

**POLICY CONTROL DOCUMENT – 1**

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| **POLICY TITLE** | **RISK MANAGEMENT POLICY** |
| **POLICY CODE** |  |
| **REPLACES POLICY CODE (IF APPLICABLE)** | This replaces the Risk Management Strategy |
| **AUTHOR**  **(Name and title/role)** | Gavin Garman, Deputy Director of Nursing and Risk |

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| TRUST BOARD SUB-COMMITTEE THAT APPROVED ORIGINAL VERSION | |
| **Name of the committee that approved version 1 of the document** | **Trust Board** |
| **DATE OF NEXT REVIEW** | 3rd Quarter 2012 |

**REVIEW HISTORY**

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| BODY THAT APPROVED REVISED VERSION | |
| Trust Board | DATE 5th May 2011 |
| Trust Board | DATE 3Q 2011 |
|  | DATE |

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| CURRENT VERSION PLACED ON INTRANET | DATE |

**CHAIR(S) OF APPROVING BODY**

**SIGNATURE(S).................................................................................................**

**TITLE(S) ..........................................................................................................**

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POLICY CONTROL DOCUMENT – 2

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| NUMBER OF PAGES (EXCLUDING APPENDICES) | | 5 |
| **SUMMARY OF REVISIONS:** | | |
| November 2011 | * Replacement of the designation “Strategy” by “Policy” * Adoption of standard NPSA risk matrix * Reformatting into new layout. * Simplification of responsibilities * Clarification of the risk committee structure * Revised assurance framework * Revised Monitoring & Evaluation | |
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| **Approval Checklist** | **✓** | **Comments** |
| **Relevant Standard identified (e.g. CQC registration standard or NHSLA standard) and how the Procedural Document meets the standard stated** | **✓** |  |
| **Consultation process undertaken**  **Outline with whom:**  Senior Executives  Director of Corporate Management  General Consultation | **✓** |  |
| **Equality Impact Assessment completed** | **✓** |  |
| **Has the potential for an impact on a person’s human rights been considered** | **✓** |  |
| **Training implications assessed and agreed where relevant with Learning and Development Team** | **✓** |  |
| **Any resource implications for operational services discussed with the Chief Operating Officer** | **✓** |  |
| **Monitoring/audit arrangements included** | **✓** |  |

**All policies are copy controlled by date. When a revision is issued previous versions will be withdrawn. Uncontrolled copies are available but will not be updated on issue of a revision. An electronic copy with be posted on the Trust Intranet for information**

*[Note: a tick (✓) or cross (🗴) is put in the tick boxes above to confirm that each of the control checks have been carried out. A comments box is given to give additional information where necessary, especially for any crosses. If the question is Not Applicable, it will be marked as a cross and the reason given in the comments]*

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| Logo | | | | | | | | | | | | | | | | | | | Policy | | | |  | |
|  |  | Review  *3Q 2012* | | | |
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| Applicable to - | | | | | |  |  |  | All areas | | | | | | **✓** | | | Specific Areas | | | | | |  |
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| **RISK MANAGEMENT POLICY** | | | | | | | | | | | | | | | | | | | | | | | | |

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| **Table of Contents** |

[1 Aim of Policy 2](#_Toc309827887)

[2 Legal and Procedural Document Framework 2](#_Toc309827888)

[3 Policy 2](#_Toc309827889)

[4 Responsibilities 3](#_Toc309827890)

[5 Training 4](#_Toc309827891)

[6 Other Associated Authorised Documents 4](#_Toc309827892)

[7. Monitoring and Evaluation 5](#_Toc309827893)

[Appendix 1: Definitions 6](#_Toc309827894)

[Appendix 2: Risk Management Framework 7](#_Toc309827895)

[Appendix 3: Assurance Framework 12](#_Toc309827896)

[Appendix 4: Committee Structure 14](#_Toc309827897)

[Appendix 5: Risk Management Tools 18](#_Toc309827898)

[Appendix 6: Responsibility and Authority of Managers 22](#_Toc309827899)

[Appendix 7: Risk Management Strategy Targets 2011-12 24](#_Toc309827900)

[Appendix 8: Equality Impact Assessment 26](#_Toc309827901)

