

Risk Management Strategy & Policy

Document Reference Information

Version	6.0
Status	Draft
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Directorate Responsible	Corporate Affairs
Ratified By and Date	GEMT 9 September 2009
Date Effective	9th September 2009
Date of Next Formal Review	July 2010
Target Audience	Trustwide

Version Control Record

Version	Description of Change(s)	Reason for Change	Author	Date
1	None	First version of policy	Catherine Afolabi	March 2003
2	Incorporate incident reporting arrangement & NHSLA	To comply with NHS Litigation Authority Risk Management Standard and fit with January 2004 Incident Management Policy	Catherine Afolabi	March 2004
3	Incorporate best practice in risk management	Changes to comply with external reviews (NHSLA and Internal Audit), Department of Health Requirements and best practice in risk management	Catherine Afolabi	March 2005
4	Changes to management structure	Changes to reflect the changes in the management and Governance structures	Patricia Atkinson Christine Bevan-Davies	March 2008
5	Changes to management structure, best practices in risk management, NHSLA requirements	Changes to comply with external reviews (NHSLA and Internal Audit), Department of Health Requirements and best practice in risk management	Bridget Pratt	June 2008
6	Provider Commissioning split, changes to management structure, best practices in risk management and NHSLA requirements	Policy out of date, structural changes in NHS Brent	Bridget Pratt	June 2009

To be read with:

Standards for Better Health Policy
Assurance Framework Policy
Incident Reporting Policy
Serious & Untoward Incident Policy

“The PCT incorporates and support the human rights of the individual as set out in the European Convention on Human Rights and the Human Rights Act 1998”

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1. Introduction

An effective Risk Management Strategy is a key part of all management systems and corporate planning as well as the setting of strategy and objectives. The PCT believes that by approaching the control of risk in a strategic and organised manner, risk factors can be reduced to an acceptable level. This should result in better quality and safer care for patients and residents and a reduction in unnecessary expenditure. By adopting a risk management approach, statutory obligations can be identified and fulfilled in a positive way, rather than as a means of avoiding litigation and prosecution.

This Strategy reflects relevant legislation and current best practice and will be reviewed in the light of any changes to either of these. It takes into account a range of governance and risk management standards set by the:

- Care Quality Commission
- The NHS Litigation Authority (NHSLA)
- Health & Safety legislation

This Strategy ensures that board level responsibility for risk management is clearly defined and there are clear lines of accountability for risk management throughout the organisation, leading to the board, with the Chief Executive of NHS Brent having overall responsibility for Risk Management.

2. Policy Statement

The PCT is committed to the active management of risk. NHS Brent's policy is to minimise risk wherever possible to patients, staff, members of the public and other stakeholders.

The PCT is dedicated to establishing an organisational culture that ensures that risk management is an integral part of everything it does. Effective risk management helps the Trust to meet its objectives.

3. The Purpose of the Strategy

The purpose of this Strategy is to define and document the Trust's commitment to, and process for, handling risks that are inherent in the provision of an optimised high quality system for the care and treatment of patients.

This Strategy identifies the management structure and responsibilities in relation to Risk Management. It details the processes involved and specifies the maintenance of Risk Registers for each Directorate and for the Trust as a whole.

4. Scope

This strategy relates to the management of the risks faced by NHS Brent and Brent Community Services. However, the activities of Primary Care Practitioners, and the actions of organisations acting on behalf of NHS Brent, involve risks which can have an impact on whether NHS Brent achieves its objectives. To this extent their activities and actions can also come within the scope of this strategy. Thus, the risks involved in the NHS Brent staff working in a Health Centre not owned by NHS Brent, need to be assessed. Likewise, NHS Brent must also assess the risk that its practitioner contractors might not perform to the standard required if NHS Brent is to achieve certain objectives. Such risks will be included in the NHS Brent Risk Register and will be managed.

5. Definitions

Risk is the chance that something will happen that will have an impact on achievement of the PCT's aims and objectives. It is measured in terms of likelihood (probability of the risk occurring) and consequences (impact of the risk occurring).

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

Risk Assessment is a careful examination of what could go wrong.

The risk management process is "the systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risk." It is illustrated at Figure 1 below.

Governance Committee: The term Governance Committee is used in this strategy to refer to both the GEMT & the BCS Governance Committee.

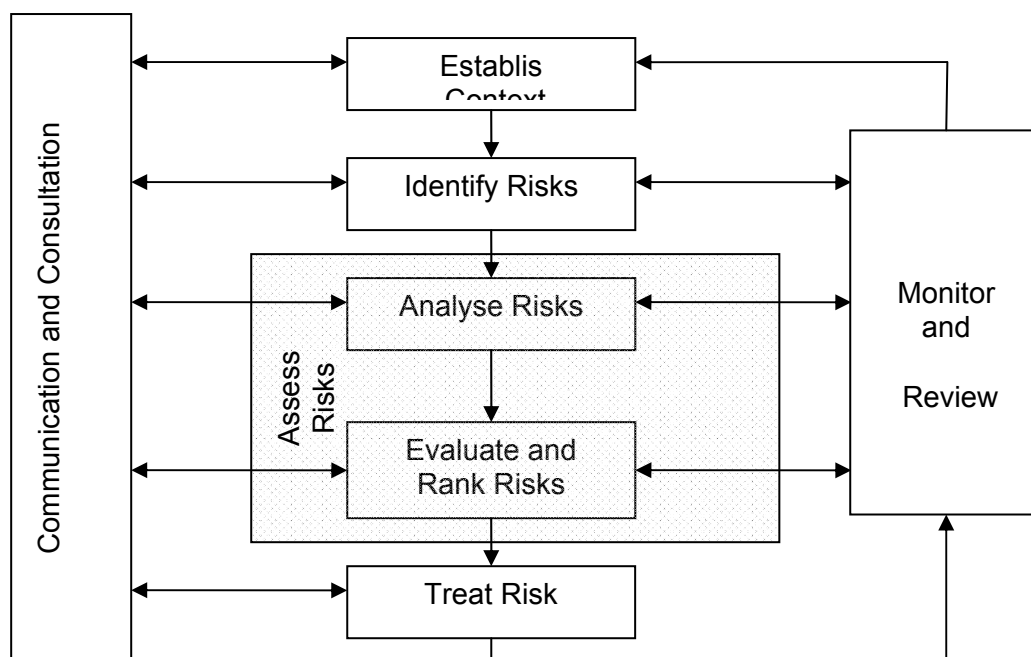


Figure 1 - Risk Management Overview from AS/NZS 4360:1999

6. Principles

The following key principles are essential for the successful implementation of this Strategy:

1. There is Board and management commitment to, and leadership of, the total risk management function.
2. The Trust will develop its integrated governance framework to include the formal application of the risk management process to clinical practices and to the work of its primary care contractors.
3. There is widespread employee participation and consultation in risk management processes, which will operate in a no blame culture.
4. There is a mechanism for all incidents and complaints to be immediately reported, categorised by their potential consequences and investigated to determine system failures, without assigning blame.

