Trust Board Paper H

University Hospitals of Leicester NHS Trust

To:	TRUST BOARD
From:	MEDICAL DIRECTOR
Date:	5 MAY 2011
Healthcare standard:	Outcome 16 – Assessing and Monitoring the Quality of Service Provision

Title:	UHL STRATEGIC RISK REGISTER AND THE BOARD ASSURANCE FRAMEWORK (SRR/BAF)

Author/Responsible Director:
Risk and Assurance Manager/ Medical Director

Purpose of the Report:
To provide the Board with an updated Risk Management Strategy for endorsement.

The Report is provided to the Board for:

Decision		Discussion	
Assurance	X	Endorsement	X

Summary / Key Points:

- There is a requirement for a Board approved risk management strategy that is annually reviewed.
- The strategy has been subject to a UHL- wide consultation exercise that began in October 2010 with Executive Directors, clinical divisions and corporate directorates culminating in endorsement by the Governance and Risk Management Committee in February 2011and the Executive Team also in February 2011.
- The revisions reflect the Trust's recent (2010) restructuring and the requirement for a revised risk reporting framework in order to inform reconfigured Trust committees.

RECOMMENDATIONS:
The Trust Board is invited to:

a. Receive and note this report;
b. Approve the 2011 UHL Risk Management Strategy.

Strategic Risk Register No	**Performance KPIs year to date** **N/A**

Resource Implications (eg Financial, HR)
None

Assurance Implications
N/A

Patient and Public Involvement (PPI) Implications
N/A

Equality Impact
N/A

Information exempt from Disclosure
No

Requirement for further review ?
Yes. Annual review required

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: TRUST BOARD

DATE: 5 MAY 2011

REPORT BY: MEDICAL DIRECTOR

SUBJECT: UHL RISK MANAGEMENT STRATEGY 2011/12

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1. INTRODUCTION

1.1 There is a requirement for a Board approved risk management strategy that is annually reviewed and, when necessary, revised to ensure that it reflects best practice for managing risks and for compliance with external standards.

1.2 The strategy provides a framework within which organisational risks of all types can be identified, assessed for severity, recorded and actions for further control implemented. It describes the risk management roles and responsibilities of the Trust's high level committees, senior management teams, and other staff grades.

1.3 The strategy describes the processes to ensure that risks are systematically identified and assessed against objectives at all levels of the Trust using both a 'top down' and 'bottom-up' approach with operational risks being identified at a Clinical Business Unit (CBU) / department level and strategic (principal) risks to the Trust's strategic objectives identified and monitored at Trust Board level. Significant risk themes that have been captured on the operational risk register can be escalated to the strategic risk register if and when required. Strategic risks and mitigating actions are identified and regularly reviewed by the Trust Board via the UHL Strategic Risk Register / Board Assurance Framework (SRR/BAF).

1.4 A description of the UHL committee structure and risk reporting framework is included in the strategy to ensure that there is a clear understanding of the requirement for regular reporting of relevant risks to the high level Trust committees and divisional / directorate boards and that those committees understand their responsibility within the risk management process. It is understood that the UHL committee structure may be subject to further review and any changes will be incorporated in future revisions to the strategy.

1.5 The strategy has been subject to a UHL- wide consultation exercise that began in October 2010 with Executive Directors, clinical divisions and corporate directorates culminating in endorsement by the Governance and Risk Management Committee in February 2011and the Executive Team also in February 2011. A copy of the final version is attached at appendix 1.

2. OVERVIEW OF CHANGES

2.1 The revisions reflect the Trust's recent organisational restructuring and the requirement for a revised risk reporting framework in order to inform reconfigured Trust committees and the Board's attention is drawn to the changes since the previous version including:

- Changes to organisational structure (section 5.1).

- Revision of roles and responsibilities to reflect changes in light of the above (section 5.2).

- UHL committee structure and reporting requirements revised to reflect organisational changes (section 5.3). The UHL risk reporting framework (appendix 2) is attached to this report for information.

- The discipline of linking risks to local objectives is made more explicit.

- Reference to risks associated with significant partnerships and other external influences ('horizon scanning').

- Greater emphasis around risk management training, including risk awareness training for Trust board members and senior management teams (section 5.4).

- The Trust's risk appetite is defined in section 6.1 and rather than stating this as an arbitrary risk score it was felt more useful to provide descriptors for risks where the Trust will accept low risks and those where the Trust may be prepared to take more significant controlled risks.

- Monitoring of the Trust's key performance indicators as an additional tool for identifying risks is included in section 6.2.1

- The development and use of a Strategic Risk Register and Board Assurance Framework to inform the annual Statement on Internal Control (SIC) is referenced in section 6.5.

- Change to section 6.5.2 and 6.5.3 to read *'not less than four times per year'* as opposed to monthly.

- Reference is now made to NHSLA 'ARMS' and CNST Maternity risk pooling schemes and the Trust's current level of compliance in section 7.1.2. Reference to the Care Quality Commission is included in section 7.1.3.

3. The Trust Board is invited to: -

a. Receive and note this report;

b. Approve the 2011/12 UHL Risk Management Strategy.

P Cleaver
Risk and Assurance Manager
22 April 2011

Appendix 1

University Hospitals of Leicester NHS
NHS Trust

UHL RISK MANAGEMENT STRATEGY 2011/12

Approved By:	
Date Approved:	
Trust Reference:	
Version:	**2.0 (April 2011)**
Supersedes:	
Author / Originator(s):	Risk and Assurance Manager
Name of Responsible Committee/Individual:	**Peter Cleaver**
Review Date:	

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Review date and Details of changes made during review:

Strategy reviewed November 2010, February 2011 and April 2011. Changes to the previous version include:

- The identification of UHL's 'risk appetite' (section 6.1)
- Description of the organisational structure amended to reflect organisational changes. (section 5.1)
- Roles and responsibilities amended to reflect changes in light of the above (section 5.2).
- Committee Structure amended to reflect organisational changes (section 5.3)
- Revision of Key Performance Indicators (section7.2)

Changes to February 2011 revision

- Change in title to UHL Risk Management Strategy 2011.
- Change to section 6.5.2 to read 'not less than four times per year' as opposed to monthly.
- Change to section 6.5.3 to read 'not less than four times per year' as opposed to monthly.
- Section 7.1.2 now includes reference to NHSLA Acute Risk Management Standards and CNST risk pooling schemes.
- Section 7.1.3 now includes reference to Care Quality Commission (CQC).

Changes to April 2011 version

- Section 2.3 reference to the Trusts objectives and risks to their achievement (including risks of significant partnerships and other external influences).
- Section 2.5 bullet point one now includes reference to quality and performance management and objective setting.
- Section 5.2.4 final bullet point includes reference to identifying risks to the achievement of objectives.
- Section 6.2.1 includes 'horizon scanning' and risks associated with significant partnerships and other external influences.
- Section 11 now includes the following as supporting documents:
- UHL Performance Strategy.
- UHL Quality Strategy.
- UHL Maternity Risk Management Strategy

1. INTRODUCTION

1.1 The objective of this strategy is to ensure that the Trust's internal control environment enables it to manage risks arising from all types of activity including governance (incorporating Information Governance), finance and mandatory services, clinical, human resource, safety, environmental service development and significant business risks. Although termed a strategy the document should be treated as a policy providing 'must do' requirements in terms of risk management processes.