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| 1 Aim of Policy | |
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|  | Oxford Health NHS Foundation Trust is committed to a policy that minimises risks to all its stakeholders through a comprehensive system of internal controls whilst providing maximum potential for flexibility, innovation and best practice in delivery of its strategic objectives. |
|  | Good risk management awareness and practice at all levels is a critical success factor for a NHS Foundation Trust. Risk is inherent in everything we do, from providing services as they are, to taking decisions about service reconfiguration and organisational change. |
|  | Each member of the Trust manages risks continuously, both in clinical and non-clinical practice. The aim of the risk management process is to provide a systematic and consistent framework through which the Trust’s objective of providing safe services is pursued. The policy sets the overarching framework for the management of risk through an integrated approach, encompassing financial controls, organisational controls and clinical governance. In this way the Trust will seek to secure a continuum of progress in improving the safety of patients, staff and members of the public, prevention of loss or damage to the business of the Trust, buildings and equipment. |
|  | Risk management underpins the Trust’s aims and objectives and enables the Trust to prioritise its risks so as to direct resources for managing risks effectively. As part of this the Trust undertakes to ensure that adequate provision of resources, including financial, personnel and information technology is, as far as is reasonably practicable, made available. |
|  | The Trust encourages all staff to have the confidence to report untoward events and risks and commits to developing a culture that welcomes knowledge of risks as an opportunity to improve patient care, services offered and the working environment and safety of staff and service users. |
|  | An additional important aim of this policy is to support the compliance frameworks for risk as required and defined by CQC, Monitor, NHSLA and other such bodies. |
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| 2 Legal and Procedural Document Framework | |
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|  | The strategy is in line with National Health service Litigation Authority (NHSLA) standards, guidance from the National Patient Safety Agency (NPSA), the Medicines and Healthcare products Regulatory Agency (MHRA) and other relevant bodies through the Safety Alert Broadcast System. |
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| 3 Policy | |
|  | The Board of Directors recognises that risk management is an integral part of good management practice, and to be most effective must be part of the organisation’s culture. The Board of Directors is committed, through the Risk Management Framework (Appendix 2), its associated Assurance Framework (Appendix 3) and Committee structure (Appendix 4), to ensure that risk management forms a key element of its philosophy, practices and business plans, with responsibility for implementation accepted at all levels of the Trust. This policy defines the broad aims and principles of risk management across the Trust, the tools that it employs to manage risk (Appendix 5) and acknowledges the strategic key targets and milestones that have been set for the next five years (Appendix 7). The policy will be reviewed and updated annually.  The principles are:   * To protect patients, carers, staff and others who come into contact with the Trust * To create awareness through the Trust about the importance of recognizing and managing risk and providing staff with the knowledge, skills and support. * To promote positive risk taking in the context of clinical care and in controlled circumstances * To provide a robust basis for strategic and operational planning through structured consideration of key risk elements * To enhance partnership working with stakeholders in the delivery of services * To improve compliance with relevant legislation and national best practice standards * To enhance openness and transparency in decision-making and management * To be compliant with the requirements for sound risk management as defined by the Care Quality Commission (CQC) and the NHS Litigation Authority (NHSLA) |
|  | The risk management process will be used:   * To provide information to the Board through the committee structure so that it can make informed decisions * To improve decisions about resources * To manage the treatment of risk in a systematic way so that the organisation can determine acceptability of residual risks * To initiate and monitor action to prevent or reduce the adverse effects of risk * To reduce the likelihood and impact of serious incidents and any associated complaints or claims made against the Trust. * To improve the level of compliance against the NHSLA risk management standards to achieve a corresponding improved risk rating from Monitor and reduction in contribution to the NHSLA schemes. |
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| 4 Responsibilities | |
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|  | The **Board of Directors** is responsible for directing the Trust in the achievement of its objectives and to ensure that an effective internal control system is in place to respond appropriately to significant organisational, operational, financial, compliance and other risks to achieve the Trust’s objectives. The Board of Directors will review and endorse the Risk Management Policy and associated strategic objectives.  The **Chief Executive** has overall responsibility for implementing an effective risk management system across the organisation.  The **Director for Nursing and Clinical Standards** has delegated responsibility for:   * Developing and delivering the Risk Management Policy and associated systems * Fire, Health and Safety * Safeguarding Children and Vulnerable Adults * Infection Control * Local Security Management * Complaints and PALS * Quality and Audit   The **Director of Finance** is accountable for financial control, information management and systems for performance management.  The **Director of Human Resources and Organisational Development** is responsible for the safe recruitment practices of the Trust and ensuring the provision and monitoring of statutory and mandatory training.  The **Chief Operating Officer** has overall responsibility for service delivery from the four clinical divisions. Each division had a Divisional Director and a Clinical Director accountable for the management of risks in their service.  The **Medical Director** for ensuring clinical effectiveness.  The **Divisional Directors** have responsibility for the risk management arrangements in their directorates, including the maintenance of a directorate risk register. The Divisional Director may identify a **Directorate Safety Lead** who is responsible for supporting and monitoring the risk management arrangements in the directorate.  All **Managers** have important and extensive duties towards the management of risk. The relevant responsibilities and authority carried by managers is described in more detail in Appendix 6.  All Staff have a responsibility to report and act appropriately on any identified risk, real or potential and to take due care and attention to reduce the impact or likelihood of the risk of incidents. |
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| 5 Training | |
|  | All members of the Trust Board of Directors and senior managers should receive risk management awareness training to enable them to undertake their role effectively. The nature of the training and its frequency is described in the Trust’s mandatory training matrix. Attendance on the training should be recorded on the Trust training record system and failure to attend should be followed up according to the usual Trust procedures.  The other managers and staff of the Trust should also receive risk management awareness training to enable them to undertake their role effectively. The nature of the training and its frequency is described in the Trust’s mandatory training matrix. Attendance on the training should be recorded on the Trust training record system and failure to attend should be followed up according to the usual Trust procedures. |
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| 6 Other Associated Authorised Documents | |
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|  | CORP21 Clinical Audit Policy  RMHS1 Incident Reporting & Management Policy  HR07 Whistleblowing Policy  CP38 Concerns, Complaints & Compliments Policy & Procedure  CORP17 Legal Claims Policy and Procedures, Legal Advice and Inquests Procedures  RMHS16 Risk Management Procedure |
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| 7. Monitoring and Evaluation |

The Trust recognizes that there is significant progress to be made in relation to the risk management process. Targets will be approved by the Integrated Governance Committee on an annual basis. The current targets that relate to clinical risk are appended to this policy (Appendix 7). Further corporate risks, including financial risks are detailed in the assurance framework.

The Risk Management Policy is subject to an annual review by the Board of Directors. The targets for implementing the strategic elements of the Risk Management Framework are agreed with the Integrated Governance Committee annually. The implementation of these targets will be monitored by the Committees identified in the work plan and the Safety Committee has a responsibility for overseeing that that work is undertaken. This is described below.