5. There are management systems in place that provide safe practices, premises and equipment in the working environment. Systems of work must be designed to reduce the likelihood of human error occurring.
6. The risk management process must be applied to contract management especially when acquiring, expanding or outsourcing services, equipment or facilities. Contracts must be reviewed and written to ensure that only reasonable risks are accepted.
7. On all Trust premises, whether owned or shared, safe systems of work must be in place to protect patients, visitors and staff.
8. The Trust maintains an effective system of emergency preparedness, emergency response and contingency planning.
9. There is a mechanism to measure the effectiveness of Risk Management Strategies, Plans, structures and processes against NHS best practice.
10. The Trust provides realistic resources to implement and support effective Risk Management throughout the Trust.

7. Developments influencing the management or risk in the PCT

7.1. Development of Commissioning and organisational Purpose

As a Commissioning organisation, NHS Brent Board has set its strategic priorities, agreed its corporate objectives and Board Assurance process for 2009/2010. The board will consider the assurance arrangements necessary to ensure that the responsibilities of the PCT are discharged effectively

7.2. Commissioning/Provider Split

In May 2009, NHS London approved Brent Community Services (BCS) as an Autonomous Provider Organisation (APO). This approval means that BCS has met all the standards and has demonstrated the capabilities to be awarded the status of Autonomous Provider Organisation. The BCS Board has been set up and has delegated authority from the NHS Brent Board. The BCS Board is chaired by a Non Executive Director. See appendix I for BCS main Committee reporting structure.

7.3. Care Quality Commission (CQC)

On the 1st of April 2009, the Healthcare Commission merged with Social Care to become the Care Quality Commission. Brent Community Services has successfully completed the first phase of registration with the CQC in relation to healthcare acquired infection. The application was approved without condition.

A mid year Standards for Better Health submission will be required from BCS in November 2009. Commissioning PCT's will not be assessed using the previous Standards for Better Health process. The exact process is yet to be agreed but is likely to involve performance with WCC competencies.

8. Risk Management Responsibilities

8.1 Chief Executive

The Chief Executive, who, as Accountable Officer, on behalf of the Board, is required to sign the annual Statement on Internal Control, has overall responsibility for having an effective risk management system in place within the

PCT and for meeting all statutory requirements and adhering to guidance issued by the Department of Health in respect of Governance.

BCS Chief Operating Officer (COO): The responsibility for risk management within BCS services lies with the COO and the Community Services Board will seek assurance that this is being discharged effectively. The audit arrangements will include a review of the process so that the NHS Brent Board has sufficient assurance of the arrangements and the Chief Executive can sign an appropriate Statement on Internal Control. It will be the responsibility of the BCS Board and COO to deliver the necessary information.

8.2 NHS Brent Board

The Board has the ultimate responsibility for risk management and for agreeing the annual Statement on Internal Control. It needs to be satisfied that appropriate policies and strategies are in place and that systems are functioning effectively. The Audit Committee will assist the Governance Committee in this process by performing an annual review of the effectiveness of the risk management activities. It will be helped in this by the Chief Internal Auditor's annual work, report and opinion on the effectiveness of NHS Brent's system of internal control.

8.3 Head of Corporate Affairs

The **Head of Corporate Affairs** is responsible for coordinating risk management activities and leading on the overall compliance process across NHS Brent including:

- Providing organisational leadership for risk management, and developing NHS Brent's approach to risk management
- Ensuring the effectiveness of NHS Brent's systems for recording, dealing with and learning from Serious & Untoward incidents, complaints and claims
- Working with the Head of Governance (BCS) to ensure a robust governance and SUI process is in place for BCS
- Working with Lead Commissioners to ensure robust governance arrangements are in place for commissioned services
- Managing legal advice on behalf of NHS Brent and BCS's
- Receiving and collating information on risks within NHS Brent, monitors new developments in risk management, develops knowledge and expertise and acts as liaison point for risk management issues, both within NHS Brent and with external bodies.
- Monitoring proposed developments and initiatives and checks that they are likely to be compliant with good risk management practice.
- Development and maintenance of the NHS Brent Corporate Risk Register

8.3 Director of Finance

The Director of Finance has the delegated responsibility for financial risk management and will:

- Ensure compliance with the Use of Resources
- Ensure the effectiveness of the Trust's financial control systems
- Ensure that the significant financial risks faced by NHS Brent is identified and managed effectively

- Ensure that the Audit Committee and internal audit effectively perform their roles in assuring the Trust's system of internal control

8.4 Executive Directors

All Executive Directors are accountable for the effective management of risk within their area of responsibility, including assurance that appropriate controls are in place and that controls are being monitored. This involves maintaining systems to:

- Identify and assess risk
- Nominate Risk Champions in their Directorate to ensure population and management of Directorate risk registers
- Implement effective risk treatments
- Report risk in accordance with the PCT's Risk Management Policy and Strategy (including reporting risks for inclusion on the Corporate Risk Register)
- Ensure all managers and staff under their management control are aware of the PCT's Risk Management Policy and Strategy and of their responsibility for implementing them.

8.5 The Risk Management responsibilities of Managers

- Ensure the PCT's Risk Management policies and procedures are implemented within their area of responsibility and adapted as necessary to reflect the local risk profile
- Carry out risk assessments using the NHS Brent's template (Appendix B)
- Support their directorate in developing and monitoring a local risk register.
- Identify and rectify poor performance on a timely basis
- Promote corporate values so that individuals provide or commission high quality care, support their colleagues, and promote the reputation of the PCT
- Foster a supportive environment to facilitate the reporting of risks and incidents
- Keep staff informed of the risks faced by the Trust and what is being done to treat the risks
- Ensure staff under their management have access to opportunities for training and development including attendance at mandatory risk management training events.

Managers are responsible for implementing and monitoring any identified and appropriate risk management control measures within their designated area(s) and scope of responsibility. In situations where significant risks have been identified and where local control measures are considered to be potentially inadequate, managers are responsible for bringing these risks to the attention of the relevant Head of Service and Director if local resolution has not been satisfactorily achieved.

8.6 Other Managers with special responsibility for risk management

Other key individuals with special responsibility for advising on and co-ordinating risk management activities include:

- Heads of Services in the APO (preparing and reviewing their departmental risk registers and action plans and forwarding it to their directorate risk champions)
- Directorate Risk Champions (populating and managing directorate risks registers)
- Health and Safety Advisor - (managing health & safety risk and incidents)
- Fire & Safety Risk Advisor, - Estates and Facilities Shared Services (managing, fire safety risk)
- Infection Control Nurse - BCS (advice on Infection Control issues)
- Occupational Health (work related ill-health, needle stick injuries)
- Pharmaceutical Advisors (Medicines Management / Prescribing issues)
- Local Security Management Specialist (LSMS) (managing security incidents, risk and violence to staff)
- Local Counter Fraud Specialist (LCFS) (managing fraud incidents and risk)

Contact details of these and other sources of advice are at **Appendix J**.

