RISK MANAGEMENT POLICY

Summary

The systematic identification, analysis and control of risks are a key organisational responsibility. A culture of ownership and responsibility for risk management / patient safety is fostered throughout the organisation and all managers and clinicians undertake risk management as one of their fundamental duties.

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1. RISK MANAGEMENT POLICY STATEMENT

The Royal Marsden NHS Foundation Trust is committed to the maintenance of a multidisciplinary, patient focused approach to care which is responsive to the needs of patients. The continued delivery of a high quality service requires the identification, management and reduction of events or activities that could compromise the safety of patients, staff, visitors and any other persons.

The systematic identification, analysis and control of risks are a key organisational responsibility. A culture of ownership and responsibility for risk management / patient safety is fostered throughout the organisation and all managers and clinicians undertake risk management as one of their fundamental duties.

All members of staff have a responsibility for risk management / patient safety and a commitment to identifying and minimising risks. This is achieved through an environment of openness and trust: where mistakes, adverse incidents and near misses are identified quickly and dealt with in a positive and responsive way. Fear of disciplinary action may deter staff from reporting an incident. The view of the Trust Board is that disciplinary action should not form part of the response to a report of an incident unless there are "exceptional circumstances".

Risk management aims to achieve the optimum balance between quality care, treatment and rehabilitation of patients and the provision of services which are safe by making maximum use of available resources and identifying prioritised risk control action plans. Risk reduction will be achieved through a continuous cycle of the identification, assessment, control, monitoring and review of risk.

The Royal Marsden NHS Foundation Trust's Five Year Strategic Plan 2018/19 – 2023/24 has a primary strategic aim to deliver the best cancer treatment through world leading research, operating a 'bench to bedside' strategy with its academic partner, The Institute of Cancer Research.

To support the strategy over the next five years there are key priorities/ core themes:

- Research & Innovation
- Treatment and care
- Modernising infrastructure
- Financial sustainability and best value
- Workforce
- Quality
- The Royal Marsden Cancer Charity
- Private care

The Trust recognises that the integration of governance and risk management / patient safety throughout all areas and services are crucial to achieving this strategic aim and associated key priorities. There are a number of other policies which support the overall risk management / patient safety framework and a summary of these are listed in Appendix G.

Annual training on risk management for Board members: Members of the Executive Board and their direct reports who have senior management responsibility is a key element of the successful implementation of the Trust's risk management strategy and contributes to internal control arrangements in the Trust (Appendix K identifies the approved process for new staff).

This document identifies the strategy for the further development, implementation, monitoring and review of risk management / patient safety throughout the Royal Marsden NHS Foundation Trust. The aim of this strategy is to embed a co-ordinated, systematic and focused approach to the management of clinical and non-clinical risk, including financial, information technology and strategic.

The Trust acknowledges that some of its activities may, unless properly controlled, create risks to members of staff, and others. The Trust will therefore:-

- Establish, implement, and maintain risk management systems to comply with the NHS requirement for risk assessment. Appendix A provides guidance on risk assessments.
- Take all reasonably practicable measures to either eliminate or reduce identified risks to an acceptable level. Appendix B gives a risk assessment template for clinical and non-clinical areas that identifies areas that might warrant risk assessments.
- Foster a culture of ownership and responsibility for risk assessment throughout the organisation by ensuring that all managers and clinicians undertake risk management as one of their fundamental duties.
- Ensure that the overall performance of the Trust's risk management/risk assessment system is reported to the Trust's Integrated Governance and Risk Management Committee for review and is the basis for annual improvement.
- Identify resource requirements and provide reasonable resources for the maintenance and implementation of risk control systems.
- Comply with external standards that relate to risk management and patient safety.

2. DEFINITIONS

2.1 Risk Management

Risk management can be defined as the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.

Clinical risk management is the use of techniques to minimise the occurrence of near misses, errors and incidents in the processes of clinical activity and thereby reducing unwanted outcomes

2.2 Risk

Risk is the likelihood that something will occur that will have an impact on achievement of aims and objectives. It is measured in terms of likelihood and severity.

2.3 RISK ASSESSMENT

2.3.1 Risk Analysis

Risk analysis is the systematic use of available information to determine how often specified events may occur and the severity of their consequences.

2.3.2 Risk Evaluation

Risk evaluation is the process used to determine risk management priorities (e.g. high, medium, low) by comparing the level of risk against predetermined standards, best practice, clinical performance targets, national performance indicators, accident/incident trend analysis or other criteria.

2.3.3 Risk Assessment

The overall process of risk analysis and risk evaluation.

2.3.4 Risk Control

Risk control is part of the risk management system, which involves the implementation of policies, standards, procedures, and physical changes to eliminate or minimise adverse risks.

2.3.5 Residual Risk

The remaining level of risk after risk treatment / risk control measures have been taken.

2.3.6 Acceptable Risk

The Trust acknowledges that some of its activities may, unless properly controlled, create organisational risks, and/or risks to staff, patients and others. The Trust will therefore make all effort to either eliminate risk or ensure that risks are as low as reasonably practicable. However, it is not possible to reduce all risks to zero and it is sometimes necessary to make judgements about achieving the correct balance between benefit and risk. To deal with these complexities, the Trust requires a basis for defining “acceptable” and “tolerable” risk.

2.3.6.1 Tolerability

Tolerability does not mean “acceptability”. Tolerability refers to a willingness to live with risk so as to secure certain benefits with the confidence that it is being properly controlled. To tolerate risk means it is not regarded as negligible or something which might be ignored, but rather something which needs to be kept under review and reduced still further if and when it is possible to do so.

2.3.6.2 Acceptability

“Acceptability” implies that the organisation is prepared to accept the risk as it is. In order to provide a framework for identifying acceptable risks, a standard risk matrix is used for risk assessment. The matrix (see Appendix A) is applied for all types of risk including:

- Health and safety risks (i.e. personal and physical risks to staff, patients and others)
- Organisational risks (e.g. IT risks, waste management, fire, security, environmental facilities management, finance and, product liability/safety risks)
- Clinical / patient safety risks.
- Strategic risks that form part of the Assurance Framework.

The Trust will not accept any risk with a combined rating of 6 or more.

3. RESPONSIBILITES

3.1 The Trust Board

The Board is responsible for providing leadership and commitment for establishing, maintaining and monitoring good risk management / patient safety systems across the Trust. The Trust Board is accountable for internal control and is responsible for ensuring that the Trust follows the principles of good governance. This includes the development of systems and processes for financial control, organisational control, clinical governance and risk management / patient safety.

3.2 Chief Executive Officer

The Chief Executive Officer has overall accountability and responsibility for risk management/patient safety. The Chief Executive Officer holds each line manager accountable for setting objectives, relevant to the Trust's objectives for their own staff.

3.3 The Chief Nurse and Medical Director

The Chief Nurse and Medical Director have been identified as the Executive Directors with responsibility for risk management/patient safety. The Chief Nurse/Director of Infection Prevention and Control (DIPC) is the Executive Lead responsible for the management of risk relating to infections and infectious agents and is also the Caldicott Guardian acting as the guardian of patient identifiable information.

3.4 The Head of Risk Management

The Head of Risk Management is responsible for coordinating and monitoring the risk management / patient safety work programmes on behalf of the Chief Nurse so that the Trust achieves compliance with the risk management / patient safety objectives, locally and nationally.

The Head of Risk Management to ensure that:-

- The Risk Management / Patient Safety programme is co-coordinated throughout the Trust.
- The Risk Management policy, programme and risk register of each division accurately reflects the risks present and the control measures and action plans required to manage them.
- Risk assessments that are a statutory requirement are undertaken and documented. The Board receive regular reports to demonstrate that the framework

for risk management / patient safety is suitable and effective in satisfying the Trust's risk management policy and strategy.

- A process for monitoring, reviewing and auditing the Trust's risk management strategy is established (Appendix H describes the schedule for risk monitoring).
- The risk register is developed and managed appropriately.
- Lessons learned within departments are shared throughout the Trust to avoid similar issues recurring.
- Reports on equipment problems are reported to the Medicines and Healthcare products Regulatory Agency (MHRA).
- Risks highlighted in external reviews and reports are incorporated into the risk register as appropriate. Ensure that appropriate risk management / patient safety issues are discussed at the appropriate forums.

3.5 Chief Operating Officer

The Chief Operating Officer is responsible for risk management / patient safety within the divisions and is the Trust Senior Information Risk Officer (SIRO). It is the responsibility of the SIRO to take forward the Trust's information risk agenda and act as advocate for information risk at board level.

3.6 Director of Workforce

The Director of Workforce is responsible for all aspects of human resource risk management and for the co-ordination and implementation of the Trust's strategy for occupational health services.

3.7 Divisional Directors and Director of Operations Private Care

The Divisional Directors and Director of Operations Private care have functional responsibility for risk management / patient safety within their areas of responsibility.

3.8 Divisional Clinical Nurse Directors

The Divisional Clinical Nurse Directors are the nominated risk management / patient safety lead within their areas of responsibility.

3.9 Chief Financial Officer

The Chief Financial Officer is responsible for ensuring that the Trust complies with statutory requirements for financial risk management. The Chief Nurse attends the Board level Audit and Finance Committee thus ensuring that the two strands of risk financial and clinical come together.

3.10 Director of IT

The Director of IT is responsible for organisational risk / patient safety issues related to the Trust's strategy for information technology.

3.11 Director of Performance and Information

The Director of Performance and Information is responsible for organisational risk/patient safety issues related to the Trust's strategy for information management.

3.12 Director of Clinical Research and Development

The Director of Clinical Research and Development is responsible for risk/patient safety issues related to research and research information management.

3.13 Chief Clinical Information Officer

The Chief Clinical Information Officer is responsible for risk and patient safety issues associated with the investment and development of clinical and patient information systems

3.14 Trust Secretary

The Trust Secretary is the Trust Data Protection Officer and is responsible for ensuring General Data Protection Regulation compliance.

3.15 Clinical Business Unit Managers & Directors

The Clinical Business Unit Managers and Clinical Business Unit Clinical Directors have functional responsibility for risk management / patient safety within their areas of responsibility.

3.16 Risk & Resilience Manager

The Risk and Resilience Manager is the lead for the development of non-clinical risk across the organisation, responsible for ensuring that the timetable of risk assessment and other initiatives are adhered to with individual participation in the work required.

3.17 Health & Safety Advisor

The Health and Safety Advisor will act as the Trust's advisor on all health and safety issues and will assist in the co-ordination and monitoring of relevant external risk management quality standards and legislation.

3.18 Chief Pharmacist

The Chief Pharmacist is the lead for risk management / patient safety in issues related to medicines management. The Chief Pharmacist reports issues related to risk and patient safety to the Executive Director with responsibility for risk management / patient safety, the Chief Nurse.

3.19 The Head of Quality Assurance

The Head of Quality Assurance is responsible on behalf of the Chief Nurse for co-ordinating and monitoring the patient safety work programmes associated with ensuring compliance with the Care Quality Commission standards and has responsibility for ensuring that the Assurance Framework is developed and managed appropriately.

3.20 Managers, Heads of Department, Heads of Clinical Unit, Professional Heads of Service, Matrons, Service Managers, Senior Sisters/Charge Nurses

Managers, Heads of Department, Heads of Clinical Unit, Professional Heads of Service, Matrons, Service Managers, Senior Sisters/Charge Nurses are responsible for:-

- Being the risk management / patient safety lead for their department.
- Ensuring that department/ward risk assessments are carried out and documented.

- Ensuring that the risk assessments identify hazards and risks associated with any work activities under their responsibility.
- Identifying resource requirements for the elimination or control of identified risks. Managers/Heads of Department are required to prioritise risks and identify appropriate actions plans.
- Ensuring that action plans are linked with the business planning process for the department and division.
- Informing staff (and others where necessary) of risk assessments and associated control measures in place to eliminate/reduce the risk.
- Monitoring compliance with risk assessment procedures and ensuring that control measures are used correctly and are effective in terms of reducing identified risks.
- Ensuring that they and their staff attend any risk assessment training commensurate with their roles.
- Reviewing risk assessment details at a frequency that depends on the grade of the risk.
- Forwarding all risk assessments that have been approved by the Divisional/ Directorate Risk Management Leads to the Head of Risk Management so that appropriate risks are included on the Trust's risk register.