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| **Criteria** | **Measurable** | **Lead person/ group** | **Frequency** | **Reported to** | **Monitored by** | **Frequency** |
| Process for the management of risk locally, which reflects the organisation-wide risk management policy | Reports on maintenance of local risk registers and implementation of actions | Divisional/ Directorate Director | Monthly | Division Management Teams | Appropriate QIC (via QIC reports) | Quarterly |
| Process for the management of corporate risks that reflect the organisation-wide risk management policy | Reports on maintenance of corporate risk registers and implementation of actions | Senior Executive | Quarterly | Integrated Governance Committee | Trust Board (via Annual Plan progress report | Quarterly |
| Ensuring that the Risk Management Policy is being adhered to | Assurance reports from Internal Audit | Internal Audit | Quarterly | Audit Committee | Trust Board (via Annual Audit Report) | Annual |
| Ensuring that all board members, executives and senior managers receive relevant risk management awareness training | Training reports | Learning and Development Team | Monthly | Chief Executive | Learning Advisory Committee | Quarterly |

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| **Appendices** | |
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|  | Appendix 1: Definitions |
|  | **Risk**  Risk is defined as ‘the chance of something happening, or a hazard being realised, that will have an impact upon objectives. It is measured in terms of consequence and likelihood’ (NPSA). The term ‘risk’ is often seen as a negative phrase. However, the taking of planned and evaluated risks to sustain development and improvement can be a positive measure of success. For a public organisation such as a NHS Foundation Trust, risks can be contained within 4 broad categories:   * **Strategic** – the risks associated with the Trust’s ability to maintain its longer term viability and the delivery of developing national and local priorities. * **Performance** - the ability of the Trust to deliver high quality care for patients in accordance with the business plan, its contracts to deliver care and the registration requirements set by the Care Quality Commission. * **Finance** – the risk that a weakness in financial control could result in a failure to safeguard assets, impacting adversely on the Trust’s overall financial viability and capability for providing services * **Reputation** – the risk that the Trust receives negative publicity, which impacts on public confidence in the organisation. |
|  | **Integrated risk management**  Integrated risk management is a process through which organisations identify, assess, analyse and manage all risks and incidents for every level of the organisation, and aggregate the results at a corporate level. In practice this means:   * Integrating all risk management functions such as patient safety, health and safety, complaints, litigation, finance, business and other risks. * Integrating risk management functions with service development and clinical governance activity to unify frameworks and improve outcomes for patients. * Integrating all sources of information, both reactive (e.g. incidents) and proactive (e.g. risk assessments). * Integrating systems of risk assessment to improve clarity and communication. * Implementing a consistent approach to training, management analysis and investigation. * Incorporating all risks into the processes for risk register development, integrating processes and decisions about risk into future business and strategic plans. |
|  | **Risk Registers**  Risk Registers are lists of related identified risks and their properties. Risks may be local to a function, area or location (low level risks) or general relating to corporate objectives (high level risks) |

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|  | Appendix 2: Risk Management Framework |

1 Establish policy, strategy, process & procedures

2 Identify Corporate Risks (Corporate Risk Register)

3 Identify Local Risks (Divisional Risk Register)

SAFEGUARD

4 Manage Risks Corporately

6 Review of local risks by Divisional Board

7 Review of relevant risks by QIC

Divisional Risk Report

QIC Risk Report

10 Review of corporate risks by IGC

Corporate Risk Report

12 Review of significant risks & process by Board

Board Assurance Framework

**DO**

**STUDY & ACT**

8 Independent audits on risks carried out

Audit Reports

5 Manage Risks locally

Risk Plans

11 Annual Audit Report produced including risks

Audit Committee Annual Report

**PLAN**

9 Review of audit reports by IGC and Audit Committee

# Key to Framework Elements

### Safeguard

* Safeguard is the computerised repository for the risks identified in the organisation.
* Risks are categorised into “Corporate”, i.e. those derived from the Corporate Plan, and “Local” which make up a subset of a corporate risk. It is important to understand that a local risk must be associated with a relevant corporate risk.
* It is the responsibility of the Trust Risk Manager to administer the Safeguard Database

### Establish policy, strategy, process & procedures

* The basis of the risk management is a sound corporate policy explaining the principles and philosophy behind risk management in the Trust.
* The process explains the general approach towards risk management, reflecting the principles enshrined in the policy and employs the Plan-Do-Study-Act cycle to control risks and to ensure adequate oversight.
* Strategic targets relating to risk management are set annually and agreed by the Integrated Governance Committee
* In practice, the policy, process and strategy are incorporated into the same document, which must be authorised by the Board.
* This current document represents that policy, process and strategy

### Identify Corporate Risks (Corporate Risk Register)

* The Corporate Risk Register is compiled from the objectives in the corporate plan. They are generic descriptions of risks (i.e. defined at a high level) and are not defined in detail.
* Each corporate risk is specifically assigned to either a Board Committee or QIC for its overall management. It is also allocated a Senior Executive as its owner.
* Assessment of the risk is accomplished using the standard 5x5 risk matrix defined in the NPSA document “[A Risk Matrix for Risk Managers](http://www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety-tools-and-guidance/risk-assessment-guides/risk-matrix-for-risk-managers/)”. This and the accompanying definitions of the categories are used throughout the Trust to evaluate the level of risk.
* The Trust Risk Manager[[1]](#footnote-2) compiles the Corporate Risk Register following consultation with the Executive Directors and ensures that they are put on Safeguard
* Initially, although an evaluation of the potential consequence can be made, it may not be possible to assess the likelihood of the risk until further analysis of local risks is carried out. However an estimate should be given at this stage.

