Report to:	Trust Board, April 2013

Enclosure 8

Title	Risk Management Strategy
Sponsoring Executive Director	Director of Corporate Governance
Purpose	The Board Assurance Framework allows the Board to focus on the key risks to strategic objectives
Previously considered by	Risk Committee (Feb 13), Operational Risk Group (Mar 13)

Executive Summary

The Trust Risk Management strategy is a core element of our system of integrated governance and underpins all risk management activities throughout the Trust. The strategy was last updated in November 2011 and it is considered best practice that the strategy is subject to annual review by the Board.

The strategy has been substantially revised to take account of internal changes such as revisions to corporate objectives, the quality and management arrangements, as well as external changes to the regulatory framework. The revisions are in line with the latest national guidance including the Audit Committee handbook (2012).

A significant amount of operational detail has been removed and this will be included in a Risk Management Handbook which will provide support and guidance to managers and staff. It is planned to complete this work by the end of April.

Related SATH Objectives	**SATH Sub-Objectives**
Related to all SATH objectives	C5. Meet regulatory requirements and healthcare standards

Risk and Assurance Issues (including resilience risks)	Links strategic objectives to risks, controls and assurances.
Legal and Regulatory Issues	Requirement to support the Annual Governance Statement.

Action required by Trust Board

- **REVIEW** and **APPROVE** the Risk Management Strategy

The Shrewsbury and Telford Hospital NHS
NHS Trust

RISK MANAGEMENT STRATEGY

RM01

To be read in conjunction with: Risk Management Handbook

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Approval date:	February 21st 2013
Ratified by:	Trust Board
Date ratified:	
Name of originator/author:	Head of Assurance
Lead Director	Director of Corporate Governance
Date issued:	
Review date:	March 2014
Target:	Overarching Strategy for specific Trust Risk Management Policies

Document Control Sheet

Author/Contact:	Clare Jowett, Head of Assurance clare.jowett@sath.nsh.uk
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Distribution	Please refer to the SATH intranet for the latest version of this policy. **Any printed copies may not necessarily be the most up to date**
Key words	RM01 risk, risk management, risk register, risk matrix, assurance, risk assessment

Version history

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V2	Jan 01	TL	Updated	
V3	Oct 02	TL	Updated	
V4	Apr 03	TL	Updated	
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V6	Dec 06	CJ	Updated	
V6.1	Jan 07	CJ	Agreed	
V7	Nov07	CJ	Updated	
V7.2	Jan 08	CJ	Updated	Final version at Trust Board
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V8	Feb 09	CJ	Agreed	
V9	Feb 10	CJ	Agreed	Updated to reflect changes to regulatory framework and internal changes
V10	Sep 11	CJ	Updated	Content restructured. Updated to reflect internal changes including sections 5; 6; 7. Addition of sections 14.3 and 17.1 (NHSLA requirement)
V10.1	Oct 11	CJ	FINAL	updated following feedback from RME and EDs
V11	Jan 13	CJ	Draft	Substantial redrafting

Contents

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, using the best evidence of what provides the greatest benefit to patients. The Trust Board recognises that effective risk management is central to achieving this aim whilst allowing the Trust to make the most of opportunities, and minimising the risks taken and should be part of the Trust's culture and strategic direction.

The Trust takes an integrated approach to risk management, irrespective of whether risks are clinical, non-clinical, financial, operational, business or strategic with the aim of minimising its exposure to risk. Risk management is embedded within the Trust's overall performance management framework, and linked to business planning. As Accountable Officers, the Board of Directors have have legal and statutory obligations which demand that risk is managed in a strategic and methodical manner. In view of these statutory duties, it is important that staff are empowered to manage risk at a local level wherever possible and that clear arrangements are in place to escalate risk issues when it is appropriate to do so

The Trust Board has delegated responsibility to the Risk Committee for overseeing the development, implementation and monitoring of this strategy. The Audit Committee undertakes a scrutiny role to ensure that the systems, structures and processes for managing strategic risks are in place.

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.

The maternity service has a complementary approved risk management strategy which describes the processes in place in the Women's and Children's Care Group for managing risk in this high risk environment as required by the CNST standards published by the NHSLA[1].

2 Definition of Risk Management

Risk is the threat that an event or action will adversely affect an organisation's ability to achieve its objectives or successfully execute its strategies.

Risk management therefore is the process by which the Trust will manage the safety of its patients, staff, resources (including information) and environment. The risk management process encompasses the identification and assessment of risks, assigning ownership and monitoring and reviewing progress with the actions taken to mitigate them.

3 Policy Aims

The Board needs to be able to demonstrate that they have been properly informed, through the Board Assurance Framework, about all strategic risks facing the organisation, 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

The Trust's key strategic risk management aims are to:

- Create a culture where the patient is central to everything we do
- To adopt an integrated approach to the management of risk, ensuring risk management is embedded within the organisational culture
- Encourage the open reporting of mistakes, within a 'just' culture and that lessons are learnt and actions promptly implemented to prevent recurrence.

- Comply with national standards including CQC, NHLSA, information governance, and emergency planning
- Embed the revised risk management process supported by the new governance committee structure
- Supporting the organisations application for Foundation Trust status by meeting the national risk management requirements
- Accept that risk management is the responsibility of each and every member of staff

A list of associated policies is at appendix H.

4 Strategic Objectives

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

- Providing the best clinical outcomes, patient safety and patient experience
- Delivering consistently high performance in healthcare standards
- Striving for excellence through people and innovation
- Improving the health and wellbeing of our community through partnership
- Building a sustainable future

5 Roles and 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.

5.1 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 requires the inclusion in Annual Reports of an Annual Governance Statement. This outlines the controls in place for management of the Trust's risk exposure. In order to sign this statement on behalf of the Board, the Chief Executive will need to review evidence that the Risk Management Strategy is being implemented, and there is an effective system of internal control.

