Royal Berkshire NHS
NHS Foundation Trust

RISK MANAGEMENT STRATEGY AND POLICY
(CG027)

Approval and Authorisation

Approval Group	Job Title, Chair of Committee	Date
Trust Board	Chairman, Chairman of the Trust Board	May 2012

Change History

Version	Date	Author	Reason
2	November 2005	Legal Services & Corporate Risk	Policy Review
3	December 2007	Legal Services & Corporate Risk	Policy Review
3.1	September 2008	Legal Services & Corporate Risk	Minor amendment
3.2	March 2009	Risk Department	Minor amendment and template update
3.3	July 2010	Corporate Risk Dept	Minor amendment to reflect reporting processes
3.4	August 2011	Legal Services and Risk	Minor amendments/updates
3.5	May 2012	Risk Manager	Updated to reflect new Care Group structures.

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Other related Trust documents

- Risk Assessment Policy (CG042)
- Adverse Incident Reporting Policy (CG038)
- Serious Incidents Requiring Investigation Policy (CG083)
- Maternity Risk Management Strategy and Policy (MRMSP)
- Complaints Policy (CG009)
- Raising Concerns at Work (Whistle Blowing) Policy (CG055)
- Clinical Negligence Claims Management Policy (CG089)
- Personal Injury Claims Management Policy (CG200)
- Investigation of Incidents Complaints and Claims Policy (CG039)
- Mandatory Training Policy (CG065)

Risk Management Strategy

1.0 Introduction

All services and clinical care within the healthcare environment contain hazards that are a potential source of risk. It is important however, to minimise risks and to ensure that when making decisions, those doing so are deliberately choosing to make judgements from a range of fully detailed and understood options.

Adverse incidents are in most cases a result of a lack of clear procedures and policies or non-compliance with both, poor working practices and/or training, inadequate communications, environmental hazards or staff working beyond their competence.

The challenge faced by the Trust is to eliminate, or at the very least reduce the potential for incidents in the proactive management of risk. This Strategy sets out how the Trust aims to manage its risks.

2.0 Strategy and Its Objectives

The Trust Risk Management Strategy and Policy (CG027) is complementary to the Maternity Risk Management Strategy and Policy (MRMSP).

The Trust's Strategy for managing risk is to implement the following objectives:

- Manage risk as part of normal line management responsibilities and provide funding to address 'risk' issues as part of the normal business planning process.
- Through the Trust Board, adopt a co-ordinated, holistic and committed approach to risk management, whether the risk relates to clinical, organisational or financial risk, through the processes and structures detailed in this document and the Trust's Risk Assessment Policy.

- Accept that whilst the provision of healthcare is not risk free the Trust will always aim to minimise the adverse effects of any risks.
- Manage risk by defining what constitutes as ‘acceptable risk’ for the Trust and ensure that the Trust is informed of any risk, which is deemed unacceptable. Ref: Risk Assessment Policy (CG042).
- Ensure that there are policies, protocols and procedures in place that are communicated to and followed by managers and staff to minimise risks.
- Ensure all staff receive appropriate training to inform them of the how to identify the risks they are exposed to and to instruct them on the controls to reduce or eliminate them. Ref: Mandatory Training Policy (CG065).
- Ensure compliance with the legislative demands on the Trust and those from external regulators and the demands of the NHS agenda for risk management. Refer to Policy for the Management of External Agency Visits, Inspections and Accreditations (CG052).
- Analyse trends in the number and severity of untoward incidents in line with local and national targets to ensure a system of continuous improvement. Ref: Investigation of Incidents Complaints and Claims Policy (CG039).
- That the Corporate Risk Register be used as a predictive tool for the management of risks associated with the Trust’s key priorities from its annual plan 2011/12, 2012/13 and 2013/14
- Further embed risk management processes throughout the organisation through the implementation of programmes of mandatory training and risk awareness.
- Operate a Risk Management Committee as a committee of the Board. The Committee will co-ordinate and prioritise non-clinical governance and non clinical risk issues. It is responsible for ensuring and monitoring the regular review of risks identified against the Trust Business Plan through the Corporate Risk Register in order to embed risk management within the organisation and to underpin the Statement of Internal Control.
- Operate a Clinical Governance Committee as a committee of the Board. The Committee is primarily concerned with the delivery of safe, high quality patient-centred care. This will be achieved through ensuring that the appropriate structures, processes and controls are in place to assure quality in clinical care.
- Operate an Audit Committee. As delegated by the Board, the Committee shall review the effectiveness of financial and clinical governance, including the systems for internal control, financial reporting and risk management and report to the Board of Directors on the levels of assurance.

Risk Management Policy

3.0 Purpose

The purpose of this document is to:

- ensure the management of risk is consistent with and supports the achievement of the Trust strategic and corporate objectives;
- encompass the Trust’s Maternity Risk Management Strategy and Policy;

- provide a high quality of service to patients;
- provide a safe working and care delivery environment;
- initiate action to prevent or reduce the adverse effects of risk;
- minimise the human costs of risks i.e. protection of patients, staff, visitors and others affected by Trust activities from risks as far as reasonably practicable;
- to meet statutory obligations;
- minimise the financial consequences of adverse risk;
- minimise the risks associated with new developments and activities.

This policy defines the arrangements and responsibilities for Risk Management and is located on the 'Policies' Intranet page.

4.0 Scope

The Royal Berkshire NHS Foundation Trust (referred to as the 'Trust) believes that an excellent organisation is, by definition, a safe and secure organisation. It therefore follows that caring for all persons and minimising risk is part of Corporate Governance and inseparable from all other objectives. As part of the Trust's decision making processes and delegated scheme of authority account will need to be taken of balancing risk against cost in ensuring the Trust meets its statutory responsibilities.

The Trust Board is committed to providing the resources and support systems for the Risk Management Strategy and Policy, in order to promote quality care and provide a safe environment for patients, staff, visitors and others affected by the activities of the Trust. On occasions significant risks will be identified and accepted by the Executive Committee and Board (with mitigation in place) and feedback communication to risk owners will be initiated by the responsible Director. (Appendix C).

This Policy applies to all Trust locations, staff employed by the Trust and all other persons engaged in business on behalf of the Trust.

5.0 Responsibilities

5.1 Chief Executive Officer (CEO)

As the 'Accountable Officer' the Chief Executive Officer (CEO) has overall responsibility for Trust. The CEO is supported by members of the Executive Committee in discharging those responsibilities and these are referred to in the Standing Financial Instructions which includes a scheme of delegation. In addition the CEO has overall responsibility for effective governance and risk management arrangements in the Trust which will include audit cycles to demonstrate we are delivering safe care and are complying with our training needs analysis (TNA) . Delegated authority for implementing and maintaining those arrangements is that of the Director of Corporate Affairs.

5.2 Director of Corporate Affairs

The Director of Corporate Affairs is responsible for implementing and maintaining effective governance and risk management arrangements in the Trust.

