Reference Number:	FOI202122514
From:	Other
Date:	04 March 2022
Subject:	Copies of Risk Management Documents

Q1 Please provide a copy of your organisations Risk Management Strategy

A1 Please see attached document: 514 Risk Management Strategy

Q2 Please provide a copy of your organisations Risk Management Policy if this is a separate document to the Strategy

A2 Please see attached document: 514 Risk Management Policy

Q3 Please provide your organisations Risk Appetite Statement

A3 This can be found as part of A1: 514 Risk Management Strategy

Q4 Please provide your organisations approach to risk tolerance

A4 This can be found as part of A1: 514 Risk Management Strategy and 514 Board Assurance Framework policy – see attached document

Q5 Please provide the minutes and any associated papers from the last meeting where your Board of Directors reviewed the Trust's risk appetite statement and setting the risk tolerance levels within the organisation

A5 This information is available on our website, it can be found in our Board Papers:

https://alderhey.nhs.uk/about-us/our-board/publications

Q6 Please provide a copy of your organisations latest Corporate Risk Register Report

A6 This information is available on our website, it can be found in our Board Papers on a quarterly basis the last of which was 31 March 2022:

https://alderhey.nhs.uk/about-us/our-board/publications

Q7 Please provide a copy of your organisations latest Board Assurance Framework

A7 Please see attached document: 514 Board Assurance Framework Policy

Q8 Please provide a copy of your latest Risk Management Internal Audit report

A8 Please see attached document: 514 Internal Audit Progress Report January 2022_Redacted

Staff names exempted under Section 40: Personal Information

Q9 Please confirm how your organisation records risk – do you use a system, if so which system e.g. in house, Ulysses, Datix, Radar etc, or do you use excel spreadsheets?

A9 Ulysses

Q10 Please provide the risk management role structure within your organisation including the Banding of these roles

A10 Please see attached document: 514 Governance and Quality Assurance Team Structure June 2022

WTE – Whole Time Equivalent

Alder Hey Children's
NHS Foundation Trust

RM58 – BOARD ASSURANCE FRAMEWORK POLICY

Version:	5
Name of ratifying committee:	Board of Directors
Date ratified:	03/09/2019
Name of originator/author:	Director of Corporate Affairs
Name of approval committee:	Integrated Governance Committee
Date approved:	10/07/2019
Executive Sponsor:	Director of Corporate Affairs
Key search words:	Assurance, Risk, BAF, RM58
Date issued:	September 2019
Review date:	September 2022

Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
5	September 2019	Director of Corporate Affairs	Current	
4	February 2018	Director of Corporate Affairs	Archived	
3	September 2016	Director of Corporate Affairs	Archived	
2	July 2015	Director of Corporate Affairs	Archived	
1	July 2014	Director of Corporate Affairs	Archived	

Record of changes made to Board Assurance Framework Policy – Version 5			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
4.5	7	It will provide an updated BAF and summary of the corporate risk register on a bi-annual basis and also an extract of the relevant risks to the other board committees.	Change in reporting
Appendix 1.4	10	Risk registers are held at Ward / Departmental level, Divisional level, business support function level, and at Trust Wide level, (Assurance Framework and Corporate Risk Register).	Updated to reflect risk registers also held at ward level

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3	Duties and Responsibilities	5
4	Process for Maintaining the Assurance Framework	7
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1 Introduction

A Board Assurance Framework (hereafter referred to as the BAF) must be driven by the objectives of the organisation. Therefore it follows that clear strategic and operational objectives need to be identified before an effective system of internal control can be established. Without clear objectives, the Trust would be unable to identify and evaluate the risks that threaten the achievement of its goals and design and operate a system of internal control to manage those risks. The corporate objectives for the Trust are determined by the Board of Directors, based on organisational, local and national priorities, stated in the Trust's operational plan and other related documents. The BAF enables the Board to demonstrate that it has been properly informed about the totality of its risks and is able to sign the Annual Governance Statement required annually by NHS Improvement.

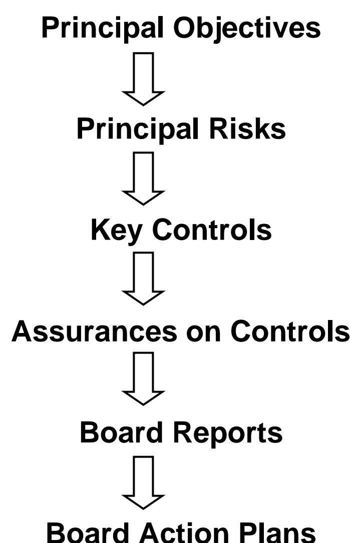
The BAF must be a dynamic tool to enable the Board to assure itself that all significant strategic risks are being managed effectively. The elements involved in this assurance process are:

- The BAF must be reviewed and updated with progress towards closing the identified risks and associated gaps in control and/or assurance at least quarterly.
- Independent scrutiny must take place to ensure that these updates are valid.
- Both of these processes must also consider whether new risks have arisen with the potential to jeopardise the achievement of the Trust’s principal strategic objectives.

2 Purpose of Policy

The purpose of this policy is to set out the key structures, systems and processes by which the Board of Directors is assured, via the BAF and the underpinning risk registers that the Trust’s strategic and operational objectives are being achieved through the effective management of the strategic and operational risks. See Fig.1 below.

The Board Assurance Framework



3 Duties and Responsibilities

3.1 Board of Directors

- It is the duty of Board members to ensure that they monitor the Trust's significant risks as detailed in the corporate risk register and that those corporate risks link into the high level risks on the BAF, that relate to specific strategic objectives and the associated controls and assurances in line with the work plan. In particular, the Board should focus upon progress by exception of action plans to address gaps in control and assurance.
- The Board should ensure that all systems, processes and procedures required for the BAF function effectively, including where elements have been delegated to Committees.

3.2 Board Committees

- The overall role of the Board's committees is to carry out the detailed work of assurance on behalf of the Board. They report recommendations to the Board. The Board Committee's core role and responsibilities is to:
  - Scrutinise reports on the relevant risks to that Committee's remit from the BAF and the corporate risk register; the delivery of the Annual Plan and compliance with CQC Standards.
  - Contribute to the development of the Annual Planning cycle and ensure that this plan reflects stakeholder requirements.
  - Give the Board confidence that the systems, policies and people they have put in place to deliver the Annual Plan are operating in compliance with CQC Standards, are effective, are focused on key risks and are driving the delivery of the Trust's objectives.
  - Recommend to the Board the level of assurance required, the source of assurance required and how the reporting of assurances will be managed and coordinated.
  - Provide the Board with the evidence required of the effectiveness of controls in order to be able to sign the Annual Governance Statement and maintain unconditional registration with the CQC.
  - Scrutinise reports and evidence of assurances provided by clinicians, managers, Trust committees and independent assurers on the status of the Trust's internal controls.
  - Ensure that unacceptable levels of assurance and risks are reported to the Trust Board for their consideration.

3.3 Integrated Governance Committee

- The Integrated Governance Committee oversees the design and effective operation of the risk management process across the Trust including the management of the production of the BAF.
- The Committee provides the Board with assurance that a comprehensive corporate risk register is in place derived from the Executives' view of the major risks to the Trust and the risks being escalated from Divisions and business support functions.

- The Committee oversees the integration of clinical, organisational and financial risk management systems across the Trust with that of corporate business planning.
- It is authorised to take remedial action to resolve weaknesses and incorporate best practice.

3.4 Divisions and Business Unit Functions

- All Divisions and Business Unit Functions should complete and report to the Integrated Governance Committee on their specific accountabilities and responsibilities as defined in the work plans.

3.5 Director of Corporate Affairs

- The Director of Corporate Affairs will facilitate the process for updating the BAF.
- The Director of Corporate Affairs will ensure the Board of Directors is provided with an updated BAF every month.
- The Director of Corporate Affairs will ensure that timely risk modelling is undertaken for all new identified or emerging risks.

3.6 Executive Directors

- Each risk identified on the BAF will have an Executive Director owner who holds accountability for updating entries in the Assurance Framework against that risk i.e. associated controls, actual assurances (reports etc), action plans and impact/likelihood score.
- Once all updates from risk owners have been received, the Executive Lead will sign off the refreshed BAF.
- The Executive Directors with responsibility for staff groups in each will be accountable for the proactive timely and accurate review and update of all risks owned by their Divisions / corporate service. This will include continuously supporting risk owners, control owners and action owners to scrutinise their existing risks and progress made to reduce them. It is also an opportunity to identify any emerging new risks for assessment and inclusion in the corporate risk register.

3.7 Non-executive Directors

- It is the role of all Non Executive Directors to contribute to Board and Committee discussions and make constructive challenges.
- They should identify issues, either through Committee activities or at the Board itself, of which the Audit Committee will undertake a more detailed review.

3.8 Associate Chief Operating Officers / Heads of Business Unit Functions, Project and Programme Managers

- Associate Chief Operating Officers, business support function Heads of Departments, Project and Programme Managers are accountable for the

complete and accurate review and update of all risks owned by their Divisions/ service/ programme. This will include continuously supporting risk owners, control owners and action owners to scrutinise their existing risks and progress made to reduce them.

- They are also accountable for identifying any emerging new risks for assessment and escalation to the corporate risk register.

3.9 All Staff

- Contributing to the identification of risk through active participation in the risk assessment and incident reporting processes by ensuring they comply with their responsibilities identified in the risk assessment and incident reporting policies.
- Following all relevant safety precautions in line with the policy.
- Keeping mandatory training up to date through attendance and updating identified in the training needs analysis.

4 Process for Maintaining the Board Assurance Framework

4.1 The BAF is utilised by the Board of Directors as a planned and systematic approach to the identification, assessment and mitigation of the risks that could hinder the Trust in achieving its strategic goals.

4.2 The BAF contains information regarding internal and external assurances that organisational goals are being met. Where risks are identified, mitigations and subsequent action plans are mapped against them.

4.3 Risks are scored using a 5x5 matrix of impact and likelihood. This 5x5 matrix, in which scores for impact or consequence of the risk is multiplied by the score for likelihood of occurrence. The total score generated is known as the risk rating.

4.4 The BAF is maintained by the Director of Corporate Affairs. The information recorded on the Framework includes:

- Description of the risk
- Current risk score
- Control measures in place
- Evidence of current assurances
- Gaps in controls/ assurances
- Target risk rating
- Actions required to achieve the target risk rating – the appetite for the specific risk.

4.5 The Board of Directors has delegated responsibility of monitoring risks and assurances to the Integrated Governance Committee (IGC), which will review and update the BAF at each of its bi-monthly meetings. It will provide an updated BAF and summary of the corporate risk register to the Board on a bi-annual basis and also an extract of the relevant risks to the other Board Committees: Clinical Quality Assurance Committee, the Resources and Business

Development Committee and Workforce and Organisational Development Committee.

4.6 The Audit Committee has delegated responsibility from the Board to oversee this process, ensuring that there is adequate external review and assurance and that this is used to inform the Annual Governance Statement.

5 Process for the Local Management of Risk (which reflects the organisation wide Risk Management Strategy)

- Each Clinical Division and Corporate Function will refresh their risk register on an annual basis as per the Trust's Risk Management Strategy.
- The locally identified risks, derived from completing the risk assessment tool, will be utilised to inform the departmental risk registers. Divisional Associate COOs/Heads of Corporate Functions are responsible for ensuring that actions are put in place to mitigate identified risks.
- The ways in which risk can be escalated from Ward and department level to Divisions and corporate levels is outlined in the Risk Management Strategy.
- Divisions/Corporate Functions will provide exception reports to the Integrated Governance Committee in line with that's Committee's work plan.

6 Monitoring Compliance with the Processes

As stipulated within this policy, the Trust will keep the BAF under review via the Integrated Governance Committee and monthly reports to Board of Directors and its Committees.

- The reports will be presented by the Director of Corporate Affairs to the Board of Directors and its assurance committees.
- An annual audit of the corporate risk register/ Assurance Framework will form part of the internal audit programme, to support the Annual Governance Statement.
- The purpose of this annual audit is to monitor the systems and processes of the approved organisation-wide risk register.
- The Trust's BAF will be monitored to assess compliance with the key performance indicators.
- The audit process will assess whether responsibilities are clearly agreed and recorded and there is evidence to support objectives which are clearly linked to the Trust's operational plan or other strategic documentation.
- Risks are clearly linked to objectives, their priority (impact/likelihood) has been determined and they have been attributed to a lead.
- Risks are assessed and new/amended risks are considered and included where appropriate.
- Controls effectively manage the risk, there is evidence that the controls are in place and that there is adequate management of controls.
- Controls relied upon are sufficient to manage the risk i.e. expected assurances have been received and provide sufficient information to efficiently manage the risk.
- Positive assurance evidence is collated and uploaded onto performance accelerator and signed off by the accountable Executive Director.

- Where gaps in control/assurance have been identified, appropriate actions plans have been agreed to address these and are monitored consistently in line with policy standards.
- Board reports, Integrated Governance Committee minutes, Resources and Business Development Committee minutes, Clinical Quality Assurance Committee minutes, Workforce and Organisational Development Committee minutes and Audit Committee minutes provide evidence that the Assurance Framework has been effectively discussed and considered and progress/ action has been taken to address areas raised following the audit.
- The Integrated Governance Committee and Audit Committee monitor reports ensuring that recommendations/actions are implemented where monitoring has identified deficiencies. This is to ensure that lessons have been learned and agreed changes in practice made.

7 Further Information

Equality Analysis *(hyperlink)*

References

- The Healthy NHS Board
- Taking it on Trust
- Board Assurance Frameworks – A Simple Rules Guide for the NHS
- CQC Standards
- NHSI Single Oversight Framework updated November 2017
- NHSI Annual Reporting Manual 2017/18

Associated Documentation

This policy should be read in accordance with the Trust Risk Management Strategy.

Appendix A

1. Definitions

1.1 Assurance

Confidence based on sufficient evidence, that internal controls including policies, procedures, practices and organisational structures are in place and operating effectively ensuring the strategic objectives are being achieved.

1.2 Key Elements Assurance Framework

- An Assurance Framework (BAF) is a simple but comprehensive method for:
- The management of the principal risks to meeting the organisation's objectives.
- Providing evidence for the Annual Governance Statement. Guidance on what should be included within the Statement is provided within Monitor's Annual Reporting Manual each year.

1.3 Principal Objectives

- Principal Objectives are statements of the crucial measurable results which the organisation must achieve in order to achieve its overall goals in line with its strategic aims.
- Clinical Divisions and Corporate functions must align their objectives with the principal objectives in order to ensure that their activities contribute to the achievement of the Trust's principal objectives.
- The BAF must specify the Director who is accountable to the Board for delivering the Principal Objectives of the corporate plan.
- The Principal Objectives must be stated in terms which are:

Specific
Measurable
Achievable
Realistic
Time-based

1.4 Risk Registers

- Risk registers are held at Ward /Departmental level, Divisional level, business support function level, and at Trust Wide level, (Assurance Framework and Corporate Risk Register). The principal risks associated with each strategic objective must be identified on the BAF.
- The risk rating tool (5x5 matrix) enables staff to consider the potential harm that would be caused if a hazard or threat was realised and how likely this is to happen. The two factors of likelihood and impact/consequence are used to establish the level of risk; this will assist staff in deciding which risks take priority and highlight areas which need rapid attention.
- The Divisional/Department/Business Support Function level risk register must reflect the proactive annual risk assessments undertaken and reactive risks identified through incident reporting etc. including demonstrating action taken against these risks at least monthly.

- Each Division/Department/Business Support function has responsibility to review their own risks and to inform the Integrated Governance Committee of actions completed to reduce or eliminate the identified risk.
- The Division /Department/Business Support Function risk assessments will contribute to the formulation of the high level Trust Corporate Risk Register along with other forms of risk identification. This will ensure that the risk registers are consistent and that meaningful decisions on the prioritisation and treatment of risks can be made.
- Risk Registers will be kept at Business Support Functions, Divisional and Department/Ward levels within the Trust.
- At Board level the corporate risk register will include risks to the achievement of Principal Objectives together with risks escalated from business support functions, Divisions and Department/Ward levels.

1.5 Principal Risks

- Factors which potentially threaten the achievement of the principal objectives are called principal risks and need to be identified. They should be stated as "If x happens then y will be the consequence".
- Using risk profiling the principal risks to achieving the principal objective are identified and summarised on the BAF together with a score of their likelihood and potential impact.

1.6 Risk Profiling

Risk Profiling is a process that involves the identification and assessment of all risks encountered by an organisation, enabling the identification of high risk issues, facilitating the management and prioritisation of such risks.