### Identify Local Risks (Divisional Risk Register)

* Divisional/Directorate Managers appoint Local Risk Managers[[2]](#footnote-3) to maintain the local risk register.
* It is the responsibility of the Divisional/Directorate Manager, with reference to the Local Risk Manager, to identify the major potential risks.
* The Local Risk Manager enters the local risks onto Safeguard. Each one **must** be associated with a corporate risk. If it is not, then the Trust Risk Manager should be informed and a decision made. Either:
  + The risk is not important and can be ignored; or
  + There is a major category of risk omitted at the corporate level that should be added.
* The divisional risk structure described does not preclude risk arrangements at lower levels – at team level for example. This is at the discretion of the individual divisions.
* In this fashion, a more rigorous approach to risk identification is established.[[3]](#footnote-4)

### Manage Risks Corporately

* It may be necessary to draw up plans to control or mitigate corporate risks. This is such as where the risk has a high risk assessment, where a new corporate initiative has given rise to a corresponding new corporate risk or where an audit report has given a negative assurance in relation to a risk. For that particular risk, management plans may have to be drawn up at a strategic level. This is the responsibility of the Senior Executive who is the owner of this risk.
* It is the responsibility of each of the relevant Divisions or Directorates to devise the appropriate mechanisms to implement the elements of the risk management plan.
* Details of how risks should be handled are given in RMHS16 Risk Management Procedure

### Manage Risks locally

* It is the responsibility of the Local Risk Manager and the Trust Risk Manager to ensure that staff understand the concepts and the implications of risk.
* Risks are managed locally on a day-to-day basis using standard management techniques.
* Procedural guidelines may be produced to help managers with these tasks
* It is the responsibility of the Local Risk Manager to ensure the local risk register is kept regularly updated and the Divisional Director to ensure that this task is undertaken on a timely basis
* Details of how risks should be handled are given in RMHS16 Risk Management Procedure

### Review of local risks by Divisional Board

* There should be a standing item on the agenda for each Divisional Board (or its equivalent) concerning risk.
* At these meetings, the Local Risk Manager should produce a report from Safeguard containing details of the relevant local risks for scrutiny and discussion by the meeting. Any major issues arising from this should be reported upwards as appropriate.

### Review of relevant risks by Quality Improvement Committee (QIC)[[4]](#footnote-5)

* For each QIC, the Trust Risk Manager produces a list of the corporate risks relevant to that meeting, along with the associated local risks.
* It is the QICs’ responsibility to oversee the management of these risks and reassess the grading of the corporate risk in the light of assurance gained including changes to the risk level for the local risks.
* This is a standing item on each QIC agenda
* Risks may be added, amended or removed depending on the results of audits: clinical, internal or external, or from other sources such as incidents, complaints and claims.
* It may be more appropriate to discuss particular categories of risks at sub-committees instead (e.g. Health & Safety). The results should be reported back to the QIC.

### Independent Audits on risks carried out

* To ensure an independent check that proper management of the risks are being carried out, audits will be commissioned by the Audit Committee to be carried out by Internal Audit, either separately or as a related part of other audits.
* Other independent audits may be carried out by external bodies, such as NHSLA and CQC, and which include national staff and patient surveys

### Review of audit reports

* The IGC receive the external independent audits from other bodies relevant to risk management and manage subsequent action plans.
* The Committee subsequently monitors the associated agreed management response and actions to the audits, ensuring that the actions are completed according to the schedule
* The Audit Committee receives the audit reports from Internal Audit and any items of concern raised by the IGC in their consideration of the external audits
* Using these results, the Audit Committee judges whether risk is being appropriately managed within the Trust

### Review of corporate risks by Integrated Governance Committee (IGC)

* The IGC performs the role of oversight and scrutiny of the risk framework.
* It is the IGC’s responsibility to receive a report from the Trust Risk Manager relating to Corporate Risk and provide the challenge on individual risks: their control, mitigation and evaluation
* The IGC may recommend specific areas of investigation by Internal Audit for additional assurance or otherwise to the Audit Committee

### Annual Audit Report

* One of the principal functions of the Audit Committee is to review the establishment and maintenance of an effective system of integrated governance, risk management and control across the whole of the Trust’s activities, i.e. to give assurance of the operation of this risk management function.
* Such assurance is given in an annual report prepared by the Audit Committee for the Board of Directors in support of the Annual Governance Statement.
* Further details are given in the Terms of Reference for the Audit Committee

### Review of significant risks by Board

* Although oversight of the risk management process has been delegated to the IGC, it is still the responsibility of the Trust Board to ensure that the Trust is not exposed to high-graded risks. They must be assured that such risks are being managed (i.e. the likelihood is decreased or the impact reduced).
* To assist with this, a Board Assurance Framework report (BAF) is produced by the Trust Risk Manager each quarter for the Trust Board itemising those risks that are either potential high risk or have a residual high risk. It is for the Board to decide the threshold and conditions for inclusion in this report.