5.3 Chief Medical Officer & Director of Clinical Standards (CMO)

The Chief Medical Officer & Director of Clinical Standards supports the CEO as the medical lead for clinical governance through the care group medical leads

5.4 Chief Nurse & Director of Patient & Public Affairs

The Chief Nurse (CN) & Director of Patient & Public Affairs supports the CEO as the nursing, midwifery and allied healthcare practitioner lead for clinical governance. The Care Group Directors of Nursing who report professionally to the CN are able to raise concerns immediately with the CN.

5.5 All Directors and Senior Managers

All Directors and Senior Managers are responsible for enforcing this policy and are accountable for the risk management (clinical, operational and financial) performance within their areas of authority and the overall performance of their Care Group/Directorate. Each Director and Senior Manager is responsible for preparing and using, as a management tool, a Directorate/Care Group Risk Register which will be kept under regular review (at least quarterly) and embedded throughout the Directorate/Care Group. They will ensure that all necessary actions are taken to mitigate significant risks and record the actions taken as part of their monitoring process. (needs specific words around doing and monitoring)

5.6 Chief Finance Officer

The Chief Finance Officer is the nominated Executive Board member charged with the responsibility for providing strategic leadership, direction and oversight of the overall financial management arrangements in the Trust.

5.7 Director of Estates and Facilities

The Director of Estates and Facilities is responsible for all Engineering infrastructure and Facilities services. The Director of Estates and Facilities will also undertake the role defined in Firecode 05-01 of Fire Safety Manager (Senior Operating Manager).

5.8 Clinical Directors (CD's) and Care Group Directorate Managers/Department Heads and Matrons

All CD's and Care Group Managers/Department Heads are responsible for ensuring effective management of risk through the:

- reviewing at least quarterly the risk register for their area, to include any new risks identified during the period and pass the modified risk register to their Operational Manager /Department Head.
- monitor the completion and review of risk assessments on an annual basis throughout all of the departments in their area.

5.9 Care Group Directors of Nursing and Director of Midwifery are Group directors of nursing/ director of midwifery have a responsibility for quality and to ensure that risk is managed at an operational level within their Care Groups.

5.10 Ward/Departmental Managers

All Ward and Departmental Managers are responsible for:

- Ensuring standards and safety, identifying risks and responding appropriately within their delegated authority and escalation to their senior manager if they cannot manage the risk.
- Ensuring the completion of risk registers and assessments are completed for their area of responsibility

5.11 Risk Manager (including Health & Safety Manager remit)

Accountable to the Deputy Director of Corporate Affairs for:

- developing, implementing and monitoring the Trust's Risk Management Strategy and Risk Management process;
- leading and co-ordinating risk management activities, to include non-clinical risk and operational risk;
- establishing and maintaining the Trust Corporate Risk Register;
- The provision of professional and quality advisory support on technical risk matters;
- Taking an essential role within the Compliance Team ensuring that the Trust works towards achieving compliance with the NHSLA Risk Management Standards for Acute Trusts and the Clinical Negligence Scheme for Trusts (CNST), Maternity Clinical Risk Management Standards, and the relevant CQC outcomes;
- the development of risk management programmes to enable the Trust to meet legal obligations and building a risk awareness culture within the Trust;
- building and developing a risk management network to ensure a structured approach to the identification of actual and potential risks and appropriate control measures;
- participating in planning and design processes to ensure that wherever possible appropriate legislative requirements and best practice have been taken into account and risks designed out;
- provide health & safety management to the Trust including the reporting of Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) events to the Health & Safety Executive.
- In conjunction with the Head of Patient Safety, on a quarterly basis develop a report aggregating the information from incidents, complaints and claims which will be submitted to the Patients Safety Council and Risk Management Committee.

5.12 Maternity Clinical Risk Manager

The role of the Maternity Clinical Risk Manager is to coordinate clinical governance (in conjunction with the Consultant Obstetrician responsible for clinical governance) and risk management across maternity services (hospital and community) including:

- Assist the Head of Legal Services on any potential cases of litigation relating to maternity services
- Investigate, monitor and review all Maternity incidents and complaints.

In conjunction with the Care Group Director of Midwifery, will be responsible for providing clinical leadership and professional advice on high risk midwifery care.

5.13 Head of Patient Safety

The role of Head of Patient Safety is to communicate and co-ordinate the processes for improving patient safety throughout the Trust. Specifically, this involves the following responsibilities:

- developing and implementing Incident Reporting Procedures to enable the Trust Board and Managers to clearly identify all incidents, incident trends, matters of concern requiring attention and the setting of targeted reductions for use as performance indicators.
- co-ordinating the investigation of all Serious Incidents
- developing patient safety policies, procedures, guidelines and protocols in accordance with best practice.
- developing and maintaining good relationships within the Trust, the NHS and key external organisations to enable a 'Best Practice' approach to patient safety.
- In conjunction with the Risk Manager, on a quarterly basis develop a report aggregating the information from incidents, complaints and claims which will be submitted to the Patients Safety Council and Risk Management Committee.

5.14 All Trust Employees including volunteers.
All Trust employees (including agency personnel working on behalf of the Trust) have the following responsibilities:

- to familiarise themselves with the Trust Risk Management Strategy and Policy on the Trust 'Policies' Intranet page and adhere to it;
- to report all incidents and near misses promptly in line with the Trust Adverse Incidents and Near Misses Reporting Policy and the Serious Incident Policy on the Trust 'Policies' Intranet page;
- to provide further information in relation to incidents and near misses as necessary.

5.15 Contractors
Trust staff responsible for the assignment of contractors shall ensure the arrangements for risk management are included in the Contract's arrangements of work. Contractors shall ensure they are aware of this and the Trust's arrangements for risk management, in particular their duties as outlined in the 'Health & Safety at Work Act 1974'.

5.16 Notification of serious incident/risk issue

Immediate action - Within office hours (Monday – Friday 08:30 – 17:00)

If a serious incident/risk issue arises in the hospital this will be reported immediately to the appropriate senior member of staff/line manager. The senior member of staff/line manager will immediately notify the Chief Medical Officer (CMO), Chief Nurse (CN) and the Head of Patient Safety by telephone or in person and by email.

Immediate Action Out of hours (weekends and 17:00 - 08:30)

The senior member of staff will inform:

- Hospital duty manager (Site Manager)/on call supervisor of Midwives /Director of Midwifery
- On-call consultant
- On-call duty Director
- The duty Director will notify the CMO, CN and Head of Patient Safety immediately if deemed necessary by phone and certainly by the next working day by phone and/ or email.

Further information on the Serious Incident process is available in the Serious Incident requiring investigation Policy (CG083).