8.8 The Risk Management responsibilities of staff

All members of staff have a responsibility to ensure the effectiveness of risk management within the Trust. Responsibility for actioning an individual Action Plan point is always allocated to a specific member of staff.

Individual employees are responsible for:

- Working to the PCT's policies and procedures
- Maintaining safe systems of work
- Taking care of their own safety and that of their colleagues and all other persons who may be affected by their actions or omissions
- Taking care of the PCT's buildings, equipment and other assets
- Reporting risks, incidents and near misses and taking remedial action in accordance with the PCT Risk Management policies and procedures
- Attending mandatory training
- Meeting professional registration requirements, including those relating to Continuing Professional Development.

8.9 Committee Responsibilities

NHS Brent Board has delegated its risk management activities to the Governance EMT (GEMT) whose terms of reference are set out in Appendix F. The GEMT is chaired by the Chief Executive and has overall responsibility for Risk Management. It aims to foster a risk aware culture throughout the Trust. The Committee may delegate work to its sub Groups and will ensure activities are seamless and fully integrated. Responsibility for clinical risk lies with the GEMT with advice from the Professional Executive Committee (PEC). A diagrammatic representation of the Risk Management structure within the PCT appears at Appendix K. The Committee and management structures are designed to work together to ensure a concerted and integrated approach to risk.

Separate Governance arrangements exist for BCS (See flowchart appendix I).

9. The Assurance Framework

The requirement to develop an Assurance Framework was established by the Department of Health in *Assurance: the Board Agenda* in July 2002. The

Assurance Framework is a tool for the Board to satisfy itself that risks are being managed and objectives are being achieved.

NHS Brent and BCS have established a clear Assurance Framework so that it can confidently sign the annual Statement on Internal Control
The Assurance Framework has four key steps, each of which is built into the the PCT's Risk Management Process:

Stage One	The Trust's objectives are clearly defined and understood
Stage Two	The system for identifying and assessing risks is clear and understood and is practised consistently throughout the PCT
Stage Three	The controls in place to manage the identified risks are effective and any deficiencies have been identified in the Action Plan
Stage Four	There is a system, which requires management and review bodies to provide the Board with the assurance it needs that the risk management systems and controls in place are effective.

The Board with specific roles, which are summarised below, has agreed a reviewing and monitoring process:

- Governance Committee – update Assurance Frameworks at least quarterly
- The Audit Committee is “the Assurance Committee” to monitor the quality of the Framework and refer significant issues to the Board
- Board – review and agree Frameworks and action plans to address gaps quarterly

10. Assessing risks

The PCT has developed a common template (Appendix B) for the assessment and analysis of all risks whether they are strategic or operational, clinical, financial or organisational. The risk scoring tool in Appendix C will be used for scoring and grading risks

Areas in which risks must be assessed are:

- Direct patient care;
- Indirect patient care;
- Health and safety risks;
- Organisational and financial risks;
- Commissioned service risks.

10.1. Categorising risks

For organisational reasons and to clarify management responsibilities, risks are categorised into clinical or non-clinical. Most risks, however, contain both these elements. For example, a risk may be principally clinical but the cause of it may be due to financial or organisational deficiencies. The three key categories of risks are set out below.

Clinical risks	Clinical risks are defined as those risks, which have a cause, or effect, which is primarily clinical or medical. Examples include clinical care activities, consent issues
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	and medicines management.
Organisational risks	Organisational risks are defined as those risks, which primarily relate to the way in which the PCT is organised, managed and governed. Examples include property related risks, human resource issues and corporate governance risks.
Financial risks	Financial risks are defined as those whose principal effect would be a financial loss or a lost opportunity to deliver a financial gain. Examples include poor financial control, fraud and ineffective insurance arrangements.

11. Risk Registers

The risk register is a management tool that enables an organisation to understand its comprehensive risk profile. It is simply a repository for all risk information. It records dependencies between risks and links between risks on the corporate and local risk registers.

11.1. Corporate Risk Register

The Corporate Risk Register contains the most significant risks i.e. graded “Extreme” or Red risks (15+) following assessment using the risk assessment matrix at Appendix C. Significant risks are those that potentially threaten the achievement of the Trust’s corporate objectives. This would include risk that could impact on the performance of the PCT as well as other high profile risks such as performance indicators and risks arising from external reviews.

The Corporate Risk Registers will be maintained detailing all the significant risks the Trust has to manage. All Risk Registers will be prepared in the same format to facilitate collation of information across the Trust into a single Trust-wide Risk Register. The template to be used is at Appendix D. The Governance Committee is responsible for managing the Corporate Risk Register and assessing if the risks seriously prejudices or prevents the achievement of any of the Trust corporate objectives

11.2. Directorate Risk Registers

The Directorate Risk Registers contains all directorate risks including operational risk assessments and risks from the Board Assurance Framework. A local risk register will be maintained in each Directorate and department. Where Directorates feel that they cannot address a risk, it should be notified to the Service Director for agreement at Governance Committee and inclusion on the Corporate Risk Register.

11.3. Risk Treatment Action Plan

The action plan section of the risk register template can be used to summarise the risk treatment plan. The Risk Action Plan template at Appendix E can be used for detailed action planning. It is the responsibility of each Directorate to ensure that its risk register and action plans are regularly reviewed to keep them up to date. Risks are constantly changing and actions should be progressively implemented. The risk treatment section in Appendix C specifies how a risk should be treated depending on its grading.

11.4. Key Controls

Effective key controls need to be in place if risks are to be effectively managed. The relationship between risks and controls is not straightforward. One specific risk may be mitigated by a number of controls. Some controls may only be effective when operating in conjunction with other controls and one control may relate to more than one risk. For each risk assessed the adequacy of the control(s) relating to the risk will be assessed and any necessary action determined and stated.

12. Reporting Arrangements

The Board will review the Board Assurance Framework (BAF) quarterly. The Governance Committee will review its Corporate Risk register and Board Assurance Framework quarterly. The Audit Committee will review the BAF bi-monthly. The output of the risk management system for clinical risk will be considered by the PEC and non-clinical risk will be considered at the Governance and Health & Safety Committee. Full Directorate Risk Registers will be presented and reviewed at the GEMT on a rotational basis. A separate (commissioning and Provider) risk management quarterly report will be prepared for the GEMT. The report will identify progress made with:

- the corporate and directorate risk registers
- the BAF
- internal auditors action plans
- the proportion of incident reports with evidence of management action
- the numbers, severity and type of incidents recorded

13. Involving Stakeholders

The Governance Committee will ensure that the PCT maintains an up-to-date stakeholder list. The purpose of the stakeholder list is to identify organisations, or individuals, who require, or might require, information on adverse events or other risks facing the PCT.