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|  | Appendix 3: Assurance Framework |
|  | **Risk Registers**  A risk register is in place that incorporates a summary of risk information at corporate and directorate (local) levels. The risk registers enable all risks identified within the Trust to be categorized and recorded, and assessed against each other and on a Trust-wide and service basis to facilitate decision-making regarding resource allocation and risk reduction. The risk registers inform the Assurance Framework.  The Trust has an organization wide risk register that is maintained on the Safeguard system by the Fire, Health and Safety and Risk Team. The risk register includes the following:   * The source of the risk (see below) * A description of the risk * The risk score * The summary risk treatment plan * Date of review * Residual risk rating   Risks are added to the Risk Register on the basis of a documented risk assessment. The risk registers will capture data from a variety of sources including:   * Incidents reports * Performance against Care Quality Commission Standards and action plans * Consultation and observation * Surveys, inspections, assessments and audit * Contingency and major incident plans, and disaster recovery * Risk Assessments * Medical records * Fire reviews * Claims and complaints * Task/process analysis * Equipment purchase/modification * Preventative maintenance issues * Risk assessments * Financial information and risks |
|  | **Assurance Framework and Corporate Risk Register**  This is the cornerstone of the Trust’s approach to risk management. The Assurance Framework is important to the Annual Governance Statement and supports the organisation to formally identify its strategic objectives and the principal risks to their achievement. It also identifies what controls are in place and the effectiveness of those controls. The Audit Committee has a key role in reviewing the process of generating the Assurance Framework. The Integrated Governance Committee approves the content of the Assurance Framework annually, reporting to the Board. The Board receives quarterly progress reports on achievement of the Business Plan and these identify the key business risks and significant operational risks. The Strategic Risk Register is contained within the Assurance Framework. The Board is updated on new significant risks at each Board meeting. |
|  | **Divisional Risk Register**  The Trust’s risk register includes local Divisional risk registers that are largely informed by the regular environmental risk assessments that are undertaken at least annually but may also include risks identified from other sources. Each risk added to the Register is supported by a risk treatment or action plan and progress on identified actions is monitored at Division level and corporately for risks graded as high. Each Division has a Division specific arrangement for reviewing the risks in its Division and recommending inclusion on the Division risk registers. With support from the Fire, Health and Safety Team, they are responsible for monitoring that the risk register is maintained and that a risk treatment or action plan and progress on identified actions is managed. The relevant Quality Improvement Committees receive regular updates and feedback on the development of the register and individual items in order to maintain robust assurance that risks are being managed appropriately. |

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|  | Appendix 4: Committee Structure |
|  | The Board of Directors has agreed an integrated committee structure, in order that the business of the Trust is managed properly and that there are appropriate approval, monitoring and performance management mechanisms. The management of risk forms part of the Trust’s overall approach to governance. The committee structure is shown in the diagram below. |
|  | **Audit Committee**  The Audit Committee is a standing committee of the Board which is made up of non-executive members of the Board of Directors, to bring an independent contribution to the Board’s overall process for ensuring that an effective internal control system is maintained. The scope of the Committee includes responsibility for the overseeing of disclosures relating to wider internal control, including the effective management of risk within the Trust, across business, environment and clinical areas and the review of the Trust’s Standing Orders and Financial Instructions. |
|  | **Finance and Investment Committee**  This committee reports directly to the Board on financial matters. It oversees the following subcommittees:   * Capital Programme Board * Cost Improvement Management Group |
|  | **Integrated Governance Committee**  The Integrated Governance Committee is a standing committee of the Board with the responsibility to support the Board in meeting its statutory duty with regard to quality of care and corporate risk. It has a remit to oversee, on behalf of the Board, the development of integrated governance; that is, the systems and processes by which the Trust leads, directs and controls functions in order to achieve organisational objectives, including risk management. |
|  | **Quality Improvement Committees**  The Integrated Governance Committee is supported by five Quality Improvement Committees. These Committees are:   * Safety * Clinical Effectiveness * Governance and Information Management * Human Resources * Services and Estates   The Committees’ main remit is to ensure delivery of the Trust’s objectives and compliance with relevant standards. To undertake these duties each committee is responsible for monitoring compliance against the allocated CQC outcome standards and action against associated risks as contained in the Trust’s Assurance Framework, approving development plans and policy in line with Standing Orders and Scheme of Delegation. |
|  | **Safety Committee**  This is a Quality Improvement Committee that reports to the Integrated  Governance Committee and has the overall responsibility for overseeing the Trust’s clinical and non-clinical risk arrangements. It oversees the following subcommittees: |
|  | * Health and Safety Committee - a statutory committee, which has responsibility for reviewing health and safety incident trends and risks across the organisation. |
|  | * Senior Risk Review Group - a corporate and operational group which examines and reviews the significant risks from local risk registers and from the investigation of complaints, incidents (including serious and untoward incidents) and claims for inclusion in the Assurance Framework/corporate risk register. |
|  | * Child Protection |
|  | * Vulnerable Adults |
|  | * Medical devices group – safety of medical devices |
|  | * Infection Control Committee – effective infection control arrangements |
|  | * Fire Safety |
|  | **Clinical Effectiveness Committee**  This is a Quality Improvement Committee that reports to the Integrated  Governance Committee and has the overall responsibility for overseeing the Trust’s risk arrangements to ensure compliance with the CQC regulations relating to care and welfare of people who use our services, including management of medicines, consent to treatment and assessing and monitoring quality of service provision.  It oversees the following subcommittees: |
|  | * Clinical Audit Group – Content of Clinical Audit Plan and assessing assurance from audits |
|  | * Ethics Committee |
|  | * Drugs and Therapeutics Committee – safety of medicines management |
|  | * Research & Development |
|  | * Psychological and social therapies group – the safe practice of approved psychological and social therapies |
|  | * Mental Health Act Forum – the use of the Mental Health Act |
|  | **Governance & Information Management Committee**  This is a Quality Improvement Committee that reports to the Integrated  Governance Committee and has the overall responsibility for overseeing the Trust’s risk arrangements. It oversees the following subcommittee: |
|  | * Information Governance and Caldicott Guardian Group – effective information governance and security |
|  | **Human Resources Committee**  This is a Quality Improvement Committee that reports to the Integrated  Governance Committee and has the overall responsibility for overseeing the Trust’s risk arrangements to ensure compliance with the CQC regulations relating to staff and staffing matters. Amongst others, it oversees the following subcommittee: |
|  | * Learning Advisory Committee – monitoring and developing mandatory and statutory training activity |
|  | **Service & Estates Committee**  This is a Quality Improvement Committee that reports to the Integrated  Governance Committee and has the overall responsibility for overseeing the Trust’s risk arrangements to ensure compliance with the CQC regulations relating to the safety and suitability of premises and meeting nutritional needs. |
|  | **Divisions**  Each division has a Division Management Team and associated governance arrangements for reviewing risk matters including: serious untoward incidents, incidents, complaints, risk assessments and the directorate and local risk registers and associated actions. These are directorate specific arrangements for considering risk matters on a formal and documented basis. |