6.0 Definitions

Acceptable Risk	Any risk assessment, which results in a rating of very low (green) and low (yellow), may be regarded as acceptable. A risk is deemed acceptable if it does not impact upon the Trust's ability to fulfil its corporate strategic aims and objectives, service provision or if the costs will be disproportionate to improvement gained.
Clinical Risk	Clinical risk is the possibility of a situation arising where a patient suffers harm from a treatment error, however caused, and is in some instances may produce significant legal, media or other interest which, if not properly managed, may result in a loss of reputation to the Trust and have financial implications.
Corporate Risk Register	The Corporate risk register is made up of all significant risks escalated from Care Group/Directorate risk registers, risks to the Trust's Annual Plan and other risks identified by Directors. It forms the Trust's Assurance Framework document and informs the Statement of Internal Control.
Directorate/Care Group Risk Register	A Directorate/Care Group risk register is established from local departmental risk registers and provides an overview of those risks within each Directorate/Care Group.
Financial Risk	A 'financial risk' is anything that compromises an effective system of internal financial control and reasonable assurance of: - safeguarding Trust assets against unauthorised use or

	disposal; - maintenance of proper accounting records; - reliability of financial information used within the Trust or for external publication.
Governance	Governance is the framework by which the organisation governs its Corporate Affairs (Corporate Governance), Clinical Practise (Clinical Governance) and it's Information (Information Governance). Governance can also encompass processes by which the Trust Board receive assurance on the effectiveness of controls to meet its Strategic objectives.
Hazard	A source of potential harm or a situation with a potential to cause loss
Likelihood	Used as a qualitative description of probability or frequency
Local (risk register)	A subdivision of the organisation, for example, Care Group, Directorate, speciality.
Mitigate	To make less severe
Organisational Risk	An 'organisational risk' is a known or potential hazard (excluding those that fall within the Clinical Risk definition), that could cause injury or ill-health of people, damage or loss to property, equipment, materials, environment or a combination of those factors.
Residual risk	The risk remaining after the risk response (treatment) has been applied.
Risk	Uncertainty of outcome (whether positive opportunity or negative threat). It is the combination of the chance of an event and its consequences.
Risk Assessment	A process that involves the identification, analysis and evaluation of risks
Risk Management	Risk Management is a systematic approach to minimising an organisation's exposure to risk. A risk management process includes: Establishing the context, risk assessment, risk treatment, monitoring and review.
Risk Register	A risk register is an ordered log of known risks that is populated and reviewed following routine events. E.g. an incident, risk assessment, a claim, a complaint.
Risk tolerance	The level at which risk is considered acceptable or unacceptable
Senior Manager	'Senior managers' are those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS foundation trust. This would include the Chair, the Executive and Non-executive Directors of the NHS Foundation Trust and others

	identified by the Chief Executive.
Significant Risk	A significant risk is any risk, with a rating of amber or red that has been identified as being significant to the fulfilment of the Trust's corporate strategic aims and objectives.
Strategic Risk	Risk concerned with where the organisation is going, how it plans to get there and how it can ensure survival.
Unacceptable Risk	Any risk assessment which results in a rating of Moderate (Amber) or High (Red) should be regarded as unacceptable and actions must be identified to reduce the risk.

7.0 Risk Management Arrangements

7.1 Trust Board

The Trust Board will oversee the adoption of a proactive and holistic approach to good Governance and the management of risk throughout the Trust. It will bring together, prioritise and co-ordinate clinical and non-clinical governance, risk and controls assurance issues, in a way that ensures that the Trust can make a Statement of Internal Control. This is undertaken through a review of the Corporate Risk Register and assurance from the Audit RM and CG committees (?check list of committees is complete) as well as review of the information contained in the Integrated Board Report and the Quality and Safety report.

7.2 Executive Committee

The Executive Committee consists of the Executive Directors, Clinical Care Group Directors and Corporate Directors. The aims of the Executive Committee are to work around a shared vision, foster strategic thinking, develop and lead change, enhance staff capability and performance, lead and co-ordinate strategic planning, formulate, advocate, communicate and implement corporate policies, and to set, monitor and enhance corporate performance. The Executive Committee meets weekly and reviews the Corporate risk register prior to submission to the monthly Trust Board.

The Executive Committee will oversee the management, performance and operation of the Trust and provide advice to the Board on all aspects of strategy, policy and performance.

7.3 Care Group Boards

The Care Group Boards have responsibility for implementation of risk management processes throughout their respective services. This includes systematic risk assessment and the use of risk registers to monitor and review levels of risk and where identified mitigating actions. Where significant risks have been identified that impact upon the Trust's Corporate Strategic aims these will be escalated onto the Trust's Corporate risk register to the Executive Team and Trust Board.

7.4 Audit Committee
As delegated by the Board, the Audit Committee shall review the effectiveness of financial systems for internal control and reporting and report to the Board of Directors on the levels of assurance. The Committee will also review the work of the other Trust assurance committees, in particular those in respect of clinical governance and risk management, drawing any issues to the attention of the relevant committee or the Board. Meetings shall be held not less than four times a year and one meeting must coincide with the financial year end timetable. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary. The Audit Committee will review and provide verification on the systems for Risk Management through annual audit and receive assurance reports in support of preparation of the Statement of Internal Control. The Audit Committee receives the minutes the Clinical Governance and Risk Management Committees. The Audit Committee reports directly to the Board. The Audit Committee receives the Corporate Risk Register direct from the Director of Corporate Affairs.

7.5 Risk Management Committee
The Risk Management Committee is established to ensure proactive, progressive and continuous improvement to the Trust's approach to risk management is achieved. The Risk Management Committee shall meet not less than quarterly and send minutes and reports to the Audit Committee and the Board. An annual report upon the effectiveness of the committees work will be presented to the Board. The Committee will review the Corporate Risk Register at each meeting and the departmental/Care Group risk registers on a rotational basis. The Committee is also responsible for approval, monitoring progress and reviewing projects to develop data quality within the Trust. The Committee will also receive reports on the aggregation of incidents, complaints and claims. Summary feedback of key issues and decisions made at the Risk Management Committee will be cascaded to Care Groups/Directorates for dissemination.

7.6 Clinical Governance Committee
The Clinical Governance Committee is established as a committee of the Board to ensure patients receive the highest quality of NHS care possible and oversee the clinical governance arrangements within the Trust. Meetings shall be held not less than six times a year. The Non-Executive Director or two board members of the Committee may request a meeting if they consider that one is necessary. The minutes of the Clinical Governance Committee shall be formally recorded and submitted to the Board and Audit Committee. The Clinical Governance Committee receives reports from Chief Medical Officer, Chief Nurse, Clinical Governance Manager, Head of Legal Services and Care Group Directors highlighting any areas of concern. Reports are received from sub committees as described in the terms of reference. The Corporate Risk Register is also received by the Committee at every meeting. The Committee also reviews the report on serious incidents.

7.7 Health and Safety Committee
The Committee acts as a forum to focus communication and consultation on health and safety matters. The committee will discuss areas of policy, arrangements and specific health and safety issues. Staff representation at the committee meetings is

encouraged. The Health and Safety Committee reports to the Risk Management Committee.

