Bradford Teaching Hospitals
NHS Foundation Trust

Risk Management Strategy

2019-2025

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Approved by:	Integrated Governance and Risk Committee
Date:	**20/3/2019**
Ratified by:	Board of Directors
Date:	

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1. Statement of intent

Bradford Teaching Hospitals NHS Foundation Trust (the Trust) is committed to establishing an organisational philosophy that ensures risk management is aligned to strategic objectives, clinical strategy, business plans and operational management systems.

We recognise that the specific function of risk management is to identify and manage risks that threaten our ability to meet our strategic objectives. We are clear, therefore, that understanding and responding to risk, both clinical and non-clinical, is vital in making the Trust a safe and effective healthcare organisation.

We will identify risk as either an opportunity or a threat, or a combination of both, and will assess the significance of a risk as a combination of probability and consequences of the occurrence.

All of our staff have a responsibility for identifying and minimising risk. This will be achieved within a progressive, honest and open culture where risks, mistakes and untoward incidents are identified quickly and acted upon in a positive way.

This document describes the Trust's Risk Management Strategy for 2019 to 2025.

2. Principles

In order to effectively deliver this risk management strategy there will be:

- An articulated and demonstrated Board and Senior Management commitment to risk management.
- A clearly articulated organisational risk appetite described and ratified on at least an annual basis by the Board of Directors.
- An effective Trust Governance and Quality framework to ensure the strategy remains effective in the application of risk management.
- Employee participation, consultation and accountability in risk management processes.
- Effective systems to ensure that risks identified from major projects are incorporated into operational risk assessment and mitigation strategies.
- Application of this strategy across the organisation, including clinical Care Groups and corporate departments.
- Effective mechanisms for incidents to be immediately reported categorised by their potential impact and consequences and investigated to determine system failures in an open and fair manner.
- System design with a focus on the reduction of the likelihood of human error occurring.
- Formal and effective mechanisms to measure the effectiveness of risk management strategies and infection control strategies, plans and processes against NHS standards.
- Preventative risk management processes applied to the management of facilities, amenities and equipment.
- Risk Management principles and processes applied to contract management especially when acquiring, expanding or outsourcing services.
- Safe systems of work and practice in place for the protection and safety of patients, visitors and staff.

- Plans for emergency preparedness, emergency response, business continuity and contingency.

3. Purpose

Our risk management strategy is designed to strengthen our ability to achieve our strategic objectives and business targets thus ensuring the continuation of the safe and effective delivery of our services. It will do this by supporting our strategic and operational decision making and planning, helping us to comply with legal and regulatory requirements, improving our governance and controls and ensuring an open culture where people feel encouraged to take responsibility for minimising any negative effects of risk on our services and support improvements to the safety of the services.

The risk management strategy will directly influence and support the:

- Development and maintenance of risk registers for all major projects, service improvement activities, and departments within the Trust.
- Implementation of a risk escalation framework.
- Development and implementation of a Board Assurance Framework.
- Training for managers to enable them to identify, assess and manage risk as part of normal everyday management responsibilities.
- Effective use of the Trust's governance system and structures.
- Implementation of systems and processes to ensure that risk assessments are undertaken systematically in all Care Groups and departments, and the effectiveness of controls is monitored.
- Development of actions plans at corporate and service level.
- Development and implementation of Trust policies to strengthen the systems of control.
- Use of information from risk assessments, incidents, complaints, audit, claims, implementation of external recommendations and other relevant external sources to improve safety and support organisational learning.
- Use of internal and external audit findings and assessments to provide assurance on the effectiveness of controls to minimise risk.

4. Approaches to identifying risk

The Trust will take both proactive and reactive approaches to identifying and understanding risk.

4.1 Proactive approaches to identifying risk

The Trust will take a number of steps to proactively identify risk by:

- The Trust will take a number of steps to proactively identify risk by:
- Ensuring a consistent approach to risk assessments/development of risk registers through implementation of this strategy and the Trust Online Risk Register (See section 5 and the Trust's Assessment Handbook, 2019).
- Developing and maintaining the Board Assurance Framework and Risk Registers (See sections 5 and 8).
- Devising robust systems of maintaining policies and procedures across the organisation (See Policy for the Development and Management of Organisation Wide

Procedural Documents (2017) and the Guideline for the Development of Clinical Guidelines (2018).

