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Magdala Avenue
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Whittington Health Trust Board

28 November 2012

Title:	**Risk Management Strategy review and updates.**		
Agenda item:	**14**	**Paper**	**I**
Action requested:	For Board approval, review of the Risk Management Strategy conducted as part of High Level Due Diligence 1 actions.		
Executive Summary:	The purpose of this paper is for the Board to approve the updated changes to this Strategy, to be aware of the revised changes and to note this was part of an agreed review cycle during October 2012 as part of the HDD1 actions. This strategy has been reviewed at the Executive Committee and Audit and Risk Committee prior to submission. The key headline changes are: • Removal of the Statement of Internal Control to be replaced by Annual Governance Statement effective from 29th February 2012. Page 4 • Inclusion of CIP Board as a committee for management of risk. Page 7 • Minor changes to job titles, role content, accountabilities and responsibilities remain the same. Page 9 • Integrated risk management system. Page 13 • Revision to the frequency of review for the Board Assurance Framework at the Board from Quarterly to Monthly. Page 19 • Updates to section 9.2.3 and 9.2.6. Page 21 • Revised organogram demonstrating committees with responsibility for Risk Management. Page 29 • Updates draft Terms of Reference for Audit and Risk Committee to be agreed at November Audit Committee. Page 30 • Monitoring arrangements updated. Pages 61, 62 • Quality Committee terms of reference to be added for inclusion within the strategy following approval at 21st November 2012 Committee. The Trust Board is asked to review and approve the changes contained within the Whittington Health Risk Management		

	Strategy at the November 2012 board.
Summary of recommendations:	Audit and Risk Committee to review and comment on changes to the Risk Management Strategy, prior to Board submission for final sign off.
Fit with WH strategy:	1. Integrated care 2. Efficient and Effective care 3. Improving Population Health 4. Culture of Innovation and Improvement
Reference to related / other documents:	NHS Litigation Authority (NHSLA) Risk Management Standards 2012/13 Standard 1, Criterions 1/3/4/ and 5
Date paper completed:	16th November 2012

Author name and title:		**David Williams Assistant Director of Governance**		**Director name and title:**		**Bronagh Scott Director of Nursing and Patient Experience**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Risk assessment undertaken?**		**Legal advice received?**	

Whittington Health NHS

Risk Management Strategy

Subject:	Risk Management Strategy
Policy Number	
Ratified By:	Whittington Health Board
Date Ratified:	December 2011
Version:	1.2
Policy Executive Owner:	Bronagh Scott
Designation of Author:	Assistant Director of Governance
Name of Assurance Committee:	Audit and Risk Committee
Date Issued:	December 2011
Review Date:	May 2012
Target Audience:	All staff
Key Words:	Risk Management

Version Control Sheet

Version	Date	Author	Status	Comment
1.0	December 2011	David Williams	Assistant Director of Governance	—
1.1	January 2012	David Williams	Assistant Director of Governance	Formatting changes
1.2	May 2012	David Williams	Assistant Director of Governance	Changes to Committee Structures.
1.3	May 2012	David Williams	Assistant Director of Governance	Committee structure chart inserted
1.4	October 2012	David Williams	Assistant Director of Governance	1. Revised committee structure chart 2. Revisions to frequency of BAF Review at Board 3. Revision of removal of Statement of Internal Control to include Annual Governance Statement. 4. Minor changes to Job Titles, role content, accountabilities and responsibilities remain the same. 5. Updates draft terms of reference for Audit and Risk Committee.

1. Introduction

1.1 This document outlines Whittington Health's organisation wide approach to risk management. Specifically:

- Whittington Health committee structure, detailing all those committees and sub-committees/groups which have responsibility for risk
- Roles and responsibilities of all staff with regards to risk management
- The process for identification, assessment and management of risk
- The process for managing, and Board review of, the organisation wide risk register
- The process for monitoring the risk management strategy and ensuring it is effective

Definition: Risk management is the identification, assessment and management of risks so as to minimise their potential consequences and likelihood of occurrence.

An effective risk management strategy is essential to ensuring a high quality of care and safe services for patients and the resident population that Whittington Health serves that is cost effective and provides a safe working environment for staff.

1.2 This strategy reflects current best practice taking into account a range of governance standards including:

- Care Quality Commission (CQC) Registration
- The NHS Litigation Authority (NHSLA) Risk Management Standards
- The National Patient Safety Agency (NPSA)
- Health and Safety and other related legislation
- Department of Health (DH) Annual Governance Statement and the Board Assurance Framework
- Monitor frameworks as an aspirant Foundation Trust (FT)

2 Purpose

2.1 Risk management is a central part of the organisation's overall activities and the strategy therefore relates to all aspects of Whittington Health's activities.
The risk management strategy by its very nature relates to a number of Whittington Health policies. All policies can be located on the intranet at: SITE

It is recommended that the strategy be read in conjunction with the following policies which directly relate to Whittington Health's risk management functions: *note this list is not exhaustive*

- Maternity Risk Management Strategy
- Incidents and Serious Incident Reporting Policy
- Complaints Policy
- Patient Advice and Liaison Service Operational Policy
- Claims Handling Policy and Procedures
- Policy on Procedural Documents (policy on policies)
- Policy for investigations, analysis and improvement
- Being Open
- Management of External Assessments Policy
- Health and Safety Policy
- Staff Induction Policy
- Mandatory Training Policy and Training Needs Analysis
- Safeguarding Vulnerable Adults Policy
- Child Protection Policy
- Infection Control Policy
- Managing concerns about doctors performance policy

2.2 This strategy has been developed to ensure this corresponds with the achievement of the strategic objectives of Whittington Health which are contained within the Whittington Health Strategy document approved by the board. The Whittington Health objectives are reviewed and then subsequently updated on an annual basis and can be accessed via the intranet.

Whittington Health will ensure all principle risks (Extreme/high risks) to the achievement of the strategic objectives are identified and effectively managed. This will form the basis of the Trust's assurance framework. The assurance framework provides direct assurance to the Board that a risk management system is in place. Its main function is to direct the Board to where assurance will be provided regarding how the key risks are being controlled. The Executive is responsible for implementing the controls approved by the Board (e.g. strategies, policies, plans) and the Board will receive assurance that these controls are working through a variety of management reports, which will be regularly received at meetings.

It should be understood that there are some risks which the Board will receive assurance from third parties (internal/external audit, CQC, NHSLA). These third party reports not only provide direct assurance to the Board, but they also help to verify internal management reports.

2.3 Application of the BAF

As the environment and technology change, new risks will appear or manifest themselves differently. This can lead to "Gaps" appearing in either the Controls or Assurances. These Gaps are a natural consequence of change and regular review of the BAF helps to identify them at an early stage. Where a Gap appears then the Board must put in place an Action Plan to close the Gap in the Control or the Assurance. If it were possible to reach a stable position then the Board should see "no Gaps and no Action Plans" in its BAF.

A common misconception of the BAF is to expect the "Action Plan" to address the risk itself. This is false as it is the "Control" that addresses the risk. This misunderstanding can lead to the potential of the situation of the Executive using the Action Plans to fire fight risks at the expense of implementing the approved "Controls" to manage the risks.

Additionally a number of specific risk management objectives have been developed to ensure this strategy is achieved. Further detail regarding the objectives is included in appendix 3.

Objective 1 - To develop a risk aware culture throughout Whittington Health by:

- Developing the organisation
- Establishing a learning culture which is accountable for its activities/actions
- Improving induction courses and continuous professional education
- Organising risk management training for all staff
- Including Risk Management updates within Whittington Health newsletters to reinforce the need for staff to consider and assess risk in all daily work activities

Objective 2 - To ensure that appropriate systems are in place for identifying, assessing and controlling key risks by:

- Ensuring all staff are aware of and understand the risk management procedures
- Developing an integrated risk management system including an incident reporting system which supports the management of risk and leads to action that reduces the likelihood of the incidents recurring

Objective 3 - To embed the concepts and ideas of risk assessment and risk management into the day to day working practices of Whittington Health by:

- Covering risk management in annual performance reviews, job descriptions and recruitment selection criteria
- Making risk management a regular agenda item at Board and Divisional Management meetings

- Ensuring all strategic and business plans consider risk management

Objective 4 - To maintain effective organisational structures for risk management so that a consistent trust-wide approach to risk management is taken by:

- Ensuring that the structures and responsibilities set out in this strategy are effective in practice
- Ensuring that the Board reviews annually the effectiveness of structures and responsibilities to identify any useful improvements
- Developing an effective framework to support the risk management activities of all services

Objective 5 - To ensure that the Whittington Health's Chief Executive is provided with evidence that risks are being appropriately identified, assessed, addressed and monitored by:

- Ensuring Risk Registers and Action Plans are kept up to date through regular reviews being undertaken in each department/service/division on an agreed cycle as defined within the **structured review cycle for risks,** this is to ensure that risk recording and analysis is effective and that suitable evidence files are maintained and risks are appropriately managed
- Monitoring the results of independent reviews by internal audit and the NHSLA's representatives
- An Audit Committee review of assurance and risk management progress on behalf of the Board, undertaken annually prior to the signing of the Statement on Internal Control by the Chief Executive

Objective 6 - To ensure good and steady progress in the implementation of effective Risk Management across the Trust by:

- Establishing and monitoring performance indicators covering the risk management process
- Taking part in available National/Regional benchmarking to identify not only how well Whittington Health is doing but also what steps it can take to improve further
- Ensure the Board has a full understanding of risk management processes and principles
- Ensure the Board has a full understanding for the management of reputational risk

Objective 7 - To comply with relevant clinical and corporate governance requirements and to adopt wherever possible best practice by:

- Completing relevant self-assessments and reviews in order to achieve compliance against the relevant governance requirements.
- Implementing a system for continuously informing the Board on compliance with such standards taking into account existing NHS Trust requirements and the aspirations for Foundation Trust status

3. Duties, roles and responsibilities

3.1 Duties within the Organisation

This section outlines the roles and responsibilities of key individuals and committees with responsibility for risk management. A committee structure is included in Appendix 4, outlining how all the committees with specific responsibility for risk management report up to the Board and Board Sub Committees.

3.2 Whittington Health Board

The Board has overarching responsibility for gaining assurance that Whittington Health has effective processes in place for managing risk, meeting all statutory requirements and adhering to guidance issued by the Department of Health in respect of risk management and governance.

The Whittington Health Board role is to undertake strategic leadership and decision making for the organisation and to utilise the use of the Board Assurance Framework in support of strategic decision making and risk management.

3.2.1 Finance and Development Committee

The Finance and Development Committee shall undertake on behalf of the Trust Board objective scrutiny of the Trust's financial plans, and proposed major investment decisions. The Board may request that the Committee reviews specific aspects of financial performance where the Board requires additional scrutiny and assurance.

3.2.2 Cost Improvement Plan (CIP) Board

The Cost Improvement Plan (CIP) Board shall undertake on behalf of the Finance and Development Committee scrutiny of the Trust's Cost Improvement Plans, identifying risks to delivery and quality. The CIP Board will undertake deep dives for CIP plans where there are concerns in terms of delivery or quality issues. Areas of concerns will be escalated via parent committees.

3.3 Audit Committee and Risk Committee

The Audit and Risk Committee has overall delegated responsibility for ensuring Whittington Health establishes and maintains an effective system of integrated governance, risk management and internal control. The committee will provide regular updates to Whittington Health Board and report any exceptional issues. (see Appendix 4 for further detail).

3.3.1 Information Governance Committee

The information governance committee will provide the professional leadership to drive and support the information governance agenda, and provide the Audit and Risk Committee with the assurance through routine reporting that effective information governance best practice mechanisms are in place within the organisation and are effective.

3.4 Health and Safety Committee

The Health and Safety Committee will be responsible for the operation and implementation of the Health and Safety Strategy and related policies including, Fire safety and security management issues.

The Health and Safety Committee has representation from the recognised Trade Unions as part of their terms of reference and activity.

The Health and Safety Committee reports to the Audit and Risk Committee on an agreed cycle.

3.5 Trust Operational Board

The Trust Operational Board will be responsible for the effective and efficient operational management of the Trusts three divisions, (Surgery, Cancer and Diagnostics; Integrated Care and Acute Medicines; Women Children and Families) to include performance on quality and access targets, financial performance, Quality Innovation Productivity and Prevention (QIPP), Cost Improvement Plans (CIP) and workforce performance.

