University Hospitals Bristol NHS
NHS Foundation Trust

Risk Management Strategy 2009-2012

DOCUMENT DETAIL

Author:	Anne Reader
Job Title:	Assistant Director of Governance and Risk Management
Contributors:	Divisional and Trust Patient Safety Advisors Head of Health & Safety Services
Signed:	
Date:	21st June 2009
Version No: (Author Allocated)	1
Next Review Date:	2010 To be reviewed following the Board Seminar on Risk Management September 2009
Approving Body/Committee:	Governance and Risk Management Committee
Chair:	Graham Rich
Signed approval checklist	N/A
Date Approved:	Draft approved 14th May 2009
Approving Body/Committee:	Trust Board
Chair:	John Savage
Signed approval checklist	
Date Approved:	30th June 2009
Target Audience:	All staff
Date of Equality Impact Assessment:	21st June 2009
Link to Healthcare Standard (s)	Domain 1 Safety, Domain 3 Governance
Link to NHSLA Standard(s)	All
Link to Corporate Objectives	Clinical Quality, Patient Experience

Document History					
Date of Issue	**Version No.**	**Next Review Date**	**Date Approved**	**Executive or Div Lead Responsible for Change**	**Nature of Change** e.g.: new legislation
1999		2000		Director of Nursing	Planned review and update.
2000		2002		Director of Nursing	Planned review and update.
2002		2004		Director of Nursing	Planned review and update.
2004		2007		Director of Nursing	Planned review and update.
2007		2009		Director of Nursing	Planned review and update.
May 2009	Draft v1	June 2009	14th May 2009	Anne Reader, Assistant Director of Governance.	Supercedes United Bristol Healthcare Trust Risk Management Strategy. Planned review and update.

Consultation: This document was reviewed with the following individuals and groups

Divisional Patient Safety Advisors	Head of Health and Safety Services
Corporate Patient Safety Team	Governance and Risk Management Committee

TABLE OF CONTENTS

1. INTRODUCTION

Risk management is an integral part of the University Hospitals Bristol NHS Foundation Trust's approach to quality improvement and good governance.

Areas of risk within the Trust include the following:

- Employment risks, (recruitment, training, health & safety);
- Clinical risks, (clinical quality and safety for patients);
- Environmental risks, (property, plant and equipment);
- Financial risks, (income, budgetary control);
- Service risks, (business planning, performance, delivery);
- Strategic risks, (external confidence and Trust reputation, statutory duties);
- Information risks (collection, storage and use of data);
- Corporate risks (legal, regulatory and statutory governance duties)

This policy therefore applies to all staff.

2. PURPOSE

As a unitary Board of a foundation trust, the Trust Board is the key driver for risk management of the organisation. Nonetheless, there are a number of external drivers for risk management which impact on the Trust, including: Monitor's Compliance Framework 2009/10, National Patient Safety Agency, NHS Litigation Authority, Care Quality Commission, contractual arrangements with commissioners, national patient safety campaigns, and local accountability arrangements with foundation trust governors and members.

It is widely recognised that an effectively planned, organised and controlled approach to risk management is a cornerstone of sound management practice. Good risk management awareness and practice at all managerial levels is a key success factor in ensuring that the Trust is able to meet its performance standards.

From a strategic perspective, the Trust aims to fully understand the risks to the organisation and to ensure that risk reduction/mitigation strategies are developed to address the risks, and provide assurance to the organisation that the controls are in place to reduce those risks, are working effectively.

The system of internal control should:

- Be embedded in the operation of the organisation and form part of its culture

- Be capable of responding quickly to evolving risks
- Include procedures for reporting any significant control failings immediately to appropriate levels of management

2.1 AIMS

The aim of this strategy is to provide a framework and structured processes for the identification and management of risk across all activities. These processes will allow for staff to implement necessary actions to resolve risks locally and facilitate reporting to more senior levels of management.

2.2 OBJECTIVES

Risk management is a pro-active approach which is ongoing and involves all staff and in all areas of the organisation. It is designed to:

- address the risks of all the activities of the Trust;
- identify the risks that exist;
- assess those risks for potential frequency and severity;
- eliminate the risks that can be eliminated;
- reduce the effect of those that cannot be eliminated;
- maintain contingency plans for the risks that remain;
- make provision for the financial consequences of the risks that remain;
- provide for continual monitoring and review of those risks

Risk Management is defined as the process where all risks to which an organisation is exposed are identified, examined, assessed and evaluated and action is taken to reduce or eliminate risks to patients, visitors and staff. In addition risk management involves continual monitoring and review of actions taken which reduce risk.
The Trust's integrated risk management system:

- Identifies and manages risks that threaten the ability of the Trust to meet its objectives
- Ensures that all Risk Registers are maintained and reflect the potential risks in delivering their objectives
- Ensures that all risk assessments are carried out in a consistent manner
- Helps the Trust meet all its statutory, regulatory and legal obligations

2.3 RISK MANAGEMENT

2.3.1 Identifying and measuring risk

Risk management is a multi-faceted process, appropriate aspects of which are often best carried out in discussion with a team, committee or Board. It is an iterative process that can contribute to organisational improvement and assist in the building of patient safety knowledge and capability. Risk management forms an integral part of good corporate governance and management practice which requires the Trust to have in place a system to explicitly and quantifiably assess risk[1] and to systematically record:

- The process and outcome of a risk assessment
- The process and outcome of decision making
- The evidence base or rationale for the decision
- The evidence base for the provision of assurance concerning risk controls

Individuals or groups can identify the principal objectives of regulatory and quality frameworks such as: Monitor's Compliance Framework (2009), the Standards for Better Health (2006) and Care Quality Commission registration requirements, which they are required to meet e.g. safety, clinical and cost effectiveness, governance, patient focus, accessible and responsive care, care environment and amenities and public health. Risk assessments undertaken by the multidisciplinary working parties following the risk assessment format should consider the following:

- What are the hazards/risks?
- What is the source of the hazard/risk? i.e.: patient safety incident, compliance with national guidance, etc
- Who or what might be harmed?
- What is already being done to reduce the risk/existing control measures?
- What further action is necessary to ensure there are adequate controls/barriers in place?
- What is the level of the risk and the category?
- What is the action that needs to be taken?