3.21 Employees

All employees have a responsibility to report unsafe practices, clinical or non-clinical risks, adverse and potential adverse incidents to the relevant person to ensure that appropriate risk control action is taken.
All employees should be aware of the risk assessments for their area of work and work activities and relevant procedures or control measures to be adopted to reduce identified risks. Employees have a responsibility to make full and proper use of any equipment and systems of work provided for them and attend any training appropriate to their duties.

3.22 Patients, relatives and volunteers

Patients, relatives and volunteers are encouraged to report unsafe practices, clinical or non-clinical risks, adverse and potential adverse incidents to a member of staff. Feedback is given where possible and if necessary the issue is escalated to a senior member of staff for action.

4. RISK REGISTER

4.1 Introduction

The Trust risk register is a tool that enables the Trust to understand its risk profile. It is a repository for all risk information and is held on the Pentana IT system.

The risk register can be described as a record of all high level risks that threaten the Trust's success in achieving its aims and objectives. All risks scoring **above** 12 including those highlighted on the Trust's Assurance Framework are logged on the Trust risk register. The risk register is populated through the organisation's risk assessment and identification process which enables risk to be quantified and ranked. The register provides a structure for collecting information about risks that helps both in the analysis of risk as well as decisions about whether or how these risks should be treated, managed, monitored and how resources will be allocated.

Risks can be identified from a variety of risk identification tools. These include: risk assessments, business cases, business plans, clinical audits, reports from PALS, incidents, complaints, claims, safety notices, new activities, increased workload and external assessment reports. The Trust risk register is a living document that will constantly be added to and modified: risks will be added or eliminated as the situation dictates.

4.2 Using a Risk Register in supporting the Organisation

The Trust risk register should be used to inform the decision making processes within the Trust. Ideally, all decisions such as changes in policy and resource commitments should result in the reduction of the highest level risks / patient safety issues. It is important that decisions are based on accurate risk evaluation, including analysis of the potential benefit. This will allow the progress of effective risk management within the Trust as well as ensuring that the Trust can justify the decisions that it has made.

4.3 Responsibility of the Integrated Governance and Risk Management Committee (IGRM)

The Trust risk register (comprising of the Trust's key risks scoring above 12), progress against action plans and the residual risk should be received at quarterly intervals by the IGRM so that the issues can be reviewed and monitored by the committee.

Risks that are on the Trust register that may have strategic implications will be identified at IGRM.

The IGRM will also review and monitor the Corporate Risk Register which contains all risk that score 9 and above.

4.4 Responsibility of the Quality, Assurance and Risk Committee (QAR)

The Trust risk register (comprising of the Trust's key risks scoring above 12), progress against action plans and the residual risk should be received at quarterly intervals by the QAR in order that the management and assurance of risk issues are discussed with the executive team. QAR is recognised as a high level committee with Board membership.

4.5 Responsibility of Trust Board

The Trust Board is responsible for monitoring the internal control system. The Board has responsibility to ensure that there is a clear and appropriate management structure that enables risk to be identified and decisions taken at an appropriate level. The Board should understand its risks to achieving its objectives and should actively re-assess and monitor them. The Trust Board will receive information from QAR regarding the risk register and the assurance framework on a quarterly basis.

4.6 Responsibility of Audit & Finance Committee

At the Audit & Finance Committee which meets four times a year, financial, organisational and clinical risks are brought together for discussion and evaluation. The Audit & Finance Committee is chaired by a Non-Executive Director of the Trust with the Chief Nurse representing clinical risk and the Chief Financial Officer representing financial risk.

4.7 Responsibility of the Chief Operating Officer and Directors

The Chief Operating Officer and Directors are responsible for ensuring the implementation of the Divisional / Directorate risk register and ensuring that any risks / patient safety issues graded 9-25 are acted upon appropriately and notified to the Head of Risk Management for inclusion in the risk register.

Action should be taken as soon as possible to reduce the risk to the lowest possible level within the organisation to eliminate, transfer or reduce the risk.

The Divisional / Directorate risk register with risks that score 9 and above should be reviewed at quarterly intervals at divisional/directorate meetings and amended as required. The Divisional / Directorate risk register should be accessible and available to all staff and Trust recognised staff representatives.

4.8 Responsibility of Clinical Business Unit (CBU) Managers, CBU Clinical Directors, Service Managers, Matrons and Professional Heads of Service

There is a triumvirate structure at Divisional and CBU level consisting of a Senior Manager (CBU Manager), Consultant (CBU Clinical Director) and Senior Nurse/Matron. The CBU triumvirate management team are responsible for reviewing the risk register in the first instance. They have a role in validating the risk register and will moderate the risk register for their division/service/ clinical business unit. As a general rule significant risks (grade 9 and above) should be brought to the attention of their relevant Divisional Director for inclusion into the Division / Directorate Risk Register.

In addition to proactive risk assessments, they will highlight any issues arising from identified serious incidents occurring within the division that are assessed as “red” so that they can be included on the divisional risk register until such time as the recommendations have been implemented. At this point, the risk will then be reviewed and providing actions have been adopted the risk will then be removed from the register.

The CBU Managers are responsible for informing the Head of Risk Management of any risks that are taken off the register or, added to the register (e.g. when a significant incident occurs or, when a new activity is implemented and assessed as high risk).

The CBU Management teams are responsible for ensuring that risks are managed locally, overseeing the risk assessment process (Appendix A) and ensuring that the key messages regarding risk are disseminated throughout the organisation.

4.9 Responsibility of Head of Risk Management

The Head of Risk Management is responsible for overseeing the Trust’s risk register. Risks will be identified from risk assessments that have been undertaken on behalf of the Trust Board and by divisions, directorates, departments and wards of the Trust.

The Head of Risk Management is also responsible for moderating the risk ratings of all risk assessments to ensure consistency across the Trust.

The Head of Risk Management will be responsible for co-ordinating and maintaining the Trust risk register and producing quarterly reports to IGRM, QAR and the Board.

The Trust risk register will be maintained on a central Pentana IT database.

4.10 Review of Trust Risk Register

The Trust risk register will be presented to the high level committee QAR quarterly after review at the Integrated Governance and Risk Management Committee. The Divisions review their registers at their quarterly management meetings. Dissemination of the divisional risk register throughout the division is the responsibility of the Divisional Director. The finalised risk register us also reviewed at Nursing, Radiography and Rehabilitation Advisory Committee and the Clinical Advisory Group.

5. COMMITTEES

5.1 The roles of the Integrated Governance and Risk Management Committee and the Quality, Assurance and Risk Committee

The Trust has two principal committees for monitoring the implementation of clinical governance and risk management / patient safety arrangements within the Trust. The two committees are the Quality, Assurance and Risk Committee (QAR) and the Integrated Governance and Risk Management Committee (IGRM). These Committees are responsible for ensuring that appropriate control systems are in place for all clinical risk management / patient safety issues, clinical governance and external standards. (Appendix C and Appendix D show the membership and terms of reference respectively for each committee). (Appendix E shows the overall committee structure for the Trust).

5.2 Sub-Committees

In addition to the two principal committees, a number of other sub-committees are in place to monitor arrangements for specific risks.

6. ASSURANCE

6.1 The Audit and Finance Committee

The Audit and Finance Committee review and provide independent verification on the systems in place for risk management / patient safety.

The Audit and Finance Committee receive external and internal reports which assess the Trust's progress on its risk management / patient safety processes.

The Audit and Finance Committee report to the Board on the effectiveness of the systems in place for risk management/patient safety as determined by the Internal Auditors. Terms of reference and membership of the Audit and Finance Committee are described in Appendix F.

6.2 External Sources of Assurance

The Lead for the varying elements of risk / patient safety has the responsibility for determining the type of external assurance needed to ensure that there are satisfactory arrangements in place to provide the Board with the assurance that risks are being managed appropriately. This will enable the Trust to submit an appropriate Annual Governance Statement. Examples of such assurance may include Care Quality Commission assessments, reports from Monitor, Internal Audit and Improving Working Lives.

6.3 The Role of the Trust Board

The Trust Board will identify its principal objectives. From these principal objectives the Board will expect each division/directorate to establish its own objectives which support these objectives. The Trust Board will ensure that, through its management arrangements, which potential risks are being managed to avoid the consequence arising from the residual risk.

7. TRAINING

All new staff (including medical staff) receive information on the Trust's strategy for risk management / risk assessment at induction. In addition, existing staff will participate in risk management / patient safety training as part of the Trust mandatory training programme. (see Mandatory Training Policy and Training Needs Analysis).

8. KEY PERFORMANCE INDICATORS

In order to ensure that progress within risk management and patient safety can be demonstrated a number of key indicators have been identified in the table below together with a compliance target and details of the evidence required.

Indicator	**Compliance Target**	**Evidence**
Compliance with standards required by the Care Quality Commission	100% compliance with Fundamental Standards	Self assessment process Care Quality Commission assessment
Incident reporting	100% specialties report incidents and all disciplines report	Incident forms Audit of incident reporting
Risk Assessment process implemented	75% of all areas to have completed a risk assessment working towards 100%	Risk assessments are completed in all areas of the Trust. Evidence of action being taken following risk assessment.
Risk Register	Trust Risk Register to be submitted to QAR quarterly with minutes to the Board. Trust Risk Register to be used as an aid to initiate organisational change.	Regular review of the risk register. Review of actions completed

9. MONITORING EFFECTIVENESS

An annual audit is undertaken by the risk management team to ensure that the requirements of the policy are being adhered to.
The audit covers the following areas:

- Committee reporting arrangements into IGRM
- Board level review of the Trust risk register
- Review of local risk registers and the process for the review by the divisions
- The terms of reference for the high level risk committee
- Reporting arrangements into the high level risk committee
- Reporting arrangements into the board from the high level risk committee
- How all risk are assessed and risk assessments conducted consistently
- Authority levels for managing different levels of risk within the organisation
- How risks are escalated through the organisation
- Content of the risk register
- How risk management training is delivered to Board members and senior managers in line with the training needs analysis.

Appendix A

COMPLETING RISK ASSESSMENTS

INTRODUCTION

Risk assessment is a careful systematic examination of the **Hazards** (*something with the potential to cause harm*) present in the organisation/ environment/ department/ workplace and, the **Risk** (*likelihood*) that this could actually happen. The risk assessment should then consider whether or not enough precautions have been taken to eliminate the hazard or reduce the risk.

Risk assessment establishes actual levels of risk and most importantly, should lead to action to prevent or control organisational risks and, individual risks to staff, patients, and visitors. Appendix I describes the key stages in completing a risk assessment.

Risk Assessment Steps

In accordance with the Risk Management System standard adopted by the NHS (AS/NZ ISO 3100), the process of risk assessment can be summarised by the adoption of the following steps:

Step 1 : Establish the context
Step 2 : Identify risks / hazards
Step 3 : Analyse the risks (Likelihood x Severity)
Step 4 : Evaluate the risks (Identify the Risk Rating)
Step 5 : Control the residual risks
Step 6 : Monitor and review the assessments

In addition to these 6 steps there is also the need to continually Inform, Communicate and Consult all stakeholders. This should take place at each step and at regular intervals along the way.

Step 1 - Establish the Context

Risk Assessments must be carried out in consultation with the multidisciplinary team to ensure that key risks / hazards are identified and agreed. It is important to involve patients and carers views on risk wherever possible and appropriate. A prompt list of some potential risk assessments that may need to be included are shown in Appendix B. Include clinical and non-clinical, normal and out of hours. As appropriate include assessing off site work activities undertaken by staff where this forms part of their normal duties, e.g. home visits, deliveries, attendance at external clinics etc. Include foreseeable, non routine work activities such as: dealing with spillage of hazardous material (chemical biological and radioactive); helping a non ambulant person evacuate in a fire; dealing with a flood; undertaking an urgent/emergency clinical/theatre procedure.

People likely to be affected by hazards include patients, staff, locum and agency staff, visitors, volunteers, contractors and trespassers. Special consideration may need to be considered for children and pregnant women.