**Board of Directors**

**Clinical Effectiveness Committee**

**Governance & Information Management Committee**

**Safety Committee**

**Human Resources Committee**

**Services & Estates Committee**

* Health & Safety
* Senior Risk Review
* Child Protection
* Vulnerable Adults
* Medical Devices
* Infection Control
* Fire Safety

**OXFORD HEALTH NHS FOUNDATION TRUST GOVERNANCE STRUCTURE**

**Audit**

**Integrated Governance Committee**

**Quality Improvement Committees**

* Clinical Audit
* Ethics
* Drugs & Therapeutics
* Research & Development
* Psychological & Social Therapies
* MHA Forum
* Information Governance & Caldicott Guardian

**Charitable Funds**

**Remuneration & Nominations**

**Finance & Investment**

**Capital Programme Board**

**Cost Improvement Management Group**

* Terms & Conditions
* HR Policy
* Learning Advisory
* Staff Support & Spiritual Care

**Section 75 Joint Management Groups**

**Investment Sub-Committee**

**Members’ Council**

**Divisional Committees**

|  |  |
| --- | --- |
|  | Appendix 5: Risk Management Tools |
|  | **Risk assessment**  A separate procedure on risk assessment has been developed and managers and key staff will be provided with training in its application. There are a range of procedures and risk assessment pro-forma that can be used depending upon the type of assessment being undertaken. These include assessments related to clinical risk, generic assessments of the workplace or general activities. Specific assessments for issues such as manual handling, display screen equipment and lone working are included as part of the individual policies for those areas.  Risks with a low potential for harm may indicate a need for re-assessment if they are repeated often. Cost benefit analysis may be used when prioritizing the use of resources. Staff must allocate any risk if they are in any doubt of their acceptability. When risks are identified, controls, assurances and gaps must also be documented. Action plans must be in place where gaps have been identified that include dates, actions, lead persons and target dates. All risk assessments must be repeated at least yearly or more frequently in the event of a change of circumstance or if a related adverse event occurs.  When assessing risks the general process for establishing the level of risk and its priority for treatment is as follows: - |
|  | **Risk management scoring**  Risks are evaluated using a standardised approach taken from the NPSA document “[A Risk Matrix for Risk Managers](http://www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety-tools-and-guidance/risk-assessment-guides/risk-matrix-for-risk-managers/)”. This method assesses potential consequence (or impact) of the risk and the likelihood of it happening, each on a 1 to 5 scale.  The product of these (consequence x likelihood) gives the risk score (1 to 25).  The risk is categorised low, moderate, high or extreme according to this score. How the risk is subsequently managed of depends on the level of categorisation.  The definitions for the consequences are shown in Table 1 below, the likelihood in Table 2 and the risk categorisation in Table 3. These are taken from the NPSA definitions. |







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|  | **Managing identified risks**   * **Residual Low and Moderate level risks** should be managed at Division or Directorate Management Team level to ensure that improvements are implemented. * **Residual High and Extreme level risks** will be reviewed by the relevant Quality Improvement Committee or equivalent. Priorities for action will be established and implemented in conjunction with Divisions Management Teams as appropriate. Where it is not possible to eliminate a high level risk the committee will ensure that documented reasons are provided to the Integrated Governance Committee or the Board of Directors.   See Appendix 6 for more details about managers’ authority towards risk. |