- Risk profiling gives a risk a 'Likelihood score' of:

  1 = rare - do not expect this to happen.
  2 = unlikely - most probably will not happen.
  3 = occasionally - 50:50 chance of occurring.
  4 = likely - most probably will happen.
  5 = almost certain - confident that this will happen.

- Risk profiling gives an impact/consequence score of

  1 = almost non - no obvious harm.
  2 = minor - no permanent harm (recovery within month).
  3 = moderate - semi-permanent harm (recovery takes longer than 1 month but no more than 1 year) and/or adverse publicity for the Trust.
  4 = major - permanent harm not resulting in death or severe disability to a person or persons and/or start of a national investigation into the Trust and/or disruption of key Trust services which significantly hinder the Trust in meeting its responsibilities.
  5 = catastrophic - death or permanent severe disability to a person or persons and/or significant loss of reputation for the Trust and/or loss of key Trust services which prevent the Trust meeting its responsibilities.

Note: Harm in all the above includes damage to the organisation, its finances, its reputation, its business, its patients, staff or visitors.

1.7 Identification of Risks

Potential principal risks to the achievement of the Trust's objectives are identified in two ways: the 'top down' proactive (risk assessment) identification of risks that directly affect the Trust's achievement of its principal objectives, combined with the 'bottom up' assessment of the most significant risks within the business support, programme and Clinical Risk Registers, which in turn originated in Clinical Business Units, programme and Business Support Function Risk Registers.

1.8 Controls and Assurance

- Controls are the many different things that are in place to mitigate risk and assist in securing the delivery of objectives; they should make a risk less likely to happen, or reduce its effect if it does happen.
- The Assurance Framework requires the Trust to consider the effectiveness of each control through the process of obtaining assurances that the control is in place and is operating effectively.
- The Assurance Framework summarises how the Board knows that the controls it has in place are effectively managing the principal risks together with references to documentary evidence that the assurances are working effectively.
- There are two groups of assurances on controls:
  - Internal Assurance
  - Independent Assurance
- Internal assurance is provided by the following Committees:
  - Audit Committee
  - Clinical Quality Assurance Committee
  - Integrated Governance Committee
  - Workforce and Organisational Development Committee
  - Health and Safety Committee
  - Clinical Systems Informatics Project Group
  - Information Governance Committee
- The purpose of the committees is to carry out an analysis of assurances received, identify any key gaps in the assurance mechanisms and provide an evaluation of the effectiveness of these mechanisms to inform the relevant strategic objectives on the Assurance Framework.
- The Board of Directors then receive summary reports from these committees together with Audit Committee reports and makes a final judgement on the level of assurances received and any actions required to ensure delivery of the Trust's objectives and obligations.
- Independent assurance is provided by:
  - Audit Committee

- Internal Audit and External Auditors
- Care Quality Commission
- Health and Safety Executive
- Monitor/NHS Improvement

1.9 Key Controls

- Key controls are the means by which the risk's impact or likelihood may be reduced together with references to documentary evidence of the existence and effectiveness of that control mechanism. Risk control is achieved by reducing the likelihood of the risk, reducing the impact of the risk and/or transferring the risk. The risk controls are also identified through a risk profiling process and summarised on the Assurance Framework as are any gaps in risk control.

- The Board of Directors and all other Trust staff grade risks must use the same tool.

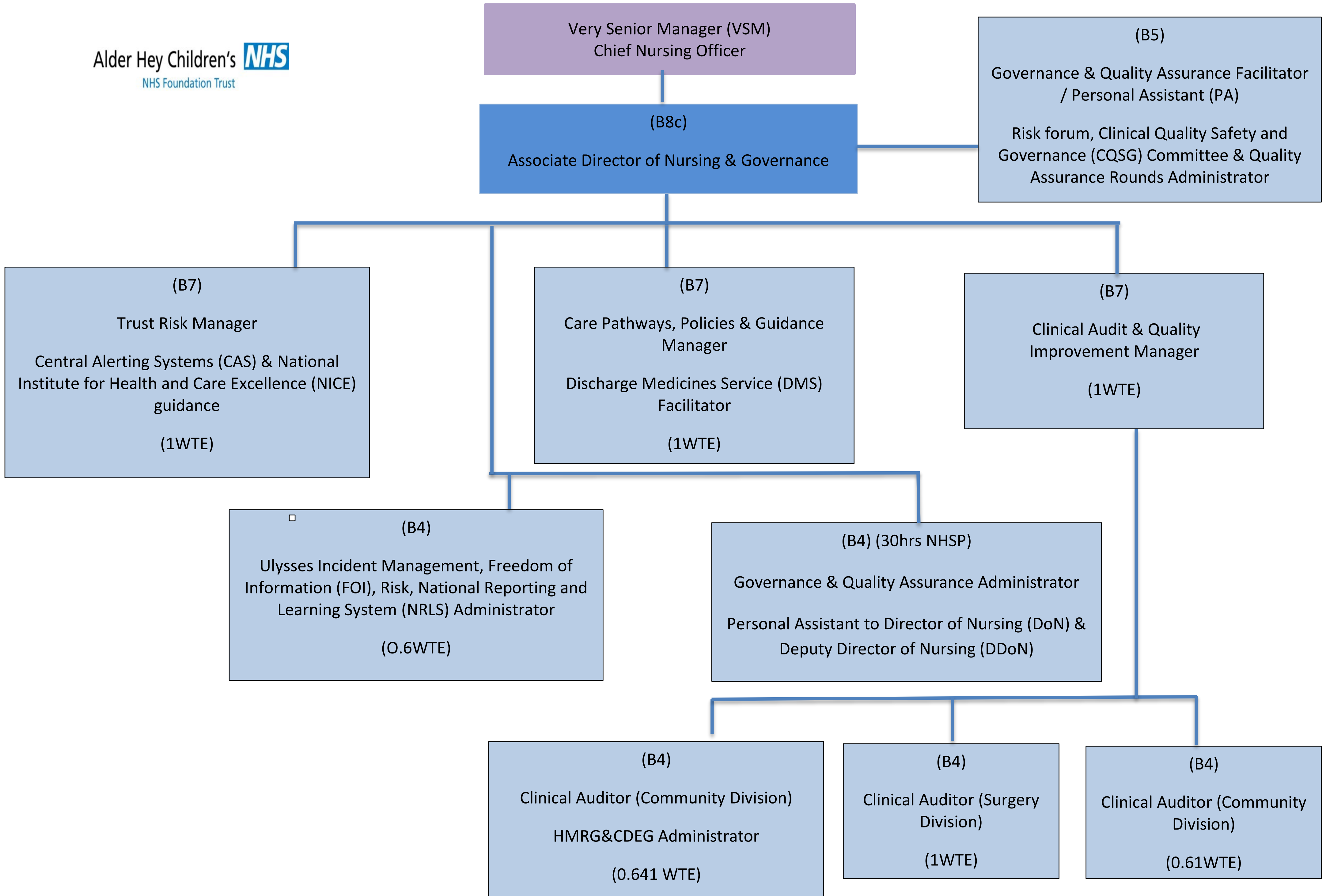
1.10 Gap in control and assurance

- A gap in control is deemed to exist where adequate controls are not in place, or where collectively they are not effective. A failure to put in place sufficient effective policies, procedures, practices of organisational structures to manage risks and achieve objectives.
- A gap in assurance is deemed to exist where there is a failure to gain evidence that the controls are effective. In other words a failure to gain sufficient evidence that policies, procedures, practices or organisational structures on which reliance is placed is operating effectively.
- Wherever gaps in control or assurance are identified, action plans must be clearly defined, monitored consistently for improvement and allocated to appropriate lead Directors.

1.11 Controls Performance Reports and Associated Action Plans

- Performance reports e.g. audit reports provide strong evidence of the effectiveness of control activities and should identify necessary improvements where controls are lacking. It therefore follows that performance reports generate valuable information for the Assurance Framework and that there is a clear need for performance reporting and the Assurance Framework to be strongly linked.
- Where there is deficits identified in performance action plans must be formulated and consistently monitored to ensure compliance with performance standards (strategic objectives).

Governance, Risk & Quality Assurance Team **June 2022**



Internal Audit Progress Report
Audit Committee (January 2022)

Alder Hey Children's Hospital NHS Foundation Trust

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1 Introduction

2 Executive Summary

Appendix A: Contract Performance

Appendix B: Performance Indicators

Appendix C: Key Areas from our Work and Actions to be Delivered

Your Team

Name	Role	Contact Details
[redacted]	Engagement Lead	[redacted] [redacted]
[redacted]	Engagement Manager	[redacted] [redacted]

Limitations

The matters raised in this report are only those which came to our attention during our internal audit work and are not necessarily a comprehensive statement of all the weaknesses that exist, or of all the improvements that may be required. Whilst every care has been taken to ensure that the information in this report is as accurate as possible, based on the information provided and documentation reviewed, no complete guarantee or warranty can be given with regards to the advice and information contained herein. Our work does not provide absolute assurance that material errors, loss or fraud do not exist.

Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management and work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, nor relied upon to identify all circumstances of fraud or irregularity. Effective and timely

implementation of our recommendations by management is important for the maintenance of a reliable internal control system.

Reports prepared by MIAA are prepared for your sole use and no responsibility is taken by MIAA or the auditors to any director or officer in their individual capacity. No responsibility to any third party is accepted as the report has not been prepared for, and is not intended for, any other purpose and a person who is not a party to the agreement for the provision of Internal Audit and shall not have any rights under the Contracts (Rights of Third Parties) Act 1999.

Public Sector Internal Audit Standards

Our work was completed in accordance with Public Sector Internal Audit Standards.

1 Introduction

This report provides an update to the Audit Committee in respect of the progress made against the Internal Audit Plan for 2021/22 and brings to your attention matters relevant to your responsibilities as members of the Audit Committee.

This progress report provides a summary of Internal Audit activity and complies with the requirements of the Public Sector Internal Audit Standards.

Comprehensive reports detailing findings, recommendations and agreed actions are provided to the organisation, and are available to Committee Members on request. In addition, a consolidated follow up position is reported on a periodic basis to the Audit Committee.

This progress report covers the period November 2021 - January 2022.

2 Executive Summary

Since the last meeting of the Audit Committee, there has been the focus on the following areas:

<table>
<tr>
<td>2021/22 Audit Reviews</td>
<td>The following reviews have been finalised:

• Key Financial Controls (High assurance – General Ledger, Accounts Receivable, Treasury Management and Budgetary Control and substantial assurance – Accounts Payable)

Overall, the review identified there is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.

• Risk Management Thematic Review (Substantial assurance)

Overall, the review identified there is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.

• Complaints & PALs (Limited assurance)

Overall, the review identified that there is a compromised system of internal control as weaknesses in the design and inconsistent application of controls puts the achievement of the system objectives at risk.

• Lessons Learnt from Covid-19 (Substantial assurance)

Overall, the review identified there is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.</td>
</tr>
</table>

	The reviews below are currently in progress: • Data Quality (fieldwork) • Committee Effectiveness (fieldwork) • IT Service Continuity & Resilience (fieldwork) • Recruitment Processes (fieldwork) The Assurance Framework Opinion Stage 2 review will be completed during quarter four.
Follow Up	A summary of the current status of all follow-up activity is included as a separate report to this Committee.
Audit Plan Changes	Audit Committee approval will be requested for any amendments to the original plan and highlighted separately below to facilitate the monitoring process. There have been no requests to amend the Internal Audit Plan.
Insights	**Briefings** Our latest briefings/blogs are: • MIAA 21/22 Checklist Series – Governance (Trusts and FTs) – Updated: On 24th December NHS England and NHS Improvement (NHSEI) issued a letter covering arrangements for *Reducing the burden of reporting and releasing capacity to manage the COVID-19 pandemic*. To support our clients in reviewing their governance arrangements we have updated the contents of our Governance Considerations Checklist to reflect NHSEI's current 'position on regulatory and reporting requirements for NHS trusts and foundation trusts' outlined in the letter issued. • [CQC Inspections through the Audit Committee Lens] • MIAA Supporting Safe Transition to Integrated Care Systems **Advisory and Support Role** We have continued to keep you updated on the latest key guidance through the regular issue of The Internal Audit Network (TIAN) Insight Report and our Fraud Threats and Advice Briefings. **Audit Committee Chairs Webinars**

We are continuing to hold webinars with groups of Trust and CCG Audit Committee Chairs focusing upon governance challenges and other key issues. The current focus of these webinars is Integrated Care Systems (ICS) with the following engagement events taking place over Microsoft Teams in January:

- Greater Manchester – 9:30-12:00 on 20th January 2022
- Cheshire & Merseyside – 9:30-12:00 on 21st January 2022
- Lancashire and South Cumbria 14:00-16:30 on 31st January

Collaborative Masterclass Events

- Leading for Diversity: Having Brave Conversations (27th January 2022)
- Behaviour Change: What Works? (11th March 2022)
- Outlook for the public sector (31st March 2022)

Appendix A: Contract Performance

The Public Sector Internal Audit Standards (PSIAS) state that 'The chief audit executive must deliver an annual internal audit opinion and report that can be used by the organisation to inform its governance statement.'

Below sets outs the overview of delivery for your Head of Internal Audit Opinion for 21/22:

HOIA Opinion Area	Process	Status	Assurance Level
Assurance Framework			
Assurance Framework Opinion Stage 1	Core Systems Review	Q2 (Final report issued)	N/a
Assurance Framework Opinion Stage 2	Core Systems Review	Q4 (Fieldwork)	
Core / Mandated Assurances			
Risk Management Thematic Review	Core Systems Review	Q2 (Final report issued)	Substantial
Key Financial Controls	Core Systems Review	Q3 (Final report issued)	High – General Ledger, Accounts Receivable, Treasury Management and Budgetary Control Substantial – Accounts Payable
Data Security & Protection Toolkit	Core Systems Review	Q1 & Q4 (Q1 Final report issued)	Assessment of self-assessment - Substantial Assessment against National Data Guardian Standards – Moderate
Risk Based Assurances			
Committee Effectiveness	Assurance	Q3 (Fieldwork)	

miaa

HOIA Opinion Area	Process	Status	Assurance Level
Waiting List Management	Assurance	Q2 (Final report issued)	Moderate
Data Quality	Assurance	Q4 (Fieldwork)	
Recruitment Processes	Assurance	Q4 (Fieldwork)	
Complaints & PALs	Assurance	Q3 (Final report issued)	Limited
Lessons Learnt	Assurance	Q3 (Final report issued)	Substantial
IT Service Continuity & Resilience	Assurance	Q3 (Fieldwork)	
Follow Up			
Quarter 1	Assurance	Completed	N/A
Quarter 2	Assurance	Completed	N/A
Quarter 3	Assurance	Completed	N/A
Quarter 4	Assurance	Q4	N/A
Advisory and Support Role			
TIAN Insight Report		Issued Monthly	N/A

If due to circumstances beyond our control we are unable to achieve sufficient depth or coverage, we may need to caveat opinions and explain the impact of this and what will be done to retrieve the position in future.

Appendix B: Performance Indicators

The primary measure of your internal auditor's performance is the outputs deriving from work undertaken. The following provides performance indicator information to support the Committee in assessing the performance of Internal Audit.

Element	Reporting Regularity	Status	Summary
Delivery of the Head of Internal Audit Opinion (Progress against Plan)	Each Audit Committee	Green	There is ongoing engagement and communications regarding delivery of key reviews to support the Head of Internal Audit Opinion. The Data Quality, Committee Effectiveness and Recruitment Processes reviews have been delayed at the request of the Trust unit Q4. We have agreed a plan to ensure that these reviews are completed in advance of year end to allow for discussion and closure of reports for inclusion in the Head of Internal Audit Opinion.
Issue a Client Satisfaction Questionnaire following completion of every audit.	Annually to the Audit Committee	Green	Client Satisfaction Questionnaire issued after each review.
Percentage of recommendations raised which are agreed	Each Audit Committee	Green	100% of recommendations raised have been agreed.
Percentage of recommendations which are implemented	Each Audit Committee	Green	Detailed in the Follow Up Report.
Qualified Staff	Annual	Green	MIAA have a highly qualified and diverse workforce. The Senior Team delivering the Internal Audit Service to the Trust are CCAB/IIA qualified.

Element	Reporting Regularity	Status	Summary
Quality	Annual	Green	MIAA operate systems to ISO Quality Standards. The External Quality Assessment, undertaken by CIPFA, provides assurance of MIAA's compliance with the Public Sector Internal Audit Standards. MIAA conforms with the Public Sector Internal Audit Code of Ethics.