1.2 The University Hospitals of Leicester NHS Trust (hereafter referred to as "the Trust") is a large, complex and highly devolved organisation. Effective risk management in such an organisation requires a culture that engages all staff with processes and structures that are integral to all activities within the Trust. Risk management is not solely the responsibility of the Trust's Risk and Safety Managers but a responsibility for all members of staff and must be part of objective setting in every business and management planning cycle and of every service development. It relies on all members of staff identifying and minimising risks within a progressive, honest, learning and open environment where mistakes and untoward incidents are identified quickly and are acted upon in a positive and constructive manner.

1.3 For this to happen it is important that risk management is a systematic process, which uses existing expertise and structures along with clear direction, guidance and support from the Trust's senior management teams to directorates. This strategy and its supporting documents set out the Trust's framework for risk management.

1.4 The strategy recognises that there is a requirement for a Statement on Internal Control, informed by an embedded system of assurance via the Board Assurance Framework (BAF) and joined by a clear public declaration on compliance with the Care Quality Commission's (CQC) registration standards, which will require the Trust Board and nominated committees to consider the whole system of internal control.

2 POLICY AIMS / STATEMENT OF INTENT

2.1 The board of directors (hereafter known as the Trust Board) is committed to ensuring the implementation of risk management and is committed to embedding risk management into the culture of the organisation. This will enable an environment which minimises risk of all types and promotes the health, safety and well being of all those who enter or use its premises whether as staff, patients or visitors.

To that end the Trust shall:

- Work to ensure compliance with all appropriate legislative and statutory requirements.
- Ensure that risk management is embedded in the Trust's business processes.
- Undertake selective, regular and systematic audit of activities in order to identify, and, where possible, eliminate or at least minimise risk.
- Act appropriately on recommendations from inspecting bodies.
- Work to secure the full co-operation of all Trust staff in identifying and managing risk.
- Pursue business and financial opportunities within a managed, risk based framework.
- Promote evidence based practice in all aspects of care and treatment.
- Work to ensure that all Trust staff are trained and competent in their roles.
- Ensure that Trust staff (including Trust Board members) receive risk awareness training commensurate with their role.
- Foster an environment where members of staff are encouraged to report risks, incidents and 'near misses' and raise concerns about matters that affect the quality of care.

- Seek to secure optimum levels of investment (staffing and other resources) in the management of risk.

2.2 The Trust's goal is to take all reasonable steps in the management of risk with the overall objective of protecting patients, staff and assets.

2.3 The aim of this document is to ensure that all risks associated with the delivery of the Trust's objectives and the provision of the Trust's services are identified, and managed appropriately. In order to achieve this it is necessary to:

- Define a co-ordinated approach for the management of risk across all its activities. This will include risks arising from significant partnerships and other external influences.
- Promote safe working practices aimed at the reduction and elimination of risk, as far as is reasonably practicable;
- Define strategic and operational (i.e. divisional / directorate / CBU/ Department) objectives.
- Define responsibilities and accountabilities for risk management at every level of the organisation
- Raise awareness of risk and its management through a programme of communication, education and training;
- Promote continuous improvement through internal and external assessment;
- Maintain a pro-active, forward-looking approach;
- Develop and sustain a systematic and consistent approach to risk assessments.
- Identify where risk cannot be eliminated and ensure it is managed so that it is contained at an acceptable level. This is defined as the level at which the probability of an event occurring can reasonably be tolerated because the cost and / or disruption of further risk reduction outweighs the financial and non-financial benefits that could be achieved.

2.4 To achieve this, the strategy calls for structures and processes for risk management at all levels of the organisation, which integrate the principles of governance (including Information Governance), internal control, and risk pooling.

2.5 The broad objectives of the strategy are that:

- Risk management shall be integrated with quality and performance management arrangements and shall become an integral part of the business planning and objective setting processes of Clinical Divisions and Corporate Directorates and the Trust as a whole.
- Senior management shall support risk management including the promotion of a learning culture
- All staff shall be empowered to report risks and register concerns about unsafe practice.
- Information/training in the key principles of risk management commensurate to their role shall be provided for all staff.
- All aspects of risk management are approached in a structured manner, in line with the Care Quality Commission registration standards, Foundation Trust Compliance framework, and the NHSLA risk management frameworks.
- Guidance on the risk management process and the benefits of risk management shall be readily available.

- Strategies, structures and processes shall be regularly reviewed to ensure that objectives are being met.
- The Trust shall contribute to a wider risk network within the health community

3 POLICY SCOPE

3.1 This strategy applies to those members of staff that are directly employed by the Trust and for whom the Trust has legal responsibility. For those staff covered by a letter of authority / honorary contract or work experience this strategy is also applicable whilst undertaking duties on behalf of the Trust or working on Trust premises. Agency workers and medical and nursing students are also expect to comply with trust policies and procedures as appropriate, to ensure their health, safety and welfare whilst undertaking work for the Trust.

4 DEFINITIONS

(Reference: Australian/New Zealand standard AS/NZS 4360:1999.)

4.1 **Risk** is the chance that something will happen to have an impact on achievement of the Trust's aims and objectives. It is usually measured in terms of likelihood (frequency or probability of the risk occurring) and severity (impact or magnitude of the effect of the risk occurring).

4.2 **Risk management** is *"the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects".*

4.3 **The risk management process** is *"the systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying, and analysing, evaluating, treating, monitoring and communicating risk."*

5 ROLES AND RESPONSIBILITIES

5.1 Organisational Structure

5.1.1 The Trust Board holds ultimate responsibility for ensuring that the Trust has relevant and robust risk management processes in place

5.1.2 The Chief Executive has overall responsibility for risk management and discharges this through the designated accountability of other Executive Directors for different aspects of risk management.

5.1.3 Executive and Corporate Directors shall be collectively and individually responsible for the management of risk, and in particular for the areas included in their portfolios and as reflected in their individual job descriptions. These responsibilities will be discharged through Divisional Directors and Managers and Corporate Directorate Managers.

5.1.4 The discharge of these responsibilities is overseen and supported by a number of Trust Committees that are ultimately accountable to the board of directors. Each committee is formally constituted, and has approved terms of reference.