Step 2 – Identify the Risks / Hazards

The next stage of the risk assessment is to identify the risks / hazards to be managed. Identification should include all risks whether or not they are under the control of the organisation or not. Consider what can happen outside of the norm at every stage of an activity. Consider how and why events can happen (i.e. possible causes and adverse event scenarios). There are often many ways an adverse event (risk) can be initiated so it is important that no significant risks are omitted. Use checklists, flow charts, follow patient pathways, integrated care pathways, protocols – all of these methods can be helpful to identify steps along the way and what could happen outside of the ideal.

Systems failures

Adverse events generally occur due to a series of system failures – flaws in the present way of working. Common system failures can include the following. Each should be considered during an assessment of potential risk of a clinical or non-clinical activity.

- Deviation / changes from the norm
- Missing steps / information (including inadequate briefing or preparation information)
- Unusual / conflicting responses / ambiguities
- Fixation
- Confusion
- Unease / fear
- Denial (everything is just fine!!)
- Fatigue
- Broken communications
- Juniors cut corners (insufficient training/supervision/briefing/support)
- Hardware alarms

Step 3 – Risk Analysis

The objectives of risk analysis are to separate the minor acceptable risks from the major ones and to identify prioritized action plans.

Risk analysis involves consideration of the sources of risk, their consequences (severity), and the likelihood that those consequences may occur. Factors, which affect severity and likelihood, should be identified. Risk is analysed by combining estimates of the two factors (severity and likelihood) in the context of what existing control measures have been implemented.

Determine control measures

Identify the existing management, technical systems and procedures in place to control risks and assess their strengths and weaknesses.
The magnitude of consequences (severity) of an adverse event should it occur and the likelihood of the event actually occurring must be assessed in the context of the existing controls. Severity and likelihood are combined to produce an overlap level of risk (Risk Rating).

Severity and likelihood may be determined using statistical analyses and calculations. Alternatively where no past data is available, subjective estimates may be made which reflect an individuals or groups degree of belief that a particular event or outcome will occur. To avoid subjective bias the best available information sources and techniques should be used when analysing severity and likelihood. Sources of information may include past records, relevant first hand experiences, published literature, research or audit data, expert opinion, and accident data. Techniques include multidisciplinary team review.

Assessing Severity

Identifying the potential severity should an adverse event occur – what are the possible consequences of an adverse event or failure to adequately control risks? Using the NHS standard severity classifications, potential severity should be graded as one of the following five grades:

Table 1

Risk rating matrix - Assessing severity

	1	2	3	4	5
Descriptor	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Staff Injury	No or minor injury not requiring first aid	Minor injury or illness requiring first aid treatment.	RIDDOR reportable	Major injuries or long term incapacity/ disability (loss of limb)	Death or major permanent incapacity
Clinical Harm	No or minor injury not requiring medical intervention	Minor injury or illness requiring limited medical treatment	RIDDOR reportable	Major injuries or long term incapacity/ disability (loss of limb)	Death or major permanent incapacity
Patient Experience	Unsatisfactory patient experience not directly related to patient care	Unsatisfactory patient experience – readily resolved	Mismanagement of patient care	Serious mismanagement of patient care	Totally unsatisfactory patient experience/ outcome
Complaint/ Claim	Locally resolved complaint	Justified complaint peripheral to clinical care	Below excess claim. Justified complaint involving lack of appropriate care	Claim above excess level. Multiple justified complaints.	Multiple claims or single major claim
Objectives/ Projects	Insignificant cost increase/schedul e slippage. Barely noticeable reduction in scope/quality.	>5% over budget/ schedule slippage. Minor reduction in scope/quality	5-10% over budget/schedule slippage. Reduction in scope/quality requiring client approval	10-25% over budget/schedule slippage. Does not meet secondary objectives	>25% over budget/ schedule slippage. Does not meet primary objectives.
Service/ Business Disruption	Loss/ interruption >1 hour	Loss/ Interruption >8 hours	Loss/Interruption >1 day	Loss/ interruption >1 week	Permanent loss of service or facility
Human Resources/ Organisational Development	Short term low staffing level temporarily reduces service quality(<1 day)	Ongoing low staffing level reduces service quality	Late delivery of key objective/ service due to lack of staff (recruitment, retention or sickness) Minor error due to insufficient training. Ongoing unsafe staffing levels	Uncertain delivery of key objectives/ service due to lack of staff. Serious error due to insufficient training.	Non delivery of key objectives/ service due to lack of staff. Loss of key staff. Very high turnover. Critical error due to insufficient training.
Financial Trust Divisions	>£50,000 0.03%	>£250,000 0.10%	>£500,000 0.25%	>£1,000,000 0.50%	>£2,500,00 1.00%
Inspection/ audit	Minor recommendations Non compliance with standards	Recommendations given. Non compliance with standards	Reduced rating. Challenging recommendations Non compliance with core standards.	Enforcement action. Low rating/critical report. Multiple challenging recommendations. Major non-compliance with core standards	Prosecution. Zero rating. Severely critical report.

Adverse Publicity / Reputation	Rumours Potential for public concern	Local media coverage. Short term reduction in public confidence. Elements of public confidence not being met.	Local media coverage. Long term reduction in public confidence.	National media coverage with <3days 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 public loss of confidence.

Assessing Likelihood

Identifying the likelihood of an adverse event actually occurring will depend on the hazards present and what risk control measures are currently in place to reduce risk.

Table 2

Likelihood: Decision Criteria

1	**2**	**3**	**4**	**5**
Rare	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
<1%	1-5%	6-20%	21-50%	>50%
Will only occur in exceptional circumstances	Unlikely to occur	Reasonable chance of occurring	Likely to occur	More likely to occur than not

Step 4 - Evaluate the risk

Even after all precautions have been taken, some risk usually remains. What has to be decided for each risk is where it is acceptable / tolerable, or, whether it is reasonably practicable to reduce risk further. The decision on acceptability of risk involves a calculation of the final residual risk rating. This involves multiplying the severity rating by the likelihood rating. The resultant risk rating figure should then be used in conjunction with Table 3 and 4 to identify an appropriate action plan.

Risk Rating Matrix

	Severity				
Likelihood	**1 INSIGNIFICANT**	**2 MINOR**	**3 MODERATE**	**4 MAJOR**	**5 CATASTROPHIC**
ALMOST CERTAIN 5	5	10	15	20	25
LIKELY 4	4	8	12	16	20
POSSIBLE 3	3	6	9	12	15
UNLIKELY 2	2	4	6	8	10
RARE 1	1	2	3	4	5

Step 5 – Control the residual risk

Controlling (eliminating or reducing) the residual risk involves identifying the range of options for treating risk, assessing these options, preparing risk treatment plans and then implementing them.

Identifying additional control measures to reduce the risk rating is the most important stage of the whole risk assessment process. The assessment should summarise what actions must be taken to comply with the law, Department of Health standards, professional standards and/or accepted standards of best practice.

If a significant risk is revealed by the risk assessment, action must be taken to eliminate/minimise it. Where the risk assessment identifies that additional controls are required, managers will need to decide on the most effective control measures available. Risk control measures can seek to either reduce the potential severity (consequences) of an adverse event, or, reduce the likelihood.

Selecting the most appropriate risk control option involves balancing the cost of implementing each option against the benefits derived from it. In general, the cost of managing risks needs to be commensurate with the benefits obtained. In some cases a series of small staged risk control measures may be more appropriate than one single action.

Where resources are not immediately available to implement identified control measures, an action plan should be identified. For all moderate and high rated risks a copy of the risk assessment and action plan should be forwarded to the relevant Divisional Nurse Director/Heads of Service for inclusion in the Divisional business plan. Copies of all high risks (grade 12 and above) should also be forwarded to the Head of Risk Management for inclusion onto the Divisional and Trust's risk register.
All risks entered onto the Trust risk register will be brought to the attention of the Trust Board through the Quality, Assurance and Risk Committee.

Step 6 – Monitoring and Review

It is necessary to monitor risks, the effectiveness of the risk control action plans identified and the divisional/operational management systems in place to make sure paper relates to practice.

Few risks remain static. For example, factors which may affect the likelihood and severity of an outcome may change, as may the suitability of existing or identified controls.

Assessments graded 6 and below should be reviewed annually, risks assessments graded 8 should be reviewed bi-annually, risks graded 9-12 should be reviewed quarterly and risks graded 15-25 should be reviewed monthly. The review should be documented on the assessment form.

In addition, assessments should be reviewed:

- If new equipment is introduced
- If new substances or premises are used
- If new clinical techniques are introduced which impact on procedures
- If other processes or operational parameters change significantly
- Following any accident or clinical incident related to an existing risk assessment.

Table 3 summarises the frequencies with which risks should be reviewed, identifies a nominated post holder to review the risks and summarises some of the key actions that should be considered.

Table 3

Reviewing Risk Assessments

Risk Rating	Lead Person	Frequency of reviewing risk	Recommended action
0-6	Local managers, Heads of Department, Heads of Clinical Unit, Ward Sister/Charge nurse	Annual	• Monitor risk to ensure that controls are maintained. Risks are acceptable.
8	Service Managers, Clinical Nurse Director (CND), Professional Heads of Service	Bi annual	• These risks must be highlighted to agree risk acceptability/tolerability • Where additional reasonably practicable controls are identified the risk is unacceptable until they have been implemented.
9-12	Assistant Directors, CBU Clinical Directors, Clinical Nurse Director (CND) and Divisional Director.	3 monthly	• Inform Head of Risk Management • Risks not acceptable • Action plan to be identified to eliminate/reduce/control risk.
15-25	Assistant Directors, CBU Clinical Directors, CND and Divisional Director. Chief Operating Officer (COO) Notified to Trust Board at earliest opportunity.	Monthly	• Inform Head of Risk Management • Risks not acceptable • Action plan to be identified to eliminate/reduce/control risk. • Significant resources may be required to reduce the risk.

Table 4

Action required depending on risk rating

RRN	RISK LEVEL	RECCOMENDED ACTION AND TIMESCALE
>4	Very Low Risk	• It is likely that nothing further can be done to eliminate/reduce/control risk further. A very low risk of occurrence may exist and this is deemed "Acceptable". • Risk assessment forms should be kept as it demonstrates an awareness of a potential hazard and an assessment of risk. Existing procedure needs to be reviewed and work may need to be monitored to ensure that the controls are maintained.
>9	Low Risk	• It is likely that nothing further can be done to eliminate/reduce/control risk further. If any action is possible to eliminate the risk of recurrence then this should be implemented. A low risk of occurrence may remain and this is deemed "Acceptable". • Risk assessment form should be kept as it demonstrates an awareness of a potential hazard and an assessment of risk. Existing procedure needs to be reviewed and work may need to be monitored to ensure that the controls are maintained.
>12	Moderate	• Management action is required at a departmental and/or divisional level to reduce the identified risk. • Risk reduction should be based on an assessment of costs and benefits of doing so/not doing so. • In some case further measures will not be reasonably practicable (e.g. the cost outweighs the benefit, the technology is not available, the procedure must be undertaken). This must be justified on the assessment. The risk is then considered as "tolerable". However, the assessment should be frequently reviewed to determine whether any new practicable control measures have become available. • Where additional reasonably practicable control measures are identified, the risk is said to be "Unacceptable" until such time as they have been implemented. An action plan, with defined time periods for implementation, should be agreed and documented within the local and divisional risk registers. • Risk assessments must be submitted to the Head of Risk Management and included on the Divisional Risk Register
15 and above	High Risk	• All High Risks are Significant (i.e. Unacceptable). • All High risks must be referred to the Chief Operating Officer / Divisional Director and an immediate action plan identified to eliminate/reduce/control risk. • Risk Management must be informed of all significant risks (clinical and non-clinical) and risk incidents. • Where not immediately reducible, the activity should be placed on the local and Divisional risk register and included on the Trust's Risk Register. • Considerable resources may have to be allocated to reduce the risk. Such resource allocation decisions will be brought to the attention of the Trust's Senior Management in order to develop a prioritised risk control programme.