Appendix C: Key Areas from our Work and Actions to be Delivered

Report Title	Key Financial Controls			
Executive Sponsor	Director of Finance / Deputy Chief Executive			
Objective	The overall objective of the review was to provide assurance that the most significant key controls are appropriately designed and operating effectively in practice. The most significant controls within: General Ledger, Accounts Payable, Accounts Receivable, Treasury Management, Budgetary Control were reviewed.			
Assurance Level	General Ledger – High Accounts Payable – Substantial Accounts Receivable – High Treasury Management – High Budgetary Control – High			
Recommendations	0 X Critical	0 x High	2 x Medium	1 x Low
Summary	This review focused on the key controls within: General Ledger, Accounts Payable, Accounts Receivable, Treasury Management and Budgetary Control for the 21/22 financial year to date. For General Ledger, reconciliations were performed on the Debtors, Creditors, Bank and GRNI accounts and no differences were identified. The Trust has a detailed control schedule in place which confirms the preparation and review of balance sheet control account reconciliations. Suspense account clearance was confirmed as achieved. User privileges to post journal entries are restricted to certain accounts and journal values depending on the user. Sample testing of 20 journals confirmed there was segregation between preparer and approver of journals. For Accounts Payable, sample testing of 20 orders confirmed that all were supported by a requisition, and invoices were automatically matched to a Goods Received Note (GRN). Sample testing of 10 orders not automatically matched within the computer system had been approved in line with the scheme of reservation and delegation. Supplier amendment forms were confirmed as completed and verified prior to making changes on the 'NEP' system and it was confirmed the			

	Trust undertake reviews to ensure supplier details are accurate. However, it was identified that one member of staff had a higher approval limit than stated in the Scheme of Reservation and Delegation (SoRD) due to a period of 'acting up'. Furthermore, we conducted a deep dive into the impact of the Trust's performance against the 'Better Payment Practice Code,' (BPPC) key performance indicators. BPPC is an NHS Digital led project which seeks to ensure suppliers are paid within 30 days of receipt of an invoice. Audit review of the Trust's BPPC targets confirmed there is a comprehensive action plan in place and performance against previous year was monitored. Audit review of the Trust's compliance with BPPC KPI's confirmed at the time of our audit, the Trust is not meeting the required targets largely due to requisitioners not receipting goods on delivery in a timely manner. For Accounts Receivable, the Trust has a robust procedure in place for the raising of credit notes and authorising credit notes. Sample testing of 10 credit notes confirmed sufficient management review. Sample testing of 20 overdue and outstanding debts identified follow up procedures had been undertaken with appropriate management oversight. For Treasury Management, cash flow reports are submitted to the Resources and Business Development (RABD) Committee prior to submission to NHS Improvement. Audit review from RABD confirmed they were consistent with the figures reported to NHSI. Urgent payments outside the AP payment run were confirmed as being made in a timely manner. However, it was also identified the Trust did not have a Standard Operating Procedure (SOP) in place for the approval of urgent payments. For Budgetary Control, comprehensive evidence of the budget setting process was reviewed with relevant approval processes confirmed as in place. The Trust provided a list of budget holders and audit review confirmed they were in line with the Scheme of Reservation and Delegation. CIP/QIPP targets are inbuilt within the budget and it was confirmed that the Trust Board are updated with progress on the implementation of CIP/QIPP schemes.
Key Areas Agreed for Action	The Trust already has an action plan to address the issues identified around delayed PO receipting and this will continue to be progressed at pace. (**Medium**) It was confirmed that the Trust often have temporary 'acting up' arrangements and they will review the options to dovetail evidence for

	any future arrangements with the details contained in the SoRD.. (**Medium**) For urgent payments, payments outside of the main AP run are minimal and are mainly limited to salary payments. These are managed via a controlled process via our payroll provider. We will capture these processes in a Standard Operating Procedure document. (**Low**)
Key Risks Highlighted with No Agreed Action	N/a

Report Title	Risk Management Thematic Review			
Executive Sponsor	Director of Corporate Affairs			
Objective	To ensure that adequate divisional arrangements are in place to manage key risks. To test the process we reviewed local treatment of the corporate risk relating to Risks of self-harm as this is a risk across the whole organisation.			
Assurance Level	Substantial			
Recommendations	0 X Critical	0 x High	1 x Medium	2 x Low
Summary	Overall, the review identified that controls have been designed appropriately and have been operating effectively. The review identified that the Trust has recently refreshed its Risk Management Strategy and Policy and Procedure, which have been appropriately approved, ratified and communicated to all staff. Roles and responsibilities are clear from the Chief Executive Officer, Non-Executive Directors to all staff within the Trust. The Trust has set a risk appetite and this was discussed and approved at Board in March 2021 subject to one change. Our review identified that this has not yet been back through Board, however it was noted that this is on the January 2022 Board agenda. We did also, identify that the Trust's website is not showing the new Strategy. It was confirmed that the Trust treats the risk 'Risks of Self Harm' consistently across the Trust through the work of the Children & Young People with Complex Behaviour Programme Board and this was observed by attendance at a number of Programme Board meetings and audit review of the papers. This group met fortnightly during this year and was a key driver in monitoring actions from this risk through detailed workstreams. Audit review of the action plans within the Ulysses system for all divisions confirmed that these are produced to mitigate risks and are regularly reviewed, however, we did identify that some actions are overdue. The Trust has recently established the Risk Management Forum in summer 2021 which reports to the Audit and Risk Committee. The review confirmed that there are established methods for the grading / scoring, monitoring and managing of the risks through the Trust's governance processes for each division. Furthermore, it was			

	confirmed that risks are escalating from a local level to Divisional risk registers, the corporate risk register and to the Board Assurance Framework.
Key Areas Agreed for Action	The Trust have confirmed that they will upload the Risk Management Strategy to the Trust website. (**Low**) The Trust have confirmed that the Risk Management Statement is due to return to the January 2022 Trust Board and will be on that Board agenda. (**Low**) The Trust have confirmed that the Divisions and Corporate Functions risk owners and managers always have the facility to review risks and associated actions on the risk register. In addition, there is auto reminders send daily from the day a risk action is about to go out of date and every day after until it is updated. Compliance with the process will be augmented by a secondary check by the corporate governance team. This will ensure that outstanding actions are picked up. The expectation of risk owners and managers will be reiterated through the Trust communication channels and the risk management system. (**Medium**)
Key Risks Highlighted with No Agreed Action	N/a

Report Title	Complaints & PALs			
Executive Sponsor	Medical Director			
Objective	To ensure that the Trust has a robust complaints management system and effective patient liaison in place and it is actively used as an opportunity to learn and drive continuous improvement.			
Assurance Level	Limited			
Recommendations	0 X Critical	2 x High	6 x Medium	3 x Low
Summary	Our review identified that there is a compromised system of internal control as weaknesses in the design and inconsistent application of controls puts the achievement of the system objectives at risk. The Trust has a Complaints and Concerns Policy in place which includes the roles and responsibilities of key contacts involved in the management of Complaints. The time frame for acknowledging and resolving complaints is clearly outlined in the Policy. The process for making a complaint and the complaint form is available on the Trust's website. The review identified that despite Covid 19 pressures, the Trust did not pause the complaints process including those that were not related to patient safety. All final response letters to the complainant are signed off by the Chief or Deputy Chief Executive. Audit review identified that the Clinical Quality Steering Group and the Safety and Quality Assurance Committee have regular oversight of complaints logged across the Divisions. The first high risk issue is that the review identified that with the exception of Community Division, lessons learned, or actions taken are not recorded on the Ulysses system and are not placed into common themes. Also, the review identified that lessons learned and actions taken are not clearly outlined in the Trust's final response letter template. The second high risk issue was that the review identified that although Community and Surgery Divisions have a monitoring spreadsheet to follow up action plans, there were instances where some actions were overdue and it was noted that the Surgery Division's monitoring tracker was not up to date. Medicine Division does not have a monitoring tracker in place for action plans identified from complaints.			

	Our testing found that all complaints sample tested had not been risk assessed although a section is available on Ulysses that includes an initial and final risk rating and these are not being completed. The Trust acknowledges complaints via email or letter. Whilst the Trust's standard acknowledgement letter makes reference to Health Watch Advocacy Service, this is not included in email acknowledgement. Testing identified one instance where consent was required, evidence was not available to demonstrate that consent had been given. Also, testing identified a final response letter had not been sent out in one instance where the complaint had been resolved and withdrawn and we further observed another instance where a final response letter was sent out although the complaint was also withdrawn. Feedback from complainants had not been requested in all complaints reviewed and audit review of the Trust's policy identified that the Trust would obtain anonymised feedback from complainants and include these in the annual complaint reports. Review of 2020/21 Quarter 4 and annual report to Trust Board identified that it does not include feedback from complainants. It was also observed that, evaluations from complainants are not being requested and the Trust's template of the final response letter does not clearly outline actions or lessons learned. In some instances where complaints were upheld, actions taken, or lessons learned were not clearly identified from the final response letters sent. Audit review also found that the Trust's Complaints and Concerns Policy is now due for review and a Complaint and PALs Annual Report has not been published on the website since 2018/19. Furthermore, we identified three low risk issues around the Complaints Policy and leaflets around the Trust, an audit trail of investigations completed and timely updates provided to complainants.
Key Areas Agreed for Action	The Trust will amend the template letter to include specific summary section on lessons learned and actions, inform divisions where a lesson must be shared immediately in respect of patient safety, inform divisional governance structures to disseminate lessons learnt from complaints, work with the provider of Ulysses to build in thematic analysis and set up a quarterly audit, in line with the quarterly complaints report from Q4, to audit compliance of capturing lessons learned and actions in the Ulysses system. Furthermore, the Trust will review the policy to ensure the inclusion of lessons learned and actions

	is clear, include the audit and ensure the process for disseminating lessons learned is clear. (**High**) The Trust will review the action spreadsheet used by Community division and implement across the divisions and ensure that the action monitoring spreadsheet is a tab within the wider Divisional investigation action document to enhance the Divisional oversight and monitoring of actions. (**High**) The Trust will review the Ulysses Complaint form and requirement and process for Risk Assessment and provide appropriate training to staff. (**Medium**) The Trust will amend the template email acknowledgement to include reference to Health Watch Advocacy Service in line with the acknowledgement letter. (**Medium**) The Trust will remind all staff involved in complaint responses, through Divisional governance structures, that consent must be obtained in line with the Complaint policy. (**Medium**) The Trust will include the procedure for withdrawn complaints in the new policy as this is not addressed in the current policy. (**Medium**) The Trust will devise an on-line evaluation form, review and amend the response template letter with a link to the on-line form and include responses from complainants in the annual report. (**Medium**) The Trust will continue to produce an Annual Complaints report, upload the 2020/21 report to the complaints page of the Trust website. (**Medium**) The Trust will update the policy and make complaints leaflets available at the front desk and around the Trust buildings, review the process in place for maintaining trail of investigations and remind all staff involved in complaint responses, through Divisional governance structures. (**3 x Low**)
Key Risks Highlighted with No Agreed Action	N/a

Report Title	Lesson Learnt from Covid-19			
Executive Sponsor	Medical Director			
Objective	To review the mechanisms the Trust has used to identify and learn lessons from their Covid-19 response and how these lessons have translated into practice changes.			
Assurance Level	Substantial			
Recommendations	0 X Critical	0 x High	2 x Medium	1 x Low
Summary	In response to the pandemic, the Trust set up a Covid-19 hub on the Trust Intranet, where daily briefings and weekly updates are available to all staff. Support with health and wellbeing and access to advice and liaison service are available to staff on the Covid-19 hub also. The Trust has an in-date Incident Reporting Policy that is available which covers the process for recording and managing incidents on the Ulysses system. The Trust continue to support changes in work practices such as hybrid working where patient care and safety is not compromised. The Trust established virtual ward rounds and virtual family visits during the peak of the pandemic. Audit review identified that several clinics have now gone virtual enabling Clinicians to reach patients in remote areas. The Trust also extended its operations to accommodate adult patients during the peak of the pandemic. Audit review found that the Trust established a Protecting Vulnerable Patients Forum during the pandemic to identify risk and safely support vulnerable patients. The Trust's Clinical Decision-Making Committee and Clinical Ethics Committee provided clinical and ethical guidance and support to clinicians making difficult decisions during the pandemic. The Trust also redeployed some staff temporarily as Yellow Helpers who provided non-clinical support to clinical teams and patients in dealing with the pressures of the pandemic. Our review of a sample of Covid-19 incidents identified that in most cases, actions had been identified and captured on the Ulysses system, however, in some instances it was not clear if they had been implemented. Furthermore, lessons learned were not always captured to support changes in practice and evidence was not always in place that the manager had reviewed the level of harm initially assigned on Ulysses.			

Key Areas Agreed for Action	The Trust confirmed that the need to review incidents and identify and record action plans will be part of the overall corporate governance teams work plan. (**Medium**) The Trust will remind Managers of the importance of sharing learning from incidents locally and ensure that staff are aware of any changes made in practice. (**Medium**) With regards to the review of harm, the Trust have confirmed that reports are auto generated every week for the current status of incidents and this will be augmented by a secondary check by the corporate governance team. This will ensure that outstanding incidents that have been pending a long time are picked up. The expectation of managers will be reiterated through the Trust communication channels and the incident reporting system management. (**Low**)
Key Risks Highlighted with No Agreed Action	N/a

NHS
Alder Hey Children's
NHS Foundation Trust

RM5 - RISK MANAGEMENT POLICY & PROCEDURE

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Record of changes made to the Risk Management Policy – Version 1			
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3. Quick Reference Guide

Risk Management at a Glance

1. WHAT IS RISK MANAGEMENT

Risk management is the process by which risks are identified, assessed, recorded, mitigated, monitored & reviewed, and communicated A risk is the threat that an event or action will adversely affect the ability to achieve our objectives

2. WHY IS IT SO IMPORTANT?

Failure to effectively identify and address issues at an early stage can lead to unnecessary adverse events affecting patient safety, staff welfare or the Trust's performance Good risk management is a preventative measure to stop bad things from happening.

3. WHO IS RESPONSIBLE FOR IT?

Everyone It is essential that we all remain alert to issues which may have a negative impact on patients, staff or the Trust. We must also take personal responsibility for reporting such issues and acting upon them.

4. HOW DO I IDENTIFY & MANAGE RISKS?

IDENTIFY

How should I identify risks?
Risk assessments can be done through a specific ***planned*** process at corporate, division or ward/department level. It is, however, essential for us all to be alerted to risks on an ***ongoing*** basis to ensure that we respond promptly to any emerging issues.

What types of risk should I identify?

- Risks to providing ***patients*** with safe, effective and personal care.
- Risks to providing ***staff*** with a safe and rewarding work environment.
- Risks to **the Trust** achieving its broader operational and financial objectives.

What specific issues should I consider that could lead to risk?

- Have you ***observed*** ay practice or behaviour which creates a risk for patients, staff or the Trust?
- Do you have ***information*** which indicates that there may be a risk for patients, staff or the trust?
- Are you aware of any ***incidents*** where appropriate action has not been taken to prevent a recurrence?
- Have you received any ***feedback*** or **complaints** from patients or staff which have not been adequately addressed?

ASSESS/RECORD

All risks that cannot be addressed immediately should be recorded on Ulysses. Having identified a risk, the impact and the likelihood of the potential event needs to be assessed having regard to the descriptors set out in the table below.

Likelihood	IMPACT				
	Insignificant Patients Minimal impact on patients. Staff Minimal impact on staff. Trust Day to day operational challenges.	**Minor** Patients Minor injury or harm to patients requiring minimal intervention. Staff Temporary staffing issues resulting in increasing pressures on staff and challenges in maintaining service quality. Trust Temporary restrictions to service delivery with limited impact on stakeholder confidence.	**Moderate** Patients Moderate injury or harm to patient(s) requiring clinical intervention. Staff Short term staffing issues resulting in low staff morale or restrictions to service quality. Trust Short term failure to deliver key objectives with temporary term adverse local publicity.	**Severe** Patients Serious or permanent harm to patient(s). Staff Medium term staffing issues resulting in very low morale or significant reduction in service quality. Trust Medium term failure to deliver key objectives with ongoing adverse publicity or negative impact on stakeholder confidence.	**Catastrophic** Patients Avoidable death of patient(s). Staff Long term staffing issues resulting in poor morale, staff welfare issues or fundamental reduction in service quality. Trust Continued failure to deliver key objectives with long term adverse publicity or fundamental loss of stakeholder confidence.
Almost Never This potentially will never happen/occur	1	2	3	4	5
Unlikely Do not expect it to happen/occur, but it may do so	2	4	6	8	10
Likely Might happen/occur occasionally	3	6	9	12	15
Highly Likely Will probably happen/occur	4	8	12	16	20
Almost Certain Very likely to happen/occur possibly frequently	5	10	15	20	25

MITIGATE/ESCALATE/COMMUNICATE

When is action required?
An action plan is required to mitigate all risks that cannot be resolved immediately. The actions must be recorded on Ulysses and must be SMART

How do I escalate high risks?
Escalation will be based on the grade of the risk as illustrated in the diagram below.