The flow chart in Figure 1 illustrates how risks are managed within the Trust:

[1] All types of risk not limited to clinical risk

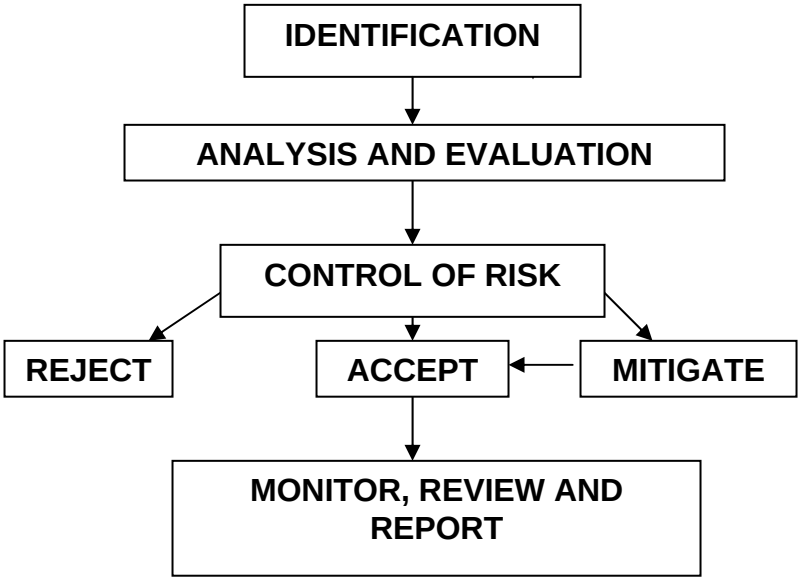


Figure 1: Risk Management Process

Following the identification of risks there must be an assessment of the risks against a set of criteria, including likelihood and impact, in order to determine the level of risk. This is achieved using the definitions, matrix and guidance at Appendix C.

2.3.2 Risk Acceptance / Rejection / Mitigation

Reject:	Putting systems in place to remove the risk
Mitigate	Putting systems in place to reduce the risk to an acceptable level.
Acceptance:	Accept that any residual risk requires further assessment.
Monitor and review:	Acknowledge any residual risk which cannot be further mitigated and monitor risk impact using the Risk Register. Contingency plans must be in place should the risk be realised. • identify and monitor the impact of the risk • review the effectiveness of the actions and controls in place • establish review plan with timescales identified
Communicate and	• identify who is affected by the risk

Consult	• identify who needs to know about the risk

The reporting structure of risk and assurance committees where key risk decisions are made is at Appendix D.

3. DEFINITIONS

A hazard is defined as: *'A situation which poses a level of threat to life, health, property or environment.'*

A risk is defined as: *'The likelihood of the potential harm of a hazard being realised.'*

The consequences of unmanaged risks can be damaging and may threaten the achievement of Trust objectives.

4. ROLES AND RESPONSIBILITIES (Duties)

Risk and Assurance Structure

The Trust has adopted an integrated governance approach, which covers all its activity and associated risks, and is outlined within this strategy. The strategy defines standards for governance, performance, financial management and the provision of service by which the organisation is monitored and controlled, in order to achieve its objectives and meet the necessary standards of accountability, probity and openness.

The Trust manages its services through a clearly defined accountability system based on:

- Clear committee structure reporting through to the Trust Board (Appendix D)
- Clear and effective management lines of accountability
- Robust performance management arrangements
- Involvement of clinical and other staff in management and decision making
- Regulatory requirements

4.1 Board Committees

Board and specified governance committees exist to consider a range of policy and strategic issues covering both clinical and non-clinical activities, and provide a forum for identifying and addressing areas of risk.

These structures are designed to ensure that there is clear accountability and that information flows quickly to the Board and its committees. In this way the Trust can identify patterns and promote best practices throughout the organisation. The identification of roles and responsibilities provides a culture of transparency of decision making.

These structures and channels of communication are complemented by links between them, provided by individuals operating within the network; including Executive Directors, Corporate and Operational leads, and the Divisional Patient Safety, Health & Safety and Clinical Governance Leads, the Director of Legal Services, the Head of Health & Safety Services and Chief Internal Auditor.

The links to terms of reference of all of the Trust committees concerned with risk and assurance activities are at Appendix E.

4.1.1 Trust Board

The Board is committed to managing risk and to controlling its activities in a manner which enables the organisation to provide the safest possible care to patients and to ensure compliance with its terms of authorisation, applicable laws and regulations while avoiding or reducing risks which could cause loss or reputation damage. It is accountable for the development of a safety culture that delivers improvement.

To achieve this, the Board has established a process for the identification, evaluation and management of risks as part of a comprehensive assurance framework.

The Trust Board has corporate responsibility for ensuring appropriate standards and policies are available for guidance and for receiving reports of risks which it is not possible for the division to resolve.

Leadership and delivering improvement are two key strands of the Board's risk management focus:

Board leadership:

- Developing explicit strategic priorities and goals
- Providing demonstrable leadership
- Ensuring executive accountability

Delivery of improvement:

- Monitoring progress and drive execution of plans
- Establishing and monitoring explicit performance indicators
- Building patient safety and improvement knowledge and capability

- The Trust Board will receive regular reports from Board Committees which ensures significant risks are escalated.

4.1.2 Audit and Assurance Committee

The Trust's Audit and Assurance Committee is a sub-committee of the Board which reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical).

In particular, the Committee reviews the adequacy of:

- All risk and control related disclosure statements (in particular the Statement on Internal Control and declarations of compliance with the Standards for the Better Health and NHS Litigation Authority Standards), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements.
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service.

4.1.3 Governance and Risk Management Committee

The Governance and Risk Management Committee is a sub-committee of the Trust Board and is responsible for establishing a strategic approach to governance and risk management across the organisation, ensuring that the approach is pro-active. The Committee is also responsible for the overall co-ordination of governance and risk management activity. It ensures that the necessary processes are in place to achieve compliance with statutory and regulatory requirements and to protect the Trust's patients, staff and assets.

4.1.4 Clinical Risk Assurance Committee

This committee has the corporate function of coordinating clinical risk management and assurance for the Trust. This includes ensuring there is consistent approach to the identification, assessment, management and monitoring of clinical risks, clinical incidents and near misses. This committee is responsible for the organisation of the patient safety walk-arounds and monitoring and implementation of national patient safety initiatives. A number of

clinical governance committees report in to the Clinical Risk Assurance Committee as shown in Appendix D.

4.1.5 Health & Safety and Fire Safety Committee

The aim of the Trust Health & Safety and Fire Safety Committee is to provide a forum for effective consultation on appropriate health and safety matters. The objective of the Committee is to promote co-operation between the Trust and its employees in instigating, developing and carrying out measures to ensure the health and safety at work of all employees. There are several sub groups of this committee which report into this committee on a quarterly basis.