5.2 Roles and Responsibilities

5.2.1 Chief Executive

The Chief Executive has responsibility for establishing and maintaining an effective risk management system within the Trust for meeting all statutory requirements and adhering to guidance issued by Monitor and the Department of Health in respect of governance. The Chief Executive is the Accountable Officer responsible for ensuring a sound system of internal control is maintained that supports the achievement of the organisation's aims

and objectives. The Chief Executive is supported in the role by the Executive and Corporate Directors below:

5.2.2 **Executive Board Directors**

Medical Director
Coordinates the processes for ensuring that the Trust achieve compliance with the CQC's registration standards and the NHSLA's Acute Risk Management Standards and CNST standards; also leads on the Trust's fulfilment of its clinical governance and clinical risk management responsibilities; and also leads on health and safety management, complaints management, maintenance and development of the Trust's Central Alerting System (CAS) and risk register, respectively;

Director of Finance and Procurement
Financial risk management;

Chief Operating Officer / Chief Nurse
Risks to operational performance, emergency preparedness, business continuity, infection control and safeguarding adults and children

Director of Human Resources
Workforce risk management;

5.2.3 **Corporate Directors**

Director of Communications and External Relations
Risks to reputation.

Director of Facilities (Accountable to the Director of Strategy)
Risks to Estates, environment, security and fire

Director of Nursing (Accountable to the Chief Operating Officer/ Chief Nurse
Operational risks to safeguarding adults and children, service equality and temporary nursing staffing

Director of Corporate and Legal Affairs
Corporate governance, including maintenance and development of the Trust's assurance framework;

Director of Research and Development
Risks to research and development governance;

Director of Strategy
Risks to business development, IM&T and Information Governance. The Director of Strategy is the Trust's Senior Information Risk Owner (SIRO)

Director of Safety and Risk (Accountable to the Medical Director)
Corporate risk and safety including development and maintenance of the Trust's risk management and assurance framework. This role also incorporates that of Patient Safety Lead reporting to the Medical Director and with a direct link to the Chief Executive.

Director of Clinical Quality (Accountable to the Medical Director)
Risks to compliance and external accreditation.

Director of Clinical Education (Accountable to the Medical Director)
Risks to clinical education and training activities

5.2.4 Divisional Managers and Corporate Directors / Managers and Heads of Nursing shall discharge their responsibilities for risk management by:

- Ensuring risk management is incorporated into all clinical and non-clinical processes (including divisional business processes).
- Ensuring that the risk management strategy and other information related to the risk management process is disseminated and upheld by all staff.
- Identifying staff that shall be responsible for championing risk management and making their roles, responsibilities and accountabilities clear both to them and to other staff.
- Ensuring that Trust and relevant national policies / strategies are translated into local procedures applicable to the work of the division.
- Ensuring that all Trust / local policies are implemented and that compliance to these policies is regularly audited.
- Ensuring that all staff have received corporate induction and specific local induction and are aware of their personal responsibility within the risk management process.
- Ensuring that the implications of introducing new equipment / practices/ techniques are fully recognised and addressed in accordance with Trust policies.
- Routinely using information gained from incident reports to review and, where necessary, update working practice;
- Providing feedback from Trust committees to directorate staff on the outcome of incident, complaint, claim and risk reporting.
- Ensuring systematic risk assessment of clinical and non-clinical processes are performed, and demonstrating outcomes from the assessment process, including action plans and evidence of implementation.
- Ensuring appropriate risks are entered onto the risk register.
- Ensuring that a robust process of audit and review exists for all risk related objectives and activity.
- Ensuring that documentary evidence exists for all risk management activity and demonstrating that Trust standards and legal and statutory requirements are being met.
- Ensuring that risks to the achievement of divisional / directorate objectives are identified and assessed.

5.2.5 Clinical Divisional Directors shall discharge their responsibilities for clinical risk management by:

- Agreeing levels of competence with medical/ dental staff in line with national and professional guidelines.
- Ensuring induction and ongoing training of medical staff to the desired levels of competence.
- Ensuring monitoring and maintenance of the quality of clinical records;
- Ensuring planned introduction of new clinical procedures.
- Ensuring the development, dissemination and review of local clinical policies, procedures and guidelines.
- Ensuring local dissemination and adaptation of Trust wide clinical policies;
- Ensuring active management of clinical risk.
- Ensuring documentary evidence exists for all clinical risk management activity.

5.2.6 Quality and Safety Managers or equivalent as agreed by the Clinical Divisional Manager /HoN, or Corporate Director/ Manager shall discharge their responsibilities for risk management by:

- Analysis and investigation of incidents, complaints and claims and subsequent implementation of improvement strategies.
- Identifying risks and ensuring relevant risks are brought to the attention of the divisional board.

- Ensuring accurate risk registers are maintained and that risks and actions to mitigate risk are regularly reviewed.
- Ensuring health and safety, incidents, complaints, claims and risk management processes are embedded within clinical divisions and corporate directorates.
- Being accountable for the clinical division or corporate directorate management of the Central Alerting System (CAS) broadcasts.
- Providing advice and support to staff in relation to incidents, claims, and complaints ensuring that any risk management issues are identified and translated into improvements in patient care.

5.2.7 Individuals shall be accountable for their own working practice and behaviour and this shall be implicit in contracts of employment and reflected in individual job descriptions, objective setting and performance review.

5.2.8 **Corporate Safety and Risk Management Team**

There are specialist officers within this team with Trust wide roles relative to specific risk areas. These are: -

- Director of Safety and Risk
- Risk and Assurance Manager
- Senior Safety Manager (Clinical Risk and Complaints)
- Senior Health and Safety Manager
- Manual Handling Service Leader

Risk management duties of these key individuals are outlined in the job descriptions attached at appendix 1

5.2.9 In addition to the Corporate Risk Management Team are:

- Claims Advisers
- Fire Safety Advisers
- Security Manager
- Local Security Management Specialist
- Radiation Protection Officer
- Information Governance Manager

All of the above shall co-ordinate and support risk management activity within the Trust by:

- Ensuring that clinical divisions and corporate directorates receive all necessary information on risk management requirements.
- Participating in the activities of Trust risk committees / groups as required
- Being responsible for corporate risk management training and contributing where required to clinical division and corporate directorate training programmes.
- Producing information materials on risk management within the Trust for staff, patients, stakeholders and the public.
- Maintaining and developing the “Datix” risk management information system.
- Advising the Trust Board on risk management objectives for the Trust and clinical divisions / corporate directorates; auditing achievement in line with those objectives.
- Co-ordinating and contributing to the development of corporate risk management tools.
- Producing reports on risk management activities for Trust committees.
- Regularly auditing compliance against, the Trust’s risk management strategy.

5.2.10 There are also other specialist groups within the Trust, who play a role in risk management who have formal links with, and reporting systems to, the corporate committees with risk management responsibilities.

NB: Paper copies of this document may not be most recent version. The definitive version is held on INsite Documents

5.3 Committee Structures and Reporting Requirements

5.3.1 The risk reporting framework shall integrate across all established committees at the Trust that have responsibility for risk in order to create a culture of risk reporting and feedback. A detailed reporting framework is attached at appendix 2.

5.3.2 **Trust Board**

Will seek assurance of the implementation of risk management processes within the Trust and will be responsible for the identification, assessment and subsequent review of the Trust's key strategic risks and Board Assurance Framework (BAF). On a day-to-day basis executive responsibility for clinical and non-clinical risk management shall be delegated in accordance with the portfolios set out in sections 5.2.2 and 5.2.3.