3.5.1 Divisional Boards

The Divisional Boards have responsibility for ensuring that within their delegated duties they have effective processes in place for managing risk within their service line accountability, they also take responsibility for the escalation of risks where this falls outside of their scheme of delegation or managerial authority.

3.6 Divisional Senior Management Team (SMT)

The Divisional Senior Management Team has the responsibility for the day to day running of the operational management of services for the three divisions, Integrated Care and Acute Medicine, Surgery Cancer and Diagnostics, Women's Children & Families. Within this operational remit also includes the operational management of Human Resources (People) Estates and Facilities.

3.7 Quality Committee

The Quality Committee has overall responsibility for ensuring that sound principles of Quality Governance are embedded and assured throughout Whittington Health with primary focus on the three elements of Patient Safety, Clinical Effectiveness and Patient Experience.

Provides regular updates to the Whittington Health Board and reports exceptional issues in relation to risks to quality of services.

There are a number of committees with specific responsibility for risk management that report into the Quality Safety Committee. These are detailed in Appendix 4

3.7.1 Executive Committee

The Executive Committee has overall responsibility for the management of day to day operations within the organisation and operational responsibility for implementing the organisations strategy, they will also take oversight of the strategic/corporate level of risks outside of the structured board meetings and will take responsibility for escalation of risks to board members.

3.8 Chief Executive

The Chief Executive has overall responsibility for ensuring an effective risk management system is in place across Whittington Health.

3.9 Director of Finance

The Director of Finance has overall responsibility for ensuring the implementation of financial and business risk management within Whittington Health and will:

- Ensure the financial and business performance systems of the trust are robust
- Provide information and financial/business risk management assurance to the board
- Provide support to the Trust Audit and Risk Committee
- Ensure relevant policies and procedures are reviewed and updated
- Work with other directors to integrate risks management across the organisation in terms of current statutory duties and aspiration to become a Foundation Trust

3.10 Chief Operating Officer

The Chief Operating Officer has overall responsibility for ensuring an effective risk management system is in place across all 3 Divisions:

- Integrated Care and Acute Medicine,
- Surgery, Cancer and Diagnostics,
- Women, Children and Wellbeing

Security Management Director (SMD)

Any other operational functions within their remit of accountability to include Human Resources (People) Estates and Facilities.

3.11 Director of Nursing and Patient Experience

The Director of Nursing and Patient Experience has an executive level of responsibility for ensuring that there are effective Corporate systems for risk management in place for Whittington Health.

3.12 Divisional Operations / Medical Directors

These Senior Management Team members have responsibility for ensuring risks are identified and managed at an appropriate level across Whittington Health Divisions and they have arrangements in place within their divisions for the ongoing management of the Divisional Risk Registers.

Specifically:

i. Risks are identified, assessed and actions agreed
ii. Managers and staff under their management control are aware of this strategy and their responsibilities for implementing it
iii. Risks are reported and recorded in accordance with this strategy
iv. That staff attend appropriate training

3.13 Non Executive Directors

All non executive directors are required to assure themselves that Whittington Health has robust and effective systems for risk management. Through membership on the Board and Board sub committees non executive directors will receive, review and comment on regular risk management updates and ensure satisfactory progress is made against action plans.

3.14 Assistant Director of Governance

Ensure that risk management processes are effective covering the following elements (strategic, financial, operational, clinical and reputational) ensure that effective flows of information for risk management are achieved from service to board. And these run as continued strands through the organisation ensuring effective escalation and management of risk.

3.15 Head of Corporate Governance and Risk

Ensure that all aspects of risk management (strategic, financial, operational, clinical and reputational) are met, to be completed and combined with quality assurance/ improvement programmes with particular focus on Care Quality Commission ongoing compliance, and linked to the achievement and ongoing improvement for NHS Litigation Authority Risk Management Standards

Lead on the development of an integrated risk and governance work plan in conjunction with Divisional/Directorate senior management leads to ensure that all aspects of risk and governance meet both current legislation and regulatory requirements and future aspirations for achievement of Foundation Trust status.

3.16 Risk Manager

The risk manager is responsible for facilitating risk management processes and activity across Whittington Health. This will include:

- Assisting with the development and review of relevant policies
- Assisting with the implementation of the risk management strategy
- Maintaining the corporate risk register
- Implementing and maintaining the organisation's system for incident reporting
- Identifying areas of actual or potential areas for patient safety risks
- Providing advice on risk management and patient safety

3.17 Director of Estates and Facilities

The Director of Estates and Facilities has overall responsibility for ensuring that optimal estate and facilities services are provided within available human and financial resources.

The Director is responsible for the day-to-day management of the Directorate of Estates & Facilities, which includes the provision of hard and soft services, decontamination services and Medical Physics services

- Be the Trusts' lead for ensuring adequate arrangements are made for fire safety, security management and health & safety across the organisation and that the necessary procedures are implemented and monitored.
- Be the Trust Lead for Decontamination Services and ensures that policies and procedures required to meet the requirements of the controls assurance standard for decontamination, and the standards required by current Health Technical Memorandums are met
- Acts as the trust's responsible officer for Security Management
- Acts as the trust's responsible officer for Fire Safety
- Acts as the trust's responsible officer for Health and Safety)

3.18 Local Security Management Specialist

The local Security Management Specialist will provide technical advice on security matters, monitoring the implementation of policies and procedures within their remit, identifying training needs and ensuring the provision of relevant training for existing and new staff, identifying and escalating risk management matters using the organisational policies and procedures.

3.19 Fire Safety Advisor

The Fire Safety Advisor is responsibly for providing advice on technical fire safety matters, monitoring the implementation of policies and procedures relating to fire safety issues, identifying training needs and ensuring the provision of relevant training for existing and new staff, identifying and escalating risk management matters using the organisational policies and procedures.

3.20 Health & Safety Advisor

The Health & Safety Advisor provides health and safety advice and support. As part of this arrangement, the Health and Safety Advisor supports a rolling programme of health and safety risk assessments on a monthly/three monthly basis with all sites and services.

The Health & Safety Advisor is responsible to the Director of Estates & Facilities for assisting with health, safety, and welfare responsibilities, and is available to all levels of management and staff for the provision of technical advice on these areas of responsibility.

This includes:

- Assisting with the development and review of policies
- Assisting with the implementation of the risk management strategy
- Implementing the organisations system for Health & Safety, Fire and Security reporting
- Identifying areas of actual or potential health and safety risks
- Providing advice on health and safety

3.21 All managers (including heads of service and service managers)

All managers are responsible for:

- Familiarising themselves with the risk management strategy and raising awareness and understanding of risk management processes within their work area
- Reviewing their areas of work to identify risks, agree appropriate actions and escalate risks as necessary
- Fostering a supportive work environment to facilitate the reporting of risks and incidents
- To investigate risks reported to them by staff
- Developing and implementing any local policies necessary to the effective implementation of risk management
- Ensuring staff have access to opportunities for training and development

- Ensuring that risk management is a regular agenda item at divisional, service and team meetings

3.22 All staff are responsible for:

- Attending mandatory and statutory training
- Co-operating with arrangements for minimising risk
- Working to Whittington Health policies
- Taking reasonable care for their own safety and that of others
- Taking care of Whittington Health's buildings, equipment and other assets
- Reporting risks, incidents and near misses

3.23 All committees are responsible for:

- Ensuring all risks raised either through committee papers or during discussion are assessed and included on the risk register as appropriate and appropriately managed in line with trust procedures.
- Receiving, reviewing and commenting on papers submitted to the committee regarding areas of risk relevant to the committee's remit

3.2 Consultation and Communication with Stakeholders

Brief description of involvement of stakeholders during the development of the document.

3.3 Approval of Policy

Sponsor/s and committees who will be approving the policy.

4 Definitions

4.1 **Risk** is defined as the possibility of incurring harm or loss, and may be associated with people (patients, staff, visitors etc), buildings and estates, systems, finance and equipment.

Risk management is the identification, assessment and management of risks so as to minimise their potential consequences and likelihood of occurrence.

Risk rating is the severity assigned to a risk. This is determined by multiplying the consequence of the risk by the likelihood of occurrence, as outlined in section 8 of this strategy.

A **risk register** can be described as: *"a log of all risks of all kinds that threaten an organisations success in achieving its declared aims and objectives. It is a dynamic living document which is populated through the organisations risk assessment and evaluation process. This enables risk to be quantified and ranked. It provides a structure for collating information about risks that helps both in the analysis of risks and in decisions about whether or how those risks should be treated"*.

4.2 **Controls –** in the context of this strategy the term 'control' refers to that which is in place to prevent a risk from occurring, or to reduce the potential consequences and likelihood. Examples of possible controls includes:

- Physical barriers such as protective clothing
- Training
- Implementation of policies and guidance
- Implementation of strategies
- Implementation of plans

Appendix 13 describes the hierarchy of controls in terms of Hazard Risk Management

Residual risk refers to the level of risk which remains after appropriate controls have been implemented.

Risk acceptability refers to the level of risk which the organisation is prepared to accept or tolerate. Whittington Health's risk acceptability is outlined in section 7.4.

Reputational risk A "reputation risk" materialises when the negative publicity triggered by certain business events, whether accurate or not, compromises the company's reputation and results in value loss for the firm, or a negative event that could have an impact on stakeholders' perception of a company or organisation.

4.3 Board Assurance Framework

A simple but comprehensive method for the effective and focussed management of principal risks for meeting the organisations objectives.

4.4 Corporate Governance

The on going activity of maintaining a sound system of internal control to safeguard stakeholders investment, protect the organisations assets and facilitate the achievement of the organisations aims.

5 Development of the Policy

5.1 Prioritisation of Work

- The justification and support for developing the new document. This strategy has been developed to ensure this corresponds with the achievement of the strategic objectives of Whittington Health which are contained within the Whittington Health Strategy document approved by the board. The Whittington Health objectives are reviewed and then subsequently updated on an annual basis and can be accessed via the intranet.

Links with service priorities all strategies and policies are linked back to strategic objectives of the organisation and this strategy supports the delivery of service priorities through setting out the framework for management of risk within the organisation, risk is an inherent part of the organisation and services carrying out their duties.

- Implementation is achievable within the resources of the service/organisation. And will be achieved through a structured implementation plan.

5.2 Responsibility for Document Development

Each policy under development should have:

A nominated author and a Lead Director.

Author: Assistant Director of Governance

Lead Director: Director of Nursing and Patient Experience

A committee with responsibility for monitoring development. This is defined within sections containing duties, roles and responsibilities

5.3 Equality Impact Assessment

Under the Race Relation (Amendment) Act 2000 the Trust is required to undertake equality impact assessments on all policies/guidelines and practices. This obligation has been expanded to include equality and human rights with regard to disability, age, gender and religion.

The Equality Impact Assessment Tool (appendix 16) is designed to help the author to consider the needs and assess the impact of this strategy in compliance with current legislation.

6. Process for the management of risk both locally and organisation-wide

This section outlines Whittington Health's processes for identifying, assessing and managing risk. This includes both corporate arrangements and local arrangements.