5.2 Director of Corporate Governance

The Director of Corporate Governance is the lead director for risk management and fulfils the role of Board Secretary. The Director develops corporate risk management strategies and policies interpreting national guidance to fit the local context and the Board Assurance Framework in conjunction with the Trust Board

5.3 Chief Operating Officer

The Chief Operating Officer is the executive lead for emergency planning and business continuity.

5.4 Finance Director

The Finance Director is responsible for financial risk management and for providing regular, timely and accurate financial reports to the Board in line with requirements and accounting standards

5.5 Directors

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. 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. Each Director has overall responsibly for ensuring that information held on the risk register and Board Assurance Framework is up to date and accurately reflects the current status.

5.6 Head of Assurance

The Head of Assurance is responsible for the coordination of risk management issues on behalf of the Director of Corporate Governance. This includes supporting the Risk Committee and Operational Risk Group and development of the risk registers.

5.7 Management Teams

The Management Teams are responsible for ensuring participation in the Trust's Governance systems by ensuring Groups and Centres have local risk management systems in place detailing arrangements in their areas of responsibility including ongoing risk assessment.

Specific responsibilities are outlined in an appendix D to this document

6 Risk Management Organisational Structure

The Trust governance (committee) structure is shown at appendix A. Terms of reference will be reviewed annually and approved by the relevant committee to which they report. The following committees have specific functions relating to risk management:

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 against risks of all kinds. In relation to this strategy the Trust Board will:

- Have a structured risk identification system covering all possible risks to its objectives, with robust controls in place for the management of identified risks 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

6.2 Risk Committee

The Trust Board has delegated responsibility for risk management to the Risk Committee which is the Trust committee with overarching responsibility for risk. The Risk Committee provides assurance to the Trust Board that the systems for risk management and internal control are effective. The Risk Committee is responsible for ensuring that **all** significant risks are properly considered and communicated to the Trust Board. The Terms of Reference are at appendix B

6.3 Operational Risk Group

The Operational Risk Group is tasked with collating risk assessments from throughout the Trust and presenting them in coherent and robust risk registers. The group will ensure that assessments are normed and that the information gathered is complete and up-to-date. The Terms of Reference are at appendix C.

6.4 Clinical Governance Executive

This committee is chaired by the Medical Director and meets monthly. Clinical risks will be monitored by this group

6.5 Health, Safety and Security Committee

The committee is chaired by the Director of Corporate Governance and meets quarterly. Non-clinical risks relevant to the terms of reference will be monitored by this group.

6.6 Trust Audit Committee

The Audit Committee, a formal sub-committee of the Board, provides overview and scrutiny of risk management. 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 including oversight and scrutiny of the Trust's systems of internal control and risk management.

6.7 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. Any risks to quality would be referred to this Committee by the Clinical Governance Executive for oversight.

7 The Risk Management System

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.[2] A summary of the risk management process in at appendix E.

In order to comply with this standard a continuous risk management process with an agreed methodology to analyse the range of potential consequences and likelihood of occurrence of risks must be in place. The Trust uses the national NPSA classification 5 x 5 matrix (Appendix F)

7.1 Risk Types

The main types of risk facing by the Trust fall into two categories:

Strategic Risks: are those that represent major threats to achieving the Trust's strategic objectives, or to its continued existence. Strategic risks can include key operational failures which would be very damaging to the achievement of the strategic objectives if they materialised. Being clear about strategic risk enables the Board to be sure that the information it receives is relevant to the achievement of these objectives.

Operational Risks: These concern the day to day issues that the Trust faces as it strives to deliver its strategic objectives. Operational risks include a broad range of risks including clinical risks, fraud, financial risks etc. These risks therefore have the potential to stop the Trust achieving nationally or locally agreed targets or may have such an impact on service delivery that the Trust becomes in breach of contract with the commissioners, or spreads across more than one area. These risks are the responsibility of line management and should be identified and managed by the executive and only considered by the Board in a high level summary form in order that they have an overview of the totality of risk facing the Trust.

Risks on the Board Assurance Framework are usually strategic risks as these are the risks which will most impact on achievement of corporate objectives; 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.

7.2 Risk Identification

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 key risks that may impact upon the ability of the Trust, Care Group or Centre to achieve its objectives. The Trust has produced a risk management handbook which includes guidance for risk assessment to assist line managers. The approach to risk identification should be both pro-active and reactive.

7.2.1 Proactive risk identification:

Proactive risk assessment enables the Trust to identify actual or potential hazards and ensure adequate control measures are in place to mitigate the risk. Proactive risk assessments fulfils the Trust's statutory duty in terms of Health and Safety risk assessments. Ongoing proactive risk assessment will minimise the likelihood of incidents occurring and will support safety improvements across the Trust. There are several processes in place to allow this to be undertaken for example: internal inspections carried out by specialist advisers eg infection control, fire, health and safety; audits and benchmarking.

7.2.2 Reactive risk identification

Reactive risk assessments should take place after adverse events to minimise the likelihood of these events recurring. For example, following incident reports, complaints and claims, root cause analysis takes place and can result in risks being identified for inclusion on risk registers. Similarly, an external assessments / reviews of Trust services could result in risks being identified.

7.2.3 Quality Impact Assessment (QIA) 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.

7.3 Risk Evaluation

All risks, independent of their origin, are evaluated using the Trust's risk matrix (appendix F). Risk scores have two components: consequence and likelihood. The evaluation is the 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. The two scores are multiplied together to give a risk score of between 1 and 25. The subsequent colour rating, from the risk matrix, identifies the level at which risks will be managed within the Trust.

7.3.1 Risk Controls

As part of risk assessment is it essential to describe the controls in place i.e. policies, procedures, protocols, training or physical safeguards in place to mitigate or manage the risk and secure the delivery of an objective.