7.8 Fire Safety Management Group

The Fire Safety Management Group will monitor the compliance and implementation of the Fire policy, and advise the Health & Safety Committee. The group is responsible for reviewing overall Trust wide fire/safety issues, to monitor and prioritise all programmes of investment in fire precautions and ensure they are properly accounted for in the Trust's annual business plan. The Director of Estates and Facilities will undertake the role defined in Firecode 05-01 of Fire Safety Manager (Senior Operating Manager). Advising and assisting management in the interpretation and application of the provisions of legislation, Firecode and other legal requirements in respect of fire safety throughout all Trust locations. The Fire Safety Management Group reports to the Risk Management Committee.

7.9 Radiation Protection Committee (RPC)

The Radiation Protection Committee (RPC) will act as the means by which the Trust Chief Executive is kept informed of the current state of radiation protection across the Trust and in any changes in legislation and good practice relating to the use of ionising radiation. The committee will assist the Trust in fulfilling their legal obligations as a Radiation Employer by raising those issues that the committee feel are relevant to the safe use of radiation within the Trust. The RPC will also advise the Trust on any Health and Safety issues in respect of non-ionising radiation used within the Trust. The minutes of the Radiation Protection Committee meetings will be formally recorded. An annual report will be submitted to the Risk Management Committee.

7.10 Engineering Management Assurance Group

The Engineering Management Assurance Group reviews areas of engineering related non-compliance, communicates these risks Corporately and develops action plans to improve and provide long term assurance regarding the engineering and building statutory and technical compliance, against Health Technical Memorandums (HTM's), statute and Care Quality Commission (CQC) requirements. The Group will provide an annual report to the Risk Management Committee.

7.11 Infection Prevention & Control Committee

The IPCC has overall responsibility for the implementation of a Trust-wide Infection Prevention and Control Plan in collaboration with all key internal (Trust) and external (community) stakeholders. The Committee meets monthly (at least ten times per year) and provides minutes of meetings to the Clinical Governance Committee together with a summary of the the issues and actions from the Infection Prevention and Control Committee within the Quality report (which is from the CMO and CNO) The Board will be made aware on a monthly basis by the Chief Nurse/ Director of Infection Prevention and Control (DIPC) of all significant infection control issues and risks.

7.12 Medicines Committee
The Medicines Committee provides the overview of medicines management in the Trust and is supported by the Drug and Therapeutics Committee. The Medicines Committee reports to the Clinical Governance Committee.

7.13 Drug and Therapeutics Committee
The Drug and Therapeutics Committee reports to the Medicines Committee and supports that committee in reviewing medicine/drug errors and providing assurance on safe systems of work involving medicines.

7.14 Critical Care Committee
The Critical Care Committees provide assurance reports to the Clinical Governance Committee on the arrangements, improvements and risks associated with critical care and resuscitation. The Critical Care Committee reports to the Clinical Governance Committee.

7.15 Resuscitation Committee
The Resuscitation Committee is responsible for reviewing and reporting upon the effectiveness of arrangements for emergency response/resuscitation. The Committee reports to the Trust Critical Care Committee.

7.16 Child Protection Steering Committee
The Committee is responsible for keeping the Clinical Governance Committee, Executive Committee and Board fully informed of their accountability to the Local Safeguarding Children Boards of the West of Berkshire. The Committee reports to the Clinical Governance Committee through submission of an annual report.

7.17 Children Forum
The Children Forum is responsible for keeping the Executive Committee and Board fully informed of their accountability for compliance with the NSF for Children, Young People and Maternity Services, 2004; CQC Essential Standards of Quality and Safety 2010 as they relate to children. The Forum reports to the Clinical Governance Committee through a report every six months.

7.18 Maternity Clinical Governance Lead Committee
The Maternity Clinical Governance Lead Committee has overall responsibility for ensuring that there are robust systems for clinical governance in place within Maternity. Reference: Maternity Clinical Risk Management Strategy and Policy (MCRMSP).

7.19 Clinical Audit Committee
The Clinical Audit Committee is responsible for developing and implementation of the Clinical Audit Strategy. The Committee reports to the Clinical Governance Committee.

7.20 Patient Safety Council
The Patient Safety Council meets quarterly to review patient safety risks and report upon these to the Clinical Governance Committee. The Council also receives reports

on the aggregation of all incidents, complaints and claims. A Patient Falls Strategy Group reports into the Patient Safety Council.

7.21 Blood Transfusion Committee
The Blood Transfusion Committee reports upon details on blood transfusion usage and safety issues for Clinical Governance Committee assurance. The Committee reports to the Clinical Governance Committee at least annually.

7.22 Information Governance Group
The Information Governance Group (IGG) chaired by the Head of Governance meets monthly. It is a sub group of the Trust's Executive Committee.

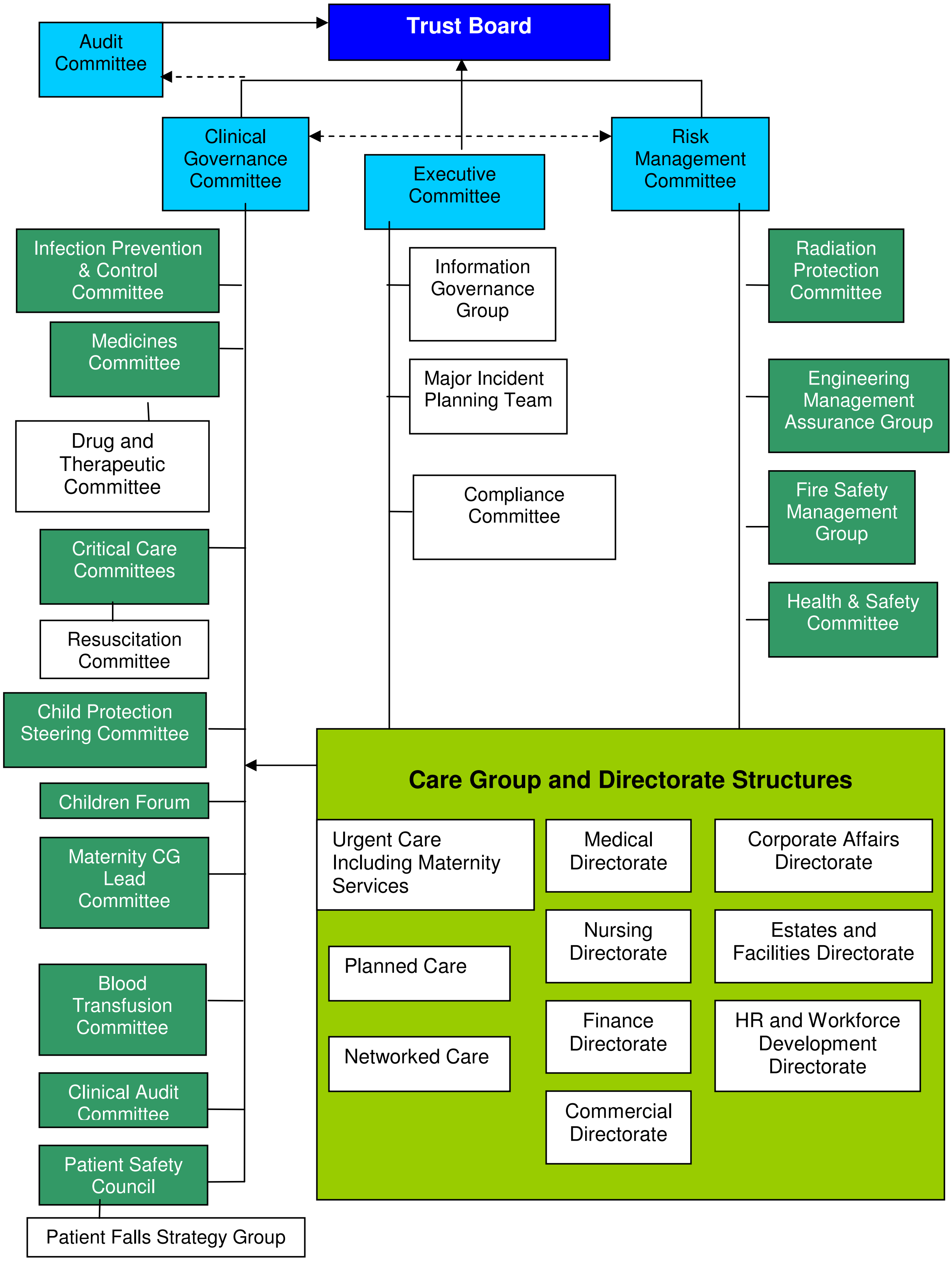
7.23 Major Incident Planning Team
The aim of the Major Incident Planning Team is to promote and facilitate the liaison and co-ordination, both within the Trust and the Emergency Services; Primary Care Trusts; Strategic Health Authority; Director of Public Health; the private sector; local authorities and voluntary aid societies, to ensure an effective co-ordinated, combined, cohesive response to a Major Incident, and to maintain operational resilience. The Team reports to the Executive Committee.