Appendix B - Royal Marsden NHS Foundation Trust

Risk Assessment Form

Staff Completing Risk Assessment		
Ward/Department: **Date of assessment:**		**Division:** **Review Date: Dependant on the risk rating below** **RR up to 6 Annual, RR 8 Bi Annual, RR 9- 12 three monthly, RR 15 and above monthly**

	ID	Title of Risk	Factors that may cause the risk to occur	Controls in place	Likelihood	Severity	Risk Rating	Update/ Action Plan	Review Date (Action Plan)	By (Action Plan)

Generic risk assessment template all areas 2018/19

Staff Completing Risk Assessment:		
Ward/Department: **Site/Location:** **Division:**		**Date of Assessment:** **Review Date: Dependent on the risk rating below** **RR up to 6 Annual, RR 8 Bi Annual, RR 9-12 three monthly, RR 15 and above monthly**

ID	Title of Risk	Factors that may cause the risk to occur	Controls in place	Likelihood	Severity	Risk Rating	Update / Action Plan	Review Date (Action Plan)	By (Action Plan)
1.	Infection / cross infection	Inadequate hand washing facilities. Failure to adhere to policy on hand washing Inadequate training. Exposure to blood and body fluids.	Hand Washing & Hygiene Policy Needle stick Procedures Staff training Staff awareness Example set by senior staff Safe disposal of sharps.						
		Failure to follow screening / isolation policies that prevent cross infection	Infection Prevention and Control Policy and associated policies Awareness of policies and procedures Staff training/induction Audit						
		Failure to follow appropriate decontamination of equipment	Policy: Decontamination of Medical Devices						
2.	Slips trips and falls	Poor housekeeping. Failure to adhere to policy.	Falls Policy, (Appendix 4) Risk Assessment. Floor surfaces and buildings kept in						

		Poor maintenance. Non-reporting of maintenance issues. Poor lighting. Failure to use appropriate signage	good repair. Staff training. Working at height risk assessment Appropriate warning signs i.e. cleaning in progress. Cable management of cleaning equipment. Clear walkways.						
	Falls from Height	Falls from open windows which are unrestrained. Falls from steps or ladders Lack of risk assessment if working at height As above and also failure to assess patients that are at risk of falling	Appropriate footwear. General tidiness of all areas. Complete risk assessment related to working at heights if steps ladders etc. are in use Always check windows/doors etc. to ensure they are secure and restrained to the 6" rule Do not use steps or ladders unnecessarily and always check for defaults before use						
	Patient slips trips and falls including falls from height		As above. A patient falls risk assessment to be completed within 4hrs for all inpatients and updated on a regular basis. Use of cot sides as indicated in the: Cot Sides Risk Assessment Guidance Patient awareness of correct footwear toileting needs and general awareness of mobility issues and the use of the call bell. Special attention needs to be paid to patients who may fall from height i.e. out of bed or whilst tackling stairs etc. Use of Red Square, Red Slippers and low height beds and crash mats.						

3.	Load/Object Manual handling musculoskeletal injuries	Inappropriate manual handling techniques. Inadequate manual handling training. Failure to complete risk assessments for tasks that involve high risk manual handling. Failure to complete patient handling risk assessments.	Manual Handling Policy Manual handling risk assessments Manual handling training Staff awareness As above Intranet pages on safe techniques						
	Mattress Turning musculoskeletal injuries	Not turning mattress correctly or not using 2 persons to complete task.	New pink covered Pentaflex mattresses must be rotated on the bed: The mattresses do not need turning over, only rotating from head to foot. Always use two persons when moving mattresses. Training to be included on mandatory update. Staff to be informed of new weight of product and weight limit.						
	Patient Manual handling	Failure to assess the needs of plus size patients and have appropriate equipment available. Privacy and dignity issues associated with manual handling.	Manual Handling Policy Appropriate pre-assessment Use equipment in an appropriate manner Staff training and education.						
4.	Liquid Nitrogen	Asphyxiation or burns – due to the mishandling of liquid nitrogen.	Specific risk assessment to be carried out please refer to the Health & Safety Advisor.						
5.	Electrical equipment	Faulty or un maintained electrical equipment.	Ensure that equipment maintenance schedule is adhered to with PAT						

		Failure to use equipment in a safe manner / not following manufacturer's guidelines.	testing labels. Equipment is tested in line with Portable Appliance Testing Guide Routine examination of equipment for signs of defects. Remove from service any faulty equipment. Report faults to the Estates Department Ensure that staff are trained to use equipment and that the manufacturer's guidelines are followed.							
	Clinical equipment / Medical Devices	Failure to follow Trust policy in all issues associated with selection, purchase, assembly, acceptance testing, storage, decontamination, loaning and borrowing, training and decommissioning in relation to medical devices	Medical Devices Policy for the Safe Management of Policy Medical Devices Policy for Evaluation Purchase and Maintenance Including Devices Used in Research Policy for Loaning, Borrowing and or Donating Equipment Medical device coordinators Equipment training records Training manuals Medical Device Inventory							
6.	Environment – working conditions	Extremes of temperature / unsatisfactory working environment.	Specific risk assessment to be undertaken for areas of concern. Advice to be sought from the H&S Advisor.							
7.	Waste	Lack of knowledge regarding waste management. Failure to adhere to the WM policy. Failure to provide WM training. Poor collection of waste.	Waste Management Policy. Waste management training. Staff awareness. Regular waste audits Ensuring correct waste streams are identified and appropriate containers provided. Report issues appropriately.							

8.	Violence & Aggression	Patients, relatives and staff have the potential to be aggressive in stressful situations. Staff may not be prepared to deal with events.	Challenging Behaviour, Violence and Aggression from Patients and Visitors - Policy and Procedure for the Management of. Conflict Resolution training. Specific Risk Assessments. Address environmental / process issues that may provide a stimulus. Report incidents / review frequency.						
9.	Security	Local security arrangements may not be in line with Trust security requirements. Need to ensure the physical security of Trust premises.	Security Strategy outlines security precautions in place Review any security incidents to ensure that precautions are adequate. Identified security issues or specific risks to patient, staff or Trust property, or inadequate access control measures then - **Additional Security Risk Assessment [within Security Policy] to be completed with assistance of Local Security Management Specialist [LSMS].**						
10.	Chemical Exposure	Dealing with hazardous substances such as cleaning chemicals, cytotoxic waste and drugs.	COSHH Assessment Policy Identification of hazardous substances used. COSHH assessments are on RM Intranet site. Staff education and training Monitoring Incident Reporting						
11.	Lone working	Staff may work alone in an isolated area, out of hours as part of the on call rota or in the community. This means that there is an	Lone Worker Policy Managerial responsibility to ensure that a risk assessment is completed for all appropriate staff. Monitoring to adherence to policy						

		increased risk unless provision to ensure safety is made.	**Additional Security Risk Assessment [within Security Policy] to be completed with assistance of Local Security Management Specialist [LSMS].**						
12.	Stress	The risk of workplace related stress is recognized within the trust and that the management of stress is important for the well-being of staff.	Managing Stress Policy Policy for supporting staff involved in potentially traumatic or stressful incidents, complaints, claim or attendance at an inquest or employment tribunal. Training for managers Early identification of stress related issues Monitoring sickness / absence ensure back to work interviews are undertaken. Management of LTS is rigorous Staff support through counselling, OH and Staff support facilitator CBT training **Complete separate risk assessment form with the support of Occupational Health**						
13.	Work related Musculoskeletal injuries	Regular use of a computer or other equipment may trigger upper limb disorders, shoulder, back strain and repetitive strain injuries.	Display Screen Equipment Policy. All staff that work with Display screens should complete an assessment as part of their local induction. Any issues that arise as a result of the assessment need to be dealt with in a timely fashion. Staff training. Staff awareness of the need to report any signs and symptoms related to DSE in a timely manner to either OH or H&S.						

14.	New and Expectant Mothers	It is a responsibility of the Trust to take reasonable and practical measures to avoid or reduce hazards to health & and safety of new and expectant mothers.	Protection of New and Expectant Mothers at Work Policy Ensure that staff are aware of the policy Complete individual risk assessments Monitor an individual's limitations and plan work accordingly.						
15.	Radiation Protection	Exposure to the hazards arising from radiation.	Radiation Protection Policy Appropriate signage Local Rules for each controlled and supervised area. Staff dosimetry where required.						
16.	Medicines Management	Failure to adhere to any aspect of policy relating to prescribing, administration, supply storage and disposal of medicines	Medicines Management Policy. Policy for the Safe Management of Controlled Drugs. Incident reporting and review Check of controlled drugs every 24 hours. Process for the disposal of CDS.						
17.	Clinical Record Keeping	Failure to adhere to the Trust policy on clinical record keeping	Clinical Documentation and Record keeping Policy. Annual audit for all departments Training. Raising Awareness.						
18.	Records Management	Failure to protect patient / staff information non-compliance to legislation, and regulations	Data Protection Policy. Local systems of records creation, storage, archiving and disposal. Compliance spot checks. Staff Induction and Mandatory Information Governance Training. Access to records. Privacy for communication. Incident monitoring. Safe Haven within departments/Service areas.						

RISK REGISTER

No.	ID & Title	Core Theme	Source & Location	Risk Description	Initial Score & Date	Current Score & Travel	Controls in Place	Description (Action Plan)	Review Date	By

Appendix C

The Royal Marsden NHS Foundation Trust

Terms of reference

Committee	**Quality, Assurance and Risk (QAR)**
Membership	Membership will be as follows: Chairman Chief Executive At least four Non-Executive Directors Chief Nurse Medical Director Chief Operating Officer Divisional Director, Cancer Services Divisional Director, Clinical Services Managing Director, Private Care or Director of Operations, Private Care Director of Transformation and Charity Liaison Director of Performance and Information Director of Workforce Chief Financial Officer Members may not send deputies if they are unable to attend
Chair	A non-executive Director with sufficient experience of clinical and risk issues or, in their absence, another Non-Executive Director can act as deputy Chair.
Secretary	Quality Officer/ Corporate Governance Manager (minute taker)
Quorum	Fifty per cent of members, to include at least two Non-executive and one Executive Director Members are expected to attend at least two meetings a year except in exceptional circumstances
Meeting Frequency	The QAR will meet on a quarterly basis to monitor the implementation of clinical governance arrangements in the Trust and the work of the Integrated Governance and Risk Management Committee (IGRM)
Authority	The Committee is the high level Committee which has overarching responsibility for non-financial risk. The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal

	or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.
Relationships with other committees	The QAR has shared responsibility with the Audit and Finance Committee to provide assurances to the Board that the Royal Marsden NHS Foundation Trust is properly governed and well managed across the full range of its activities. As such, both committees need to work collaboratively to ensure that all aspects of governance are covered and that the Board receives comprehensive assurances on the Trust's business and activities. This committee will address the full spectrum of risk other than Financial risks, which will be addressed by the Audit and Finance Committee.
Main Aims	The QAR is formally constituted as a subcommittee of the Trust Board and its main purpose is to support the Board in developing an integrated approach to risk, control and governance by ensuring robust systems, which enable achievement of its objectives. The Board Assurance Framework will be central to the committee achieving its purpose. A key focus of the Committee is patient safety, including infection control, and quality monitoring.
Duties & Responsibilities	1. To monitor the implementation of clinical and research governance and risk management arrangements within the Trust, including the development of local standards and performance monitoring mechanisms to supplement national standards. 2. To oversee clinical governance and risk management arrangements within the Trust, including clinical audit, Complaints, Claims and Serious Untoward Incident produces and environmental risks and to ensure action plans are implemented and evaluated in a timely manner. 3. To review all appropriate policies relating to Clinical Governance, Risk Management (other than Financial) and Health & Safety. 4. To review an Integrated Governance Monitoring Report on a quarterly basis on behalf of the Board and to advise the Board of any issues arising from the Report on an exception basis. 5. To be responsible for the monitoring and review of the Trust's risk register on a quarterly basis ensuring action is taken as appropriate in relation to identified risks. 6. To be advised on the progress of any major quality initiatives

	in the Trust, including JACIE, ISO9001 for Radiotherapy and Chemotherapy and external accreditation arrangements. 7. To review the Trust's Quality Accounts and the processes by which they are produced. 8. To review and monitor the Care Quality Commission's Fundamental Standards *(or successor Standards)*. 9. To review compliance with corporate governance arrangements including but not limited to the Provider License, Board Assurance Framework and Corporate Risk Register 10. To review policies on and controls over Information Governance and Data Quality. 11. To be advised of any research and development or research ethics issues which may impact on clinical governance in the Trust. 12. To develop a communication and reporting relationship with the Council of Governors, with particular reference to the development of patient, carer and public involvement at all levels. 13. To undertake an annual review of the effectiveness of the Committee.
Recording	The key issues discussed with decisions and outcomes will be recorded.
Reporting	The Chairman will ensure that the business of the QAR is reported to the Trust Board including any recommendations for action. The minutes of the meetings of the Committee, together with a summary of the key issues, matters discussed and decisions taken will be made available to the Trust Board after each meeting through a report from the Chair of the Committee. An annual report of the work of the Committee will be presented to the Board and Council of Governors, including how it has met its Terms of Reference and duties and responsibilities.
Date created	June 2017
Revision date	June 2018