- Board Assurance Framework
- Corporate Risk Register (CRR)
- Division /corporate Services Risk Register
- Ward/department Risk Register

It is important to note that the escalation of a risk does not negate the responsibility of the identified risk manager for specific risks or governance group to pursue and follow-up identified risks.

How are risks reviewed and followed up?
Divisions, corporate functions, wards/departments are responsible for reviewing their risks on a regular basis. Risks will also be reviewed via the Trust governance systems including board sub-committee's The Trust executive team will review serious risks as part of its regular performance review.

4. Introduction & Purpose

This risk management policy and procedure is aligned to the Risk Management Strategy, with the aim to minimise risk to all stakeholders through a comprehensive system of internal control. The policy and procedure provides practical guidance on process and procedure for risk management within the Trust.

Alder Hey Children's Hospital NHS Foundation Trust is committed to creating a culture of good risk management through simple processes that will identify, analyse, evaluate, control and monitor risks, with the overall aim of delivering safe, high quality effective care and create a safe environment for patient's staff and the public.

Risk management is about continually asking and answering the following questions

Context - What is the objective or goal we wish to achieve?

Identify - What is the risk(s) associated with that objective or goal?

Analyse - What would be the impact if the risk occurred and what would be the likelihood of the risk occurring at that impact?

Evaluate - What is the capacity, appetite and tolerance of the Trust for the identified risk(s)?

Treat - How should we respond to the risk?

Escalate - What is our escalation process (ward to board)?

Monitor - How do we assure ourselves we are managing our risks effectively?

Communicate - Are we communicating our risks via the right channels?

5. Scope

This Policy & Procedure applies to all Trust employees and staff working on behalf of the Trust. This included permanent, temporary, locums, voluntary, work experience and bank staff, contractors and partners involved in Trust's business

6. Duties and Responsibilities

Risk Owner

Risks will be assigned to a named individual, who is responsible for ensuring the risk is managed, including ensuring controls and actions are in place to mitigate the risks and reporting on the risk. High/extreme risks will be owned by executive directors. Any changes of risk ownership will be discussed and agreed with the new proposed risk owner

Risk Manager

The risk manager is assigned to manage a risk by the risk owner, following discussion and agreement. The risk manager is responsible for completing the

risk assessment, with relevant expert support. They report to the risk owner and are responsible for ensuring the risk is identified on the register, reviewed and updated in a timely way, ensuring actions are progressing and inform the risk owner of any change in status of the risk. Changes to risk manager during the lifetime of the risk will be discussed and agreed with the new proposed risk manager.

Risk Action Owner;
Risk action owners are chosen for their expertise in the subject matter and are responsible and have the authority to address deficits. All risks have action owners with whom the risk manager has agreed the action specifics (SMART), including target completion dates. The action owner thus has delegated responsibility for ensuring the delivery of a task or activity that will help to mitigate the risk and provide regular reporting on progress, including documenting this clearly on the risk register and attaching relevant reports, meeting minutes etc, to support progress reporting.

Note: Refer to Risk Management Strategy for duties and responsibilities of individual staff and committees/groups.

7. The Risk Management Process

7.1 Establishing the Context

We need to have a clear understanding of the Trusts strategic and operational objectives, the external environment, the internal environment and the organisations approach to risk management. The external context will include, but is not limited to social and cultural, political, economic, the competitive environment, whether local, regional, national and/or international. Also consider key drivers and trends impacting on the strategic objectives and relationships, perceptions and values of external stakeholders.

7.2 Risk Identification

Risk assessments can be taken through a specific planned process at corporate, division, ward/department level, for example Health and Safety. However, it is essential for us all to be alerted to risks on an ongoing basis, to ensure that we respond promptly to any emerging issues. The risk identification wheel at Appendix A will support the identification of different sources through which risk can arise in the organisation.

The types of risks that should be identified are:

Risks to providing patients services which do not meet national and local quality standards, as identified by the Care Quality Commission (CQC) in the five domains of safe, effective, caring, responsive to people's needs and well-led.

- Risks to providing patients with a safe environment
- Risks to providing staff with a safe working environment

- Risks to the Trust achieving its broader operational and financial objectives and managing the Trust reputation.

Should there be a situation/issue where immediate action to mitigate the risk is required and the action has been taken, this does not need to be recorded on the risk register. However, all risks that cannot be addressed immediately will be recorded on the risk register on Ulysses (electronic risk management system).

7.3 Risk Assessment

It is essential all risks are assessed in an objective and consistent manner, if they are to be managed effectively and to guide operational, project and programme planning and resource allocation.

Risks are first assessed on what would happen (impact/consequence) should the risk occur and the probability (likelihood of the risk happening). When assessing what the impact/consequences of the risk could be if it happened, consider what the impact would be in most circumstances within your environment and what is reasonably foreseeable.

When assessing how likely a risk is to occur, take into account the current environment. Consider the adequacy of the controls already in place within the environment, which could address the causes of the risk and therefore the likelihood of the risk being realised, for example systems, processes, policies, current practice training etc.

Not all risks can be dealt with in the same way. The 5 ‘T’’s’ provide the options available when considering how to manage risk:

- **Tolerate:** the consequences and likelihood of the risk is accepted
- **Treat:** actions are carried out to reduce the consequences or likelihood of the risk (this is the most common action)
- **Transfer:** shifting the responsibility or burden for loss to another party e.g. the risk is insured against or subcontracted to another party.
- **Terminate:** an informed decision not to become involved in a risk situation e.g. terminate the activity.
- **Take the opportunity:** actively taking the advantage, regarding the uncertainty as an opportunity to add benefit.

The assessment is completed by scoring the impact multiplied by the likelihood. In addition, to the matrix in the quick reference guide at the beginning of this document, an additional more detailed 5x 5 matrix is available at Appendix B. The risk score will inform the risk owner at what level of the organisation and to whom the risk needs to be escalated.

Refer to the Trust Risk Assessment Policy for further guidance on the risk assessment process including the 5 steps to follow in the risk assessment process.

7.4 Risk Registers

Wards/department, divisions and corporate service risk registers (repository of risks) are 'live' records that support safety and sound risk management. They contain all unresolved risks identified to services (both clinical and non-clinical) Also as a minimum when reporting a risk onto Ulysses the risk will contain:

- Date risk first identified
- Date of last review
- Trust objective
- CQC domain
- Risk cause
- Risk description
- Risk impact/consequences
- Current controls in place
- Current gaps
- Actions to address gaps
- Initial risk rating
- Current risk rating
- Target risk rating
- Expected review date
- Risk manager
- Risk owner
- Assurance

The risk needs to be described clearly to ensure there is a common understanding by stakeholders of the risk. The recommended format for risk descriptions is to identify the cause, the event and the effect. The Bow Tie tool identified at Appendix C can be used to describe the risk and structure statements. When wording the risk, it is helpful to think about it in three parts. There is a risk (event) that …… this is caused by ……… and would lead to an impact/consequence on …….

7.5 Risk Analysis (Scoring)

Having identified a risk, the impact of the potential event and the likelihood of the event occurring will be assessed having regard to the impact descriptors in the risk matrix, Appendix B.

The impact score will be dependent on what the impact (what could happen should the risk occur) would be in most circumstances within the current environment and what is reasonably foreseeable, rather than defaulting to the 'worst case scenario'.

The likelihood scoring is dependent on firstly the inherent risk without any controls in place. The current likelihood scoring is dependent on adequacy of existing controls, for example systems, policies, training, and current practice.

Having assessed the impact and likelihood Ulysses will calculate the risk grading. All risks reported to Ulysses will have three scores as set out below

Inherent (gross) risk score	Is the level of risk score when the risk is first identified and reported before the effect of the mitigation
Current risk score	Is the score at the time of the last review taking into consideration the controls in place? The minimum review timescale for risks on the register is monthly or more frequently if there is any change in the risk status, for example if mitigating actions completed and identified as controls that will mitigate the risk, or the environment has changed resulting in an increase in the risk score requiring further action to mitigate.
Target (mitigated) risk score	Is the estimated exposure arising from a specific risk after implementing the proposed controls and actions contained in the action plan

7.6 Escalation Process

The Board Assurance Framework (BAF) is submitted to the Trust board at each Board meeting and is monitored through Board Assurance Committees

Any risk scoring 15 or above is escalated to the corporate risk register and with agreement of relevant executives would recommend risks being added to the BAF.

The Trust executive team will review serious risks as part of their regular performance review.

Any risks 15 or above (corporate or divisional) added to the corporate risk register and any risks that cannot be managed locally (above tolerance) at division or corporate function level will be escalated to the Care Delivery Board.

Risks scoring 8 and above that cannot be managed at ward/department level will be escalated to the divisional or corporate function governance assurance group.

It is important to note that the escalation of a risk does not negate the responsibility of the individual risk manager for that risk, or the ward/department, division or corporate function to pursue or follow up identified risks including associated actions, where they have identified responsibility on Ulysses.

Refer to the Trust Risk Assessment Policy for further guidance on authority to manage risk and the escalation process.

7.7 Action Planning

Following completion of the risk assessment, consideration will be given to whether the risk requires further management action that will minimise the

impact and likelihood of the threat. A risk should be scored on Ulysses for each risk that cannot be resolved immediately, to either eliminate, minimise or accept the risk.

The focus of the actions is to address the gaps in controls identified during the assessment process. The actions will be recorded on Ulysses together with the risk grading following completion of the action plan. It is expected that actions will be Specific, Measurable, Realistic Achievable Time bound, (S.M.A.R.T), to enable stakeholders have confidence that the goal will be reached. When the actions are completed, they then become controls that will mitigate the risk.

The risk manager with the agreement of the risk owner will assign risk action owner(s) who understand the required action and is capable of delivering the required outcome.

The risk manager and risk action owner(s) will agree the detail of the mitigating action and the expected completion date(s). The risk action owner will update on progress via the risk register and the risk manager will:

- Review the progress of all mitigating actions
- Ensure completed actions are recorded as an existing control
- Record the review by entering the review date and amend current risk grading appropriately.

It is not always possible to identify and then fully implement actions that eliminate or minimise risk. Where this is the case, it is essential the significance of the remaining risk is understood, and the Trust confirms it is prepared to accept that level of residual risk. Acceptance of risk level is determined by the Trust risk appetite and tolerance.

Risk action plans are an important performance measure and are incorporated into performance management via the Trust executive team

7.8 Monitoring and Closure

Risks registers should be a standing item at ward/department, division, corporate function and Trust governance committee agenda. This ensures that risks are consistently identified, monitored and re-evaluated throughout the year. Once all possible actions have been completed and the risk is at the identified target or eliminated the risk on Ulysses will be closed.

8. Management of Trust Wide Risks

Trust wide risk is an integral part of the system of internal control and defines risks that cross a number of divisions and/or corporate functions and which may impact on the Trusts ability to deliver its objectives. Ownership and management of Trust wide risks sits with the person who has primary organisational responsibility for the risk domain, this could either be at corporate function level or division level. Risks may be owned and managed in a division or corporate function but can have actions assigned to a number of staff in other

divisions or corporate functions. It is important that when risk actions are assigned to action owners this is discussed and agreed with them before adding to the risk register.

9. Monitoring, Implementation and Review

The Associate Director of Nursing and Governance will oversee the implementation and monitoring of this policy.

Monitoring will be reported to the Care Delivery Board, and the Audit and Risk committee on behalf of the Trust Board.

This policy will be reviewed every three years or in response to any significant organisational changes.

10. Communication

This Policy & Procedure will be communicated to staff via the following means

- Dissemination and sharing via representatives at approving group
- Divisional notification via relevant Divisional Board/Quality Board and corporate function governance processes.
- Email via communications to all staff
- Available on the Trust document management system

11. References

- Risk Management Strategy
- Risk Assessment Policy - RM4

12. Associated Documents

The Management of Health and Safety at Work Regulations 1999

- Five steps to risk assessment HSE. INDG 163
- The Health and Safety at Work etc. Act 1974
- ISO 31000: 2009 – Risk Management – Principles and Guidelines
- Alder Hey Children's NHS Foundation Trust Constitution. V 11. January 2020.
- The Management of Health and Safety at Work Regulations 1999
- Five steps to risk assessment HSE. INDG 163
- The Health and Safety at Work etc. Act 1974
- ISO 31000: 2009 – Risk Management – Principles and Guidelines
- Alder Hey Children's NHS Foundation Trust Constitution. V 11. January 2020.
- Step by Step guide to managing Risks on the Risk Register. February 2018
- Risk Matrix (5x5) and risk scoring guide for Risk Assessments Guide. November 2020
- SMART actions guide. July 2019

- Incident Management Policy inclusive of Serious Incident Management Procedure and AAR procedure. January 2020
- The Manual Handling Operations Regulations 1992
- Provision and use of Work Equipment Regulations 1992
- The Lifting Operations and Lifting Equipment Regulations (LOLER) 1998
- Workplace (Health, Safety and Welfare) Regulations 1992
- Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) 1995
- Reducing Error & Influencing behaviour HSG48
- Health and Safety Policy - RM1
- Slips, Trips and Falls Policy - RM30
- COSHH Policy - RM13
- Fire Policy - RM11
- Manual Handling of Loads and People Policy - RM10
- Security Policy - RM48
- Incident Reporting and Management Policy Inclusive of Serious Incident Policy RM RM2
- Complaints and Concerns Policy RM6
- Claims Policy RM7
- Safeguarding Children Policy - M3
- Business Continuity Policy – RM5
- Business Continuity Plan
- Supporting Sickness and Attendance Policy - E4
- Mandatory Training Policy - E21
- Preventing and Managing Violence and Aggression at Work and Protecting Lone Worker Policy - RM9
- Policy on the Management of External Agency Visits, Inspections and Accreditations - M43

13. Appendices

13.1 Appendix A – Risk Identification Wheel

Risk Identification Wheel

Alder Hey Children's Hospital Foundation Trust Risk Wheel

Different sources through which risk could arise in the organisation.

Use the risk wheel as a checklist to ensure that risk identification is comprehensive.

13.2 Appendix B - Risk Matrix

The risk matrix used by Alder Hey Children's Hospital NHS Foundation Trust is based on the Australian / New Zealand standard (AS/4360:1999 – Risk Management), which is the system recommended for the NHS to use by the Department of Health.

Consequence Score

The consequence (impact) scores are derived by choosing the most appropriate domain for the identified risk from the left hand side of the table by working along the columns in same row to assess the severity of the risk on the scale of 1 to 5, to determine the consequence score, which is the number given at the top of the column.

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

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

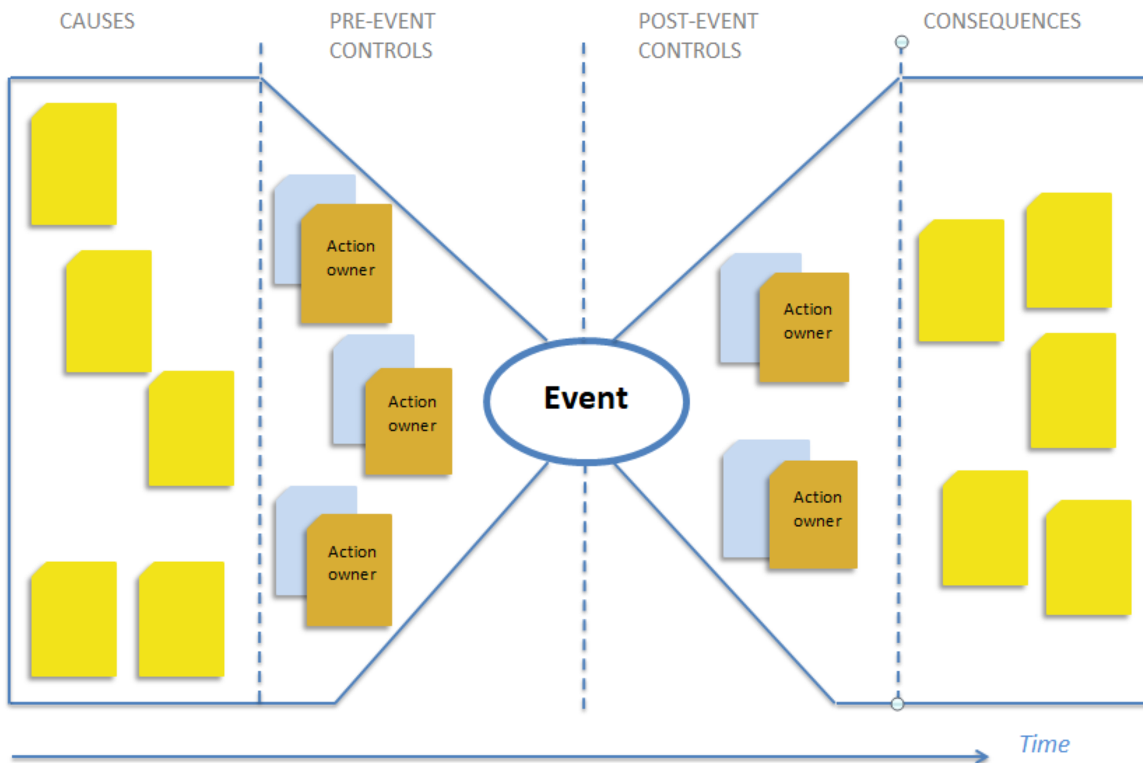
Likelihood score (L)

What is the likelihood of the risk being realised?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency. Alternatively, the probability chance of occurrence is also a useful method for identifying likelihood of risk being realised.

