

RISK MANAGEMENT STRATEGY

RM01

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1 Statement of Intent

The Shrewsbury and Telford Hospital NHS Trust is committed to changing healthcare for the better and believes that our role as individuals and as an organisation is to provide the safest possible care at the highest level of quality we can afford using the best evidence of what provides the greatest benefit to patients.

The Trust Board recognises that to achieve this highest level of quality, it is essential that effective risk management should become part of the Trust's culture and strategic direction.

The Board is committed to an open and honest approach in all matters. It expects all staff to acknowledge that risks within the Trust can be identified and managed if everyone adopts an attitude of openness and honesty. The overall approach expected within the organisation is one of help and support rather than blame and recrimination. The Trust's Whistleblowing Policy complements this approach by providing an alternative mechanism for raising concerns if staff do not feel able to raise these through the usual routes. The Board acknowledges that the provision of appropriate training is central to the achievement of this aim.

2 Introduction

2.1 Overview

The effective management of risk is central to providing the safest possible care at the highest level of quality we can afford whilst allowing the Trust to make the most of opportunities, whilst minimising the risks taken. Boards need to be able to demonstrate that they have been informed about all risks not just financial and that they arrived at their conclusions on the totality of risk based on all the evidence presented to them. The purpose of the Risk Management Strategy is to detail the Trust's framework for setting objectives, providing assurance and managing risk to enable:

- The Trust to maintain a corporate risk register, that details those risks that could prevent the achievement of Trust strategic and operational objectives as stated within the Trust's business plan.
- The resulting risk register to be reported through the Trust Risk Management Executive to the Trust Board. The Risk Management Executive is the overarching risk management committee in the Trust.
- The Trust to develop an Assurance Framework that informs the Board of the effectiveness of key controls that seek to mitigate or manage principal identified risks to the Trust's stated objectives.
- The resulting Assurance Framework to be scrutinised by the Audit Committee.

The Trust aims to manage risk in an integrated way; considering all aspects of risk including clinical, non-clinical, financial, operational, business and strategic with the aim of minimising its exposure to risk.

The maternity service has a complementary approved risk management strategy which describes the processes in place in the Women's and Children's Centre for managing risk in this high risk environment as required by the CNST standards published by the NHSLA¹.

2.2 Definition of Risk

There are many definitions of risk, but most imply that risk is something which should always be avoided. However, without any risk there would be very few opportunities or innovations. Modernising and improving our services requires the Trust to take opportunities whilst managing the risks. For the purpose of this strategy "risk" is defined as -

"Anything which could prevent The Shrewsbury and Telford Hospital NHS Trust from achieving its objectives"

Risk has two main components: consequence and likelihood. Consequence is a reflection of the damage or loss which may occur. Likelihood is an indication of how often the event might occur. Taken together, they give an indication of how much damage could be caused as a result of unwanted or unplanned events.

2.3 Risk Appetite

The risk appetite of the organisation determines the balance between not adequately managing risks, therefore leaving the organisation exposed; and over managing risks, stifling creativity and causing loss of opportunity. The Trust risk appetite addresses risk without a culture of blame. By taking a positive approach to risk, the Trust will create greater opportunities and increase the chances of success. All our risks must be managed appropriately; this strategy explains how we are managing risk to create opportunities.

2.4 Policies

All policies and procedures developed by the Trust are relevant to risk management. Following the appropriate standards, legal / statutory guidance and best practice identified in policies and procedures will minimise risk. There are some policies which link directly to this strategy which are listed in appendix P.

2.5 Legal and National Requirements

2.5.1 Care Quality Commission: Essential Standards of Safety and Quality

The Health and Social Care Act 2008 sets out the legal framework for NHS organisations in assessing and monitoring the quality of service provision. The Care Quality Commission (CQC) is responsible for monitoring implementation of the Act, through assessing the Trust's compliance with the Essential standards of Quality and Safety.² Compliance with the standards is monitored nationally by the Care Quality Commission. The main monitoring tool is the Quality and Risk Profile (QRP). The CQC will use the QRPs to help assess where risks lie within an organisation and will act as a prompt for implementing front line regulatory activity, such as inspection. The Commissions also assess performance against national targets and service reviews.

2.5.2 NHSLA Risk Management Standards

The NHS Litigation Authority Risk Management Standards have clear minimum requirements in relation to risk management³. The standards cover general risk management (NHSLA standards) and maternity (CNST standards)

2.5.3 Civil Contingencies Act

The Civil Contingencies Act (2004)⁴ requires the Trust to ensure that all risks associated with business critical services are identified and mitigated including the development of business continuity plans

2.5.4 Assurance Framework

The Department of Health require all NHS organisations to have in place a robust Assurance Framework as set out in "Building the Assurance Framework-A *Practical Guide for NHS Boards*"⁵

2.5.5 Statement of Internal Control

It is a requirement for all NHS Chief Executives each year to sign a Statement of Internal Control (SIC)⁶ as part of the statutory accounts and annual report. The SIC provides evidence that the Chief Executive as the Accountable Officer, has maintained a sound system of internal control throughout the year, to support the organisation in achieving its objectives.

2.5.6 Clinical Governance

Clinical governance is a key aspect of risk management for the Trust and a major determinant of organisational success through its controlling influence and potential for mitigating clinical risks. It has been defined as:

“A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.”

A First Class Service⁷

2.5.7 Integrated Governance

The Trust operates an integrated approach to governance, based on the Integrated Governance Handbook⁸ (March 06) and its structures and processes reflect this. Corporate governance and risk management have long played a major role in providing stakeholders with evidence that their NHS service is meeting their needs in a resource efficient manner – as well as being willing and capable of avoiding foreseeable adverse occurrences, or at least of competently managing them.

3 Aims

The aim of this strategy is to create robust structures, systems and processes that will minimise to a tolerable level, or eliminate altogether, risks to staff, patients, visitors and the organisation, by promoting consistency in practice in all services. The strategy is aimed at creating a deep awareness and responsibility for the assessment and management of risk at all levels in the organisation through individual practice and in management arrangements.

4 Key Definitions

Assurance	Internal or external evidence on how the identified risks are managed.
Assurance Framework	A structure within which Board identify the principal risks to the organisation meeting its corporate objectives and map out both the key controls in place to manage them and how the Board will gain sufficient assurance about the effectiveness of these controls
Contingencies	Plans put into place which will be actioned should the risk materialise
Control	Mechanisms, procedures and protocols that are put into place to manage the risk to the lowest reasonably practicable level
Hazard	Something with the potential to cause harm, injury, or damage
Internal Control	The ongoing policies, procedures, practices and organisational structures designed to provide reasonable assurance that objectives will be achieved and that undesired events will be prevented or detected and corrected
Reasonably practicable	Practicable means something is possible, however ‘reasonably practicable’ calls for a balance of the risk against costs in time, money and other resources.
Risk Assessment	The identification and analysis of relevant risks to the achievement of objectives
Risk Identification	The process of determining what can happen, why and how. The mechanism by which risks become known to the organisation
Risk Management	A logical and systematic way by which potential risks are identified, analysed, treated, monitored and communicated in a way which will enable the organisation to minimise losses and maximise opportunities
Strategic Objective	An overarching goal of the organisation.

For a more comprehensive list of terms and definitions see appendix N.

5 Strategic Objectives

The Trust believes it is essential to develop a strategy that is balanced between four elements or strategic domains.⁹ The Trust reviews and updates its strategy annually. Each objective has a designated Executive lead, responsible for assessing and monitoring the risks associated with delivery of the objective. This assessment forms part of the corporate risk register and assurance framework. The four strategic domains are:

- Financial Strength: We will develop and deliver robust plans that generate surpluses to reinvest in quality.
- Patients, GPs and Commissioners: We will insist that we deliver the best service to our patients, GPs and commissioners
- Quality and Safety: We will always provide the right care for our patients
- Learning and Growth: We will develop our internal processes to sustain our ability to change and improve

The Trust believes that you cannot manage what you cannot describe. The Strategy Map¹⁰ - a "plan on a page" represents the most important elements of the strategy aims to help everyone to understand what the Trust must do to deliver and achieve the Trust's vision of the future, and the part they play in this. The Vision, Mission and Values that will support the Trust to continue Putting Patients First is depicted in 'The Pyramid' – the Trust 'management system on page'¹¹

6 Risk Management Organisational Structure

6.1 Trust Board

The Trust Board is responsible for ensuring that the Trust follows the principles of sound governance. The Board is required to produce statements of assurance that it is doing its "reasonable best" to ensure the Trust meets its objectives and protect patients, staff, the public and other stakeholders against risks of all kinds. In relation to this strategy the Trust Board will:

- Agree clear objectives, which provide the framework for all the Trust's activity
- Have a structured risk identification system covering all possible risks to these objectives,
- Have robust controls in place for the management of risk including action and contingency plans
- Develop appropriate monitoring and review mechanisms that provide independent assurance to the Board that the system of risk management across the trust is effective
- Agree action plans to ensure best practicable control over significant risks
- Retain risks only where other strategies have been explored and found to be impracticable or economically unjustifiable
- Demonstrate and support model behaviour throughout the organisation, consistent with good governance practice and an organisational culture based on openness and learning.