Each risk will be reviewed to establish internal and external reporting requirements. A list of stakeholders is included in appendix H.

To ensure PCT staff are kept fully informed on risk management issues:

- Directors are responsible for ensuring processes are in place for informing staff about significant adverse events and risks
- The Governance Committee will ensure actions are implemented and information disseminated rapidly across the PCT
- All members of staff will receive a regular update on risk issues, summarising: incidents reported, complaints received, information on hazards: and publicising training opportunities, good practice and lessons learnt.

14. Risk Management Training

An effective implementation of the strategy requires staff to be both aware of the Trust's approach to risk management, and to be clear about their roles and responsibilities within the risk management process.

An assessment of training needs will be commenced through the Staff Development Review (this will be reviewed annually) and programmes will be in place so that:

- All new staff will attend an Induction Programme which includes risk management training and covers complaints and incident reporting
- All staff will receive a risk management training update every two years
- To establish a baseline, all staff (including Non-executive Directors) will receive risk management training
- The PCT will produce a Training Matrix to identify which training courses are mandatory for different staff groups. The Matrix will serve as a guide to staff and managers, and facilitate the reporting of attendance to the Governance Committee
- A Training Prospectus will be published identifying the availability of training and development opportunities for staff (including mandatory training)
- A programme of “specialist courses” will be available for staff with specific needs e.g. operating syringe drivers or having specific risk management responsibilities.

Every member of staff will have an annual personal development review with their line manager and agree a Personal Development Plan (PDP). This process provides assurance that the training needs of individuals are identified at all levels in the organisation, and serves to inform the content and delivery of future training programmes and plans. The PCT will meet the training requirements of its staff that are essential for them to perform their roles. All staff will operate within their code of professional conduct.

15. Implementation plan, monitoring, review and the use of Key Performance Indicators

The Risk Management Quarterly Report to the GEMT will be used to demonstrate how this Strategy is being implemented.

The Board will review this Strategy and progress annually and also whenever procedural, legislative or best practice changes occur. The Chief Executive is responsible for ensuring this Strategy is reviewed in accordance with the above statement. This task may be delegated to an appropriate Director or senior manager.

The GEMT will monitor in detail risk management performance. This includes recording and analysis of incidents, complaints and claims. Key performance indicators have been developed and information will be collected to enable risk management performance to be more directly monitored and controlled.

These key performance indicators are capable of showing improvements in the management of risk and can provide early warning of changes in risk. They will be used at all levels of the Trust, including the Board, and reports will be structured to enable performance to be identified by service area. The GEMT will review the efficacy and usefulness of these indicators annually. Consequently, they will continue to be refined and developed. The indicators currently include:

- The organisational risk management structure, details all those committees/sub-committees/groups which have some responsibility for risk
- The process for board review of the organisation-wide risk register
- The duties of the key individual(s) for risk management activities is monitored against the risk management strategy

- The authority of all managers with regard to managing risk is monitored against the strategy
- The process for assessing all types of risk
- The process for ensuring a continual, systematic approach to all risk assessments is followed throughout the organisation
- The process for assignment of management responsibility for different levels of risk within the organisation
- The establishment and regular updating of risk registers and action plans in each Directorate and service area which reflects the organisation-wide risk management strategy
- The design and promotion of mandatory and other risk management training courses in line with the Trust's training needs assessment
- The percentage of staff attending each of these courses
- The percentage of staff with a Personal Development Plan
- The regular meeting and effective operation of the GEMT and its sub Groups
- The number and outcome of risk assessments
- The number and type of incidents, complaints and claims recorded and dealt with
- The percentage of incidents, complaints and claims which featured risk management learning points and the percentage of these learning points which have been analysed and dealt with
- The number of incidents requiring reporting to external bodies (e.g. NPSA, RIDDOR)
- Steady improvement towards the integration of risk issues in the Trusts systems for both business planning and also the setting of individual and corporate objectives and the monitoring of performance against those objectives.

The indicators will be used at all levels in the organisation; all staff will receive feedback on performance through the distribution of regular information.

16. Annual Risk Management Report

A Risk Management (Governance) annual report will be produced for approval by the GEMT and the Board. The report will report on risk management performance over the previous twelve months, and identify actions and resource requirements for the following year. This report will draw upon the performance indicators outlined above.

17. Embedding of Policy

Embedding of this policy will be documented through the use of the Assurance Form (appendix P)

Appendix A: Risk Assessment Process.

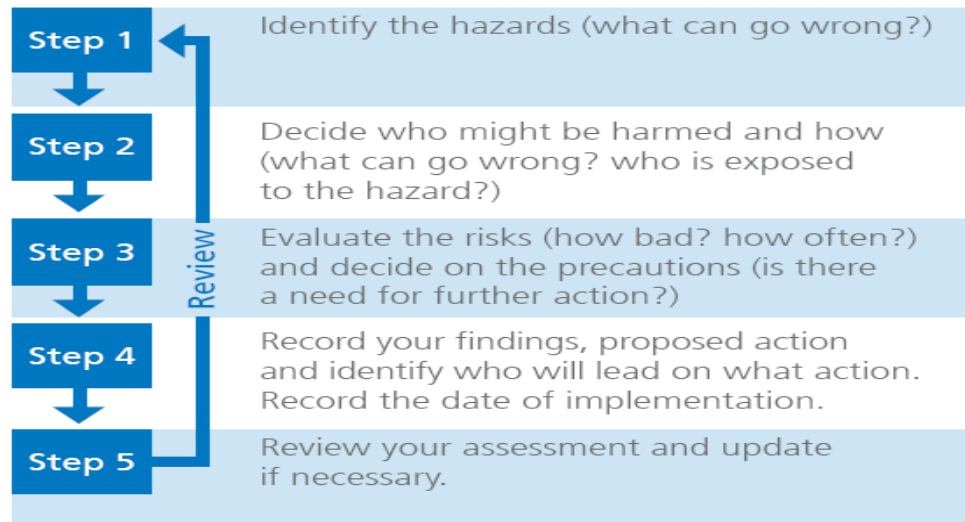
Risk Assessment is about identifying, analysing, evaluating, treating, monitoring and communicating risk.

- There are two key systems, which govern risk management in the PCT: Trust-wide Risk Assessment/Register
- Incident reporting and management

Both systems use the same risk grading process to assess risks in terms of likelihood and consequence, which is described fully below.