4.1.6 Divisional Structure

The Trust has adopted a divisional management model. Within this model the Trust Executive Group plays a central role in enacting the Trust's strategy and risk and assurance process, monitoring Divisional performance and feeding back through the relevant work streams or to the Governance and Risk Management Committee any significant issues and learning points raised through the Divisional monitoring and review process.

University Hospitals Bristol NHS Foundation Trust is divided into five clinical Divisions plus a Trust Services Division. The clinical Divisions are:

- Division of Surgery, Head and Neck
- Division of Women's and Children's Services
- Division of Medicine
- Division of Specialised Services
- Division of Diagnostics and Therapies

Each Division is independent with its own divisional board led by a Head of Division, Lead Doctor, Head of Nursing or Midwifery or Heads of Diagnostic and Therapy Services, and a Divisional Manager. The Trust Services divisional board comprises the Executive Team and Directors of non-clinical services.

4.1.7 Governance and Assurance Team

The Trust Governance and Assurance Team, which includes corporate Patient Safety Managers, will:

- ensure that all reporting to Trust Committees is co-ordinated
- provide reports, training and on-going support in relation to Ulysses database and risk registers
- provide additional advice as required

4.2 Duties of Individuals

All staff are responsible for managing risk. They have a key role in identifying and reporting risks and incidents promptly thereby allowing risks to be managed and added to the risk register if appropriate. In addition, staff have a responsibility for taking steps to avoid injuries and risks to patients, staff, and visitors. In fulfilling this role, which may involve raising concerns about standards, staff might consider the need for reporting under the Trust's Speaking Out Policy (link to Policy http://nww.avon.nhs.uk/dms/download.aspx?did=7822**)**

4.2.1 Chief Executive (Accounting Officer)

The Chief Executive is the Accounting Officer for risk management within the Trust and is supported by the Chief Nurse for overall governance and assurance, and all of the Executive Directors for each of their designated areas of responsibility, which includes those allocated healthcare standards (Appendix F). The Chief Executive is responsible for the Trust Risk Register.

The Chief Executive will sign an annual Statement of Internal Control, outlining the Trust's governance and assurance systems, and a Statement of Accounting Officer's Responsibilities which are submitted to Monitor, the independent regulator of NHS foundation trusts, and published in the Trust's annual report.

4.2.2 Chair of Audit and Assurance Committee.

There is a named Non Executive Director who has responsibility for risk management and chairs the Audit and Assurance Committee.

4.2.3 Chief Nurse

The Chief Nurse supports the Chief Executive in respect of risk management and is the executive lead with for managing the strategic development and implementation of integrated governance. With the Chief Nurse portfolio of responsibilities are the key safety areas of infection control and safeguarding children and vulnerable adults. The Chief Nurse is the named executive director for maternity services.

4.2.4 Medical Director

The Medical Director is responsible for patient safety across the Trust and chairs the Clinical Risk and Assurance Committee (CRAC). With the Medical Director portfolio of responsibilities are the key safety areas of clinical quality and associated risk, serious untoward incidents, information governance and production of quality accounts.

4.2.5 Assistant Director of Governance and Risk Management

The Assistant Director of Governance and Risk Management supports the Chief Nurse and Medical Director in their risk management duties.

4.2.6 Executive Directors

All Executive Directors have corporate responsibility for risk management within the activities of the Trust. This is exercised through attendance at Board Committee meetings, through the assurance framework and through reporting on compliance with the healthcare standards, and is monitored by the Audit and Assurance Committee and Governance and Risk Management Committee.

4.2.7 Head of Health & Safety Services

The Head of Health & Safety Services advises on health and safety issues and reporting serious non clinical incidents to the Governance and Risk Management Committee and on to the Health & Safety Executive.

4.2.8 Director of Legal Services

The Director of Legal Services reports to the Governance and Risk Management Committee on all matters relating to the Freedom of Information Act, Human Rights and other legal matters.

4.2.9 Heads of Division and Divisional Managers

Each Division has the prime responsibility for identifying and addressing risks within its area of activity. Heads of Division and Divisional Managers are responsible for implementing and monitoring any identified and appropriate risk management control measures within their designated area(s) and scope of responsibility. This will involve reviewing and updating the divisional risk register at divisional board meetings. The Heads of Division are supported in this responsibility by identified governance leads.

4.2.10 Heads of Nursing/Midwifery/ Diagnostic and Therapy Services

The Heads of Nursing/Midwifery/ Diagnostic and Therapy Services are key members of the Divisional Governance Committees and are jointly responsible for the implementation of the Divisional Risk and Assurance arrangements.

4.2.11 Lead Doctors

Lead doctors are key members of the Divisional Governance Committees and are jointly responsible for the implementation of the Divisional Risk and Assurance arrangements for their specialties.

4.2.12 Divisional Managers

All managers in the division or service area will ensure that staff are aware of the risk management processes and report risks for consideration. There is a requirement, where significant risks have been identified and where local resources/control measures are considered inadequate, that Divisional Managers report such risks to the Governance and Risk Management Committee. (Divisional Expectations Assurance and Governance – 2008)

4.2.13 Divisional Patient Safety Leads

Divisional Patient Safety Leads are responsible for patient safety relating to activity within their divisional locations and are responsible for communication between Trust and Divisional Committees. They are informed of all 'High Risk'. 'Avoidable Catastrophic' or 'Serious Untoward Incident' occurring within their Division of responsibility and liaise with the relevant Patient Safety Teams. They are also responsible for building patient safety and improvement knowledge and capability within their division.

4.2.14 Patient Safety Managers/Advisors

Patient Safety Managers are responsible for advising and supporting on patient safety issues through linking with risk leads within divisions. In addition, they are responsible for reporting serious incidents to the Clinical Risk Assurance Committee.

4.2.15 Divisional Health & Safety Leads

Appointed Divisional Health & Safety leads will attend/advise the Trust Health & Safety and Fire Safety Committee and present compliance reports against incident reduction targets on a quarterly / annual basis to their Divisional Board.

5. RISK REGISTERS

The Risk Register is a vital tool in the reporting and monitoring of controls within the assurance framework and provides a record of all types of risk that impact upon the Trust's successful achievement of standards and objectives.

Any identified risks and associated action plans are cross-referenced to Healthcare Standards and the Assurance Framework. These are reviewed by the relevant Committees and all identified high risks are reviewed by Board Sub-Committees.

A list of standards and committees responsible for review of risks associated with the standards is attached at Appendix G. A table summarising the structures, accountabilities and reporting framework for Risk Registers is attached at Appendix H.