7.3.2 Risk Owners

The risk management process specifies risks which need to be actively managed. These are assigned a risk owner who is accountable for owning and reporting on the risk and overseeing the development and maintenance of appropriate controls and mitigation. While the risk owner has overall accountability for the management of the risk, they may 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

7.4 Addressing Risks – Action plans

Once a risk has been identified, it is important to consider the additional control measures which can be put in place to reduce 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. Action plans are required for all high and medium risks. These action plans will be monitored though Care Group and Centre governance systems. For high risks, progress against action plans will be monitored by the Operational Risk Group. 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 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

It should be noted that there are some instances where a risk may be deemed unacceptable and yet still be tolerated by the organisation. For example the cost of treating the risk may be prohibitive or the risk may be untreatable.

7.4.1 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 taken the required actions. An individual risk may have several identified actions – and each of these may have a different action owner.

7.4.2 Funding of Control Measures
Groups and departments are responsible for funding the cost of control measures, which relate to risks identified as being within the control of the Care Group/Department.

7.4.3 Risk Contingencies
For 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.

7.4.4 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 Care Groups, and anytime a process change is about to occur, or a new hazard is identified. However, throughout the Trust, risk assessment is an ongoing process with the risk registers being constantly updated.

8 Managing the Trust Risk Registers
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 area and corporate department, as well as strategic and trust-wide risks.

8.1 Responsibility and accountability arrangements
The trust aims to empower staff to assume responsibility for 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 feed into local action plans or risk reduction programmes, or Care Group / 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 is shown below:

Risk Colour (score)	Remedial Action	Action	Decision to accept risk	Level of Monitoring
Very low (0-3)	Individual	watching brief	Ward / Service Manager	Ward / Service
Low (4 – 6)	Ward/ Service Manager	retain and manage risk	Service Head	Service Line
Medium (8 – 12)	Service Head	attempt to manage avoid or transfer risk	Centre Management Team	Centre / Care Group Governance meeting
High* (15 – 25)	Centre, Care Group Management Teams, Executive Directors	Eliminate or transfer risk	Operational Risk Group (operational risks) & Risk Committee (strategic risks - BAF)	Centre, Care Group, Operational Risk Group. Risk Committee & Trust Board

8.2 Acceptability of risk

The acceptability of risk is a complex issue and will vary according to local circumstances. Acceptable risk can be defined as the residual risk remaining after controls have been applied to known hazards. In relation to operational risks, it will be the responsibility of individual Care Groups to decide what level of risk is acceptable. In respect of strategic risks, it will be the responsibility of the Chief Executive, as Accountable Officer, to determine the acceptability of a risk.

8.3 Local Risk Registers

Each service and corporate department must maintain a comprehensive risk register of its identified risks with agreed action plans. The responsibility for maintaining the local risk register will be that of the service head who has responsibility for clearly delegating actions to named individuals. 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. The registers should be discussed at local governance meetings where clinical and non clinical risks should be identified and discussed.

8.4 Local Management of Risk

Responsibility for the management, control, and funding of a particular risk lies within the Care Group/Department concerned. However, when action to control a risk falls outside the remit of a Care Group or cannot be dealt with at that level, it will be escalated. Risks scoring 15 or over must be signed off by the appropriate Director. For Care Groups, this will be the Chief Operating Officer, or their delegated deputy. The risk should then be forwarded with a risk reduction plan to the Operational Risk Group (ORG). The ORG will discuss the risk and agree the risk scoring taking account of all known factors. An outcome summary of the ORG will be reported to the Risk Committee which will include any amendments to the register. If appropriate, ORG will recommend that the risk owner be invited to the Risk Committee to present the risk.

8.5 Risk Profiles

Each quarter at Operational Risk Group, services and departments will be expected to report on their top 3 risks and by exception update on action plans for minimising those risks. In addition to the top risks, the ORG will also discuss the following items quarterly:

- Overall risk profile – and direction of movement
- Red risks where score has stayed the same for 12 months
- Risks where action plans are behind target
- Risks without action plans developed within a month of identification

8.6 Process for the Executive Review of Risk and Board Assurance Framework

All risks scoring 15 or above must be signed off by the appropriate director to ensure executive oversight of high risks.

The Risk Committee will review the Board Assurance Framework (BAF) quarterly and will receive a high level extract of the risk register at this meeting, mapped to the themes within the BAF.

8.6.1 Managing the Trust Board Assurance Framework

The Board Assurance Framework (BAF) represents all the agreed strategic risks of the Trust. It is developed annually by the Board who will review quarterly known and potential strategic risks. Whilst strategic risks will automatically migrate to the BAF, the Trust management team, with assistance from the Operational Risk Group and sub-committees, will determine whether or not any other risks from the risk registers should be considered at the Risk Committee for inclusion in the BAF.

Any significant operational risks which cannot be controlled within the Care Groups and corporate departments will be recorded on the Trusts Board Assurance Framework (BAF) following discussion with the appropriate director and ORG. Risk Owners will present such risks at the Risk Committee for discussion and consideration and explain the reason why the risk cannot be managed, together with a suggested course of action. This will provide a structure to aid the analysis of risks and the process of making decisions about risk treatment.

The Board Assurance Framework will be presented at least three times a year to the Audit Committee and Trust Board by the Director of Corporate Governance.

9 Sub-certification of Annual Governance Statement

As part of the Annual Governance Statement Care Groups and corporate Heads of Department will be required to sub certify (see appendix G) that, at year end, local risk register:

- is up-to-date,
- reflects all risks rated at 8 or above in their areas of responsibility
- identifies the controls currently in place for the identified risks
- identifies actions to mitigate the risk (with dates and named individuals)
- Identifies the assurances (received or planned) that will demonstrate that the risk is adequately managed.