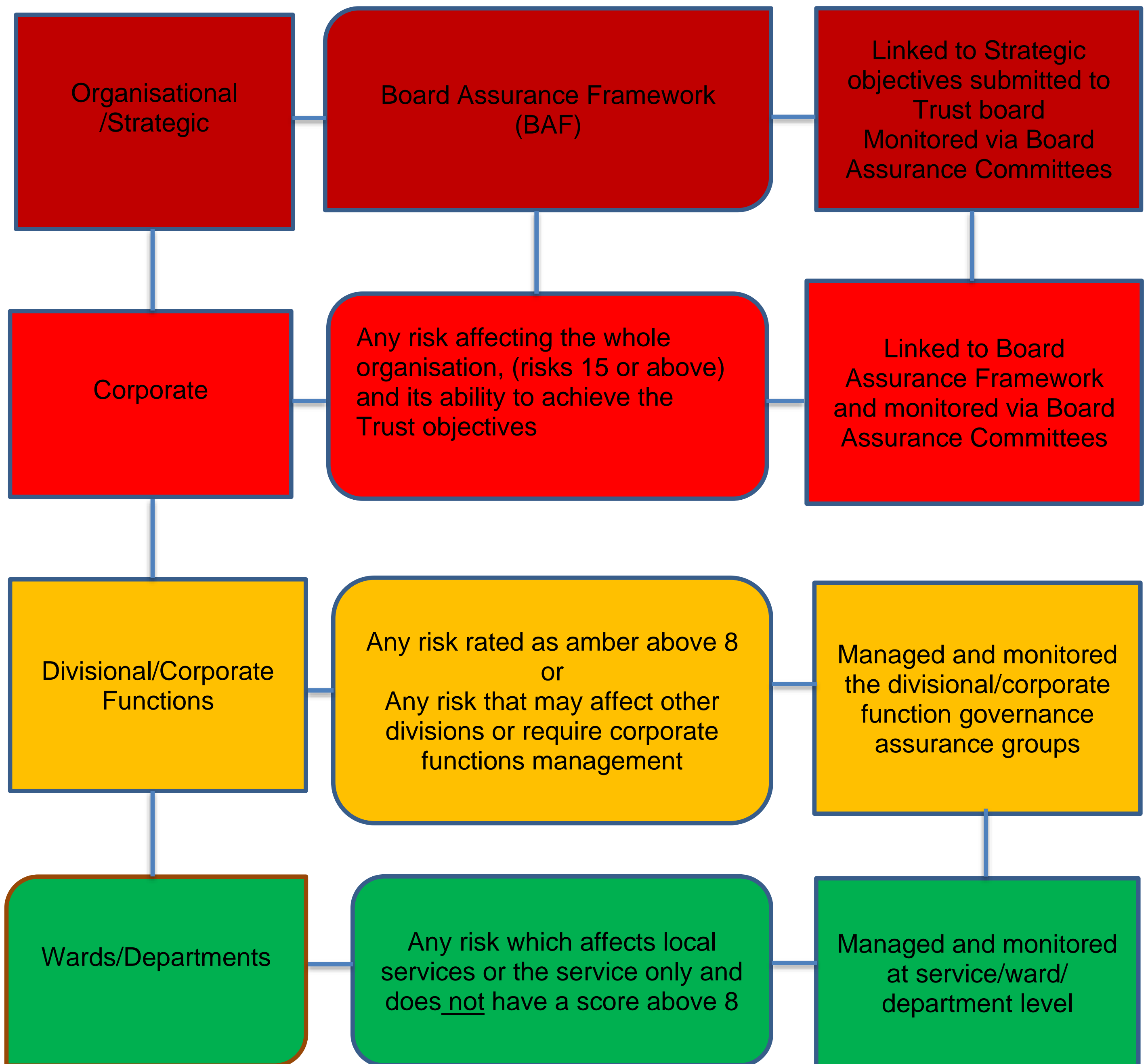
Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Probability chance of occurrence	Less than 20%	20-40%	40%- 60%	60%- 80%	Greater than 80%

13.3 Appendix C - Bow Tie Tool



1. Add Event in the centre box – State the risk and context for the risk
2. List causes in the left-hand section
3. List consequences in the right-hand section
4. Then think about the control measures – Proactive (Pre-event) and Reactive (Post-event) controls.
5. Then draw the links between the proactive controls and causes
6. Draw the links between the reactive controls and consequences
7. Look for causes or consequences with no controls – a control that has many causes
8. Decide which of the controls are in place (those are controls) and those that are not in place (those are actions)
9. Decide your level of confidence in the controls – Giving assurance to risk owner that the risk is manageable
10. Allocate action owners to the actions and put in place an action plan.

13.4 Appendix D - Risk Escalation Process



13.5 Appendix E - Definitions

	The BAF is the tool by which the Board corporately assured itself about the successful delivery of the Trusts strategic objectives. The BAF is designed to focus the Board on controlling principle risks threatening the delivery of those objectives. The BAF aligns principle risks, key controls and assurances on the operation of the controls.
Risk appetite	The level of risk the Trust is prepared to accept or be exposed to at any point in time
Cost	Activities, both direct or indirect, which result in a negative outcome or impact for an individual or the Trust. For example, cost could include money, labour, reputation, political and intangible losses.
Hazard	Potential source of harm or adverse health effect
Issue	Essentially a risk that has happened
Risk	The chance of something happening that will have an adverse impact on the achievement of the Trusts objectives and the delivery of high-quality care. It is measured in terms of consequences and likelihood.
Risk Management Process	Systematic application of management policies, procedures and practice to the tasks of establishing the contest of risk, then identifying, analysing, evaluating, treating, monitoring and communicating risk.
Material risk	Most significant risks or those on which the Board or equivalent focuses
Risk assessment	Overall process of risk identification, risk analysis, risk action and risk evaluation. *Refer to Trust Risk Assessment Policy available on the Trust document management system (DMS)*
Risk analysis	A systematic use of the available information to determine how often specific events may occur and the magnitude of the consequences
Inherent risk	This is the score assigned to a risk if the controls in place are found to be ineffective or absent. *It involves the use of the 5x5 matrix at Appendix B*.
Residual risk	This is also known as the current risk score. It is the score assigned to any risk after the control measures in place are taken into account. It involves the use of the 5x5 matrix with impact and likelihood being adjusted following the inherent risk score. *The scoring 5x5 matrix is provided at Appendix B.*
Target risk	This is the future risk score assigned to a risk after gaps in control measures have been addressed and outstanding actions implemented. This should reflect the risk tolerance.
Risk Tolerance	The boundaries of risk taking outside of which the organisation is not prepared to venture in the pursuit of its objectives,
Impact	The potential consequences if the adverse effect occurs as a result of the hazard.
Likelihood	A qualitative measure/description or probability of frequency
Probability	The likelihood of a specific event or outcome occurring. This is measured by the ratio of specific events or outcomes occurring to the total number of possible events or outcomes. Probability is expressed along a scale ranging from rare to almost certain. Refer to 5x5 risk matrix at Appendix B.
Risk Rating	The total score worked out by identifying the consequences and likelihood score and cross referencing with the risk matrix. *Refer 5x5 matrix at Appendix B*.

Risk Control	That part of risk management which involves the development and implementation of policies, standards, procedures and/or physical changes to eliminate or minimise adverse events of risk.
Adverse events	Any event or circumstances leading to unintended harm and/or suffering which resulted in admission to hospital, prolonged stay, significant disability at discharge or death.
Gaps in controls	Processes or activities not yet in place in order to effectively manage the risk
Risk actions	A specific, measurable, achievable, relevant and time-specific piece of work that is to be completed, that will address an identified gap in control or assurance.
Secondary risks	risks caused by actions/treatment
monitor	To check, supervise, observe critically or record the progress of an activity, action or system on a regular basis in order to identify change
Controls Assurance	A process designed to provide evidence that the NHS in total (and its constituent parts) is doing its reasonable best to manage, direct and control itself so as to protect itself, its employees, patients and stakeholder's safety and interests against all types of risks.
Risk assurance	Evidence that supports the measurement of controls in place, to ensure they are operating effectively, and the desired outcome is being achieved.
Inadequate Assurance	When assurance or evidence is limited and cannot provide full assurance that controls are effectively managing the risk. Gaps should be identified and lists with actions to mitigate
Gaps in assurance	Lack of measures or evidence to support the measurement of controls
Internal assurance	Assurance provided by reviewers, auditors and inspectors who are part of the organisation such as clinical audit or management peer review
External Assurance	Independent assurance provided by reviewers, auditors and inspectors from outside the organisation for example the CQC, Commissioners, NHS Improvement.
System Failure	A non-conformance with, malfunction or deviation from a defined management system. A system failure may also be defined as inadequate performance, non-participation in or non-application of a defined management system or process.

13.6 Appendix F – Equality Analysis

14. Equality Analysis (EA) for Policies		
The Public Sector Equality Duty (section 149 of the Equality Act 2010) requires public authorities to have due regard for the for need to achieve the following objectives in carrying out their functions: a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010. b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it. Please refer to guidance when completing this form		
Policy Name	Risk Management Policy & Procedure	
Policy Overview	This document sets out the Policy & Procedure for the management of risk at all levels of the organisation, including identification, analysis, evaluation, control and monitoring risks, with the overall aim of delivering safe, high quality effective care and create a safe environment for patients staff and the public.	
Relevant Changes (if any)	New document	
Equality Relevance Select LOW, MEDIUM or HIGH	LOW	
If the policy is LOW relevance, you **MUST** state the reasons here.	The Policy & Procedure applies to all members of staff working in Alder Hey Children's NHS Foundation Trust including permanent, temporary, locums, voluntary, work experience and bank staff, including contractors and partners involved in Trust's business Having considered the equality implications of this policy, they are of low relevance.	
Form completed on:	Date: 14/04/2021	
Form completed by:	Name: Cathy Umbers	Job Title: Associate Director of Nursing and Governance

Approval & Ratification of Equality Analysis		
Policy Author:	Name: Cathy Umbers	Job title: Associate Director of Nursing and Governance
Approval Committee:	Audit and Risk Committee	Date approved: 22/04/2021
Ratification Committee:	The Trust Board	Date ratified: 29/04/2021
Person to Review Equality Analysis:	Name: Cathy Umbers	Review Date: 29/04/2024
Comments:	Click here to enter text.	

NHS
Alder Hey Children's
NHS Foundation Trust

Risk Management Strategy
2021-2022

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1. Version Control, Review and Amendment Logs

Version Control Table				
Risk Management Strategy				
Version	**Date**	**Author**	**Status**	**Comment**
15	April 2021	Associate Director of Nursing and Governance	Current	Rewritten
14.2	December 2019	Associate Director of Nursing and Governance	Archived	Executive approval of edits
14.1	December 2017	Associate Director of Nursing and Governance	Achieved	Executive approval of edits
14	January 2017	Deputy Director of Risk & Governance	Archived	Integrated Governance Committee
13.1	January 2017	Deputy Director of Risk & Governance	Draft	For discussion at Audit Committee
13	January 2017	Deputy Director of Risk & Governance	Draft	For discussion at IGC / Audit Committee
12	December 2014	Interim Governance & Risk Manager	Archived	Amended following comments at IGC, 13/11/14
11	November 2014	Interim Governance & Risk Manager	Archived	To Integrated Governance Committee (IGC), 13/11/14
10	April 2014	Clinical Risk Advisor	Archived	To Corporate Risk Committee, 12/4/14
9	March 2013	Clinical Risk Advisor	Archived	
8	February 2012	Clinical Risk Advisor	Archived	To Corporate Risk Committee, 28/02/12
7	August 2011	Risk Manager	Archived	To Board of Directors, 6/9/11
6	December 2010	Risk Manager	Archived	
5	December 2009	Head of Integrated Risk Management and Clinical Governance	Archived	
4	March 2008	Risk Manager	Archived	
3	January 2007	Risk Manager	Archived	
2	September 2006	Risk Manager	Archived	
1	November 2003	Risk Manager	Archived	
0	July 2003	Risk Manager	Archived	

Record of changes made to Risk Management Strategy – Version 15			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
All	All	Rewritten	Out of date.

2. Statement of Purpose

The Trust Board is committed to ensuring Risk Management is an integral part of the Trust Board , Divisions, Wards, Departments, and Corporate Support Functions objectives and management systems, so that all corporate, clinical, operational and financial risks are eliminated or reduced to an acceptable level with appropriate control measures in place.

The Trust Vision is to *build a healthier future for children and young people as one of the recognised world leaders in healthcare and research.* Implementation of the Risk Management Strategy and Policy Framework is critical to delivery of the vision, and commitment and engagement from all members of staff is required to ensure children receive high quality, safe, effective care within a culture that values honesty and openness at all levels of the organisation. The Trust Risk Management system will ensure that

- Risks that have the potential to adversely affect the quality of care, safety and wellbeing of people (patients, staff and the public) and on the business, performance and reputation of the Trust, are proactively identified and effectively managed
- Anticipate opportunities or threats and adapt a response through the Trust's explicit Risk Management process.
- Priorities are identified, expressed through objectives, understood and owned by staff and are under continuous review.
- Controls are in place which are effective in their design and application to manage risk to the level of the Trust risk appetite.
- Risk treatment is implemented effectively by risk owners and managers
- Gaps in controls are identified and treated effectively to mitigate risks.
- Risk owners and managers are held to account for the effective implementation of controls.
- Assurances are reviewed and acted on where deficits are identified in line with this framework.
- The escalation process is followed in line with this framework.
- Risk Management systems and processes are embedded at all levels of the organisation including divisions and their associated wards, departments, corporate services, education and development, business planning cycles, service development, financial planning, project and programme management.

The strategic approach reflected in this document strongly supports the requirements of the 'Well Led' Care Quality Commission (CQC) domain underpinned through the medically led devolved governance model, ensuring clear accountabilities at all levels of the organisation and effective processes to measure performance and address concerns in a timely manner.

3. Contents

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4. Introduction & Purpose

Alder Hey Children's NHS Foundation Trust is committed to a Risk Management Strategy which aims to minimise risk to all its stakeholders, through a comprehensive system of internal control. Accordingly, the Trust takes an integrated approach to Risk Management across the organisation, which incorporates all risks.

The purpose of this strategy is to detail the framework which defines the Trust's governance arrangements in terms of the way the Trust leads, directs and controls risks to its key functions, in order to support the Trust strategic objectives and comply with Health and Safety legislation, its Provider License, CQC regulations and NHS Constitution commitments, all of which are interlocked.

The Trust accepts that it carries a number of risks that have the potential to cause harm to patients, staff and the public or loss of its assets and reputation if not effectively managed and controlled. The Trust further accepts that the nature of health care services means that some risks cannot be eliminated entirely Fundamentally it is essential that the Trust has good Risk Management systems and processes in place, which eliminate risk where possible and reduce the impact of those risks that cannot be eliminated to a 'tolerable' level.

The Trust is committed to understanding the causes of risks that may impact on the organisation's achievement of its stated strategic objectives and addressing the issues to prevent risk from occurring, thereby improving the quality, safety and effectiveness of the services we provide. To achieve this, we will apply a proactive risk-based approach to all aspects of our undertakings, activities and condition of our estate. This will be achieved using the Trust's risk assessment methodology as a tool to identify potential hazards and any associated risks to ensure appropriate control measures are identified and implemented to either eliminate or mitigate risks as far as is reasonably practicable.

5. Scope

Everyone employed by the Trust or acting on behalf of the Trust is responsible for Risk Management in the Trust. In practice this means that everyone is responsible for making sure that risks associated with the activities and assets they are responsible for are identified, assessed for hazards and associated risk and managed accordingly.

6. Risk Management and Corporate Governance

Corporate Governance is the system whereby the Trust is directed and controlled at its most senior level to achieve the Trust's strategic objectives and meet its standards of accountability and probity. The Trust has adopted an integrated approach to risk management, meaning it has systems, processes and behaviours by which it leads, directs and controls its functions in order to achieve organisational objectives and the safety, quality and value for money of services as they relate to patients, carers, staff, the wider community and partner organisations.