5.1 Population of Risk Registers

The Risk Register is populated by risks associated with all activities of the Trust such as:

- Safety
- Clinical and Cost Effectiveness
- Governance
- Patient Focus
- Accessibility and responsive care
- Care Environment and Amenities
- Public Health

5.2 Sources of Risks

The source of the risks can be identified by:

- Strategic decision making
- Capital and service development projects
- Performance monitoring
- Regulatory compliance
- Individuals or working parties
- Complaints and Claims
- Near miss/incident (clinical and non clinical) reporting
- Proactive risk assessments
- Divisional Risk Registers see section 5.4.4
- Health and Safety Executive investigations
- Potential / actual changes in service provision

Other sources including:

- Services user satisfaction surveys
- National Service Frameworks
- Service – wide risk reviews
- National Confidential Enquiries
- Standards for Better Health
- Audit Commission
- National Patient Safety Agency alerts/ CMO alerts
- National Institute for health and Clinical Excellence (NICE)
- Patient Safety First
- Standards for Better Health
- External assessments e.g. Clinical Negligence Scheme for Trust, Human Fertilisation Embryology Authority
- Quality Care Commission Reports
- Potential / actual changes in services provision

This list is not exhaustive.

5.3 Description of the risk.

It is important that the assessors fully describe the risk, provide evidence that the risk has impact on the service and, where possible, explain the context of the risk in referring to national or international reports / incidents. This will enable the clinical governance committee, Divisional Management Team, Divisional Board and the trust Clinical Risk Assurance Committee to understand the risk which will enable:-

- The addition of further controls which the original assessors were unaware.
- The additional actions
- Make an assessment of the actual risk.
- Make a judgment on what could be considered an acceptable target residual risk

5.4 Risk Register Management

The Trust Risk Register comprises nine separate registers from the following areas:

- Corporate (Trust Board)
- Trust-wide
- 5 Clinical Divisions
- Information Management and Technology
- Estates and Facilities

5.4.1 Corporate Risk Register

The Corporate Risk Register is owned by the Trust Board and comprises high level risks to the achievement of Trust objectives and duties. On a quarterly basis the Trust Board receives a report on any changes to the risks or any additions to the register. The Trust Board is required to approve the register and to accept residual risk levels.

5.4.2 Trust-wide Risk Register

The Trust-wide risk register is made up of those risks arising in more than one division or across the Trust. This register allows for co-ordination of action plans in relation to common risks and helps to reduce duplication of effort and ensure consistency. The Governance and Risk Management Committee reviews the register on a quarterly basis. A report is made to the Audit and Assurance Committee on a quarterly basis.

5.4.3 Divisional Risk Registers

The remaining 7 registers comprise those risks arising in the division or service area. These registers are reviewed by the Divisional Boards or management teams of the service area. The Governance and Risk Management Committee reviews all high risks on a quarterly basis and additionally each division presents an update on the full register on a quarterly rotational basis.

The Audit and Assurance Committee receives a report on the review of these registers on a quarterly basis via submission of minutes of Governance and Risk Management Committee.

5.4.4 Identifying Trust-wide risks from Divisional Risk Registers

Some risks are easily identified as Trust-wide risks e.g. norovirus outbreak.
The decision for when a risk identified in more than one Division becomes a Trust-wide risk rests with the Governance and Risk Management Committee. All committees in Appendix D should review all risks mapped to their core standards as set out in Appendix G, quarterly for assessment of closure or moving to Trust wide.
General guidance is that if the same risk is identified in at least two divisions it should be moved to Trust-wide. Non-clinical Trust-wide risks are identified from divisional and non-clinical committee reports into Governance and Risk Management Committee.

6. RISK MANAGEMENT TRAINING

The importance of risk management is reflected by the inclusion of risk management awareness within Trust Induction, attendance at which is compulsory for all staff.

The Trust has conducted a comprehensive Training Needs Analysis for Risk Management and has developed a Risk Management Training Plan based on a Risk Training Matrix which identifies different levels of training required for staff in different roles - link to Risk Management Training Needs Analysis, Training Plan and Training Matrix http://nww.avon.nhs.uk/dms/download.aspx?did=10736

Risk management training will include risk assessment, incident reporting and management of risk within their working environment for all staff and more detailed information for staff in key areas of risk management and patient safety relevant to their roles.

The Trust Board will specifically receive training in their responsibilities for the management of strategic and organisational risk relevant to the Board's status as the first line of regulation for the Trust.

6.1 Risk Management Strategy Dissemination

This strategy will be disseminated by the Assistant Director of Governance and Risk Management through:

- Governance and Risk Management Committee
- Executive Directors for dissemination their teams
- Trust Board
- Divisional Managers and Heads of Division for dissemination throughout their division
- Newsbeat with link to strategy document

7. MONITORING COMPLIANCE AND EFFECTIVENESS OF RISK MANAGEMENT STRATEGY – Monitoring Table

NHSLA Requirement	Criteria	Minimum Requirements	What is the Evidence	Who Reviews the Evidence and Frequency	Who Prepares the Evidence and frequency
The Trust is required to have approved documentation setting out the approach to Risk Management	Organisation-wide Risk Management Strategy 2009-2012	a) Organisational risk * management structure detailing all those committees/sub-committees/groups which has some responsibility for risk	Terms of Reference for Committees	Chairs of Committees. At least bi-annually – more often as necessary	Chairs of Committees
		b) Process for board or high level committee review of the organisation-wide risk register	Minutes and papers of Board Meetings	Quarterly Trust Board review of corporate risk register	Quarterly – Lead PA for Governance and Assurance
			Minutes and papers of Governance and Risk Management Committee	Quarterly review of Trust-wide and non-clinical risks	Quarterly – Lead PA for Governance and Assurance
			Minutes and papers of Clinical Risk Assurance Committee	Monthly review of all high risk clinical incidents and related risk register	Monthly Trust Patient Safety Manager
			Minutes and papers of Health and Safety and Fire Committee	Health and Safety and Fire Committee	Head of Health and Safety Services

† Risk includes but is not limited to incident reports, risk assessments and risk register reviews

NHSLA Requirement	Criteria	Minimum Requirements	What is the Evidence	Who Reviews the Evidence and Frequency	Who Prepares the Evidence and frequency
		Risk register reports to include details of: • Source of risk • Risk description • Risk score • Action plan • Date of review • Residual risk score	Review of sample of risk register reports	Division or Corporate Lead for element of Risk Register	Annually as a minimum Assistant to Division or Corporate Lead for Risk Register
		c) Process for the management of risk† locally, which reflects the organisation-wide risk management strategy	Minutes and Papers of Divisional Board Meetings Minutes and papers of corporate patient safety committees	Divisional Board	Divisional Manager
		d) Duties of the key individuals for risk management activities • Chief Executive - Accounting officer for risk management within the Trust who will sign an annual Statement on Internal Control. • Executive Lead for risk management and for managing the strategic	Minutes and papers of Governance and Risk Management Committee and Terms of Reference	Quarterly – Governance and Risk Management Committee	Quarterly – Lead PA for Governance and Assurance