Risk is analysed by combining estimates of consequences and likelihood in the context of existing control measures. The objectives of risk analysis are to separate the minor acceptable risks from the major risks, and to provide data to assist in the evaluation and management of risks.

2. Appendix A: Five steps in completing a Risk Assessment



Appendix B: Risk Assessment Template

RISK ASSESSMENT TEMPLATE

Title of Risk Assessment:
Name / Title of assessor:
Directorate/Department:
Date of Assessment:
Date of next review:

WHAT HAS THE POTENTIAL TO CAUSE LOSS OR HARM (HAZARD) ?	WHAT IS THE RISK? (DESCRIBE THE HARM OR LOSS THAT COULD OCCUR)	WHO IS THE RISK LIKELY TO AFFECT?	WHAT ARE YOU ALREADY DOING TO MANAGE THE RISK? (CURRENT CONTROLS)	WHAT IS THE LIKELIHOOD (L) CONSEQUENCE (C) & RISK RATING (RR) SCORE? (LXC =RR)			WHAT FURTHER ACTION IS NECESSARY?	PROJECTED RISK RATING SCORE FOLLOWING FURTHER CONTROLS	OWNERSHIP
				L	C	RR			

Assessor's Signature

Appendix C: Risk Grading Tool

The risk-grading tool (also known as risk matrix / risk assessment tool) is used by the PCT for all risk processes (risk assessment, Risk Register, incident reporting and near miss assessment) and risks are measured according to the following formula. The tool can be used as the basis for identifying acceptable and unacceptable risks.

For some risks there may be physical as well as financial consequences. When assessing the score for the consequences of such a risk, the clinical assessment (e.g. serious injury or death) will always take precedence over the financial assessment.

Table 1 Consequence scores (C)

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

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood score (LXC)

What is the likelihood and consequence of the risk?

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

	Most Likely Consequence				
Likelihood of occurrence	1) Negligible No obvious injury or harm Loss of 0.1–0.25 per cent of budget Claim less than £10,000	2) Minor More than 3 days off sick due to injury Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	3) Moderate Hospitalised or medium term injury Major financial loss (£20K to £100K) including litigation settlement.	4) Major Significant / permanent harm Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget. Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	5) Catastrophic Death or major disaster / loss Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
1) Rare - Can't believe the risk will ever happen	1	2	3	4	5
2) Unlikely - Do not expect the risk to happen but it is possible	2	4	6	8	10
3) Possible - The event may occur occasionally	3	6	9	12	15
4) Likely - The event will probably occur but is not a persistent issue	4	8	12	16	20
5) Almost certain - The event will undoubtedly occur, possibly frequently	5	10	15	20	25

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

Risk Key

Red (15-25)	Extreme risk
Amber (8–12)	High risk
Yellow (4–6)	Moderate risk
Green (1-3)	low risk

Instructions for use

- 1 Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.
- 2 Use table 1 (above) to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.

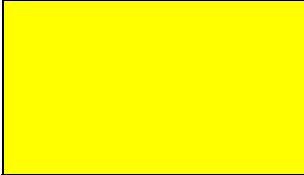
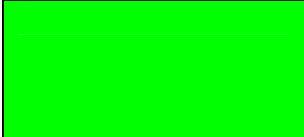
- 3 Use table 2 (above) to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.
- 4 Calculate the risk score the risk multiplying the consequence by the likelihood: C (consequence) \times L (likelihood) = R (risk score)
- 5 Identify the level at which the risk will be managed, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings. Include the risk in your directorate risk register.

Risk Treatment

The above four categories of risk provide an initial prioritisation for management action. The precise timing of actions will be set out in the Action Plan. In general, the four categories of risk will be treated as follows:

Further Action Required Based on the Risk Grading

Risk Level	Further Action	By Whom
Extreme (RED)	<p><i>Significant risk:</i></p> <ul style="list-style-type: none"> • Immediate action required • Director must be informed and he/she to take responsibility for immediate action planning • Report to Board identifying treatment options (use action plan template) • Quarterly report to the Board monitoring progress on treatment action plans 	Director
High (AMBER)	<ul style="list-style-type: none"> • Urgent senior management attention required • Agree action point within 1 month with deadline for completion of no more than 6 months • Report to Governance Committee identifying treatment options • Quarterly report to Governance Committee monitoring progress on treatment action plans 	Senior Management

<p>Moderate (YELLOW)</p> 	<ul style="list-style-type: none"> • Specific responsibility for risk assessment and action planning must be allocated to a named person • Deadline for completion will be within 6 to 24 months and will depend on resource availability • Discuss whether any further action should be taken to reduce future risk 	<p>Team Leaders</p>
<p>Low (GREEN)</p> 	<p><i>Acceptable Risk.</i></p> <ul style="list-style-type: none"> • Can be managed by routine procedures • Record on risk register • Inform all appropriate stakeholders 	<p>All staff</p>

**NOW RECORD YOUR FINDINGS ON THE RISK REGISTER TEMPLATE
(AN EXAMPLE IS ALSO SHOWN BELOW)**

Appendix D: Risk Register Template

Directorate/Department:

Date:

Objective & Ref. (1)	Source of the Risk (2)	Risk Description (3) Including quantification of impact	Current measures (controls) in place (4)	Current Risk Rating (5)			Direction of risk rating score (6) (up↑ static↔ down↓)	Ownership (7)	Action Plan (8)	Review date/Action plan update(9)	Projected Residual risk rating following action plan (10)
				L	C	RR					
		Risk 1:									
		Risk 2:									
		Risk 3:									
		Risk 4:									

1. cross reference each risk with the Trust objective/target it will have an impact on. Give a unique reference no
2. State the source of the risk (including, but not limited to, incident reports, risk assessment, and complaints)
3. Enter a simple statement about the risk – include what the risk is and how it might be caused. Include the quantification of impact, in line with the consequence scale i.e. reputational, clinical, health & safety, financial environmental etc
4. Include any systems, processes, measures, controls etc that are currently in place to manage these risks. Consider whether there are contingency arrangements in place should these risks materialise.
5. what would the consequence of this risk be should it occur, and how likely is it to occur (use the scale at the bottom of the register and refer to impact definitions). Enter a current risk rating (RR) score
6. Has the risk rating score gone up ↑ down or ↓ stayed static ↔. Use the arrow to indicate and enter a score as required
7. who owns the risk, please identify a named person for the risk.
8. if you have identified actions necessary to improve the management of the risk, list the actions
9. when do you intend to review the assessment of the risk and any actions identified? Provide update status on actions
10. Enter the projected risk rating score you will reside with following risk treatment

Appendix E: Risk Treatment Action Plan

DESCRIPTION OF RISK/ ISSUE (what can happen & how it can happen):

*

REF (from risk assessment, register / assurance framework):

ACTION PLAN

Proposed action	Resource requirements	Lead Person / Department	Completion date	RAG status (Red/Amber/Green)
*				
*				
*				

COMPILER: _____

REVIEWER: _____

DATE: _____

DATE: _____

Appendix F: Governance EMT Terms of Reference

Constitution

The Board hereby resolve to establish a Committee of the board to be known as the Governance Executive Management Team

Membership

Chief Executive (Chair)
Director of Finance and Performance
Director of Primary and Community Care Commissioning
Director of Strategic Commissioning
Director of HR & Organisational Development
PEC Co-Chairs
Head of Press & Communications
Head of Corporate Affairs
Co-ordinators for Standards for Better Health and the NHSLA Risk Management Standards will be invited, as appropriate, for regular reports.