The Trust's organisational structure chart is shown at appendix A. This details the lines of reporting including specialist groups.

6.2 Risk Management Executive (RME)

The Trust Board has delegated responsibility for risk management to the Risk Management Executive which is the Trust committee with overarching responsibility for risk. The RME provides assurance to the Trust Board that the systems for risk management and internal control are effective. The summary of this meeting is submitted to the Trust Board.

The RME is responsible for providing leadership for the co-ordination and prioritisation of clinical, non-clinical and organisational risk, ensuring that **all** significant risks are properly considered and communicated to the Trust Board.

The Terms of Reference are at Appendix B

6.3 Hospital Executive Committee (HEC)

The remit of the HEC is to inform and implement the Trust Board's policy and strategic direction of the organisation and to reach decisions on, and monitor the progress of, the Trust's business and organisation objectives.

It will also discuss and approve relevant procedural documents and strategic plans before submission to Trust Board to monitor performance against action plans, national targets and financial plans and take necessary actions to correct any deviation from plan. The summary of this meeting is submitted to the Trust Board.

The Terms of Reference are at Appendix C

6.4 Health and Safety and Security Committee

The committee will be chaired by the Director for Compliance and Risk Management and will meet at least once every three months. The purpose of the Committee is -

- To review new legislation and guidelines on Health and Safety and Security issues, and advise the Trust Board, the Hospital Executive Committee, Centre Chiefs, Departmental Heads and staff.
- To be a source of professional advice which may not be available in Centres.
- To receive reports from the Health and Safety Executive and confirm/advise on action to ensure compliance.
- To arbitrate on cross Centre issues
- The Committee reports to the Risk Management Executive

The Terms of Reference are at Appendix D

6.5 Trust Audit Committee

The Audit Committee, a formal sub-committee of the Board, provides overview and scrutiny of risk management. This meets bi-monthly. It is chaired by a Non-Executive Director and the terms of reference have been devised in line with the Audit Committee Handbook to reflect its role as the senior Board committee taking a wider responsibility for scrutinising the risks and controls which affect all aspects of the organisation's business. The Audit Committee is responsible for oversight and scrutiny of the Trust's systems of internal control and risk management.

The Terms of Reference are at Appendix E

6.6 Clinical Quality and Safety Committee

This Committee is a formal sub-committee of the Board established to provide assurance to the Board on Clinical Quality & Safety, (including Clinical Effectiveness, Patient Safety and Patient Experience) utilising best practice metrics that provide robust clinical governance processes to deliver safe, high quality and patient centred care.

The Terms of Reference are at Appendix F

7 Duties/ Responsibilities

All members of staff have an individual responsibility for the management of risk and all levels of management must understand and implement the Trust's risk management strategy. This section details specific lines of accountability and communication, through which the Trust manages risk.

7.1 Responsibility of the Chief Executive

The Chief Executive is the Accountable Officer for the Trust and has overall accountability and responsibility for ensuring the Trust meets its statutory and legal requirements and adheres to guidance issued by the Department of Health in respect of governance. This responsibility encompasses risk management, financial and organisational controls, health and safety and clinical governance and the Essential Standards of Quality and Safety. The Chief Executive is the nominated individual for the Trust's registration with the CQC.

Whilst the Trust Board has the collective accountability for internal control, the Accountable Officer has the responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. The Accountable Officer also has the responsibility for safeguarding the public funds and the organisation's assets for which they are personally responsible as set out in the Accountable Officer Memorandum. The Accountable Officer will sign the annual Statement of Internal Control, on behalf of the Trust Board, after reviewing the effectiveness of the system of internal control.

7.2 Responsibility of Non-Executive Directors

The Non-Executives are accountable to the Secretary of State. They are expected to hold the Executive to account and to use their skills and experience to make sure that the interests of patients, staff and Trust as a whole, remain paramount. They have a significant responsibility for scrutinising the business of the Trust particularly in relation to risk and assurance.

7.3 Responsibility of the Directors

Whilst the Chief Executive has overall responsibility they delegate various aspects of risk management, including implementation of this strategy as follows:

Director	Area of Risk Management Responsibility
Executive Directors	
Chief Operating Officer	Business Continuity Centres and Value Streams Environmental Estates and Facilities Major Incident Planning
Director of Quality and Safety	Child and Adult Protection Clinical Governance (with Medical Director) Infection Prevention and Control Nursing and Midwifery Practice Patient Experience Patient Safety
Finance Director	Finance Fraud prevention Information Governance SIRO Performance and Contracts
Medical Director	Caldicott Guardian Clinical Safety Officer Clinical Governance (with Director of Quality & Safety) Information Technology Medical Education Medical Practice Medicines Management Research and Development Revalidation
Directors	
Director of Communications	Media Reputation Management
Director of Compliance and Risk Management	Risk and Assurance Framework Foundation Trust programme Health and Safety Legal Services Security Management
Director of Strategy	Business planning Future Configuration of Hospital Services Strategy

Workforce Director	Human Resources Organisational Development Training and Development
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Each Director has delegated responsibility for the delivery of specific objectives and therefore for assessing the risks associated with the delivery of those objectives. This includes a Quality Impact Assessment on all CIP schemes. (see appendix L) It is the responsibility of each Director and their management team to implement local arrangements which accord with the principles and the objectives set out in this strategy. The Director will assign a risk owner for each identified risk. Each Director has overall responsibility for ensuring that information held on the Corporate Risk Register and Assurance Framework is up to date and accurately reflects the current status.

For each of the Care Quality Commission’s Essential Standards of Quality and Safety the Trust has designated Director Leads. Risks to compliance are managed by the development of an action plan to demonstrate annual improvements and this is linked to both the assurance framework and corporate risk register

7.4 Responsibility of the Director of Compliance and Risk Management

- Lead Director for risk management
- Fulfil the role of Board Secretary
- Develop corporate risk management strategies and policies interpreting national guidance to fit the local context
- Develop the Board Assurance Framework in conjunction with the Trust Board
- Update the Trust Board and Audit Committee on any assurances received.

7.5 Responsibility of Chief Compliance Officer

The Chief Compliance Officer is responsible for

- Develop and maintain the Corporate Risk Register and submit reports to every meeting of the Risk Management Executive
- Providing advice and guidance on use of the electronic risk register (4Risk)
- Oversee the running of the Risk Management Executive ensuring risks are reported, assessed and managed through the submission of the Corporate Risk register (at least 3 times a year)
- Produce an annual risk management report for the Risk Management Executive
- Keep an up to date assurance schedule of planned external visits and audits (clinical and non-clinical)

7.6 Responsibility of Centre Chiefs

The Centre Chiefs are responsible for ensuring participation in the Trust’s Governance systems through:

- ensuring Centres have local risk management systems in place detailing arrangements in their areas of responsibility including ongoing risk assessment.
- ensuring Centre risk register is in place and escalate identified risks, in the form of a written template (appendix I), to the Risk Management Executive in line with the requirements of this strategy.
- the promotion of an open, reporting and learning culture
- participation in, and taking action upon, recommendations from regional and national reporting systems, assessments, guidance and reports
- completing sub certification to support the Statement of Internal Control

7.7 Responsibility of Managers

Trust Managers will have delegated responsibility for assessment, management and reporting of risks to ensure potential harm to patients, staff and visitors is minimised and that risks to achievement of business plans are controlled. They will

- Ensure all risk assessments are recorded together with the identified control methods and action plans to ensure that the risk is managed at the lowest reasonably practicable level
- Provide assurances to the Trust Board on the Essential Standards of Quality and Safety and report any risks to achievement through the Risk Management Executive.