No less than four times per year the Board will receive an updated integrated Strategic Risk Register and BAF (SRR/BAF) compiled by the Risk and Assurance Manager following discussions with the relevant Executive Director(s).

Extreme risks (i.e. those scoring 25) identified as a direct threat to achieving corporate objectives will be reported to the Board, from the UHL Executive Team as and when necessary.

The function of the Board within the risk management process is to;

a. Review and comment upon the SRR/BAF, as it deems appropriate;

b. Note the actions identified within the SRR/BAF to address any gaps in either controls or assurances (or both);

c. Identify any areas in respect of which it feels that the Trust's controls are inadequate and do not effectively manage the principal risks to the organisation meeting its objectives;

d. Identify any gaps in assurances about the effectiveness of the controls in place to manage the principal risks; and consider the nature of, and timescale for, any further assurances to be obtained;

e. Identify any other actions which it feels need to be taken to address any identified 'significant control issues' to provide assurance that the Trust is meeting its principal objectives.

5.3.3 **Audit Committee**

Is a committee of the Trust Board and its duties include:

a. Reviewing the UHL SRR/BAF, on a twice yearly basis, to ensure that there is an appropriate spread of strategic objectives and that the main inherent/residual risks have been identified, as well as any that are newly arising.

b. Assuring itself that the process that has been undertaken by management to populate the UHL SRR/BAAF is appropriate, in that the necessary directors and managers have been involved and take responsibility for their entries, and that there are no major omissions from the list of controls.

c. Monitoring the implementation of action plans that have been drawn up to cover gaps in controls, assurances and reports to management.

d. Considering, in particular, the "audit needs" of the organisation in terms of the sources of assurance, both independent and from line management, and ensure that there is a plan for these assurances to be received.

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e. Reviewing the results of assurances, either in whole or specific to a risk or objective, and the implications that these have on the achievement of objectives.

Terms of reference are attached at appendix 3

5.3.4 **Governance and Risk Management Committee (G&RMC)**

The G&RMC is a committee of the Trust Board and will receive on a quarterly basis:-

a. A risk exception report providing a summary of:-
   i. Risks with a score of 15 or above that are new.
   ii. Risks where the severity score has changed from the previous report.
   iii. Risks that have been closed during the reporting period.
   iv. The length of time that risks have remained on the register.
   v. The trend of risk subtypes.

b. An excerpt from the UHL risk register showing risks with a score of 15 or above.

c. A copy of the UHL SRR/BAF.

The function of the Governance & Risk Management Committee will be to;

a. Set risk management policy, process and approach (with Trust Board approval)
b. Challenge the assurance of the risk management process in UHL across clinical divisions and corporate directorates.
c. Identify risk management gaps in assurance and themes across UHL periodically, subsequently recommending courses of action as appropriate.

Terms of reference are attached at appendix 4

5.3.5 **Executive Team**

Is an Executive level group constituted by the Chief Executive and meets weekly. Membership includes Chief Executive, Executive and Corporate Directors, and Divisional Directors. It will receive notification any extreme risks (i.e. risk score of 25) that are a fundamental risk to the achievement of UHL's objectives as and when applicable. These risks will be presented by the relevant Executive Director.

The function of the Executive Team is to;

a. Confirm and challenge the risks reported to the Executive Team
b. As a result, escalate risks that would have a direct influence on the achievement of UHL objectives to the Trust Board.

Terms of reference are attached at appendix 5.

5.3.6 **Quality and Performance Management Group (Q&PMG)**

The Q&PMG is a sub-committee of the UHL Executive Team and will receive on a monthly basis:

a. A risk exception report for risks scoring 15 or above compiled by the Risk & Assurance Manager. This will provide a summary of:-

- Risks with a score of 15 or above that are new.
- Risks where the severity score has changed from the previous report.
- Risks that have been closed during the reporting period.
- The length of time that risks have remained on the register.
- The trend of risk subtypes.

b. An excerpt from the UHL risk register showing all risks with a score of 15 or above.

c. A copy of the UHL SRR/BAF.

d. The Q&PMG will receive on a quarterly basis a risk exception report for risks scoring 15 or above compiled with information received from all clinical Divisional Directors / Managers, and corporate Directors/ Managers. The report will include the summaries highlighted in a) above and in addition will provide details of risk mitigating actions that have not been completed within agreed timescales.

The function of the Q&PMG will be to;

i. Ensure relevant clinical divisions and corporate directorates are held to account for those risks.

ii Challenge Divisional Directors/ Managers ownership of risks with a score of 15 or above as to what is identified, risk score, progress of actions to mitigate risks and any change in the overall risk environment.

iii. Decide on courses of action for the mitigation of risks reported beyond the risk appetite of directorates.

iv Escalate any risks of strategic importance to the UHL Executive Team.

Terms of reference are attached at appendix 6

5.3.7 **Clinical Division Boards and Corporate Directorate Boards**

Will receive on a monthly basis:-

a. A risk report from Clinical business Units (CBU's) / departments identifying risks scoring 15 or above.

Will receive on a quarterly basis:

a. A risk report from CBU's / departments identifying risks scoring less than 15

The function of the Clinical Division Board and Corporate Directorate Boards will be to:-

i. Ensure relevant personnel are held to account for those risks within divisions / directorates.

ii. Challenge CBU / Department Manager's ownership of risks as to what is identified, risk score, progress of actions to mitigate risks and any change in the overall risk environment.

iii. Decide / agree on courses of action for the mitigation of risks reported beyond the risk appetite of CBU's/ departments.

iv. Identify and assess common risk themes across the clinical division/ corporate directorate.

Clinical Divisional Directors /Managers and Corporate Directors / Managers will be required to provide a quarterly risk exception report to the Risk and Assurance Manager identifying risks scoring 15 or above that are new or where the risk score has changed from the previous reporting period or where there are outstanding actions, or any overarching commentary of the risk environment. These reports must be signed-off by Divisional / Corporate Directors or Managers to provide accountability of the current status of all risks scoring 15 or above within their Division/ corporate directorate. In addition 'extreme' risks (i.e. risk score of 25) must be reported to the relevant Executive Director for onward reporting to the Executive Team.

5.3.8 **Clinical Business Units (CBU's)**

Will be responsible for:-

a. Providing a quarterly risk report to the Divisional Board identifying all risks scoring below 15.

b. Providing a monthly report to the Divisional Board identifying all risks scoring 15 or above.

5.4 Risk Management Training

5.4.1 The Trust is committed to the provision of training and education to ensure the workforce is informed, competent and prepared, possessing the necessary skills and knowledge to perform and respond appropriately to the demands of clinical care and service delivery.

5.4.2 Staff are offered risk management training commensurate with their duties and responsibilities. Risk management training is summarised in the risk management training needs analysis (TNA) and will be provided in line with the Trust's Statutory and Mandatory Training Policy. This document has been developed in conjunction with a training prospectus to provide managers and staff with information about the relevant areas of training relevant to their role, the frequency with which it needs to be accessed and session/ programme information.