NHSLA Requirement	Criteria	Minimum Requirements	What is the Evidence	Who Reviews the Evidence and Frequency	Who Prepares the Evidence and frequency
		development and implementation of integrated governance • Medical Director is responsible for patient safety across the Trust and chairs the Clinical Risk Assurance Committee. • Assistant Director of Governance and Risk Management who supports the Chief Nurse and Medical Director in their risk management duties. • Executive Directors have corporate responsibility for risk management within activities of the Trust. • Head of Health and Safety Services advises on health and safety issues and reporting serious non clinical incidents. • Director of Legal Services reports to the Governance and Risk Management	review Minutes and papers of Governance and Risk Management Committee and Terms of Reference review	Quarterly – Governance and Risk Management Committee	Quarterly – Lead PA for Governance and Assurance

NHSLA Requirement	Criteria	Minimum Requirements	What is the Evidence	Who Reviews the Evidence and Frequency	Who Prepares the Evidence and frequency
		Committee, • Named Non-Executive who chairs the Audit and Assurance Committee	Minutes of Audit and Assurance Committee	Quarterly – Audit and Assurance Committee	
		e) Authority of all managers with regard to managing risk • Heads of Nursing/Midwifery/ Diagnostic and Therapy Services jointly responsible for implementation of the Divisional Risk Assurance arrangements. • Lead Doctors are key members of the Divisional Governance Committees and are jointly responsible for the implementation of the Divisional Risk and Assurance arrangements. • Divisional Managers will	Minutes and Papers of Divisional Board Meetings Minutes and Papers of Divisional Governance Committees Minutes and Papers of Governance and Risk Management Committee	Monthly Divisional Board Divisional Governance Committees Quarterly Governance and Risk Management Committee	Divisional Managers Chair of Divisional Governance Committees Quarterly – Lead PA for Governance and Assurance

NHSLA Requirement	Criteria	Minimum Requirements	What is the Evidence	Who Reviews the Evidence and Frequency	Who Prepares the Evidence and frequency
		ensure that staff are aware of the risk management processes and report risks for consideration. Divisional Managers report risks to the Governance and Risk Management Committee. • Divisional Patient Safety Leads are responsible for the local building with respect to patient safety and for communication between the Trust and Divisional Committees. • Patient Safety Managers/Advisors are responsible for advising and supporting on patient safety issues through linking with risk leads within Divisions.	Minutes and Papers of Divisional Board Meetings	Monthly Divisional Board	Divisional Managers

NHSLA Requirement	Criteria	Minimum Requirements	What is the Evidence	Who Reviews the Evidence and Frequency	Who Prepares the Evidence and frequency
		• Divisional Health and Safety Leads will attend/advise the Trust Health and Safety and Fire Committee and report to their Divisional Board.	Minutes and Papers of the Trust Health and Safety and Fire Committee and Minutes and Papers of Divisional Board Meetings.	Monthly Trust Health and Safety and Fire Committee and Monthly Divisional Board	Trust Health and Safety Advisor/Divisional Managers

8. REFERENCES

Related UH Bristol Policies:

1. Women's Services Risk and Assurance Strategy 2009-2010

2. Policy on the Management of Incidents. (2008). http://nww.avon.nhs.uk/dms/download.aspx?did=3900

3. Serious Untoward Incident Standard Operating Procedure. (2009). http://nww.avon.nhs.uk/dms/download.aspx?did=9637

4. Policy for Cross-Organisational Clinical Incident Reporting and Investigation (2007). http://nww.avon.nhs.uk/dms/download.aspx?did=8059

5. Incidents, Complaints, Patient Advice and Liaison Service and Claim Joint Policy Statement. (2008). http://nww.avon.nhs.uk/dms/download.aspx?did=7052

6. Patient Safety Strategy (2008) http://workspaces/Committees/ClinicalRiskAssuranceCommittee/14th%20October%202008/Document%20Library/1/06a.%20Patient%20Safety%20Strategy.pdf

7. Risk Assessment Policy http://nww.avon.nhs.uk/dms/download.aspx?did=5728

References:

1. Assessment for Improvement/Standards for Better Health; 2006: Department of Health www.doh.org

2. The NHS Improvement Plan; 2006: Department of Health www.doh.org

3. Making it Happen – a Guide for Risk Managers on How to Populate a Risk Register. Controls Assurance Support Unit

4. Foundation Trust Code of Governance. Monitor 2006

5. The Compliance Framework for NHS Foundation Trusts. Monitor 2009.

6. The How to Guide for Leadership for Safety. Patient Safety First Campaign. 2008.www.patientsafetyfirst.nhs.uk

APPENDIX A

EQUALITY IMPACT ASSESSMENT SCREENING FORM			
Title: Risk Management Strategy			
Author: Anne Reader		**Division: Trust wide**	**Date: 21 June 2009**
Document Class: Strategy	**Document Status: v 1**	**Issue Date: May 2009**	**Review Date: 2010**

What are the aims of the document?
To provide a framework and structured processes for the identification and management of risk across all activities.

What are the objectives of the document?
Risk management is a pro-active approach which is ongoing and involves all staff and in all areas of the organisation. It is designed to:

- address the risks of all the activities of the Trust;
- identify the risks that exist;
- assess those risks for potential frequency and severity;
- eliminate the risks that can be eliminated;
- reduce the effect of those that cannot be eliminated;
- maintain contingency plans for the risks that remain;
- make provision for the financial consequences of the risks that remain;
- provide for continual monitoring and review of those risks

How will the effectiveness of the document be monitored?
By the Trust's Governance and Risk Management Committee and as set out in Section 7 of the document.

Who is the target audience of the document (which staff groups)? All staff
Which stakeholders have been consulted with and how? Governance and Risk Management Committee members Corporate Patient Safety Team Divisional and Trust Patient Safety Advisors Head of Health & Safety Services
Who is it likely to impact on? [✓] Staff [✓] Patient [✓] Visitors [✓] Carers [ ] Other (please specify):

Does the policy/strategy/function or proposed change affect one group more or less favourably than another on the basis of:	**Yes or No**	**Give reasons for decision**	**What evidence was examined?**
Race	No	The strategy itself impacts on a process rather than individuals and is to be applied consistently to all risk management within the Trust. When individuals carry out risk assessments on situations/services and put in place mitigation, they should apply a situation/service specific equality impact assessment.	