- Ensure that an open, reporting and learning culture exists for staff to report incidents and near misses and any remedial action taken to prevent further recurrence.
- Ensure that a thorough risk assessment has been carried out for all potential business cases and all project initiation documents
- Ensure that where the Trust enters into partnership agreements, a risk assessment is carried out and the management of risk included in any ensuing Service Level Agreement.
- Develop robust Business Continuity Plans
- Ensure all staff are aware of the Trust Whistleblowing process (see appendix O)

In order to ensure compliance and achievement with the above, senior managers will ensure that:

- Staff attend training appropriate to their role as identified in the mandatory training plan and in particular on starting within the Department, with an appropriate local induction programme and that all new starters attend the Trust's generic induction programmes.
- Appropriate Trust staff are identified and released to receive training as risk assessors, first-aiders, management of emergency procedures, such as fire, violence & aggression, health & safety representatives, health & safety link workers, infection control links nurses, food handlers, etc
- No individual carries out specific duties until they have been passed fit for their duties by Occupational Health. All employees who require health surveillance according to risk assessments attend Occupational Health as appropriate, and required by statutory regulations
- The correct equipment is available and appropriate for the duties and tasks required of staff and is safe and fit for the purpose, that it is maintained and tested to ensure its continued suitability.
- All staff in their area of responsibility receive annual an appraisal with objectives and a performance development plan aligned to the Trust's corporate objectives.

7.8 Responsibility of Senior Information Risk Owner (SIRO)

The Trust (SIRO) is responsible for coordinating the development and maintenance of information risk management policies, procedures and standards for the Trust. At SATH the SIRO is the Finance Director.

7.9 Responsibility of Information Asset Owners (IAO's)

The Trust IAO's are responsible for undertaking risk assessments on their information assets in order to identify and manage associated risks

7.10 Responsibility of Safety Advisors

The Trust has a number of specialist safety advisors who are available to support staff:

- Catering/Food Hygiene Professionals
- Chief Pharmacist
- Child Protection Lead
- Director of Infection Prevention & Control (DIPC)
- Estates Professionals
- Finance Managers
- Fire Safety Advisor
- Health & Safety Advisors
- Human Resources Advisors
- Emergency Planning Advisor
- Information Governance Manager
- Local Counter Fraud Specialist
- Medical Equipment Professional
- Moving & Handling Advisors
- Occupational Health Service
- Patient Safety Advisors
- Research and Development Lead
- Security Manager
- Union Health and Safety Representatives
- Vulnerable Adults Lead

7.11 Responsibilities of all Employees

All staff are expected to:

- Reporting to their line manager any perceived risk in the area which requires assessment and management and participate in risk assessment and risk control as required
- Report incidents/accidents and near misses using Datix.
- Attend training as identified by their manager through appraisal, or as stated in the Trust mandatory training plan.
- Be aware that they have a duty under legislation to take reasonable care for their own safety and the safety of all others that may be affected by the Trust's business, and that they are responsible

for their acts and omissions. This duty includes notifying managers of any personal factors that may influence their ability to perform.

- Comply with all Trust rules, regulations and instructions to protect health, safety and welfare of anyone affected by the Trust's business
- Be aware of emergency procedures, e.g. resuscitation, evacuation and fire precaution procedures appertaining to their particular location (Please refer to Local Policies in own area and Trust Policies on Trust Intranet)
- Be aware of the Whistleblowing Policy

8 Philosophy of Risk Management

The management of risk is everyone's responsibility. Good risk management underpins quality patient care, be it direct clinical care or indirectly from support services.

No area of life is without risk. Every activity occurring in the workplace carries a level of risk, but at work employers are required by law to *eliminate the risk where possible*¹². If this is not possible *then as far as is reasonably practicable* the risks should be mitigated by the use of control measures. In limited specific circumstances the risk must be reduced to the lowest level practicable. The level of risk varies, but the requirement to manage the risks remains the same and is a manager's/supervisor's responsibility. The risk management strategy is based upon the following principles:

- The success of the risk management programme is dependent upon the demonstrated and leadership and senior management support for risk management including the promotion of a learning as opposed to a blaming culture
- The promotion of an open objective culture where mistakes by staff can be reported in a fear free culture which supports them and enables them to learn from the experience. For this to occur there must be commitment and open support by management at all levels;
- The identification of risk is considered in all areas of the Trust's work from strategic planning to operational delivery. Risk management is not a process to be dealt with in isolation, but should be embedded in practice.
- The identification and management of risks requires the active involvement of staff at all levels throughout the Trust. Staff operating within a service are best placed to understand the risks and to manage change; this will be achieved through well structured communication and support systems;
- Risk management is a joined up process, to be successful all indicators must be reviewed in conjunction with each other, i.e. complaints, claims, incident reports, performance indicators, sickness absence, and other key indicators

9 The Risk Management System

Guidance issued by the Department of Health indicates that an organisations' system of internal control should be based on an ongoing risk management process. To meet this requirement NHS organisations are required to produce a comprehensive organisation-wide risk register that must be capable of recording clinical risk, organisational risks and financial risks. The Trust embeds risk management through the full and formal adoption of the national NHS framework, the Australian / New Zealand Risk Management Standard 4360:2004.¹³ In order to comply with this standard the following procedures must be in place:

- A continuous risk management process
- An agreed methodology to analyse the range of potential consequences and likelihood of occurrence of risks using the national standard classification 5 x 5 matrix (Appendix G).

See Risk Management Process Summary (Appendix H)

Risk Assessment is every employee's responsibility. Staff will be supported by training, specialist risk advisors, and line management. Risk assessment is a key feature of all normal management processes. All Centres, Departments, Ward and Team leaders must have an ongoing programme of proactive risk assessments.

9.1 Risk Types

The main types of risk facing by the Trust fall into two categories: strategic risks and operational risks.

Strategic Risks: these concern the long term strategic objectives of the Trust. They can be affected by such areas as capital availability, political risks, legal and regulatory changes, and reputation.

Operational Risks: These concern the day to day issues that the Trust faces as it strives to deliver its strategic objectives.

Risks on the Board Assurance Framework are usually strategic risks as these are the risks which will most impact on achievement of corporate objectives; although some operational risks may be considered by the Board to be so significant, if they materialise, that they will be included on the Board Assurance Framework.

9.2 Approach to Risk Identification

The Trust will maintain its structured approach to risk management. It is not possible to manage risks until they have been identified. Risk identification is the process of identifying what can happen or has happened and why. The first step is to review business plan objectives, identifying the Principle Risks (Hazards) that may impact upon the ability of the Trust or Centre to achieve its objectives. The Trust has produced a document 'Guide for ongoing Risk Assessment' to assist line managers.

Examples of potential and actual risks include:

- Financial risks (e.g. controlling money, remaining within budget, investments, etc)
- Clinical risks (e.g. in the delivery of effective care and treatment)
- Quality Risks (Clinical outcomes; Patient experience and Patient safety), each CIP scheme will need to be risk scored for its potential to have an adverse impact on these three dimensions of quality
- Health, safety and security risks (e.g. preventing accidents, ensuring the safety and welfare of staff, patients and the people using our premises)
- Workforce and recruitment risks (e.g. retention, training, skill shortages, etc)
- Estate, facilities and environmental risks (e.g. ensuring the Trusts buildings and equipment are operational and well-maintained)
- Decision making risks (e.g. choosing to act or not, selecting priorities, etc)
- Hidden risks (e.g. reputation)
- Stakeholder and partnership risks e.g. patients, PCTs, local authorities, Department of Health and suppliers
- IT risks
- Business risks (e.g. failing to meet targets, loss of income, business continuity and contingency planning)
- Regulatory Risks e.g. non compliance with CQCs regulatory framework or with equality and human rights legislation

The approach to risk identification includes:

- A "pro-active approach" to the identification and management of Principle Risks that may threaten the achievement of Strategic and operational objectives as identified within the Trust Business Plan.
- A "reactive approach" to the identification and management of risks that may threaten the achievement of the Trust Risk Management workstreams as indicated in Section 13.0 of this strategy.

9.2.1 Proactive risk processes:

Strategies, policies and procedures – In addition to this Risk Management Strategy there are a range of other policies that support the management of risk in the Trust. These are available on the Trust's intranet site. Policies that link strongly to this strategy are listed in the following section with further policies listed at appendix P.

Business Continuity Management – The Trust has in place a [Major Incident Plan](#), as well as a range of plans and other associated documents that are designed to ensure the resilience of the Trust in a range of scenarios that would limit the operating capacity of the Trust. The overarching document is the [Business Continuity Planning Policy and Strategy](#)

Implementation of clinical guidance – the Trust has mechanisms in place to implement the latest guidance and recommendations from NICE. These processes are covered by the [Policy for the dissemination, implementation and monitoring of NICE and other national guidance](#)

Standards and Accreditation, Internal and External reviews/reports - the Trust ensures that it meets a range of standards and accreditations. Other risks are identified from internal and external reports and reviews, e.g Peer Review, NHSLA Risk Management Standards, BSI assessments. The [Policy on the management of external agency reviews](#) describes the process in place to manage these recommendations.