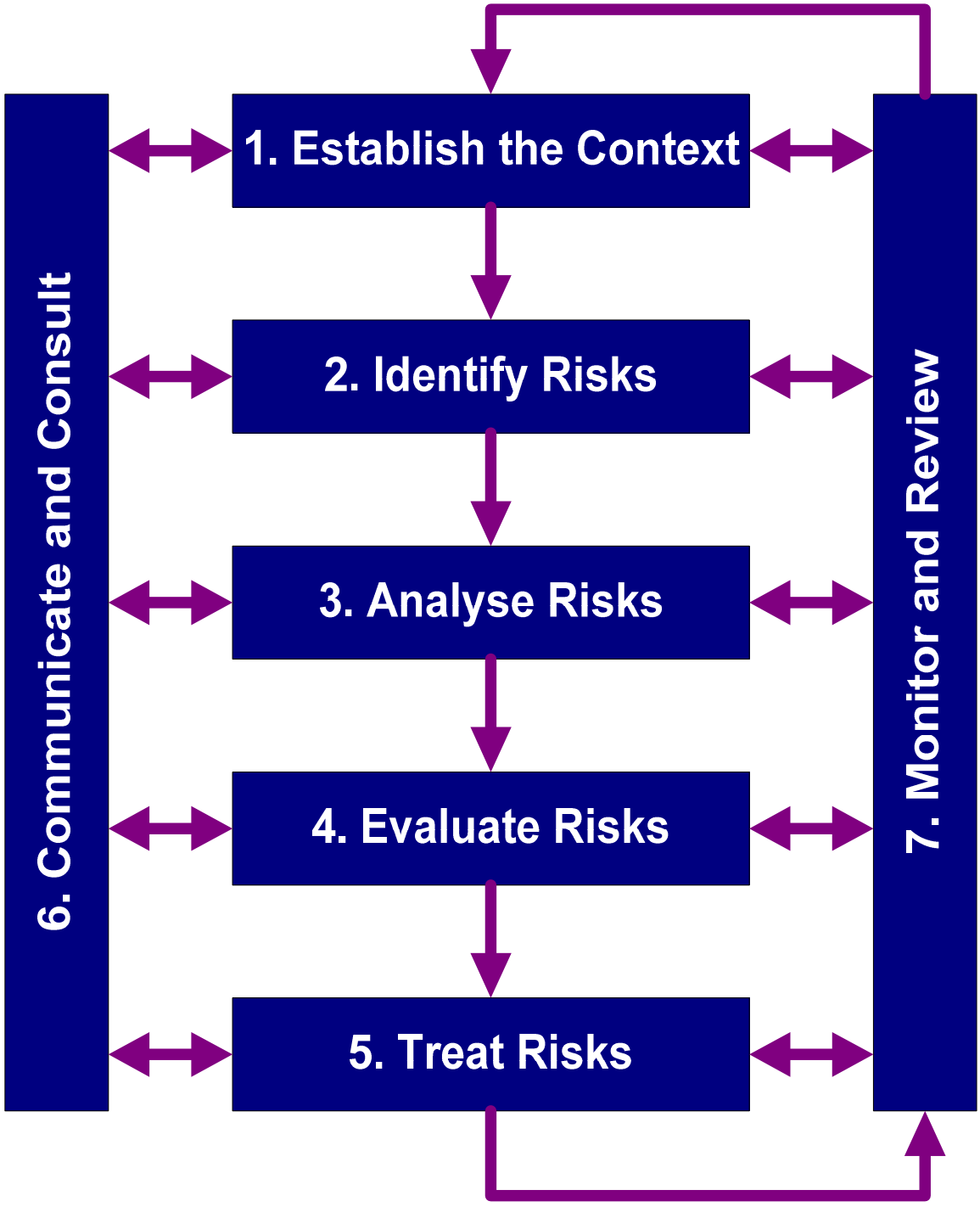
Overall the NHS approach to risk management can be described pictorially in the cycle demonstrated below, there are 7 major elements to this process and these are incorporated into the approaches described within this document:

The National Health Service has adopted the Risk Management Standard broadly in terms of arrangements for the management of risk, these standards were developed by Standards Australia and Standards New Zealand, the use of terminology for management of risk adopted by organisations is varied however the main principles of risk management are followed by Whittington Health and correspond with the diagram below.

Integrated Risk Management System:

The Risk Management Process for Whittington Health is supported bv the use of an integrated risk management system datix, this is used to capture information about the organisation across the following modules, Incidents, Complaints, Claims, Inquests, PALS and and the Risk Register.

The Risk Register component will support staff to highlight risks in real time and to ensure these are updated in real time thus supporting the organisation in terms of dynamic risk management. In addition the datix system will allow the organisation to map risks back to their source which will support thematic analysis of risks and the source of the risk supporting the correlation of risk management across the quality domains of Safety, Clinical Effectiveness and Patient Experience, this can then be used to undertake aggregated reviews of risks with the emphasis to focus on proactive risk management through reviews of systems and processes and related corrective activities.


1. Establish the Context
2. Identify Risks
3. Analyse Risks
4. Evaluate Risks
5. Treat Risks
6. Communicate and Consult
7. Monitor and Review

6.1. Categorising risk

Whittington Health categorises risk into distinct types detailed below: Some risks may contain aspects of all these elements, in which case the risk should be categorised as the type that would be most significantly compromised by the risk. If there are significant implications across more than one element the risk should be categorised and therefore recorded for all relevant types.

Clinical risks – those risks for which the impact would be primarily clinical or medical. Examples include clinical care activities, medicines management and consent issues.

Organisational risks – those risks for which the impact would relate primarily to the way Whittington Health is organised, managed and governed. Examples include property related risks, human resource issues, targets and corporate governance risks which impact on the achievement of the organisations objectives.

Financial risks – those risks for which the impact would relate primarily to financial loss. Examples include poor financial control, fraud and ineffective insurance arrangements.

Reputation risks – those risks for which the event will have a negative impact on how the organisation is perceived by our stakeholders, staff, public, partnership organisations, local community groups, regulators nb: this list is not exhaustive and would need to account for the organisations stakeholder analysis.

The diagram below (Examples of the Drivers of Key Risks) demonstrates how risks can be reviewed from an internal/external driven perspective and is to be used as a guide in addition to the categories identified above to categorise risk. There are a plethora of different models in terms or risk categorisation therefore this strategy does not aim to clarify all.

Further advice in terms of categorisation of risk can be sourced from the Governance Team.

6.2. Identification of risk

Risks can be identified through a variety of ways. The following are examples of some of the ways in which Whittington Health identifies risks, although this is not intended to be exhaustive.

Project management

All Whittington Health projects must be managed in line with Whittington Health guidance and a divisional/directorate risk register a risk register must populate all risks affecting project delivery. All risks identified as part of a project must be assessed and managed in line with this strategy (this may be in addition to the requirements of a given project).

Project management templates and guidance can be accessed from the Planning and Performance Directorate.

Incidents, complaints and claims

All incidents, complaints and claims must be reported and managed in line with the respective policies (referenced in section 3). Any risks identified as part of these processes must be assessed and managed in line with this strategy, as indicated in the relevant policies.

In particular this can focus on incidents, complaints or claims that are forming a trend or result in poor media coverage

Policies

Whittington Health has a process for ensuring that all necessary policies and procedures are in place and up to date, easily accessible to those who need them and implemented effectively.

Committee reports

All reports to Whittington Health Committees must be submitted in the committee report template. This template includes a requirement to highlight any risks identified in relation to the content of the report. All risks identified and reported in this way must be assessed and managed in line with this strategy.

The committee report template can be accessed on the intranet:

External assessments

Whittington Health is required to undertake a number of external assessments every year. Whittington Health has a policy outlining the process for managing external assessments and ensuring that recommendations are implemented. All risks identified in relation to the requirements of an external assessment must be assessed and managed in line with this strategy.

Confidential Inquiries are a source of potential risk and require internal review when published these include (NCEPOD, CISH, SHOT, CEMACH) note this list is not exhaustive.

NICE guidance/Safety Alerts/National Guidance

Whittington Health has processes in place for managing the dissemination and implementation of relevant NICE guidance, national guidance, and safety alerts. All risks identified in relation to implementation of such guidance must be assessed and managed in line with this strategy.

Internal Audit

Whittington Health's internal auditors will provide an independent and objective opinion on the effectiveness of risk management and governance within the organisation. All risks identified through in the internal audit process must be assessed and managed in line with this strategy.

See also table for identification of risk appendix 9

6.3 Risk assessment

All identified risks must be assessed to determine the severity of the risk. Risk assessment is a systematic and effective method of determining the level of risks and most cost-effective means to minimise or remove them. This is completed using a risk assessment matrix to calculate an overall risk rating. Risk assessments should be recorded using the template in appendix 6. There are some further risk assessment tools tailored to specific areas of risks appended to relevant policies available on the intranet.

The risk rating is calculated by combining the consequence and likelihood of the risk

Risk rating = Consequence x Likelihood

To assess the risk, the consequence of the risk occurring must be measured (in other words how bad would the impact of the risk occurring be).

For grading risks the scores obtained from the risk matrix are assigned in terms of structured grading and are covered within appendices.

Please refer to appendix 5 for details of how to conduct a risk assessment.

There are further specific risk assessment tools utilised within the organisation for Health and Safety, Fire Security and Moving and Handling risks these risk assessments and further guidance can be obtained from the relevant specialist advisors within the trust (note this list is not exhaustive).

See appendix 12.

Describing the risk

All risks will be written using a structured approach to support organisational analysis/assessment of risks.

The format to be adopted when describing a risk is:

> **"If ….. (event)….. then…… (consequence)"**
>
> ***Example: If there is poor and inconsistent record keeping then this will lead to sub optimal care.***

This will allow for an easier assessment of the likelihood and consequence.

Further advice in relation to this is contained within appendix 5.

6.4 Risk rating and risk acceptability

It should be acknowledged that it is not possible to reduce all risks to a score of 0. This section provides a breakdown of what level of risk is regarded as acceptable and how risks should be managed once an appropriate score is identified (in other words the organisation's risk appetite).

When assessing individual risks, the following questions should be considered to assist in determining whether a risk is acceptable:

- What is the level of risk we think we are facing?
- What is the impact?
- Can we tolerate the possibility of that risk actually happening? Could this impact on a breach of legislation or statutory requirement?
- If not, do we want or need to do more?
- Will the cost of managing this risk outweigh the benefit

Low risks are regarded as acceptable and should be managed locally within the relevant service/directorate areas. Services should review low risks on a regular basis at relevant directorate and team meetings.

Moderate risks are regarded as acceptable and should be included on the divisional risk register. Relevant departmental managers/heads of service must be assigned as the overall risk owner with responsibility for overseeing management of the risk.

High risks are regarded as unacceptable and should be included on the divisional risk register. Relevant directors/assistant directors must be assigned as the overall risk owner with responsibility for overseeing management of the risk.

Extreme risks are regarded as unacceptable and should be included on the corporate risk register. Relevant executive directors must be assigned as the overall risk owner with responsibility for overseeing management of the risk. Extreme risks must also be linked to the relevant strategic objectives as outlined in section 3.3.

Appropriate controls and actions need to be agreed and taken to reduce all risks to an acceptable level, or where it is not possible to reduce the level of risk ensure that it is managed appropriately.

Overall the organisation's level of risk acceptability is as outlined in appendix 5:

6.5 Risk register and managing the risk

This section outlines the authority of all managers with regards to managing risk as well as the reporting and monitoring process.

Risk management involves a judgement and therefore levels of risk have been identified to aid the judgement in terms of risk.

Adding to the Risk Register

To add a risk to the risk register the risk assessment form appendix 6 **MUST** be completed and approved at the agreed level as outlined in appendix 5

Removing and or down grading a risk from the Risk Register

The Risk Register must be updated to reflect the mitigation/management of the risk.

- Evidence must be provided to demonstrate implementation of the related controls to manage the risk
- The approving Board/Committee as defined in appendix 7 will agree to remove/reduce the risk
- These actions must be recorded within the appropriate Board/Committee minutes as evidence of compliance.

Low risks

Divisions/Directorates must keep local risk registers of all low risks and ensure that these are updated and monitored on a regular basis through divisions/directorate and service level management team meetings.

All completed risk assessment forms must be recorded locally.

Moderate and high risks

All moderate and high risks must be communicated on to the divisional/directorate risk register and routinely shared with the risk manager for analysis and review by providing an updated version of the risk register on a monthly cycle. All completed risk assessment forms must be recorded locally.

Extreme risks

All extreme risks must be communicated to the Risk Manager for inclusion within the Corporate Risk register for routine reporting to the Executive Committee and subsequent review by the Board and the Audit committee.

The risk manager will maintain the corporate risk registers and facilitate the review of those extreme risks on the register.

For overseeing management of the risk, the risk manager will work with Risk Management leads within Divisions/Directorates to facilitate routine reviews of the risk register processes.

The diagram contained in appendix 10b shows the relationship of the levels of risk register held within the organisation.

Committee reporting: The risks registers will be submitted to the following committees with the following remit:

1. Board (quarterly), Corporate risk and assurance from Divisional Boards on management of divisional risks.
2. Quality Committee (monthly) identified risks that impact on quality across 3 domains of Quality, Safety/Clinical Effectiveness/Patient Experience.

3. Audit Committee (quarterly) and will include the corporate elements of the Risk Register and assurance on how the risk management process is working through the organisation (as a standing agenda item at each meeting).
4. Executive Committee (monthly) all Corporate Risks
5. Divisional Boards (monthly review of risk registers) attention on individual risk is dependent on defined cycle of review and risk grading.