The group will not be quorate unless at least five attendees are present. If quorum is not reached, a meeting can still be held, and decision ratified at the next quorate meeting. If members are unable to attend a meeting they must nominate a deputy.

Attendance at meeting

As above

Frequency of meetings

Every month

Role

GEMT is responsible for all aspects of governance and risk management, both clinical and non-clinical, for NHS Brent as a commissioning organisation.

With the separation of commissioning and provider functions it is **not** the body which considers provider side risk. That function is undertaken by the APO structure, reporting to the Provider Sub-Committee, which in turn reports to the full board.

The GEMT will monitor the risk management and governance arrangements of all services commissioned by NHS Brent to ensure compliance with legislation and best practice.

Duties

GEMT will:

- review the PCT's Board Assurance Framework, Corporate Risk Register and the Integrated Governance Action Plan as well as progress against this on a regular basis;
- review risk management, claims, complaints and incident reporting policies annually;

- ensure that appropriate information, education and training about risk management is provided for all staff including members of the PCT Board and Professional Executive Committee;
- ensure the various activities of the PCT are examined to identify the key risks that exist; to analyse and assess those risks for potential frequency and severity; to eliminate risks where possible and appropriate; to manage and control the risks that cannot be eliminated; to review action taken in the PCT as a result of incidents and link all of this with business planning;
- receive reports from the Information Governance Group, JNCC and Education & Training Group
- ensure compliance with the NHS Litigation Authority's Risk Management Standard(s) where they apply to a commissioning organisation;
- ensure full compliance with the Care Quality Commissions requirements for a Commissioning organisation
- ensure the effectiveness of the Trust's arrangements for recording, dealing with and learning from incidents, complaints and claims.
 - monitor and review all Commissioning Serious and Untoward Incidents (SUIs) in line with NHS London guidance
 - review all complaints affecting the commissioning PCT
 - receive regular exception reports on risks affecting commissioned services

Reporting requirement

- GEMT is a sub-committee of the Board. It aims to foster a risk aware culture throughout the Trust covering all activities, both clinical and non-clinical. Minutes of the Governance EMT will be sent to Board.

Review and Monitoring the Terms of Reference

Key performance indicators (KPIs) will be used by the Corporate Affairs Team to monitor the effectiveness of the committee annually to ensure it has met its Terms of Reference and has been effective. The KPIs will review the duties of the committee, accountability, reporting arrangements, membership, including nominated deputy where appropriate, required frequency of attendance by members, reporting arrangements into the committee(s) from sub-committees, requirements for a quorum, frequency of meetings. The findings of the review will be presented to the Governance EMT.

13 May 2009 GEMT

Appendix G: Audit Committee Terms of Reference

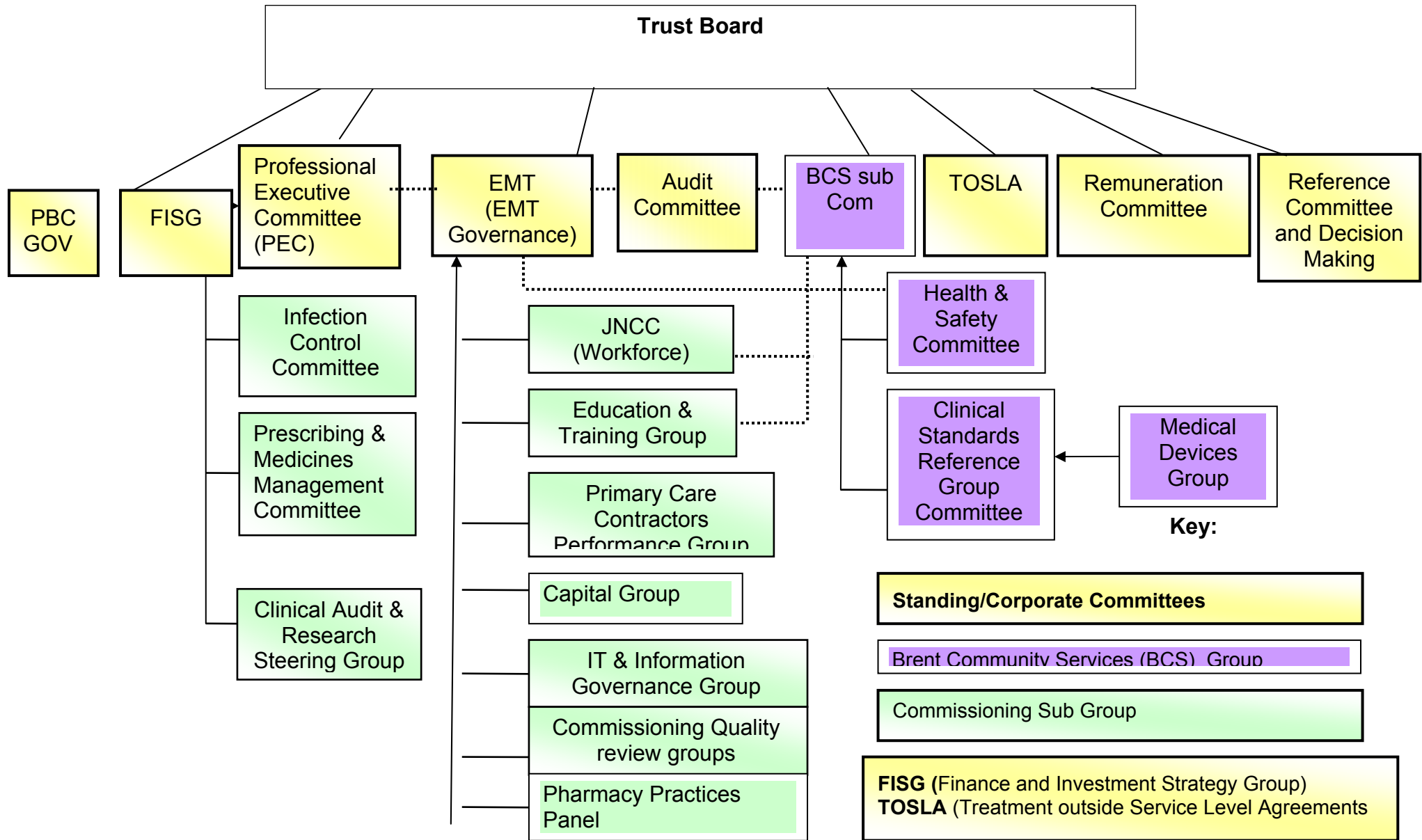
http://www.brentpct.org/files/D_AuditCommitteeTOR.doc