Appendix D

The Royal Marsden NHS Foundation Trust

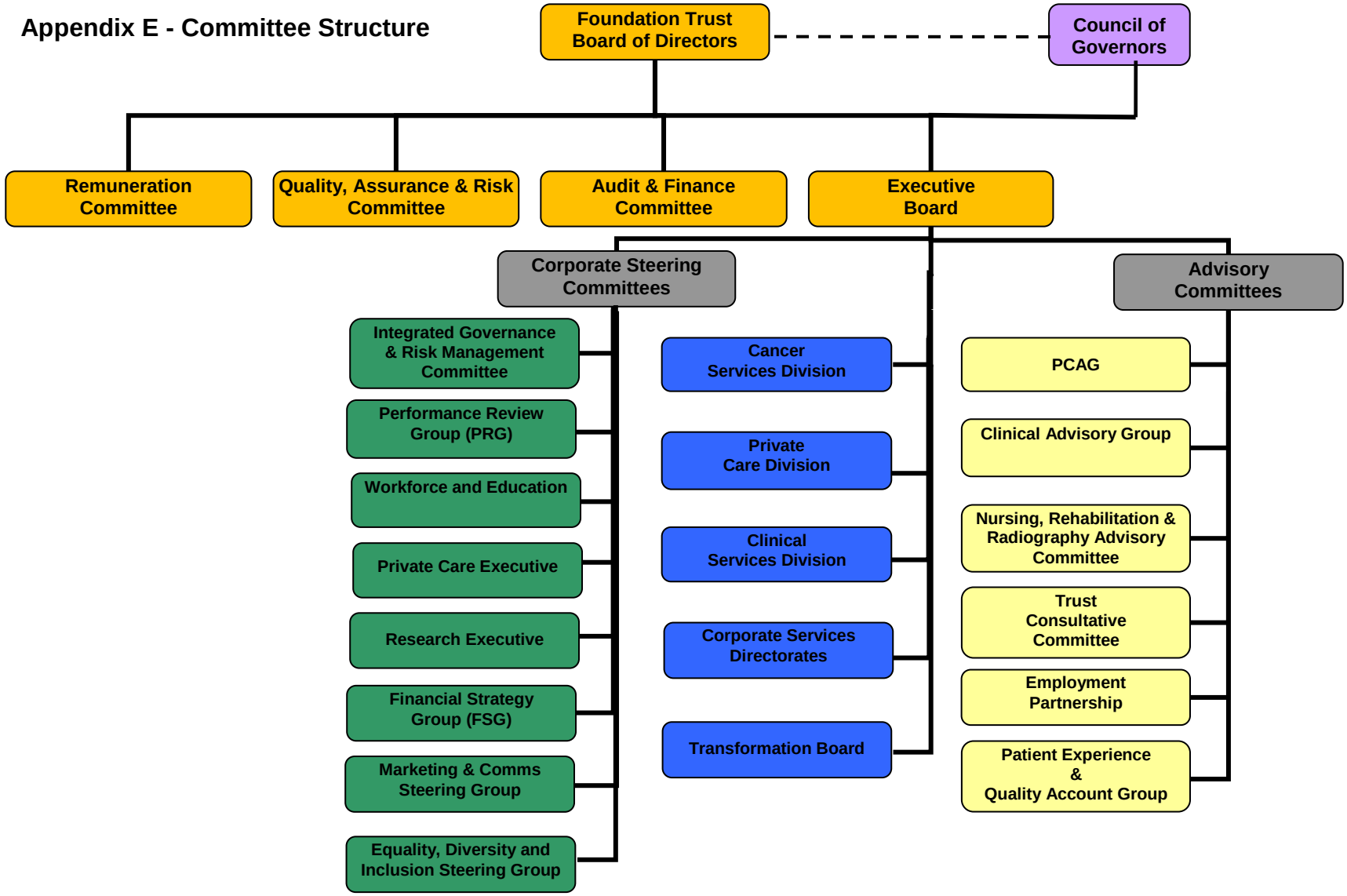
Terms of reference

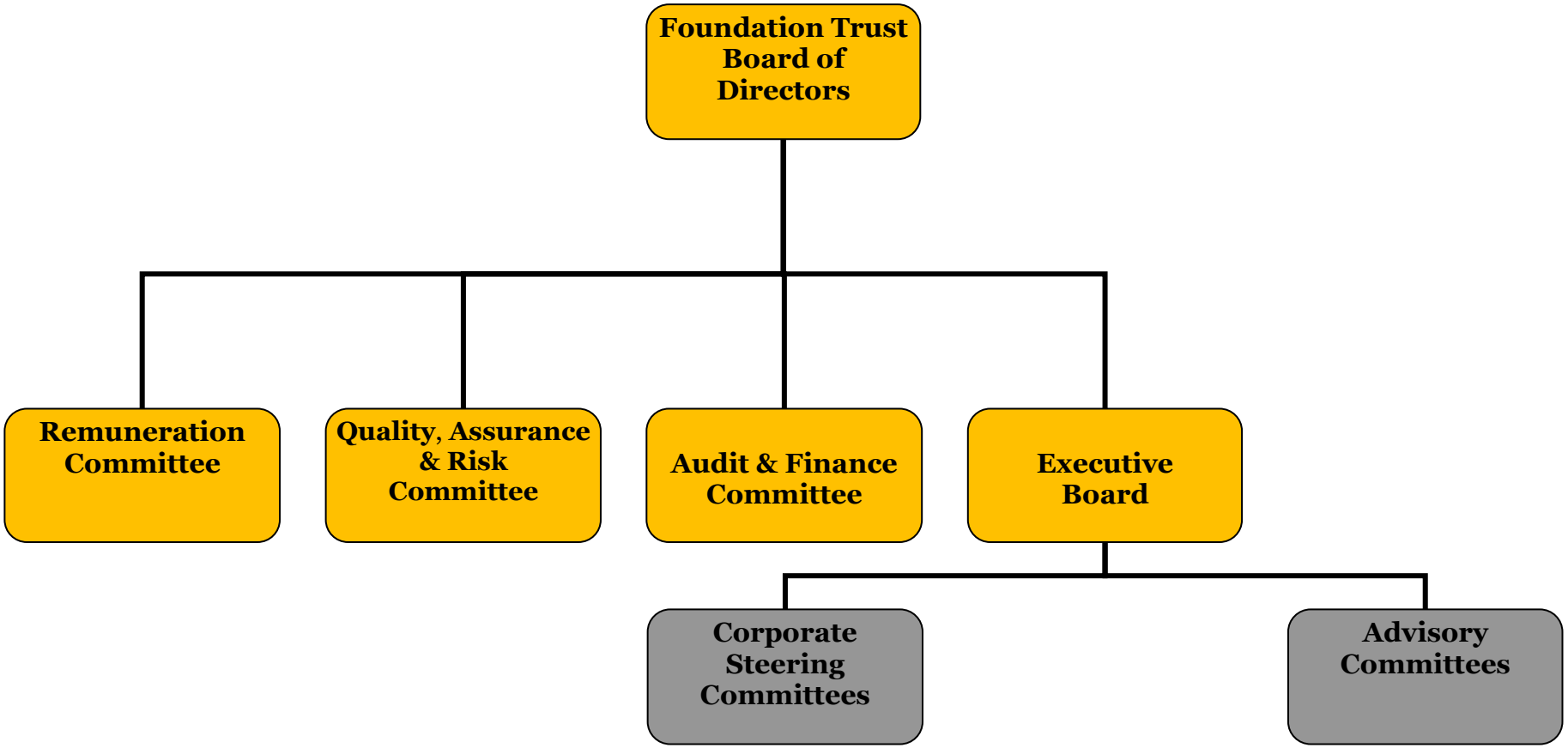
Committee	**Integrated Governance and Risk Management Committee (IGRM)**
Membership	Membership will be as follows: Chief Nurse (Co-chair) Medical Director (Co-chair) Patient/lay representatives Chief Pharmacist Chief Operating Officer Deputy Chief Nurse Deputy Director/Lead Nurse Infection Prevention and Control Director of Transformation & Charity Liaison Divisional Directors Divisional Clinical Nurse Directors Chief of Surgery Clinical Directors of Clinical Business Units Clinical Director of Children's Services Research and Development Manager Assistant Director of Workforce Development Head of Adult Safeguarding (to also represent the Child Protection Team) Head of Quality Assurance Head of Risk Management Clinical Fellow in Patient Safety Chief Information Officer Chairman of the Clinical, Scientific and Technical Advisory Committee Director of Operations, Private Care Director of Workforce
Chair	Co-Chaired by the Chief Nurse and Medical Director. The Chief Operating Officer or Deputy Chief Nurse can act as Chair should neither the Chief Nurse nor Medical Director be present.
Secretary	Quality Officer
Quorum	The committee is quorate when 50% of the group are present. This must include one Divisional Director, one clinical nurse director and a member of medical staff who are members of the committee or if no medical member of the committee is able to attend a Clinical Business Unit Clinical (medical) Director can stand in. The Chief Nurse, Medical Director, Chief Operating Officer or Deputy Chief Nurse must be present to Chair the meeting.

Deputies, attendance and staff development	Limited attendance by deputies is permitted in certain circumstances for example if the member is on leave. It is expected that members will attend at least 75% of meetings in a calendar year. Attendance is to be audited annually. Staff who are not members of the Committee can attend for training and development purposes.
Meeting Frequency	IGRM will meet monthly at least in 10 months of the year.
Authority	
Relationships with other committees	There are two principal committees for making sure the Trust's patient safety arrangements are effective: • the Quality, Assurance and Risk Committee (QAR) is configured as a monitoring sub-committee of the Board • the Integrated Governance and Risk Management Committee takes the operational lead. These committees are responsible for ensuring that appropriate control systems are in place for all clinical risk, patient safety, clinical governance and external accreditations.
Main Aims	IGRM is an executive committee to ensure the Trust has an effective integrated approach to managing quality, risk, safety, control and governance across the Trust's operations that affect patient safety. The committee ensures robust monitoring systems are in place to achieve this.
Duties & Responsibilities	To be responsible for monitoring and assuring the development of safe robust processes for clinical and research governance, information governance, risk management, quality assurance and infection control arrangements in the Trust. To review the quarterly Integrated Governance Monitoring Reports prior to presentation and discussion at the Quality, Assurance and Risk Committee and subsequently the Trust Board. Review action plans that address external quality and safety standards, performance monitoring mechanisms and accreditations. Ensure that appropriate actions are implemented to achieve and/or improve compliance. To regularly review and monitor the Care Quality Commissions Fundamental Standards - July 2014. Monitor Trust compliance with the Health and Social Care Act 2012. To evaluate the management and organisation of quality, safety and related clinical governance functions, and make recommendations for change as required. To receive reports as indicated in the *Schedule of reporting to the Integrated Governance and Risk Management Committee.*