Does the policy/strategy/function or proposed change affect one group more or less favourably than another on the basis of:	Yes or No	Give reasons for decision	What evidence was examined?
Ethnic Origin (including gypsies and travellers)	No	As above.	
Nationality	No	As above.	
Gender (including transgender)	No	As above.	
Culture	No	As above.	
Religion or belief	No	As above.	
Sexual Orientation (including lesbian, gay, bisexual and transgender)	No	As above.	
Age	No	As above.	
Disability (including learning disability, physical, sensory impairment and mental health)	No	As above.	
Socially excluded groups (e.g. offenders, travellers)	No	As above.	
Human Rights		As above.	
Are there opportunities for promoting equality and/or better community relations? **NO** If YES, please describe:			

Please state links with other relevant policies, strategies, functions or services: **This strategy applies to all aspects of the Trust's operations.** **Adverse Incident Policy,** **Serious Untoward Incident Policy,** **Health & Safety Policy** **Risk Assessment Policy**	
Action Required:	
Action Lead:	To be delivered by when:
Progress to date:	
Next steps:	
How will the impact on the service/policy/function be monitored and evaluated?	
Person completing the assignment: **Anne Reader**	Date: **21st June 2009** Review **Date: 2010**

APPENDIX B

Methodology for defining the level of risk

Grading risks will establish the potential impact the risk could have on the organisation and identify the reporting requirements. The risk assessor should grade the risk using the risk matrix, the likelihood table and the most appropriate descriptor should be selected from the consequence table. This can be subjective and it is vital that wider risk assessment knowledge and expertise is sought where appropriate.

Risk Assessment Steps

Step 1: **Assess risk likelihood using Table 1**

Step 2: **Assess risk consequence using Table 2**

Step 3: **Grade the risk using the scoring system in the Risk Assessment Grid Table 3**

Step 4: **If risk unacceptable, consider entering in Risk Register. Report high risks to appropriate Divisional or Corporate Lead.**

Step 5: **Determine and apply controls**

Step 6: **Use Table 4 to determine the effectiveness of controls on original risk assessment.**

Step 7: **Assess residual risk by combining the outcomes of Table 3 and Table 4**

Step 8: **Update Risk Register with residual risk score. Report residual high risks to appropriate Divisional or Corporate Lead. Set date of next review of risk.**

Table 1: Likelihood

Level	Description	Guidance
1	Rare	Not expected to occur for years
2	Unlikely	Expected to occur at least annually
3	Possible	Expected to occur at least monthly
4	Likely	Expected to occur at least weekly
5	Almost Certain	Expected to occur at least daily

Table 2 Consequence Score

Choose the most appropriate descriptor for the risk issue you have identified from the left hand side of the table. Working along the row, what could happen if this risk were to materialise?					
Descriptor	**Insignificant**	**Minor**	**Medium**	**Major**	**Catastrophic**
Objectives / Projects	Insignificant cost increase / schedule slippage. Barely noticeable reduction in scope or quality	< 5% over budget / schedule slippage. Minor reduction in quality / scope	5 -10% over budget / schedule slippage. Reduction in scope or quality requiring client approval	10 - 25% over budget / schedule slippage. Doesn't meet secondary objectives	> 25% over budget / schedule slippage. Doesn't meet primary objectives
Injury	Minor injury not requiring first aid	Minor injury or illness, first aid treatment needed	RIDDOR reportable	Major injuries, or long term incapacity / disability (loss of limb)	Death or major permanent incapacity
Patient Experience	Unsatisfactory patient experience not directly related to patient care	Unsatisfactory patient experience - readily resolvable	Mismanagement of patient care	Serious mismanagement of patient care	Totally unsatisfactory patient outcome or experience
Complaint / Claim Potential	Locally resolved complaint	Justified complaint peripheral to clinical care	Below excess claim. Justified complaint involving lack of appropriate care	Claim above excess level. Multiple justified complaints	Multiple claims or single major claim
Service / Business Interruption	Loss / interruption > 1 hour	Loss / interruption > 8 hours	Loss / interruption > 1 day	Loss / interruption > 1 week	Permanent loss of service or facility
Human Resources / Organisational Development	Short term low staffing level temporarily reduces service quality (< 1 day)	Ongoing low staffing level reduces service quality	Late delivery of key objective / service due to lack of staff (recruitment, retention or sickness). Minor error due to insufficient training. Ongoing unsafe staffing level	Uncertain delivery of key objective / service due to lack of staff. Serious error due to insufficient training	Non delivery of key objective / service due to lack of staff. Loss of key staff. Very high turnover. Critical error due to insufficient training
Financial	Small loss	Loss > 0.1% of budget	Loss > 0.25% of budget	Loss > 0.5% of budget(>	Loss > 1% of budget(>
Inspection / Audit	Minor recommendations. Minor non-compliance with standards	Recommendations given. Non-compliance with standards	Reduced rating. Challenging recommendations. Non-compliance with core standards	Enforcement Action. Low rating. Critical report. Multiple challenging recommendations. Major non-compliance with core standards	Prosecution. Zero Rating.Severely critical report
Adverse Publicity / Reputation	Rumours	Local Media - short term	Local Media - long term	National Media < 3 Days	National Media > 3 Days MP Concern (Questions in House)

Table 3: Risk Assessment Grid.

This utilises the 5x5 method of likelihood of occurring x severity of consequence if occurred. This approach is consistent with all the other assessments of risk done in the Trust.

Risk Assessments						
		Severity				
Likelihood		None	Minor	Moderate	Major	Catastrophic
	Scores	1	2	3	4	5
Almost Certain	5					
Likely	4					
Possible	3					
Unlikely	*2*					
Rare	*1*					

Risk Rating	
	High
	Moderate
	Low
	Very low

Table 4: Effectiveness of Controls.

No Effect	4	The controls in place will not affect the risk in any way or the Trust's has no control over the risk.
Low	3	There will be a minimal effect on the risk.
Medium	2	The controls identified will offset at least 50% of the chance of the risk becoming real.
High	1	In this case the controls will offset a large proportion of the expected risk.
Complete	0	The controls identified will contain the risk completely.