7.24 Compliance Committee
The role of the Committee is to provide direction, assurance and leadership, on behalf of the Executive Committee, on the satisfactory completion of the Trust's compliance regimes in respect of Care Quality Commission (CQC) Registration and NHS Litigation Authority (NHSLA) assessment. It will also drive and ensure successful implementation of the two regimes, resolving any specific issues reported to it and tracking and escalating to Directors/the Executive Committee as necessary. The Committee is chaired by the Director of Corporate Affairs and reports to the Executive Committee.

7.25 Local Clinical Governance Committee
Local Clinical Governance Committees are established to identify and build on good practices in order to assess and minimise the risk of untoward events and governance issues as they arise in the local area of activity. Annual Reports of these Committees go to the Clinical Governance Committee.

7.26 Resourcing / Funding
The Trust funds the addressing of risk minimisation through its operational budget arrangements devolved to the Care Groups and Departments.

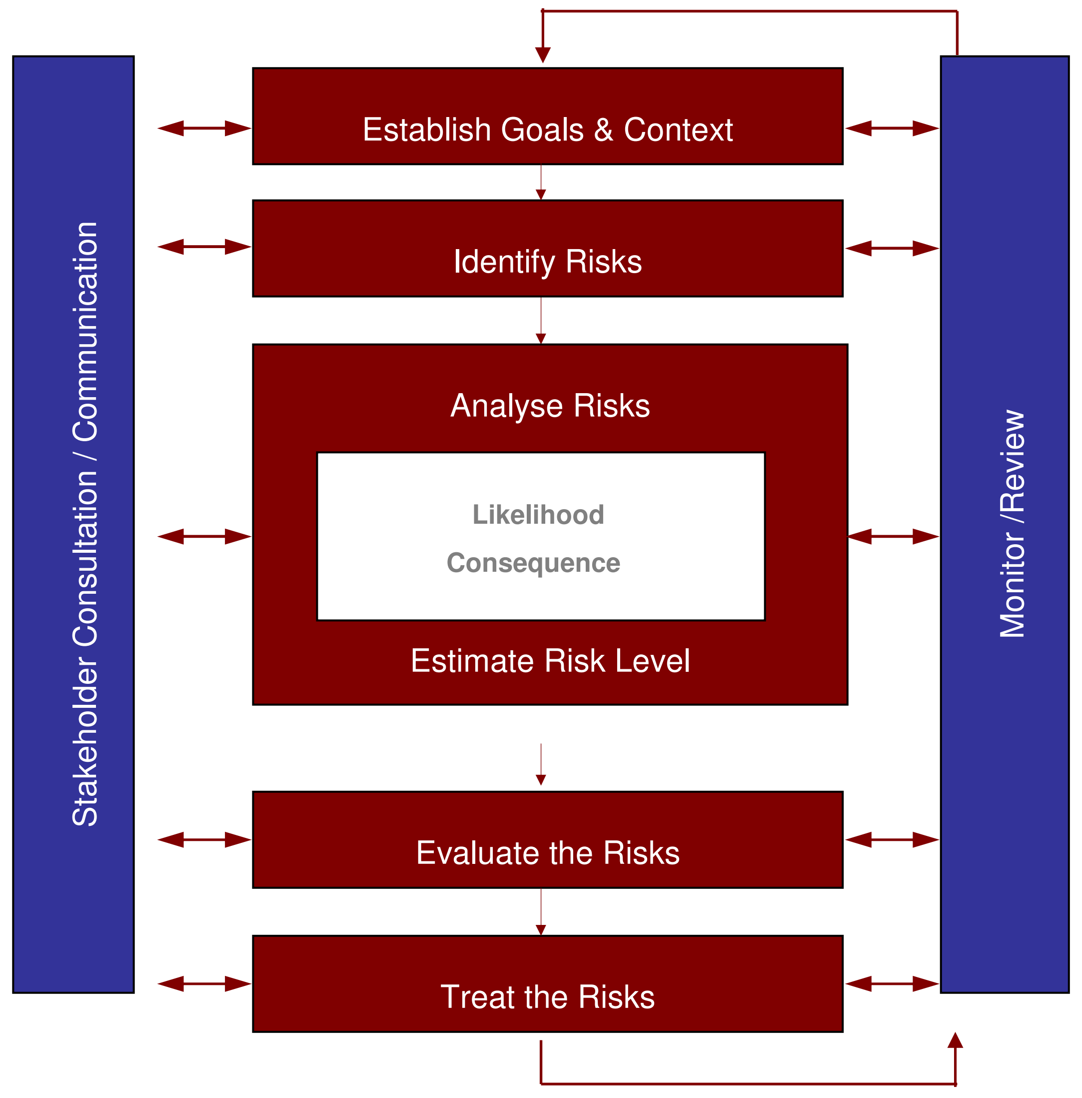
Figure 1: Organisational risk management structure.



8.0 Risk Management Process

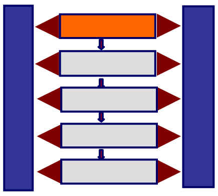
The Risk Management process is described as a list of co-ordinated activities that enable the Trust to assess all risks and ensuring a continual, systematic approach to all risk assessments is followed throughout the organisation.