10 Training, development and appraisal

Training and education are key elements in establishing and maintaining the risk management culture. It provides staff with the necessary knowledge and skills to work safely and to minimise risks at all levels. This process starts at induction: all staff must have a local induction and are required to attend a corporate induction programme on joining the Trust. This includes an introduction to the risk management culture within the Trust.

A corporate training plan is drawn up and regularly reviewed comprising training required under legislation and any other training deemed to be mandatory by the Trust for an individual to undertake the duties. Advice and information on training is available from the Learning Zone on the Intranet.

Every employee will have personal objectives linked to the corporate objectives, including training reviewed annually at the time of appraisal. Where appropriate personal objective and development plans will link to identified risks.

10.1 Risk awareness training for senior managers and Board Members

Board members and other identified senior managers[1] will be appropriately trained and skilled in risk management for their role. They will be provided with bespoke risk awareness training to ensure they have a clear understanding of their role and responsibilities for risk management.

[1] see Trust 'Who's Who on a Page'

The Executive and Non-Executive Directors will receive training as part of the annual Board Development Programme. The content is likely to vary from year to year but will include presentations and discussions of new developments, legislation or standards in risk management

Senior managers and Care Group management teams (excluding admin support) 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 updates on relevant risk management issues and clarification of roles and responsibilities in relation to risk management

11 Communication and Consultation

Managers are responsible for communicating the Risk Management Strategy and associated documents to all their staff. The strategy and associated documents can be accessed through the Trust Intranet (risk management pages) so that they are readily available in departments staff.

12 Monitoring Mechanisms

The Risk Committee has responsibility for overseeing the implementation of this strategy. This will include production of an annual report to 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 an Annual Governance Statement that confirms that action has been taken to manage risk and to publish this statement in its annual report.

13 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.

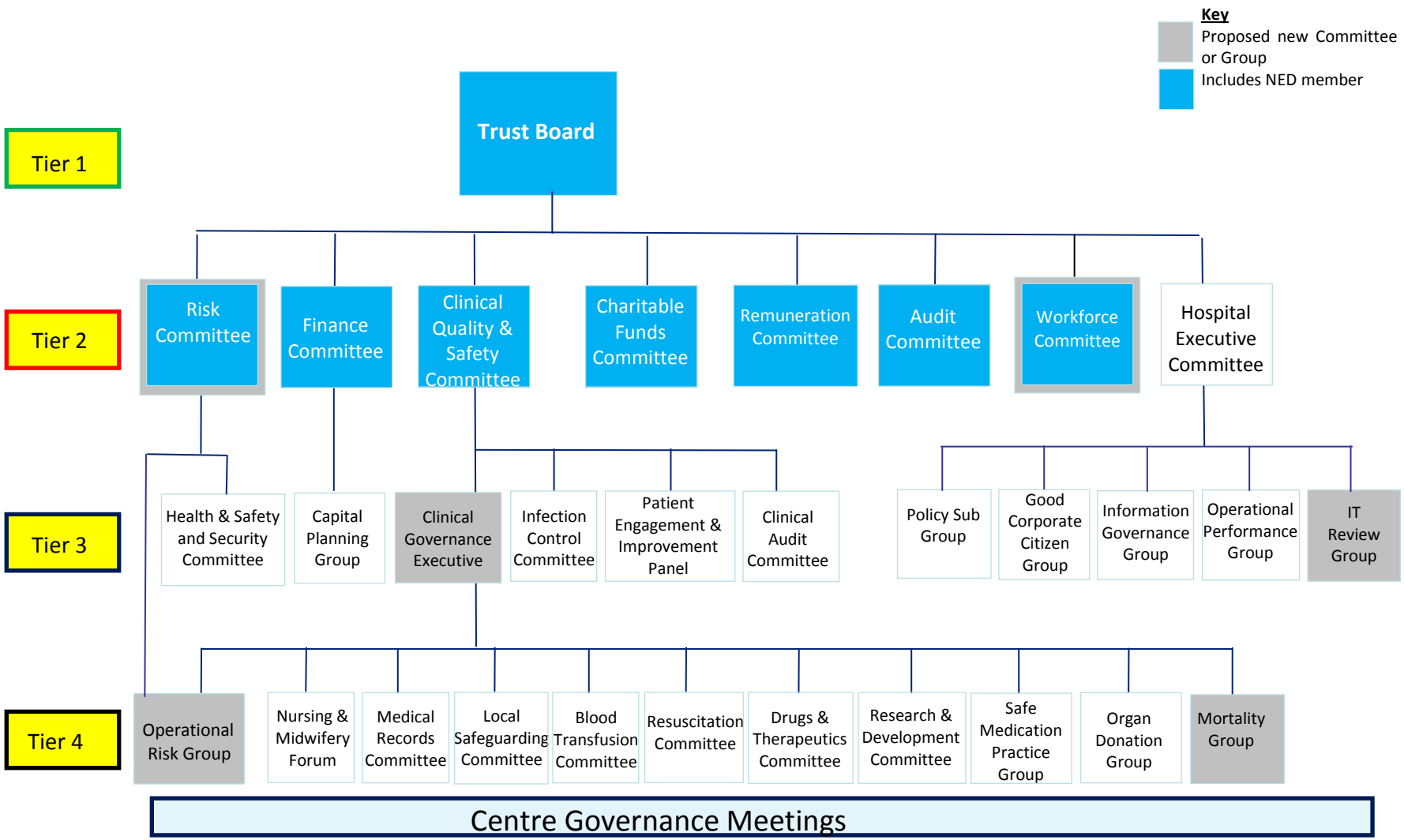
In order that the Risk Management Strategy remains current, any of the appendices to the strategy can be amended and approved during the lifetime of the strategy without the entire strategy having to return to the Board. The strategy as a whole will be reviewed and ratified annually by the Board (or 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	***Signed*** .....
Dated _____	***Dated*** _____

