	The preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential.
Moderate.	The preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
High	Open and being willing to consider all potential delivery options while also providing an acceptable level of reward (and VfM).
Significant.	Seek and to be eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk), also described as Mature being confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

The Risk Appetite Statement below is composed of two parts:

1) A general written statement, supported by the cumulative risk appetite scores across the risk categories, in line with this Risk Management Strategy; and
2) A more detailed summary of risk appetite score for each of the individual risks in the Board Assurance Framework.

The statement is a dynamic live system and may be subject to change over time.

9.3 General Risk Appetite Statement

"The Trust recognises that its long term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners. As such, the Trust will not accept risks that materially impact on patient safety. However the Trust has a greater appetite to take considered risks in terms of their impact on the organisation and its reputation. The Trust has greatest appetite to pursue innovation and challenge current working practices where positive gains can be anticipated, within the constraints of the regulatory environment. This statement is depicted in the chart below."

9.4 Risk Appetite by area 2016-2017

Risk Category	Low	Moderate	High	Significant
Risk to Patients	Low appetite to take risks			
Risk to Organisation		Moderate appetite to take risk		
Risk to Reputation		Moderate appetite to take risk		
Opportunistic Risk				Significant appetite to take risk

9.5 Risk appetite detailed breakdown supporting the risk appetite by area table in 9.4 above

BAF no.	BAF Risk	Low	Moderate	High	Significant
1	System fluidity: System fluidity due to developments within Sustainability & Transformation Plan (STP), including challenges within primary care sustainability will prevent timely delivery of SCFTs operating model		Moderate appetite to take risk		
2	Construct, capacity and capability: There is a risk that organisational design will not effectively respond to strategy requirements to deliver communities of practice and new ways of working due to insufficient capacity and capability to cope with pace of change, inconsistent leadership/management approaches and therefore resistance to change.		Moderate appetite to take risk		
3	Workforce: Due to current vacancy rates alongside national and local staffing shortages there is a risk SCFT will have insufficient permanent staff of the right calibre, in the right place at the right time to consistently deliver high quality safe services and comply with Monitor agency rules.		Moderate appetite to take risk		
4	Business Intelligence: Pace of		Moderate appetite to		

	organisational improvement toward strategic goals insufficient due to lack of excellent systems, processes and technology (business intelligence) to manage the business. Sub-optimal decision-making and improvement will impact strategy delivery.		take risk		
5	Commercial sustainability : A loss of business / risk of procurement might destabilise SCFT ability to consolidate and deliver SCFT commercial strategy				Significant appetite to take risk
6	Regulation: There is a risk that changes to the current regulatory inspection regime and future proposal to inspect across care pathways/organisations, may affect SCFT's current "Good" rating and prevent the organisation moving to outstanding status.	Low appetite to take risk			
7	Strategic & clinical leadership: There is a risk that SCFT may lose key leaders to other health and care organisations including competitors, due to the enhanced reputation of the individuals following a good CQC inspection HDD3 and FT authorisation, and the ability of other trusts to offer different challenges and incentive.		Moderate appetite to take risk		

10.0 THE RISK MANAGEMENT ACTION PLAN

10.1 The annual Risk Management Plan will be developed by the Patient Safety and Risk Manager.

10.2 The annual Risk Management Plan will include objectives to address key risk issues in order to ensure continuity and progression in the Trust's strategic direction for risk management. This includes issues relating to business, financial, clinical and non-clinical risks.

10.3 The Trust Wide Clinical Governance Group, is responsible for approval of the annual Risk Management Plan and monitoring its implementation.

10.4 The programme priorities for 2016/17 are:

Foundation Trust Requirements:

- To ensure on-going compliance with Foundation Trust standards (Provider Licence/Risk Assessment Framework) by raising trust wide awareness of the new requirements and reporting assurance schedules.

System developments:

- To configure, implement and embed Datix, the new electronic risk management system.

- Targeted risk management and 'Datix' system training for managers and the development of Datix risk assessment guidance to compliment the current risk management processes incorporated within this document.