Audit Activity (clinical, internal and external) – there is extensive audit activity within the Trust covering a wide range of issues. Findings from these reviews are fed back to appropriate members of staff, and reports made to the local Governance Groups or the Trust Clinical Audit Committee (clinical audit) and to the Audit Committee (internal and external audit). Recommendation tracking is used to monitor the implementation of recommendations from all audits. The [Clinical Audit Policy](#) describes this process for clinical audit.

Reports to the Trust's Executive Committees / Board on key Trust priorities – Every report to the Committees identify potential risks to the Trust's strategic priorities, (by means of an executive summary sheet), and what actions are being taken to minimise these risks. The Integrated Performance Report covers a number of key trust targets, lined to strategic priorities. Triggers linked to these targets result in remedial action when performance is below acceptable levels.

Organisational Learning (supported by the being open policy) – the Trust seeks to learn from the experiences of other organisations. For example, published reports from key regulators are reviewed, with findings compared to existing Trust practice. The [National Confidential Enquiries Policy](#) covers the processes in place for learning from these bodies.

Training (incorporating Statutory and Mandatory Training) – Extensive training activity takes place in the Trust on a range of subjects. Much of this is regulated by professional bodies such as the GMC, RCN etc, while some is linked to individual personal development plans, or to the implementation of Trust policies. As a minimum all staff receive appropriate statutory / mandatory training as described in the policies: [Corporate and Department Induction, Statutory and Mandatory Training](#)

Risk Assessments and Risk Register Risks are identified during risk assessment which is carried out throughout the Trust on an ongoing basis. The risks identified are fed into the centrally held risk registers and collated into the Corporate Risk Register. This Risk Register is used to collate risk information, prioritise risks and determine risk treatments. It is populated from a wide range of sources, including the assurance frameworks. More detail is available in [Guidance for ongoing risk assessment including maintenance of risk registers](#) and [Health and Safety Risk Assessment Templates](#)

9.2.2 Reactive risk processes

The Trust also identifies potential risks from events that have already occurred. The main drivers of this come from:

Complaints - The Trust has well-established complaints process that is responsible for handling all Trust complaints and ensures that all concerns are responded to within the approved timescales. Complaints are graded using the Trust's risk matrix; all serious complaints are the subject of a full root cause analysis. Information and action plans arising from complaints are used to develop or change the service delivery. The Trust Complaints handling process is described in detail in the [Complaints, Concerns and Compliments Policy & Procedure](#)

Incident Reporting: The reporting of incidents by staff is one of the most efficient and effective systems of identifying risk. It enables action to be taken and lessons to be learnt with the aim of preventing recurrence. The [Procedure for the reporting and investigation of incidents, complaints and claims](#) sets out details of the system in place, including the investigation, analysis and learning from incidents. The Trust has a system for reporting Serious Incidents, which is described in the [Serious Incident Policy](#). All notified incidents are graded using a simple risk assessment matrix, consistent with that to be used for Risk Management.. The [Learning from Adverse Events policy](#) describes who learning will be disseminated following investigation of incidents, complaints and claims.

Claims, Litigation and inquests: The Trust's Legal Department works closely with the Complaints and Risk Departments to enable the early identification of potential legal claims against the Trust. The Legal Department liaises with HM Coroner and clinicians in respect of the inquest process. Any concerns or recommendations raised by the Coroner are communicated appropriately to ensure that remedial action is taken. The process for claims and litigation is set out in the [Claims Policy](#). The process for Coroners is set out in [Coroner's Inquests – Policy and Procedure](#)

Root Cause Analysis – where something happens within the Trust that impacts on services, potential risks are identified and appropriate management action put in place to reduce or eliminate the possibility of a similar occurrence. This can be separate or complimentary to the processes described in the policies listed above. Guidance is available in [10 Steps to Successful Root Cause Analysis Reports](#)

Central Alerting System (incorporating Safety Alert Broadcast System) - The Trust has robust Clinical Alert System (CAS): this is the method of communication of essential information to Trust personnel in circumstances where the information is urgent, requires immediate action from, or needs to be brought to the urgent attention of staff. This system is described in [Actioning Safety Alerts](#)

Staff Concerns (Whistleblowing)

The [Whistleblowing Policy \(HR05\)](#) which enables staff to voice any concerns they have. The Policy should be referred to for further details. See appendix N for a summary.

9.2.3 Quality Risk Assessment of Improvement Programme schemes

In assessing the impact of proposed Improvement Programme schemes on the ability to deliver commitments to quality as defined within the Annual Corporate Plan the Quality KPIs and the Monitor requirements of Clinical outcomes; Patient experience and Patient safety, each scheme will need to be risk scored for its potential to have an adverse impact on these three dimensions of quality. See appendix K for more details.

9.3 Risk Assessment

For sources of further guidance refer to the related policies and procedures listed in appendix P.

9.3.1 Evaluate the nature and extent of identified risks

The evaluation is the undertaking of an assessment of the “likelihood” that the controls put in to manage a risk are likely to fail and determining the “consequences” arising from that failure. Please refer to Appendix G which is a guide to measuring the likelihood and consequence of risk matrix and appendix H, the risk template.

9.3.2 Confirm existing controls:

Describe the adequacy of existing controls, i.e. policies, procedures, protocols, training or physical controls in place to mitigate or manage the risk and secure the delivery of an objective.

9.3.3 Assess the level of residual risk:

Assess the effectiveness of the existing controls put in place, i.e. the level of available evidence (assurance) that demonstrates risks are being managed and objectives are being met. This review of control and assurance effectiveness will then inform a re-calculation of the nature and extent of the risk and determine the level of residual risk.

9.4 Classification of Residual Risk:

Following each risk assessment, managers will be required to determine whether the risk is “acceptable”, “high” or “very high” in order to agree the action that will be required. All risks identified must have controls in place.

The acceptability of risk is a complex issue and will vary according to local circumstances. The risk tool allows for the categorisation of risks into levels of acceptability effectively governed by the timing of subsequent actions. For example risks assessed, as “very high” require immediate attention and hence are deemed unacceptable in most circumstances. Risks assessed as low have the lowest likelihood of occurring and are therefore deemed as acceptable.

It is accepted that it is not possible to totally eliminate all areas of risk. However, achieving the Trust’s risk management objectives will minimise the possibility of incurring misfortune or loss. Levels of acceptable risk are determined by working within agreed Trust policies and procedures. Working outside Trust policies and procedures is unacceptable to the organisation.

9.4.1 Acceptable Risk (Very Low Risk)

Risks scored between 0 to 3 (*Green shaded area*) are mainly insignificant and would probably be unlikely to occur. These will be considered “acceptable risk”, i.e. the quantified residual risk (residual being after taking account of the effectiveness of existing controls) in terms of its likelihood and consequence should remain between 0 and 3. However there still needs to be evidence of controls and monitoring

9.4.2 Acceptable Risk (Low Risk)

Risks scored between 4 to 6 (*light amber shaded area*) will be considered tolerable providing the appropriate controls are in place to minimise the likelihood of undesirable occurrences. These will be registered on Department Risk Registers as appropriate, i.e. such risks are to be quantified with controls, and procedures put into place and maintained to control the risk to an acceptable level.

9.4.3 Medium Risk

Risks scored between 8 to 12 (*dark amber shaded areas*) will be considered “medium risk”. This should be the quantified residual risk. These should be entered on the Centre risk register. All such risks are to be prioritised and are likely to be mitigated from the work undertaken by the Centre.

9.4.4 High Risk

Risks with scores between 15 and 25 (*Red shaded area*) will be considered a “high risk”. This should be quantified residual risk. These risks will be forwarded to the Risk Management Executive for discussion and monitoring of action plans. The will from part of the Corporate Risk Register requiring Board consideration. Unacceptable Risk.

Any risk that has an impact of 5 (catastrophic) will be considered as high due to the unacceptable nature of the consequence.

9.5 Risk Owners

The risk management process specifies risks that need to be actively managed. These are assigned a risk owner who is accountable for:

- owning the risk;
- overseeing the development and maintenance of an appropriate control environment;
- monitoring the risk where there is material change in its status; and
- reporting on the risk.

While the risk owner has overall accountability for the management of the risk, he / she might not own or operate the control(s) which relates to the risk. In this case, the role of the risk owner is to oversee that the control(s) are owned, are fit for purpose and operate effectively and that identified actions are implemented by the action owners (see 10.6)

9.6 Action Plans

Action plans are required for all high and medium risks. These action plans will be monitored through Centre governance systems according to the local risk management strategy. For high risks, progress against action plans will be monitored by the Risk Management Executive. For the action plan template see appendix J.

9.7 Action Owners

Risk owners may not be in a position to take all the necessary actions to mitigate a risk. Action owners are nominated individuals with responsibility for taking the required actions. An individual risk may have several identified actions – and each of these may have a different action owner.