The Trust is required to demonstrate that it is "doing its reasonable best" to manage risks. This is accomplished by ensuring that corporate governance and Risk Management are aligned and integrated.

In practice this means having systems and processes in place to identify, access, mitigate, evaluate, and assign responsibility to manage risks at all levels of the organisation, monitor and aggregate the findings at corporate level. To achieve this the Trust will carry out the following:

- ✓ Integrate Risk Management into all decision-making processes.
- ✓ Integrate Risk Management into all functions including patient safety, health and safety, incidents, complaints, claims, safeguarding, business continuity, quality improvement.
- ✓ Integrate Risk Management with service developments and clinical governance activities to improve patient safety.
- ✓ Implement a consistent approach to investigation of risks, incidents and complaints.

7. Trust Objectives

The Trust Board recognises that the implementation of an effective Risk Management Strategy and associated Risk Management processes is essential to the delivery of the Trust's objectives, the development of a positive learning environment and risk aware culture. The tool the Board uses to facilitate this is the Board Assurance Framework (BAF). The BAF contains those principal/strategic risks that without mitigation have the potential to fundamentally impact on the achievement of the strategic objectives. They are agreed annually by the Trust Board and are reviewed at each Board meeting. The BAF underpins the Annual Governance Statement (AGS) and is the subject of annual review by both internal and external audit.

The strategic risks are monitored by the Board's Assurance Committees and reviewed on a monthly basis by the executive team or more frequently if there are any changes in month and updated on the Ulysses Risk Management system, to provide assurance that the risks are being managed and mitigated.

The corporate risk register report details the high-level operational risks which may impact on the BAF risks and these are monitored by the Care Delivery Board and the relevant Board committees. The terms of reference for these committees are detailed at appendix 2. The Audit and Risk committee ensures that the Trust Risk Management Strategy remains effective and as such reviews and monitors the BAF, the corporate risk register and receives reports on all Trust risks.

8. Risk Appetite

The Trust recognises that it is not always possible to eliminate risks, nor is it always appropriate. Systems of control need to be balanced in order that innovation and use of resources are supported when applied to healthcare. Therefore, the Trust may be willing to accept a certain level of risk when the cost of mitigating the risk is high when compared to the potential severity of the risk and the likelihood of it occurring.

The Board will set the risk appetite, including tolerance annually, for the risks identified on the BAF. The annual review will be informed by an assessment of the Trust's risk maturity, which in turn enables the Board to determine the Trust's capacity to control risk.

The risk appetite statement will be communicated via governance processes to all staff and stakeholders to formalise and clarify the Trust's overall approach to risk. Additionally, all Trust risks are linked to BAF risks on the Ulysses Risk Management system, risk register module, which will enable staff to identify Trust risk appetite and tolerance for individual risks when they apply the linked BAF risk.

In practice the Trust risk appetite should address several dimensions including the nature of the risks to be assumed, the amount of risk to be taken (tolerance), on the desired balance of risk versus reward.

The Board has completed the annual assessment for the Trust Risk appetite 2021/22 and this will be available for staff to access on the Trust intranet.

The model risk appetite matrix used by the Board to support the development of the Trust risk appetite statement for NHS organisations is located at appendix 3.

9. Risk Management Maturity Model

The value of the Risk Maturity Model is that it provides an assessment tool for the organisation to use in order to understand its current Risk Management maturity level. The results together with key performance indicators etc. can then be used to create an improvement plan which will guide us to reach our target maturity level. The more mature the Risk Management system, the better the decision making, with better outcomes for the Trust. Full details of the model are available at appendix 4. The Trust will be undertaking a risk maturity assessment in 2021/22 and develop and implement a plan according to the findings from that assessment.

10. The Risk Management Process

The Trust's governance structure has systems in place to identify, assess, manage, evaluate and control risk throughout the organisation. This system provides the Trust with assurance that risks which the Trust could be exposed to are controlled and escalated at the appropriate level. The Trust Risk Management Policy and Procedure is aligned with this Strategy and is available for all staff to access on the Trust document management system.

11. Duties, Accountabilities and Responsibilities

11.1. Statutory

Health and Social Care Act; The Trust is legally required to register with the Care Quality Commission under the Health and Social Care Act 2008 and as a legal requirement of the Trust's registration, must protect patients, workers and others.

Management of Health and Safety at Work Regulations (1999): The Trust is required to undertake a suitable and sufficient assessment of risks to the health and

safety of all employees and persons not in its employ to which they are exposed to while at work and arising out of or as a result of Trust activities.

Health and Safety at work Act 1972 (HASWA): Section 2 of the act places a duty on the Trust to ensure as far as is reasonably practicable the health, safety and welfare of all employees and anyone who may be affected by its work activities.

11.2. Regulation and Assurance

NHS England (NHSE) and NHS Improvement (NHSI): From 1 April 2019 both organisations joined to form one body. NHS Improvement is the sector regulator for health services in England. It authorises and regulates NHS Foundation Trusts, ensuring they are well-led (governance) and run efficiently (financial) in order that they deliver good quality services for patients. NHSI has created a risk-based system of regulation, which determines the intensity of the monitoring it undertakes. The Trust is required to demonstrate compliance with its licence and Oversight Framework.

NHS Improvement established the Oversight Framework to ensure there is clear compliance framework that all trusts can provide assurance that they are operating within their provider license. Therefore, it is essential that the Trust identifies any risks that may impact on its ability to adhere to that framework.

The Care Quality Commission (CQC): is the independent regulator of health and social care services in England. The Trust is required to provide robust assurance to the CQC of its compliance against the essential quality and safety standards which include the five domains of safe, effective, caring, responsive and well-led.

Mersey Internal Audit (MIAA): is the Trust's independent internal auditor who develop and deliver an annual internal audit programme for the Trust. This includes verifying that the Trust has suitable and effective systems of internal control in terms of Risk Management and that it is effective.

Ernst & Young: is the Trust's independent external auditor appointed by the Council of Governors. The external auditors provide an unbiased and independent opinion on the annual report and accounts, which includes the Annual Governance Statement.

11.3. Organisation

The Trust manages risk proactively through a number of individuals, specific committees, and groups working together to integrate Risk Management activity across the organisation. The roles and responsibilities of specific individuals and functions are described, including specific Trust Board Assurance Committees

A key component of an effective and mature Risk Management organisation is a culture of knowledge and understanding of Risk Management and leadership. This means that roles and responsibilities need to be clearly defined so that Risk Management is owned by appropriate members of staff and that all staff are encouraged and supported to be risk aware through the promotion of openness and support at every level of the organisation

Individuals

Chief Executive Officer: has overall accountability for Risk Management and as such has responsibility for maintaining a sound system of internal control that supports the achievement of the Trust objectives. The Chief Executive is also responsible for ensuring the Trust is administered prudently and economically and that resources are applied efficiently and effectively. The Chief Executive has delegated responsibility for risk within the management structure to the executive directors for their respective areas.

Deputy Chief Executive/Director of Finance is the executive lead for Risk Management and is accountable to the Board and the Chief Executive for the Trust's Risk Management activities. In addition, the Director of Finance/Deputy CEO is responsible for ensuring that the Trust carries out its business within sound financial governance arrangements that are controlled and monitored through effective audit and accounting systems.

Medical Director: is jointly accountable with the Chief Nurse to the Board of Directors and the Chief Executive for clinical Risk Management and Clinical Governance via governance reporting mechanisms. The Medical Director has professional responsibility for medical practice within the Trust.

Chief Nurse: is jointly accountable with the Medical Director to the Board of Directors and the Chief Executive for clinical Risk Management and Clinical Governance via governance reporting mechanisms. The Chief Nurse is also responsible for embedding compliance with CQC standards across the organisation. The Chief Nurse is the Trust Caldicott Guardian.

The Chief Operating Officer: is accountable to the Board of Directors and the Chief Executive for the management of operational risks and risks relating to facilities services.

The Chief Digital Officer: is accountable to the Board of Directors and the Chief Executive for the management of Digital risks.

The Director for Human Resources and Organisational Development:
Is responsible for the development and delivery of the Trust's People Plan and Organisational Development Strategy, staff training and management of risk relating to the Trust's workforce and associated policies and as such is accountable to the Board of Directors and the Chief Executive for risks associated with the activities therein. They are also responsible to the Trust Board and the Chief Executive for the management of risk relating to Health and Safety.

The Director of Corporate Affairs: is responsible for Information Governance and is the nominated Senior Information Risk Owner.

Non-Executive Directors: The Chairman and Non-Executive Director have responsibility for the promotion of Risk Management through their participation in the Trust Board and its Assurance Committees. They have responsibility for scrutinising systems of governance and hold executives to account for their Risk Management responsibilities.

The Associate Director of Nursing and Governance is the Trust operational lead for Risk Management, accountable to the Director of Finance/Deputy CEO and has line management responsibility for the Trust's corporate level Risk Management team. She is responsible for ensuring that the Trust's Risk Management systems and processes are effective and operate in accordance with best practice.

The Divisional Directors: and their senior teams, including the Associate Chief Operating Officers, Associate Chief Nurses and Risk and Governance Assurance leads, are responsible for ensuring that Risk Management systems within the Divisions are effective and meet the objectives outlined within the Risk Management Strategy and associated Policy and Procedure. Divisional boards and integrated governance assurance groups have a key role in assuring the effectiveness of Risk Management in all their services, including regular scrutiny and validation of divisional risk registers.

Associate Chief Operating Officers, Associate Chief Nurses and Divisional Risk and Governance Leads: are accountable to the Divisional Directors for leading, monitoring and reviewing, risk assessments, incidents, claims and complaints and ensure that agreed actions are carried out to completion and feedback is given to staff and provide assurance of compliance via governance and integrated risk based systems.

The Health and Safety Manager: is the Trust operational lead for Health and Safety, accountable to the Director of Human Resources and Organisational Development for the management of operational risk relating to Health and Safety. She is responsible for ensuring that the Trust's Health and Safety systems and processes are effective and operate in accordance with statutory requirements.

All Staff : have an individual responsibility for the management of risk within the Trust. Managers (clinical and non-clinical) at all levels will understand the Trust's Risk Management Strategy, associated risk procedure and associated policy documents and be aware that they have the authority and duty to manage risk effectively within their area of responsibility.

Assurance Committees

The Trust Board Assurance Committees' terms of reference is located at Appendix 1.

The Trust Board along with the **Council of Governors** sets the Strategic goals and objectives for the organisation. They monitor how the Trust is performing against these objectives and make sure appropriate action is taken where necessary. The Board is structured in line with the Trusts constitution which enables it to comply with its terms of authorisation.

Audit and Risk Committee: is responsible for providing the Board with a means of independent and objective review of financial and corporate governance, assurance processes for Risk Management and the control environment across the whole of the Trust's activities. It will also provide the Board with assurance on the delivery of the Risk Management Strategy and the operational management of risks.

Safety and Quality Assurance Committee: is responsible for providing the Board with assurance that high standards of care are provided by the Trust, particularly that

robust clinical governance structures, systems and processes are in place Trust wide. They will also provide assurance that controls are in place to identify, prioritise and manage risks arising from clinical care and assurance to the Board on specific clinical risks identified on the BAF.

People and Well Being Committee: is responsible for overseeing the implementation and monitoring of the People Plan and organisational development.

It will provide assurance to the Board on workforce issues and specific people risks identified on the BAF. Additionally, it will provide assurance to the Board on the effectiveness of Health and Safety risk management.

Resource and Business Development Committee: is responsible for providing Board assurance for financial management of the Trust including key financial assumptions used in strategic and business planning and any associated risks including those identified on the BAF.

Care Delivery Board - Risk Management: is responsible for providing assurance to the Audit and Risk committee on the delivery of the Risk Management Strategy and operational management of risks held on the Trust and corporate services risk registers. It is responsible for escalating risks to Audit and Risk committee that are concerning, including those on the BAF, corporate risk register, or risks outside the Trust risk tolerance levels.

Clinical Quality Steering Group: is responsible for providing assurance to the Safety and Quality Assurance Committee for clinical quality including patient safety, clinical effectiveness and patient experience. They will also provide assurance that controls are in place to identify, prioritise and manage risks arising from clinical care in line with their work plan responsibilities.

Information Governance Steering Group: is responsible for providing assurance that effective arrangements are in place to manage the processing of and control risks to information and data through the Information Governance framework based on legal requirements and Department of Health guidelines.

Divisions and Corporate Functions - Governance and Quality Assurance boards and groups: are responsible for providing assurance for local implementation of the Risk Management Strategy and associated policy and procedure and provide formal assurance on progress to the Care Delivery Board and Board Assurance Committees demonstrating that systems and controls are in place to ensure wards and departments and services, are proactively reviewing risks and implementing appropriate mitigating actions.

12. Communication, Training and Awareness

The strategy will be widely shared across the organisation utilising electronic means, governance structures, and training sessions. It will form part of the Trust mandatory training sessions, and the Trust Induction package. Additional bespoke Risk Management training sessions will be provided, which all staff are invited to attend.

The Trust will work collaboratively with other local organisations and stakeholders in relation to Risk Management. This will include participating in local and regional forums

related to risk management, working closely with the relevant, Health & Safety Executive, Care Quality Commission, and NHS Improvement/England (NHSi/e) representatives, and working with other local agencies including Clinical Commissioning Groups to identify risks, learn lessons and share good practice.

13. Monitoring, Implementation and Review

The Deputy CEO/Director of Finance with the support of the Executive Team will oversee the implementation and monitoring of this strategy.

Monitoring will be reported to the Care Delivery Board, and the Audit and Risk committee on behalf of the Trust Board. Implementation of this Strategy is also formally monitored by the Trust's Internal Auditors (Mersey Internal Audit Agency), as well as external regulators such as CQC, NHSI and HSE.

Annual review of effectiveness of Board Assurance Committees and groups with responsibility for risk management.

Trust Board annual review of the Board Assurance framework content and process.

This strategy will be reviewed annually or earlier in response to any significant organisational changes.

14. References

- The Management of Health and Safety at Work Regulations 1999
- Five steps to risk assessment HSE. INDG 163
- The Health and Safety at Work etc. Act 1974
- ISO 31000: 2009 – Risk Management– Principles and Guidelines
- Alder Hey Children's NHS Foundation Trust Constitution. V 11. January 2020.
- Risk Management Policy and Procedure
- Board Assurance Framework Policy (BAF) – RM 58Risk Assessment Policy - RM4

15. Associated Documentation

- Step by Step guide to managing Risks on the Risk Register. February 2018
- Risk Matrix (5x5) and risk scoring guide for Risk Assessments. November 2020
- SMART actions guide. July 2019
- The Manual Handling Operations Regulations 1992
- Provision and use of Work Equipment Regulations 1992
- The Lifting Operations and Lifting Equipment Regulations (LOLER) 1998
- Workplace (Health, Safety and Welfare) Regulations 1992
- Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) 1995
- Reducing Error & Influencing behaviour HSG48
- Health and Safety Policy - RM1
- Slips, Trips and Falls Policy - RM30
- COSHH Policy - RM13