- To incorporate risks that might affect delivery of local objectives or reflect community needs onto the service/local section of the risk register. Looking to the future, with the introduction of 'Communities of Practice', this could be adapted so the service section of the register becomes the risk repository for informing and monitoring local decision-making processes. This will facilitate greater learning and a collaborative approach enabling greater mitigation of local risks or the development of actions to lessen the impact of issues.

Risk Profile:

- To establish a clinical risk review group to oversee the quality of data recorded, triangulate system information where applicable, monitor strategy compliance and champion a standardised approach to trust wide risk analysis and review. This will enable the Trust to utilise this data to inform service delivery, care improvements and on-going business planning.

- To expand systems of coordinating and recording risk related data regarding partnerships and new business arrangements to ensure corporate oversight of both internal and external challenges.

- To work with partners across the sustainability and transformation plan footprint to develop a system wide risk register including partners in health social care and third sector organisations.

11.0 ISSUES LOG

Issues Management:

All issues should be analysed and assessed for impact. Assessment of the likelihood of an issue is not applicable as the event has already occurred or is still occurring. Issues must be recorded on the Datix system 'Issues Log'.

All issues should have a pre-actions and post-actions impact score and include the details of all actions in place to address the problems. The issues log should also record if the issue is active or closed. (see appendix

The first section details all recorded issues. All issues with **impact scores of 3 and above** are escalated to the Divisional Management Team. The Trust Wide Clinical Governance Group and the Executive Leadership team must be advised of any issues with an **impact score of 4 and above**.

12.0 ACCOUNTABILITY AND RESPONSIBILITY ARRANGEMENTS

Chief Executive
The Chief Executive, as Accountable Officer has overall responsibility for risk management and for ensuring the Trust has a Risk Management Strategy and infrastructure in place to provide a comprehensive system of internal control and systemic and consistent management of risk. S/He will delegate specific roles and responsibilities to the appointed Executive Director/Senior Managers to ensure risk management is co-ordinated and implemented equitably to meet the Trust's objectives.

Medical Director
The Medical Director has delegated board level responsibility for ensuring that all risk and assurance processes are devised, implemented and embedded, reporting to the Chief Executive and Executive Team any significant issues arising from the implementation of this strategy/policy including evidence of non-compliance or lack of effectiveness arising from the monitoring process so that remedial action can be taken. Governance of medical devices and medicines management sits within the Medical Director's portfolio.

Chief Nurse
The Chief Nurse has the delegated board level responsibility for quality, health and safety, patient experience, safeguarding and infection prevention and control. The Chief Nurse holds the responsibility for overseeing Trust compliance with Care Quality Commission requirements. .

Director of Finance and Estates
The Director of Finance and Estates has the delegated board level responsibility for financial constraints and balances competing financial demands. The Director of Finance holds strategic responsibility for estates and facilities and coordinating the corporate audit programme within the Trust. S/He is also the Senior Information Risk Owner (SIRO) with responsibility for the management of information governance risk. Within the Director of Finance and Estates portfolio is procurement.

Chief Operating Officer
The Chief Operating Officer is responsible for the operational delivery of the Trust's services, and as such holds the executive level ownership for risks relating to the delivery of operational services.

Senior Managers
All Senior Managers are responsible for ensuring systems are in place to implement and monitor programmes of quality improvement within their areas of responsibility in line with the Trust's priorities. Senior Managers are responsible for managing the strategic development and implementation of integrated risk and governance within their divisions and service lines. This includes ensuring:

- Systems are in place to identify, assess and manage risks through implementation and review of the service/operational sections of the Risk Register; and
- Effective systems are employed for reporting, recording and investigating of all adverse events, such as serious incidents, incidents, near misses, complaints and claims.

Senior Managers are responsible for identifying risks within the service line, ensuring these are documented, appropriate mitigations, reporting and governance arrangements

are applied. Senior managers are responsible for monitoring their staff and service compliance against identified standards and safe systems of work.