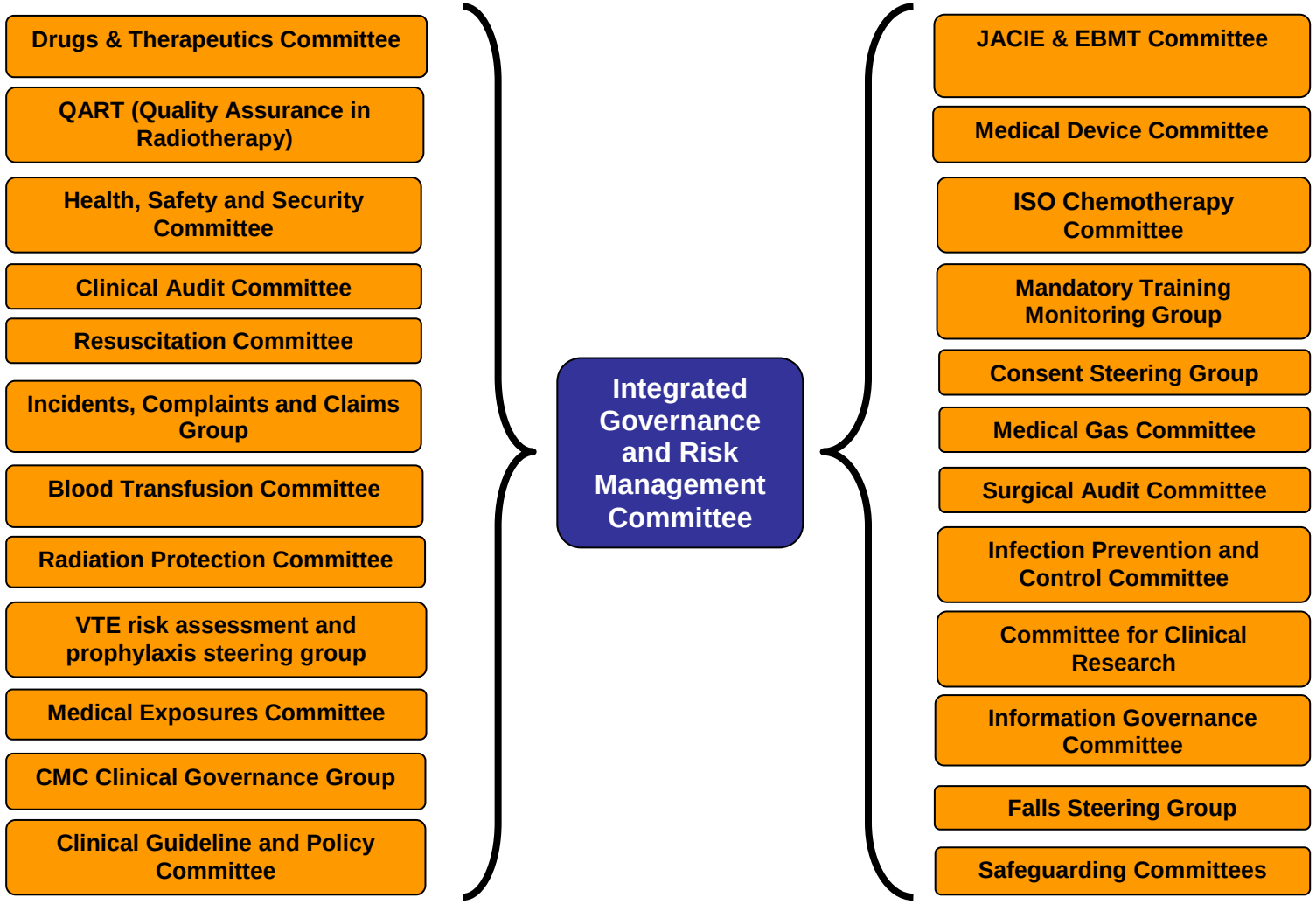
	To receive and review the Trust risk register on a quarterly basis, ensure that appropriate actions are implemented and monitored and identify risks to be reviewed by the Trust Board. To receive and agree investigation reports and recommendations relating to significant incidents complaints and claims and Serious Incidents. To ensure that effective organisational learning is achieved and that action plans are implemented and monitored within agreed timeframes. To ensure that monitoring and audit systems can identify: • Where actions taken to reduce risk are evaluated, effective and sustained, for example, complaints, and risk assessments. • That external and internal standards are implemented appropriately, e.g. NICE guidelines, Cancer Services Standards, NCEPOD reports, Safer Practice Notices, National Service Frameworks, National Confidential Enquiries and other High Level Enquiries. • To review and monitor compliance with other legislation including the Human Tissue Act 2004 and the Blood Safety and Quality Regulations. To receive an annual report on progress against the fifty risk management audit plans (formally NHS LA standards). To ensure that appropriate mechanisms are in place for research governance including detecting and handling fraud and misconduct and poor performance in the Trust, and to ensure that these mechanisms are reviewed. Act as the Caldicott Committee. To receive an annual report from the Major Incident Planning Committee on the Trust's arrangements for emergency preparedness.
Recording	The key issues discussed with decisions and outcomes will be recorded in the minutes of the meetings.
Reporting / Monitoring Effectiveness	The Chair will ensure that the business of the IGRM is reported to the Quality, Assurance and Risk Committee including any recommendations for action. The Quality, Assurance and Risk Committee will receive an annual report that reviews the effectiveness of the committee.
Date created	April 2018
Revision date	April 2019

Appendix E - Committee Structure




Foundation Trust Board of Directors
Remuneration Committee
Quality, Assurance & Risk Committee
Audit & Finance Committee
Executive Board
Corporate Steering Committees
Advisory Committees

Committees/Groups that report into the Integrated Governance and Risk Management Committee



Estates input into the Integrated Governance and Risk Management Committee through several of the committees listed above

Appendix F

The Royal Marsden NHS Foundation Trust

Audit and Finance Committee

Terms of Reference

Committee	**Audit and Finance Committee**
Membership	Membership of the Audit and Finance Committee will be sought from amongst the Non-Executive Directors of the Trust Board and shall consist of not less than three members.
Attendance	The Chief Financial Officer, one other Board level Executive Director (either the Chief Nurse or Chief Operating Officer), the Head of Internal Audit and a representative from the External Auditors shall normally attend meetings. However, at least once a year the Committee may wish to meet with the External and Internal Auditors without any Executive Board members present. The Chief Executive has an open invitation to attend the meetings, but particularly annually to discuss the process for assurance that supports the annual governance statement. Board members only would normally be present for discussion of matters covering the Financial Duties (6. Below).
Chair	A Non-Executive Director with the requisite financial experience and recognised accounting qualification (or on his/her absence another Non-Executive Director)
Secretary	Board Secretary or their designate
Quorum	Two members
Meeting Frequency	Not less than four times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary. At least one private meeting without management present with the External Auditor and Head of Internal Audit is required each year.
Authority	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.
Relationships with other committees	The Audit & Finance Committee has shared responsibility with the Quality Assurance & Risk Committee (QAR) to provide assurances to the Board that the Royal Marsden NHS Foundation Trust is properly governed and well managed across the full range of its activities. As such, both Committees need to work collaboratively to ensure that all aspects of governance are covered and that the Board receives comprehensive assurances on the Trust's business and activities. The Audit and Finance Committee has specific responsibility for monitoring of financial risks.

Main Aims	The Audit & Finance Committee is formally constituted as a subcommittee of the Trust Board and its main purpose is to contribute independently to the Board's overall process for ensuring that an effective internal control system is maintained for all Trust operations including any subsidiary entities. In particular the Audit & Finance Committee will have the following key objectives: 1. Providing confidence in the objectivity and fairness of financial reporting; 2. Providing assurance about the adequacy of internal controls; 3. Safeguarding of assets; 4. Reducing the risk of illegal or improper acts; 5. Reinforcing the importance, independence and effectiveness of internal and external audit
Duties & Responsibilities	**1. Internal Control and Risk Management** The Committee shall review the establishment and maintenance of an effective system of internal control and risk management. In particular, the Committee will review the adequacy of: • All risk and control related disclosure statements, together with any accompanying Head of Internal Audit statement, prior to endorsement by the Board (including the annual governance statement and declarations to NHSI); • The structures, processes and responsibilities for identifying and managing key financial risks facing the organisation; • The key risks of the Trust through the Board Assurance Framework (BAF) in conjunction with QAR; • The operational effectiveness of policies and procedures; • The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Counter Fraud Authority or any replacement organisation with similar national remit for fraud and security; • Standing Orders and Standing Financial Instructions and Codes of Conduct. **2. Internal Audit** • To have overall responsibility for the provision of an effective internal audit function • To consider the appointment of the internal audit service, the audit fee and any questions of resignation or dismissal; • To review the internal audit programme and ensure it is aligned to the key risks of the business; • Consider the major findings of internal audit investigations (and management's response)and ensure co-ordination between the internal and external auditors; • To monitor the implementation of all recommendations from Internal Audit and ensure they are completed in an appropriate timeframe; • To ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organisation. • To undertake an annual review of the effectiveness of internal audit, in conjunction with QAR.

3. Anti-Fraud and whistleblowing

- To consider the appointment of the Local Anti-Fraud Specialist, its fee and any questions of resignation or dismissal;
- To review the anti-fraud programme, and consider the major findings of its investigations (and management's response);
- To ensure that the Accredited Anti-Fraud Specialist has appropriate standing within the organisation.
- Review arrangements by which employees and contractors may, in confidence, raise concerns about possible improprieties in financial reporting or other matters. These arrangements should allow proportionate and independent investigation of such matters and appropriate follow up action.

4. External Audit

- Consider the appointment of the External Auditor and make recommendations to the Council of Governors;
- Discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy;
- Review and approve the annual audit plan and ensure that it is consistent with the scope of the audit engagement, having regard to the seniority, expertise and experience of the audit team
- Review External Audit reports, including review any representation letter(s), management letter(s) and management's response to the auditor's findings and recommendations requested by the external auditor before they are signed by management;
- Develop and implement policy on the supply of non-audit services by the external auditor to avoid any threat to auditor objectivity and independence, taking into account any relevant ethical guidance on the matter.

5. Financial Reporting

Monitor the integrity, review and approve the annual financial statements on behalf of the Board, focusing particularly on:

- Changes in, and compliance with, accounting policies and practices;
- The methods used to account for significant or unusual transactions where different approaches are possible;
- All material information presented with the financial statements such as the annual governance statement, internal control, the going concern and value for money assessment as well as the quality report.
- Major judgmental areas; and
- Significant adjustments resulting from the audit.

6. Financial Review

On behalf of the Board, the Committee, meeting without external attendees, will have responsibility for the following financial aspects of the Trust's activities:

- Review the annual financial plan and recommend to the Trust Board its adoption;
- Monitor in-year performance and corrective action and consider further

	actions the Trust Board should take to ensure the financial plan is achieved; • Oversee the ongoing development and review of the medium term financial plan; • Review strategic plans and major business cases and consider proposals for action/discussion at the Trust Board; • Oversight of the Capital programme – regular review of spending against plan, procurement, including tender waivers; • Review of Accounting Policies – at least annually.
Recording	The key issues discussed with decisions and outcomes will be recorded.
Reporting	The Chairman will ensure that the business of the Audit & Finance Committee is reported to the Trust Board including any recommendations for action. A copy of the minutes of the Audit & Finance Committee will be made available to the Trust Board after each meeting (together with a verbal or written report from the Chair of the Committee). An annual report of the work of the Committee will be presented to the Board and the Council of Governors, including how it has met its Terms of Reference and duties and responsibilities. This report should include: • a summary of the role and work of the audit committee; • the number of audit committee meetings • an explanation of how the committee has assessed the effectiveness of the external audit process and of the approach taken to the appointment or reappointment of the external auditor; the length of tenure of the current audit firm; the current audit partner name, and for how long the partner has held the role; when a tender was last conducted; and advance notice of any retendering plans; • an explanation of how the committee has assessed the effectiveness of internal audit and satisfied itself that the quality, experience and expertise of the function is appropriate for the business; • the significant issues that it considered in relation to the financial statements and how these were addressed, having regard to matters communicated to it by the auditors; and • any other issues on which the board has requested the committee's opinion.
Approved	1st November 2017
Review Date	1st November 2018 To be reviewed annually by the Audit and Finance Committee.
Forward Agenda Plan	A Forward Agenda Plan will be documented in line with the Audit and Finance Committee's responsibilities.