9.8 Addressing Risks

Once a potential risk has been identified, it is important to consider the control measures which can be put in place to mitigate the risk. A balance must be found between the potential impact if the risk comes to fruition and the costs of additional controls. The Trust is required to manage its risks in such a way that people are not harmed and losses are minimised to the lowest acceptable level (*reasonably practicable*). There are several possible courses of action:

Treat the risk (risk elimination or risk reduction)

It is expected that most risks identified will be treated. The purpose of treatment is not necessarily to eliminate the risk completely but, more likely, to put in place a plan of mitigating actions to contain the risk to an acceptable level.

Terminate the risk

This is a variation of the “treat” approach, and involves quick and decisive action to eliminate or avoid a risk altogether. The introduction of new technology may remove certain existing risks, although it will often result in a new set of risks to be addressed.

Transfer the risk

This may be done through insurance or by asking a third party to take on the risk in another way. Contracting out some of the Trust’s services, for example, transfers some, but not all risks (and often introduces a new set of risks to be managed)

Tolerate the risk

The ability to take effective action against some risks may be limited, or the cost of taking action may be disproportionate to the potential benefit gained. In this instance, the only management action required is to monitor the risk to ensure that its likelihood or impact does not increase. If new management options arise, it may become appropriate to treat this risk in the future.

Avoid the risk

This is an informed decision not to become involved in a risk situation or to cease activities in a particular area because the risk is too high

Exploit the risk

The potential to exploit opportunities when actions are taken to mitigate or transfer the risk, as should the opportunity to redeploy resources where risks are terminated

9.9 The Funding of Control Measures

Centres and departments are responsible for funding the cost of control measures, which relate to risks identified as being within the control of the Centre/Department. However, if the cost of effective control measures is prohibitive, or if the control of risk does not rest with the Centre/Department then this will be referred to the Risk Management Executive for agreement of risk scoring and then to the Capital Planning Group who agree capital allocations. The scoring of the risks on the risk registers will be taken into account by the Capital Planning Group in decision making about funding to mitigate risk

9.10 Classification of Target Risk

When action plans are developed, the risk owner should calculate the impact on the risk score when the action plan has been completed. This is the target risk

9.11 Risk Contingencies

For residual risks that may occur contingency plans should be developed in case they do. Contingency plans should be appropriate and proportional to the impact of the original risk. In many cases it is more cost effective to allocate a certain amount of resources to mitigate a risk rather than start by developing a contingency plan which, if necessary to implement, is likely to be more expensive.

9.12 Reassessment

All risks must be periodically reviewed and re-assessed in view of contextual changes. It is recommended that reviews of risk assessments take place quarterly within the Centres, and anytime a process change is about to occur, or a new hazard is identified. However, it is noted that throughout the Trust, risk assessment is an ongoing process with the Corporate Risk Register and Centre risk registers being constantly updated.

10 Managing the Corporate Risk Register

The risk register is a tool which enables the Trust to identify its risk profile. It contains details of all high risks and associated action plans. It provides a structure for collating information about risks that helps both the analysis of risk and in decision about whether or how the identified risks should be treated, managed or monitored.

10.1 Risk Register database

Registers of risks are held on the web-based risk register system (4Risk). This allows risk and action owners to update the status of assigned risks and actions. The system holds a structured set of risk registers for each centre and corporate department, as well as strategic and trust-wide risks. It enables the compilation of organisational risk registers and reporting at corporate, operational, departmental or centre level. Risks are mapped to the key organisation objectives. The system:

- Evaluates and ranks individual risks;
- Maps the internal control framework
- Records assurances received;
- Maps business contingency arrangements;
- Provides an organisational risk profile and analysis;
- Enables action plans to be formulated to improve the management and tracking of risk;

Appendix I is the risk register template and appendix K illustrates the information flows for risk throughout the organisation

10.2 Responsibility and accountability arrangements

The trust aims to empower staff to assume responsibility for contributing to effective risk management by setting out a framework that meets the needs of the day to day management practice and encourages a freedom to act hierarchy. This means that risk assessment can take place throughout the hierarchy; for example individual staff can undertake risk assessments, within a ward or department; ward or department heads may undertake assessment for their department. The results of this may feed into local action plans or risk reduction programmes, or centre / service level risk registers in circumstances where the outcome suggests the need for involvement outside the immediate team.

The level at which risks will be managed / escalated

Risk Colour (score)	Remedial Action	Action	Decision to accept risk	Level of Monitoring
Green (0-3)	Individual	watching brief	Ward / Service Manager	Ward / Service
Light Amber (4 – 6)	Ward/ Service Manager	retain and manage risk	Service Head	Service Line
Dark Amber (8 – 12)	Centre Chief	attempt to manage avoid or transfer risk	Centre Chief	Service & Centre Governance meeting
Red* (15 – 25)	Centre Chiefs, Executive Directors	Eliminate or transfer risk	Risk Management Executive & Trust Board	Centre, Risk Management Executive & Trust Board

* Plus any strategic risks that have an impact of 5.

10.3 Corporate Risk Register

The Corporate Risk Register will be presented at least three times a year to the Audit Committee by the Director of Compliance and Risk Management.

The Corporate Risk Register represents all the high and strategic risks of the Trust. These risks are identified by the Trust Board supplemented by information obtained through ongoing risk assessment, risks identified through the governance processes (e.g. incidents, complaints, audit and claims), user involvement and external agencies and stakeholders.

The Audit Committee will receive updates at least three times a year of the register for risks scoring 15 and above and assure the Trust board that risks are being appropriately managed.

10.4 Local Registers

Risks scoring 8-12 should be held in a Centre risk register with agreed action plans. The Centre risk register should be discussed at local governance meetings where clinical and non clinical risks should be identified and discussed. It is expected that local registers will contain risks identified from a number of sources including analysis of incidents (clinical and non-clinical), complaints and claims; benchmarking against national guidance and national reports; patient safety alerts; patient and staff surveys; business planning and performance.

Any local risks scoring 15 and above must be forwarded along with a risk reduction plan to the Risk Management Executive, which maintains the Trust risk registers. The RME will discuss the risk and agree the risk scoring taking account of all known factors. An outcome summary of the Risk Management Executive will be reported to the Trust Board which will include any amendments to the register. The full risk register will be presented to the Board annually.

11 Managing the Trust Assurance Framework

The Assurance Framework provides a simple but comprehensive method for the effective and focused management of the principal risks to meeting the organisations objectives. It coordinates the relationship with performance management arrangements, the clinical governance reporting framework and other sources of assurance. The Assurance Framework also provides evidence to support the Statement on Internal Control. The Assurance Framework is developed annually by the Board who will review quarterly known and potential risks.

The key elements of the Assurance Framework are:-

11.1 Principal objectives

The clinical, financial and generic objectives that are crucial to the achievement of the Trust's overall goals (both at strategic and divisional level). The principal objectives of the Trust Board are the main drivers at Centre level when it comes to business planning. Corporate objectives are developed by the Executive team.

11.2 Principal risks

These are key risks that threaten the achievement of the Trust's principal objectives. These should not be considered in isolation, but through the prioritisation of risks fed up through the whole organisation through the Risk Management Executive. It should be noted that the principal risks identify what could prevent this objective being achieved (rather than what will). Principal risks should be routinely identified from the existing risk management arrangements, i.e. ongoing risk assessment. Principal risks may be composite risks which group a number of individual risks on the risk register. e.g. workforce issues or risks related to the estate.

All risks on the Corporate Risk Register are linked to the most relevant corporate objective and where appropriate the Care Quality Commissions Essential Standards and thus form part of the Assurance Framework. The Assurance Framework will change throughout the year as new risks are identified, or existing risks are mitigated. Therefore the Assurance Framework will be regularly updated to reflect the changing risk profile of the Trust.

11.3 Key controls

These are designed to manage the principal risks and are subject to scrutiny through external review including Internal Audit, the Care Quality Commission, external audit, the Clinical Negligence Scheme for Trusts, the NHS Litigation Authority (NHSLA) and other specialists.

11.4 Assurance & Co-ordination

One of the key challenges for the Board is to implement a system to gain assurances about the effectiveness of the operation of the controls they have in place to manage their principal risks. The most objective assurances are derived from independent reviewers and are supplemented by internal sources such as clinical audit, performance management and self-assessment reports. Complementary assurance through clinical governance reporting and organisational self-assessments can also support the Statement on Internal Control (SIC). A schedule of external assurances received and expected will be maintained to provide an overview of assurances.

11.5 Assurance Framework action plan

Where gaps in control or assurance have been identified, or negative assurances received, an action plan will be developed and presented and scrutinised by the Audit Committee.