Figure 2 – Risk Management Process



Adapted from Risk Management Standard AS/NZS ISO 31000 2009

8.1 Establishing the goals and context



Effective risk management requires a thorough understanding of the context in which the Trust and its Core Directorates/Care Groups operates. The analysis of this operating environment enables managers to define the parameters within which the risks to their outputs need to be managed.

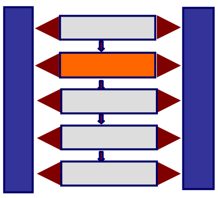
The context sets the scope for the risk management process. The context includes strategic, organisational and risk management considerations. Strategic context defines the relationship between the organisation and its environment. Factors that influence the relationship include financial, operational, competitive, political (public perceptions / image), social, client, cultural and legal. The definition of the relationships is usually communicated through analysis frameworks such as the SWOT (Organisational strengths, weaknesses, opportunities and threats) and PESTEL (Political, Economic, Social, Technological, Environmental and Legal). Other tools can also be used.

The organisational context provides an understanding of the organisation, its capability and goals, objectives and strategies. Organisational context is important because:

a) risk management occurs within the context of endeavouring to achieve the goals and objectives,
b) failure to achieve the objectives is one set of risks that need to be managed, and
c) the goals and strategies assist to define whether a risk is acceptable or unacceptable.

The risk management context defines that part of the organisation (goals, objectives, or project) to which the risk management process is to be applied. i.e. Ward/Department/Directorate/Corporate levels)

8.2 Identifying risks

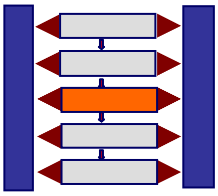


A range of information sources can be used to identify risks. These include, but are not limited to: Adverse events, incidents, near misses, serious incidents, investigation reports, complaints, claims, risk assessment, audit/internal control reports, assurance framework, CQC standards, legislation, financial reports, workforce reviews, survey reports and stakeholder reviews.

Although the above list is not exhaustive, it provides an indication of the various sources of information used to identify risks. Managers shall identify all types of risk that may impact upon the delivery of services for which they are responsible.

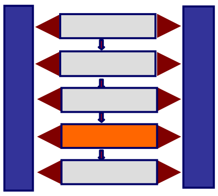
Identify the risks most likely to impact on your objectives, together with their sources and impacts. It is important to be rigorous in the identification of sources and impacts as the risk treatment strategies will be directed to sources (preventive) and impacts (reactive).

8.3 Analyse risks



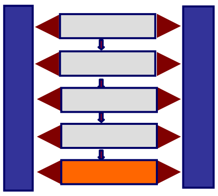
Identify the controls (currently in place) that deal with the identified risks and assess their effectiveness. Based on this assessment, analyse the risks in terms of likelihood and consequence. Refer to the **Trust Risk Matrix** to assist you in determining the level of likelihood and consequence, and the current risk level (a combination of likelihood and consequence).

8.4 Evaluate risks



This stage of the risk assessment process determines whether the risks are acceptable or unacceptable. This decision is made by the person with the appropriate authority. A risk that is determined as acceptable should be monitored and periodically reviewed to ensure it remains acceptable. A risk deemed unacceptable should be treated (see below). In all cases the reasons for the assessment should be documented to provide a record of the thinking that led to the decisions. Such documentation will provide a useful context for future risk assessment.

8.5 Determine the treatments for the risk



The range of risk treatment options or combination of risk treatments will vary dependant upon each risk and the costs and benefits applied to each option.

Treatment strategies will be directed towards:

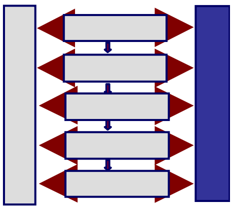
i. Avoiding the risk by discontinuing the activity that generates it, (rarely an option when providing services to the public),
ii. Reducing the likelihood of the occurrence,
iii. Reducing the consequences of the occurrence
iv. Transferring the risk, and
v. Retaining the risk.

Potential treatment options are developed according to the selected treatment strategy. The selection of the preferred treatment options takes into account factors such as the costs and effectiveness.

The determination of the preferred treatments also includes the documentation of implementation details (eg responsibilities, a timetable for implementation and monitoring requirements).

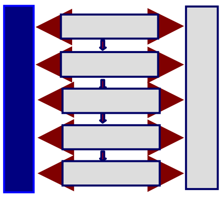
The intention of these risk treatments is to reduce the risk level of *unacceptable* risks to an *acceptable* level (ie: the target risk level). Use the **Trust Risk Matrix – APPENDIX A** to determine the expected reduction in level of risk (expected consequence, likelihood and Target risk level) resulting from the successful implementation of the treatment.

8.6 Monitor and report on the effectiveness of treatments



Managers are required to monitor the effectiveness of risk treatments and have the responsibility to identify new risks as they arise and treat them accordingly. Managers are also required to report on the progress of risk treatments at regular intervals. The person who has the responsibility for a risk treatment is expected to provide feedback on the progress of the 'project / initiative' as detailed in the 'monitoring' field of the treatment.

8.7 Stakeholder consultation/Communication



Involving key individuals/groups that may be affected by the risk can help with gaining an understanding of their perspective and ensure commitment and buy-in to changes that may be required for treatment. Communication may occur at any phase of the process and particularly when authority for decisions are required.

9.0 Corporate Risk Register Review

The Corporate Risk Register contains the risks associated with the Trust's Annual Plan and is populated with Red and Amber risks from the Care Group and Core Directorate Risk Registers that impact on the Trust's Corporate/Strategic priorities. Each Care Group/Core Directorate reviews their risk register at least quarterly and submits the register to the Trust Risk Manager.

The Trust Risk Manager will then review the risk registers and update the Corporate Risk Register for submission to the monthly Trust Board via the Executive Committee.

The Trust Risk Manager will review the Corporate Risk Register with the Executive and Corporate Directors on an individual basis prior to submission to the Trust Board via the Executive Committee.

The Risk Management Committee and Clinical Governance Committee will receive the Corporate Risk Register at every meeting. The Audit Committee receives the Corporate Risk Register direct from the Director of Corporate Affairs.

10.0 Local risk management process

Each Care Group/Core Directorate will produce a local risk register.

- For Care Groups, these will be Care Group/Specialty risk registers
- For the Core services, this will be a Core Directorate risk register.

Risk Registers are living documents which show the status of risk affecting the Trust at a local level. Risks are entered onto the register through the identification of risks from incident reports, risk assessments, local risk registers and external recommendations and other sources. .

The risk register is essential to the direction the Trust takes in assigning resources to control or eliminate risks of a financial, organisational or clinical nature and deciding when a risk is acceptable.

10.1 The Risk Assessment and Risk Register Process

All Trust staff should refer to the Trust Risk Assessment Policy for further details on risk assessment. The following stages describe the processes for escalation of risks through the organisation to the Board.