Appendix G

RELATED RISK MANAGEMENT POLICIES AND PROCEDURES

- Accident and Incident Reporting Procedure including Serious Incidents
- Bed rails - Risk Assessment Guidance on Safe Use
- Being Open & Duty of Candour
- Blood Transfusion Policy
- Bullying and Harassment - Managing Incidents at Work Policy and Procedure
- Challenging Behaviour, Violence and Aggression from Patients and Visitors - Policy and Procedure for the Management of
- Concerns and Complaints Policy and Procedure
- Confidentiality and the Data Protection Act Policy
- Consent to Examination, Procedure or Treatment Policy
- COSHH Assessment Policy
- Discharge from Hospital Policy and Procedure
- Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy (Patients 18 Years and over)
- Document Control of Trust Policies and arrangements for other documents
- Environmental Management Policy
- Fire Safety Policy
- Health and Safety Policy
- Information Governance Policy & Procedure
- Investigation of Incidents, Complaints and Claims
- Ionising Radiation Protection - Radioactive Substances Management Policy
- Management of Medical Records - Policy and Procedures
- Manual Handling Policy
- Mandatory Training Policy / Training Needs Analysis
- Major Incident Plan
- Medical Devices - Policy for the Safe Management of
- Resuscitation Policy
- Security Policy
- Stress Management Policy
- Waste Management Policy
- Whistleblowing Policy and Procedure

Appendix H

SCHEDULE OF RISK MONITORING

RISK	INTERNAL REVIEW	EXTERNAL REVIEW	LEAD
Adverse Events	Quarterly provision of incident statistics to the Integrated Governance Monitoring Report Reporting of SIs & significant incidents and their follow up to the Integrated Governance and Risk Management Committee (IGRM) Divisional and Departmental review of incident data	Review of SIs by the Commissioners Care Quality Commission Internal Audit	Head of Risk Management
Health & Safety	Annual statistics on violence and aggression report to HRSG. Quarterly accident/incident reports to Health, Safety & Security Committee (HS&SC) Annual H&S Report to IGRM.	HSE inspections and RIDDOR reporting (ad hoc). Care Quality Commission	Risk & Resilience Manager, Health & Safety Advisor
Security	Quarterly review of security incidents and report to HS&SC.	Police Local Community Action Group Counter Fraud and Security Management Services Care Quality Commission	Head of Facilities
Fire	Quarterly reports to Health, Safety and Security Committee Annual Reports to IGRM, QAR and Board Quarterly report to IGRM Monthly workplace audits Timely fire risk assessment reviews	Inspections by Fire Service and Local Authority. Care Quality Commission Various audit reviews	Fire Safety Advisor
Control of Infection	Continuous monitoring of alert organisms and scheduled analysis of environmental risks reported to quarterly Infection Prevention and Control Committee. Annual report to IGRM, QAR and Board.	Communicable Consultant for Disease Control (CCDC) Public Health England NHS London Commissioning Team Environmental Health Officer Inspections NHS Executive – PLACE Inspections Care Quality Commission	Director of Infection Prevention and Control (DIPC) and Infection Prevention and Control Committee

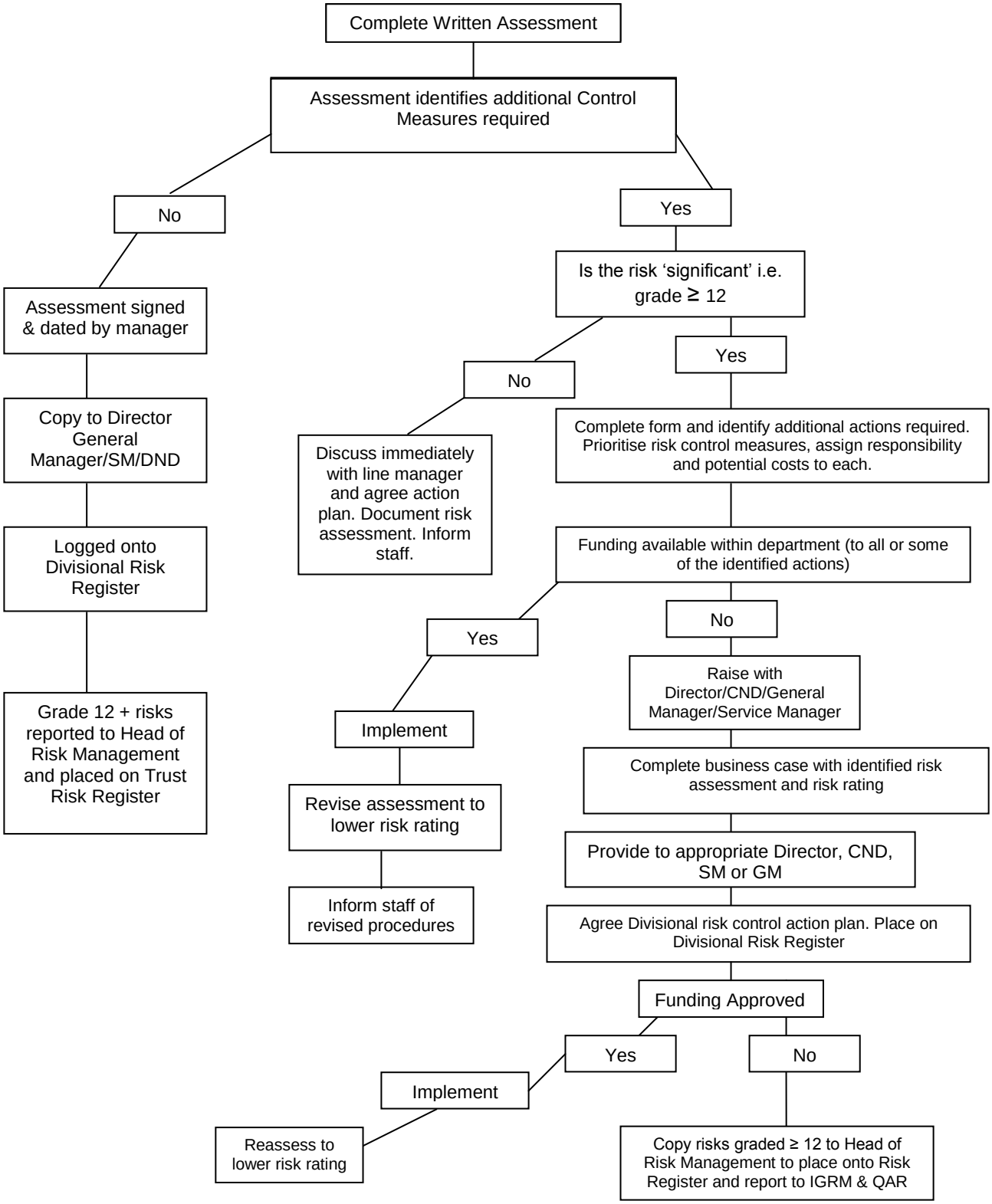
Staffing	Annual review of staff appraisal by HRSG. Sickness absence monitoring by HR. Monitoring of Employment Partnership by HR.	Inspections by Royal Colleges and ENB and other professional bodies. Review by commissioners. Care Quality Commission	COO/ Director of Workforce
Documentation and Medical Records	Continuous audit of clinical records (availability and confidentiality)	Care Quality Commission	Information Governance Committee
Buildings and Non-medical equipment	Continuous monitoring of critical functions and exception reports by Estates Department. Annual Capital inventory and estates maintenance audit.	Licensing where appropriate. HSE Inspection. NHS Estates. (ERIC Return)	Director of Estates
Consent	Annual audit of compliance	Care Quality Commission	Head of Quality Assurance
Complaints	Quarterly reports of complaints to IGRM and QAR Annual Report	Care Quality Commission	Head of Clinical Legal Services, Complaints and Patient Information
Competence	Annual staff appraisal. Quarterly monitoring of registration of qualifications.	Care Quality Commission	COO / Director of Workforce
Contractor Control	Annual review of compliance with NHS Executive Standards.	HSE inspections and RIDDOR reporting (ad hoc)	Director of Estates
Waste	Annual Waste Audit by Waste Manager/H&S Lead and Infection Prevention and Control team. Infection Prevention and Control Committee Annual Report.	Licensing where appropriate by appropriate authority. Local Authority Environmental Agency. Care Quality Commission	Waste Manager/H&S Lead
Resuscitation	Quarterly reporting of CPR training.	Care Quality Commission	Matron Critical Care Outreach
Emergency preparedness	Annual review of major incident plans (Radiation, Chemical Spill, flood, and fire) by Health, Safety and Security Committee.	Care Quality Commission	Risk and Resilience Manager

Environmental Management	BREEAM assessments are carried out on new capital builds or very large refurbishment projects and not annual assessments.	Licensing where appropriate by appropriate authority. Local Authority Environment Agency. Care Quality Commission Carbon Trust	Energy / Estates Manager
Medical Devices	Review and action of all alerts from the MHRA Update to IGRM	Care Quality Commission MHRA	Head of Risk Management
Organisational Structure	All committees with a responsibility for risk management / patient safety to have risk management/ patient safety as a standing agenda item.	Care Quality Commission	Committee Chair
Risk Assessment	Annual Departmental review of risks rated 0-10 Annual Directorate review risks rated 0-10 Quarterly Divisional review risks 12 and above	Care Quality Commission	Heads of Department Divisional Directors
Risk Register	Quarterly submission to QAR of Trust Risk Register Quarterly Divisional review Quarterly review of corporate risk register	Care Quality Commission	Head of Risk Management Divisional Directors COO
Risk Management Training	All staff to receive information on Risk Management at induction All staff that complete risk assessments to have training Managers to have training on risk assessment / risk register	Care Quality Commission	Head of Risk Management supported by HOD.
IM & Technology	Quarterly reports to Information and Data Quality Group (IDQG).	Information Governance Toolkit Care Quality Commission	Director of Performance and Information
Medical Equipment and Devices	Medical Device Committee (MDC) annual report to IGRM. Quarterly review of Hazard Notices and Adverse Incident Reports Annual review of Medical Device Management Policy. Quarterly review of product evaluation procedures (by Clinical Product Review Committee) Annual audit of training records for medical device management.	MHRA (Adverse Incidents Centre) HSE Care Quality Commission CAS	Chair of MDC

Blood Transfusion	Quarterly Blood Transfusion Committee meetings	SHOT Healthcare Commission	Chair of the HTC
Medicines Management	Annual report on medication errors to QAR. Annual review of Medicines Management Policy (DTC, CAG, NRRAC & IGRM)	Drugs and Therapeutics Committee MCA Care Quality Commission	Chief Pharmacist

Appendix I

What to Do With Written Risk Assessments – A Simple Flowchart



Appendix J

Schedule of reporting to the *Integrated Governance and Risk Management Committee (IGRM)*

Date	Annual report – with speaker	Half yearly report – with speaker	Quarterly and two monthly reports including reports via the *Integrated Governance Monitoring Report*
January	• Emergency Preparedness, Resilience and Response Annual Report • Freedom of information	• Children joint principal treatment centre • Policy document control • LocSSIPs audit report • Interventional radiology • Duty of candour audit report	• Safeguarding adults • Safeguarding children report • Two monthly hotline update • JACIE (Joint Accreditation Committee of ISCT (International Society for Cellular Therapy) Europe and EBMT (European Group for Blood and Marrow Transplantation)) • ISO (incl. QART) • Imaging Services Accreditation Scheme report • Risk register
February	• Incidents, Complaints and Claims Group • Medical Gas Committee • VTE • Coordinate My Care Clinical Governance Group • Radiation protection	• Radiology discrepancies update	• Complaints • Integrated Governance Monitoring Report, October-December • Mortality audit
March	• Annual business planning – review of risks • ISO 15189 pathology	• Information governance • HTA progress • Falls	• Incident outstanding actions • Two monthly hotline update • Palliative Care Team