- Putting in place policies to ensure achievement of corporate objectives and mitigating risks associated with their achievement (e.g. Incident Reporting and Investigation Policy (including Serious Incidents and Never Events) (2018), Health and Safety Policy (2018)).
- Ensuring an effective Safety Alert System (See the Central Alert System (CAS) Policy, 2018).
- Ensuring a robust approach to clinical audit and the identification of risk (See the Clinical Audit Policy including National Confidential Enquiries, 2017).
- Ensuring efficient Emergency Planning and Business Continuity Planning (see the Emergency Preparedness, Resilience and Response Policy, 2018 and the Incident Response Plan incorporating Mass Casualty Arrangements (2018)).
- Ensuring an appropriate response to recommendations of National Institute of Clinical Excellence (NICE) guidelines (See the Policy for Management of External Recommendations Policy including NICE Guidance, 2018).
- Ensuring training and development of staff (Appraisal, Development and Performance Management Policy, 2018)).
- environment for instance through the review of:
    - Legislation
    - Government White Papers
    - Government consultations
    - Socio-economic trends
    - Trends in public attitude towards health
    - International developments
    - Department of Health publications
    - Local demographics
    - Stakeholder views

4.2 Reactive approaches to risk management

The Trust has a range of sources of information about areas of actual and emergent risk within the organisation. These include:

- Near-miss and Incident reporting process.
- Complaints and Patient Advice and Liaison Service (PALS) contacts.
- Claims management.
- Inquest management.
- National Clinical Audits.
- Implementing recommendations from National Enquiries, internal/external reviews/recommendations etc.
- The outcome of ProgRESS reviews.
- Implementing legislative changes to those resulting from changes in national policy.
- Using information about services published by our regulators and commissioners.
- The aggregation of all the above (see section 6).

5. Risk assessment, management and monitoring

The formal proactive method of identifying operational risks within the Trust is through the use of risk assessments. Clinical, non-clinical and business planning risk assessment is well established within the Trust. These risks then populate the Care Group/Clinical Business Unit/specialty/corporate department/committee risk registers. The Board of Directors is

responsible for identifying strategic risks associated with the delivery of the strategic objectives of the organisation.

The Trust is committed to ensuring that integrated clinical and non-clinical risk assessments in all departments are regularly updated and formally reviewed at least on an annual basis.

All types of risk identified are graded using a common grading matrix, which measures the risks in terms of both consequence and likelihood (See the Trust's Risk Assessment Handbook). All risks that require active and monitored mitigation (usually those that are graded 8 or above (see section 9.3)) are recorded on local level risk registers. Local level risk registers are managed and reviewed within the specialties, clinical Care Croups and corporate departments. The use of risk registers to support the management of risk within the Care Group quality and safety system is described in the Trust's risk assessment handbook. However, in summary, in a local risk register, the risk owner will be required to identify:

- Source of the risk
- Description
- Current risk rating
- Target risk rating
- Controls in place
- Actions
- Residual risk rating
- Date of review

Identified risks will initially be graded for their impact at a Corporate Department/Speciality level using the Trust's Grading Matrix. Any risks grading 'high' or 'extremely high' at this level are reported to the Trust Integrated Governance and Risk Committee for discussion and where appropriate, added to the Strategic Risk Register. All risks with a confirmed grading of moderate, high or extremely high from a strategic perspective will be entered onto the Strategic Risk Register allowing meaningful comparison of risk priorities for the organisation and will be reported to the Board of Directors (see the Risk Escalation Framework in Appendix 3).

Therefore the Trust's Strategic Risk Register provides a Trust-wide database of all extremely high, high and moderately graded risks that have an impact on the delivery of the Trust's Strategic Objectives. The Register is populated from risks identified in the following key areas:

- Strategic Objectives: direct identification of risks associated with their delivery
- Business Planning Processes
- Ad-hoc speciality/corporate department risk assessment
- Speciality/corporate level risk registers
- Ongoing risks identified from incident reporting

The Register has been developed to provide an overarching analysis for all types of risk providing information about the current control measures and assurances in place, and action plans for reducing risks.

All risks on the strategic risk register are analysed and themed into a suite of 'Principal risks' which are aligned to the Strategic Objectives for contextualisation within the Board Assurance Framework. These Principal risks are categorised as follows:

1. Failure to maintain the quality of patient services.

2. Failure to sustain an effective and engaged workforce.
3. Failure to maintain operational performance.
4. Failure to maintain financial sustainability.
5. Failure to deliver the required transformation of services.
6. Failure to achieve sustainable contracts with commissioners.
7. Failure to deliver the benefits of strategic partnerships.
8. Failure to maintain a safe environment for staff, patients and visitors
9. Failure to meet regulatory expectations and comply with laws, regulations and standards
10. Failure to continually learn and improve the quality of care for our patients

The Strategic Risk Register is a dynamic document which is constantly changing as actions are taken addressing high risk issues for the organisation. New risks are added as they are identified, from specific internal incidents, national external reviews, local Risk Registers and as part of the review of Risk Assessments.