5.4.3 Trust Board members will receive risk awareness training, commensurate with their role and responsibilities within the organisation. As a minimum, legislative and relevant risk awareness will be delivered annually by the UHL Risk Management Team to:

- Chief Executive, Chairman, Executive, and Non-Executive Directors:
- Divisional Directors/ Corporate Directors/ Divisional Managers.

5.4.4 Attendance at Trust Board and senior manager's risk awareness training will be recorded by the course facilitator. Attendance records will be monitored on a four times per year basis for non-attendees. In the event of non-attendance a letter / email will be written by the director of Safety and Risk to the non-attendee to arrange another time/date for training to be given.

5.4.5 The Trust employs advisers in specialist areas (see section 5.2.8 and 5.2.9) to ensure that a link is provided for information advice and training in these specialist areas.

6. POLICY STATEMENTS AND PROCEDURES

6.1 Risk Appetite

6.1.1 The Trust has a zero tolerance of undue clinical risks, i.e. a level of risk that is greater than that accepted as consistent with safe clinical practice.

6.1.2 The Trust has a zero tolerance of undue risks relating to failure to meet national targets and /or registration requirements from regulators, except where this would conflict with 6.1 above.

6.1.3 The Trust may decide to accept risks in developing innovative pathways to improve patient care where this is in line with its clinical quality strategy. This level of risk will be no more than accepted as consistent with safe clinical practice.

6.1.4 The Trust may decide to accept financial risks and will use its financial capabilities to enable change in support of its ambitions.

6.1.5 The Trust may decide to take calculated reputational risks where it deems the outcomes will be beneficial to its stakeholders.

6.2 Systems for Managing Risk

6.2.1 The Trust cannot manage its risks effectively unless it knows what the risks are. Identification and assessment systems are vital to the success of the Trust's risk management process. The Trust uses a number of risk identification tools to ensure a structured approach to risk management including the following:-

- Risks to the achievement of objectives at all levels of the organisation (including monthly monitoring of the Trust's key performance indicators)
- Incidents / near misses analysis and investigation
- Complaints analysis and investigation
- Claims analysis and investigation
- Risk assessments
- Review of the Board Assurance Framework
- Review of Care Quality Commission (CQC) compliance statements
- External reviews

- Whistle blowing
- Review of compliance monitoring with legislation
- Review of internal and external audit reports
- National reports and guidance
- Central Alerting System broadcasts
- Workshops and discussions with staff
- Health and safety audits
- 'Horizon scanning for risks from significant partnerships and other external influences

6.2.2 Risk assessment and the maintenance of local and organisational risk registers are essential components of the Trust's risk management programme and these systems are described in detail in the following documents that should be read in conjunction with the Risk Management Strategy:

i) A Brief Guide to Populating the UHL Datix Risk Register
ii) UHL Risk Assessment Policy

6.2.3 The risk assessment process provides for a systematic examination of clinical and non-clinical processes and enables a Trust-wide risk profile to be developed. This process is described in detail in the UHL Risk Assessment Policy.

6.2.4 Risk assessments should identify the significant risks arising from tasks/ activities undertaken in Clinical Divisions, Clinical Business Units and Corporate Directorates, and assess their potential to:-

- Cause harm to staff, patients, public and contractors
- Result in claims / litigation /complaints
- Result in enforcement action (e.g. by the Health and Safety Executive, Care Quality Commission, etc)
- Result in financial loss / affect service delivery
- Cause property loss damage
- Cause damage to the environment
- Result in operational delays
- Result in loss of reputation
- Result in a lower than accepted level of quality of care
- Impact upon the achievement of Trust objectives

6.2.5 Once a hazard is identified the severity of risk is measured using a matrix, plotting an ascribed numerical value to the consequence (impact) and an ascribed value to the likelihood (probability) of the risk occurring to produce a single risk severity score. The Trust uses a risk grading matrix to measure clinical and non-clinical risks with a score of 1 – 25 or a level of low to extreme.

6.2.6 Line managers are responsible for implementing and monitoring appropriate risk control measures within their designated areas. Where the implementation of risk control measures is beyond the authority or resources available to the manager then this should be brought to the attention of the Division /Directorate Board.

6.2.7 *Low Risks (Risk Score 1 – 6)*
Shall be entered onto the CBU / directorate risk register and reported to Divisional / Directorate boards on an annual basis to ensure the boards are aware of the risk profile of the Division / Directorate. Low risks shall be subject to annual review by the relevant line manager.

6.2.8 *Moderate Risks (Risk Score 8-12)*
Shall be entered onto the CBU/ directorate risk register. An action plan to reduce the risk shall be developed and implemented within six months. The action plan shall be

reviewed by the relevant manager and monitored by the Divisional/ Directorate boards on a quarterly basis until the target risk rating is achieved and the risk is closed.

6.2.9 *High Risks (Risk Score 15 – 20)*
Shall be entered onto the CBU/ directorate risk register following formal agreement by the directorate /CBU board. An action plan to reduce the risks shall be developed and implemented within three months. The plan shall be reviewed by the relevant manager and monitored on a monthly basis by Divisional/ Directorate boards until the target risk rating is achieved. High risks shall be reported to the Trust's Risk and Assurance Manager in line with the Trust' s risk reporting framework (appendix 1).

6.2.10 *Extreme Risks (Risk Score 25)*
Shall be brought to the immediate attention of the Clinical Divisional Director /Manager, or Corporate Director as appropriate who will subsequently contact the Director of Safety and Risk or the Trust's Risk and Assurance Manager to perform a "confirm or challenge" exercise. Downgraded risks shall follow the guidance outlined in sections 6.2.6 – 6.2.9. If the risk remains as 'extreme' it shall be reported to the Executive Team as soon as possible. The risk shall be entered onto the CBU/ directorate risk register and an action plan to reduce the risks must be developed and implemented as soon as possible. The action plan must be reviewed by the CBU/Directorate Manager on a weekly basis and monitored at the Divisional / Directorate board meetings on a monthly basis until the risk score has reduced. Extreme risks shall also be reported to the Executive Team reporting to the Trust Board as required. The Q&PMG and the G&RMC will be informed via a risk report as outlined in appendix 1.
Table 1 summarises the risk escalation process described in sections 6.2.7 – 6.2.10.

Table 1

Risk Rating / Score	Risk Owned by	Reviewed by	Reported to/ Monitored by
Low (1 – 6)	Dept Manager	Dept Manager	Divisional/ Directorate Board (Quarterly)
Moderate (8 – 12)	Dept Manager	Dept Manager/	Divisional / Directorate Board (Quarterly)
High (15 – 20)	Dept Manager	Dept Manager	Divisional/ Directorate Board, Q&PMG / G&RMC, Risk and Assurance Manager
Extreme (25)	Dept Manager	CBU/Directorate Manager Divisional/ Directorate Board/ Relevant Exec Director/ Exec Team/ TB	Exec Team/ Q&PMG/ G&RMC/ TB (if required)

6.3 Key Strategic Risks

6.3.1 Key strategic risks are defined as those risks that are identified to / by the Trust Board as being potentially damaging to the achievement of the Trust's principal objectives.