Patient Safety and Risk Manager
Reporting to Head of Quality Governance the Patient Safety and Risk Manager is responsible for ensuring the development and implementation of the Risk Management Strategy coordinating regular reporting to the Board. The Patient Safety and Risk Manager is responsible for overseeing the management and maintenance of the Board Assurance Framework (BAF) and ensuring the Board follows due process

The Patient Safety and Risk Manager is responsible for maintaining the Risk Register as an active document and monitoring mitigation and action plans. The Patient Safety and Risk Manager oversees the risk and safety requirements of external agencies, including, but not limited to:
- NHS England Patient Safety Division (formally National Patient Safety Agency)
- Medicines and Healthcare Products Regulation Authority (MHRA);
- Health and Safety Executive
- Care Quality Commission.

The Patient Safety and Risk Manager has responsibility for the development and implementation of suitable and sufficient risk management training provision across the Trust, ensuring role specific training is provided.

All staff
All staff are accountable for the quality of the services they deliver and complying with, and participating in risk assessment processes as required. All staff must comply with identified standards and safe systems of work specific to their roles, whether identified in national, professional or Trust policy, procedures and guidelines. They will report quality issues, however caused, through identified channels to ensure prompt action can be taken using existing reporting systems within the Trust.

All Managers and staff have responsibility for managing risks in the services within which they work and for ensuring that they have attended the appropriate risk management training commensurate to their role.

Patients, relatives and volunteers
Patients, relatives and volunteers are encouraged to report or feedback any concerns regarding clinical care or services provision and this data is used to inform the Trust's understanding of its risk profile. .

13.0 ORGANISATIONAL ARRANGEMENTS AND RISK MANAGEMENT STRUCTURE

Committee	Key duties	Frequency
Board	The Board is responsible for establishing the principal strategic objectives and for driving the organisation forward to achieve these. It is also responsible for ensuring that there are effective systems in place to identify and manage the strategic risks associated with the achievement of these objectives through the Board	Monthly

Committee	Key duties	Frequency
	Assurance Framework.	
Quality Committee (Chair: NED)	The Quality Committee has delegated responsibility on behalf of the Board to seek satisfactory assurance that there are adequate controls in place to ensure the Trust provides high quality services and care to its patients and is capable of meeting the CQC outcomes in relation to risk.	Bi - monthly
Audit Committee (Chair NED):	The Audit Committee has delegated responsibility on behalf of the Board to seek satisfactory assurance that the Trust is meeting statutory internal and external requirements to remain a safe and effective business through embedded and effective risk management systems and processes with appropriate support from internal/external audit. The Committee is also responsible for seeking assurance that action plans resulting from audit findings are satisfactorily completed.	Bi-Monthly
Finance and Investment Committee (Chair: NED)	The Finance and Investment Committee has delegated responsibility on behalf of the Board to seek satisfactory assurance that there are suitable financial controls in place, providing scrutiny of major business cases and proposed investment decisions, whilst regularly reviewing contracts with key partners to ensure suitable and sufficient risk management	Monthly
ELT Performance and Governance Group (ELT P&G) (Chair: Deputy CEO)	The ELT is responsible for reviewing and monitoring the corporate section of the operational risk register and all risks scored 15 or more, escalating to the Board any risks, which may affect the achievement of the Trust's Strategic Objectives and for de-escalating risks from the Board Assurance Framework to the Trust Wide Clinical Governance Group and Operational section of the risk register where applicable	Monthly
Trust Wide Clinical Governance Group (TWCGG) (Chair: Medical Director)	The TWCGG is responsible for ensuring the delivery of the Trust's Clinical Governance requirements, including risk management procedures and practices. The group reviews escalated risks from divisional risk registers, divisional clinical governance meetings, and specialist subject group reports and reviews all risks which score 12 or more. Specifically in relation to risk the TWCGG; • Regularly reviews and monitors the application of the Risk Management Strategy; • Regularly review the operational risk register, escalating risks as required to the Executive Leadership Team; • Ensure systems support delivery and compliance with legislation, mandatory NHS standards and relevant bodies;	Monthly