The Strategic Risk Register is fully reviewed every month at the Integrated Governance and Risk Committee and a summary of the key changes and risk ranking is reviewed by the Board of Directors at each meeting. At every meeting of Board Committees and the Board of Directors itself receive and review the full Strategic Risk Register (risks graded as 12 and above) and Board Assurance Framework (See section 7).

6. Linking and aggregation of risk and learning

The formal reactive method of identifying risks within the Trust is through the Quality Oversight System (See Appendix 1). Risks are identified from individual incidents and/or the aggregated analysis of a range of sources of intelligence (including incidents, complaints and claims) across the organisation to ensure trends and key themes are identified and acted upon, both in relation to the identification of risk and also in relation to learning (See the Organisational Framework for the Aggregation of Risk and Learning from precursor incidents, 2019).

A Trust-Wide Risk and Compliance Development Group and the Integrated Governance and Risk Committee will both enable the linking of risks being managed by the organisation, within Care Groups and corporately, where separate risks, when considered collectively represent a higher overall risk.

7. Risk escalation framework

This strategy makes it clear that theTrust manages risks at a strategic, Care Group, Clinical Business Unit and service level.

Strategic risks are risks that have the potential to impact significantly on the Trust's strategic objectives (see section 8) or organisational risks that apply to the organisation as a whole and cannot be managed at Care Group level or are considered a risk to the delivery of the Trust's strategic objectives. These are reflected on the Strategic Risk Register (see section 5). Service level risks are risks that, having been assessed as active in relation to their likelihood and consequence, and following assessment, are considered appropriate to be managed and mitigated at Care Group, Clinical Business, Speciality or department level. Service level risks can also be managed through the Corporate infrastructure of the Trust, at Corporate Directorate or team level.

The risk escalation framework is presented in Appendix 3 and is supported by the governance infrastructure described in Section 10 and the roles and responsibilities of staff across the Trust described in Section 11.

8. Strategic risk and assurance: the Board Assurance Framework

The purpose of the Board Assurance Framework (BAF) (see the Trust's Board Assurance and Escalation Framework, 2019) is to assure the Board that the Trust is mitigating the identified significant risks to the delivery of its strategic objectives adequately and that there are no significant gaps in assurance. The BAF document identifies the:

- Strategic objectives
- Risks in achieving those objectives
- Level of risk
- Assurances
- Lead director
- High level position/progress statement

The Board Assurance Framework document provides a high level overview of the Trust's position against the corporate risks and strategic objectives. It is a Board level document and is the responsibility of the Chief Executive and the Executive team. (See process for managing the Risk Register and Board Assurance Framework in the Trust's Risk Management Handbooks 2019 and the Trust's Board Assurance and Escalation Framework, 2019). The document is structured to satisfy both the requirements of Trust regulators and supports the Annual Governance Statement.

9. Risk taking, risk appetite and risk tolerance

9.1 Risk taking

Bradford Teaching Hospitals NHS Foundation Trust acknowledges that in delivering health improvements and in embracing positive advantages risks may need to be taken. The Trust recognises that it cannot create a risk free environment, but rather one in which risk is considered as an integral part of everything it does and is appropriately identified and controlled.

9.2 Risk appetite

The Foundation Trust understands risk appetite as a mechanism to translate risk metrics and methods into decisions, reporting and the day to day business of the Trust and that it provides a framework linking corporate strategy, target setting and risk management. Risk appetite is the amount of risk that any organisation is prepared to accept, or tolerate, or be exposed to at any point in time and every risk needs to be assessed for the acceptable level of risk appetite.

On an annual basis the Foundation Trust's Board of Directors will publish its risk appetite statement as a separate document. The risk appetite statement will be generated from a formal discussion and will focus on key categories of applied the delivery of the strategic objectives and the application of a risk appetite matrix (See Appendix 2). The use of risk appetite is described in the Risk Assessment Handbook.

9.3 Risk tolerance

Risk tolerance is the acceptable level of variation relative to achievement of an individual objective. It is the amount of risk to which a programme or an activity is prepared to be exposed to or that its resources allow it to be exposed to, before actions become necessary.

The Trust has set its tolerance threshold for acceptable risk at moderate. This threshold is set in expectation of what risks are likely to be actually realised and the resources needed to realistically control them (See Figure1).

Below this level 'all' risks are monitored and evaluated on an on-going basis to confirm or reassess that rating. All risks at and above this threshold (at any level of the organisation) are actively managed and mitigating actions taken to bring the risks back to within tolerance.