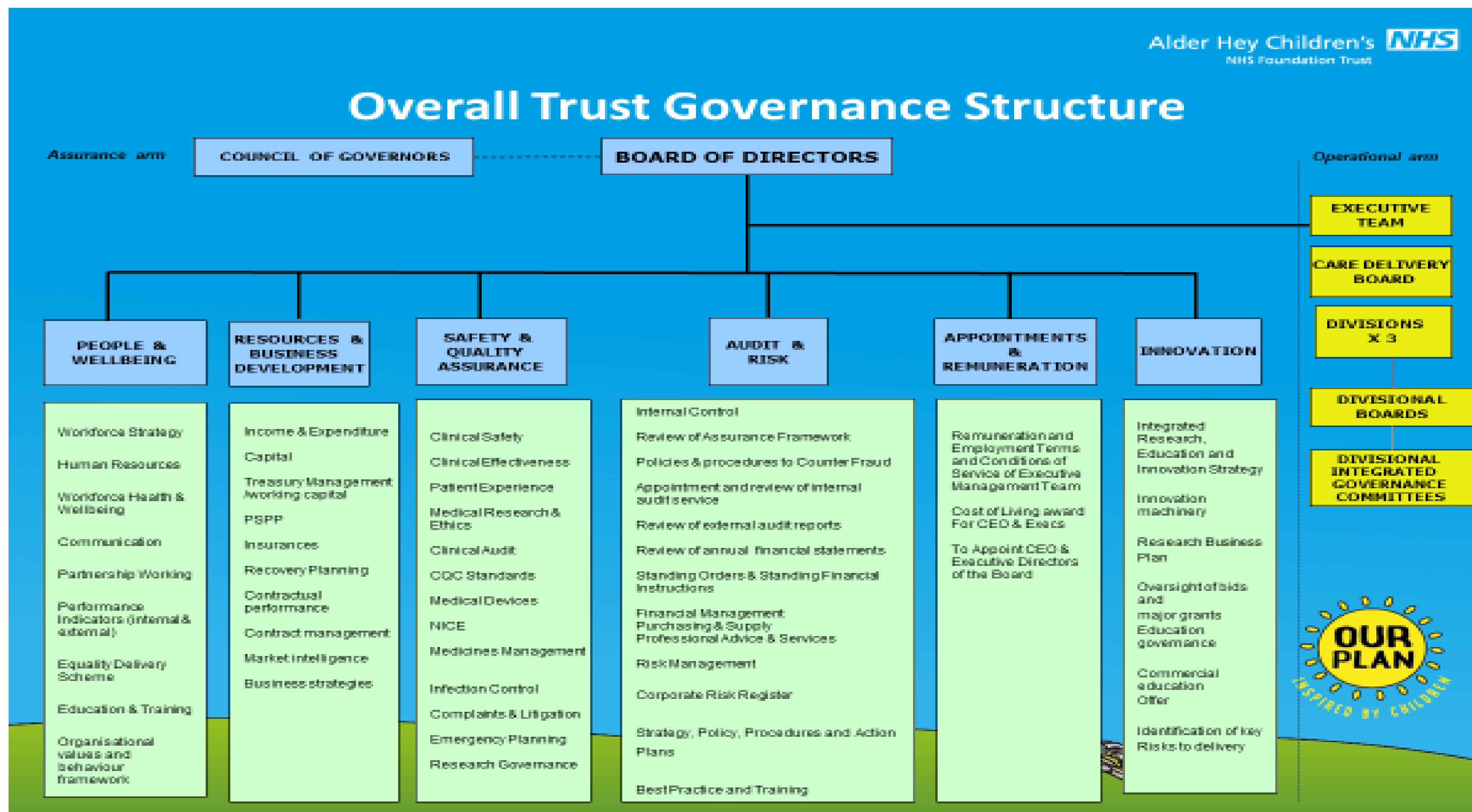
- Fire Policy - RM11
- Manual Handling of Loads and People Policy - RM10
- Security Policy - RM48
- Incident Reporting and Management Policy Inclusive of Serious Incident Procedure RM RM2
- Complaints and Concerns Policy RM6
- Claims Policy RM7
- Safeguarding Children Policy - M3
- Business Continuity Policy – RM5
- Business Continuity Plan
- Sickness Absence and Management of Attendance Policy - E4
- Mandatory Training Policy - E21
- Preventing and Managing Violence and Aggression at Work and Protecting Lone Worker Policy - RM9
- Policy on the Management of External Agency Visits, Inspections and Accreditations - M43

16. Definitions

Refer to Trust Risk Management Policy and Procedure - Appendix 5.

17. Appendices

17.1. Appendix 1 - Trust Committee Governance Structure



17.2. Appendix 2; Terms of reference - Board Assurance Committees

17.2.1. Audit and Risk Committee (ARC)

Has been delegated authority by the Trust Board to carry out the following duties:

The Committee shall review the establishment and maintenance of an effective system of governance, Risk Management and internal control, across the whole of the organisation's activities (both clinical and non-clinical); including its subsidiaries, that supports the achievement of the organisation's objectives. In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of governance, Risk Management and internal control, together with indicators of their effectiveness. This will be evidenced through the committee's use of an effective workplan to guide its work and that of the audit and assurance functions that report to it. As part of its approach, the Committee will have effective relationships with other key committees (for example, the Safety and Quality Assurance Committee) so that it understands processes and linkages.

Governance

The Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (the Annual Governance Statement), together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Board.
- Statements within the quality account together with the external audit assurance.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.

Clinical Audit

Whilst the Committee is responsible for overseeing the effectiveness of internal control for the whole of the organisation's activities, in practice the detailed oversight of clinical activities is undertaken by the Safety and Quality Assurance Committee through the activity of Clinical Audit. The Safety and Quality Assurance Committee's

Terms of Reference includes:

- In conjunction with the Audit Committee, commission and direct a Clinical Audit Programme to provide assurance of clinical quality.
- Responsible for monitoring the assurance provided via the quarterly Clinical Audit and Effectiveness Report and the Annual Clinical Audit Forward Programme and Update.

In reviewing the work of the Safety & Quality Committee and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the Clinical Audit function. This will be achieved by:

- Receiving the Annual Work Programme of Clinical Audit, and at the end of the year a summary of the results from completing the work programme including the implementation status of recommendations made.
- Receiving throughout the year from the Safety & Quality Committee notification of any significant findings arising from Clinical Audit's work.

The Safety & Quality Committee will also seek the input of the Committee in commissioning the Clinical Audit Annual Work Programme and include within its' Annual Report a section on its' oversight of Clinical Audit providing assurance as to its' effectiveness.

Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review any follow-on actions required of the counter fraud work. This will be achieved by:

- Reviewing the systems, plans and actions taken to develop an anti-fraud culture.
- Reviewing the detailed Counter Fraud Plan.
- Consideration of reports produced by the counter fraud service.
- Ensuring that the counter fraud function has appropriate standing within the organisation.

External Audit

The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the committee will receive the work and findings of the External Auditor appointed by the Governors of the Trust and consider the implications of, and management's responses to, their work. This will be achieved by:

- Consideration of the appointment and performance of the External Auditor as far as the rules governing appointment permit.
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan and ensuring co-ordination, as appropriate, with other auditors in the local health economy.
- Discussion with the External Auditors of their evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
- Reviewing all external audit reports, including agreement of the Annual Audit Letter before submission to the Trust Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.
- Ensuring that there is a clear policy for the engagement of external auditors to supply non-audit services.

Financial Reporting

The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.
- Changes in, and compliance with, accounting policies and practices.
- Unadjusted misstatements in the financial statements.
- Significant judgements in the preparation of the financial statements.
- Significant adjustments resulting from the audit.
- Any Letter of Representation.
- Qualitative aspects of financial reporting.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

Other

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation and consider the implications to the governance of the organization. These will include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/inspectors (e.g. Care Quality Commission (CQC), NHS Resolution, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.). in addition, the Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Audit and Risk Committee's own scope of work. This will particularly include the Safety & Quality Committee, Resources and Business Development Committee, Workforce and Organisational Development Committee and Innovation Committee who will provide an annual report on their work.

Management

The Committee shall request and review reports and positive assurances from Directors and Managers on the overall arrangements for governance, Risk Management and internal control. They may also request specific reports from individual functions within the organisation as they may be appropriate to the overall arrangements. The Committee will receive assurance on compliance with Standing Financial Instructions.

Raising Concerns ('Whistleblowing')

The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties and ensure that any such concerns are investigated proportionally and independently.

17.2.2. Safety and Quality Assurance Committee (SQAC)

Has been delegated authority by the Trust Board to carry out the following duties:

- Ensure that the key risks to safety and quality are identified and monitored by the Committee via the Board Assurance Framework and underpinned by detailed assurance reports as appropriate.
- Assess the quality and equality impact of proposed service developments or service changes, including those arising from external strategic change programmes such as reconfiguration of clinical pathways, national initiatives such as Getting it Right First Time, and Sustainability and Transformation Partnership (STP) led changes in clinical services.
- On behalf of the Board, champion and oversee the Trust's Quality Assurance Round programme, ensuring that themes and risks are captured and actioned as appropriate.
- Ensure that robust quality governance structures, processes and controls are in place that reflect national guidance and best practice
- Oversee the production of the Annual Quality Account and review the final draft prior to submission to the Board for approval
- Ratify on behalf of the Board of Directors all Trust wide policies pertaining to safety and quality.
- Ensure that all areas addressed through the Committee contribute where appropriate to the Annual Governance Statement.

- Undertake an annual self-assessment of activities of the assurance committee as contained within the terms of reference.
- Provide input to the Audit Committee on matters within its terms of reference.
- Identify resource implications of introducing quality and safety initiatives and managing high risk clinical issues and take recommendations to the Board of Directors.
- Seek assurance on matters identified by the other Board assurance committees and remitted to SQAC as appropriate.

Safety

- Develop the Strategy for patient safety and ensure that the Trust has the right structure and environment to deliver it.
- Agree and monitor specific high-level safety KPI's to achieve the Trust's ambition of Zero Harm.
- Champion and drive the Trust's safety culture, by gathering information effectively, analysing it appropriately and taking actions to improve patient safety, to create the environment to continuously learn, learn the lessons from others and provide assurance to the Board.
- Monitor the management of high-profile inquests, complaints, incidents and legal cases and receive completed SUI/RCA reports and case reports.
- Maintain oversight of key issues e.g. sepsis, mortality as identified through incidents, reviews and other mechanisms.
- Ensure corporate and Divisional review of all confidential enquiries, national service frameworks and other national clinical guidance and that recommendations for action are considered and implemented as appropriate within the Trust.
- Ensure that the Trust works collaboratively with relevant external statutory bodies in line with national legislation, reviews any relevant reports and implements associated guidance in a timely manner.
- Undertake a review of progress of clinically related action plans as delegated by the Board.
- Monitor strategic safety risks on behalf of the Board.

Quality

- Oversee the development and implementation of the next phase of the Trust's Quality Strategy
- Monitor any current CQC action plan and obtain assurance evidence that all requirements have been fully met
- Oversee compliance with CQC Standards and other statutory and mandatory requirements and evidence-based guidance that pertain to the delivery of clinical services.
- Ensure the development and implementation of clinical outcome measures for all services and receive benchmarking data with peers where available.
- In conjunction with the Audit Committee, commission and direct a clinical audit programme to provide assurance of clinical quality
- Ensure the effectiveness of the organisational arrangements for measuring and acting on feedback from our patients and families and that the methodologies used are in line with best practice nationally and internationally.
- Oversee the development of effective working relationships with organisations that represent patients in order to maximize engagement opportunities.

- Receive and review evidence and assurance from appropriate internal sub-committees and working groups.
- Monitor strategic quality risks on behalf of the Trust Board.

17.2.3. People and Well-being Committee

Has been delegated authority by the Trust Board to carry out the following duties:

- To oversee the development and implementation of the Trust's People Plan, to assure the Trust Board that the Strategy is implemented effectively and supports the Trust's vision and values.
- To monitor strategic workforce risks and report these to the Trust Board via the Board Assurance Framework.
- To obtain assurance that the Equality, Diversity and Inclusion plans are being effectively implemented
- To monitor compliance against strategic Health & Safety requirements, to ensure that the Trust is meeting its statutory obligations in relation to Health & Safety, and that plans are effectively implemented
- To ensure mechanisms are in place to support the development of leadership capacity and capability within the Trust, including talent management.
- To ensure robust and proactive plans are in place to support the personal and professional development of all staff.
- To monitor the overall resilience of the organisation and staff and support the development of a positive and healthy culture through appropriate measurement of engagement and wellbeing.
- To ensure the optimum design and development of the workforce to ensure that the Trust has productive, engaged staff with the right skills, competencies and information to deliver outstanding care.
- To ratify new and existing HR/Health and Safety policies and procedures, based on changes to legislation/regulations or best practice following development at other committees (Policy Review Group/JCNC/LNC) and reflect the Trust's People and OD Strategy.
- To ensure effective arrangements to support partnership working with Trade Unions.
- To ensure that all legal and regulatory requirements relating to the workforce are met.
- To gain assurance that the Trust has an appropriate pay and reward system that is linked to the delivery of the Trust's strategic objectives and desired behaviours.
- To provide assurance to the Board that there are mechanisms in place to allow staff to raise concerns and that they are dealt with in line with policy and national guidance.
- To monitor education, training and learning activities to ensure it complies with required regulations i.e. Learning and Development Agreement, Education Outcomes Framework Deanery, GMC Standards, CQC, Health Education England. Receive regular reports from Education Governance Group.
- Ensure that the Trust is meeting its legal obligations in relation to equality and diversity. This will include overseeing the development of the workforce elements of the Equality Delivery Scheme (EDS), Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) action plans and ensure the effective implementation of the EDS by receiving regular reports against the action plans.
- Ensure robust and proactive plans are in place for supporting innovative approaches to diversity and inclusion, ensuring we support all staff from all backgrounds to have a positive experience working at Alder Hey.
- Obtain assurance that the organisational Values and Behaviours Framework continues to be embedded and championed across the Trust.

- Ensure that processes are in place to support the mental and physical health and wellbeing of Trust staff. Monitor and review the Trust's Occupational Health Service, receiving reports where required.
- Ensure delivery of an improved Strategy for internal communications, and monitor progress against this Strategy. To advise of any significant issues identified through internal communications.

Performance Indicators

To monitor progress on achieving workforce standards and targets. To ensure timely and appropriate information is provided to the Trust Board to fulfil governance and monitoring duties, including:

- Absence
- Management and Leadership Development
- PDR/appraisal
- Education, Learning and Development activity
- Occupational Health and wellbeing activity
- Equality, Diversity and Inclusion activity
- NHS staff survey/internal engagement measures

The Committee will also agree and monitor the work programmes of various sub-committees and working groups reporting to the Committee, ensuring that action plans complement each other. Where new groups are established this will mean confirming the terms of reference and action plans of the sub-groups.

17.2.4. Resource and Business Development Committee

Has been delegated authority by the Trust Board to carry out the following duties:

Finance & Performance

- To agree annually the top 5 risks to finance and performance for inclusion in the work plan
- To receive and consider the annual financial plan for revenue and capital and make recommendation to the Board.
- To advise the Board on all proposals for major Capital expenditure over £500,000 and to approve proposals under £500,000
- The Committee will review the Trust's performance against key financial and external targets, including performance ratings (e.g. NHS Improvement metrics).
- To monitor progress against CIP targets, working with the Clinical Quality Assurance Committee to ensure any risks to service quality are addressed
- Ensure appropriate contracting arrangements are in place and review overall performance against contract.
- To review PFI compliance and performance against the agreed metrics ensuring remedial actions are taken as appropriate.
- Advise the Board on best practice and policy in relation to performance and financial management, including latest NHS Improvement guidance.
- Examine specific areas of financial risk within the Board Assurance Framework and highlight these to the Board as appropriate.
- To review Productivity and Efficiency.
- To review the Trust's procurement policies and functions and ensure they are fully aligned with the savings plan.

Business Development

- To review the Trust's Operational Plan and to advise the Board in respect of that plan
- To advise the Board and maintain an oversight on all major investments and business developments
- To monitor performance of the business development plans
- To scan the environment and identify strategic business risks within the Operational Plan and report to the Board on the nature of those risks and their effective management
- To oversee delivery of the marketing Strategy, including brand management, market positioning, marketing activity, market research and competitor analysis.
- To advise and provide insight to the board on changing dynamics in the market and stakeholders

IM&T

- To have an oversight of the 'Digital Futures' Strategy
- To advise the Board of digital developments
- To seek assurance that Digital Transformation programmes are delivered in accordance with agreed milestones to have oversight on operational IT performance

To identify key risks within the Board Assurance Framework associated with the delivery of the 'Digital Futures' Strategy and ensure these are reported to the Board.

The Committee will ensure that the minutes of its meetings are formally recorded and submitted to the Board along with a Chair's report identifying key areas for the Board's attention highlighting any issues that require disclosure or require executive action.

The Resources and Business Development Committee has no established sub-committees, but it will receive information and assurances from the following:

- Marketing and Business Development Committee
- Procurement Advisory Group
- Capital Projects Group
- Care Delivery Board

The Committee will also receive regular reports on performance metrics which will include information compiled from Divisions

The Care Delivery Board shall operate to an agreed monthly business cycle to ensure oversight of the Trust's top five priorities: Safety, Access, Staff Partnerships, Research and Innovation.

Each meeting will begin with a brief update on key operational metrics and issues; the remainder of the business will by rotation focus on:

- Access to care and finance
- Safety of patient care
- People, and Research
- Risk management

Care Delivery Board key duties and responsibilities include, but not be limited to the following:

Oversee the delivery of high standards of care and performance

- To use the performance dashboard and corporate performance report to monitor performance against safety, responsiveness, effectiveness, caring, people, use of resources and Strategy.
- To agree clear plans and actions to support improvements in performance where recovery is required
- To monitor the delivery of the annual Operational Plan as submitted to NHSI/E.
- To produce and share ideas, plans and investment cases that will support the delivery of performance standards
- To ensure that operational delivery plans are sufficiently robust and integrated to meet performance standards.