Table 5: Residual Risk

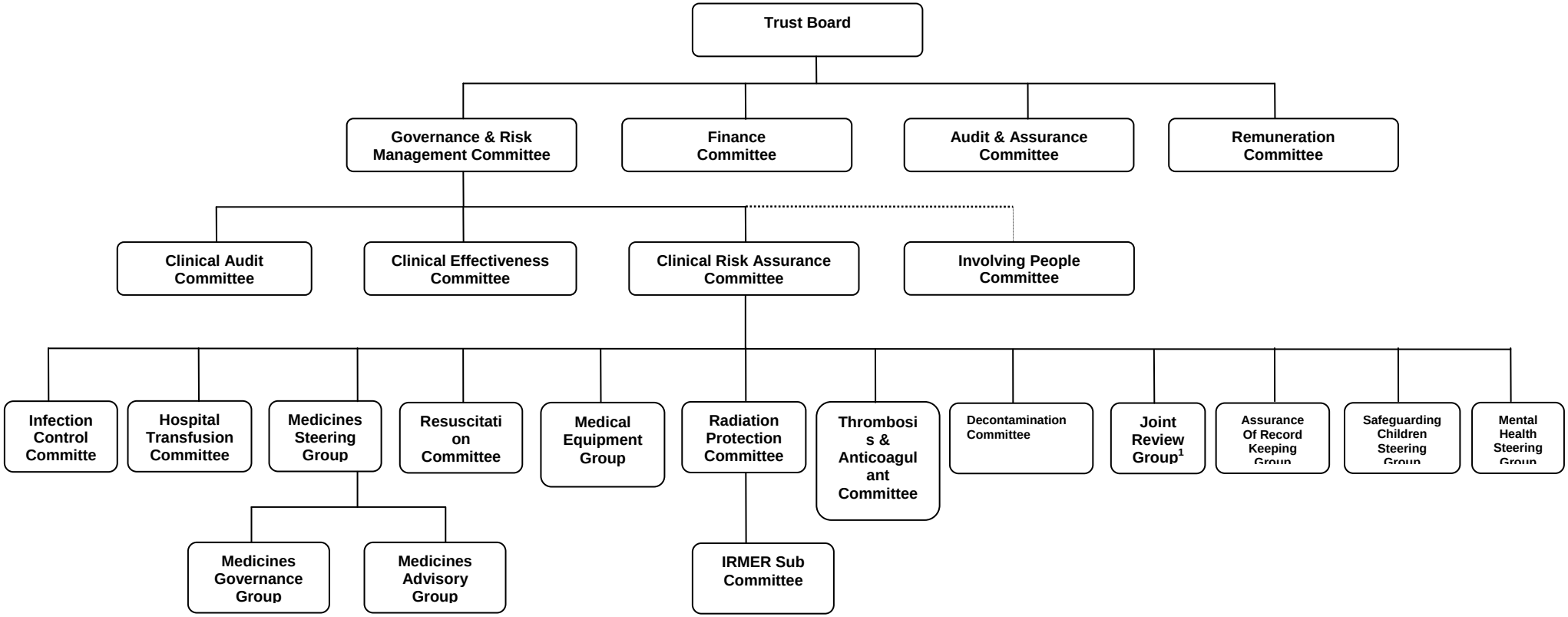
The residual risk is a measure of the risk posed to the Trust despite having a range of controls to minimise the risk. This is derived from the risk rating x the effectiveness of the controls in place.

Residual Risk					
		Risk Rating			
Effectiveness of controls	Grid Number	Very Low	Low	Moderate	High
		1	2	3	4
No Effect	4				
Low	3				
Medium	2				
High	*1*				
Complete	*0*				

Residual Risk Indicator	
	Serious Poorly Controlled Risk
	High
	Moderate
	Low
	Very Low

APPENDIX C

Risk Management Structure



OTHER GOVERNANCE GROUPS

- End of Life Steering Committee
- Palliative Care Steering Group
- Questionnaire Interview & Survey Group

Notes:

1. Joint Review Group - for Incidents, Complaints and Claims.

APPENDIX D

Terms of Reference of Board and Risk Committees

- Audit and Assurance Committee
  http://workspaces/Committees/AuditandAssuranceCommittee/Working%20Group%20Papers/Audit%20and%20Assurance%20-%20Terms%20of%20Reference.pdf

- Finance Committee
  http://connect/StaffAndLineManagersInfo/FinanceAndProcurement/boardreports/Documents/August08/Item5TOR26Aug08.docx

- Governance & Risk Management Committee
  http://workspaces/Committees/GovernanceandRiskManagementCommittee/Working%20Group%20Papers/June%202008%20Governanceand%20Risk%20Management%20Committee.pdf

- Clinical Risk Assurance Committee
  http://workspaces/Committees/ClinicalRiskAssuranceCommittee/Working%20Group%20Papers/CRAC%20Terms%20of%20Reference.pdf

- Clinical Effectiveness Committee
  http://workspaces/Committees/CEC/Working%20Group%20Papers/CEC%20Terms%20of%20Reference.doc

- Clinical Audit Committee
  http://workspaces/Committees/ClinicalAuditCommittee/default.aspx

- Trust Executive Group
  http://workspaces/Committees/TrustExecutiveGroup/Working%20Group%20Papers/Terms%20of%20Ref%20-%20TEG.doc

- Trust Operational Group
  http://workspaces/Committees/TOG/Working%20Group%20Papers/Forms/AllItems.aspx

APPENDIX E

Trust Executive Director Leads for the Assurance Framework

No.	Standard	Exec Lead
1a.	Healthcare organisations protect patients through systems that identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents	Medical Director
1b.	Healthcare organisations protect patients through systems that ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required timescales	Medical Director
2	Healthcare organisations protect children by following national child protection guidelines within their own activities and in their dealings with other organisations	Chief Nurse
3	Healthcare organisations protect patients by following National Institute for Health and Clinical Excellence (NICE) interventional procedures guidance	Medical Director
4a	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year on year reductions in Methicillin-Resistant Staphylococcus Aureus (MRSA)	Chief Nurse
4b	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all risks associated with the acquisition and use of medical devices are minimized	Medical Director
4c	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed	Chief Nurse
4d	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that medicines are handled safely and securely	Chief Nurse
4e	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment	Chief Operating Officer
5a	Healthcare organisations ensure that they conform to National Institute for Health and Clinical Excellence (NICE) technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care	Medical Director
5b	Healthcare organisations ensure that clinical care and treatment are carried out under supervision and leadership	Medical Director /

No.	Standard	Exec Lead
		Chief Nurse
5c	Healthcare organisations ensure that clinicians continuously update skills and techniques relevant to their clinical work	Medical Director / Chief Nurse
5d	Healthcare organisations ensure that clinicians participate in regular clinical audit and reviews of clinical services	Medical Director
6	Healthcare organisations cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met	Director of Corporate Development
7a&c	Healthcare organisations apply the principles of sound clinical and corporate governance. Healthcare organisations undertake systematic risk assessment and risk management	Chief Nurse
7b	Healthcare organisations actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources	Director of Workforce and Organisational Development
7e	Healthcare organisations challenge discrimination, promote equality and respect human rights	Director of Workforce and Organisational Development
8a	Healthcare organisations support their staff through having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services	Director of Workforce and Organisational Development
8b	Healthcare organisations support their staff through organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under-representation of minority groups	Director of Workforce and Organisational Development
9	Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required	Medical Director
10a	Healthcare organisations undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies	Director of Workforce and Organisational Development
10b	Healthcare organisations require that all employed professionals abide by relevant published codes of professional practice	Director of Workforce and