6.3.2 The application of Trust's Risk Assessment Policy shall assist in the rating of these risks.

6.3.3 The Trust board shall no less than four times per year be presented with an updated Strategic Risk Register and Board Assurance Framework (SRR/BAF) systematically identifying, recording, assessing, and analysing strategic risks.

6.3.4 The minutes of the Trust board shall evidence that it identifies, records, assesses and analyses the Trust's strategic risks and that it is involved in taking decisions on risk treatment options.

6.4 Risk Register

6.4.1 The risk register is a real-time electronic database and shall provide a dynamic risk profile of the Trust. It shall be used in conjunction with the Trust's key strategic risk register to provide an overall view of the Trust's risk profile.

6.4.2 The register shall provide a mechanism for risks and risk treatments to be recorded and accessed by individuals, teams, and directorates to assist in informing clinical, non-clinical and business decisions.

6.4.3 As a minimum the risk register will hold details including:-

- Title of the risk
- Site of the risk
- Business Unit
- Risk subtype
- Manager of the risk
- Source of the risk (including but not limited to, incident reports, risk assessments and directorate risk registers)
- Description of the risk
- Controls in place
- Initial, current and residual risk score
- Summary risk treatment plan
- Date of review

6.4.4 Clinical Divisions and Corporate Directorates shall maintain CBU/ directorate risk registers and all risks shall be entered onto these registers.

6.4.5 The Trust's Risk and Assurance Manager shall be responsible for reviewing the risk register on a monthly basis and producing regular and ad-hoc reports for Trust Committees in line with the Trust's risk reporting framework (appendix 2).

6.5 Board Assurance Framework (BAF)

6.5.1 NHS Chief Executive Officers are required to sign a Statement on Internal Control (SIC) as part of the statutory accounts and annual report. The Board must be able to demonstrate they have been properly informed about the totality of risks within the Trust, both clinical and non-clinical (including business risks). The Board shall assure itself that strategic objectives have been systematically identified and the key strategic risks to achieving them are adequately managed. The BAF fulfils this purpose.

6.5.2 No less than four times per year the Board will be presented with an integrated Strategic Risk Register and Board Assurance Framework identifying the Trust's principal objectives. Key strategic risks to the achievement of these objectives, controls in place and assurance sources along with any gaps in assurance will be identified.

6.5.3 The BAF shall be received and monitored no less than four times per year at the Trust Board and twice yearly by the Audit Committee.

6.6 Reporting, Monitoring and Learning

6.6.1 Learning from risks, incidents and other such events is the key to developing a culture within the trust that welcomes investigation of such events to provide opportunities to improve patient care, the services offered within the Trust, the working environment and the safety of staff.

6.6.2 A well established and active internal reporting culture provides the Trust with information about actual and potential harm and associated risks for clinical and non-clinical incidents. Data from incidents, claims, inquests, and complaints activity, are managed, monitored and investigated in conjunction with Clinical Divisions and Corporate Directorates by the:-

- Patient Safety/ Patient Information and Liaison (PILS)Team
- Litigation (Claims)Team
- Health and Safety Team (including Manual Handling)

6.6.3 Clinical incident data is uploaded to the National Patient Safety Agency (NPSA) as part of the external reporting requirement.

6.6.4 The responsibility for investigation incidents will be undertaken by designated individuals within Clinical Divisions and Corporate Directorates with support from the Corporate Safety and Risk Team according to the nature, severity and outcome of the incident.

6.6.5 Learning the lessons from internal incidents, claims, inquests and complaints is an important factor in the Trust's approach to managing risk. Following investigation, presentation of the final report and action plan will be monitored via the relevant Clinical Division or Corporate Directorates and relevant Trust-wide groups.

6.6.6 The Trust supports the principle of an open and fair culture where staff report incidents promptly and information about adverse events is communicated promptly, openly and effectively to patients and their families. Support will be provided to staff and patients immediately following an incident according to their respective needs. Following the investigation and review of incidents feedback will be provided to staff and patients.

6.6.7 More detailed information regarding the management of incidents, complaints and Claims can be found in the following Trust Policies:

- Policy for the Support of Staff Involved in incidents, inquests, complaints and claims.
- Policy for the Management of Clinical and Non-Clinical Incidents.
- Claims Handling Policy and Procedure

6.7 Embedding Risk Management

6.7.1 The effective implementation of this risk management strategy will facilitate the delivery of a quality service and alongside staff training and support will provide an improved awareness of the measures needed to prevent, control and contain risks. The Trust will:

Ensure all staff have access to a copy of this strategy;
Maintain an organisational risk register that will be subject to regular review and will reflect the risk profile of the Trust;
Communicate to staff any actions to be taken in respect of risk issues;
Deliver risk management training and evaluate and monitor its effectiveness;
Ensure that training programmes raise and sustain awareness throughout the Trust of the importance of identifying and managing risk;
Monitor and review the performance of the Trust in relation to the management of risk and the continuing suitability and effectiveness of the systems and processes in place to manage risk:
Dedicate resources to support risk management
Analyse data relating to incidents, complaints and claims and undertake structured reporting of the same.

7 PROCESS FOR MONITORING COMPLIANCE

7.1 Systems for Monitoring the Effectiveness of the Strategy

7.1.1 An annual report on risk management in the Trust, based on all available relevant information, shall be produced by the UHL Risk Management Team in the first quarter following the end of the financial year. To ensure compliance with the strategy this report, together with performance against the Key Performance Indicators (KPI's), shall be reviewed annually by the G&RMC and used to inform the development of action plans to remedy deficiencies and to inform future strategies. Wherever possible existing audit / review mechanisms shall be used to avoid duplication.

7.1.2 The Trust is a member of the NHSLA risk pooling scheme. As a requirement of this membership the Trust will be regularly assessed for compliance with the NHSLA Acute Risk Management Standards and CNST Maternity Standards. Performance at these assessments will have a direct impact on the level of contributions the Trust makes to the risk pool. At present the Trust has achieved compliance at level 2 for both sets of standards securing a 20% discount on contributions.

7.1.3 Regular self assessment of compliance against the Care Quality Commission is a requirement of registration and the Trust has to demonstrate that it meets the essential standards of quality and safety across all its services.

7.1.4 Other internal and external audits shall take place as required by the Department of Health, Monitor, Audit Commission and other bodies.

7.1.5 This strategy shall be reviewed annually by the Trust's Risk and Assurance Manager

7.2 Key Performance Indicators

7.2.1 Systematic review of the risk management process is a key responsibility of the Audit Committee and the G&RMC.

7.2.2 Review systems shall be in place to monitor and report performance against KPI's. Findings shall be reported to the Audit Committee and G&RMC as required.