Appendix A Trust Governance Structure



Appendix B Risk Committee Terms of Reference

Constitution

The Risk Committee reports to the Trust Board and oversees the ongoing development, implementation and monitoring of the Trust's Risk Management Strategy. This includes overview of the most significant risks to the achievement of the Trust's objectives to 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

	Member	**Nominated Deputy**
Chief Executive (Chair)	P Herring	V Morris
Director of Safety & Quality (Deputy Chair)	V Morris	S Bloomfield
Medical Director	A Fraser	C Beacock
Director of Corporate Governance	J Clarke	C Jowett
Chief Operating Officer	D Kadum	to be agreed
Non-executive Director	R Hooper	P Vernon
Head of Assurance	C Jowett	K Titley
Attendance when required:		
Finance Director	N Nisbet	J Price
Workforce Director	V Maher	L Walton
Director of Communications	A Osborne	C Hudson
Director of Strategy	D Vogler	T Finch
Other staff may be invited to attend to discuss specific issues		

Quorum

For the Committee to be quorate, the presence of at least 4 members or their nominated deputy is required.

Attendance

Members may appoint suitable deputies to represent them. Deputies must attend when required. 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 Risk Committee shall meet quarterly. 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 the risk management arrangements within the Trust and is authorised to investigate any activity within its terms of reference

Duties

- 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

- Provide a clear statement of the risk appetite for the management of risk throughout the organisation.

- 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 Trust wide 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 strategic risks and consider whether they pose a principle risk to the Trust's strategic objectives and should be included on the Board Assurance Framework

- 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

- Identify potential threats and opportunities that may impact on the achievement of the Trust's objectives

- Monitor progress with the NHSLA and CNST risk management standards

Reporting from the Committee

The Committee will be directly accountable to Trust Board.

The Chairman of the Committee will report on the proceedings of each meeting to the next meeting 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.

The Risk Committee will produce an annual risk management report for the Trust Board

Reporting to the Committee
The Operational Risk Group, and Health & Safety and Security Committee will report to the Risk Committee

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

November 2012

Appendix C Operational Risk Group Terms of Reference

Constitution
The Operational Risk Group (ORG) reports to the Clinical Governance Executive and Executive Risk Committee and supports the Trust's governance Committees in ensuring risk assessment and risk reduction plans are in place across the Trust. ORG will be required to adhere to the Standing Orders of the Trust.

Membership

	Member	Nominated Deputy
Core Members		
Medical Director (Chair)	E Borman	
Director of Corporate Governance (Deputy Chair)	J Clarke	C Jowett
Head of Assurance	C Jowett	K Titley
Assistant Chief Operating Officer	S Biffen I Donnelly	I Donnelly S Biffen
Associate Director of Patient Safety	J Banks	S Carling
MES Manager	T Penrose	
Health and Safety Team Leader	K Titley	H Smith
Head of Contracts & Performance	P Hodson	S Taylor
Head of IT	N Appleton	G Madin / G Thelwell
Matron for IPC	J Pritchard	D Snooke
Head of Estates	C Needham	T Penrose
Interim Financial Controller	J Price	A Parkinson
Deputy Chief Nurse	S Bloomfield	G Mitchell
Deputy HR Director	S Hayes	L Walton
Head of Planning	T Finch	
Security Manager	J Simpson	-
Care Group Governance Leads / Care Group Chiefs / Care Group Managers / Value Stream Leads	Can attend any meeting. Must attend to present new risks. Must attend if outstanding actions for Care Group and as required to present updates to action plans. Must attend a minimum of 1 meeting per quarter. Will receive agenda and minutes.	
Directors (or Nominated Deputy)	Must attend to present new risks. Can attend any meeting. Will receive agenda and minutes.	
The Group can call upon any member of staff to attend to discuss specific issues.		

Quorum
The Chair or Vice-Chair should be present, plus five members or their nominated deputy. At least one Care Group must be represented.

Attendance
Core members may appoint suitable deputies to represent them. Deputies must attend when required. It is expected that a core member or their nominated deputy will attend for a minimum of 75% of meetings in a year. New risks will not be discussed if the relevant Care Group /Department is not represented at the meeting. Attendance will be monitored by an attendance matrix.

Frequency
ORG shall meet monthly. Additional meetings may be held at the discretion of the Chair

Authority

The meeting will consider risks identified by Care Groups /departments and through corporate incidents e.g. serious untoward incidents, CQC inspections, MHRA/SABs alerts/ H&S and audit recommendations.

The Trust Risk Register (scores of 20 or above) will be presented quarterly to the Risk Committee with any changes to the highest risks being reported in-year.

New risks will not be considered unless they have gone through due process as described in the risk register procedure. All new risks should have an associated action(s) and this will be reviewed quarterly.

Duties
ORG will:

1. Identify and validate new risks and consider whether they should be forwarded for inclusion on the Board Assurance Framework

2. Review all risks with a risk score of 15 or above.

3. Ensuring risk owners and risk action owners have plans in place to control identified risks and to ensure remedial plans are put into place should mitigation fall behind plan by quarterly review of action plans.

4. Oversee the maintenance and further development of the Care Group'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 mitigating the organisations risks.

5. If ORG are not happy with progress, refer matter to COO/ Directormeeting, highlighting:
   - The top 3 risks for each Centre/Corporate Department
   - High (red) risks with unchanged scores for more than 12 months
   - Any risk not mitigated in line with the target date including risks with actions past their original implementation date
   - Risks with no actions recorded on 4Risk within 1 month of identification

6. Review findings and ensure implementation of recommendations arising from internal audits of Trust risk and compliance processes

7. Review and monitor actions arising from Rule 43 letters from the Coroner, inquests, claims, and solicitor's risk management reports

8. Ensure the CQC framework is up to date and any outstanding actions are being progressed by the relevant area.

9. To receive BAF on a quarterly basis.

Reporting from the Committee
The Committee will be directly accountable to the Clinical Governance Executive and support the work of the Trust Risk Committee.