**Table 1 Consequence scores**

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Consequence score (severity levels) and examples of descriptors** | | | | |
|  | **1** | **2** | **3** | **4** | **5** |
| **Domains** | **Negligible** | **Minor** | **Moderate** | **Major** | **Catastrophic** |
| **Impact on the safety of patients, staff or public (physical/psychological harm)** | Minimal injury requiring no/minimal intervention or treatment.  No time off work | Minor injury or illness, requiring minor intervention  Requiring time off work for >3 days  Increase in length of hospital stay by 1-3 days | Moderate injury requiring professional intervention  Requiring time off work for 4-14 days  Increase in length of hospital stay by 4-15 days  RIDDOR/agency reportable incident  An event which impacts on a small number of patients | Major injury leading to long-term incapacity/disability  Requiring time off work for >14 days  Increase in length of hospital stay by >15 days  Mismanagement of patient care with long-term effects | Incident leading to death  Multiple permanent injuries or irreversible health effects    An event which impacts on a large number of patients |
| **Quality/complaints/audit** | Peripheral element of treatment or service suboptimal  Informal complaint/inquiry | Overall treatment or service suboptimal  Formal complaint (stage 1)  Local resolution  Single failure to meet internal standards  Minor implications for patient safety if unresolved  Reduced performance rating if unresolved | Treatment or service has significantly reduced effectiveness  Formal complaint (stage 2) complaint  Local resolution (with potential to go to independent review)  Repeated failure to meet internal standards  Major patient safety implications if findings are not acted on | Non-compliance with national standards with significant risk to patients if unresolved  Multiple complaints/ independent review  Low performance rating  Critical report | Totally unacceptable level or quality of treatment/service  Gross failure of patient safety if findings not acted on  Inquest/ombudsman inquiry  Gross failure to meet national standards |
| **Human resources/ organisational development/staffing/ competence** | Short-term low staffing level that temporarily reduces service quality (< 1 day) | Low staffing level that reduces the service quality | Late delivery of key objective/ service due to lack of staff  Unsafe staffing level or competence (>1 day)  Low staff morale  Poor staff attendance for mandatory/key training | Uncertain delivery of key objective/service due to lack of staff  Unsafe staffing level or competence (>5 days)  Loss of key staff  Very low staff morale  No staff attending mandatory/ key training | Non-delivery of key objective/service due to lack of staff  Ongoing unsafe staffing levels or competence  Loss of several key staff  No staff attending mandatory training /key training on an ongoing basis |
| **Statutory duty/ inspections** | No or minimal impact or breech of guidance/ statutory duty | Breech of statutory legislation  Reduced performance rating if unresolved | Single breech in statutory duty  Challenging external recommendations/ improvement notice | Enforcement action  Multiple breeches in statutory duty  Improvement notices  Low performance rating  Critical report | Multiple breeches in statutory duty  Prosecution  Complete systems change required  Zero performance rating  Severely critical report |
| **Adverse publicity/ reputation** | Rumours  Potential for public concern | Local media coverage –  short-term reduction in public confidence  Elements of public expectation not being met | Local media coverage –  long-term reduction in public confidence | National media coverage with <3 days service well below reasonable public expectation | National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House)  Total loss of public confidence |
| **Business objectives/ projects** | Insignificant cost increase/ schedule slippage | <5 per cent over project budget  Schedule slippage | 5–10 per cent over project budget  Schedule slippage | Non-compliance with national 10–25 per cent over project budget  Schedule slippage  Key objectives not met | Incident leading >25 per cent over project budget  Schedule slippage  Key objectives not met |
| **Finance including claims** | Small loss Risk of claim remote | Loss of 0.1–0.25 per cent of budget  Claim less than £10,000 | Loss of 0.25–0.5 per cent of budget  Claim(s) between £10,000 and £100,000 | Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget  Claim(s) between £100,000 and £1 million  Purchasers failing to pay on time | Non-delivery of key objective/ Loss of >1 per cent of budget  Failure to meet specification/ slippage  Loss of contract / payment by results  Claim(s) >£1 million |
| **Service/business interruption Environmental impact** | Loss/interruption of >1 hour  Minimal or no impact on the environment | Loss/interruption of >8 hours    Minor impact on environment | Loss/interruption of >1 day  Moderate impact on environment | Loss/interruption of >1 week  Major impact on environment | Permanent loss of service or facility  Catastrophic impact on environment |

**Table 2 Likelihood score (L)**

What is the likelihood of the consequence occurring?

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

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

**Table 3 Risk scoring = consequence x likelihood ( C x L )**

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

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

|  |  |
| --- | --- |
| 0 - 3 | Low risk |
| >3 - 6 | Moderate risk |
| >6 - 12 | High risk |
| >12 | Extreme risk |

**Instructions for use**

1 Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

2 Use table 1 (page 13) to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.

3 Use table 2 (above) to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.

4 Calculate the risk score the risk multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score)

5 Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organization’s risk management system. Include the risk in the organisation risk register at the appropriate level.

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|  | Appendix 6: Responsibility and Authority of Managers |
|  | **Responsibility**  All **managers** have a responsibility to comply with the risk management policies and procedures of the Trust, that their staff and patients are kept safe and that their **staff** are aware of their responsibilities for health and safety and are aware of and follow the Trust’s risk management policies and procedures. There will be a joint approach between managers and staff to increase the effectiveness of risk management activities. They will ensure that operational services are integrated with risk management processes and that risk registers are updated. Managers must bring risks to the attention of the Senior Risk Group if local resolution has not been achieved. All members of staff have a responsibility to co-operate with managers in identifying, assessing, monitoring and taking appropriate action to eliminate or minimize all risks. Managers must exercise the level of authority granted to them within their job description to manage risk  Managers are responsible for implementing and monitoring any identified and appropriate risk management control measures within their designated area(s) of control and scope of responsibility. In situations where significant risks have been identified and where local treatment measures are considered to be potentially inadequate, managers are responsible for bringing these risks to the attention of their line manager and the Trust Risk Manager.  If local resolution has not been satisfactorily achieved the Trust Risk Manager will report the matter to the Integrated Governance Committee.  The Governance Committee or if necessary the Board will determine the acceptability of risks. |
|  | **Authority**  For grading risk, the scores obtained when using the risk matrix (Appendix 5) are assigned grades as follows:   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | |  | = Low risk |  | = Medium Risk |  | = High Risk |  | = Extreme Risk |   The authority of managers depends on the grading of the risk:  **Low/Medium Risks** (They are not significant now and are not likely to increase in future.)  Actions:   * End current assessment and record assessment details. * Review assessment if situation changes or in 1 year. * Provide induction and ongoing training, and follow safe working procedures   **High Risks** (These risks are the maximum acceptable by the Trust, providing they are effectively controlled, however they should be monitored as they could increase in the future)  Actions:   * Determine precautions to maintain controls and minimise chances of higher exposure occurring. Consider resource needs. * Determine additional measures for regaining control if a high risk event occurs, despite precautions. Determine if monitoring or health surveillance is required to check effectiveness of controls. * Review assessment if situation changes or in 1 year, provide induction and ongoing training, and ensure that safe working procedures are followed.   ***Extreme Risks*** (*They are not normally acceptable within the Trust and because they are not adequately controlled, action should be taken to either remove them or, wherever possible reduce the risk to an acceptable level.)*  Actions:   * Identify and implement immediate measures for preventing or controlling exposure. * Consider stopping the process. * Commence review of longer term control requirements and resource needs. * Re-evaluate exposures when the upgraded control measures are in place. * Determine if monitoring or health surveillance is required, provide induction and ongoing training, and ensure that safe working procedures are followed. |
|  |  |