All strategic risks graded at 12 or above, meaning that a moderate outcome is likely or a major outcome is possible are routinely considered by the Integrated Governance and Risk Committee and reported Board Committees and to the Board of Directors.

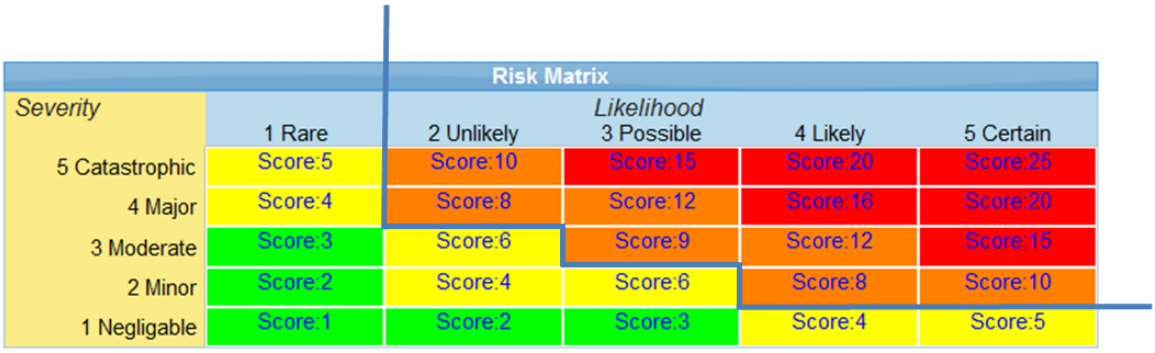


Figure 1. The 'line of risk tolerance'

10. Board Governance

The Trust has an established Board governance framework that supports the implementation of this strategy. A summary of the key elements of the governance framework is described in detail in Appendix 2. In brief, the Board of Directors is accountable for the delivery of this risk management strategy. This accountability is underpinned by an assurance sub-structure. The delivery of elements of the strategy is supported by an inter-related sub-committee infrastructure. The sub-committees have a range of responsibilities and specialist support functions. The Board Governance Framework and its reporting infrastructure are depicted in Appendix 4.

11. Individual roles and responsibilities supporting the delivery of this strategy

11.1The Chief Executive and Board of Directors

- Commitment, through endorsement of the Risk Management Strategy and Policy Statement, to maintaining a sound system of internal control.
- Assessment and approval of any necessary risk management developments
- Identification and allocation of any resources required to implement risk management initiatives.
- Monitoring, review and approval of the Trust Strategic Risk Register and Board Assurance Framework.

11.2 Executive Directors

- Each Executive Director will ensure that all risks on the strategic risk register for which they are identified as executive lead, are appropriately described, scored, mitigated, monitored and reviewed.
- Are responsible for ensuring that significant strategic risks are esclated to the Integrated Governance and Risk Committee.
- Ratification of any risk management policies and procedures.

11.3 Director of Governance and Corporate Affairs

- Is responsible for organising the Board of Director's work plan making provision for the discussion of all new risks entered on to the Strategic Risk Regsiter and for ensuring that the BAF is maintained and reported to the Board, Committees and the Integrated Governance and Risk Committee.

11.4 Care Group Directors/Directors of Corporate Departments will ensure through their line management strtuctures that:

- There is active implementation of the Risk Management process and undertaking necessary changes and improvements through the development and introduction of departmental specific risk management strategies based on identified key core objectives
- Annual, clinical and non clinical risk assessments are undertaken and local level risk registers are maintained.
- Specific policies and procedures are implemented.
- Ensure attendance of staff at appropriate risk management training sessions.
- Raise risk awareness on risk management issues as required.
- Seek advice on risk management issues as required.
- Notify the Risk Manager of identified risks.

11.5 All staff are responsible for

- Having a general awareness of risk at all times.
- Notifying line managers of any identified risks.
- Compling with the Trust's incident reporting procedure.
- Attending risk management training.

12. Training

Contributing to risk management is the responsibility of all members of staff, and the Trust recognises the importance of providing risk education and awareness training for all grades of clinical and non-clinical staff.

A formal risk management training needs analysis will be undertaken every three years to ensure that training provided meets the needs of specific groups of staff. Risk management training is part of the mandatory training for all clinical staff.

The following training and education will be provided to support the implementation of the governance and risk management strategy.

12.1 Board of Directors

The commitment and engagement of the Board of Directors within the organisation is paramount in creating a foundation for the implementation of this strategy and embedding

the key principles throughout the Trust. To support this priority, updates and awareness training programmes will be provided at least annually from both internal and external experts. For executive and non-executive directors, this will form part of the on-going Board development programme.