The risk register must include the following information:

- A description of the risk (the corporate risk register will also stipulate which strategic/corporate objectives are effected)
- Controls in place to mitigate (prevent) the risk
- Any existing gaps in controls
- The current risk rating and residual risk rating (the residual risk rating refers to risk remaining once appropriate controls are in place)
- Actions in progress or planned and timescale for delivery
- Assurance source (i.e. what evidence is there that the risk is being effectively managed)
- Any existing gaps in assurance
- An assigned risk owner
- Review date

The following appendices are included in this strategy to assist staff and managers with the process of risk assessment and management:
Appendix 4 – Committee Structures for Committees that manage risk.

Appendix 5 – risk assessment tool (to calculate the risk rating)

Appendix 6 – generic risk assessment template (to document the risk assessment)

Appendix 7 – risk register template for divisional/directorate use

Appendix 8 (available on the intranet) – corporate risk register template

The templates must be used to record and review risks locally to enable monitoring of the risk management strategy as outlined in section 11.

6.6 Board Assurance Framework (BAF)

The organisation BAF provides the board with a simple but comprehensive method for the effective and focussed management of strategic/corporate risks that could affect the delivery of the organisations strategic/corporate objectives.

Risks to strategic/corporate objectives are identified through Board workshops which are held as part of the annual business planning cycle at an annual Board risk seminar, action plans are developed where controls are identified as being insufficient.

The BAF is then reviewed as part of a routine cycle at the Board Monthly, Audit and Risk Committee at each meeting and by the Executive Committee on a bi monthly basis.

The BAF and the Corporate Risk Register are reviewed in conjunction with each other as the management of risks needs scrutiny at all levels within the organisation the process is illustrated within the diagram in appendix 10b.

7. Consultation, Approval and Ratification Process

7.1 Consultation process

Relevant stakeholders in the development of this strategy are identified as below either key people or a committee and their involvement in the process:

- Audit and Risk Committee Non Executives, ***development***.
- Executive Committee members, ***development and review in draft format***.
- Board, ***ratification of the final document***.
- Divisional Senior Management Team, **development**.
- Governance Team, **development**.
- Heads of Nursing, **development**.
- Quality Lead, **development**.

7.2 Policy Approval and Ratification Process

This strategy will be submitted to the Whittington Health Board for approval and then will be reviewed on an annual basis to account for organisational change or to changes in legislation or organisational form.

The Director of Nursing and Patient Experience will have responsibility for presenting this strategy at the Board as part of the process for approval.

8 Dissemination and Implementation

8.1 This strategy will be disseminated throughout the trust via the newsletter, relevant managers and divisional/directorate meetings and publishing on the trust intranet. Copies of this document are available to all staff and all stakeholders of the organisation both electronically and in hard copy.

8.2 Generic risk management responsibilities are included in the job descriptions of all members of staff. Specific responsibilities for risk management will be outlined in the job descriptions of relevant members of staff.

9 Process for Monitoring Compliance and Effectiveness

9.1 Standards/Key Performance Indicators

SEE ATTACHED MONITORING DEVELOPMENT TOOL TO HELP IDENTIFY APPROPRIATE MONITORING APPROACH

Key performance indicators associated with the implementation of the policy will be identified by the author and agreed with the ratifying committee.
KPI's can be included as an appendix.
See Appendix 14.

9.2 Responding To Issues Relating to Policy Implementation

9.2.1 The Audit and Risk committee will monitor assurance against compliance with the risk management strategy on a quarterly basis through:

- Risk register updates, with focus on Corporate Risks and assurance on the process of risk management which will include the impact on the organisations strategic objectives and controls/actions in place or in progress to mitigate those risks.

9.2.2 Overall assurance on progress in line with the objectives of the risk management strategy:

Internal audit will conduct a review of governance processes to include the management of risks within the organisation and report findings from the outcomes of the audits. Corrective actions will then be taken by the Executive Team to respond to any deficient areas.

The Audit and Risk committee will ensure the Board is advised of concerns with assurance on processes and escalate any other concern areas in terms of risk management and controls that require disclosure to the Board or require executive directors actions.

9.2.3 Whittington Health's Board will receive a quarterly risk highlights report of all current corporate risks as part of the Director of Nursing and Patient Experience update on a quarterly basis alongside submission of the corporate risk register. The annual risk report will form part of the Annual Governance Statement.

9.2.4 The Executive Committee will conduct a review of the corporate risk register monthly. Both the Board and the Executive Committee will agree and minute any necessary actions to further mitigate risks.

9.2.5 Risk Management Training will be monitored as outlined in the Mandatory Training Policy and the organisational Training Needs Analysis.

9.2.6 In addition the Board as part of their development programme will receive training in relation to Risk Management this is highlighted within the training needs analysis. Board development training is recorded at each development seminar and is planned on an annual cycle, responsibility for this lies with the Corporate Secretary.

9.2.7 Further to this regular risk register updates will be provided to the Divisional/Directorate Senior Management Teams, any other meeting or committee with particular responsibilities in relation to given risks. Any necessary actions will be agreed as part of the groups terms of reference and any identified issues will be escalated as appropriate to the related parent committee and recorded within the minutes of the committee. See appendix 4 for Governance Committee structure.

9.2.8 Directors of Divisions/Directorates will facilitate all services populating local risks onto the divisional risk registers with a routine review of the divisional risk registers being submitted to the Risk Manager on a monthly basis. Reports will then be submitted to the related parent Committee who will monitor compliance. In addition managers must ensure regular monitoring of local risk registers at relevant team meetings (as outlined in 7.12). Managers must ensure minutes are recorded in order to demonstrate that review and discussion has taken place.

Actions

The nominated lead and the appropriate committee are expected to read and interrogate any monitoring report presented to identify issues/deficiencies and act upon them. Required actions will be identified and completed within a specified timeframe. All agreed actions pertaining to the above will be recorded in the minutes of the appropriate committee.

Changes to Practice

Required changes in practice will be identified and actioned within a specific timeframe. A nominated lead will be identified to take each change forward where appropriate. Lessons learnt will be shared with all the relevant stakeholders. All agreed actions pertaining to the above will be recorded in the minutes of the appropriate committee.

10 References

- A risk matrix for risk managers, National Patient Safety Agency, January 2008 (http://www.nrls.npsa.nhs.uk/resources/patient-safety-topics/risk-assessment-management/)
- NHSLA Risk Management Standards (http://www.nhsla.com/RiskManagement/)
- Standards Australia/Standards New Zealand. Risk Management. AS/NZS 4360:2004. (http://www.theirm.org/publications/PUstandard.html)
- http://www.cimaglobal.com/Thought-leadership/Research-topics/Enterprise-governance-restoring-boardroom-leadership/Corporate-reputation/

11 Associated Documentation

Appendices – Must include ratification document and Equality Impact Assessment (Appendices 17 and 16 of this document).

Appendix 1
Whittington Health's commitment to a fair and open culture

The value of high quality incident reporting systems has long been recognised in the NHS. A robust incident reporting system enables an organisation to establish what is going wrong and why. Enabling the organisation to identify trends and take appropriate action to reduce the likelihood and impact of risks and incidents. It provides information essential to the quality improvement programme. A key part of the task ahead is to encourage a culture, throughout the NHS, where doctors, nurses, patients and everyone involved in the delivery of safe healthcare, are happy to report and discuss incidents and where it is clear that there are real benefits to be gained.

All members of staff, as employees, have a duty to see that all incidents are reported in order to ensure that any trends may be identified at an early stage. However, because of the threat of sanctions or disciplinary action against employees, or their perception of 'failure', there can be a disincentive to report incidents. This can be overcome by promoting an open and fair learning culture within the organisation. This culture does not mean that staff are not accountable to users, carers, or the organisation and their professional bodies for their actions.

It is important that all staff realise that the purpose of reporting an incident is not to apportion blame to any individual or group of people but to identify actual or potential problems or, and take appropriate action. Errors and incidents are often caused by a number of factors including: system failures, human factors and lack of knowledge or skills. For this reason Whittington Health has established a fair blame approach, encouraging all staff to acknowledge and report incidents, risks and near misses.

Whittington Health operates an open and fair Incident and Serious Untoward Incident Reporting Policy. The reporting of an untoward incident will not, in itself, result in disciplinary action being taken against the member of staff making the report. It is intended that this will shift the emphasis from punishing errors to learning from them across the organisation.

There are some instances where this undertaking cannot apply:

- The reporting is, in itself, done with malicious intent
- The incident reported is malicious, reckless or criminal
- The incident reported constitutes professional or personal misconduct

Whittington Health's Raising Concerns at Work ('Whistle-Blowing') Policy is another document which is also relevant to risk management. Staff using the Whistle-Blowing Policy (also available on the Whittington Health Intranet) are encouraged to analyse the activities they are concerned about and to consider whether there are any potential risks which can be identified for inclusion in the Risk Register.

Appendix 2
Strategy Principles and Aims

The following key principles are essential for the successful implementation of this strategy:

- There is Board and management commitment to, and leadership of, the total risk
- Whittington Health will develop its clinical governance framework to include the formal application of the risk management process to clinical practices and to the work of its primary care contractors.
- There is widespread employee participation and consultation in risk management processes, which will operate in a fair blame culture.
- There is a mechanism for all incidents, near misses and complaints to be immediately reported, categorised by their actual and potential impact and investigated to determine system failures, without assigning blame.
- There are management systems in place that provide safe practices, premises and equipment in the working environment. Systems of work must be designed to reduce the likelihood of human error occurring.
- The risk management process must be applied to contract management especially when acquiring, expanding or outsourcing services, equipment or facilities. Contracts must be reviewed and written to ensure that only reasonable risks are accepted.
- On all Whittington Health premises, whether owned or shared, safe systems of work must be in place to protect patients, visitors and staff.
- Whittington Health maintains an effective system of emergency preparedness, emergency response and contingency planning.
- Whittington Health provides realistic resources to implement and support effective Risk Management throughout the organisation.

The aims of effectively managing risks are to:

- Ensure the management of risk is consistent with and supports the achievement of Whittington Health's strategic and corporate objectives
- Provide a high quality service to patients
- Initiate action to prevent or reduce the adverse effects of risk
- Protect patients, visitors and staff from risks where reasonably practicable
- Meet statutory and legal obligations and improve compliance with the ongoing requirements of best practice governance standards
- Link into the Clinical Governance framework of Whittington Health
- Minimise the financial and other negative consequences of losses and claims, for example, poor publicity, loss of reputation
- Minimise the risks associated with new developments/activities

Appendix 3
Risk management objectives

Objective 1
To develop a risk aware culture throughout Whittington Health

Whittington Health's key risk management resources are its people, systems, equipment, buildings and estate. The risk management aspects of these resources are monitored by key Directors and Committees. They rely on the other directors, managers and all staff to work together to provide an integrated approach to the management of risk. This means that there must be a pervading culture that encourages:

- People to work together effectively and to recognise and manage risks
- Systems to be developed so that better performance management, health and safety, finance, operational and other information is more readily available
- More effective incident and near miss reporting, complaints and claims handling activities
- Better and safer buildings and estates
- Better maintained and safer equipment
- All risks and information about the management of risks to be identified and co-ordinated through the organisations Risk Registers and Action Plans no matter whether the risks are clinical, financial or organisational in nature

Developing a learning culture is a prerequisite of successful risk management. Whittington Health is committed to being a learning organisation. To support this Whittington Health will ensure the following:

- PDPs for all staff that are regularly reviewed and acted upon
- Delegated budgets down to appropriate levels to support training and development
- Regular analysis of incidents/potential incidents/near misses to identify learning points and necessary actions
- Communications systems which reach all staff and stakeholders
- Opportunities for front line staff and users/carers to directly contribute to the process of continuous improvement
- A culture that encourages innovation and is founded on no blame

This strategy identifies risk management as the business of everyone in Whittington Health. The training and development of its staff is an integral part of the organisation's approach to risk management. An effective implementation of the strategy requires staff to be both aware of the Whittington Health's approach to risk management, and to be clear about their roles and responsibilities within the risk management process.

Training needs analysis is completed and programmes will be in place so that:

- All new staff will complete an Induction programme which includes risk management training and covers complaints and incident reporting
- Whittington Health will produce a Training Matrix to identify which training courses are mandatory for different staff groups. The Matrix will serve as a guide to staff and managers, and facilitate the reporting and monitoring of attendance.
- A Training guide will be published identifying the availability of training and development opportunities for staff (including mandatory training) focusing on the levels of staff within the organisation.