Review investment cases

- To have delegated authority to approve or reject investment cases with a value of £0.1-£0.5m.
- To review investments greater than £0.5m and inform Resource & Business Development Committee as to whether the Board recommends approval.

Operational Risk Oversight

- Processes, structures and responsibilities for identifying and managing risks at all levels of the organisation from wards and departments to Board Committees.
- The continuing evolution of Risk Management processes across the Division's and Corporate Functions.
- Ensure that key risks to innovation are identified and monitored by the Committee via the Board Assurance Framework and underpinned by detailed assurance reports as appropriate.
- Discuss risks for escalation to / de-escalation from the Corporate Risk Register
- Update on corporate risks relevant to the Division or corporate Function
- Feedback from Integrated Governance Committee (IGC), Clinical Quality Assurance Committee (CQAC), Clinical Quality Steering Group (CQSG), Weekly Meeting of Harm (Whom) and any other meetings as appropriate
- Recognition and triangulation of themes/trends from incidents, claims, complaints and PALS
- Sharing of lessons learned from investigations, root cause analyses, inspections and compliance reports
- Compliance with CQUINs, NICE guidance, CAS Alerts, and other relevant quality related mandates
- Clinical Audit and Health & Safety related issues

Division governance leads will establish cross Division working practices that will provide an opportunity for detailed discussion of local risk related matters and challenges experienced in the implementation of the Risk Management Strategy & Policy framework, including responses to specific quality and risk related issues. This will ensure learning and good practice is shared widely and can be implemented Trust wide.

17.3. Appendix 3

RISK APPETITE FOR NHS ORGANISATIONS
A MATRIX TO SUPPORT BETTER RISK SENSITIVITY IN DECISION TAKING

TO USE THE MATRIX: IDENTIFY WITH A CIRCLE THE LEVEL YOU BELIEVE YOUR ORGANISATION HAS REACHED AND THEN DRAW AN ARROW TO THE RIGHT TO THE LEVEL YOU INTEND TO REACH IN THE NEXT 12 MONTHS. 0 - 5

Risk levels ▶ / Key elements ▼	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal (ALARP)** (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focused on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

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17.4. Appendix 4 - Risk Management Maturity Model: Assessment Criteria

High Level Characteristics >	1 - Risk naïve	2 - Risk aware	3 - Risk defined	4 - Risk managed	5 - Risk enabled
	The Trust has little or no awareness of the importance of risk management/ No formal approach developed for Risk Management as part of an integrated governance model.	*The Trust is aware of Risk Management responsibilities and needs to embed systems/ Scattered silo-based approach to risk management.*	*The Trust has considered Risk Management and put in place strategies which are communicated.*	*Board and all staff are aware of the importance of and how the Trust handles Risk Management/ Board and staff at all levels actively consider and manage risk in all areas of activity.*	*Risk appetite defined and used to drive Board agenda. / Risk Management fully embedded into day to day workings of the Trust. / Learning lessons and providing feedback key part of approach.*
	Reactive >> **Proactive**				
Specific Key Characteristics : Leadership & Management					
Appropriate Risk Management culture for an NHS Trust.	Focus is primarily on responding to crises at an operational level with little strategic oversight.	People tend to be risk averse. Risks are identified primarily at the operational and project level with no effective escalation to senior levels.	Risk Management is done proactively to anticipate risks and develop mitigation plans. Risk implications are considered in all major decisions.	Risks are always managed effectively and at the most appropriate level. People are encouraged to be innovative. The organisation fosters a culture of continuous learning.	Risk Management is effective at every level in the Trust and is integrated with related governance issues and other disciplines across the organisation.
A Risk Management Strategy and associated policies have been put in place across the Trust.	Central risk team establishes a minimum of mandated policies, but these are not communicated to staff.	Risk Management Strategy has been put in place, but there are no Risk Management guidelines at Business Unit (BU)/ programme level and below	Divisions, Service, programmes appoint a Risk Lead who facilitates the awareness of and compliance to the Risk Management Strategy at a local level	Local Risk Leads liaise with the central risk team to ensure that staff at all levels are aware of their roles and responsibilities. Compliance to the Strategy monitored by Care Delivery Board and Audit and Risk Committee	Risk Management Strategy has been approved and owned by the Board and is underpinned by detailed systems & process, guidelines, training and awareness initiatives.
Risk Management is clearly linked to business planning and performance management	Risk Management is not linked with, or forms part of the business planning and or performance management process.	Risks relating to the planning activity of the Board are identified as part of the annual development of the BAF. No linking of risk to business planning and performance at BU level.	Risk Management is an integral part of strategic and business planning at Board, corporate, Division and local level with risks identified as the planning process unfolds. No link to performance management.	Risks associated with the management of performance are reviewed and monitored by appropriate Board Committees, e.g. RABD, S , and WAD).	Risks on the Corporate Risk register are reviewed in total by THE Care Delivery Board and disseminated to the appropriate Board Assurance Committee

High Level Characteristics >	1 - Risk naïve	2 - Risk aware	3 - Risk defined	4 - Risk managed	5 - Risk enabled
	The Trust has little or no awareness of the importance of risk management/ No formal approach developed for Risk Management as part of an integrated governance model.	*The Trust is aware of Risk Management responsibilities and needs to embed systems/ Scattered silo-based approach to risk management.*	*The Trust has considered Risk Management and put in place strategies which are communicated.*	*Board and all staff are aware of the importance of and how the Trust handles Risk Management/ Board and staff at all levels actively consider and manage risk in all areas of activity.*	*Risk appetite defined and used to drive Board agenda. / Risk Management fully embedded into day to day workings of the Trust. / Learning lessons and providing feedback key part of approach.*
	Reactive	**>>**			**Proactive**
Arrangements have been established for overseeing all aspects of risk management.	There is no evident overseeing by the Board or Executives of the management of risk within the Trust.	There is a central risk team and an operational Risk Management committee, chaired by an Executive. There are local risk meetings at Division and service level that feed into the risk committee.	Audit and Risk Committee chaired by a non-Exec with supporting committees which provides assurance to the Board on the BAF, corporate risk register and embedding risk management.	The Audit Committee receives reports from IGC and challenges the overall systems and processes relating to Risk Management and the effectiveness thereof.	Clear reporting lines and responsibility for performance related risks across the various Board Committees.
An effective Board Assurance Framework (BAF) has been established.	There is a basic BAF but there are no structured systems in place to collate the Trusts corporate risks and link those to the risks on the BAF or to those at BU/programme level.	There is a corporate risk register (CRR) derived from escalated risks from each Divisions, Service, programme but it is not linked to the risks on the BAF.	The BAF is updated quarterly by the Board but does not drive its agenda or those of its Committees. Each risk on the BAF is linked to several risks on the CRR.	The BAF is reviewed at each Board meeting following review at Care Delivery Board and Audit Committee. It is utilised by the Board to aid its decision making.	The BAF is utilised by the Board in order to provide structure to Board and Committee meetings and provide clear challenge of issues and decisions.
Appropriate Risk Management training is provided at all levels of the Trust.	No formal Risk Management training takes place.	Central risk team attend relevant external training events. Risk features as part of mandatory training cycle	Risk Management awareness is included as part of the induction process. Awareness session is backed up material available on Trust Intranet.	Risk Management training sessions are held and promoted via Risk leads in each Divisions, Service, programme.	On-going Risk Management training is provided as appropriate for all staff (including the Board).
Specific Key Characteristics : Roles & Responsibilities					
Responsibility for Risk Management has been clearly defined at all levels of the Trust.	Risk Management is seen as being the sole responsibility of the central risk team/ risk manager.	Risk Leads established in each Division but with little support in terms of resource and commitment.	Responsibility for risk has been clearly defined within each Divisions, Service, and programme and has appropriate commitment and resources to back that up.	Responsibility for Risk Management is defined within job descriptions and forms part of each Divisions, Service, programme and individual performance assessment criteria.	Board level responsibility/ sponsorship for risk has been clearly defined. There are clear lines of accountability for risk throughout the Trust.

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	The Trust has little or no awareness of the importance of risk management/ No formal approach developed for Risk Management as part of an integrated governance model.	*The Trust is aware of Risk Management responsibilities and needs to embed systems/ Scattered silo-based approach to risk management.*	*The Trust has considered Risk Management and put in place strategies which are communicated.*	*Board and all staff are aware of the importance of and how the Trust handles Risk Management/ Board and staff at all levels actively consider and manage risk in all areas of activity.*	*Risk appetite defined and used to drive Board agenda. / Risk Management fully embedded into day to day workings of the Trust. / Learning lessons and providing feedback key part of approach.*
	Reactive	>>			**Proactive**
Employees are clear regarding their role in managing risk.	Employees do not see themselves as being accountable for managing risk. Roles and responsibilities are not documented, and are unclear	Roles and responsibilities established in Risk Management Strategy &Policy Framework but no guidelines at what that means to staff. Senior members of staff receive some basic briefing,	Responsibilities and accountabilities for managing risk are clear, well communicated, understood and followed.	Management of risk is embedded in managers/ senior clinical/ technical staff' behaviour and their accountabilities are an integral part of their job descriptions.	Management of risk is embedded in behaviour at all levels of the organisation. Every employee sees himself / herself as a risk manager.
Specific Key Characteristics : Systems & Processes					
Processes have been defined to systematically identify, record, assess and analyses risks on a continuous basis.	There are no formal Risk Management processes in place	A system of risk registers has been established and is managed by the central risk team and progress reported to an operational risk committee but not the Board.	Each Divisions, Service, programme has its own risk register which feeds into a corporate register maintained by the central risk team with reports provided to Care Delivery Board and Audit and Risk Committee	Effective escalation and de-escalation of risks to /from wards/ departments up to each Divisions, Service, programme Care Delivery Boar, Audit and Risk Committee and Board	The whole system of Risk Management is continuously monitored and reviewed by Executives, Audit and Risk Committee and the Board in order to learn and improve.
Risks are regularly reviewed by the Trust.	There is no effective review process in place	Risks are reviewed on an ad hoc basis in specific areas by the central risk team. No challenge to/ from the Executives or the Board.	Risk system set up to enable managers have access to or request updates on risks relating to their areas of responsibility.	Each Division, Service, programme has its own Risk/ Quality/ Governance meeting where risks are reported to and reviewed on a regular basis with exception reports going to Audit and Risk Committee Meetings should challenge progress and lessons learned as appropriate.	There is a thorough process of review embedded in the organisation. Trust Board and its assurance committees receive reports on specific risks and associated actions from Car Delivery Board and Audit and Risk Committee. Lessons learned features on every Board agenda.

High Level Characteristics >	1 - Risk naïve	2 - Risk aware	3 - Risk defined	4 - Risk managed	5 - Risk enabled
	The Trust has little or no awareness of the importance of risk management/ No formal approach developed for Risk Management as part of an integrated governance model.	*The Trust is aware of Risk Management responsibilities and needs to embed systems/ Scattered silo-based approach to risk management.*	*The Trust has considered Risk Management and put in place strategies which are communicated.*	*Board and all staff are aware of the importance of and how the Trust handles Risk Management/ Board and staff at all levels actively consider and manage risk in all areas of activity.*	*Risk appetite defined and used to drive Board agenda. / Risk Management fully embedded into day to day workings of the Trust. / Learning lessons and providing feedback key part of approach.*
	Reactive	>>>			**Proactive**
Effective aggregated analysis of risks	Risks, incidents, claims, complaints and PALS; reported separately without any triangulation across and between them.	Risks and incidents linked via RM system. Some annual aggregated analysis at corporate level but not within each Divisions, Service, programme.	Complaints and PALS link into risks and incidents via RM system/ inter team liaison.	Quarterly aggregate analysis at Divisions of risks, incidents, claims, complaint, PALS and associated lessons learned, presented at Divisions Risk/ Quality/ Governance meetings with reports to Board.	Aggregate analysis of risks, incidents, claims, complaints, PALS and associated lessons learned reported to Board.
Management report risks to Executives where responses have not managed the risks to a level acceptable to the Board.	No apparent/ regular reporting or review of high-level risks	High level risks reported to operational risk committee on basis of highest scores, but the Board not generally aware of those risks.	Unclear and informal escalation process from Ward to Board means that confusing/ incomplete information may reach the Board.	Streamlined process for reporting and escalation of risks from Ward/ department/ project to each Divisions, and then to Care Delivery Board, Audit and Risk Committee and Board.	Board members are continually updated on current state of corporate risks, BAF including any urgent ones being escalated, any requiring urgent action and any emerging risks which may cause significant problems.
All significant new projects are routinely assessed for risk.	Project teams do not consider risks to the project or the wider implications to the Trust.	Risks are assessed from project point of view but not for the wider impact on the Trust. No appreciation of project risks by Executives or Board.	Project teams assess risks from project and operational perspectives, reporting on progress to appropriate Project/ Programme Board but not into mainstream risk reporting cycle.	Effective escalation of risks from projects and work streams with Programme Board escalating their top programme risks to Integrated Governance Committee with most strategic ones being considered for the BAF.	Project risk assessments consider opportunities as well as conventional risks. Board Committees receive update on progress on the major programmes and challenge on their risks as appropriate.

Specific Key Characteristics : Monitoring and Feedback					
Measurement and monitoring	No measurement framework is in place to assess Risk Management practices.	Number of internal and external reviews provide a range of opinions but no one overall framework to evaluate progress	Risk Management Improvement Plan (RMIP) developed, updated and progress reported via Integrated Governance Committee with assurance report to Audit Committee.	RM Maturity Model developed to provide cross Trust measurement and monitoring of the effectiveness of the embedding of Risk Management in each Divisions, Service, and programme. Key Performance Indicators established for each Division/ programme on risk and governance matters.	Performance against indicators is measured and results are tracked over time. Action plans are developed to improve performance and action is taken as required. Performance indicators and benchmarks are refined and updated.
Managers provide assurance on the effectiveness of their risk management.	No but typically not asked for either.	Risk Manager reports to operational Risk Management committee on activity within the year.	Central risk team and Risk Leads take forward actions from the RMIP and provide feedback to Integrated Governance Committee with assurance reports to Board and Audit Committee.	Risk Leads report to their Divisions, Service, programme /Governance meeting on the effectiveness of the Risk Management processes within their Division, Service, programme	For all risks there is a clear reporting structure for responsible officers to assure Board via governance structures that risks are being managed as agreed.
Assurances are received regarding the effectiveness of the Trusts Risk Management system.	No effective assurance processes in place, nor are any sought from Executives or the Board.	Internal assurances on Risk Management process are received via the central risk team and operational Risk Management committee.	The Trust receives regular assurance both internally and externally regarding the effectiveness of its Risk Management system.	Action plans and feedback from internal and external reviews are formally documented and progress monitored.	The Trust has clear mechanisms in place to proactively seek assurance in respect of risk management. Assurances are identified, monitor and reviewed with feedback used to further enhance the arrangements in place. The Board would typically be challenging Executives as appropriate on all matters risk.

17.5. Appendix 5 – Equality Analysis

<table>
<tr><th colspan="3">2. Equality Analysis (EA) for Policies</th></tr>
<tr><td colspan="3">The Public Sector Equality Duty (section 149 of the Equality Act 2010) requires public authorities to have due regard for the for need to achieve the following objectives in carrying out their functions:
a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010.
b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
Please refer to guidance when completing this form</td></tr>
<tr><td>Policy Name</td><td colspan="2">Risk Management Strategy</td></tr>
<tr><td>Policy Overview</td><td colspan="2">This document sets out the Trusts strategic direction for Risk Management and the systems of internal control to achieve compliance</td></tr>
<tr><td>Relevant Changes
(if any)</td><td colspan="2">Document rewritten</td></tr>
<tr><td>Equality Relevance
Select LOW, MEDIUM or HIGH</td><td colspan="2">LOW</td></tr>
<tr><td>If the policy is LOW relevance, you MUST state the reasons here.</td><td colspan="2">The Strategy applies to all members of staff working in Alder Hey Children's NHS Foundation Trust including permanent, temporary, locums, voluntary, work experience and bank staff, including contractors and partners involved in Trust's business Having considered the equality implications of this Strategy, they are of low relevance.</td></tr>
<tr><td>Form completed on:</td><td colspan="2">Date: 14/04/2021</td></tr>
<tr><td>Form completed by:</td><td>Name: Cathy Umbers</td><td>Job Title: Associate Director of Nursing and Governance</td></tr>
</table>

Approval & Ratification of Equality Analysis		
Policy Author:	Name: Cathy Umbers	Job title: Associate Director of Nursing and Governance
Approval Committee:	Audit and Risk Committee	Date approved: 22/04/2021
Ratification Committee:	The Trust Board	Date ratified: 29/04/2021
Person to Review Equality Analysis:	Name: Cathy Umbers	Review Date: 29/04/2024
Comments:	Click here to enter text.	