11.6 Review of Assurance Framework

The framework will be presented to the Board annually with quarterly updates and to at least four meetings of the Audit Committee per year. Each presentation will include:

- A high level summary with a RAG rating for each risk and an indication of whether the control of the risk is improving
- Board Assurance Framework Heat Map
- The detailed Board Assurance Framework
- Board Assurance Framework Action plan
- Schedule and status of external assurances

When the strategic direction is reviewed or corporate objectives revised, the Assurance Framework will be mapped to these revised objectives to ensure any foreseeable gaps in assurance or control are highlighted at the earliest opportunity and action taken.

12 Sub-certification of SIC

As part of the Statement of Internal Control (SIC) Centres and Corporate Heads of Department will be required to sub certify (see appendix M) at year end that the Centre/Local Risk Register:

- is up-to-date,
- reflects all risks rated at 8 or above in their areas of responsibility
- identifies all the controls currently in place for the identified risks
- Identifies the assurances (received or planned) that will enable the Centre/Department to demonstrate that the risk is adequately managed.

Details of action plans will be required for any lapses identified

13 Risk Reporting Arrangements

Although the various committees listed above have responsibility for overseeing the implementation of risk management, there are other monitoring mechanisms in place to ensure that all risk issues are appropriately managed.

The Trust Board will receive routine reports, which detail the management of risk on a regular basis throughout each year. Examples include regular financial reports, complaints and incident reports, risk reports, Business Continuity plans, Quality and Risk profile updates, reports on performance, updates on National guidance and minutes of the Audit Committee.

14 Risk Management Work-Streams

This section summarises work-streams in place to systematically manage risk. This includes the following principal work-streams.

- Creating a risk management culture
- Training, development and appraisal
- Clinical Risk Management
- Essential Standards of Quality and Safety
- Health and Safety
- Policies and procedures

14.1 Creating a Risk Management Culture

The development of a risk management culture throughout the organisation is key to the success of this strategy. Action will be taken through a range of operational policies and procedures to ensure that everyone who works in the Trust understands the significance of risk management and actively participates in it.

All Centres must have local clinical governance arrangements underpinned by the risk management strategy. Regular meetings should be held with a set agenda and outcome focussed minutes.

14.2 Training, development and appraisal

Training and education are key elements in establishing and maintaining the “risk management culture”. They provide staff with the necessary knowledge and skills to work safely and to minimise risks at all levels.

The Trust will undertake to provide training in all areas for staff and other agencies working within Trust sites to ensure the development of a risk management culture.

This process will start at induction. All staff are required to attend a corporate induction programme on joining the Trust and this will include an introduction to the risk management culture within the Trust. The session will also encourage staff to self-assess their personal responsibilities and development needs in relation to risk management and the task they will be undertaking.

A corporate mandatory training plan will be drawn up comprising of all training required under respective legislation and any other training deemed to be mandatory by the Trust for an individual to under take the duties and responsibilities of the position.

Staff will be required to undertake further training as identified in the mandatory training plan. There will be an on-going need to revise and update this plan in response to the changing needs of the Trust and specific staff groups. Advice and information on mandatory training is available from the Learning Zone on the Intranet. Action will be taken to ensure that accurate and consistent training records are maintained and that appropriate follow-up action is taken when staff do not attend mandatory or statutory training courses.

All Trust staff are required to attend certain mandatory risk management training courses. In addition certain staff groups are required to attend additional courses or undertake e-learning / distance learning programmes as appropriate, which are mandatory for their specific work groups, these are detailed in the relevant policies.

Staff health, safety and welfare programmes will be developed across the Trust. Specific consideration will be given to statutory requirements, violence in the workplace initiatives and stress reduction.

Each and every employee will have personal objectives linked to the corporate objectives, including training reviewed annually at time of staff appraisal in line with Trust policy. Where appropriate personal objective and development plans will directly link to identified risks.

14.3 Risk awareness training for senior managers and Board Members

Board members, Executive and Non-Executive Directors and other identified Senior Managers will be appropriately trained and skilled in risk management for their role as Board member or members of the Senior Management Team. They will be provided with Risk Awareness Training for Senior Managers to ensure that they have a clear understanding of their role and responsibilities for risk management throughout the organisation. Attendance will be recorded and forwarded to the Chief Compliance Officer. This will be reported in the Risk Management Annual Report to the Risk Management Executive.

14.3.1 Executive and Non-Executive Directors

The Executive and Non-Executive Directors will receive risk management training as part of the annual Board Development Programme. The content is likely to vary from year to year but will cover the following:

- Updating Board Members on relevant risk management issues
- Presentations and discussions of new developments, legislation or standards in risk management
- Clarification of roles and responsibilities in relation to risk management

This training will be mandatory with those unable to attend receiving a briefing from the Director of Compliance and Risk Management following the session and /or any relevant papers subsequent to the session. Attendance will be recorded by the Director of Compliance and Risk Management.

Subjects will be identified by a number of means including:

- Regular Gap analysis of knowledge and skills
- Annual review of Committees' effectiveness eg Audit Committee, which may highlight development needs
- Horizon scanning to highlight risk management developments

In addition, as part of the annual review of the Board Assurance Framework a session on risk management will be organised by the Director of Compliance and Risk Management.

14.3.2 Senior Management Teams

Centre Chiefs and their management teams will receive risk management training as part of the annual Trust Leadership Team training. The content is likely to vary from year to year but will cover the following:

- Updating on relevant risk management issues

- Presentations and discussions of new developments, legislation or standards in risk management
- Clarification of roles and responsibilities in relation to risk management

This training will be mandatory with those unable to attend receiving briefing following the session and /or any relevant papers subsequent to the session. Attendance will be recorded by the Chief Compliance Officer.

Subjects will be identified by a number of means including:

- Review of Committees' effectiveness eg Audit Committee, which may highlight development needs
- Horizon scanning to highlight risk management developments
- Appraisals

In addition, as part of the regular review of the risk register a session on risk management will be facilitated by the Chief Compliance Officer with each Centre Management Team.

14.4 Clinical Risk Management

14.4.1 The NHS Litigation Authority (NHSLA) Standards

The scheme funds the cost of clinical negligence claims from incidents occurring on or after 1 April 1995. The NHSLA risk management programme supports the scheme by providing incentives by way of reduced contributions to the scheme which are awarded if adherence to stringent risk management standards are demonstrated. There are two sets of standards: Maternity standards and general standards for acute trusts.

14.4.2 Incident Reporting

The Trust has adopted a unified Incident Reporting system for reporting all adverse incidents, whether to patient, staff, clinical or non-clinical. (DATIX). Reporting can be either by use of a paper form, or electronically. Serious Incidents (SIs) are reported to the Trust Board (and other agencies in accordance with the guidance in the SI Policy). The procedure for the reporting and investigation of Incidents is a separate but related policy to this strategy and gives further detail of the procedure. A single database is in place to record all incidents, complaints, claims and PALs contacts.

Learning from experience is critical to the Trust in delivering a safe and effective service to patients and clients. Root cause analysis (RCA), is a retrospective review of an adverse incident, undertaken in order to identify what, how, and why it happened. The analysis is then used to identify areas for change, recommendations and sustainable solutions, to help minimise the re-occurrence of the incident type in the future. It is expected that root-cause analysis will be carried out on all serious and high risk cases.

14.4.3 Complaints Management

The system of managing complaints will be regularly reviewed to ensure that guidelines are being met, and that examples of change as a result of complaints are evident.

14.4.4 Advice and Consent

The Trust will ensure that information is provided to patients about the risks and benefits of treatment and the alternatives available. Consent procedures will be reviewed and implemented in appropriate services and full records maintained.

14.5 Essential Standards of Quality and Safety

The Trust will meet all the essential standards and develop outcome focussed measures of compliance. Risks are mapped to the standards and a Ward to Board assurance system is being implemented.

14.6 Health and Safety

Health & Safety aspects of risk management are an integral part of the process of managing risks within the Trust. Its only unique factor is in that legislation places an absolute duty on the 'employer' (Management & Supervisors) to undertake risk assessments with regards to the health, safety and

welfare of staff, patients, visitors and neighbours; and in so doing to reduce such risks to the lowest reasonably practicable level.

14.7 Trust Policies and Procedures

For policies to be effective they must be supported and understood at all levels through out the organisation. There will be two basic levels of policies.

14.7.1 Departmental Policies

Those policies that only concern and effect that department. Such policies are to be sponsored by the Head of Department.

14.7.2 Trust Policies

These are policies that affect more than one area / department / ward of the Trust. They must be sponsored by a Director of the Trust and have an appropriate level of approval and ratification as suggested in the Organisation-wide Policy for the Development and Management of Procedural Documents. It is essential when drawing up policies that consultation as appropriate is undertaken with those staff involved or their representatives. In some instances there are specific legal requirement for such consultation to take place. All policies must contain an equality impact assessment.