7.2.3 KPI's are shown in Table 2 below.

Table 2

Key Performance Indicator	Method of Assessment	Evidence
Compliance with NHSLA Acute Risk Management Standards and Maternity CNST.	NHSLA 'ARMS' and CNST assessments	Achievement of required standard
Compliance with Health & Safety Executive requirements	HSE assessments	Achievement of required standards
Compliance with CQC registration requirements	Quarterly returns and ongoing compliance	Registration status
Review of Risk Management Strategy	Annual review by G&RMC (G&RMC) and approval by Trust Board	Up to date strategy G&RMC minutes Trust Board minutes
Attendance figures at risk management training sessions by division /	Monitoring of attendance	Quarterly attendance reports to G&RMC Monitoring of Health and

directorate (including Trust Board and Senior Managers).		Safety training by directorate and staff group
Reporting Culture Indicators a) Number of reported incidents per Clinical Division / Corporate Directorate b) Number of incident reports from medical staff per Clinical Division / Corporate Directorate c) Number of risks opened / closed per Clinical Division / Corporate Directorate d) Consistent updating of Strategic Risk Register and Board Assurance Framework	Quarterly analysis of data	Annual report to G&RMC Annual report to G&RMC Quarterly report to G&RMC. Monthly report to Q&PMG Trust Board minutes
No. of Serious Incident investigations completed within 60 days per Clinical Division / Corporate Directorate	Quarterly analysis	Quarterly report to G&RMC and monthly report to Q&PMG
Compliance with RIDDOR reporting deadlines per Clinical Division / Corporate Directorate	Quarterly Analysis	Quarterly report to G&RMC

8 DEVELOPMENT, CONSULTATION AND DISSEMINATION PROCESS

8.1 This document has been developed in consultation with all UHL clinical divisions and corporate directorates, Executive Directors, Directors, and the Governance and Risk Management Committee.

8.2 This document will be available in electronic format via the UHL Document Management System (DMS). In addition an electronic copy will be forwarded by the trust's Risk and Assurance Manger to Clinical Divisional Directors and Managers, Corporate Directors and Managers, Heads of Nursing and Quality and Safety Managers for further dissemination to all areas within clinical divisions and corporate directorates.

9. DOCUMENT CONTROL, ARCHIVING AND REVIEW OF THE DOCUMENT

9.1 It is a requirement of the NHSLA Acute Risk Management Standards that this document is reviewed and revised on an annul basis.

9.2 Old versions residing on the UHL DMS will be archived automatically. Old versions in paper format must be destroyed in all areas upon receipt of the newer version.

10. LEGAL LIABILITY

The Trust will generally assume vicarious liability for the acts of its staff, including those on honorary contract. However, it is incumbent on staff to ensure that they:

- Have undergone any suitable training identified as necessary under the terms of this policy or otherwise.
- Have been fully authorised by their line manager and their Directorate to undertake the activity.
- Fully comply with the terms of any relevant Trust policies and/or procedures at all times.
- Only depart from any relevant Trust guidelines providing always that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible clinician it is fully appropriate and justifiable - such decision to be fully recorded in the patient's notes.

It is recommended that staff have Professional Indemnity Insurance cover in place for their own protection in respect of those circumstances where the Trust does not automatically assume vicarious liability and where Trust support is not generally available. Such circumstances will include Samaritan acts and criminal investigations against the staff member concerned.

Suitable Professional Indemnity Insurance Cover is generally available from the various Royal Colleges and Professional Institutions and Bodies.

For advice please contact: Assistant Director - Head of Legal Services on Ext 8585

11. EVIDENCE BASE AND RELATED POLICIES

This framework will be supported by a series of linked risk related policies, procedures and protocols. These will include:

- UHL Health and Safety Policy
- UHL Safer Handling Policy
- UHL Policy for the Management Clinical and Non-Clinical Incidents,
- UHL Risk Assessment Policy
- UHL Risk Reporting Framework
- UHL Information Governance Policy
- UHL Statutory and Mandatory Training Policy (includes TNA)
- UHL Corporate and Local Induction Policy
- UHL Policy for the Management of Complaints,
- UHL Policy for the Management of Claims,
- UHL Central Alerting System Policy
- The Public Interest Disclosure Act 1998 (Whistle blowing in the NHS).
- Infection Control Policy
- A Brief Guide to Populating the UHL Datix Risk Register
- UHL Freedom of Information Policy
- UHL Performance Strategy
- UHL Quality Strategy
- UHL Maternity Risk Management Strategy

Appendix 2

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

RISK REPORTING FRAMEWORK

Robust and effective risk reporting is required to enable escalation of risks to relevant UHL committees in order that:-

a. Risks undergo 'confirm or challenge' exercises where necessary.
b. Assurance is gained that the risk management processes within UHL are effective and that risks are owned, managed and controlled.
c. Common risk management strategies are adopted to manage similar risks across UHL thereby ensuring resources are used effectively.
d. Accountability is recognised.
e. Decisions regarding risk treatment for those risks that cannot be adequately controlled can be taken at the appropriate level within UHL and these decisions can be communicated to divisions.

This risk reporting framework is intended to integrate across all established UHL committees and create a culture of risk reporting and feedback. Each committee has an intended purpose and in carrying this out improves the ability of UHL to achieve its corporate objectives. Each committee's risk reporting process and responsibilities are set out below.

Trust Board

No less than four times per year the Board will receive an updated integrated Strategic Risk Register and Board Assurance Framework (SRR/BAF) compiled by the Risk and Assurance Manager following discussions with the relevant Executive Director(s).

Extreme risks (i.e. those scoring 25) identified as a direct threat to achieving corporate objectives will be reported to the Board, from the UHL Executive Team as and when necessary.

The function of the Board is to;

Review and comment upon the SRR/BAF, as it deems appropriate;

Note the actions identified within the SRR/BAF to address any gaps in either controls or assurances (or both);

Identify any areas in respect of which it feels that the Trust's controls are inadequate and do not effectively manage the principal risks to the organisation meeting its objectives;

Identify any gaps in assurances about the effectiveness of the controls in place to manage the principal risks; and consider the nature of, and timescale for, any further assurances to be obtained;

Identify any other actions which it feels need to be taken to address any identified 'significant control issues' to provide assurance that the Trust is meeting its principal objectives;

Executive Team
Is a sub-committee of the Trust Board and meets weekly. Membership includes Chief Executive, Executive and Corporate Directors, and Divisional Directors. It will receive notification any extreme risks (i.e. risk score of 25) that are a fundamental risk to the achievement of UHL's objectives as and when applicable. These risks will be presented by the relevant Executive Director.

The function of the Executive Team will be to;
- Confirm and challenge the risks reported to the Executive Team
- As a result, escalate risks that would have a direct influence on the achievement of UHL objectives to the Trust Board.

Governance and Risk Management Committee (G&RMC)
The G&RMC is a sub-committee of the Trust Board and will receive on a quarterly basis:-

a) A risk exception report compiled by the Risk and Assurance Manager. This will provide a summary of:-
   - Risks with a score of 15 or above that are new.
   - Risks where the severity score has changed from the previous report.
   - Risks that have been closed during the reporting period.
   - The length of time that risks have remained on the register.
   - The trend of risk subtypes.

b) An excerpt from the UHL risk register showing risks with a score of 15 or above.

c) A copy of the UHL SRR/BAF.