Every member of staff will have an annual personal development interview with their line manager and agree a Personal Development Plan. This process provides assurance that the training needs of individuals are identified at all levels in the organisation, and serves to inform the content and delivery of future training programmes and plans. Whittington Health will meet the training requirements of its staff that are essential for them to perform their roles. All clinical/professional staff will operate within their code of professional conduct.

Objective 2

To ensure that appropriate systems are in place for identifying, assessing and controlling key risks by…

Through the implementation of this strategy and appropriate training, it is anticipated that staff will develop a deeper understanding of the breadth of their statutory duties of care. This should lead to staff feeling confident in identifying potential risks and in reporting untoward incidents and near misses, freely participating in audits and peer reviews and having ownership of polices, procedures and guidelines. Managers in particular should appreciate the value of their contribution to Risk Management through implementing the risk assessment process within their area.

Actual incidents or near misses will result in risks being identified that need to be entered in the Risk Register if they are not already identified. The full requirements are set out in the Incident and Serious Untoward Incident Reporting Policy.

Whittington Health's Raising Concerns at Work ('Whistle-Blowing') Policy is another document which is also relevant to risk management. Staff using the Whistle-Blowing Policy (also available on the Whittington Health Intranet) are encouraged to analyse the activities they are concerned about and to consider whether there are any potential risks which can be identified for inclusion in the Risk Register.

There is no shortage of expertise within Whittington Health to provide further advice relating to risk management. Advice can be sources from specialist advisors identified in appendix 12 and further advice can be obtained from the Governance Team within the Nursing and Patient Experience Directorate.

The best sources of information are the policies and procedures already developed and implemented to safeguard patients, staff and Whittington Health.

Objective 3

To embed the concepts and ideas of risk assessment and risk management into the day to day working practices of Whittington Health

To ensure Whittington Health staff are kept fully informed on risk management issues:

- Directors are responsible for ensuring processes are in place for informing staff about significant adverse events and risks and the learning and improvement that can be implemented as a result of these.
- The Audit and Risk Committee will monitor progress to ensure actions are implemented and information disseminated rapidly across Whittington Health. Accountable staff will be required to attend the Committee to provide assurance that any overdue actions are receiving due resource and management time.

Objective 4

To maintain effective organisational structures for risk management so that a trust-wide consistent approach to risk management is taken

Established management and operational structures are in place to manage the risks that Whittington Health faces. The current dedicated committees and groups are shown in Appendix 4, with the Board responsible for overseeing the risk management programme. The committees and management structures

set out in this strategy are designed to work together to ensure a concerted and integrated approach to risk management.

All directors report directly to the Chief Executive, who has overall accountability for risk management and is required, on behalf of the Board, to sign the annual Statement on Internal Control. The Chief Executive, the Committees and the Directors have responsibility for the operation and integration of all key risk management systems and their output.

All staff have a responsibility to identify, assess, analyse and treat risks, although the allocation of specific responsibilities and levels of authority for each service area will be set by the appropriate Director.

Any member of staff may be in a position to accept a risk but this action must be communicated. In addition the risk must be recorded on the Risk Register so that it can be monitored.

All the Trust Board Directors are responsible, collectively, for the Trust's system of risk management. By working closely together these directors will ensure an integrated and holistic approach to Whittington Health's risk management activities.

Objective 5

To ensure that the Whittington Health's Chief Executive is provided with evidence that risks are being appropriately identified, assessed, addressed and monitored

A comprehensive organisation wide Risk Register is maintained. All risks must be assessed and recorded in line with this process. An assessment will be made of the consequences should the risk happen, the likelihood of the risk actually happening and the residual risk.

An assessment is also required as to the current controls in existence to manage the risk. The Risk Register will contain a reference linking each risk to the overall Whittington Health strategic objectives. The more significant risks will be afforded a higher priority and the prioritisation will be based on the categories of risk set out in the qualitative risk assessment matrix.

The risk register will contain details of each action required to treat the identified risks set out. Each action will be assessed as to its importance and its priority. An individual will be named and given responsibility for ensuring the action is carried out by the chosen due date. Where possible an assessment will be made of the resources required to undertake the action. The assessment of the resources required should contain an analysis of staff resources as well as revenue and capital financial resources

The Audit and Assurance Committee will review risk management progress on behalf of the Board.

Objective 6

To ensure good and steady progress in the implementation of effective Risk Management across the Trust

The Audit and Risk Committee will regularly review how this strategy is being implemented as outlined in section 11, monitoring. Section 7, roles and responsibilities further outlines how effective risk management will be assured.

Objective 7

To comply with relevant clinical and corporate governance requirements and to adopt wherever possible best practice

Whittington Health is required to comply with a number of clinical and corporate governance standards as stipulated by external agencies. Key examples include:

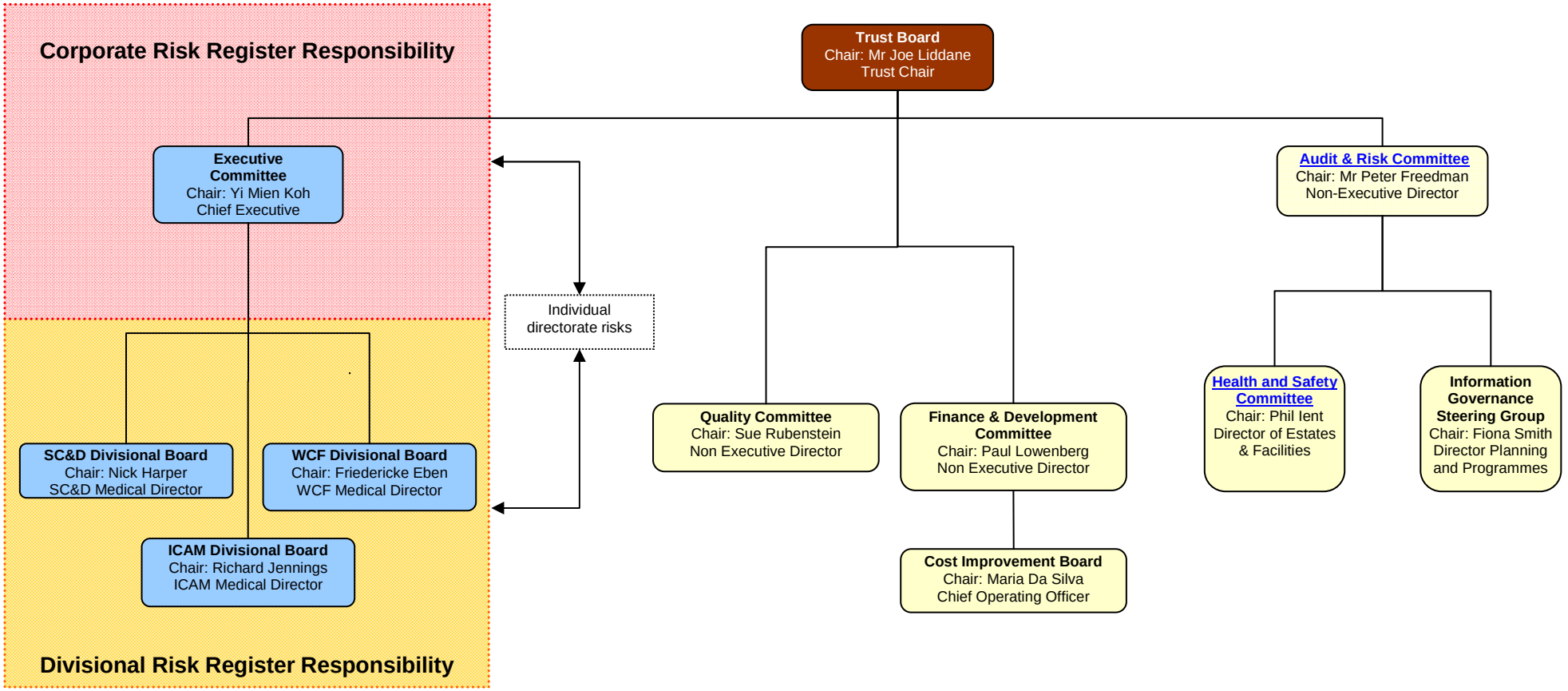
- Care Quality Commission (CQC) Registration
- The NHS Litigation Authority (NHSLA) Risk Management Standards

- Health and Safety Legislation
- Department of Health Statement on Internal Control

Whittington Health has a policy in place outlining how external agency requirements will be met. Risks in relation to compliance with standards and best practice will be managed as outlined in this strategy.

Appendix 4

Whittington Health committee structure
(outlining the Board Committees, Board Sub Committees and all those committees with responsibility for risk)



Governance and risk committees	Operations committees

Appendix 4a

Audit and Risk Committee
Terms of Reference

1. AUTHORITY

1.1 The Audit Committee is constituted as a Standing Committee of the Trust Board. Its constitution and terms of reference shall be as set out below, subject to amendment at future Trust Board meetings.

1.2 The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff, and all members of staff are directed to co-operate with any request made by the Committee.

1.3 The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

2. PURPOSE

2.1 Audit

The Board of Directors is responsible for ensuring effective internal control including:

- the management of the Trust's activities in accordance with laws and regulations;
- the establishment and maintenance of a system of internal control to give reasonable assurance that assets are safeguarded, and waste or inefficiency avoided;
- the provision of reliable financial information;
- the maintenance of systems to ensure that value for money is continuously sought.

The Audit Committee shall provide the Board of Directors with a means of independent and objective review of financial and corporate governance and risk management. In addition the Committee shall provide assurance of the independence of both external and internal audit.

2.2 Assurance

The Committee shall monitor and review the risk management, control and governance processes which have been established in the organisation, and the associated assurance processes. This will be in order to help the Trust Board to be fully assured that the most efficient, effective and economic risk management, control and governance processes are in place, and that the associated assurance processes are optimal.

The Board Assurance Framework (BAF) will be central to the Committee achieving its purpose. The Committee will be responsible for providing the Board with assurance in relation to:

- Corporate Governance (e.g. Standing Orders, Standing Financial Instructions, Codes of Conduct and Accountability)
- Information Governance
- Clinical Governance
- Research and Development Governance
- Management of clinical, financial and non financial risk
- Legislative and regulatory compliance
- Accreditation and assessment (e.g. the Care Quality Commission, Audit Commission, NHS LA)

3. DUTIES

3.1 Assurance

3.1.1 Continually review the relevance and rigour of the BAF and the arrangements surrounding it, including the escalation where appropriate of significant risks on the Risk Register.

3.1.2 Review the adequacy of all risk and control related disclosure statements, together with any accompanying Head of Internal Audit statement, prior to endorsement by the Board. This will include:

- Support the production of the Annual Governance Statement by reviewing the reliability and integrity of the assurances.
- Identifying to the Board any control issues which could be considered significant and require disclosure in the Annual Governance Statement.
- Statement of compliance with controls and processes for the ongoing monitoring of the Care Quality Commission (CQC) essential standards of quality and safety, consisting of the 28 regulations (and associated outcomes) that are set out in two pieces of legislation: the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

3.1.3 Oversee the work of the Health and Safety Committee and receive regular performance and assurance reports.

3.1.4 Oversee the work of the Information Governance Committee and receive regular performance and assurance reports

3.1.5 While not having detailed oversight of performance in relation to clinical effectiveness and patient safety, the Audit Committee will receive periodic reports from the Quality Committee to enable it to report via the BAF on the adequacy of internal controls relating to clinical governance.

3.1.6 Ensure comprehensive coverage with minimal duplication between the Audit and Risk Committee and the Quality Committee through the attendance of the Audit & Risk Committee Chair at the Quality Committee.

3.2 Internal Control and Risk Management

3.2.1 Ensure the provision and maintenance of an effective system of financial and non-financial risk management covering identification, associated controls, reporting and governance

3.2.2 Maintain an oversight of the Trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control related disclosure statements.

3.2.3 Review the adequacy of the policies and procedures for all counter fraud work.

3.2.4 Receive and approve the annual Counter Fraud plan and review the Local Counter Fraud Specialist's reports on pro-active and reactive investigations.

3.2.4 Review the adequacy of the Trust's arrangements by which Trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control, or related matters.

3.3 Internal Audit

3.3.1 Approve the specification for internal audit services and appoint internal auditors within a competitive tendering process

3.3.2 Oversee the effective operation of Internal Audit and ensure its coordination with External Audit.

3.3.3 Approve the annual Internal Audit plan

3.3.4 Review the Internal Audit programme, consider the major findings of Internal Audit investigations and management's response, and monitor progress on the implementation of recommendations.