15 Public Interest Disclosure (Whistle Blowing)

The Board is committed to an open and honest approach in all matters. The overall approach expected within the organisation is one of help and support rather than blame and recrimination. The Trust's Whistleblowing Policy supports this approach. This allows staff to by-pass line management to raise concerns. The Whistleblowing procedure is primarily for concerns where the interests of others or of the organisation itself are at risk. The general principles are as follows:

- The organisation takes such concerns seriously
- Staff have the option to raise concerns outside of line management by use of a staff hotline that allows staff to make comments, queries or suggestions about working at the Trust
- The policy details how to access confidential advice from an independent body.
- The organisation will respect the confidentiality of a member of staff raising a concern.
- It is a disciplinary matter both to victimise a bona fide whistleblower and for someone to maliciously make a false allegation.
- All staff should be familiar with the Trust's guidance to staff on raising concerns and the requirements of the Public Interest Disclosure Act 1998. The Whistleblowing Policy is available on the Trust Intranet and a flowchart is at appendix N.

16 Communication and Consultation

Managers are responsible for communicating the Risk Management Strategy and associated documents to all their staff. The Strategy and associated documents should also be readily available in departments to enable the Trust's stakeholders to be able to read them. In addition, these documents can be accessed through the Trust Intranet (risk management pages).

There is a need to communicate certain information externally, e.g. RIDDOR¹⁴ reporting to the Health & Safety Executive, and medical devices reports to the Medicines and Healthcare products Regulatory Agency. Serious Incidents are reported to externally in line with requirements and the Trust reports to the National Reporting and Learning system.

17 Monitoring Mechanisms

The Risk Management Executive has responsibility for overseeing the implementation of this strategy. This will include production of an annual report, which will demonstrate the continuing effectiveness of the risk management system.

Internal Audit and the Audit Committee have responsibility for monitoring the risk management system and providing appropriate verification to the Chief Executive and Board. Each year the Trust will be required to develop a Statement on Internal Control that confirms that action has been taken to manage risk and to publish this statement in its annual report.

17.1 Monitoring table

Aspect of compliance or effectiveness being monitored	Monitoring method	Responsibility for monitoring (job title)	Frequency of monitoring	Group or Committee that will review the findings and monitor completion of any resulting action plan
Duties of the key individual(s) for risk management activities	<i>To be addressed through the monitoring below</i>			
The organisational risk management structure detailing all those committees/sub-committees/groups which have some responsibility for risk	Review of Structure	Director of Compliance & Risk Management/ Internal Audit	Annual work programme	RME
The process for board or high level committee review of the organisation-wide risk register	Review of minutes and reports	Director of Compliance & Risk Management / Internal Audit	Annual	AC
The process for the management of risk locally, which reflects the organisation-wide risk management strategy	Review of risk registers including update and actions Audit of Risk management	Chief Compliance Officer Internal Audit	Six monthly Annual	RME AC
The authority of all managers with regard to managing risk	Review of agendas and minutes from RME, AC and TB	Chief Compliance Officer	Annual	Risk Management Annual Report to RME, and TB
Reporting arrangements from the RME to the Board	Review of Board Agenda	Director of Compliance & Risk Management	Annual	Risk Management Annual Report to RME, and Trust Board
Membership of RME	Review of Terms of Reference	Director of Compliance and Risk Management	Annual	Risk Management Annual Report to RME
Attendance at RME	Attendance matrix	Chief Compliance Officer	Annual	Risk Management Annual Report to RME
Reporting into the Risk Management Executive	Review of RME agenda	Chief Compliance Officer	Annual	Risk Management Annual Report to RME
Quoracy	Review of RME minutes	Chief Compliance Officer	Annual	Risk Management Annual Report to RME
Frequency of meetings	Review of RME minutes	Chief Compliance Officer	Annual	Risk Management Annual Report to RME
The process for ensuring that all board members and senior managers receive relevant risk management awareness training, that attendance is recorded and non-attendance followed up.	Review of training records	Director of Compliance & Risk Management	Annual	Trust Board

AC Audit Committee HEC Hospital Executive Committee RME Risk Management Executive

Following these reviews:

- Required actions will be identified and completed in a specified timeframe

- Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders

17.2 Key performance Indicators

The Trust will measure its performance by using the following standards as a benchmark:

- Achieving compliance with the Essential Standards of Quality and Safety
- The Quality and Risk profile of the Trust
- Achieving the new NHSLA standards at the current CNST levels
- Meeting Financial targets,
- Standards specified in Training Needs Analysis

Indicator	Evaluation
Number of incidents reported	Reported in monthly performance report Number of overdue incidents reported monthly
Balance between actual and near miss incidents	Safety annual report
Balance between harm and no harm/low harm incidents	Safety annual report
Incident reporting by staff groups	Safety annual report
Top five incident types reported	Trend analysis reported quarterly Annual summary report
Number of serious incidents	Reported in monthly performance report Risk management annual report Monthly report to HEC and TB
Number of incidents reported externally (e.g. STEISS, DoH, SHOT HSE)	Safety annual report
Number of claims received	Six monthly report to TB Risk Management Annual Report
Claims status – settled, discontinued, open	Six monthly report to TB Risk Management Annual Report
Number and type of staff incidents	Quarterly report to Health and Safety and Security Committee Risk Management Annual Report
Number and types of complaints	Six monthly report to Trust Board Risk Management Annual Report
Rule 43 letters received	Serious Incident report to HEC and Trust Board Risk Management Annual Report
Review of risk register	Bi monthly Reports to Audit Committee Report at each Risk Management Executive
Attendance at Risk Management Executive	Risk Management Annual Report

18 Equality Impact Assessment (EQIA)

This document has been subject to an Equality Impact Assessment and is not anticipated to have an adverse impact on any group.

19 Approval and Review Mechanisms

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

In order that the Risk Management Strategy remains current, any of the appendices to the strategy can be amended and approved during the lifetime of the strategy without the entire strategy having to

return to the Board. The strategy as a whole will be reviewed and ratified annually by the Board (or sooner if there are significant changes at national policy level).