Reporting to the Committee
All risks from tier 3 and tier 4 committees, along with Care Group risks will be discussed at ORG.

Review
The Terms of Reference will be reviewed annually.

February 2013 – V6

Appendix D Responsibilities

Trust Board of Directors
The Board as a whole is responsible for reviewing the effectiveness of internal controls and for managing the Trust efficiently and effectively.

Chief Executive
The Chief Executive has overall responsibility for ensuring the implementation of an effective risk management system, supported by the Director of Corporate Governance and other key individuals (see below) with delegated responsibility.

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.

Directors
Whilst the Chief Executive has overall responsibility he delegates 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 Care Groups Environmental 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 Estates and Facilities
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 Corporate Governance	Risk and Assurance Framework Foundation Trust programme Health and Safety Legal Services Security Management
Director of Business and Enterprise	Business planning Future Configuration of Hospital Services Strategy
Workforce Director	Human Resources Organisational Development Training and Development

Director of Corporate Governance

- Lead Director for risk management
- Fulfils 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 (BAF) in conjunction with the Trust Board

Head of Assurance

- Develop and maintain the risk registers, providing advice and guidance on use of the electronic risk register (4Risk)
- Maintain the BAF
- Oversee the running of the Operational Risk Group and Risk Committee ensuring risks are reported, assessed and managed though the submission of the risk registers
- Produce an annual risk management report for the Risk Committee
- Keep an up to date assurance schedule of planned external visits and audits (clinical and non-clinical)

Head of Legal and Security Services

The Head of Legal and Security Services is responsible for claims management, liaising with solicitors and insurers to ensure timely and cost effective claims handling. They are also responsible for liaison with HM Coroner and the Police. They ensure that any risk management issues/actions identified during a claim, or inquest is referred for action.

Security Manager

The Trust's Security Manager is accountable to the Director of Corporate Affairs in their role as Local Security Management Specialist (LSMS) and is responsible for developing systems for the security of staff, patients, property and assets

Health & Safety Team Manager

The Trust Health & Safety Team Managers reports to the Head of Assurance and is the Trust lead for Health and Safety. Their duties include planning, advising and monitoring the Trust's day to day compliance with:

- The Health and Safety at Work etc, Act 1974 and the relevant statutory Regulations and provisions of appropriate Approved Code Of Practice
- All procedures that comprise The Shrewsbury and Telford NHS Trust's Health and Safety Framework (See Policy on Intranet for more details)

Deputy Director of Nursing

The Deputy Director of Nursing supports the Director of Quality and Safety

Associate Director of Patient Experience

Reports to the Director of Quality and Safety and is responsible for;

- Management and coordination of formal complaints ensuring that required follow up action is taken to prevent a recurrence
- Trend analysis and the identification and notification complaints to the Board
- Oversees the Patient Advice and Liaison Services (PALS).

Associate Director of Patient Safety

Reports to the Director of Quality and Safety and is responsible for;

- Developing and maintaining effective clinical risk systems. Specifically ensuring effective systems for reporting incidents and near misses, appropriate investigations (including root cause analysis) are carried out, feedback is given, and an accurate database is maintained.
- Trend analysis and the identification and notification of serious incidents to the Board and external stakeholders.
- Supporting the Care Groups through education and communication in their Clinical Governance programmes

Research and Development Director

The Research and Development Director is responsible for management of research, and research governance processes. Incidents arising from research will be reported via the Trust's incident reporting procedure.

Head of Education
The Head of Education is responsible for coordinating education, development and training activities within the Trust and leads on the use of the NHS Knowledge and Skills Framework

Director of Estates and Facilities Management
The Director of Estates and Facilities Management has corporate responsibility for all relevant fire safety legislation and NHS Fire Code; and compliance with the Environmental Protection Act 1990, together with associated Acts & Regulations;

Head of Facilities
The Trust's Head of Facilities is accountable to the Director of Estates and Facilities Management for:

- The Food Safety Act 1990 and Food Safety (General Food Hygiene) Regulations 1995 together with other associated Acts and Regulations

Other specialist support
For managers or staff who need specialist support, it is available from the following post holders for their respective area of expertise:

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

Care Group / Centre Management Teams
The Management Teams have delegated responsibility for assessment, management and reporting of risks within their areas and engaging all staff in this process. In particular, they will be responsible for:

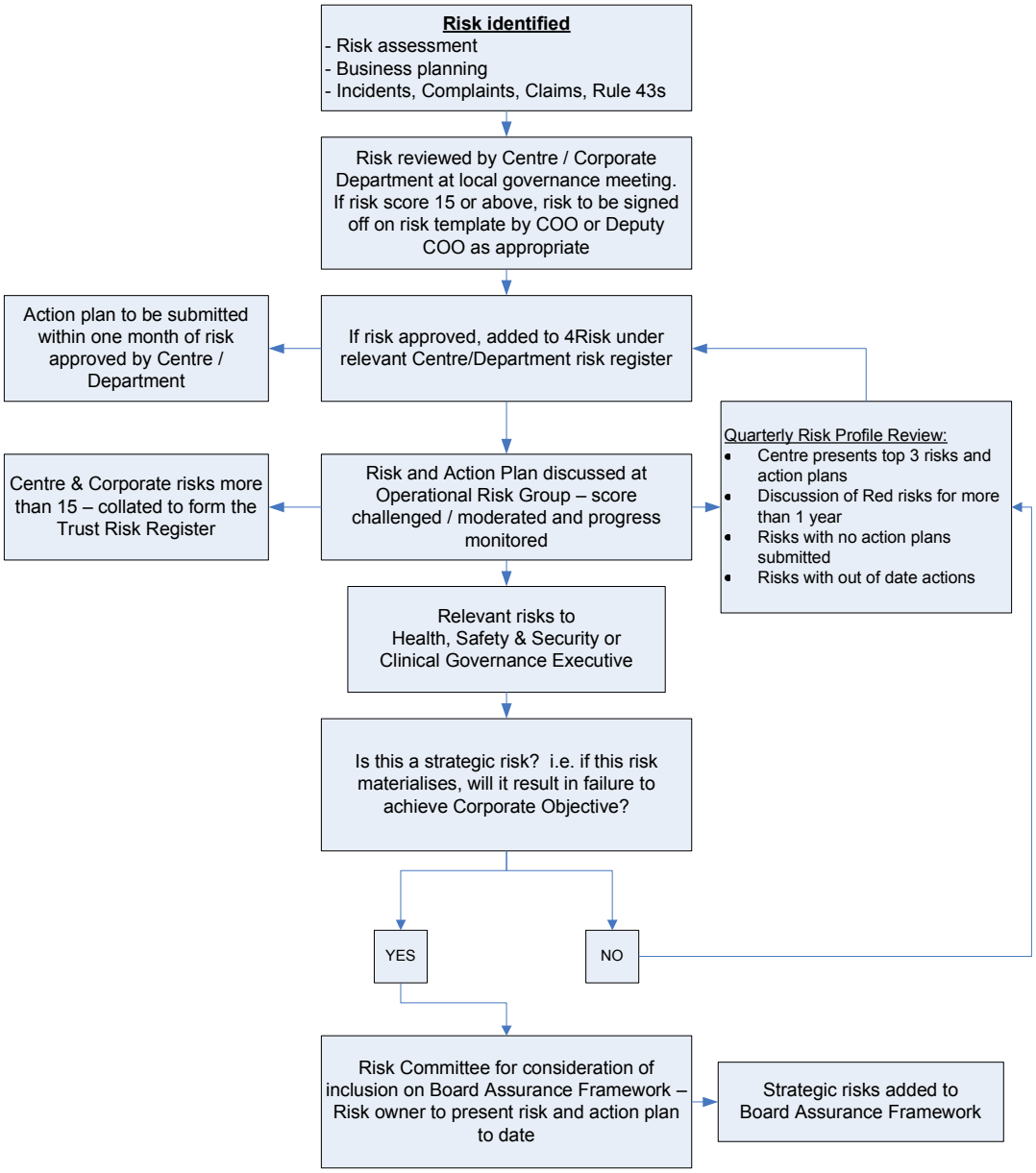
- Ensuring all areas have local risk management systems in place and that all staff are made aware of the risks within their work area and of their personal responsibilities in relation to risk management.
- Ensuring there are effective systems in place for the identification, management and review of risks including risks to the achievement of CQC standards
- Ensuring risk registers are in place and escalate identified risks to the Operational Risk Group in line with the requirements of this strategy.
- Ensuring risk assessments are taken forward and appropriate and sufficient controls are established and maintained to ensure that the risk is managed at the lowest reasonably practicable level.
- Ensuring that their staff receive the required level of information and training to enable them to work safely and comply with Trust policies and that they are competent to identify, assess and manage risk within their areas.
- Completing sub certification to support the Annual Governance Statement
- Ensuring the promotion of an open, reporting and learning culture

Responsibilities of all Employees
All staff are expected to:

- Report 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 risk management training policy.

Appendix E Information Flows for Risk

Risk Management Process



Appendix F Risk Matrix

RISK CONSEQUENCE SCORE

	1	2	3	4	5
Descriptor	**Insignificant**	**Minor**	**Moderate**	**Severe**	**Catastrophic**
Safety	None or minimal harm – no intervention required H&S – Little chance of injury or illness due to lack of maintenance or process.	Minor avoidable injury or illness, requiring minor intervention H&S – small chance of injury or illness	Moderate avoidable injury requiring professional intervention (RIDDOR reportable) H&S – moderate chance of injury or illness due to lack of maintenance or failure in process	Major avoidable injury leading to long term incapacity / disability H&S – Probable serious injury due to lack of maintenance or failure in practice.	Incident leading to avoidable death or serious permanent harm (for example e.g. wrong site surgery or loss of vision.) H&S – Probable fatality due to lack of maintenance or failure in practice.
Quality	Peripheral element of treatment or service sub optimal Informal complaint	Clinical outcome not affected OR increase in length of stay 3 – 10 days (department level) Overall treatment or service suboptimal Minor implications for patient safety if unresolved	Individual consultant clinical outcome in lower 25% for up to a month OR increase in length of stay for large number of patients <15 days (Care Group level) Repeated failure to meet internal standards Patient safety implications if findings are not acted on	Individual consultant clinical outcome in lower 10% for up to a month OR speciality clinical outcomes in lower 25% for up to one month OR increase in length of stay for large number of patients >10 days (Trust level) Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent critical report	Individual consultant clinical outcome in lower 10% for in-excess of 3 months OR speciality clinical outcomes in lower 25% for over one month OR increase in length of stay for significant number of patients >10 days (Trust level) Gross failure of patient safety if findings are not acted on Inquest Rule 43 potential/ ombudsmen inquiry Gross failure to meet national standards
Finance	Costs within the remit of individual employees as set by the Scheme of delegation	0.5% of budget OR Major impact on budget holder's financial position	Financial impact £100k - £250k	Financial impact £250k - £1million	Financial impact £1million+
Inspection / Audit	Minor recommendations. Minor non-compliance with standards. No breach of guidance	Single breach of statutory duty.	Challenging external recommendations / improvement notice issued	Multiple breach and prosecution notice issued Enforcement Action Prohibition notice.	Multiple breach and prosecution Severely critical report
Service / Business Interruption Environmental impact	Loss / interruption > 1 hour OR Minimal / no impact on environment OR Little damage to machinery / equipment	Loss / interruption > 1 day (department level) OR Minor impact on environment OR Moderate damage to machinery, easily repairable	Loss / interruption > 1 day (Care Group level) OR Moderate impact on environment OR Machinery shut down immediately and restarted in less than half a day	Loss / interruption > 1 week OR Major impact on environment OR Machinery will be out of action more than a week to repair	Permanent loss of service or facility (Trust level) OR Catastrophic impact on environment OR Damage will spread beyond one item of machinery and take over one week to repair
Service Delivery / business management	Failure to meet individual objectives set out in KSF process or minimal impact	Failure to meet internal standards with some impact on overall performance of business unit	Failure to meet internal standards with some impact on overall performance of Trust	Major impact on overall performance which puts achievement of standards or ability to meet Monitor risk rating and national requirements at risk	Sustained failure to meet standards or failure to meet Monitor risk rating and national requirements. Serious impact on overall performance and possible intervention
Adverse Publicity / Reputation	Minimal impact	Short term local interest and impact from an issue (e.g. leading to reduced public confidence in a service)	Moderate or short term impact on reputation leading to moderately reduced public confidence in the Trust	Major or medium term impact on reputation leading to significantly reduced public confidence in the Trust	Serious and long term impact on reputation leading to total loss of public confidence in the Trust
Human Resources / Organisational Development	Nil	Low staffing level reduces service quality	Late delivery of key objective / service due to lack of staff (recruitment, retention or sickness). OR Unsafe staffing level or competence (>1 day).OR OR Low staff morale OR Poor staff attendance for mandatory / key training	Uncertain delivery of key objective / service due to lack of staff OR Unsafe staffing level or competence >5 days) OR Loss of key staff. Very low staff morale. OR No staff attendance for mandatory / key training. OR Serious error due to insufficient training	Non delivery of key objective / service due to lack of staff OR Ongoing unsafe staffing levels or competence OR Loss of several key staff OR No staff attending mandatory / key training on an ongoing basis