Stage 1 Local risk registers are developed by the responsible Department Manager with assistance from the Risk Manager if required. Risks categorised as very low and low are to be managed locally within the Department. Those risks that are graded as moderate or high risk must be escalated to the Care Group/Core Directorate risk register.

Stage 2 Each Care Group/Core Directorate will develop and maintain a Care Group/Directorate risk register which will be populated by risks identified from incident reports, risk assessment, local risk registers, external recommendations and other sources. Each Care Group/Directorate will review their risk register at least quarterly and those risks graded as moderate or high risk that impact upon the Trust's Corporate Strategic aims and objectives will be escalated to the Trust's Corporate Risk Register. Each Care Group/Core Directorate will continue to be responsible for managing the treatments/actions of their risks unless further authority is required.

Stage 3 The Corporate Risk Register is populated with Trust's Annual Plan risks and also populated with Red and Amber risks from the Care Group and Core Directorate Risk Registers that impact upon the Trust's Corporate/Strategic aims and objectives. The Corporate Risk Register is then reviewed by the Executive Committee prior to submission to the Trust Board.

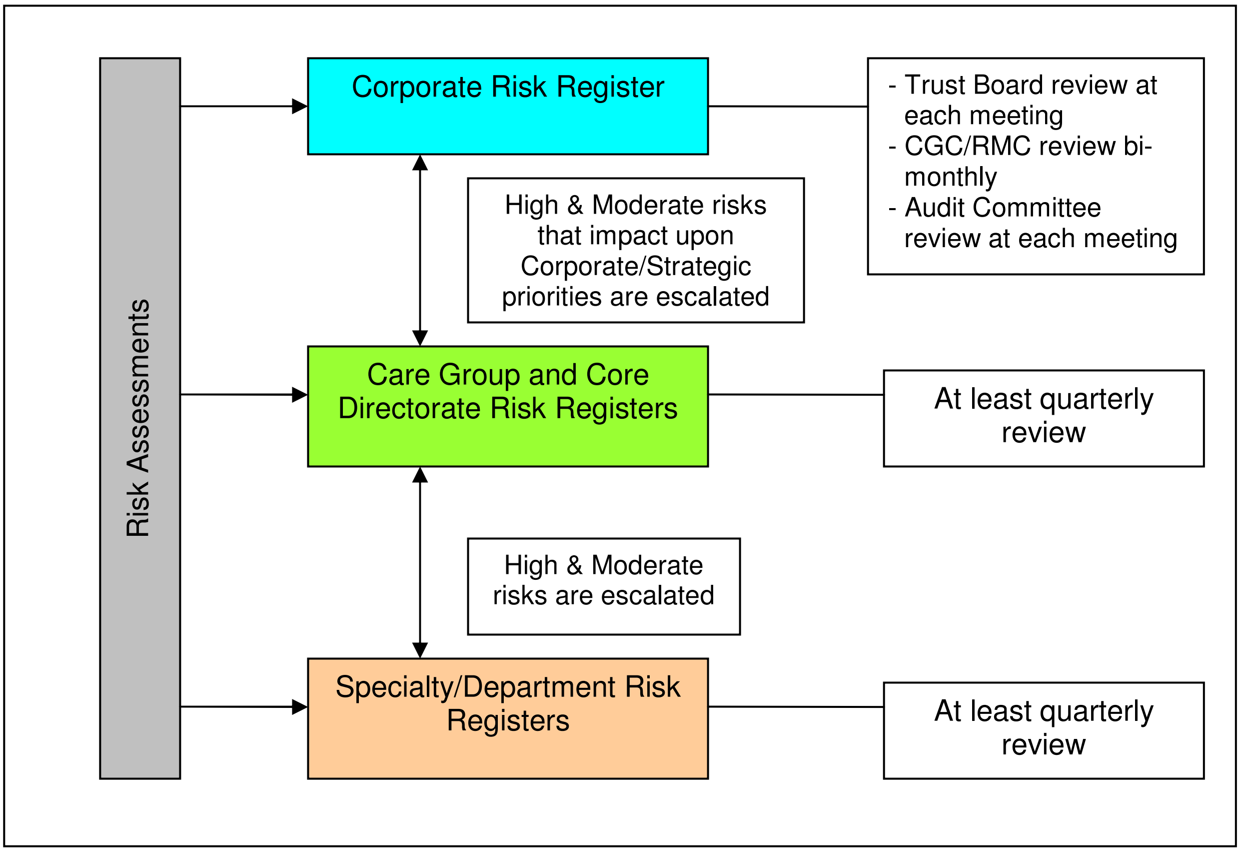
10.2 Manager's authority for dealing with identified risks

All Managers are responsible for managing risks, implementing and monitoring any appropriate risk management control measures within their designated areas and scope of responsibility. Where budgetary/resource restrictions apply Managers should escalate those risks to their Care Group/Core Directorate Manager.

Care Group/Departmental Managers have the authority to address risk treatments in their Care Group, utilising their budget.

Where the risk cannot be managed within the Manager's resources it must be escalated to the respective service Director. In situations where significant risks have been identified and where local control measures are considered to be potentially inadequate, this should be raised at the Executive Committee by the Director responsible or representative. The Executive Committee will discuss the matter and decide appropriate action. The responsible Director or representative will be responsible for providing feedback on the decision made by the Executive Committee to the relevant persons.

Figure 3 – Risk Register Flow



11.0 Risk Register layout

As a minimum risk registers must include the following:

- The source of the risk (including, but not limited to, incident reports, risk assessments local risk registers and external recommendations) i.e. where did this risk originate
- Description of the risk
- Risk score or rating
- Summary risk treatment plan i.e. what action is being taken by whom and when will it be completed
- Date of review
- Residual risk rating i.e. what is the risk score after action/treatment has been completed.

Appendix B shows **an example** of the Risk Register format to be used throughout the Trust. The actual template is in Excel spreadsheet format and can be obtained from the Corporate Risk Department intranet page.

12.0 Consultation Undertaken

Prior to review and ratification through the Risk Management Committee, the policy will be circulated to Executive Directors/Care Group Directors for comment.

The Head of Governance is responsible for archiving all previous versions and supporting evidence of approval for this policy.

13.0 Dissemination/Circulation/Archiving

Following approval this document will be brought to the attention of all staff through Trust briefings and available on the Trust's Intranet in the Policies section. The Head of Governance is responsible for archiving all previous versions and supporting evidence of approval for this policy.

14.0 Implementation

All Managers will be expected to disseminate to their service /departments for implementation and to ensure that the Trust Risk Management Strategy and Policy is effectively embedded within their respective areas.

15.0 Training

Awareness and compliance with Trust policies and procedures must be undertaken through training systems. Training of all Trust staff in the risk management system is not only essential to the operation of the system, strategy and Trust culture; it is also required by law under the Health & Safety at Work etc. Act 1974. All staff will receive risk awareness training through core induction supported further by specific risk training programmes as identified in the Trust's Training Needs Analysis. The process for recording attendance and follow-up of non-attendance is described in the Trust's Mandatory Training Policy.