3.3.5 Receive and review the Internal Audit Annual Report and the Head of Internal Audit Opinion.

3.4 External Audit

3.4.1 Assess the External Auditor's work and fees on an annual basis and, based on this assessment, make a recommendation to the Trust Board on the reappointment of the Auditor as far as the Audit Commission's rule permit

3.4.2 Approve the annual External Audit plan and associated fees

3.4.3 Discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure coordination, as appropriate, with other External Auditors in the local health economy.

3.4.4 Review External Audit reports, including the Annual Audit Letter, together with the management response, and monitor progress on the implementation of recommendations.

3.4.5 Develop and implement a policy on the engagement of the external auditor to supply non-audit services.

3.5 Annual Accounts Review

Review the annual statutory accounts, before they are presented to the Trust Board, to determine their objectivity, integrity and accuracy. This review will cover:

- the meaning and significance of the figures, notes and significant changes;
- accounting policies and practices followed and significant changes;
- explanation of estimates or provisions having material effect;
- the schedule of losses and special payments;
- any reservations and disagreements between the External Auditors and

management not satisfactorily resolved

-

3.6 Standing Orders, Standing Financial Instructions and Standards of Business Conduct

3.6.1 Review on behalf of the Board proposed changes to the SOs and SFIs.

3.6.2 Examine the circumstances of any significant departure from the requirements of SOs, SFIs or Standards of Business Conduct.

3.6.3 Review the Scheme of Delegation and the Reservation of Powers to the Trust Board.

3.7 Other

3.7.1 Review performance indicators relevant to the remit of the Committee.

3.7.2 Review the trust's Treasury Management policy and the policy for the investment of charitable funds.

3.7.3 Review the systems, procedures, and internal controls related to fundraising and the management and application of charitable funds, including the postgraduate medical education funds.

3.7.4 Examine any other matter referred to the Committee by the Board of Directors and to initiate investigation as determined by the Committee.

4. MEMBERSHIP

4.1 The Audit Committee shall comprise at least three non-executive members of the Trust Board, excluding the Chairman of the Trust Board.

4.2 The chairman of the Audit Committee shall be appointed by the chairman of the Trust Board and shall have recent and relevant financial experience.

Membership Table

Peter Freedman	Non Executive Director, Chair	Member
Robert Aitken	Non Executive Director ,Deputy Chair	Member
Paul Lowenberg	Non Executive Director	Member
Yi Mien Koh	Chief Executive	In attendance
Richard Martin	Director of Finance	In attendance
Martin Kuper	Executive Medical Director	In attendance
David Williams	Assistant Director of Governance	In attendance
Bronagh Scott	Executive Director of Nursing & Patient Experience	In attendance
Maria DaSilva	Chief Operating Officer	In attendance
Margaret Boltwood	Director of People	In attendance
Andrea White	Audit Commission	In attendance
Antony Smith	Audit Commission	In attendance
Max Lai	Parkhill Audit Agency	In attendance
Surinder Ahir	Parkhill Audit Agency	In attendance
Nigel Sedgwick	Parkhill Audit Agency	In attendance

5. MEETINGS

5.1 The Audit Committee will meet at least six times a year.

5.2 The meeting shall be quorate if a minimum of two members are present for core business and two members to scrutinise the annual accounts.

5.3 Audit Committee will normally be attended by Head of Internal Audit, the Local Counter Fraud Specialist and a representative of External Audit.

5.4 Members will attend six meetings a year and a meeting for the Annual Accounts scrutiny.

5.5 The Committee will be serviced by the finance department business support manager.

5.6 The Chief Executive and other executive directors will be invited to attend when the committee is discussing areas of risk or operation that are the responsibility of that director.

5.7 The Audit Committee may ask any other officials of the organisation to attend to assist it with its discussions on any particular matter.

5.8 The Audit Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

5.9 The Accountable Officer or Trust Board may ask the Audit Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

5.10 The External and Internal Auditors shall be invited at least once a year to meet with the Committee without Executive Directors present and may request other meetings either separately or together.

Monitoring
As set out in the table below and more frequently if necessary

		Date next due:
Terms of Reference Review	Annual	January 2013
Membership Attendance	Annual Report to Whittington Health Chairman	May 2013
Health & Safety Committee report	6 monthly	17th January 2013
Information Governance Committee report – or by exception	Annual plus routine reports	May 2013 July/November/January 2013
Reports to Trust Board	Every Trust Board	Following committee
Approved Internal	Annual	April / May 2013

Audit Plan		
Annual Review to Trust Board		September 2013
Internal Audit Plan	Annual (Then to EC)	7th March 2013
Local Counter Fraud Work Plan	Annual	10th May 2013
External Audit Fee	Annual	Sept/Oct 2012/13 (due to Audit Commission re tendering and appointment timetable).
Annual Accounts Review		June 2013
Review Standing Orders & Financial Instructions		March 2013

Annual Terms of Reference Review

6. REPORTING

6.1 The minutes of all meetings shall be formally recorded and approved at the next meeting. A summary in the form of action notes shall be submitted, together with commentary and recommendations where appropriate, to the Trust Board.

6.2 The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on:

- the fitness for purpose of the Assurance Framework
- the completeness and embedding of risk management in the organisation;
- the integration of governance arrangements;
- the appropriateness of the self-assessment process for Care Quality Commission Core Standards, the NHS London performance management framework and the Foundation Trust application.

6.3 The Trust's annual report should include a section describing the work of the Committee in discharging its responsibilities.

7. REVIEW

The terms of reference of the Committee shall be reviewed by the Board of Directors at least annually and will be amended to reflect any change in organizational structure or legal status.

Next review date: January 2013 or earlier in the event of change as above.

Appendix 4b

Quality Sub-Committee of Trust Board (UNDER REVIEW)

Terms of Reference

1. Authority & Scope

1.1 The Quality Committee is constituted as a standing Committee of the Trust Board. Its constitution and terms of reference shall be as set out below, subject to amendment by the Trust Board.

1.2 The Quality Committee shall meet no fewer than eight times per year.

1.3 The Committee is authorised by the Trust Board to scrutinise all services provided by the Integrated Care Organisation. It is authorised to seek information from all parts of the ICO.

1.4 Subject to the conditions set out in the Trust's Standing Financial Instructions, the Committee is authorised by the Trust Board to obtain external legal or other independent professional advice and to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary. Any such action is however subject to ratification by the Trust Board.

2. Membership

2.1 The Committee will be chaired by a Non-executive Director of the Trust and administered by the Trust Board Secretariat or its nominated officer.

2.2 The Quality Committee will comprise at least three non-executive members of the Trust Board, including the Chairman of the Audit Committee. Appendix 2 outlines membership as at January 2011.

2.3 In the absence of the Chair, any Non-executive Director present at a meeting may be asked to act as Vice-chair for the duration of that meeting.

2.4 All Trust Board members may attend the Quality Committee as ex-officio members.

2.5 The Committee shall be deemed to be quorate if attended by any two non-executive directors of the Trust (to include the Chair or designated alternate) and any two executive directors, one of whom should have a clinical background.

2.6 Members are required to attend a minimum of six meetings per year a record of attendance will be recorded at each meeting and monitored throughout the year to ensure compliance with the minimum attendance level. In the event of any executive member being unavailable, a nominated deputy should attend in their place, and such deputies should be recorded in the minutes as having been in attendance.

2.7 The following may also be invited to attend meetings at the discretion of the Chair:

- representatives of the Council of Governors
- representatives of local LINks.

3. Purpose:

3.1 The purpose of the Committee is to focus on service quality and improvement through the following the three NHS defined components:

- Patient Safety,
- Effectiveness, and
- Patient Experience.

3.2 This can be further defined as being:

- To provide assurance to the Trust Board that the Trust has adequate systems and processes in place to ensure and continuously improve patient safety and management of risk

- To provide assurance to the Trust Board that the Trust has effective structures in place to measure and continuously strive to improve the effectiveness of care

- To provide assurance to the Trust Board that the Trust is responding to patients' feedback about their experiences and taking action appropriately.

4. Duties

4.1 Members of the committee are required to read and interrogate all monitoring reports presented in order to identify issues/deficiencies and act upon them as appropriate. Required actions will be recorded and completed within a specified timeframe and monitored at each meeting through the use of an action log. All agreed actions pertaining to the above will also be recorded within the minutes of the Quality Committee.

4.2 The Committee will receive twice yearly reports from care divisions outlining their structures and processes for managing and monitoring quality, governance and patient experience and assure itself and the Trust Board that divisions are giving appropriate priority to continuous improvement in quality and patient safety.

4.3 The Committee will receive regular quality dashboard reports for each division around an agreed set of Key Performance Indicators within the domains of quality, these are clinical effectiveness, patient safety and patient experience.

4.4 The Committee will review, approve and monitor implementation of the Trust's Quality Strategy and Quality Account.

4.5 Where performance in respect of quality and patient safety is proven to have fallen short of agreed standards, the Committee will request evidence that all concerns have been investigated, corrective action has been taken and lessons have been learned.

5. Reporting Structure:

5.1 The following groups / committees will report to the Quality Committee:

- Patient Safety
- Patient Experience
- Effective Care
- Workforce & Development
- Research Governance
- Clinical Ethics
- Divisional Boards
- Infection Control
- Child Protection
- Safeguarding Adults
- Drugs & Therapeutics

5.2 The minutes of all meetings shall be formally recorded and approved at the subsequent meeting. A formal summary report will be submitted to the Trust Board following each meeting, thus enabling the Board to oversee and monitor the work programme, functioning and effectiveness of the Committee.

5.3 Appendices 1 and 1a outline the Trust Committee Structure.

6. Review

6.1 The terms of reference of the Committee shall be reviewed by the Board of Directors at least annually, and will be amended to reflect any change in organisational structure or legal status.

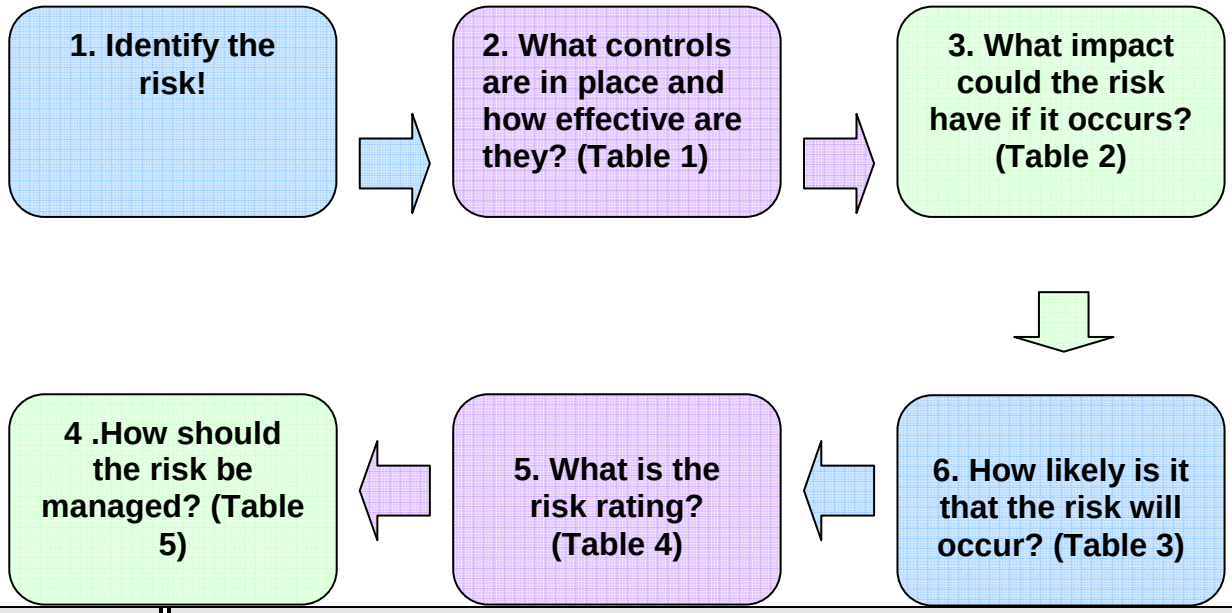
6.2 The next review date will be January 2013 or earlier in the event of change as above.