Committee	Key duties	Frequency
	• Monitors the delivery of action plans to ensure gaps in controls are closed and to identify robust assurance mechanisms; • Undertake critical review of system governance; and • Encourage and foster greater awareness of risk management throughout the Trust.	
The Clinical Governance Structure incorporates various TWCGG specialist subject groups, which are responsible for risks within their area of specialism (please refer to appendix 1).		
Divisional Management Teams (Governance) (Chair: DCOOs/Deputy Chief Nurse)	The Divisional Management Team (governance), report to the Trust Wide Clinical Governance Group. The chair (on behalf of the Chief Operating Officer) holds the divisional responsibility for; • Ensuring the division is compliant with risk management strategies, policies and processes; • Escalating risks, issues or requests for assistance to the Trust Wide Clinical Governance Group; • Providing divisional reporting on risk to the Trust Wide Clinical Governance Group; and • Managing, implementing and tracking mitigating actions, plans and lessons identified within operational services	Monthly

14.0 ENSURING COMPLIANCE WITH NATIONAL STANDARDS

The Risk Team is responsible for facilitating and ensuring compliance with core risk standards. The Risk Management Annual Plan identifies how compliance will be assured and its progress monitored by the Trust Wide Clinical Governance Group.

The Patient Safety and Risk Manager works in collaboration with the Quality Governance Team and services to ensure compliance with the Care Quality Commission outcomes, and formulates and monitors action plans pertinent to risk.

The Patient Safety and Risk Manager works in collaboration with the Health and Safety Committee to ensure compliance with Health and Safety Standards.

15.0 DOCUMENT CONTROL, MONITORING AND APPROVAL

15.1 Author and Owner

The Patient Safety and Risk Manager is the Author of this document, with ownership by the Medical Director.

15.2 Ratification and Approval

Consultation of this strategy will occur via the Trust Wide Clinical Governance Meeting. The Executive Leadership Performance and Governance Meeting will approve the strategy before subsequent ratification by the Trust Board. Approval of the strategy (at each level) must be reflected within the minutes taken to ensure there is a full auditable records.

15.3 Review

This strategy will be reviewed annually from the date of ratification, or sooner should there be a change to business process, which affects the arrangements outlined in this document.

15.4 Equality Analysis

The Trust aims to design and implement services, policies & other procedural documents and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

Under the Equality Act 2010, policy or other procedural document authors have a statutory duty to give “due regard” to issues of race, disability, gender (including transgender), religion or belief, age, sexual orientation and human rights when developing their policy or other procedural document. This means that policy or other procedural document authors have to assess the potential for their document to discriminate on any of these grounds. Alternatively, the impact of the policy or other procedural document on these groups might be positive or the same for everyone.

15.5 Dissemination Plan

This document will be made available to all staff via the internal SCFT website ‘The Pulse’. It is the policy of Sussex Community NHS Foundation Trust to make Risk Management documents publically available via the public facing website with information redacted as necessary/required.

15.6 Freedom of Information

The Freedom of Information Act 2000 gives the public a wide-ranging right to see all kinds of information held by the government and public authorities. Authorities will only be able to withhold information if an exemption in the Act allows them to. As such, a publically available version of this document will be made available. In line with Government and NHS Document Protection Markings some information (confidential and sensitive) may be redacted from publically available versions.