The Strategic Risk Management Training Needs Analysis describes the key training requirements of all levels of staff including Board Members and Senior Managers.

Progress against the Strategic Risk Management Training Needs Analysis will be monitored by the Integrated Governance and Risk Committee.

12.2 All Staff

Risk management awareness and the incident reporting procedure is a structured part of the Trust's induction programme for new staff. This is also included in the induction programme for all medical staff. In addition there will be:

- Regular risk management updates for staff which can be linked to specific clinical risk or health and safety training programmes, including raising awareness of policies, i.e. Health and Safety Policy, Infection Control and Incident Reporting Procedure.
- Training for Line Managers in risk assessment and grading, root cause analysis, Supporting Staff and Duty of Candour.
- Training for Line Managers in the implementation of the Strategy and to support the devolvement of the Risk Management process.
- All staff will be given risk awareness training upon commencement of their employment within the Trust, with regular updates thereafter.

13. Funding

Risk management plans form part of the Trust's business plans. Risk Management issues are funded at the budget setting process from business cases submitted from each Care Group. Where unforeseen risk management issues are identified, these are prioritised by the Integrated Governance and Risk Committee and funding agreed by the Management Executive (Executive Management Team).

The continued development of the Strategic Risk Register profile identifying the key principal risks for the Trust enables better prioritisation and more informed decision making by the Board of Directors.

14. Monitoring and assurance

Compliance with the Risk Management Strategy will be monitored through an annual report for the previous financial year to the Trust Integrated Governance and Risk Committee in October of each year.

The report will be prepared by the Director of Governance and Corporate Affairs, it will monitor as a minimum:

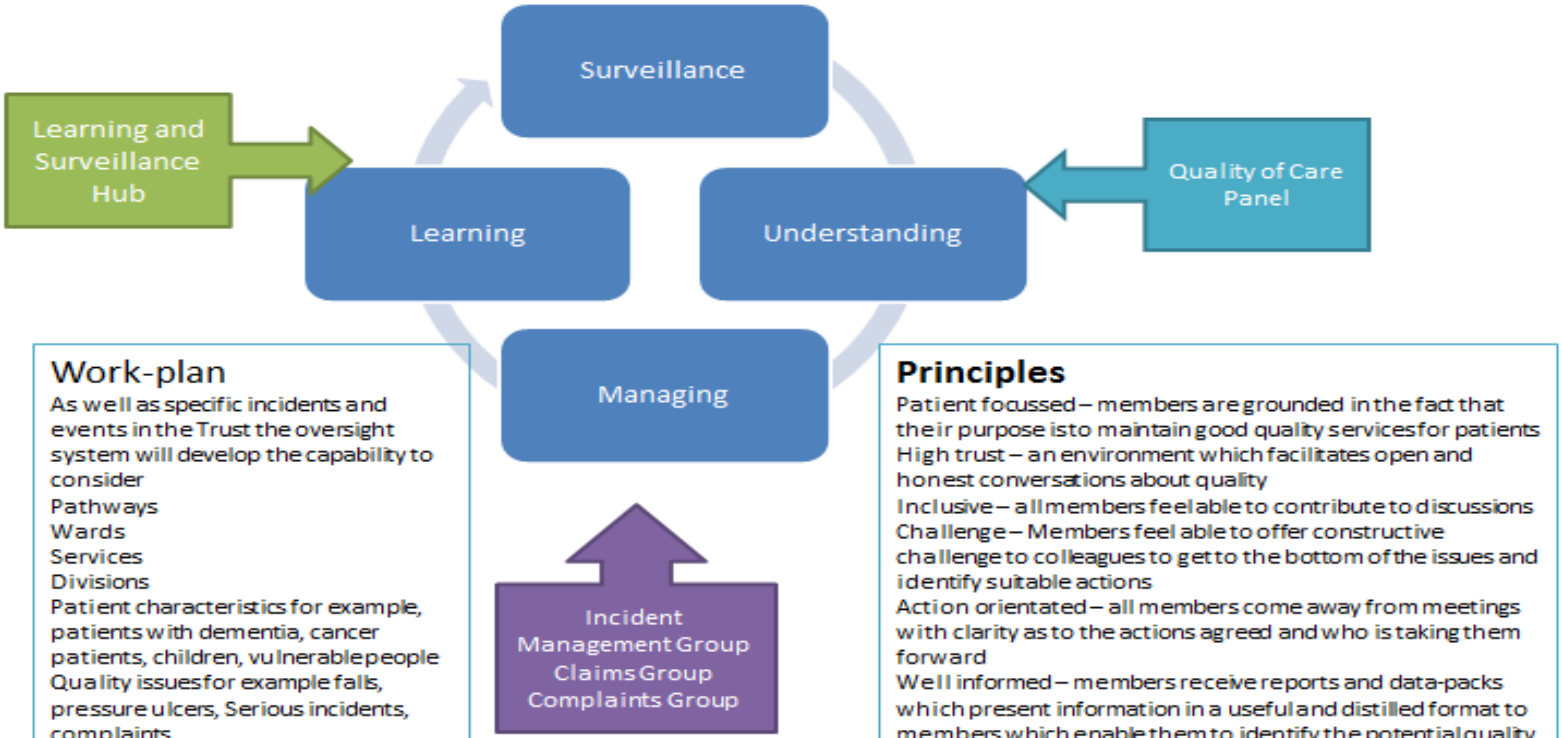
- The key individuals for risk management are discharging their responsibilities in line with the Strategy through attendance at key risk management committees and there is evidence of activity through the minutes of those meetings.
- The high level risk committees have discharged their responsibilities in line with the relevant Terms of Reference including reporting arrangement into the committee and