## Appendix 7: Risk Management Strategy Targets 2011-12

These targets were approved by the Integrated Governance Committee on 5th May 2011

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Target** | | **Time-frame** | **Performance Indicator** | **Comments** | **Monitoring Committee** |
| 1 | To meet NHSLA Level 1 requirements as a new combined organisation | 2011-12 | Achieve Level 1 at assessment in 2012 | Informal assessment from NHSLA to take place in 2011 with formal re-assessment in 2012. Agreement on use of NHSLA PCT and/or Mental Health Standards required. | Safety Committee |
| 2 | Integrate Serious Incident arrangements across the new organisation | 2011-12 | Revised Incident Reporting Policy in place.  Agreed processes in place on review of SIRIs and RCAs.  Monitoring of timeliness of reports and actions in place. | Policy drafted. Different patterns of SIRIs and review mechanisms in two organisations to be integrated April 2011. | Safety Committee |
| 3 | Implement Leading Improvements in Patient Safety Programme | 2011 | LIPs objectives are to reduce Inpatient and Community Suicides and to increase reporting of less serious incidents. Targets are over 3 years. | Programme will include developing new Patient Safety at a Glance boards, using communication tools, Developing care clusters, Safety Walkabouts, Human Factors awareness, Use of Suicide Prevention Toolkits and Monitoring themes of less serious incidents | Safety Committee |
| 4 | To continue to improve on the no needless incident priorities in Community Division/ Community services | 2011-12 | Levels of incidents in relation to:  Preventing needless skin breakdown which can lead to pressure ulcers  Preventing needless drug errors  Preventing needless falls | The action plans for the three priority areas will be reviewed to identify what has been effective in delivering improvement and what additional or alternative approaches need to be adopted, using national best practice guidance and what we have learnt from work with our staff and patients. | Safety Committee |
| 5 | To continue to embed Risk Registers in risk management across the organisation | 2011-12 | Assurance Framework, Directorate and Local Risk registers to be integrated into one up to date and monitored risk register. | Risk registers currently on different systems: Performance Accelerator, Safeguard and Word formats.  Project underway to implement a new version of Safeguard across the new organisation with expanded capability, including one integrated risk register. | Safety Committee |
| 6 | To ensure performance against CQC outcomes 7,8,11,18,19 and 20. | 2011-12 | Board assurance that outcomes are achieved | Care Quality Commission regulatory framework now in place. | Safety Committee |
| 7 | To develop senior leadership in relation to patient safety | 2011-12 | Effective system of executive walkabouts in place to include coverage of patient safety | This is part of LIPs programme. | Safety Committee |
| 8 | Ensure all reasonable steps are taken to avoid Never Events happening | 2011-12 | No Never Events | New Framework published. New organisation has increased range of possible events. | Safety Committee |
| 9 | Continue development of Productive Ward Programme | 2011-12 | Number of wards following programme. Evidence of progress against PW measures. | Programme well advanced in Community Hospitals. Good practice potentially to be shared. | Services and Estates Committee |
| 10 | To continue to develop processes around Learning from Incidents | 2011-12 | Learning Events occur. Newsletter published.  Processes for dissemination of Learning in place in each division. | Content of learning and structures for dissemination to be adjusted for new organisation. | Safety Committee |

## Appendix 8: Equality Impact Assessment

**Part 1**

**Equality Impact Assessment**

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| --- | --- |
| **Service Area** | **Date: November 2011** |
| **Title of Procedural Document , strategy or service**  Risk Management Policy | |

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| --- |
| **Short description of policy, strategy or service:**  The Risk Management Policy describes the framework to minimise risks to all the Trust’s stakeholders through a comprehensive system of internal controls whilst providing maximum potential for flexibility, innovation and best practice in delivery of its strategic objectives. |

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| --- |
| **What is the likely positive or negative impact on people in the following groups?** |
| Older or younger people  Equal impact |
| People with disabilities  As above |
| People from different ethnic/cultural backgrounds (including those who do not speak English as a first language)  As above |
| Men, women or transgender people  As above |
| People with different religious beliefs or no religious beliefs  As above |
| Gay, lesbian, bisexual or heterosexual people  As above |
| People from a different socio-economic background  As above |

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| --- |
| **Evidence** |
| What is the evidence for your answers above?  This document describes internal procedures that do not relate to individual service users or staff, but are generic in design and implementation |
| What does available research say?  N/A |
| What further research would be needed to fill the gaps in understanding the potential difficulties or known effects of the Procedural Document ?  N/A |
| Have you thought about consulting/researching this gap? What would you need?  N/A |
| Does the Procedural Document need a Full Equality Impact Assessment?  No |

1. The Trust Risk Manager represents a function, not necessarily a job title. It may be part of a person’s other duties and responsibilities [↑](#footnote-ref-2)
2. As with the Trust Risk Manager, this describes a function and not necessarily a separate position. [↑](#footnote-ref-3)
3. A risk represents a **potential** risk, not necessarily one that has already happened. If there is a likelihood that such an event may reoccur, then it could be regarded as a new risk [↑](#footnote-ref-4)
4. The term “QIC” is used for convenience and should be regarded as relevant to the other Board Level Committees too (such as the Finance and Investment Committee which is not a QIC) [↑](#footnote-ref-5)