15.7 Breach

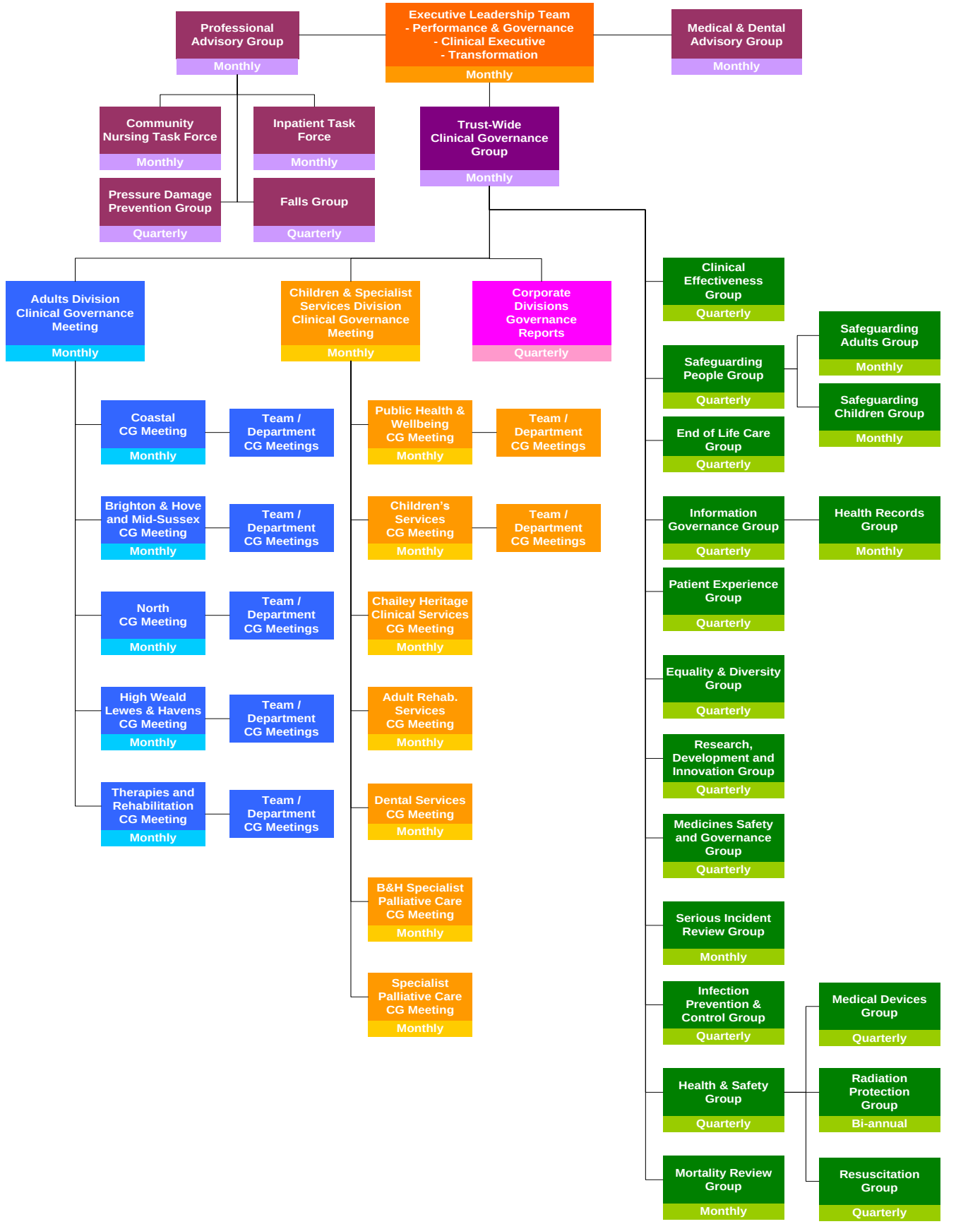
Non-compliance with strategies, policies and procedural documents can affect patient safety, SCFT’s compliance with the Care Quality Commission (CQC) regulations, NHSI requirements , and audits or inspections carried out by internal and external auditors.

Compliance with Trust strategies, policies and other procedural documents is a contractual condition of SCFT employment.