The function of the Governance & Risk Management Committee will be to;
- Set risk management policy, process and approach (with Trust Board approval)
- Challenge the assurance of the risk management process in UHL across clinical divisions and corporate directorates.
- Identify risk management gaps in assurance and themes across UHL periodically, subsequently recommending courses of action as appropriate.

Audit Committee
Is a sub-committee of the Trust Board and its duties include:

Reviewing the UHL SRR/BAF, on a twice yearly basis, to ensure that there is an appropriate spread of strategic objectives and that the main inherent/residual risks have been identified, as well as any that are newly arising.

Assuring itself that the process that has been undertaken by management to populate the UHL SRR/BAAF is appropriate, in that the necessary directors and managers have been involved and take responsibility for their entries, and that there are no major omissions from the list of controls.

Monitoring the implementation of action plans that have been drawn up to cover gaps in controls, assurances and reports to management.

Considering, in particular, the "audit needs" of the organisation in terms of the sources of assurance, both independent and from line management, and ensure that there is a plan for these assurances to be received.

Reviewing the results of assurances, either in whole or specific to a risk or objective, and the implications that these have on the achievement of objectives.

Quality and Performance Management Group (Q&PMG)
The Q&PMG is a sub-committee of the UHL Executive Team and will receive on a monthly basis:

a) A risk exception report for risks scoring 15 or above compiled by the Risk & Assurance Manager. This will provide a summary of:-
   - Risks with a score of 15 or above that are new.
   - Risks where the severity score has changed from the previous report.
   - Risks that have been closed during the reporting period.
   - The length of time that risks have remained on the register.
   - The trend of risk subtypes.

b) An excerpt from the UHL risk register showing all risks with a score of 15 or above.

c) A copy of the UHL SRR/BAF.

- The Q&PMG will receive on a quarterly basis a risk exception report for risks scoring 15 or above compiled with information received from all clinical Divisional Directors / Managers, and corporate Directors/ Managers. The report will include the summaries highlighted in a) above and in addition will provide details of risk mitigating actions that have not been completed within agreed timescales.

The function of the Q&PMG will be to;

- Ensure relevant clinical divisions and corporate directorates are held to account for those risks.
- Challenge Divisional Directors/ Managers ownership of risks with a score of 15 or above as to what is identified, risk score, progress of actions to mitigate risks and any change in the overall risk environment.
- Ensure appropriate Executive Director(s) oversight of actions that have not been completed within specified timescales.
- Decide on courses of action for the mitigation of risks reported beyond the risk appetite of directorates.
- Escalate any risks of strategic importance to the UHL Executive Team.

Divisional Confirm and Challenge meetings
Take place on a monthly basis and membership includes the Chief Operating Officer, Director of Finance and Medical Director. Senior Management representatives from Clinical Divisions will also attend.

Clinical Divisions will present risks, as requested by Executive Directors, where there are likely to be significant operational / financial impacts over the long-term that are not being adequately controlled.
The function of the Divisional Confirm and Challenge meetings will include:-

- Scrutiny of outstanding risk mitigating controls / actions and risks with an expired review date in order to understand the reasons for delays and to receive Divisional assurance of a timely resolution.

Clinical Divisional Directors/ Managers and Corporate Directors / Managers (via Divisional Board or Corporate Directorate Board)
Will receive on a monthly basis:-
- A risk report from CBU's / departments identifying risks scoring 15 or above.

Will receive on a quarterly basis:
- A risk report from CBU's / departments identifying risks scoring less than 15

The function of the Divisional Board will be to:-
- Ensure relevant divisional personnel are held to account for those risks within divisions.
- Challenge CBU Managers ownership of risks as to what is identified, risk score, progress of actions to mitigate risks and any change in the overall risk environment.
- Decide / agree on courses of action for the mitigation of risks reported beyond the risk appetite of CBU's (i.e. scoring 15 or above).
- Identify and assess common risk themes across the division.

Clinical Divisional Directors /Managers and Corporate Directors / Managers will be required to provide a quarterly risk exception report to the Risk and Assurance Manager identifying risks scoring 15 or above that are new or where the risk score has changed from the previous reporting period or where there are outstanding actions, or any overarching commentary of the risk environment. These reports must be signed-off by Divisional / Corporate Directors or Managers to provide accountability of the current status of all risks scoring 15 or above within their Division/ corporate directorate. In addition 'extreme' risks (i.e. risk score of 25) must be reported to the relevant Executive Director for onward reporting to the Executive Team.

Clinical Business Units (CBU's)
Will be responsible for:-
a) Providing a quarterly risk report to the Divisional Board identifying all risks scoring below 15.
b) Providing a monthly report to the Divisional Board identifying all risks scoring 15 or above.

Clinical Quality Review Group
Monthly meetings are held with representation from UHL and its commissioners for the purpose of performance monitoring against the Quality Schedule and CQUINS.

On a quarterly basis the group will receive an excerpt from the UHL risk register showing all risks with a score of 15 or above for the purpose of Commissioners assurance.

The Director of Safety and Risk will forward on a weekly basis all new risks scoring 15 or above to the Commissioners.

Peter Cleaver
Risk and Assurance Manager
12 August 2010

Appendix 2

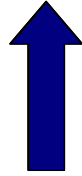
UHL RISK REPORTING FRAMEWORK

Executive Function

Assurance Function

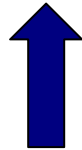
Trust Board

- Will review strategic risks & Board Assurance Framework (BAF) no less then 4 times per year.



Executive Team

- Will receive notification from Divisions / Directorates of risks scoring 25.
- Will escalate risks scoring 25 and of strategic significance to Trust Board for potential inclusion in BAF.

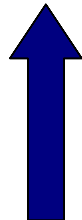


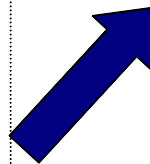
Q P M G

- Will receive a monthly report from the UHL Risk & Assurance Manager showing risks scoring 15 or above.
- Will receive a quarterly report on mitigating actions not completed within agreed timescales.
- Ensures accountability at divisional level.

Audit Committee

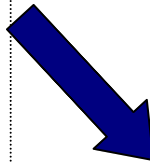
- Will receive an update of the Trust's Strategic Risk register and Board assurance Framework (SRR/BAF) no less than twice per year.





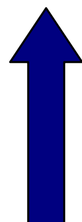
Divisional / Directorate Boards

- Will receive a monthly report from CBU`s depts showing risks scoring 15 or above.
- Will receive a quarterly report from CBU / Depts showing risks scoring below 15.
- Will decide/agree actions for CBU /Dept risks scoring 15 or above.
- Ensures accountability at CBU / Dept level.



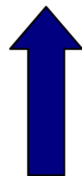
G R M C

- Will receive a quarterly report showing risks scoring 15 or above.
- Will receive a quarterly update of the Trust's strategic risk register and Board Assurance Framework (SRR/BAF).



Risk Register

- Risks of all types/scores entered on risk register.



CBU / Dept.

- Identify risks of all types/scores.