No.	Standard	Exec Lead
		Organisational Development
11a	Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare are appropriately recruited, trained and qualified for the work they undertake	Director of Workforce and Organisational Development
11b	Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in mandatory training programmes	Director of Workforce and Organisational Development
11c	Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in further professional and occupational development commensurate with their work throughout their working lives	Director of Workforce and Organisational Development
12	Healthcare organisations which either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied	Medical Director
13a	Healthcare organisations have systems in place to ensure that staff treat patients, their relatives and carers with dignity and respect	Chief Nurse
13b	Healthcare organisations have systems in place to ensure that appropriate consent is obtained when required, for all contacts with patients and for the use of any confidential patient information	Medical Director
13c	Healthcare organisations have systems in place to ensure that staff treat patient information confidentially, except where authorised by legislation to the contrary	Medical Director
14a	Healthcare organisations have systems in place to ensure that patients, their relatives and carers have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services	Chief Nurse
14b	…..to ensure that patients, their relatives and carers are not discriminated against when complaints are made	
14c	…..to ensure that patients, their relatives and carers are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery	
15a	Where food is provided, healthcare organisations have systems in place to ensure that patients are provided with a choice and that it is prepared safely and provides a balanced diet	Chief Nurse
15b	Where food is provided, healthcare organisations have systems in place to ensure that patients' individual nutritional, personal and	

No.	Standard	Exec Lead
	clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day	
16	Healthcare organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after care	Chief Nurse
17	The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services	Chief Nurse
18	Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably	Chief Operating Officer
20a	Healthcare services are provided in environments which promote effective care and optimise health outcomes by being a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation	Director of Workforce and Organisational Development
20b	Healthcare services are provided in environments which promote effective care and optimise health outcomes by being supportive of patient privacy and confidentiality	Chief Nurse
21a	Healthcare services are provided in environments which promote effective care and optimise health outcomes by being well designed	Chief Operating Officer
21b	and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises	Chief Nurse
22a&c	Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by cooperating with each other and with local authorities and other organisations. Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health	Director of Corporate Development
22b	Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by ensuring that the local Director of Public Health's annual report informs their policies and practices	Medical Director
23	Healthcare organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the national service frameworks (NSFs) and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections	Medical Director
24	Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations, which could affect the provision of normal services	Chief Operating Officer

No.	Standard	Exec Lead
OTHER DOMAINS OF THE ASSURANCE FRAMEWORK		
Finance		Finance Director
Service Performance		Chief Operating Officer
Strategy and Planning		Director of Corporate Development
Information Management and Technology		Finance Director

APPENDIX F

Individual and Committee Responsibilities for the Core Standards for Better Health

Safety	Clinical and Cost Effectiveness	Governance	Patient Focus	Accessible and Responsive care	Care Environment and Amenities	Public healt
Patient safety is enhanced by the use of health care processes, working practices and systemic activities that prevent or reduce the risk of harm to patients	Patients achieve health care benefits that meet their individual needs through health care decisions and services based on what assessed research evidence has shown provides effective clinical outcomes	Managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices ensure that probity, quality assurance, quality improvement and patient safety are central components of all of the activities of the health care organisation	Health care is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choice, and in partnership with other organisations (especially social care organisations) whose services impact on patient well being	Patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or of the care pathway	Care is provided in environments that promote patient and staff well-being and respect for patients' need and preferences in that they are designed for the effective and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients	Programmes and services are design and delivered in collaboration with a relevant organisatio and communities to promote, protect an improve the health population served a reduce health inequ between different population groups a areas
Clinical Risk Assurance Committee – C1a Medical Equipment Group – C1b/4b Safeguarding Children's Group – C2 Clinical Effectiveness Committee – C3 Infection Control Committee – C4a/4e	Clinical Effectiveness Committee – C5a Clinical Audit Committee – C5d Trust Operational Group – C6	Governance and Risk Management Committee – C7a&c/7b/8a/10a/10b /11a/12 Trust Executive Group – C7b/8a/10a/10b/11a/11b Equality and Diversity Steering Group – C7e Teaching and Learning Strategy Group – C8b/11c Information Governance Steering Group – C9	Privacy and Dignity Steering Group – C13a Clinical Risk Assurance Committee – C13b Information Governance Steering Group – C13c Governance and Risk Management Committee – C14 Nutrition Steering Group – C15 Involving People Committee – C16	Involving People Committee – C17 Trust Operational Group – C18	Health and Safety Committee – C20a Privacy and Dignity Group – C20b Trust Operational Group – C21a Infection Control Committee – C21b	Trust Executive Gro C22a&c Trust Operational G – C24

Note: Committees for Core Healthcare Standards 5b, 5c, 22b and 23 to be identified

APPENDIX G

SUMMARY OF RISK REGISTERS

RISK REGISTER	OWNER / ACCOUNTABLE BODY	INDIVIDUAL [S] / GROUPS RESPONSIBLE FOR MAINTAINANCE	REPORTING FRAMEWORK
1. Corporate	Trust Board	Six executive directors for individual risks, named according to the risk	Direct reporting quarterly to the Trust Board
2. Trust-wide	Governance and Risk Management Committee	Named Committee members in Terms of Reference	➢ Full quarterly review by the Governance and Risk Management Committee ➢ Audit and Assurance Committee overview via minutes of above quarterly
3. Medicine 4. Surgery Head and Neck 5. Women's and Children 6. Specialised Services 7. Diagnostic and Therapies	Divisional Boards	Divisional Manager accountable for ensuring process for risk register in place Named individuals in division responsible for maintaining the register *List of them kept by Personal Assistant Governance and Assurance, for training purposes*	➢ Updating at all Divisional Board o management group meetings ➢ Formal review at the above ***at leas quarterly*** ➢ New significant high risks and 'high' residual risks in exception report to Governance and Risk Management Committee quarterly ➢ Full register to Governance and Risk Management Committee on a cyclical basis ***Once every 18 months***
8. IM&T	Director of IM&T	Trust Services Division Board	
9. Estates and Facilities	Director of Estates and Facilities	Trust Services Division Board	