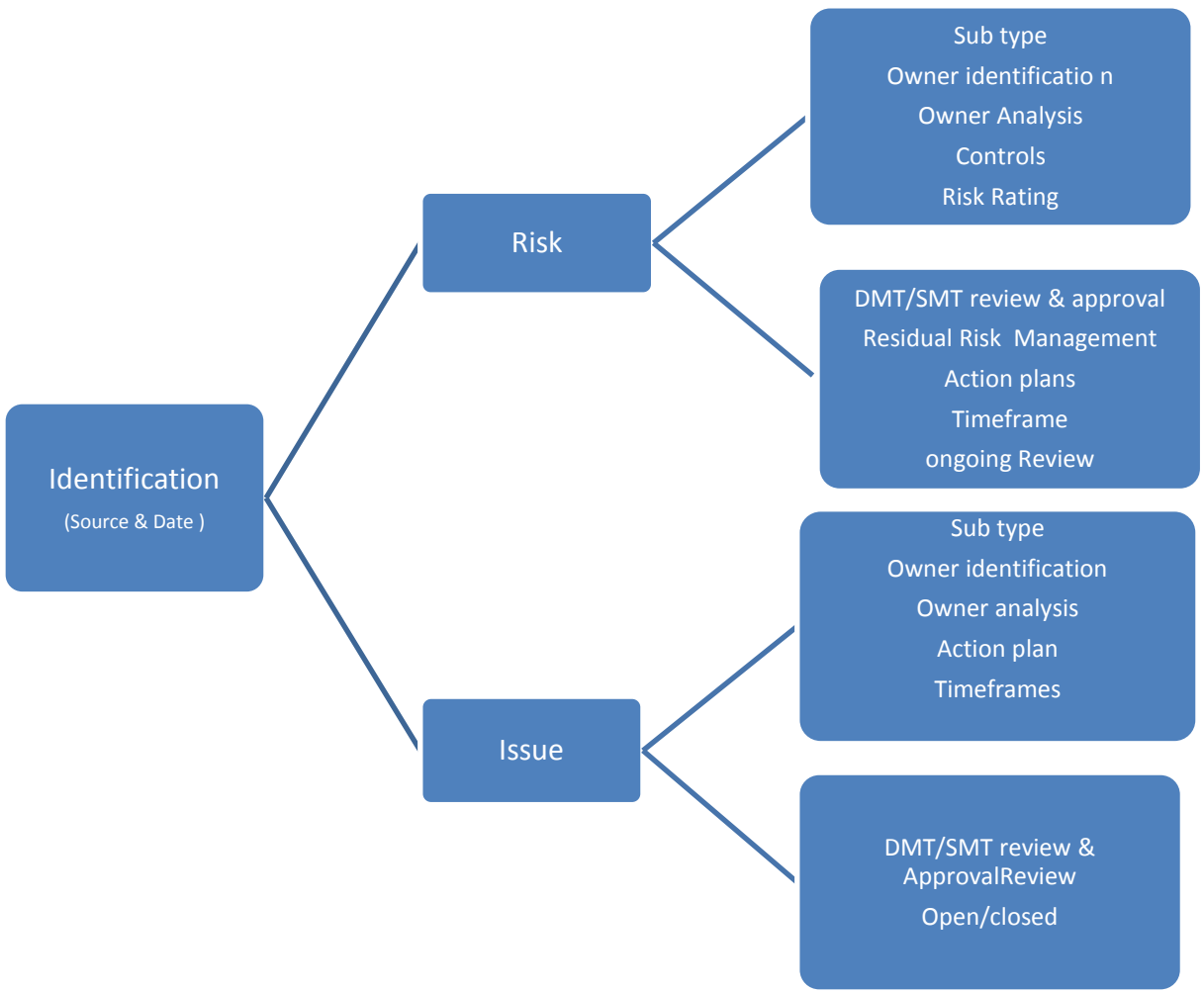
Appendix 1

Quality Governance Operational Structure 2016/17

Sussex Community NHS Foundation Trust



Risk Assessment Process Flow chart



Appendix 3

Definitions

Risk: The potential of an event occurring with the combined likelihood and consequence of harm, injury, damage or loss occurring or impacting the achievement of the Trust's objectives or strategic goals.

Issue: An actual event that has already occurred or is still occurring that may affect achievement of strategic or local objectives or generate other risks.

Risk Appetite: The level of aggregated risk the Trust is willing to accept after application of mitigations, in order to deliver its strategic goals.

Risk Assessment: The analysis and evaluation of risk

Risk Management: The systematic identification, assessment, analysis and monitoring of risk

Risk Register: A central dynamic repository for the recording of identified risks and their mitigation plans to enable the Trust to understand its risk profile.

Risk Profile: The nature and level of threats faced by an organisation**.**

Residual Risk: The remaining level of risk after risk treatment and control measures are applied.

Target risk score: The expected score to be reached after the controls and mitigating actions have been fully implemented to enable the risk to be reduced to a level, which is tolerable.

Tolerable risk: The level of risk the trust is prepared to hold so as to secure certain benefits with the confidence that it is being properly controlled.