the committees reporting arrangements into the Board of Directors as identified in the Board Planner.

- The Board of Directors and high level risk committee(s) review the organisation-wide risk register as identified through minutes of the appropriate meetings.
- How all risks are assessed using a standard template and Trust-wide grading matrix in line with the Risk Assessment Handbook.
- How risk is managed locally through review of incident reporting, compliance with the Trust-wide annual clinical and non-clinical risk assessment process and evidence of maintenance of local risk registers and presentation of those to the Integrated Governance and Risk Committee.

Where deficiencies are identified, an action will be developed and monitored on a quarterly basis through the Integrated Governance and Risk Committee.

Appendix 1: Quality Oversight System



Appendix 2: Risk Appetite Matrix

	0. Avoid	1. Minimal	2. Cautious	3. Open	4. Seek	5. Mature
	Avoidance of risk and uncertainty is a key Organisational objective	As little as reasonably possible: Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward	Willing to consider all potential delivery options and choose while also providing acceptable level of reward (and VfM)	Eager to be innovative and choose options offering potential higher business rewards (despite greater inherent risk)	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limits financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits and constraints. Resources generally restricted to existing commitments.	Prepared to invest for a return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price.) Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return- 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ Regulatory	Play safe: avoid anything which could be challenged even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliance.	Limited tolerance for stick our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovative/ Quality/ Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems/ technology developments to protect current operations.	Tendency to stick to the status quo. Innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems/technology developments used routinely to enable operations delivery. Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior Management distances themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little change of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons and benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

Appendix 3: Risk escalation framework

Risk identified and assessed	An initial discussion takes place with a line manager (and the Care Group/Specialty/Corporate Directorate Governance Lead for assistance if required) and then be assessed, graded and added to the risk register as appropriate
Ward/Speciality/Clinical Business Unit/corporate service level	Monthly review of risks is undertaken at ward/specialty/Clinical Business Unit/corporate service level. Where the ward specialty or department feel unable to manage the risk this should be formally escalated to the Care Group Governance Lead for consideration at next meeting
Care Group/Corporate Department Level	Monthly review of risks escalated formally from ward/specialty/ Clinical Business Unit/corporate service and all risk scored at 9 or greater to be reviewed at Care Group level. Where the Care Group /Department feel unable to manage or address the risk themselves this should be escalated formally to the Strategic Risk Register. This is to be undertaken by checking the box escalate to the Strategic risk register on Datix and by informing the Director of Governance and Corporate Affairs in writing
Strategic level	The Integrated Governance and Risk Committee reviews all risks newly escalated, considering whether to accept them onto the strategic risk register. Risks accepted are identified with an executive lead.
	All risk on the strategic risk register scoring greater than 12 are reviewed monthly at the Integrated Governance and Risk Committee., and managed within the principal risk structure of the register to enable alignment to the Board Assurance Framework
Committee Level	Board committees will review the principal risks and their component risks assigned to them and consider their impact on the Board Assurance Framework and how they should be reflected
Board Level	The Board reviews a high level register of Trust wide risks graded at 15 or greater at each meeting. The Board reviews its strategic risks (12 or above) via the BAF, receiving assurances from the Board Committees and undertaking a review of all BAF risks at each meeting.