Board members and senior managers
Board members and senior managers receive relevant risk management awareness training through induction and annual seminars. Risk management awareness training is a mandatory requirement and the processes are described in the Trust's Mandatory Training Policy and training needs analysis.

16.0 Monitoring compliance and effectiveness

The following table provides a summary of the monitoring processes for this document.

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual or department responsible for the monitoring	Frequency of the monitoring activity	Group/committee/ forum which will receive the findings/monitoring report	Committee/ individual responsible for ensuring that the actions are completed
The duties of the key individual(s) for risk management activities	To be addressed by the monitoring activities below				
The organisational risk management structure detailing all those committees/sub-committees/groups which have some responsibility for risk.	Review of structural arrangements	Legal Services and Risk	Annual	Risk Management Committee, Audit Committee	Risk Management Committee
The process for board or high level committee review of the organisation-wide risk register.	Review of meetings	Director of Corporate Affairs	Quarterly	Risk Management Committee, Audit Committee, Trust Board	Risk Management Committee
The process for the management of risk locally, which reflects the organisation-wide risk management strategy.	Review of risk management processes	Risk Manager	Quarterly	Risk Management Committee	Risk Management Committee
The authority of all managers with regard to managing risk.	Audit and inspection of local risk assessments and risk management methods	Directorate/ Care Group managers	Rolling programme with annual review and report	Risk Management Committee	Risk Management Committee
The process for ensuring that all board members and senior managers receive relevant risk management awareness training, that attendance and completion of training is recorded and non-attendance	Review of training log	Risk Manager	Annual	Risk Management Committee	Risk Management Committee

followed up.					
Minimum requirements for risk registers and significant risk from incidents, risk assessments, directorate/Care Group risk registers and external recommendations	Review of risk register minimum requirements and significant risks populated on Corporate Risk Register	Risk Manager	Quarterly	Risk Management Committee	Risk Management Committee

Note: The monitoring requirements may be amended in order to meet the changing requirements of the organisation.

17.0 Supporting Documentation and References

Health and Safety at Work Act 1974

NHSLA Risk Management Standards for (Acute) Trusts

Integrated Governance Handbook -A handbook for executives and non-executives in healthcare organisations – Department of Health, February 2006

The NHS Foundation Trust -Code of Governance – Monitor 2006
http://www.monitor-nhsft.gov.uk/documents/Monitor_Code_Gov_final.pdf

18.0 Equality Impact Assessment – Risk Management Strategy

	Age	Disability	Race	Gender	Religion or Belief	Sexual Orientation
Do different groups have different needs, experiences, issues and priorities in relation to the proposed policy?	**N**	**N**	**N**	**N**	**N**	**N**
Is there potential for or evidence that the proposed policy will not promote equality of opportunity for all and promote good relations between different groups?	**N**	**N**	**N**	**N**	**N**	**N**
Is there potential for or evidence that the proposed policy will affect different population groups differently (including possibly discriminating against certain groups)?	**N**	**N**	**N**	**N**	**N**	**N**
Is there public concern (including media, academic, voluntary or sector specific interest) in potential discrimination against a particular population group or groups?	**N**	**N**	**N**	**N**	**N**	**N**

The Policy has no relevance to employment, educational, organisational services which might affect any persons under any of the equality groups in the table above.

Based on the information set out above I have decided that an equality impact is not necessary.

Name: Niall Smyth, Risk Manager

Signed:

Care Group/Dept/area: Legal Services and Risk

Date: May 2012

APPENDIX A

Risk Grading Matrix

Risk Grading	**Most likely severity/impact (if in doubt grade up, not down)**				
	Insignificant 1	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**
Consider the severity/impact of the risk first and then the likelihood of the event occurring. Use the matrix to determine the risk grading of the risk. e.g. Moderate severity (3), Unlikely likelihood ((2), Risk Grade Low (6) Record your score as: 3 X 2 = 6 to demonstrate how you arrived at your grading.	• No injury or identifiable damage	• Minor injury or minor damage to property	• Moderate injury, ill health, damage or loss of function lasting more than 3 working days	• Serious injury/death, ill health, damage to property	• Multiple deaths/ serious injuries
	• No disruption to service or the organisation	• Impact would threaten the efficiency of some aspect of the organisation	• Disruption to a service	• Serious disruption to a service which impacts on patient care	• Organisation unable to function
	• Financial implications are negligible	• Some financial impact	• Moderate financial impact (> £50k)	• High financial impact (>£500k)	• Very high financial impact (>£1M)
	e.g. spills of non-hazardous liquids – no injury	e.g. absence from work of less than 3 working days	e.g. RIDDOR reportable injury, local adverse publicity	e.g. Major property damage, roof collapse, national adverse publicity, major IT network failure.	e.g. large scale fraud, national adverse publicity (more than a week), adverse event involving more than 50 people.
Likelihood:					
Rare 1	Very Low 1	Very Low 2	Low 3	Low 4	Low 5
Unlikely 2	Very Low 2	Low 4	Low 6	Moderate 8	Moderate 10
Possible 3	Low 3	Low 6	Moderate 9	Moderate 12	High 15
Highly likely 4	Low 4	Moderate 8	Moderate 12	High 16	High 20
Certain 5	Low 5	Moderate 10	High 15	High 20	High 25

Example Trust Risk Register Template

Appendix B

Strategic Objective/Annual Plan Target	ID Number	Source of Risk (e.g. incident reports, risk assessments, local risk registers, external recommendations)	Care Group/Directorate, Service or Department	Risk Description	Impact	Likelihood	Risk Score (LxI)	Summary of risk treatment plan	Responsibility (Name & Designation)	Resource implication (£)	Expected date of Completion & Action Plan	Exec Ownership	Date of Review	Residual Rating	Is this rating acceptable?	**Positive Assurance** (there are sufficient and relevant, assurances to confirm the effectiveness of key controls and that objectives will be met)	**Gaps in Control** (there's clear conclusion, based on sufficient and relevant work that one or more of the key controls are not effective)	**Gaps in Assurance** (There's a lack of assurance, either positive or negative about the effectiveness of one or more of the key controls.
Below are the risks identified for monitoring at corporate level				**This is a "live" document and risks can vary from time to time**	**I**	**L**												
Develop the best place to work, train and learn	CRR1	Risk assessment	HR & Workforce Development	Failure to achieve Trust appraisal rate of 95%	4	3	12	Reviewed appraisal and monitoring systems	HR & Workforce Development Director	none	31/03/2012	JCI	Monthly	3	Y			
	2																	

Author:	Niall Smyth	Date:	May 2012
Job Title:	Risk Manager	Review Date:	May 2014
Policy Lead:	Keith Eales, Director of Corporate Affairs	Version:	Version 3.5
Location:	Corporate Governance shared drive – CG027		

Risk Management Process Chart

APPENDIX C