Monitoring:

Activity	**Frequency**	**Dates next due:**
Terms of reference review	Annual	January 2013
Membership Attendance	• Monitored at each committee • Annual review summarising committee year position	January 2013
Reports to Trust Board	After each committee, monthly.	Monthly return
Submissions of papers/information sources as identified in committee work plan.	Monthly/Quarterly/Bi Annual.	Ongoing review

Appendix 5
Risk assessment tool (this can be accessed via the intranet)

Table 1
How effective are the current controls (systems, processes, etc)?



Level	Descriptor
A	Adequate controls in place (strategy, policy, plans)
B	Limited controls in place and/or controls have known weaknesses (results from audits/reviews/visits/investigations telling us they are not working so well)
C	Controls non-existent or largely ineffective (results from audits/reviews/visits/investigations telling us they are not working so well)

Table 2 • Risk consequence (impact) score

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or	Overall treatment or service suboptimal	Treatment or service has significantly reduced	Non-compliance with national standards with significant risk to	Totally unacceptable level or quality of treatment/service

	service suboptimal Informal complaint/inquiry	Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet

			£100,000	Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption **Environmental impact**	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

If the risk has multiple potential consequences these may require separate assessment.
The likelihood of the consequence occurring must then be measured. Table 3 should be used to assess the likelihood and obtain a likelihood score. When assessing the likelihood it is important to take into consideration the controls (i.e. a mitigating factors that may prevent the risk occurring) already in place.

Table 3 • Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

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

Table 4 • Consequence and Likelihood score (C x L)

The consequence and likelihood scores must then be multiplied and plotted on table 3 to establish the overall level of risk and necessary action.

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
Consequence	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15

2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

Instructions for use

1. Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.
2. Use table 2 to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.
3. Use table 3 to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.
4. Calculate the risk score the risk multiplying the consequence by the likelihood table 4: C (consequence) x L (likelihood) = R (risk score)
5. Identify the level at which the risk will be managed in the organisation table 5, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.

Table 5: Managing the risk: risk acceptability levels and cycles of risk review

Risk Acceptability levels:

The table below is used to determine the levels of risk within the organisation that are acceptable and the activity required to manage the risk.

Risk Score / Rating	Acceptability of exposure	Remedial Action	Decision to accept risk	Risk Register Level
Green Risk Score: 1-3	Acceptable – subject to periodic passive review	Teams, in conjunction with Manager	Manager	Team/Service
Yellow Risk Score: 4-6	Acceptable – subject to regular passive review	Team Lead/ Manager	Service Manager	Service/Directorate/ Division
Amber Risk Score: 8-12	Acceptable – subject to regular active monitoring	Service Manager	Head of Service/ Director	Directorate/Division
Red Risk Score: 15 – 25 Report to Executive Director immediately	Unacceptable – requires constant active monitoring and if necessary immediate corrective action	Director	Executive Team and/or Board	Corporate Risk Register/Assurance Framework

Structured review cycle for risks:
The table below is used to determine the frequency of review cycle for all risks.

Risk Score / Rating	Review Cycle
Green Risk Score: 1-3	Acceptable – subject to periodic passive review **(YEARLY) Team Level (Divisional Risk Register)**
Yellow Risk Score: 4-6	Acceptable – subject to regular passive review **(Six Monthly) Service Level (Divisional Risk Register)**
Amber Risk Score: 8-12	Acceptable – subject to regular active monitoring **(3 Monthly) Divisional Level (Divisional Risk Register)**

Red **Risk Score: 15 – 25** **Report to Executive Director immediately**	Unacceptable – requires constant active monitoring and if necessary immediate corrective action **(MONTHLY) Executive Level (Corporate Risk Register/Board Assurance Framework)**

Appendix 6
Generic risk register assessment template

Directorate/Division:	Service/Dept:
Assessed by:	Date: 21/11/2012
Location:	
Source of the risk:	

1. Risk/Hazard

Are there any risks or hazards likely to affect health, safety, security or welfare of any person(s)?

State the risk/hazard and define the actual problem.
Example: if there is unplanned activity then this may incur losses; if there poor record-keeping then this can lead to suboptimal care

List any controls already in place.
Controls are strategies, policies and plans in place to address the risk. See the hierarchy of controls in Appendix 13.

2. Initial Risk Assessment

In order to calculate the initial degree of risk associated with the above risks/hazards use the following equation (see Appendix 5 for the Risk Matrix table):

Consequence x Likelihood of harm occurring = Risk Rating

Consequence	Likelihood of occurrence	Risk Rating
Catastrophic	Almost certain	Red

3. Appropriate Actions

What immediate action should be taken?
Continue on a separate sheet if necessary

Description	By whom?	By when?

What subsequent action should be taken?
Continue on a separate sheet if necessary

Description	By whom?	By when?

4. Review and Revise Risk Assessment

Date of assessment review	
Who should undertake this review?	

In order to calculate the residual degree of risk associated with the above risks/hazards use the same equation as in the initial risk assessment.

Consequence	Likelihood of occurrence	Risk Rating
Catastrophic	Almost certain	Red

5. Authentication

Name and job title of the person completing this assessment	
Name and job title of the manager responsible for this area of assessment	
Name of manager taking ownership for this assessment and agreeing level of risk	
Date of completion	
Has this risk/hazard been added to the risk register	Yes
If yes, when?	

ADDITIONAL COMMENTS

Appendix 7

Risk register template for divisional/directorate use (see related section of the strategy for further guidance)

Date risk added	Division	Service	Divsion Risk Owner	Reference	Source (eg assessments, key targets etc)	Divisional Responsibility & Designated Lead	Summary risk description (specific points) (What could go wrong)	Impact	Likelihood	Risk score/rating	Summary of existing control measures to manage the risk	Summary of planned actions	Deadline date (when actions expected to be complete)	Resources to implement e.g. (financial, staff, equipment) & funding source	Specific date of interim review	Impact	Likelihood	Risk score and rating	Risk Acceptable? Y/N	Progress to date (Enter here specific details of how the evidence of actions to manage the risk are progressing and dates of when this was updated)	Movement Rating (select correct statement from drop down list)

Appendix 8

Corporate risk register template for use (see related of the strategy for further guidance)

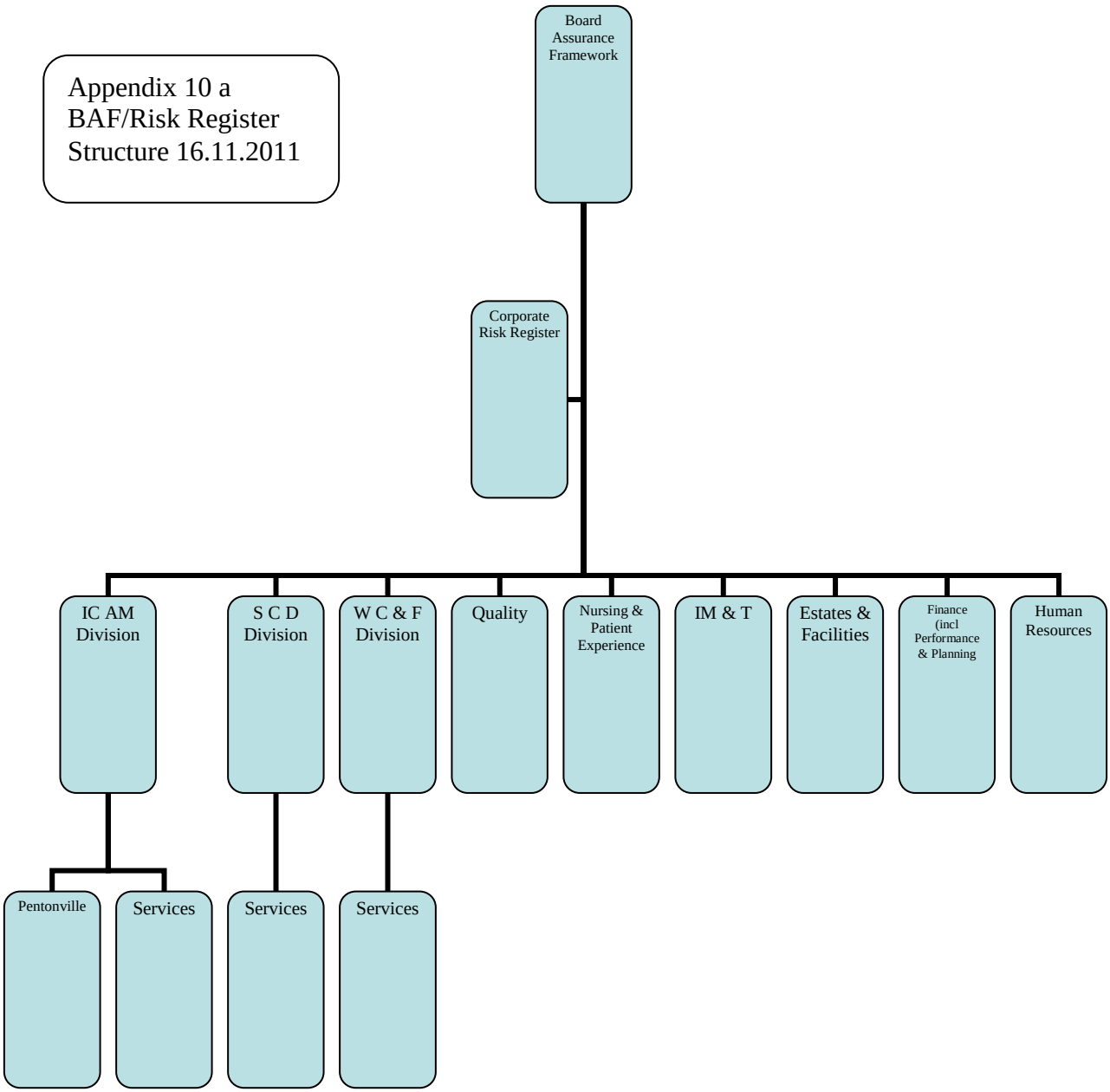
Date risk added	Division	Service	Divsion Risk Owner	Reference	Source (eg assessments, key targets etc)	Divisional Responsibility & Designated Lead	Summary risk description (specific points) (What could go wrong)	Impact	Likelihood	Risk score/rating	Summary of existing control measures to manage the risk	Summary of planned actions	Deadline date (when actions expected to be complete)	Resources to implement e.g. (financial, staff, equipment) & funding source	Specific date of interim review	Impact	Likelihood	Risk score and rating	Risk Acceptable? Y/N	Progress to date (Enter here specific details of how the evidence of actions to manage the risk are progressing and dates of when this was updated)	Movement Rating (select correct statement from drop down list)

Appendix 9

Table for Risk Identification Sources/Approaches

Sources/Approaches
Benchmarking
BPEST (Business, Political, Economic, Social, Technological) Analysis
Brainstorming
Business Continuity Planning
Business Impact Analysis
Claims and Investigations Audit Internal or External
Complaints PALS (Patient Advice and Liaison Service) Risk Assessments
Event/Threat/Decision/Fault Tree Analysis
Governance reviews of processes and structures
Incident Reports and InvestigationsPALS (Patient Advice and Liaison Service)
Market Intelligence / Surveys
Media
National Patient feedback websites
Patients and staff surveys
Performance reporting
Performance reports
PESTLE (Political, Economical, Social, Technical, Legal, Environment) analysis
Quality and Risk Profiles Care Quality Commission (CQC)
Research and Development
Reviews/Inspections/Audits, other service providers feedback
Scenario Analysis
Self assessments
SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis
Workshops