Appendix 4: Governance framework supporting risk escalation and management

Level	Structure	Function in relation to the Risk Management Strategy
Accountable	Board of Directors	The Board of Directors has a clear focus on ensuring that the Trust operates to high ethical and compliance standards. In addition it seeks to observe the principles set out in the NHS Improvement NHS Foundation Trust Code of Governance. The Board is responsible for the management of the Trust and for ensuring proper standards of corporate governance are maintained. The Board accounts for the performance of the hospital and consults on its future strategy with its members through the Council of Governors. The Board of Directors receives exception reports against performance standards and these have been introduced to assist the Board in identifying areas of high risk. Significant high graded risks facing the organisation are monitored and added to the Trust Risk Register and Board Assurance Framework. The Board of Directors is responsible for: • Monitoring progress against the Trust's Strategic Objectives • Identifying the significant risks that may threaten the achievement of the Trust objectives • Maintaining dynamic risk management arrangements including, crucially, a well-founded Risk Register and Board Assurance Framework, which are reviewed at each meeting by the full Board of Directors. It is **crucial** that the Board knows what the key risks are and is satisfied that they are being properly managed
Assuring (Trust-wide Level)	Audit and Assurance Committee	The Committee reviews the establishment and maintenance of an effective system of audit, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives. In particular, the Committee will review the adequacy of: • The processes supporting all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the Care Quality Commission Outcomes of Quality and Safety), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances. • The underlying assurance processes that indicate the degree of the achievement of strategic objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements. • The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements. • The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service.
Assuring (Trust-Wide Level)	Integrated Governance and Risk Committee	• Review all strategic risks scoring 12 or greater on a monthly basis together with new, updated, closed or overdue for review corporate risks. • Review all Care Group risks scoring 15 or greater which have not been escalated to the strategic risk register. • Assess, prioritise and monitor the Trust performance in managing risk and ensuring progressive improvement against the Trust 'live' Strategic Risk Register and Care Group or corporate department risk registers • To prioritise the top risks to inform the Audit Committee and to be reviewed by the Board of Directors.

		• To ensure the Trust has a Board Assurance Framework that is robust and fit for purpose and complies with best practice. • To review the Board Assurance Framework identifying any gaps in assurance to inform the Audit Committee and to be reviewed by the Board of Directors. • To compile, in conjunction with the Chief Executive, the Annual Governance Statement. This will be passed to the Audit Committee to review its adequacy. • To advise the Trust in respect of the development and use of key performance and risk indicators. • To sign off compliance with the current Care Quality Commission Fundamental Standards of Quality and Safety and subsequent registration requirements. • To initiate systematic reviews of practice in the light of external reports and act upon key recommendations. • To support the Audit Committee to undertake risk based work programmes where gaps in assurance are identified. • Responding to findings of the Audit Committee ensuring action is taken.
Responsible (Trust-Wide Level)	Finance and Performance Committee	• To ensure that major capital investment schemes are in line with the Trust's overall agreed strategy. • To offer the Board of Directors assurance on the rigour of the Transformation Plan. • To review key commercial arrangements including long term leases and major service developments and track progress of such developments as appropriate. • To review the financial aspects of the Trust's Annual Plan before its submission to the Board of Directors. • To provide the Board of Directors with assurance that effective financial governance is in place. • To offer the Board of Directors with assurance of delivery against national and local performance indicators.
Responsible (Trust-Wide Level)	Quality Committee	• To set, agree and review the strategic direction for Quality Improvement. • To provide the Board with assurance that effective quality governance arrangements are in place. • To review the overall quality of each specialty by exception, ensuring areas of concern are identified and addressed. • To receive specialist reports in relation to precursor events (e.g. complaints, incidents, claims etc.). • To agree and monitor performance of individual care group, clinical business unit or specialty level action plans with particular reference to Patient Safety, Infection Control, risks assessments/registers, compliance with the Care Quality Commission Fundamental Standards. • To receive reports from the relevant sub committees and recommend actions. • To ensure that corporate and Care Group clinical audit programmes are harmonised. • To monitor performance against the Trust's Quality Account.
Responsible (Trust-wide Level)	Health and Safety Committee	• To report effectively to the Quality Committee • To ensure that the Trust complies with Health and Safety Legislation. • To address Occupational, Health and Safety risk issues. • To monitor non-clinical incidents.
Responsible (Trust-Wide	Workforce Committee	• To ensure workforce related risks in terms of staffing and training and education are identified, contextualised