Trust Board approved the policy on _____

And becomes effective on _____

**Chief
Executive**

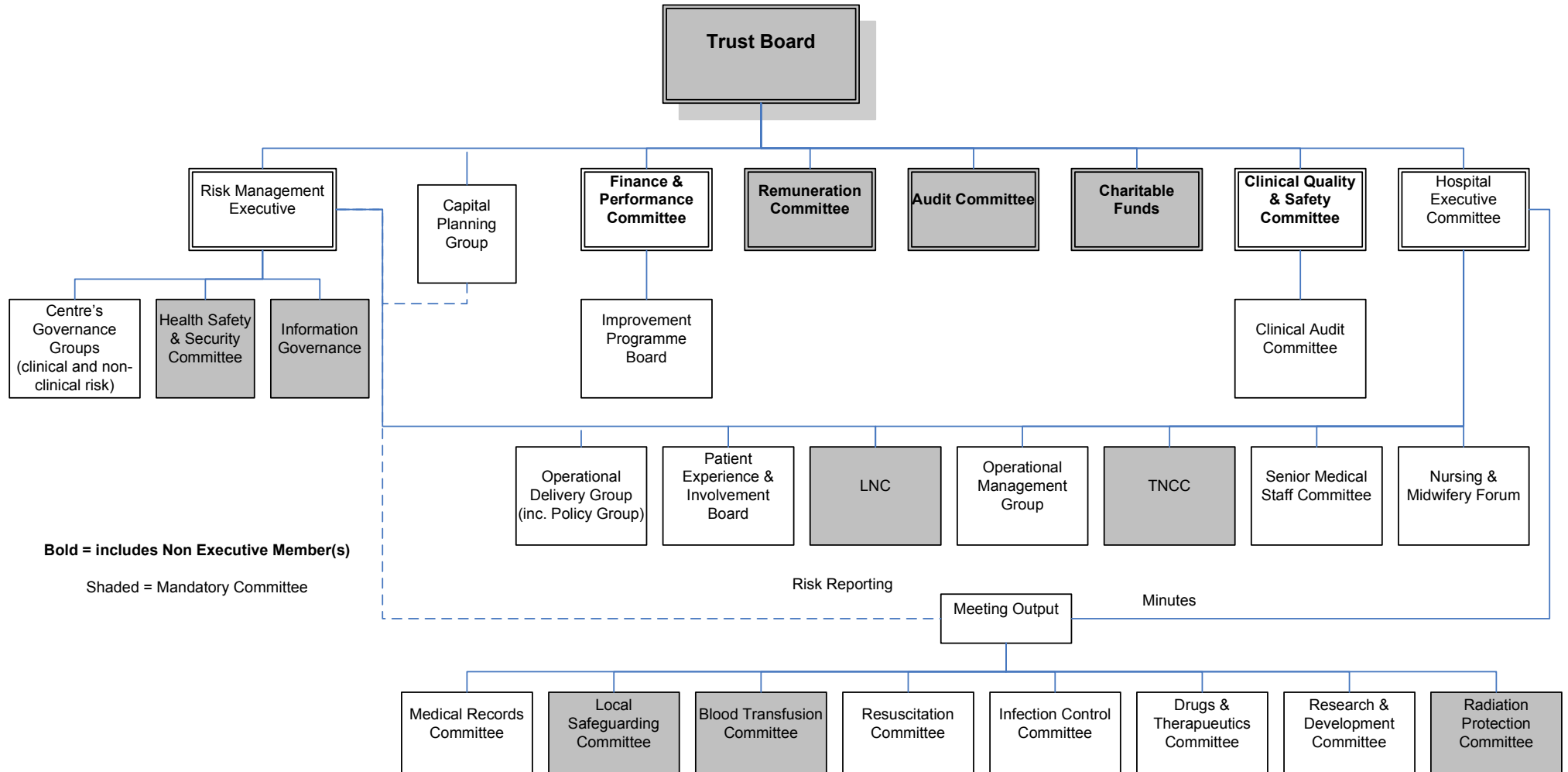
Trust Chair

Signed
Dated _____

Signed
Dated _____

Appendix A Trust Governance Structure

GOVERNANCE STRUCTURE



Appendix B Risk Management Executive Terms of Reference

Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Risk Management Executive (The Committee). The Committee is an Executive Committee of the Board and has delegated powers to review the most significant risks to the achievement of the Trust's objectives and ensure there are robust controls and mitigation actions in place. The Committee will be required to adhere to the Standing Orders of the Trust.

Membership

The Chief Executive will be the Chair of the Committee

Membership shall comprise:

Chief Executive (Chair)

Director of Compliance & Risk Management (Deputy Chair)

Director of Safety & Quality or nominated Deputy

Medical Director or nominated Deputy

Chief Operating Officer or nominated Deputy

Finance Director or nominated Deputy

Director of Strategy or nominated Deputy

Chief Compliance Officer or nominated Deputy

Centre Chief or nominated Deputy (eg governance Lead, senior manager)

To attend as required

Value Stream Leads

Workforce Director

Director of Communications

Head of Estates or nominated Deputy

Head of Patient Safety

Health and Safety Team Manager

Associate Medical Directors

Deputy Medical Director

Quorum

For the Committee to be quorate, it requires the presence of at least a third of members with at least 3 Centre Chiefs or their nominated deputy

Attendance

Members may appoint suitable deputies to represent them. Deputies must attend when members are not able to so that there is Centre representation at each meeting. It is expected that a member or their nominated deputy will attend for a minimum of 75% of meetings in a year. Attendance will be monitored by an attendance matrix

Frequency

The Committee shall meet monthly. Additional meetings may be held at the discretion of the Chair

Authority

Authority for all decisions relating to risk management lies with the Trust Board of the Shrewsbury and Telford Hospital NHS Trust. The Committee has delegated powers from the Trust Board to oversee and assess the effectiveness of risk management arrangements within the Trust. The Committee is authorised by the Board to investigate any activity within its terms of reference

Duties

The Committee will:

- Oversee the implementation and further development of the Trust's Risk Management Strategy ensuring it supports the achievement of the Trust's objectives and business plan
- Develop and manage the risk management system (including clinical risk) in line with the Trust's strategy, prevailing policies, standards, and guidance, and the changing environment in which the Trust operates
- Approve risk management policies and strategies and ratify relevant policies approved by sub-committees and groups which report to the Risk Management Executive.
- Assess and review the composition and ongoing development of the Board Assurance Framework ensuring it provides a robust tool through which the Board can monitor management of the organisation's key strategic risks, ensuring effective control and assurance mechanisms in place and that effective actions are being taken to address gaps in controls and assurance.
- Provide the Trust Board with assurance that a comprehensive Corporate Risk Register is maintained which will enable the Board to have a shared and clear understanding of the key risks in the Trust; what mitigations are in place to manage risks and which risks are being tolerated

- Identify and validate new risks and consider whether they pose a principle risk to the Trust's strategic objectives and should be included on the Board Assurance Framework
- Oversee the maintenance and further development of the Centre's Risk Registers as key tools to support achievement of high levels of internal control, patient safety, and clinical quality to inform risk based decision making and specifically promote local level responsibilities and accountability for identifying and monitoring the organisations risks
- Assess all risks with a risk score of 15 and above and bring to the attention of the Board all serious risks (risk score to be decided) to consider whether to be added to the Board Assurance Framework.
- The Risk Management Executive will consider all risks with an consequence of 5.
- Ensuring Director risk owners and risk action owners have plans in place to control identified risks and to take necessary action to ensure remedial plans are put into place should mitigation fall behind plan
- Coordinate all risk management activities of the Trust using reports from Centres, specialist risk teams and operational groups with risk management responsibilities (eg Health & Safety, Information Governance) and agree actions to be taken to mitigate risk across the Trust, and where relevant monitor action/treatment plans.
- Ensure that standards for risk management and control are related legislation and regulations are brought to the attention of the responsible clinician/ manager and through the specialist risk teams and audit compliance with the standards
- Review and monitor compliance with the CQC standards using the trust's performance assurance framework
- Review progress against CQC Quality Risk Profile
- Review findings and ensure implementation of recommendations arising from internal audits of Trust risk and compliance processes

Reporting into the Committee

The Committee will receive minutes from the quarterly Health, Safety and Security Committee), Capital Planning Group, Information Governance, and Centre Governance reports. In addition, any risk (clinical and non clinical) issues from any of the current Trust subgroups will be submitted to the Committee. The Care Quality Commission Quality and Risk Profile will be reported to the Committee quarterly. Centres will report new risks to the Committee and provide updates on existing risks as required

Reporting from the Committee

The Committee will be directly accountable to the Board. The Chairman of the Committee will report on the proceedings of each meeting to the next meeting of the Trust Board and will draw to the attention of the Trust Board any matters of concern in relation to the effective management of the organisation's risks

The Chairman of the Committee will ensure that the Trust Board receives the Trust's Board Assurance framework and high level risk summary. The Committee will produce an annual risk management report for the Trust Board which will include monitoring compliance with these terms of reference.

Monitoring compliance with the Terms of Reference

Aspect of compliance or effectiveness being monitored	Monitoring method	Responsibility for monitoring (job title)	Frequency of monitoring	Group or Committee that will review the findings and monitor completion of action plan
Duties of the key individual(s) for risk management activities	<i>To be addressed through the monitoring below</i>			
Reporting arrangements from RME to the Board	Review of Board Agenda	Chief Compliance Officer	Annual	Risk Management Annual Report to RME, & Trust Board
Membership of RME	Review of Terms of Reference	Director of Compliance and Risk Management	Annual	
Attendance at RME	Attendance matrix	Chief Compliance Officer	Annual	
Reporting into RME	Review of agenda	Chief Compliance Officer	Annual	
Quoracy	Review of minutes	Chief Compliance Officer	Annual	
Frequency of meetings	Review of minutes	Chief Compliance Officer	Annual	

Review

The Terms of Reference will be reviewed by the Board of Directors annually.
October 2011

Appendix Q References

- ¹ CNST maternity Clinical Risk Management Standards NHSLA (January 2011)
- ² Essential Standards of Quality and Safety Care Quality Commission (Dec 2009)
- ³ Risk management standards NHSLA (January 2010)
- ⁴ Civil Contingencies Act (2004) <http://www.legislation.gov.uk/ukpga/2004/36/contents>
- ⁵ Building the Assurance Framework: A Practical Guide for NHS Boards Department of Health (March 2003)
- ⁶ NHS Chief Executives Bulletin 186 (2003) Statement on Internal Control 2003/04. Department of Health, London
- ⁷ A First Class Service – Department of Health (2008)
- ⁸ Integrated Governance Handbook – Department of Health (2006)
- ⁹ Trust Business Plan
- ¹⁰ Trust Strategy Map ‘Strategy on a page’
- ¹¹ Trust Vision, Mission and values – ‘The Pyramid’ Management system on a page’
- ¹² Management of Health and Safety at Work: Approved Code of Practice. (1999). Health and Safety Executive, London.
- ¹³ Australian/ New Zealand Standard. Risk Management: AS/NZS 4360 19. (19) Copyright Standards Association of Australia, Strathfield, New South Wales, Australia
- ¹⁴ Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995