Appendix H: Internal & External Stakeholders

Patients and their families / carers
Staff (both employed by the PCT & working in Practices within the PCT)
NHS Brent Health & Social Care forum
Brent LINKs
Staff representative groups such as unions
NHS London & Department of Health (DoH)
Specialist commissioning and specialist providers
London Borough of Brent (Education and Social Services)
North West London Hospitals, St Mary's Hospital and other local acute Trusts
Hammersmith & Fulham PCT
Hounslow PCT (all local PCTs)
Ealing PCT
Hillingdon PCT
Kensington & Chelsea PCT
Central & North West London Foundation HealthTrust
Westminster PCT
Local Voluntary user groups: MIND, Brent Carers', Mencap, Partnership Boards
Internal Audit & External Audit
All local Primary Care Contractors: General Practitioners, Dentists, Pharmacists and Opticians.
Local Medical, Dental, Opticians and Pharmaceutical Committees
Research bodies e.g. Medical Research Council
Colleges: Royal College of Nursing, Thames Valley University and College of North West London
Professional Regulatory Bodies: General Medical Council, Nursing and Midwifery Council, British Medical Association, Royal Colleges
Public
Media
Commission for Equality and Human Rights (CEHR)
Suppliers of goods and services
National charities
Local charities / voluntary organisations
IHSM, NHS Confederation

Police & Probation services for Brent
<p>National regulatory bodies:</p> <p>Food Standards Agency</p> <p>Healthcare Commission</p> <p>Health and Safety Executive</p> <ul style="list-style-type: none"> • Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 • Ionising Radiations Regulations 1999 <p>Home Office</p> <ul style="list-style-type: none"> • Mental Health Act Notification Scheme <p>Medicines & Healthcare Products Regulatory Agency (MHRA)</p> <ul style="list-style-type: none"> • Voluntary user reporting of all adverse incidents involving medical devices and equipment • Mandatory “vigilance” reporting scheme for medical device and equipment manufactures • Adverse drug reaction (yellow card) scheme • Defective medicines reporting <p>National Patient Safety Agency</p> <ul style="list-style-type: none"> • Adverse patient safety incidents <p>NHS Estates</p> <ul style="list-style-type: none"> • Firecode – reporting of fire incidents • Buildings – Buildings and non-medical equipment defect and failure reporting <p>NHS Litigation Authority</p> <ul style="list-style-type: none"> • Clinical Negligence Scheme for Trusts (CNST) • Liability to Third Parties (LTPS) and Property Expenses Scheme (PES)
Estates & Facilities Shared Services
Advisory bodies i.e. NSCAG, NICE, networking partners i.e. Cancer and Learning Disability networks
External and internal auditors

Appendix I: Chart Showing Accountability of Committee Reporting to the Board



Appendix I: Sources of further Advice

Specialist Area	Name	Job Title	Contact Details (Telephone Number & E-mail)
Overall Risk Management Risk Registers & Risk Assessments	Bridget Pratt	Head of Corporate Affairs	020 8795 6395 bridget.pratt@brentpct.nhs.uk
BCS Governance	Christopher Brooks-Daw	Head of Governance (Interim)	020 3114 7213 Christopher.brooks-daw@brentpct.nhs.uk
BCS Clinical Governance & Risk Management	Faisal Ahmed	Clinical Governance Lead	020 3114 7144 faisal.ahmed@brentpct.nhs.uk
Emergency Planning Advice and Provider Risk	Shirley Parker	Emergency Planning Officer & Provider Risk Manager	020 3114 7208 shirley.parker@brentpct.nhs.uk
Health and Safety	Darryl Stevens	Health and Safety Advisor	0118 952 5315 darryl.stevens@brentpct.nhs.uk or darryl.stevens@nhs.net
Fire & Safety (Contracted)	Barry Carpenter	Fire & Environmental Risk Advisor	Kensington & Chelsea PCT 020 8962 4248 barry.carpenter@kc-pct.nhs.uk
Infection Control	Lynn Leaver	Infection Control Nurse	020 3114 7136 lynn.leaver@brentpct.nhs.uk
Medicines Management	Rashmi Rajayaguru	HEAD OF PRESCRIBING	020 8795 6226 rashmi.rajayaguru@brentpct.nhs.uk
Fraud (contracted)	Hannah Wenlock	Counter Fraud trainer & investigator	Counter Fraud Services, Bentley Jennison 07860 461142 hannah.wenlock@rsmbentleyjennison.com
Staff security (theft, physical or verbal assault) (contracted)	Darryl Stevens	LSMS Specialist	0118 952 5315 darryl.stevens@brentpct.nhs.uk or darryl.stevens@nhs.net
Occupational Health (provided via a Service Level Agreement)	Reception		020 8795 6048