Risk Likelihood : Frequency or Probability Score

Descriptor	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
Frequency ***How often might it/does it happen?***	Highly unlikely but it may occur in exceptional circumstances. It could happen but probably never will.	Not expected but there's a slight possibility it may occur at some time	The event might occur at some time as there is a history of casual occurrence at the Trust or within the NHS	There is a strong possibility the event will occur as there is a history of frequent occurrence at the Trust or within the NHS	Very likely. The event is expected to occur in most circumstances as there is a history of regular occurrence at the Trust or within the NHS
Probability ***ie will it happen or not within given time frame?***	<0.1 percent	0.1 – 1 percent	1 – 10 percent	10 – 50 percent	> 50 percent

Risk Quantification Matrix

Likelihood	**Consequence**				
	1 **Insignificant**	**2** **Minor**	**3** **Moderate**	**4** **Severe**	**5** **Critical**
5 - Almost Certain	**5**	**10**	**15**	**20**	**25**
4 - Likely	**4**	**8**	**12**	**16**	**20**
3 - Possible	**3**	**6**	**9**	**12**	**15**
2 - Unlikely	**2**	**4**	**6**	**8**	**10**
1 - Rare	**1**	**2**	**3**	**4**	**5**

Risk Rating: level at which risks will be managed

Insert Consequence and likelihood scores on the risk assessment form and consult matrix below
High - Prompt action is required, so far as is reasonably practicable. Risk MUST be signed off by COO or deputy and then notify OPERATIONAL RISK GROUP. MANAGEMENT BY CARE GROUP / Centre Strategic risks only for consideration of inclusion on BAF via RISK COMMITEE.
Medium - Risk reduction is required, so far as is reasonably practicable. PROACTIVE REVIEW and MANAGEMENT BY CENTRE with assurance through local governance.
Low - Risk within tolerance. Risk reduction is required, so far as is reasonably practicable ONGOING REVIEW & MANAGEMENT by DEPARTMENTS with assurance through local governance.
Very Low - Risk within tolerance and further risk reduction may not be feasible or cost effective. MONITORING AT OPERATIONAL LEVEL.

Risks which directly threaten the Corporate Objectives are strategic risks and must be escalated to Risk Committee. All other risks are operational and will be managed in line with RM Strategy

Appendix G Subcertification of Annual Governance Statement

The Shrewsbury and Telford Hospital NHS
NHS Trust

Annual Governance Statement

Subcertification Process

I certify that the [ ] Risk Register:

- is up-to-date,
- reflects all risks rated at 8 or above in my areas of responsibility
- identifies all the controls currently in place for the identified risks
- identifies timed actions for mitigation of all identified risks
- Identifies the assurances (received or planned) that will enable [ ] to demonstrate that the risk is adequately managed.

For any lapses please provide details of action taken:

Signature Date

Position

Appendix H Related Policies and Procedures

Reservation of Powers to the Board and Delegation of Authority
Standing Financial Instructions and Standing Orders

Risk Management Handbook
Corporate Risk Register
Board Assurance Framework
Women's Risk Management Strategy

An Organisation-wide Policy for the Development and Management of Procedural Documents (Gov 01)

Procedure for the reporting and Investigation of incidents, complaints and claims
Serious Incident policy
Learning from adverse events policy

Health and Safety Policy
Health and Safety Risk Assessment Templates
Claims Handling policy
Complaints policy
Guidance for Risk Assessment
Fire Policy
Security Policy
Major Incident Plan

Induction Policy
Whistleblowing policy HR05
Maintaining high standards of performance
Maintaining high professional standards for Doctors and Dentists
Knowledge and Skills Framework
Training and Development Support

Infection Control Policies
Resuscitation Policy
Medical Devices Policy
Medical Equipment Training Policy

Appendix I References

[1] *CNST maternity Clinical Risk Management Standards NHSLA (January 2011)*
[2] *Australian/ New Zealand Standard. Risk Management: AS/NZS 4360 19. (19) Copyright Standards Association of Australia, Strathfield, New South Wales, Australia*