Level)		and mitigated as appropriate.
Responsible (Trust-Wide Level)	Partnerships Committee	• To manage risk associated with the delivery of relevant strategic objectives. • To assure the effective delivery of the relevant strategic objectives.
Responsible(Trust-Wide Level)	Major Projects Committee	• To manage risk associated with the delivery of relevant strategic objectives. • To assure the effective delivery of the relevant strategic objectives.
Responsible(Trust-Wide Level)	Charitable Fund Committee	• To manage risk associated with the delivery of relevant strategic objectives. • To assure the effective delivery of the relevant strategic objectives.
Responsible (Trust-wide Level)	Information Governance Committee	• To report to the Board of Directors through the Senior Information RO on a quarterly basis. The SIRO is also responsible for keeping the Board of Directors informed of any issues of note on a monthly basis. • To approve information governance action plans to meet central and local Information Governance requirements. • To approve the Trust's Information Governance toolkit scores and submissions to NHS Digital. • To oversee the activities of staff in light of data protection, confidentiality, security, information quality, record management, information asset management and Freedom of Information responsibilities. • To ensure training needs are identified and training programmes are developed to facilitate successful implementation.
Responsible (Trust-wide Level)	Resilience and Emergency planning group	• To review and implement all Trust emergency plans to enable the hospital to respond to a major incident (of whatever nature) whilst maintaining critical services. • To agree and establish a training programme to deliver emergency training to relevant staff groups. • To agree and establish an exercise programme to ensure the Trust is compliant with the Civil Contingencies Act. • To ensure that Business Continuity Plans are established, monitored and reviewed and a governance structure established. • To ensure that contracts with suppliers and external organisations provide assurance regarding their business continuity planning and the sustainability of services provided to the Trust.
Responsible (Trust wide Level)	Clinical Audit and Effectiveness Committee	• To assess and support the management of risk associated with the implementation of national best practice. • To assess and support the management of risk associated with the national and local clinical audit programme.
Responsible (Local Level)	Care Group Accountability and Performance Framework	Care Group Directors and Directors/Heads of Corporate Services are responsible for ensuring that the principles of the Trust Risk Management Strategy are implemented locally in each department and monitoring compliance with the following key objectives: • To evidence incident reporting from all staff and formal review of incidents, complaints and claims following the principles of Root Cause Analysis where required. • To undertake an annual clinical and non-clinical risk assessment. • To maintain local level risk registers populated from local incident reporting, risk assessments, and national targets which will be monitored by the Executive Team on a monthly basis at the Integrated Governance and

		Risk Committee. • To complete an annual review of the compliance with the CQC Fundamental Standards of Quality and Safety. • Will regularly review all risks scored at 8 or greater and all escalated, new, amended or closed risks. • Will routinely consider whether risks require escalation to the strategic risk register when they cannot be appropriately managed at local level.
Responsible (Local Level)	Clinical Business Unit / Departmental Quality Meetings	• Are responsible for ensuring the effectiveness of risk management systems and processes amongst the wards and teams in their specialty (including the maintenance of a specialty risk register). • Will regularly review all risks in the specialty/department and consider whether they need escalation to the relevant Meeting where they cannot be appropriately managed at a clinical business unit level.
Contributory (High Level)	Executive Management	• Reviews financial, contractual and quality performance. • Discusses and agree recommendations relating to policy and strategy. • Ensures that the hospital is patient-focused and has improving patient experience at the heart of all it does.
Contributory (High Level)	Nursing and Midwifery Forum	• Oversees, monitors, reviews and reports on the performance of all nursing clinical wards and departments. • Ensures effective action plans are developed by the Clinical Matrons and Heads of Nursing quarterly to address areas of poor performance and deliver sustained improvement based upon national best practice. • Ensures action is taken promptly in response to patient feedback with the aim of improving patient and public satisfaction throughout the Trust. • Undertakes benchmarking with other high performing Trusts and introduce innovative programmes to enhance Nursing Clinical Outcomes, Patient Safety and Patient Experience. • Reviews Nursing/Midwifery serious incident findings and ensures that learning is acted upon. • Receives relevant National and Local monitoring reports regarding Clinical Outcomes, Patient Safety and Patient Experience as appropriate.
Contributory (High Level)	Patient Safety Committee	• Monitors the Trust performance against the agreed Patient Safety Key Performance Indicators and objectives. • To receive and review the findings of risk related analysis undertaken by the risk team and agree actions, act upon the results and liaise directly with relevant Clinical Care Groups • To coordinate and oversee the work of Clinical Care Groups in improving Patient Safety.
Contributory (High Level)	Mortality Committee	• Monitors Hospital Standardised Mortality Rates. • Monitors the outcome of the Structured Judgement Review process.
Specialised analysis (High Level)	Quality Oversight System	• Review significant clinical incidents, monitor trends, agree and monitor actions required, and initiates audit of changes in practice as a result. • Report issues of immediate concern through to the Executive Management, and Board of Directors through the Quality Committee.
Specialised analysis (Operational level)	Compliance and risk development group	• Support high quality risk assessment processes through peer support and development • Review care group and corporate department risk registers to enable linking of risks and mitigation and learning

Appendix 5: Board Governance reporting structure