April	• Controlled Drug Accountable Officer Annual Report • IT risk portfolio • Sign up to Safety • Customer Service Excellence • NCEPOD • Clinical audit forward plan • IGRM terms of reference	• Resuscitation Committee • Immunotherapy Governance Group • SBAR tool compliance	• Safeguarding adults • Safeguarding children • JACIE (Joint Accreditation Committee of ISCT (International Society for Cellular Therapy) Europe and EBMT (European Group for Blood and Marrow Transplantation)) • ISO (incl. QART) • Imaging Services Accreditation Scheme report
May	• Medicines Safety Thermometer	• Drug and Therapeutics Committee (DTC) • Committee for Clinical Research • Safer staffing • Fire safety report	• Complaints • Risk register • Integrated Governance Monitoring Report, January-March • Two monthly hotline update • Mortality audit
June	• Surgical Audit Group • Quality Surveillance Team	• Research Standard Operating Procedures Working Group • Legal Services • Patient Experience Strategy Meeting • PALS • The Friends and Family comments report?	• Incident outstanding actions • Palliative Care Team

July	• Medical Devices Strategy Group • Infection control	• Children joint principal treatment centre • Policy document control • LocSSIPs audit report • Interventional radiology • Duty of candour audit report	• Safeguarding adults • Safeguarding children report • Two monthly hotline update • JACIE (Joint Accreditation Committee of ISCT (International Society for Cellular Therapy) Europe and EBMT (European Group for Blood and Marrow Transplantation)) • ISO (incl. QART) • Imaging Services Accreditation Scheme report • Risk register
August ***No meeting***			• Integrated Governance Monitoring Report, April-June *circulated for comment outside the meeting*
September	• Environmental issues • Non-medical prescribing • Scanning healthy volunteers	• HTA progress • Falls • Information governance • Radiology discrepancies	• Complaints • Incident outstanding actions • Two monthly hotline update • Mortality audit • Palliative Care Team
October	• Health and Safety • IGRM annual review for QAR sign off • Clinical Audit Committee (CAC)	• Resuscitation Committee • Immunotherapy Governance Group • SBAR tool compliance	• Safeguarding adults • Safeguarding children • JACIE (Joint Accreditation Committee of ISCT (International Society for Cellular Therapy) Europe and EBMT (European Group for Blood and Marrow Transplantation)) • ISO (incl. QART) • Imaging Services Accreditation Scheme report • Risk register

November	• Consent Steering Group • Mandatory Training Steering Group	• Drug and Therapeutics Committee (DTC) • Committee for Clinical Research • Safer staffing • PALS • Fire safety report	• Complaints • Integrated Governance Monitoring Report, July-September • Two monthly hotline update • Mortality audit
December	• Hospital Transfusion Committee • Clinical Guidelines and Policy Committee • Patient and Carer Advisory Group (PCAG)	• Research Standard Operating Procedures Working Group • Legal Services • Patient Experience Strategy Meeting • The Friends and Family comments report?	• Incident outstanding actions • Palliative Care Team

June 2018

Appendix K

RISK MANAGEMENT AWARENESS TRAINING
FOR BOARD MEMBERS AND SENIOR MANAGERS

CONTENTS

Section

1. INTRODUCTION

1.1 Regular training on risk management for Board members and senior managers is a key element of the successful implementation of the Trust's risk management strategy and contributes to internal control arrangements in the Trust.

1.2 The Board requires the organisation to have identified and approved the process for delivering risk management awareness training for all board members, executives and senior managers.

1.3 The document sets out the format for risk management training for Board members, members of Executive Board and their direct reports.

2. THE RISK MANAGEMENT AWARENESS TRAINING PROCESS FOR BOARD MEMBERS AND SENIOR MANAGERS

2.1 On induction all new board members, new members of Executive Board will be provided with a Risk Management Awareness Training Aid that provides an overview of the risk management process.

2.2 All new Board members, new members of Executive Board will be requested to return a declaration slip indicating that they have read and understood the document to the Head of Risk Management.

2.3 The Head of Risk Management will keep a record of all new board members, new members of Executive Board that have returned declarations and will pass the information onto Learning & Development in order that the information can be entered onto the Electronic Staff Record.

2.4 In the event that a declaration has not been received the Trust Secretary will contact the individual concerned and if necessary refer the issue to the Executive Lead for Risk Management.

2.5 Issuing the risk management training aid to new Board members, new members of Executive Board will become part of the Trust induction process.

3. ONGOING AWARENESS TRAINING

3.1 The Head of Risk Management or the Executive Lead for Risk Management will provide a yearly update at annual risk management training sessions for Board members, members of Executive Board and where possible their direct reports with senior management responsibility. This training may be supplemented by appropriate e learning packages for staff unable to attend the individual sessions.

3.2 This session will be influenced by internal and external factors influencing the Risk Management agenda both internally and nationally.

3.3 The process for recording and following up attendance will be as for the other mandatory training.

4. MONITORING EFFECTIVENESS

4.1 The risk management team will audit yearly that relevant staff have received awareness / follow up training.

4.2 Training received by the Board will be evaluated by those receiving training and this will influence further the annual update sessions.

Appendix

RISK MANAGEMENT AWARENESS TRAINING AID

1. BACKGROUND

1.1 This document is designed to give an overview of the Risk Management Process and to provoke thoughts and further questions. If you have any questions arising from this document then please contact the appropriate person for more information (see details at the end of this document). Issues that arise can be dealt with on a one-to-one basis and can also be addressed at the annual risk management training session for Board members and senior managers that are to be developed.

1.2 Once you have read this document, please complete and detach the form at the back and return to Kate Rumble, Head of Risk Management either by email to kate.rumble@rmh.nhs.uk or by post to the Risk Management Team, Sutton.

1.3 This document contains hyperlinks to recommended further reading.

2. DIRECTORS' AND MANAGERS' DUTIES AND RESPONSIBILITIES

2.1 One of the key roles of NHS Trust Boards is to provide active leadership of the organisation within a framework of prudent and effective controls which enable risk to be assessed and managed. This is taken from the Higgs Report on the Review of the role and effectiveness of non-executive directors, January 2003.

2.2 Legally there is no distinction between the Board duties of executive and non-executive directors, they both share responsibility for the direction and control of the organisation.

2.3 The Healthy NHS Board 2013 Principles for Good Governance http://www.leadershipacademy.nhs.uk/wp-content/uploads/2013/06/NHSLeadership-HealthyNHSBoard-2013.pdf

2.4 The Board is expected to have in place a system for continuous risk management which extends from the front-line service through to the Board. It should be able to assess the risks to the achievement of its strategic objectives and whether the management processes and controls are in place to achieve them.

2.5 The Board is accountable for ensuring the organisation operates with openness, transparency and candour. The board has an overarching responsibility, through its leadership and oversight, to ensure and be assured that the organisation operates with openness, transparency, and candour, particularly in relation to its dealings with patients and the public.

2.6 Senior Managers have a responsibility to ensure that risk management processes are in place in line with the Trust's risk management policy and functioning appropriately in their respective areas to enable risks to be managed and the right level of information regarding risks to reach the Trust Board.

3. LEGISLATIVE BACKGROUND AND COMPLIANCE REGIMES

3.1 **The Health and Safety at Work act 1974**, also referred to as HASAW or HSW, is the primary piece of legislation covering occupational health and safety in the United Kingdom. The Health and Safety Executive is responsible for enforcing the Act and a number of other Acts and Statutory Instruments relevant to the working environment. The full text of the Act is available from: www.hse.gov.uk/legislation/hswa.htm

3.1.1 Statutory instruments are the secondary types of legislation made under specific Acts of Parliament. These cover a wide range of subjects, from Control of Asbestos Regulations 2012 (CAR2012), ionising radiation and working at height. See http://www.hse.gov.uk/legislation/enforced.htm for more details.

3.2 **Internal audit** primarily provides an independent and objective opinion to the Accountable Officer, the Board and the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisations agreed objectives. In addition, internal audit's findings and recommendations are beneficial to senior managers in the audited areas. Risk management, control and governance comprise the policies, procedures and operations established to ensure the achievement of objectives, the appropriate assessment of risk, the reliability of internal and external reporting and accountability processes, compliance with applicable laws and regulations, and compliance with the behavioural and ethical standards set for the organisation.

3.2.1 Internal audit also provides an independent and objective consultancy service specifically to help managers improve the organisation's risk management, control and governance. Such consultancy work contributes to the opinion which internal audit provides on risk management, control and governance. This opinion is given on the Trust's systems and processes and, ultimately, the Statement on Internal Control.
For further information on Internal Audit see the Internal audit standards for the NHS:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212826/NHS-internal-audit-standards-april-2011.pdf

3.3 **External audit** is an essential element in the process of accountability for public money and makes an important contribution to the stewardship of public resources and the corporate governance of public services. Audit in the public sector is underpinned by three fundamental principles:

(i) Auditors are appointed independently from the bodies being audited;
(ii) The scope of auditors' work is extended to cover not only the audit of financial statements but also value for money and the conduct of public business; and
iii) Auditors may report aspects of their work widely to the public and other key stakeholders.

3.3.1 The duties and powers of auditors appointed by the Audit Commission are set out in the Audit Commission Act 1998 and the Commission's statutory Code of Audit Practice.

3.4 **The Care Quality Commission** reviews Trusts against standards. These standards typically cover a large area of the Trust's activities and explicitly include corporate governance and risk management. New standards have been developed which are called the Fundamental Standards http://www.cqc.org.uk/content/our-fundamental-standards

3.4.1 NHS Trusts prepare and submit an annual self-declaration of compliance against the standards and the Hygiene Code, which is reviewed by key stakeholders.

3.4.2 There are numerous other bodies that assess and accredit aspects of the Trust's services with a view to reducing risk and improving quality. These include: Royal Colleges, Medicines and Healthcare Products Regulatory Agency, Fire Authority, Environmental Agency, Environmental Health and Professional/service accreditation bodies such as Clinical Pathology Accreditation (UK) Ltd (CPA).

3.5 Transfer of Patient Safety to NHS Improvement allows the key functions and expertise for patient safety developed by the National Patient Safety Agency (NPSA) to continue to progress.

NHS Improvement utilizes the National Reporting and Learning System (NRLS), the world's most comprehensive database of patient safety information, to identify and tackle important patient safety issues at their root cause.
www.improvement.nhs.uk/resources/learning-from-patient-safety-incidents/

Other relevant documents are located in the Risk Management intranet site.

4. TRUST CORE POLICIES / COMMITTEES AND GROUPS

4.1 There are a number of policies in place across the Trust relating to risk management. The principle ones are:

- Risk Management Policy
- Accident and Incident Reporting Policy including SIs
- Health and Safety Policy
- Incident, Complaints and Claims Investigation Policy
- Being Open and Duty of Candour Policy
- Major Incident Plan

4.2 In order to gain an understanding of how the process of risk management works within the Royal Marsden NHS Foundation Trust including the associated roles and responsibilities it is advised that you read the policies mentioned above.

4.3 There are many committees and groups in the Trust that look at areas of risk management. The roles of the principle groups with respect to risk are set out in the Risk Management Policy.

5. BUILDING THE ASSURANCE FRAMEWORK

5.1 In accordance with Department of Health guidance, all NHS Trusts are required to submit an annual Statement on Internal Control (SIC) signed by the Chief Executive and underpinned by a supporting Assurance Framework. This should provide the Trust with confidence that systems are safe and subject to appropriate scrutiny and

that the Board is able to demonstrate that they have been informed about key risks affecting the Trust.

5.2 There are a number of questions that this process sets out to answer:

- Can the organisation achieve its objectives?
- What are the risks that may prevent the achievement of those objectives?
- What controls are in place to manage those risks?
- How does the Trust Board know these controls are effective?
- How can the Trust Board be confident that its objectives can be achieved?
- How are the gaps in control and gaps in assurance being addressed?

5.3 This information is set out in the Assurance Framework and the risks to achieving the objectives are identified as part of the annual business planning process.

6. CONTACT DETAILS OF KEY MEMBERS OF STAFF

6.1 If you have any queries, worries or concerns please do not hesitate to contact one of following:

Chief Nurse	Ext 2121
Head of Risk Management	Ext 3534

Declaration slip:

I have read and understood the Risk Management Awareness Training for Board Members and Senior Managers, 2018/19

Name…… Job Title……

Signature…… Date……..

Please complete and detach this section and return to Kate Rumble, Head of Risk Management either by email to *kate.rumble@rmh.nhs.uk* or by post to the Risk Management Team, Sutton.

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