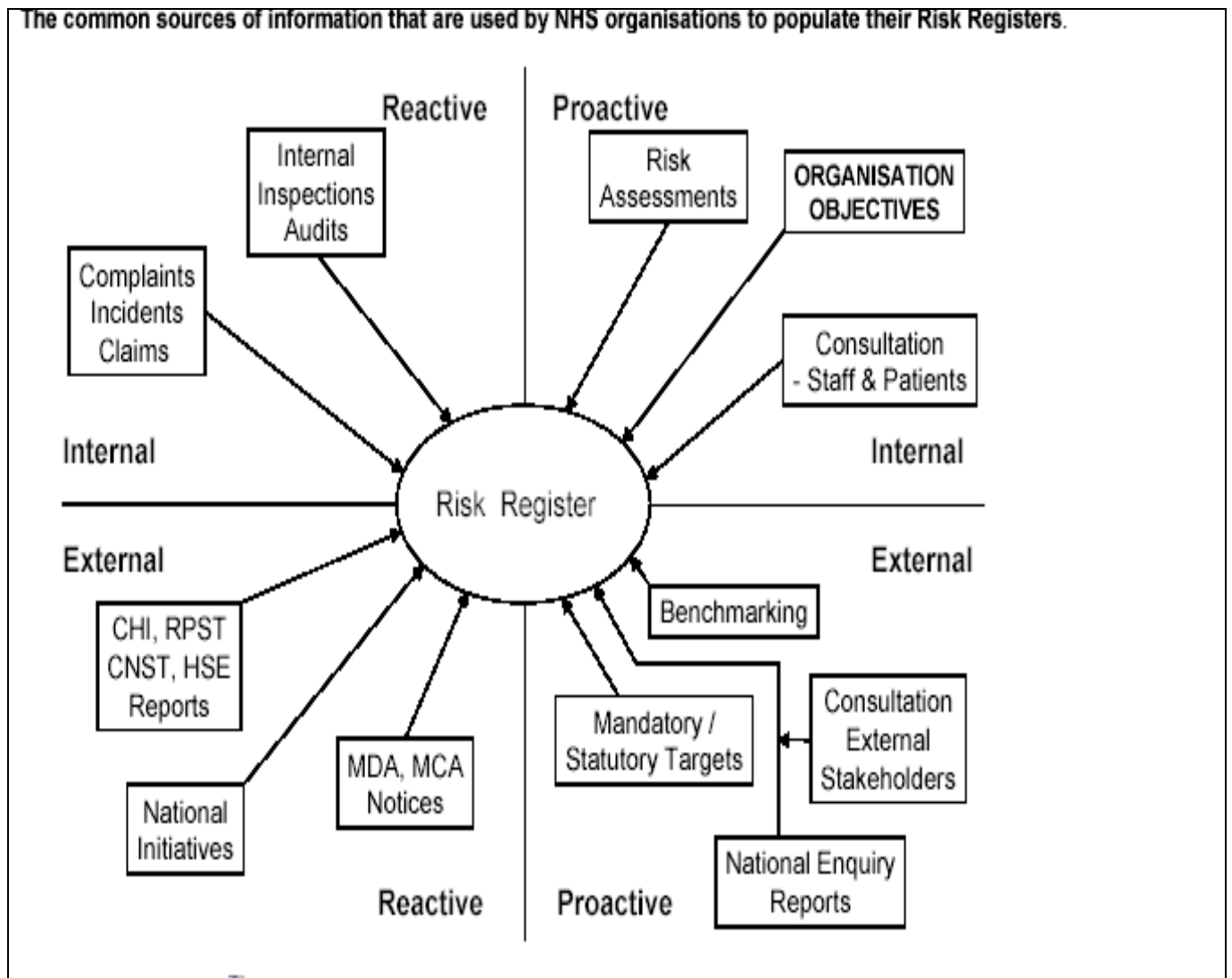
Appendix J: Glossary of Key Risk Management Terms

The following definitions of risk management terms have been adopted by the PCT from the Australian/New Zealand Standard 4360:1999 on "Risk Management" except where otherwise indicated.

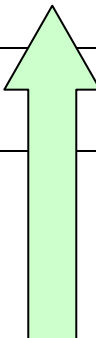
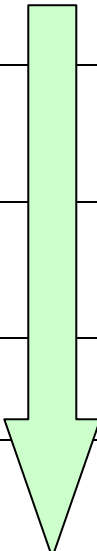
Term	Definition
Consequence	The outcome of an event expressed either in financial terms or qualitatively, being a loss, injury, disadvantage or gain.
Likelihood	The possibility of an event happening
Risk	The chance of something happening that will have an impact upon objectives. It is measured in terms of consequences and likelihood.
Risk Assessment	The overall process of risk analysis and risk evaluation.
Risk Analysis	A systematic use of available information to determine how often specified events may occur (likelihood) and the magnitude of their consequences .
Risk Evaluation	The process used to determine risk management priorities by comparing the level of risk against target risk levels or other criteria
Risk Management	The culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.
Risk Register	A management tool that enables an organisation to understand its comprehensive risk profile. It is simply a repository for all risk information.

* From *Making it Happen. A guide for Risk Managers on how to populate a risk register*. Controls Assurance Support Unit, Keele, 2002

Appendix K: Sources of Risk Identification



Appendix L: Integrating the Risk Register into the Risk Management Process

1	All Staff	Risks/Hazards/Complaints etc. reported in line with appropriate policy	
2	Team/Department Managers	Perform risk assessments and inform Heads of Services	
3	Heads of Services	Prepare team/departmental risk registers and forward to Risk Champions Review team/departmental risk registers	
4	Risk Champions	Prepare Directorate Risk Registers Review and Implement Directorate Risk Registers & Risk Action Plans	Process monitored by Internal Audit who report to Audit Committee
5	Head of Corporate Affairs and Governance	Prepare Corporate Risk Register	
6	Governance Committee	Review all Directorate & Corporate risk registers	
7	Specialist Committees e.g. PEC, Prescribing & Medicines Management Committee, Health & Safety, Infection Control etc.	Review specific risk issues Advise on the treatment of risks	
8	Audit Committee	Receive and review exception reports on risks and make recommendations as required	

Appendix M: Equality Impact Assessment

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

DOCUMENT AUTHOR: Bridget Pratt- Head of Corporate Affairs	DIRECTORATE: Corporate Affairs & Governance
NAME OF DOCUMENT/POLICY/STRATEGY/PROCEDURE Risk Management Strategy/Policy	NEW EXISTING <input checked="" type="checkbox"/> ASSOCIATED POLICIES, STRATEGIES OR PROCEDURES Standards for Better Health Policy Assurance Framework Policy Incident Reporting Policy Serious & Untoward Incident Policy
DATE 9/9/09	

Aim/Status

[a] What is the aim/purpose of the policy/strategy/procedure? To provide a clear policy, procedure and protocols for staff in NHS Brent.
[b] Who is intended to benefit from this policy/strategy/procedure and in what way? Staff and patients in NHS Brent leading to improved communication and an enhanced service
[c] How have they been involved in the development of this policy/strategy/procedure? Policy consulted on with key stakeholder and ratified by GEMT
[d] How does it fit into the broader corporate aims? The policy ties in with the corporate objectives of the Trust: CO6: Develop NHS Brent as a World Class Commissioning Organisation
[e] What outcomes are intended from this policy/strategy/procedure? Improved quality of patient care
[f] What resource implications are linked to this policy/strategy/procedure? None

Impacts

[a] what is the likely impact [whether intended or unintended, positive or negative] of the initiative on individual users or on the public at large? Raise staff awareness		
[b] Is there likely to be differential impact on any group? If yes, please state if this impact may be adverse and give further details [e.g. which specific groups are affected, in what way, and why you believe this to be the case] No		
[i] Grounds of race, ethnicity, colour, nationality or national origin	Please tick box no	Please tick box Adverse? <input type="checkbox"/> Please give further details
[ii] Grounds of sex or marital Status Women and Men	no	Adverse? <input type="checkbox"/> Please give further details
[iii] Grounds of gender: Transgender or Transsexual People	no	Adverse? <input type="checkbox"/> Please give further details
[iv] Grounds of religion or belief: Religious /faith or other Groups with a recognised belief system	no	Adverse? <input type="checkbox"/> Please give further details

Appendix O: Policy Ratification and Publication Flowchart