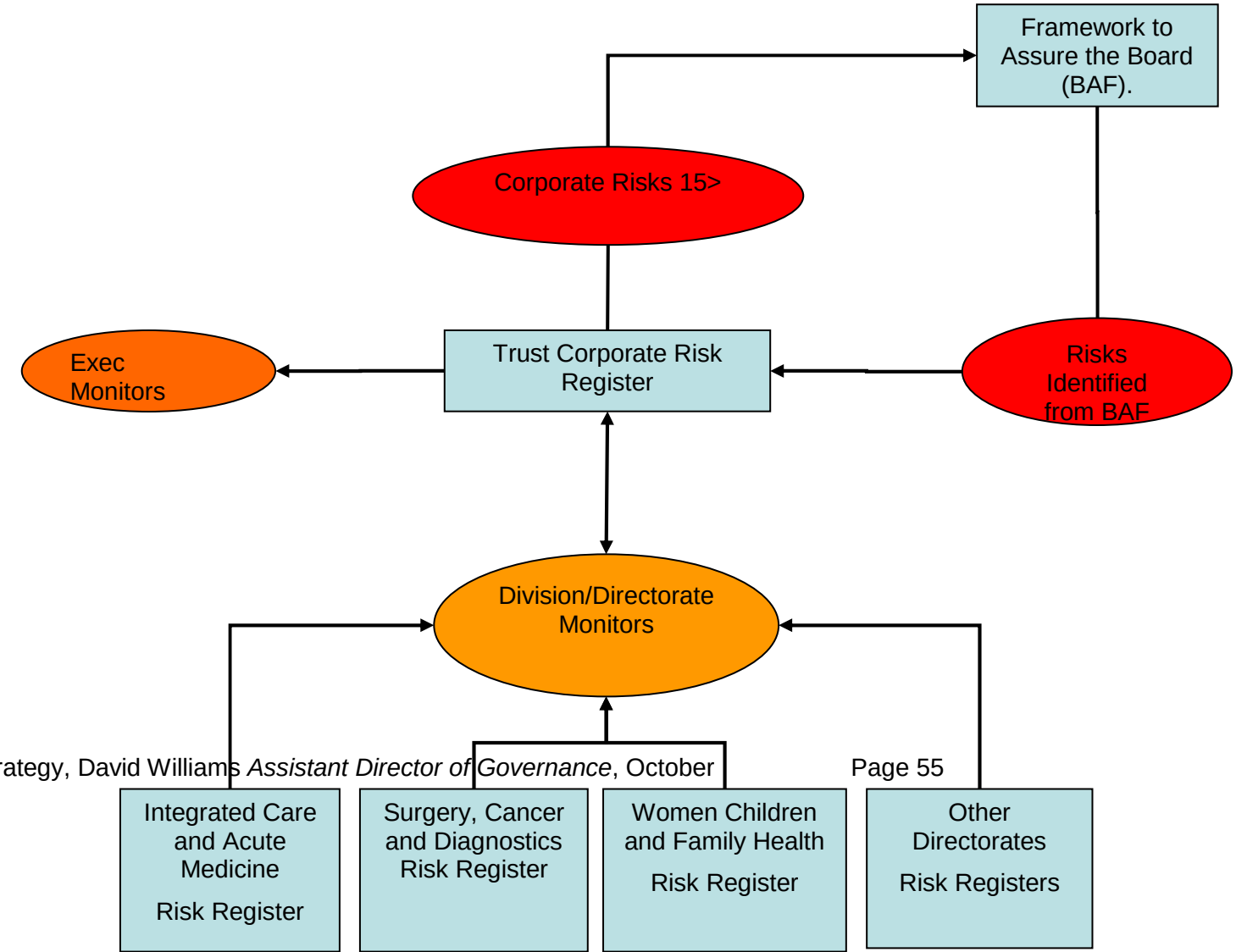
Appendix 10 a
BAF/Risk Register
Structure 16.11.2011



Appendix 10 b

Risk Register Process Diagram

Risk Registers underpinned by Risk identification sources/approaches



Appendix 11
Reputational risk basic guidance

What puts reputations at risk?
Reputation has a value even if it cannot be expressed financially; the possibility of this value being reduced represents a business risk.

A risk to reputation occurs where the organisation fails to meet the expectations of a specific stakeholder group, the key to effective reputation risk management is therefore the management of expectations. It has been said that reputation risk lies in the gap between expected and actual behaviour, this is why stakeholder mapping is useful to "mind the gap"

It is clear that:

- Organisations have no direct control over stake holders perceptions but they can influence them.
- The quality of reputation must be monitored across all stakeholders. Organisations must look for positive news especially in the midst of adverse situations
- Organisations must understand who their stakeholders are and what impact they have on the organisation.
- Reputation and branding are not the same thing.
- Reputation should be seen as an asset to the organisation.
- It is difficult to value reputation in monetary terms
- Reputation should be covered in narrative reports. It is best dealt with within the risk section of reports as "reputational risk".
- It is important to assign ownership for reputation- the board has prime responsibility for reputation.
- Reputation is ultimately a measure of trust.
- The extent of damage to reputation caused by an event will depend on how easily trust can be recovered. This will naturally depend on prior state of reputation, the nature of the threat and the way that the situation is handled.

Source (CIMA Corporate Reputation)

Appendix 12
Specialist Advisors

Health and Safety	**James Ward**
Security	**Peter Brown**
Fire	**Steven Primrose**
Moving and Handling	**Paul Ratcliff**

Appendix 13
Hierarchy of control measures.

This list of control measures is ordered according to effectiveness at reducing risks. To choose the best control for any risk, begin by considering the most effective option, only considering the next option on the list if the more effective one can't be used.

1. Eliminate
The best way to reduce a risk is to remove the hazard. E.g. using a trolley instead of carrying eliminates a manual handling hazard.

2. Substitute
If you can't remove it altogether, substitute the hazard for something less risky. E.g. cleaning products with bleach can be harmful. Another product without bleach might do the same job.

3. Contain
Preventing access to a hazard - e.g. using a guard over a sharp blade or a locked cupboard for hazardous chemicals - is important where removing the hazard just isn't feasible.

4. Reduce exposure
Reducing exposure to a hazard means you're reducing the likelihood of harm occurring and so reducing the risk. E.g. computer users can lower the risk of upper limb disorders by doing tasks away from their PC every so often.

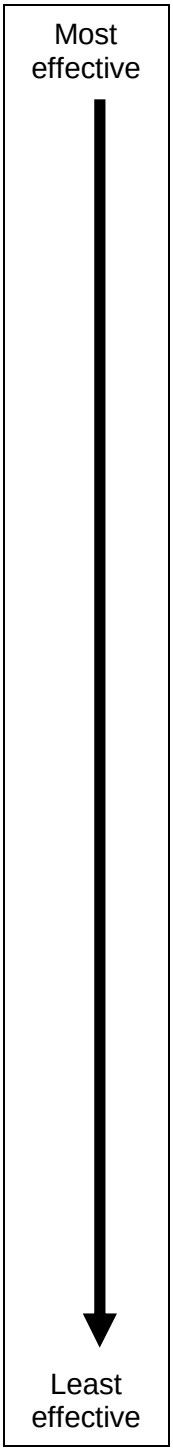
5. Training and supervision
Information, training and supervision help to make sure people follow procedures and are aware of the risks when working with hazards. These measures only work together with other controls.

6. Personal protective equipment (PPE)
The law says PPE must be supplied and used at work wherever there's a risk that can't be adequately controlled in other ways. It's always better to control risks at source than to protect from the outcome. People often don't use PPE properly if they find it annoying, so it should always be a last resort when risks can't be controlled any other way.

7. Welfare facilities
If facilities for washing or first aid are on hand for quick treatment after an accident, the extent of injury can sometimes be controlled. It's always better to prevent accidents occurring in the first place. Welfare should only ever serve as a back-up for emergencies if all other controls fail.

Risk controls and their cost should be offset against the level of risk identified. In general the most effective control should always be implemented to reduce the risk as far a possible.

However when a particular control involves excessive costs compared to the safety gains it's usually acceptable to consider a less effective control.



Appendix 14

Tool to Develop Monitoring Arrangements for Policies

What key element(s) need(s) monitoring as per local approved policy or guidance?	Who will lead on this aspect of monitoring? Name the lead and what is the role of the multidisciplinary team or others be if any.	Which tool will be used to monitor/check/observe/ Assess/inspect/ authenticate that everything is working according to this key element from the approved policy?	How often is the need to monitor each element? How often is the need complete a report ? How often is the need to share the report?	What committee will the completed report go to?
Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting arrangements**
Organisational Risk Management Strategy and Structure detailing, committees/sub committees groups which have some responsibility for risk	Corporate Governance and Risk Manager Assistant Director of Governance	DH Guidance Monitor Framework	Annually	Quality Committee Board Audit and Risk Committee
Process for review of Corporate Risk Register Executive Committee	Corporate Governance and Risk Manager	Review of Risk Register against Risk Management Strategy	Monthly	Executive Committee
Process for Board Review of Corporate Risk Register	Corporate Governance and Risk Manager	Review of Risk Register against Risk Management Strategy	Quarterly	Board
Process for Audit & Risk Committee Review of Corporate Risk Register	Corporate Governance and Risk Manager	Review of Risk Register against Risk Management Strategy	Quarterly	Audit and Risk Committee
Process for Quality Committee review of Risk Registers in terms	Corporate Governance and Risk Manager	Review of Risk Register against Risk	Quarterly	Quality Committee

of Quality (Safety, Clinical Effectiveness, Patient Experience)		**Management Strategy**		
Process for Divisional/Directorate Review of Risk Registers	**Corporate Governance and Risk Manager**	**Review of Risk Register against Risk Management Strategy**	**Monthly**	**Divisional Board**
Duties of the key individual(s) for risk management activities	**Corporate Governance and Risk Manager**	**Review of Duties undertaken against Risk Management Strategy**	**Annual**	**Board** **Audit Committee** **Quality Committee**
Authority of all managers with regard to managing risk	**Corporate Governance and Risk Manager**	**Review of authority against risk management process**	**Ongoing as part of risk register review.** **Annual Report**	**Board** **Audit Committee** **Quality Committee**
Process for assessing all types of risk	**Corporate Governance and Risk Manager** **Assistant Director of Governance**	**BAF Risk Agreed at Annual Risk/Objectives Seminar** **BAF Review** **Corporate and Divisional Risk Registers reviewed on routine cycles.**	**Annually** 1. **Bi-monthly** 2. **Each Meeting** 3. **Monthly**	**Board** 1. **Executive Committee** 2. **Audit Committee** 3. **Board** **Executive Committee Monthly** **Divisional Boards**

				Monthly
Process for ensuring a continual, systematic approach to risk assessments/risk identification is followed through the organisation	**Internal Auditors/Corporate Governance and Risk Manager/ Assistant Director of Governance**	**Internal Auditors to review the risk management processes annually as part of the annual audit plan.** **Risk Management Annual risk profile report will also review the risk management process and inform the DH Annual Governance Statement.** **Risk will become a standing agenda item on all committees/team meetings.** **Risk assessments will be monitored through the Divisional/Directorate Structures and programmes.** **Aggregation of Incidents Complaints and Claims and the correlation between these and identified risk assessments/risks on risk registers.**	**Annually** **On going review sample checks.** **Quarterly.** **Quarterly.**	**Board** **Audit Committee**

Appendix 15

Stakeholders for development of this document.

- Audit and Risk Committee Non Executives, ***development***.
- Executive Committee members, ***development and review in draft format***.
- Board, ***ratification of the final document***.
- Divisional Senior Management Team, **development**.
- Governance Team, **development**.
- Heads of Nursing, **development**.
- Quality Lead, **development**.

Appendix 16
Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the procedural document affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the procedural document likely to be negative?**	No	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the procedural document without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Director of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Director of Human Resources.

Appendix 17

Checklist for the Review and Approval of Procedural Document

To be completed and attached to any procedural document when submitted to the relevant committee for consideration and approval.

	Title of document being reviewed:	Yes/No	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is it clear that the relevant people/groups have been involved in the development of the document?	Yes	
	Are people involved in the development?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
5.	**Evidence Base**		
	Are key references cited in full?	Yes	
	Are supporting documents referenced?	Yes	
6.	**Approval**		
	Does the document identify which committee/ group will approve it?	Yes	Board
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	Monitoring Appendix
8.	**Document Control**		
	Does the document identify where it will be held?	Yes	

	Title of document being reviewed:	Yes/No	Comments
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes	
	Is there a plan to review or audit compliance with the document?	Yes	
10.	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	Yes	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes	

Executive Sponsor Approval			
If you approve the document, please sign and date it and forward to the author. Procedural documents will not be forwarded for ratification without Executive Sponsor Approval			
Name		Date	
Signature			
Relevant Committee Approval			
The Director of Nursing and Patient Experience's signature below confirms that this procedural document was ratified by the appropriate Governance Committee.			
Name	Bronagh Scott	Date	14 December 2011
Signature	Evidence within minutes of December Board meeting.		
Responsible Committee Approval – only applies to reviewed procedural documents with minor changes			
The Committee Chair's signature below confirms that this procedural document was ratified by the responsible Committee			
Name		Date	
Name of Committee		Name & role of Committee Chair	
Signature			